Date: _____ **Institution:** _____

Participant Initials: _____ **Hospital Chart #:** _____

Participant Number: _____

M. D. Anderson Symptom Inventory (MDASI – CLL)

Part I. How **severe** are your symptoms?

People with cancer frequently have symptoms that are caused by their disease or by their treatment. We ask you to rate how severe the following symptoms have been ***in the last 24 hours***. Please select a number from 0 (symptom has not been present) to 10 (the symptom was as bad as you can imagine it could be) for each item.

		Not Present										As Bad As You Can Imagine
		0	1	2	3	4	5	6	7	8	9	10
1.	Your **pain** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
2.	Your **fatigue (tiredness)** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
3.	Your **nausea** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
4.	Your **disturbed sle**ep at its WORST?	○	○	○	○	○	○	○	○	○	○	○
5.	Your feeling of being **distressed (upset)** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
6.	Your **shortness of breath** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
7.	Your problem with **remembering things** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
8.	Your problem with **lack of appetite** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
9.	Your feeling **drowsy (sleepy)** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
10.	Your having a **dry mouth** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
11.	Your feeling **sad** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
12.	Your **vomiting** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
13.	Your **numbness or tingling** at its WORST?	○	○	○	○	○	○	○	○	○	○	○

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		Not Present										As Bad As You Can Imagine
		0	1	2	3	4	5	6	7	8	9	10
14.	Your **night sweats** at their WORST?	○	○	○	○	○	○	○	○	○	○	○
15.	**Fevers and chills** at their WORST?	○	○	○	○	○	○	○	○	○	○	○
16.	**Lymph node swelling** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
17.	Your **diarrhea** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
18.	Your **bruising easily or bleeding** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
19.	Your **constipation** at its WORST?	○	○	○	○	○	○	○	○	○	○	○

Part II. How have your symptoms **interfered** with your life?

Symptoms frequently interfere with how we feel and function. How much have your symptoms interfered with the following items ***in the last 24 hours***? Please select a number from 0 (symptoms have not interfered) to 10 (symptoms interfered completely) for each item.

		Did Not Interfere										Interfered Completely
		0	1	2	3	4	5	6	7	8	9	10
20.	**General activity?**	○	○	○	○	○	○	○	○	○	○	○
21.	**Mood?**	○	○	○	○	○	○	○	○	○	○	○
22.	**Work (including work around the house)?**	○	○	○	○	○	○	○	○	○	○	○
23.	**Relations with other people?**	○	○	○	○	○	○	○	○	○	○	○
24.	**Walking?**	○	○	○	○	○	○	○	○	○	○	○
25.	**Enjoyment of life?**	○	○	○	○	○	○	○	○	○	○	○