

Identification (Name): _____

Date: _____

chronic GVHD Symptom Scale

By circling one (1) number per line, please indicate how much you have been bothered by the following problems in the past month:

SKIN:	Not at all	Slightly	Moderately	Quite a bit	Extremely
1. Abnormal skin color.....	0	1	2	3	4
2. Rashes.....	0	1	2	3	4
3. Thickened skin.....	0	1	2	3	4
4. Sores on skin.....	0	1	2	3	4
5. Itchy skin.....	0	1	2	3	4

EYES AND MOUTH:	Not at all	Slightly	Moderately	Quite a bit	Extremely
6. Dry eyes.....	0	1	2	3	4
7. Need to use eye drops frequently..	0	1	2	3	4
8. Difficulty seeing clearly.....	0	1	2	3	4
9. Need to avoid certain foods due to mouth pain.....	0	1	2	3	4
10. Ulcers in mouth.....	0	1	2	3	4
11. Receiving nutrition from an intravenous line or feeding tube....	0	1	2	3	4

BREATHING:	Not at all	Slightly	Moderately	Quite a bit	Extremely
12. Frequent cough.....	0	1	2	3	4
13. Colored sputum.....	0	1	2	3	4
14. Shortness of breath with exercise..	0	1	2	3	4
15. Shortness of breath at rest.....	0	1	2	3	4
16. Need to use oxygen.....	0	1	2	3	4

EATING AND DIGESTION:

	Not at all	Slightly	Moderately	Quite a bit	Extremely
17. Difficulty swallowing solid foods....	0	1	2	3	4
18. Difficulty swallowing liquids.....	0	1	2	3	4
19. Vomiting.....	0	1	2	3	4
20. Weight loss.....	0	1	2	3	4

MUSCLES AND JOINTS:

	Not at all	Slightly	Moderately	Quite a bit	Extremely
21. Joint and muscle aches.....	0	1	2	3	4
22. Limited joint movement.....	0	1	2	3	4
23. Muscle cramps.....	0	1	2	3	4
24. Weak muscles.....	0	1	2	3	4

ENERGY:

	Not at all	Slightly	Moderately	Quite a bit	Extremely
25. Loss of energy.....	0	1	2	3	4
26. Need to sleep more/take naps.....	0	1	2	3	4
27. Fevers.....	0	1	2	3	4

MENTAL AND EMOTIONAL:

	Not at all	Slightly	Moderately	Quite a bit	Extremely
28. Depression.....	0	1	2	3	4
29. Anxiety.....	0	1	2	3	4
30. Difficulty sleeping.....	0	1	2	3	4