Patient Self-Assessment Dysphagia (Head and Neck) I

Please fill out the following questionnaire.

This questionnaire asks about your health and quality of life **over the past 7 days**. Please answer all of the questions by checking one box for each symptom.

Please describe your symptom(s). Select one box for each category.

Pain ☐I have no pain (100) ☐There is mild pain not needing medication (75) ☐ I have moderate pain that requires regular medication (50) ☐ I have severe pain controlled only by prescription medication (25) ☐ I have severe pain, not controlled by medication (0)

Appearance: ☐There is no change in my appearance (100) ☐The change in my appearance is minor (75) ☐My appearance bothers me but I remain active (50) ☐ I feel significantly disfigured and limit my activities due to my appearance (25) ☐I cannot be with people due to my appearance

Activity: ☐ There is no change with my activity (100) ☐There are times when I can't keep up with my old pace, but not often (75) ☐I am often tired and have closed down my activities although I still get out (50) ☐I don't go out because I don't have the strength (25) ☐I am usually in bed or chair and don't leave home (0)

Recreation ☐ There are no limitations to recreation at home or away from home (100) ☐There are a few things I can't do but I still get out and enjoy life (75) ☐There are many times when I wish I could get out more, but I'm not up to it (50) ☐There are severe limitations to what I can do, mostly I stay at home and watch TV (25) ☐ I can't do anything enjoyable (0)

Swallowing ☐ I can swallow as well as ever (100) ☐I cannot swallow certain foods (70) ☐ I can only swallow liquid foods (30) ☐I cannot swallow because it "goes down the wrong way" and choked me (0)

Chewing ☐I can chew as well as ever (100) ☐I can eat solids but cannot chew some foods (50) ☐I cannot even chew soft foods (0)

Speech ☐My speech is the same as always (100) ☐I have difficulty saying some words but I can be understood over the phone (70) ☐Only my family and friends can understand me (30) ☐ I cannot be understood (0)

Shoulder
☐ I have no problem with my shoulder (100) ☐ My shoulder is stiff but it has not affected my activity or strength (70) ☐ Pain or weakness in my shoulder has caused me to change my work/hobbies (30) ☐ I cannot work or do my hobbies due to problems with my shoulder (0)

Taste
☐ I can taste food normally (100) ☐ I can taste most foods normally (70) ☐ I can taste some foods (30) ☐ I cannot taste my foods (0)

Saliva
☐ My saliva is of normal consistency (100) ☐ I have less saliva than normal, but it is enough (70) ☐ I have too little saliva (30) ☐ I have no saliva (0)

Mood
☐ My mood is excellent and unaffected by my career (100) ☐ My mood is generally good and only occasionally affected by my career (75) ☐ I am neither in a good mood nor depressed about my cancer (50) ☐ I am somewhat depressed about my cancer (25) ☐ I am extremely depressed about my cancer (0)

Anxiety
☐ I am not anxious about my cancer (100) ☐ I am a little anxious about my cancer (70) ☐ I am anxious about my cancer (30) ☐ I am very anxious about my cancer (0)

Health-Related Quality of Life a Month Prior to Your Diagnosis of Cancer
☐ Much better (100) ☐ somewhat better (75) ☐ about the same (50) ☐ somewhat worse (25) ☐ Much worse (0)

What issues have been most important to you <u>during the past 7 days</u>? Check up to 3 boxes.

☐ Pain ☐Appearance ☐Activity ☐Recreation ☐Swallowing ☐Chewing ☐Speech ☐Shoulder
☐Taste ☐Saliva ☐Mood ☐Anxiety

Compared to the month before you developed cancer, how would you rate your health-related quality of life?

☐ Outstanding (100) ☐ Very Good (80) ☐ Good (60) ☐ Fair (40) ☐ Poor (20) ☐ Very Poor (0)

Health-Related Quality of life during the past 7 days
☐ Outstanding (100) ☐ Very Good (80) ☐ Good (60) ☐ Fair (40) ☐ Poor (20) ☐ Very Poor (0)

Overall Quality of life during the past 7 days
☐ Outstanding (100) ☐ Very Good (80) ☐ Good (60) ☐ Fair (40) ☐ Poor (20) ☐ Very Poor (0)

Adapted from University of Washington, 1999. V.4.

Patient Self-Assessment Dysphagia (Head and Neck) II

Please read each statement and circle the response which best reflects your experience this past week.

1 = Strongly Agree 2 =Agree 3 = No Opinion 4 =Disagree 5 = Strongly Disagree

	Statement					
1.	My swallowing ability limits my day-to-day activities.	1	2	3	4	5
2.	I am embarrassed by my eating habits.	1	2	3	4	5
3.	People have difficulty cooking for me.	1	2	3	4	5
4.	Swallowing is more difficulty at the end of the day.	1	2	3	4	5
5.	I do not feel self-conscious when I eat.	1	2	3	4	5
6.	I am upset by my swallowing problem.	1	2	3	4	5
7.	Swallowing takes great effort.	1	2	3	4	5
8.	I do not go out because of my swallowing problem.	1	2	3	4	5
9.	My swallowing difficulty has caused me to lose income.	1	2	3	4	5
10.	It takes me longer to eat because of my swallowing problem.	1	2	3	4	5
11.	People ask me "Why can't you eat that?"	1	2	3	4	5
12.	Other people are irritated by my eating problem. 1	2	3	4	5	
13.	I cough when I try to drink liquids.	1	2	3	4	5
14.	My swallowing problems limit my social and personal life.	1	2	3	4	5
15.	I feel free to go out to eat with my friends, neighbors, and relatives.	1	2	3	4	5
16.	I limit my food intake because of my swallowing difficulty.	1	2	3	4	5
17.	I cannot maintain my weight because of my swallowing problem.	1	2	3	4	5
18.	I have low self-esteem because of my swallowing problem.	1	2	3	4	5
19.	I feel that I am swallowing a huge amount of food.	1	2	3	4	5
20.	I feel excluded because of my eating habits.	1	2	3	4	5

Adapted from MD Anderson Dysphagia Inventory (MDADI), Chen AY(1), Frankowski R, Bishop-Leone J, Hebert T, Leyk S, Lewin J, Goepfert H. Arch Otolaryngol Head Neck Surg. 2001 Jul;127(7):870-6