

# IPSS Questionnaire

In the past month:	Not at all	Less than 1 in 5 Times	Less than Half the Time	About Half The Time	More than Half the Time	Almost Always
<b>1. Incomplete Emptying</b> How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5
<b>2. Frequency</b> How often have you had to urinate less than every two hours?	0	1	2	3	4	5
<b>3. Intermittency</b> How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
<b>4. Urgency</b> How often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>5. Weak Stream</b> How often have you had a weak urinary stream?	0	1	2	3	4	5
<b>6. Straining</b> How often have you had to strain to start urination?	0	1	2	3	4	5
	<b>None</b>	<b>1 Time</b>	<b>2 Times</b>	<b>3 Times</b>	<b>4 Times</b>	<b>5 Times</b>
<b>7. Nocturia</b> How many times did you typically get up at night to urinate?	0	1	2	3	4	5

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Overall IPSS score	Mild	Moderate	Severe
1+2+3+4+5+6+7	1-7	8-19	20-35

# ICIQ-SF Questionnaire

1. Please write in your date of birth: \_\_/\_\_/\_\_

2. Are you:

- ☐ Female
- ☐ Male

3. How often do you leak urine?

- ☐ Never (0)
- ☐ about once a week or less often (1)
- ☐ two or three times a week (2)
- ☐ about once a day (3)
- ☐ several times a day (4)
- ☐ all the time (5)

4. How much urine do you usually leak (whether you wear protection or not)?

- ☐ None (0)
- ☐ a small amount (2)
- ☐ a moderate amount (4)
- ☐ a large amount (6)

5. Overall, how much does leaking urine interfere with your everyday life?

- 0. not at all
- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10. a great deal

6. When does urine leak?

- ☐ never – urine does not leak
- ☐ leaks before you can get to the toilet
- ☐ leaks when you cough or sneeze
- ☐ leaks when you are asleep
- ☐ leaks when you are physically active/exercising
- ☐ leaks when you have finished urinating and are dressed
- ☐ leaks for no obvious reason
- ☐ leaks all the time

ICIQ-SF Objective	Mild	Moderate-Severe
3+4	1-3	4-10

# Gastrointestinal toxicity

## Diarrhoea

*Did you have diarrhoea?*

## Rectal Pain

*Did you have pain in the rectum?*

- ☐ Not at all (1)
- ☐ A little (2)
- ☐ Quite a bit (3)
- ☐ Very much (4)

## Tenesmus

*Did you have the feeling that you have to go to the bathroom without passing stools?*

## Faecal Urgency

*Did you have an imperative urge to go to the toilet?*

## Faecal Incontinence

*Did you accidentally lose stool?*

## Mucus discharge

*Have you had any mucus discharge from the rectum?*

## Blood in stools

*Have you noticed blood in your stool?*

- ☐ Never (1)
- ☐ Sometimes (2)
- ☐ Often (3)
- ☐ Always (4)

## **EORTC-C30 – Systemic symptoms**

### **Pain**

Have you had pain?

### **Fatigue**

Did you need to rest?

Have you felt weak?

Were you tired?

### **Insomnia**

Have you had trouble sleeping?

- ☐ Not at all (1)
- ☐ A little (2)
- ☐ Quite a bit (3)
- ☐ Very much (4)

# EORTC-C30 – Quality of Life

## Physical functioning

1. *Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?*
2. *Do you have any trouble taking a long walk?*
3. *Do you have any trouble taking a short walk outside of the house?*
4. *Do you need to stay in bed or a chair during the day?*
5. *Do you need help with eating, dressing, washing yourself or using the toilet?*
  - ☐ Not at all (1)
  - ☐ A little (2)
  - ☐ Quite a bit (3)
  - ☐ Very much (4)

## Role functioning

6. *Were you limited in doing either your work or other daily activities?*
7. *Were you limited in pursuing your hobbies or other leisure time activities?*
  - ☐ Not at all (1)
  - ☐ A little (2)
  - ☐ Quite a bit (3)
  - ☐ Very much (4)

## Emotional functioning

21. *Did you feel tense?*
22. *Did you worry*
23. *Did you feel irritable?*
24. *Did you feel depressed?*
  - ☐ Not at all (1)
  - ☐ A little (2)
  - ☐ Quite a bit (3)
  - ☐ Very much (4)

## Cognitive functioning

20. *Have you had difficulty in concentrating on things, like reading a newspaper or watching television?*
25. *Have you had difficulty remembering things?*
  - ☐ Not at all (1)
  - ☐ A little (2)
  - ☐ Quite a bit (3)
  - ☐ Very much (4)

## Social functioning

26. *Has your physical condition or medical treatment interfered with your family life?*
27. *Has your physical condition or medical treatment interfered with your social activities?*
  - ☐ Not at all (1)
  - ☐ A little (2)
  - ☐ Quite a bit (3)
  - ☐ Very much (4)

## EORTC-C30 – Quality of Life

### Global health/general QOL

29. *How would you rate your overall health during the past week?*

30. *How would you rate your overall quality of life during the past week?*

1. Very poor
- 2.
- 3.
- 4.
- 5.
- 6.
7. Excellent

Conversion to continuous score (0-100):

$$\text{RawScore} = (I_1 + I_2 + \dots + I_n) / n$$

I = item of the scale

n = number of items

### Functioning scales:

$$\text{Score} = (1 - (RS - 1) / r) \times 100$$

### Global Health/QOL

$$\text{Score} = ((RS - 1) / r) \times 100$$

r = the difference between the possible maximum and the minimum response to individual items (3 or 6)