

CHRONIC GVHD ACTIVITY ASSESSMENT-PATIENT SELF REPORT

Symptoms											
Please rate how severe the following symptoms have been in the <u>last seven days</u> . 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										As Bad As You Can Imagine
	0	1	2	3	4	5	6	7	8	9	10
Your skin itching at its WORST?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your mouth dryness at its WORST?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your mouth pain at its WORST?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your mouth sensitivity at its WORST?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eyes	What is your main complaint with regard to your eyes?										
	Please rate how severe is this eye symptom, between 0 (not at all severe) and 10 (most severe):										0 1 2 3 4 5 6 7 8 9 10
Vulvovaginal Symptoms (females only)	Do you have any burning, pain or discomfort in the area of your vagina, vulva or labia? OR Do you have any discomfort or pain with sexual intercourse?										<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable

Patient Global Ratings:

1. Overall, do you think that your chronic graft versus host disease is mild, moderate or severe?
 0= none
 1= mild
 2=moderate
 3=severe

2. Please circle the number indicating how severe your chronic graft versus host disease symptoms are, where 0 is cGVHD symptoms that are not at all severe and 10 is the most severe chronic GVHD symptoms possible.

0 1 2 3 4 5 6 7 8 9 10

cGVHD symptoms not at all severe Most severe cGVHD symptoms possible

3. Compared to a month ago, overall would you say that your cGVHD symptoms are:

+3= Very much better
 +2= Moderately better
 +1=A little better
 0= About the same
 -1=A little worse
 -2=Moderately worse
 -3=Very much worse

Attach copies of:

Adults (persons 18 years or older):
 -Lee cGVHD Symptom Scale
 -Human Activity Profile
 -SF-36 v.2
 -FACT-BMT

Children/Adolescents (persons 17 years or younger):
 -Lee cGVHD Symptom Scale (persons 8-12 years old may complete with help of the health care professional)
 -ASK - Activities Scale for Kids
 -CHRIS-Generic and Disease Specific Inventory