

EPIC

The Expanded Prostate Cancer Index Composite

This questionnaire is designed to measure Quality of Life issues in patients with Prostate cancer. To help us get the most accurate measurement, it is important that you answer all questions honestly and completely.

Remember, as with all medical records, information contained within this survey will remain strictly confidential.

Today's Date (please enter date when survey completed): Month _____ Day _____ Year _____

Name (optional): _____

Date of Birth (optional): Month _____ Day _____ Year _____

1. In general, would you say your health is:

- Excellent..... 1
- Very good..... 2
- Good..... 3 (Circle one number)
- Fair..... 4
- Poor.....5

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2. The following questions are about activities you might do during a typical day.
Does your health now limit you in these activities? If so, how much?

(Circle 1, 2, or 3 on each line)

	<u>Yes</u> Limited <u>A Lot</u>	<u>Yes,</u> Limited <u>A Little</u>	<u>No, Not</u> Limited <u>At All</u>	
a. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.....	1	2	3	12/
b. Climbing several flights of stairs.....	1	2	3	13/

3. During the **PAST 4 WEEKS**, have you had any of the following problems with your work or other regular daily activities as a result of your **PHYSICAL HEALTH?**

(Please answer YES or NO for each question by circling 1 or 2 on each line.)

	<u>Yes</u>	<u>No</u>	
a. Accomplished less than you would like	1	2	14/
b. Were limited in the kind of work or other activities	1	2	15/

4. During the **PAST 4 WEEKS**, have you had any of the following problems with your work or other regular daily activities as a result of any **EMOTIONAL PROBLEMS,** such as feeling depressed or anxious?

(Please answer YES or NO for each question by circling 1 or 2 on each line)

	<u>Yes</u>	<u>No</u>	
a. Accomplished less than you would like	1	2	16/
b. Didn't do work or other activities as carefully as usual	1	2	17/

5. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- Not at all 1
- Slightly 2
- Moderately 3 (Circle one number)
- Quite a bit 4
- Extremely 5

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6. These questions are about how you feel and how things have been with you during the PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

(Circle one number on each line)

	<u>All of the Time</u>	<u>Most of the Time</u>	<u>A Good Bit of the Time</u>	<u>Some of the Time</u>	<u>A Little of the Time</u>	<u>None of the Time</u>	
a. Have you felt calm and peaceful?.....	1	2	3	4	5	6	19/
b. Did you have a lot of energy?	1	2	3	4	5	6	20/
c. Have you felt downhearted and blue?	1	2	3	4	5	6	21/

7. During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time 1
- Most of the time.....2
- Some of the time.....3 (Circle one number)
- A little of the time..... 4
- None of the time.....5

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URINARY FUNCTION
This section is about your urinary habits. Please consider **ONLY THE LAST 4 WEEKS.**

8. Over the **past 4 weeks**, how often have you leaked urine?

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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9. Over the **past 4 weeks**, how often have you urinated blood?

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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10. Over the **past 4 weeks**, how often have you had pain or burning with urination?

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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11. Which of the following best describes your urinary control **during the last 4 weeks**?

- No urinary control whatsoever..... 1
- Frequent dribbling..... 2 (Circle one number)
- Occasional dribbling..... 3
- Total control..... 4

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12. How many pads or adult diapers per day did you usually use to control leakage **during the last 4 weeks?**

- None 0
- 1 pad per day..... 1
- 2 pads per day..... 2 (Circle one number)
- 3 or more pads per day..... 3

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13. How big a problem, if any, has each of the following been for you **during the last 4 weeks?**

(Circle one number on each line)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>	
a. Dripping or leaking urine	0	1	2	3	4	28/
b. Pain or burning on urination.....	0	1	2	3	4	29/
c. Bleeding with urination.....	0	1	2	3	4	30/
d. Weak urine stream or incomplete emptying.....	0	1	2	3	4	31/
e. Waking up to urinate.....	0	1	2	3	4	32/
f. Need to urinate frequently during the day	0	1	2	3	4	33/

