

Γ

T

7

HUNT 3
Questionnaire 3
Breast cancer

┆

1

┆

Dear HUNT participant,

Thank you for participating in the first part of this health study. You have received this questionnaire because you answered Yes to the question about having or having had breast cancer. We hope that you will also answer this questionnaire. Please put an X in the box of your answer for each question using a blue or black ball point pen or marker.

CORRECT

INCORRECT

Return the questionnaire in the enclosed, stamped envelope.

Date of completion

| |
|--------------|
| ___/___200__ |
|--------------|

Put an X in the box to show to what extent you have had these symptoms or problems

THINK ABOUT THE PAST WEEK

| | Not at all | A little | Quite a bit | Very much |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Did you have a dry mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did food and drink taste different than usual? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Were your eyes painful, irritated or watery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you lost any hair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Answer this question only if you had any hair loss: Were you upset by the loss of your hair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Did you feel ill or unwell? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Did you have hot flushes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Did you have headaches? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you felt physically less attractive as a result of your disease or treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been feeling less feminine as a result of your disease or treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Did you find it difficult to look at yourself naked? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you been dissatisfied with your body? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Were you worried about your health in the future? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

THINK ABOUT THE PAST 4 WEEKS

| | Not at all | A little | Quite a bit | Very much |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 14. To what extent were you interested in sex? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. To what extent were you sexually active?(with or without intercourse) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Answer this question only if you have been sexually active: To what extent was sex enjoyable for you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

THINK ABOUT THE LAST WEEK

| | Not at all | A little | Quite a bit | Very much |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 17. Did you have any pain in the arm or shoulder on the operated side? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Did you have a swollen arm or hand on the operated side? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Was it difficult to raise your arm on the operated side or to move it sideways? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had any pain in the area of your affected breast? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Was the area of your affected breast swollen? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Was the area of your affected breast oversensitive? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you had skin problems on or in the area of your affected breast (e.g., itchy, dry, flaky)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

LIFE OUTLOOK

Put an X in the box of the answer that best represents your view

| | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 24. Having had cancer makes me feel unsure about my future. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. I worry about my future. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. I am afraid to die. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. I feel like time in my life is running out. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. I learned something about life because of having had cancer. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Having had cancer has made me realize that time is precious. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Having had cancer has strengthened my religious faith or my sense of spirituality. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Return the questionnaire in the enclosed, stamped envelope.

Thank you for your participation in HUNT 3.