# Has your prostate cancer progressed?

**Help your doctor evaluate your symptoms**

NAME

DATE

Please answer the following questions about your symptoms and bring a printout of the completed form to the next visit with your doctor. This data will only be used by your treating healthcare provider for your individual therapy and will not be shared with any third party.

## 1 MOBILITY

Rate your ability to move and walk *(choose 1 number)*

I have no problems walking

I am unable to walk

## 2 USUAL ACTIVITIES

Rate your ability to do your usual activities, eg, work, study, housework, family or leisure activities *(choose 1 number)*

I have no problems doing my usual activities

I am unable to do my usual activities

## 3 ANXIETY AND DEPRESSION

Rate how you are feeling emotionally *(choose 1 number)*

I am not anxious or depressed

I am extremely anxious or depressed

## 4 FATIGUE

Rate your level of fatigue *(choose 1 number)*

I feel no fatigue

I constantly feel fatigue

## 5 SLEEP

Rate your quality of sleep *(choose 1 number)*

Best quality sleep

No sleep at all

## 6 QUALITY OF LIFE

Rate how good or bad your overall quality of life has been in the last month *(choose 1 number)*

Best quality of life

Worst quality of life

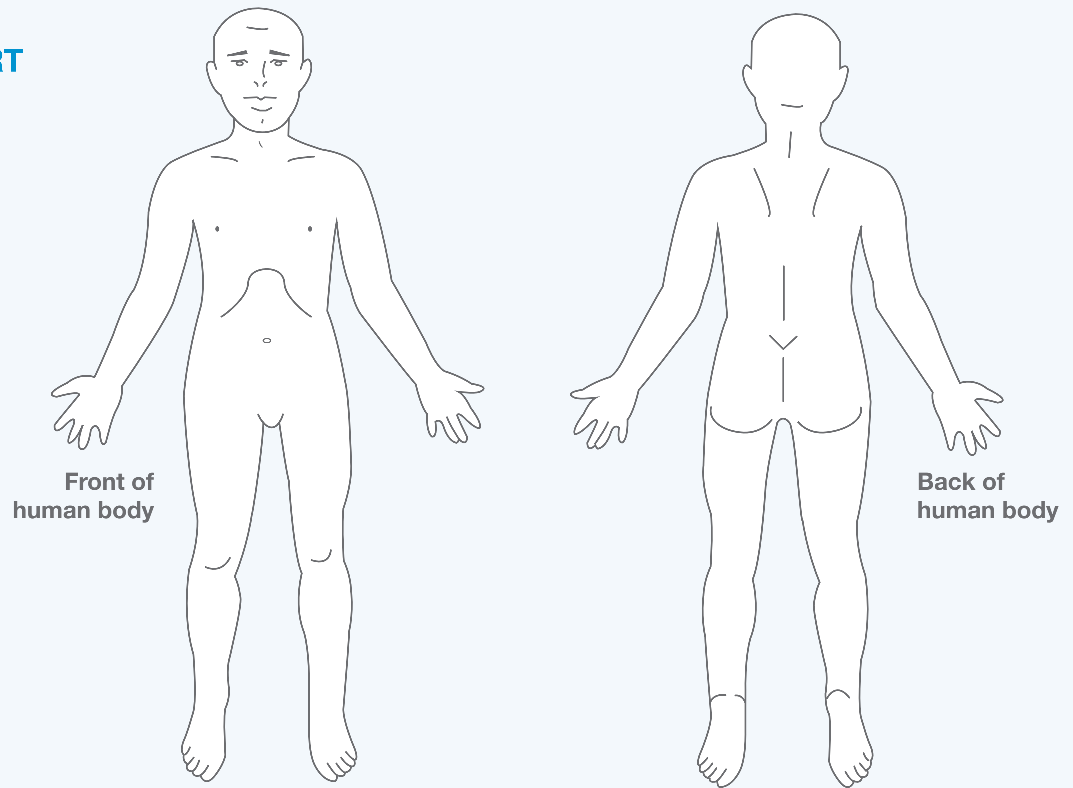
# 7 PAIN/ DISCOMFORT

Have you felt any pain/discomfort in your bones (eg, spine, back, shoulder, or hip) or joints since your last visit? *(choose 1 answer)*

If you answered YES, please answer questions 8-10.

# 8 LOCATION OF PAIN/DISCOMFORT

If you answered YES to question 7, select the area(s) of the body on the right to show where you have pain/discomfort.




# 9 LEVEL OF PAIN/ DISCOMFORT

If you chose area(s) of pain in question 8, how would you rate your highest level of pain? *(choose 1 number)*

No pain/discomfort

Pain/discomfort as bad as I can imagine

# 10 CURRENT MEDICATION/ TREATMENT FOR PAIN

**1. Do you take any medication to relieve your pain?**

**2. If you answered YES, are you taking:** *(choose as many as apply)*

a. Over the counter *(eg, aspirin, acetaminophen, ibuprofen). These OTC meds are known generally to treat mild (and at times) severe pain.*

Opioids *(eg, codeine, hydrocodone, oxycodone, morphine).*

**3. If you take medication, do you take it:**

a. Every few days  b. 1-2 times daily  c. Several times a day

**This checklist is not a validated scale. It is meant to provide suggested questions to patients that may help detect the onset or worsening of symptoms.**

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