



Fatigue Questionnaire (Adult)

Patient ID ___ - ___ ID ___ - ___

Date of Evaluation: **DOEDATE**

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

Instructions: This questionnaire captures symptoms of fatigue and the experience and impact fatigue has on daily activities. For each statement or question, mark one box.

Form completed by (check all that apply):
 Patient **COMP** Coordinator **COMC** Interpreter **COMI**
 Family member/friend **COMF** Other **COMO**

In the past 7 days...

		Never	Rarely	Sometimes	Often	Always
1. How often did you feel tired?	FQTIRED	<input type="checkbox"/>				
2. How often did you experience extreme exhaustion?	FQEXHAU	<input type="checkbox"/>				
3. How often did you run out of energy?	FQENGY	<input type="checkbox"/>				
4. How often did your fatigue limit you at work (include work at home)?	FQWORK	<input type="checkbox"/>				
5. How often were you too tired to think clearly?	FQTHINK	<input type="checkbox"/>				
6. How often were you too tired to take a bath or shower?	FQBATH	<input type="checkbox"/>				
7. How often did you have enough energy to exercise strenuously?	FQEXER	<input type="checkbox"/>				

Thank you for completing this questionnaire!