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Quality of life and Health Economy Questionnaire

A. Demographic part

1. Gender: male female

2. Weight (in kg):

3. Height (in cm):

4. Age (in years):

5. Education: Primary school Secondary school University

6. Marital status: single married widow/widower living in shared household

7. Number of children: of which number of children with no income:

8. Smoking: smoker: average number of cigarettes per day:
nonsmoker

9. Alcohol: no yes beer (daily amount in liters)
wine (daily amount in liters)
spirits (daily amount in deciliters)

B. Clinical part

B1. Filled out by healthcare worker (physician)

1. Stage of cancer.
    FIGO stage: I (ovaries) II (+pelvis) III (peritoneum)
    Lymph nodes regionall with metastases yes no
    Metastasis yes no
        If yes (also number)
            lungs
            intrathoracic lymph nodes
            liver
            other (specify)

2. What treatment was applied?
    surgical yes no
        If yes, what type of intervention:
        surgery was without any residue? yes no

    chemotherapy yes no
        If yes, indicate original name and (approximate) cumulative dose/number of cycles

....
....
....
....
....
....

bevacizumab yes no

If yes, indicate the number of cycles
....
....
....

B2. Filled out by the patient

1. How long is it since the diagnosis of the disease?
   number of years
   number of months

2. How long before diagnosis did you experience symptoms of the disease?
   number of years
   number of months

4. Were you hospitalized because of the disease or attended a spa? – if yes, how many times in the last year?
   no
   yes number of hospitalizations in the last year
   yes number of spa visits in the last year

5. Due to this disease, how many times a year on average do you visit:
   oncologist number of visits
   pulmonologist number of visits
   general practitioner number of visits
   other physician number of visits

6. What medication and in what daily dosage is prescribed to you for this disease?
   Medication .... daily dose ....
   Medication .... daily dose ....
   Medication .... daily dose ....
   Medication .... daily dose ....

7. Do you take any other medications for this disease than the ones prescribed by your physician, e.g. medication that can be bought over the counter in pharmacies (other than homeopathic medicines)? If yes indicate the name of the medicine.

never rarely occasionally often always

8. Do you take homeopathic medicines for this disease? If yes, indicate the name of the medicine.

never rarely occasionally often always

9. Do you take any dietary supplements for this disease? If yes, indicate the name of the supplements.

never rarely occasionally often always

10. Do you take any medication from herbs or any teas for this disease? If yes, indicate the name.

never rarely occasionally often always

11. How would you rate how well are you informed about your disease

poor fair mediocre good excellent

12. From what sources did you gain most valuable knowledge about your disease?

Physician Nurse Family Acquaintances Internet

Magazines Disease patient group Other

13. How would you rate the care provided to you by the physician regarding this disease?

poor fair mediocre good excellent

14. How would you rate the care provided to you by the nurse regarding this disease?

poor fair mediocre good excellent

15. Which area of healthcare do you perceive as the most negative in connection to this disease? If yes, you can indicate multiple answers.

a) yes ☐ b) none ☐

a1) appointment scheduling system ☐
a2) attitude of the health care staff ☐
a3) financial burden ☐
a4) social care ☐
a5) rehabilitation care ☐
a6) psychological care ☐
a7) other area ☐ specify ....

16. How many years have you been treated for other diseases? You can indicate multiple answers.

Ischemic heart disease .... number of years ....
Arrhythmia .... number of years..............................
High blood pressure .... number of years..............................
Chronic bronchitis .... number of years..............................
Bronchial asthma .... number of years..............................
Diabetes .... number of years..............................
High blood lipids .... number of years..............................
Mental disease .... number of years..............................
Rheumatic disease (joints) .... number of years..............................
Low back pain .... number of years..............................
Osteoporosis .... number of years..............................
Heart attack .... number of years..............................
Stroke .... number of years..............................
Other .... number of years..............................
Other .... number of years..............................