14. Overall, how big a problem has your urinary function been for you **during the last 4 weeks?**

- No problem..... 1
- Very small problem..... 2
- Small problem..... 3 (Circle one number)
- Moderate problem..... 4
- Big problem..... 5

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Urinary Symptoms

(Circle one number on each line)

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
15. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?.....	0	1	2	3	4	5	35/
16. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?.....	0	1	2	3	4	5	36/
17. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?.....	0	1	2	3	4	5	37/
18. Urgency Over the past month, how often have you found it difficult to postpone urination?.....	0	1	2	3	4	5	38/
19. Weak Stream Over the past month, how often have you had a weak urinary stream?.....	0	1	2	3	4	5	39/
20. Straining Over the past month, how often have you had to push or strain to begin urination?.....	0	1	2	3	4	5	40/
21. Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	(none)	(1 x)	(2 x)	(3 x)	(4 x)	(5x or more)	
	0	1	2	3	4	5	41/

BOWEL HABITS

The next section is about your bowel habits and abdominal pain.
Please consider **ONLY THE LAST 4 WEEKS**.

22. How often have you had rectal urgency (felt like I had to pass stool, but did not) **during the last 4 weeks?**

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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23. How often have you had uncontrolled leakage of stool or feces?

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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24. How often have you had stools (bowel movements) that were loose or liquid (no form, watery, mushy) **during the last 4 weeks?**

- Never..... 1
- Rarely..... 2
- About half the time..... 3 (Circle one number)
- Usually..... 4
- Always..... 5

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25. How often have you had bloody stools **during the last 4 weeks?**

- Never..... 1
- Rarely..... 2
- About half the time..... 3 (Circle one number)
- Usually..... 4
- Always..... 5

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26. How often have your bowel movements been painful **during the last 4 weeks?**

- Never..... 1
- Rarely..... 2
- About half the time..... 3 (Circle one number)
- Usually..... 4
- Always.....5

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27. How many bowel movements have you had on a typical day **during the last 4 weeks?**

- Two or less..... 1
- Three to four.....2 (Circle one number)
- Five or more.....3

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28. How often have you had crampy pain in your abdomen, pelvis or rectum **during the last 4 weeks?**

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week.....4
- Rarely or never..... 5

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29. How big a problem, if any, has each of the following been for you? (Circle one number on each line)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>	
a. Urgency to have a bowel movement	0	1	2	3	4	49/
b. Increased frequency of bowel movements.....	0	1	2	3	4	50/
c. Watery bowel movements.....	0	1	2	3	4	51/
d. Losing control of your stools.....	0	1	2	3	4	52/
e. Bloody stools	0	1	2	3	4	53/
f. Abdominal/ Pelvic/Rectal pain...	0	1	2	3	4	54/

30. Overall, how big a problem have your bowel habits been for you **during the last 4 weeks?**

- No problem..... 1
- Very small problem..... 2
- Small problem..... 3 (Circle one number)
- Moderate problem..... 4
- Big problem..... 5

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SEXUAL FUNCTION

The next section is about your **current** sexual function and sexual satisfaction. Many of the questions are very personal, but they will help us understand the important issues that you face every day. Remember, THIS SURVEY INFORMATION IS COMPLETELY **CONFIDENTIAL**. Please answer honestly about **THE LAST 4 WEEKS ONLY**.

