

**MELODY**

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

**Patient Questionnaire (PRO)**

Dear Patient,

As a part of the MELODY study, we kindly ask you to answer several questions regarding your quality of life and any problems related to your breast surgery.

Please do not think in terms of "right" or "wrong" but indicate the answer that best applies to you. Please answer the questions without discussing with others and try not to leave any questions without answers since they are all equally important. The information that you provide will remain strictly confidential.

Please give this questionnaire back to your doctor or study nurse after the surgery.

Thank you for your participation!

**Date of surgery:**    \_ \_ / \_ \_ / \_ \_ \_ \_  
                                    DAY        MONTH        YEAR

**Was a wire, marker or ink placed in your breast to localize the tumor during surgery?**

**YES → think about the time after this procedure when answering questions 1-10**

**NO → think about the hours before your surgery when answering questions 1-10**

**1. How strong was the pain you experienced during activity, such as moving, walking, washing, coughing, breathing?**

Please answer by circling the number that best applies, "0" meaning no pain at all and "10" the strongest pain you can imagine.

**0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

**2. How strong was the strongest pain you experienced?**

**0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

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**3. How strong was the lightest pain you experienced?**

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Now we would like to ask you to answer the following questions regarding activities that were impaired due to pain, meaning that the activity was either not possible or possible only with great difficulty.**

4. Moving:             yes             no
5. Coughing:         yes             no
6. Deep breathing:  yes             no
7. Sleeping:          yes             no
8. Was your mood affected by the pain?     yes             no
9. Have you felt nausea?                     yes             no
10. Have you felt dizzy?                     yes             no

**The following questions are about your concerns regarding the anaesthetic and the surgery. All questions refer to the time before surgery.**

- |   | Not at all               |                          |                          | Extremely                |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|   | 1                        | 2                        | 3                        | 4                        | 5                        |
| 11. I was worried about the anaesthetic.                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. The anaesthetic was on my mind continually.                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. I wanted to know as much as possible about the anaesthetic. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. I was worried about the surgery.                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. The surgery was on my mind continually.                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. I wanted to know as much as possible about the surgery.     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Information for the Study Team:**

**Please transfer the above answers into the eCRF online.**