



## Symptom Assessment (Adult)

Patient ID \_\_\_\_ - \_\_\_\_ **ID** \_\_\_\_ - \_\_\_\_

Date of Evaluation: **DOEDATE**

Protocol timepoint (see codes): **TMPT**

**Instructions:** This questionnaire captures symptoms that can occur in persons with liver disease. For each of these you are asked whether you have the symptom and how much you are bothered by it. For each symptom, mark one box, depending on whether you are not bothered by it at all ("none at all") or either "a little bit", "moderately", "quite a bit", or "extremely" bothered by it. If you do not have the symptom, you should mark "none at all".

Form completed by (check all that apply):

- ☐ Patient **COMP**    ☐ Coordinator **COMC**    ☐ Interpreter **COMI**  
☐ Family member/friend **COMF**    ☐ Other **COMO**

**During the last month**, how much have you been bothered by the following:

		None at all	A little bit	Moderately	Quite a bit	Extremely	Unknown
Fatigue	<b>SAFAT</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain over liver	<b>SAPLIV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<b>SANAU</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<b>SAAPP</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<b>SAWGT</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<b>SAITCH</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<b>SAIRR</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/sadness	<b>SADEPR</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<b>SAJAU</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark urine	<b>SAURN</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***Thank you for completing this questionnaire!***