31. How would you rate each of the following during the last 4 weeks? (Circle one number on each line)

	Very Poor to <u>None</u>	<u>Poor</u>	<u>Fair</u>	<u>Good</u>	Very Good	
a. Your level of sexual desire?.....	1	2	3	4	5	56/
b. Your ability to have an erection?.....	1	2	3	4	5	57/
c. Your ability to reach orgasm (climax)?.....	1	2	3	4	5	58/

32. How would you describe the usual **QUALITY** of your erections **during the last 4 weeks?**

None at all.....	1					
Not firm enough for any sexual activity.....	2					
Firm enough for masturbation and foreplay only.....	3					(Circle one number) 59/
Firm enough for intercourse.....	4					

33. How would you describe the **FREQUENCY** of your erections **during the last 4 weeks?**

I NEVER had an erection when I wanted one.....	1					
I had an erection LESS THAN HALF the time I wanted one.....	2					
I had an erection ABOUT HALF the time I wanted one	3					(Circle one number) 60/
I had an erection MORE THAN HALF the time I wanted one.....	4					
I had an erection WHENEVER I wanted one.....	5					

34. How often have you awakened in the morning or night with an erection **during the last 4 weeks?**

Never	1					
Less than once a week.....	2					
About once a week.....	3					(Circle one number) 61/
Several times a week.....	4					
Daily.....	5					

35. **During the last 4 weeks**, how often did you have any sexual activity?

- Not at all..... 1
- Less than once a week..... 2
- About once a week..... 3 (Circle one number)
- Several times a week..... 4
- Daily..... 5

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36. **During the last 4 weeks**, how often did you have sexual intercourse?

- Not at all..... 1
- Less than once a week..... 2
- About once a week..... 3 (Circle one number)
- Several times a week..... 4
- Daily..... 5

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37. Overall, how would you rate your ability to function sexually **during the last 4 weeks**?

- Very poor..... 1
- Poor..... 2
- Fair..... 3 (Circle one number)
- Good..... 4
- Very good..... 5

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38. How big a problem **during the last 4 weeks**, if any, has each of the following been for you?

(Circle one number on each line)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>	
a. Your level of sexual desire.....	0	1	2	3	4	65/
b. Your ability to have an erection.	0	1	2	3	4	66/
c. Your ability to reach an orgasm.	0	1	2	3	4	67/

39. Overall, how big a problem has your sexual function or lack of sexual function been for you **during the last 4 weeks**?

- No problem..... 1
- Very small problem..... 2
- Small problem..... 3 (Circle one number)
- Moderate problem..... 4
- Big problem..... 5

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HORMONAL FUNCTION
The next section is about your hormonal function. Please consider **ONLY THE LAST 4 WEEKS**.

40. **Over the last 4 weeks**, how often have you experienced hot flashes?

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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41. How often have you had breast tenderness **during the last 4 weeks**?

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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42. **During the last 4 weeks**, how often have you felt depressed?

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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43. **During the last 4 weeks**, how often have you felt a lack of energy?

- More than once a day..... 1
- About once a day..... 2
- More than once a week..... 3 (Circle one number)
- About once a week..... 4
- Rarely or never..... 5

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44. How much change in your weight have you experienced **during the last 4 weeks**, if any?

- Gained 10 pounds or more..... 1
- Gained less than 10 pounds 2
- No change in weight..... 3 (Circle one number)
- Lost less than 10 pounds 4
- Lost 10 pounds or more..... 5

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45. How big a problem **during the last 4 weeks**, if any, has each of the following been for you?

(Circle one number on each line)

	<u>No Problem</u>	<u>Very Small Problem</u>	<u>Small Problem</u>	<u>Moderate Problem</u>	<u>Big Problem</u>	
a. Hot flashes.....	0	1	2	3	4	74/
b. Breast tenderness/enlargement..	0	1	2	3	4	75/
c. Loss of Body Hair.....	0	1	2	3	4	76/
d. Feeling depressed.....	0	1	2	3	4	77/
e. Lack of energy.....	0	1	2	3	4	78/
f. Change in body weight	0	1	2	3	4	79/

Overall Satisfaction

46. Overall, how satisfied are you with the treatment you received for your prostate cancer?

- Extremely dissatisfied..... 1
- Dissatisfied..... 2
- Uncertain..... 3 (Circle one number)
- Satisfied..... 4
- Extremely satisfied..... 5

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THANK YOU VERY MUCH!!