Patient's Name _____ Date ___/___/___ ID # ____

MEMORIAL SYMPTOM ASSESSMENT SCALE – Short Form [MSAS-SF]

I. INSTRUCTIONS: Below is a list of symptoms. If you had the symptom DURING THE PAST WEEK, please check Yes. If you did have the symptom, please check the box that tells us how much the symptom DISTRESSED or BOTHERED you.

Check *all* the symptoms you have had during the PAST WEEK.	Yes [✓]	➔➔ IF YES: How much did it DISTRESS or BOTHER you? Not at All [0]	A little Bit [1]	Some-what [2]	Quite a Bit [3]	Very Much [4]
Difficulty concentrating						
Pain						
Lack of energy						
Cough						
Changes in skin						
Dry mouth						
Nausea						
Feeling drowsy						
Numbness/tingling in hands and feet						
Difficulty sleeping						
Feeling bloated						
Problems with urination						
Vomiting						
Shortness of breath						
Diarrhea						
Sweats						
Mouth sores						
Problems with sexual interest or activity						
Itching						
Lack of appetite						
Dizziness						
Difficulty swallowing						
Change in the way food tastes						
Weight loss						

Patient's Name _____ Date ___/___/___ ID # ____

MEMORIAL SYMPTOM ASSESSMENT SCALE – Short Form [MSAS-SF]

I. INSTRUCTIONS: Below is a list of symptoms. If you had the symptom DURING THE PAST WEEK, please check Yes. If you did have the symptom, please check the box that tells us how much the symptom DISTRESSED or BOTHERED you.

Check *all* the symptoms you have had during the PAST WEEK.	Yes [✓]	➔➔ IF YES: How much did it DISTRESS or BOTHER you? Not at All [0]	A little Bit [1]	Some-what [2]	Quite a Bit [3]	Very Much [4]
Hair loss						
Constipation						
Swelling of arms or legs						
"I don't look like myself"						
If you had any other symptoms during the PAST WEEK, please list them below, and indicate how much the symptom DISTRESSED or BOTHERED you. 1. _____						
2._____						

II. Below are other commonly listed symptoms. Please indicate if you have had the symptom DURING THE PAST WEEK, and if so, how OFTEN it occurred.

Check *all* the symptoms you have had during the PAST WEEK	Yes [✓]	➔➔ IF YES, How OFTEN did it occur? Rarely [1]	Occasionally [2]	Frequently [3]	Almost Constantly [4]
Feeling sad					
Worrying					
Feeling irritable					
Feeling nervous					