Figure 3-1: Memorial Symptom Assessment Scale

Memorial Symptom Assessment Scale

Name: Date:

Section I:

Instructions: We have listed 24 symptoms below. Read each one carefully. If you have had the symptom during this past week, let us know how OFTEN you had it, how SEVERE it was usually and how much it DISTRESSED OR BOTHERED you by circling the appropriate number. If you DID NOT HAVE the symptom, mark an "X" in the box marked "DID NOT HAVE."

During the past week, did you have any of the following symptoms?	Did Not Have	If YES, How OFTEN did you have it?				If YES, How SEVERE was it usually?				If YES, How much did it DISTRESS or BOTHER you?				
		Rarely	Occasionally	Frequently	Almost Constantly	Slight	Moderate	Severe	Very Severe	Not At All	A Little Bit	Somewhat	Quite A Bit	Very Much
• Difficulty concentrating		1	2	3	4	1	2	3	4	0	1	2	3	4
• Pain		1	2	3	4	1	2	3	4	0	1	2	3	4
• Lack of energy		1	2	3	4	1	2	3	4	0	1	2	3	4
• Cough		1	2	3	4	1	2	3	4	0	1	2	3	4
• Feeling nervous		1	2	3	4	1	2	3	4	0	1	2	3	4
• Dry mouth		1	2	3	4	1	2	3	4	0	1	2	3	4
• Nausea		1	2	3	4	1	2	3	4	0	1	2	3	4
• Feeling drowsy		1	2	3	4	1	2	3	4	0	1	2	3	4
• Numbness/tingling in hands/feet		1	2	3	4	1	2	3	4	0	1	2	3	4
• Difficulty sleeping		1	2	3	4	1	2	3	4	0	1	2	3	4
• Feeling bloated		1	2	3	4	1	2	3	4	0	1	2	3	4
• Problems with urination		1	2	3	4	1	2	3	4	0	1	2	3	4
• Vomiting		1	2	3	4	1	2	3	4	0	1	2	3	4
• Shortness of breath		1	2	3	4	1	2	3	4	0	1	2	3	4
• Diarrhea		1	2	3	4	1	2	3	4	0	1	2	3	4
• Feeling sad		1	2	3	4	1	2	3	4	0	1	2	3	4
• Sweats		1	2	3	4	1	2	3	4	0	1	2	3	4
• Worrying		1	2	3	4	1	2	3	4	0	1	2	3	4
• Problems with sexual interest or activity		1	2	3	4	1	2	3	4	0	1	2	3	4
• Itching		1	2	3	4	1	2	3	4	0	1	2	3	4
• Lack of appetite		1	2	3	4	1	2	3	4	0	1	2	3	4
• Dizziness		1	2	3	4	1	2	3	4	0	1	2	3	4
• Difficulty swallowing		1	2	3	4	1	2	3	4	0	1	2	3	4
• Feeling irritable		1	2	3	4	1	2	3	4	0	1	2	3	4

Continue on next page.

Figure 3-1: Memorial Symptom Assessment Scale (continued)

Memorial Symptom Assessment Scale

Section 2:
Instructions: We have listed 8 symptoms below. Read each one carefully. If you have had the symptom during this past week, let us know how SEVERE it was usually and how much it DISTRESSED OR BOTHERED you by circling the appropriate number. If you DID NOT HAVE the symptom, mark an "X" in the box marked "DID NOT HAVE."

During the past week, did you have any of the following symptoms?	Did Not Have	If YES, How SEVERE did you have it?				If YES, How much did it DISTRESS or BOTHER you?				
		Slight	Moderate	Severe	Very Severe	Not At All	A Little Bit	Somewhat	Quite A Bit	Very Much
• Mouth sores		1	2	3	4	0	1	2	3	4
• Change in the way food tastes		1	2	3	4	0	1	2	3	4
• Weight loss		1	2	3	4	0	1	2	3	4
• Hair loss		1	2	3	4	0	1	2	3	4
• Constipation		1	2	3	4	0	1	2	3	4
• Swelling of arms or legs		1	2	3	4	0	1	2	3	4
• "I don't look like myself"		1	2	3	4	0	1	2	3	4
• Changes in skin		1	2	3	4	0	1	2	3	4

** If you had any other symptoms during the past week, please list below and indicate how much the symptom has distressed or bothered you.

Other:		0	1	2	3	4
Other:		0	1	2	3	4
Other:		0	1	2	3	4

Figure 3-1 revised version of the Memorial Symptom Assessment Scale. Copyright 1994, reprinted with permission from Elsevier Science Ltd, The Boulevard, Langford Lane, Kidlington OX5 1GB, UK.

Source: Portenoy RK, Thaler HT, Kornblith AB, et al. The Memorial Symptom Assessment Scale: an instrument for the evaluation of symptom prevalence, characteristics and distress. *Eur J Cancer* 30A:1326-36, 1994. Copyright 1994. Reproduced with permission of Elsevier Science Ltd.