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Supplementary Materials 1. Questionnaire EORTC QLQ-C30 (version 3.0.) (English)

Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

1. Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?

Not at all	A little	Quite a bit	Very much

2. Do you have any trouble taking a long walk?

Not at all	A little	Quite a bit	Very much

3. Do you have any trouble taking a short walk outside of the house?

Not at all	A little	Quite a bit	Very much

4. Do you need to stay in bed or a chair during the day?

Not at all	A little	Quite a bit	Very much

5. Do you need help with eating, dressing, washing yourself or using the toilet?

Not at all	A little	Quite a bit	Very much

During the past week:

6. Were you limited in doing either your work or other daily activities?

Not at all	A little	Quite a bit	Very much

7. Were you limited in pursuing your hobbies or other leisure time activities?

Not at all	A little	Quite a bit	Very much

8. Were you short of breath?

Not at all	A little	Quite a bit	Very much

9. Have you had pain?

Not at all	A little	Quite a bit	Very much

10. Did you need to rest?

Not at all	A little	Quite a bit	Very much

11. Have you had trouble sleeping?

Not at all	A little	Quite a bit	Very much

12. Have you felt weak?

Not at all	A little	Quite a bit	Very much

13. Have you lacked appetite?

Not at all	A little	Quite a bit	Very much

14. Have you felt nauseated?

Not at all	A little	Quite a bit	Very much

15. Have you vomited?

Not at all	A little	Quite a bit	Very much

16. Have you been constipated?

Not at all	A little	Quite a bit	Very much

During the past week:

17. Have you had diarrhea?

Not at all	A little	Quite a bit	Very much

18. Were you tired?

Not at all	A little	Quite a bit	Very much

19. Did pain interfere with your daily activities?

Not at all	A little	Quite a bit	Very much

20. Have you had difficulty in concentrating on things, like reading a newspaper or watching television?

Not at all	A little	Quite a bit	Very much

21. Did you feel tense?

Not at all	A little	Quite a bit	Very much

22. Did you worry?

Not at all	A little	Quite a bit	Very much

23. Did you feel irritable?

Not at all	A little	Quite a bit	Very much

24. Did you feel depressed?

Not at all	A little	Quite a bit	Very much

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25. Have you had difficulty remembering things?

Not at all	A little	Quite a bit	Very much

26. Has your physical condition or medical treatment interfered with your family life?

Not at all	A little	Quite a bit	Very much

27. Has your physical condition or medical treatment interfered with your social activities?

Not at all	A little	Quite a bit	Very much

28. Has your physical condition or medical treatment caused you financial difficulties?

Not at all	A little	Quite a bit	Very much

For the following questions please circle the number between 1 and 7 that best applies to you

29. How would you rate your overall health during the past week?

1	2	3	4	5	6	7
Very poor						Excellent

30. How would you rate your overall quality of life during the past week?

1	2	3	4	5	6	7
Very poor						Excellent