C. Quality of life

A. Quality of life

1. How would you rate your current quality of life? (worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

2. How would you rate your quality of life at the time of diagnosis of your disease?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

3. How would you rate your quality of life at times you were without this disease?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

4. How would you rate your quality of life at times you felt absolutely healthy?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

B. Ability to work

5. How would you rate your current ability to work?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

6. How would you rate your ability to work at the time of diagnosis of your disease?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

7. How would you rate your ability to work at times you were without this disease?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

8. How would you rate your ability to work at times you felt absolutely healthy?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

C. Impact of the disease on quality of life of the patient and family

9. How would you rate the impact of treatment on your quality of life since diagnosis?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

10. How would you rate the impact of your disease on quality of life of your close relatives who you share a household with?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

D. Impact of religious beliefs on quality of life of the patient

11. How would you rate the impact of religious beliefs on your quality of life?
(worst- 0, best – 10)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

E. Personality type and expectations for the future

12. Personality type: pessimist more of a pessimist
both optimist and pessimist more of an optimist optimist

13. Expectations for the future:

Expectations	Very bad	Quite bad	Neutral	Quite good	Very good
Health					
Economic					
Work					
Family					
Total					

D. Social-economic part

1. Your social state:
   a) employed
   b) unemployed
   c) age pension
   d) health pension due to:
   basic disease (................................) other disease:
   e) partial health pension due to:
   basic disease (................................) other disease:

2. Number of days on sick leave due to basic disease during last 12 months:

3. Number of days on sick leave due to other diseases during last 12 months:

4. Did any change occur in your social life due to this disease?
   yes partially no
   If yes or partially yes, you can indicate more answers.
   If yes or partially, please describe the change:
   a, in family (worsening of relationships, divorce, etc.)
   b, in work (e.g. reassignment to a different position, loss of employment etc.)
   c, social life (e.g. loss of social status etc.)
   d, in interests (e.g. limited or lost interests/hobbies/)

5. Did any change occur in your social life due to other diseases?
   yes partially no
   If yes or partially, you can indicate more answers.
   If yes or partially, please indicate the disease and describe the change:
   a, in family (worsening of relationships, divorce, etc.): Disease ……………………….
   b, in work (e.g. reassignment to a different position, loss of employment etc.):
   Disease ………………………..
   c, social life (e.g. loss of social status etc.):
   Disease ………………….
   d, in interests (e.g. limited or lost interests/hobbies/):
   Disease………………….

6. Loss of monthly income due to this disease (a very important question for the evaluation of economic burden of the disease): You can indicate more answers.

a, for medications
b, for physician visit
c, for other examinations
d, for transportation
e, for lower wage
f, for financial “incentives” for the physician or nurse
d, for other expenses

7. Loss of monthly net income due to other diseases (a very important question for the evaluation of economic burden of diseases): You can indicate more answers.

a, for medications: disease …………………..
b, for physician visit: disease …………………..
c, for other examinations: disease …………………..
d, for transportation: disease …………………..
e, for lower wage: disease …………………..
f, for financial “incentives” for the physician or nurse: disease …………………..
d, for other expenses: disease …………………..

8. Your current monthly net income (pension) in euro (a very important question for the evaluation of economic burden of the disease):

9. How much money would you be willing to sacrifice monthly for a permanent cure of this disease considering your current financial situation?

F. Selected questions from EORTC QOL-OV28

In the last week:

1. Did you have abdominal pain?
   a. Not at all b. A little c. A lot d. A significant amount
2. Dis you have bloated feeling in your stomach?
   a. Not at all b. A little c. A lot d. A significant amount
3. Did you feel “full” fast during meals?
   a. Not at all b. A little c. A lot d. A significant amount
4. Did you lose your hair?
   a. Not at all b. A little c. A lot d. A significant amount
5. If yes – how much did the hair loss affect you?
   a. Not at all b. A little c. A lot d. A significant amount
6. Did you experience numbness of fingers on your hands and toes?
   a. Not at all b. A little c. A lot d. A significant amount
7. Did you feel weak?
   a. Not at all b. A little c. A lot d. A significant amount
8. Did you experience hot flashes/sweating?
   a. Not at all b. A little c. A lot d. A significant amount