

**Name**
**Patient ID**
**Date**

Please fill in the checklist and bring it to your next appointment.

 Health professional: refer to *Cancer Fatigue QRS Assessment Guide* on Peter Mac Intranet

		Yes	No	Add notes here
<b>SYMPTOMS</b>	Were you tired before your cancer diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>	
	Have you been feeling down recently?	<input type="checkbox"/>	<input type="checkbox"/>	
	Have you ever been diagnosed with depression? When?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you have trouble sleeping at night?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you sleep during the day?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you have sleep apnoea?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you have any pain?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you feel worried a lot of the time?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NUTRITION</b>	Have you lost more than 5 kg weight in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
	Are you overweight or underweight?	<input type="checkbox"/>	<input type="checkbox"/>	
	Are you eating enough to maintain your weight?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ACTIVITY</b>	Do you get out of breath easily, such as when sorting washing or talking?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you get out of breath having a shower?	<input type="checkbox"/>	<input type="checkbox"/>	
	Can you get up from the floor without puffing?	<input type="checkbox"/>	<input type="checkbox"/>	
	Are you fully active, able to do all your usual things without restriction?	<input type="checkbox"/>	<input type="checkbox"/>	
	Are you exercising as much as previously?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you walk at a moderate pace for 30 minutes each day?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>HEALTH</b>	Are you taking any medications that can cause drowsiness or fatigue? E.g. prescribed or recreational	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you take 10 or more medications a day?	<input type="checkbox"/>	<input type="checkbox"/>	
	Do you have any long term health problems?	<input type="checkbox"/>	<input type="checkbox"/>	

Long term health problems other than cancer			
Do you have or have you had...	Yes	No	Details (more space below)
<ul style="list-style-type: none"> <li>• A heart condition?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> <li>• Problems with hormone or thyroid levels?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> <li>• Any lung disease?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> <li>• Kidney or liver disease?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> <li>• Any condition that affects the way your body processes the foods you eat?               <ul style="list-style-type: none"> <li>○ <i>For example, food allergies or intolerance, diabetes, Crohn's disease, slow or fast metabolism.</i></li> </ul> </li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> <li>• A stroke, multiple sclerosis, Parkinson's Disease or rheumatoid arthritis?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> <li>• Any other condition that could cause tiredness?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	

### What next?

- Please discuss your health checklist with your health professional
- If you ticked 'yes' for any of the questions on this page, please visit your GP and check if any long term condition needs to be reviewed
- Please also let your cancer care team know