Date: ☐☐ / ☐☐ / ☐☐
(month) (day) (year)

Subject's Initials: _____

Study Subject # ☐☐☐☐

Study Name: _____

Protocol #: _____

PI: _____

Revision: 07/01/05

PLEASE USE BLACK INK PEN

MD Anderson Symptom Inventory - Head & Neck (MDASI-HN)

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 fill in the circle below 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 (s epy)** its WORST?	○	○	○	○	○	○	○	○	○	○	○
10. Your having a **dry mouth** at WORST?	○	○	○	○	○	○	○	○	○	○	○
11. Your feeling **sad** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
12. Your **vomiting** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
13. Your **numbness or tingling** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
14. Your problem with **mucus** in your mouth and throat at its WORST?	○	○	○	○	○	○	○	○	○	○	○
15. Your difficulty **swallowing/chewing** at its WORST?	○	○	○	○	○	○	○	○	○	○	○

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	NOT PRESENT 0	1	2	3	4	5	6	7	8	9	AS BAD AS YOU CAN IMAGINE 10
16. Your **choking/coughing** (food/ liquids going down the wrong pipe) at its WORST?	○	○	○	○	○	○	○	○	○	○	○
17. Your difficulty with **voice/speech** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
18. Your **skin pain/burning/rash** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
19. Your **constipation** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
20. Your problem with **tasting food** at its WORST?	○	○	○	○	○	○	○	○	○	○	○
21. Your **mouth/throat sores** at their WORST?	○	○	○	○	○	○	○	○	○	○	○
22. Your problem with your **teeth or gums** at its WORST?	○	○	○	○	○	○	○	○	○	○	○

Part II. How have your symptoms interfere[d] with your[life]?

Symptoms frequently interfere with how w[ell] [you] function. How much have your symptoms interfered with the following items in the last [24] hours:

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

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