Date: _____ **Institution:**_____

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

Participant Number: _____

MD Anderson Symptom Inventory (MDASI - CML)

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 0	1	2	3	4	5	6	7	8	9	As Bad As You Can Imagine 10
1. Your **pain** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
2. Your **fatigue (tiredness)** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
3. Your **nausea** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
4. Your **disturbed sleep** 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** 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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Participant Number: _____

	Not Present 0	1	2	3	4	5	6	7	8	9	As Bad As You Can Imagine 10
14. Your **diarrhea** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
15. Your **swelling of your hands, legs, feet, abdomen, or around your eyes** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
16. Your **rash or skin change** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
17. Your **muscle soreness or cramping** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
18. Your **bruising easily or bleeding** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
19. Your **feeling of malaise (not feeling well)** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
20. Your **headache** at its WORST?	○	○	○	○	○	○	○	○	○	○	○

Part II. How have your symptoms **interfered** with y[illegible]

Symptoms frequently interfere with how we f[illegible]nd [illegible]tion. How much have your symptoms interfered with the following items ***in the last 24 ho[illegible]***? Pleas[illegible]elect a number from 0 (symptoms have not interfered) to 10 (symptoms interfered completely) [illegible]**em.**

	Did [illegible]rfere 1	2	3	4	5	6	7	8	9	Interfered Completely 10
21. **General activity?**	○	○	○	○	○	○	○	○	○	○
22. **Mood?**	○	○	○	○	○	○	○	○	○	○
23. **Work (including work around the house)?**	○	○	○	○	○	○	○	○	○	○
24. **Relations with other people?**	○	○	○	○	○	○	○	○	○	○
25. **Walking?**	○	○	○	○	○	○	○	○	○	○
26. **Enjoyment of life?**	○	○	○	○	○	○	○	○	○	○

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