EAPC ONLUS **BASIC DATASET**

	PATIENT FORM	
	What is your:	**Please fill in or tick the right box as appropriate.**
1	Date of birth	*(Day.Month.Year)*
2	Gender	☐ Male ☐ Female
3	Living situation	☐ Alone ☐ With spouse/partner ☐ With spouse / partner and children ☐ With children ☐ With other adult(s) ☐ In an institution ☐ Other
4	Highest completed level of education	☐ Primary school ☐ Secondary school / high school ☐ College/university
5	Ethnicity	

	Symptoms. Please circle the number that best describes how you feel NOW:											
6	No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Pain
7	No Tiredness *(Tiredness = lack of energy)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Tiredness
8	No Drowsiness *(Drowsiness = feeling sleepy*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Drowsiness
9	No Nausea	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Nausea
10	No Lack of of Appetite	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Lack of Appetite
11	No Shortness of Breath	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Shortness of Breath
12	No Depression *(Depression = feeling sad)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Depression
13	No Anxiety *(Anxiety = feeling nervous)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Anxiety
14	Best Wellbeing *(Wellbeing = how you feel overall)*	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Wellbeing
15	Best Sleep	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Sleep
16	No Constipation	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Constipation
17	No Vomiting	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Vomiting