

## OMDQ: ORAL MUCOSITIS DAILY QUESTIONNAIRE

*To be administered at baseline and daily thereafter BEFORE all clinical oral mucositis assessments throughout the oral mucositis evaluation period for cycles 1 and 2.*

1. How would you rate your **OVERALL HEALTH** during the **PAST 24 HOURS**? Please circle the most appropriate number.

0	1	2	3	4	5	6	7	8	9	10
Worst possible										Perfect Health

2. During the **PAST 24 HOURS**, how much **MOUTH AND THROAT SORENESS** did you have? (*Circle one number*)

No soreness .....	0
A little soreness .....	1
Moderate soreness .....	2
Quite a lot of soreness .....	3
Extreme soreness .....	4

3. During the **PAST 24 HOURS**, how much did **MOUTH AND THROAT SORENESS** limit you in each of the following activities? (*Circle one number on each line*)

	Not Limited	Limited A Little	Limited Some	Limited A Lot	Unable To Do
a. Sleeping	0	1	2	3	4
b. Swallowing	0	1	2	3	4
c. Drinking	0	1	2	3	4
d. Eating	0	1	2	3	4
e. Talking	0	1	2	3	4

4. On a scale from 0 to 10, how would you rate your **OVERALL MOUTH AND THROAT SORENESS** during the PAST 24 HOURS?

Please circle the most appropriate number.

0      1      2      3      4      5      6      7      8      9      10

No  
Soreness

Worst  
Possible  
Soreness

**If you have had a colostomy, please skip to question 6**

- 5a. During the PAST 24 HOURS, how many **BOWEL MOVEMENTS** did you have?  
(Please enter the number in the box)

- 5b. If you had a bowel movement during the past 24 hours, how would you best describe your stools?

Normal	0
Hard or lumpy	1
Loose or watery	2
Bloody	3
Passing mucus (white material) during bowel movement	4

**If you have NOT had a colostomy, please stop here**

When your chemotherapy treatment begins, you will be asked to compare your ostomy output to what it was before your treatment began. Please try to compare the ostomy output you have during your treatment to the ostomy output you currently have prior to the start of your chemotherapy treatment.

6. Have you had an increase in ostomy output during the PAST 24 HOURS?

Yes                      No

*(Please circle yes or no)*

How would you rate your increase in ostomy output compared to before your chemotherapy began?

*(Please circle the most appropriate number)*

No increase	0
Mild increase	1
Moderate increase	2
Severe increase	3