CONFIDENTIAL

Haematological Malignancy Patient-Reported Outcome Measure
(HM-PRO)

Please read the introduction before starting to complete the questionnaire.

Introduction

This questionnaire seeks your views about how your disease condition and/or treatment is affecting your daily life.
PART A is related to different aspects of your daily activity and **PART B** is related to the symptoms you are experiencing due to your condition and/or treatment you are receiving.

PART A

If the area is not a problem for you in any way, please tick the box marked:

'NOT AT ALL'

If the area is affected by your haematological condition, please choose the extent to which it is affected by ticking one of the boxes marked:

'A LITTLE'; 'A LOT'

If any of the statements does not apply to you, please tick the box marked:

'NOT APPLICABLE'

PART B

If you do not experience this symptom, please tick the box marked:

'NOT AT ALL'

If the symptom is affecting you, please choose the severity of the symptom by ticking one of the boxes marked:

'MILD'; 'SEVERE'

There is no 'right' or 'wrong' answer. If you are unsure about how to answer a question, please give the best answer you can.

The information that you provide will remain strictly confidential.

Please fill in your details:

Patient ID: _____ *** Start Time:-** _____

Date of Birth: D D / M M / Y Y Y Y Today's date: D D / M M / Y Y Y Y

PART A

PLEASE TICK THE BOX WHICH BEST DESCRIBES HOW YOUR HAEMATOLOGICAL CONDITION AFFECTS YOU AND **HOW YOU FEEL ABOUT THESE THINGS TODAY**

		Not at all	A little	A lot	Not Applicable
A.	***The following statements describe your physical behaviour***				
1.	I have difficulty with walking……	☐	☐	☐	☐
2.	I have difficulty with self-care (e.g. dressing, bathing, etc.).	☐	☐	☐	☐
3.	I have difficulty with physical activity/sports……	☐	☐	☐	☐
4.	I have difficulty travelling (e.g. bus, train, flight and car)…..	☐	☐	☐	☐
5.	I have difficulty leaving the house……	☐	☐	☐	☐
6.	I have difficulty with work (or studies)……	☐	☐	☐	☐
7.	I have difficulty going on holidays……	☐	☐	☐	☐
B.	***The following statements describe your social well-being***				
1.	I have difficulty socialising……	☐	☐	☐	☐
2.	I am having difficulty with personal relationships……	☐	☐	☐	☐
3.	I have problems with my sex life……	☐	☐	☐	☐
C.	***The following statements describe your emotional behaviour***				
1.	I worry about being a burden to others……	☐	☐	☐	☐
2	I am concerned about people judging me……	☐	☐	☐	☐
3.	I worry about my appearance……	☐	☐	☐	☐
4.	I feel distressed ……	☐	☐	☐	☐
5.	I feel anxious……	☐	☐	☐	☐
6.	I worry about dying……	☐	☐	☐	☐
7.	I don't feel confident……	☐	☐	☐	☐
8.	I am worried about my future health……	☐	☐	☐	☐
9.	My sleeping pattern has changed……	☐	☐	☐	☐
10.	I have difficulty concentrating……	☐	☐	☐	☐
11.	I worry about treatment……	☐	☐	☐	☐

Have you read and responded to all the statements on this page? ☐

PLEASE TICK THE BOX WHICH BEST DESCRIBES HOW YOUR HAEMATOLOGICAL CONDITION AFFECTS YOU AND **HOW YOU FEEL ABOUT THESE THINGS TODAY**

	Not at all	A little	A lot	Not Applicable
D. *The following statements describe your eating and drinking*				
1. I have trouble with my appetite……	☐	☐	☐	☐
2. My eating habits have changed……	☐	☐	☐	☐
3. My drinking habits have changed……	☐	☐	☐	☐

Please comment below on any other area of your daily life which has been affected by your disease or the treatment.

Comments:

Have you read and responded to all the statements on this page? ☐

Please turn over to next page.

PART B

PLEASE TICK THE BOX WHICH BEST DESCRIBES THE SYMPTOMS YOU HAVE BEEN EXPERIENCING **OVER THE PAST THREE DAYS**

The following statements describe disease symptoms or treatment side effects.		Not at all	Mild	Severe
1.	I have/had fever.....	☐	☐	☐
2.	I have stomach ache.....	☐	☐	☐
3.	I have problems with my energy level.....	☐	☐	☐
4.	I have hair loss.....	☐	☐	☐
5.	I feel tired	☐	☐	☐
6.	I have back pain.....	☐	☐	☐
7.	I have problems with my sense of taste.....	☐	☐	☐
8.	I have difficulty breathing.....	☐	☐	☐
9.	I have skin problems (e.g. itching, bruises, rashes, etc.).....	☐	☐	☐
10.	I have headaches.....	☐	☐	☐
11.	I have constipation.....	☐	☐	☐
12.	I have lumps.....	☐	☐	☐
13.	I have body pain.....	☐	☐	☐
14.	I have infections (e.g. chest, lung, urinary, etc.).....	☐	☐	☐
15.	I have night sweats.....	☐	☐	☐
16.	I have diarrhoea.....	☐	☐	☐
17.	I have nausea.....	☐	☐	☐
18.	I have/had chest pain.....	☐	☐	☐

Please list below any other symptom that concerns you or any other comment you would like to make.

Have you read and responded to all the statements on this page? ☐

Thank you!

*** End Time: -** _____