DIAGNOSTIC INTERVIEW FOR CANCER-RELATED FATIGUE
(1998 DRAFT-REVISED)

NOTE: Capitalized text represents instructions to the interviewer. Text in quotations represents statements to be read verbatim to the respondent.

1. “Over the past month, has there been at least a two-week period when you had significant fatigue, a lack of energy, or an increased need to rest every day or nearly every day?”  
   CIRCLE ONE: NO   YES

   **IF NO, STOP HERE. IF YES, CONTINUE.**

   “For each of the following questions, focus on the worst two weeks in the past month (or else the past two weeks if you felt equally fatigued for the entire month).”

2. “Did you feel weak all over or heavy all over? (every day or nearly every day?)”  
   CIRCLE ONE: NO   YES

3. “Did you have trouble concentrating or paying attention? (every day or nearly every day?)”  
   CIRCLE ONE: NO   YES

4. “What about losing your interest or desire to do the things you usually do? (every day or nearly every day?)”  
   CIRCLE ONE: NO   YES

5. “How were you sleeping? Did you have trouble falling asleep, staying asleep or waking too early? Or did you find yourself sleeping too much compared to what you usually sleep? (every night or nearly every night?)”  
   CIRCLE ONE: NO   YES

6. “Have you found that you usually don’t feel rested or refreshed after you have slept” (every day or nearly every day?)”  
   CIRCLE ONE: NO   YES

7. Did you have to struggle or push yourself to do anything? (every day or nearly every day?)”  
   CIRCLE ONE: NO   YES

8. “Did you find yourself feeling sad, frustrated, or irritable because you felt fatigued? (every day or nearly every day?)”  
   CIRCLE ONE: NO   YES

9. “Did you have difficulty finishing something you had started to do because of feeling fatigued? (every day or nearly every day?)”  
   CIRCLE ONE: NO   YES

10. “Did you have trouble remembering things? For example, did you have trouble remembering where your keys were or what someone had told you a little while ago? (every day or nearly every day?)”  
    CIRCLE ONE: NO   YES

11. “Did you find yourself feeling sick or unwell for several hours after you had done something that took some effort (every time or nearly every time?)”  
    CIRCLE ONE: NO   YES

   **IF LESS THAN SIX ITEMS INCLUDING #1 ARE MARKED YES, STOP HERE.**
12. “Has fatigue made it hard for you to do your work, take care of things at home, or get along with other people?”

CIRCLE ONE: NO YES

IF #12 IS NO, STOP HERE.

13. IS THERE EVIDENCE FROM THE HISTORY, PHYSICAL EXAMINATION, OR LABORATORY FINDINGS THAT THE SYMPTOMS ARE A CONSEQUENCE OF CANCER OR CANCER THERAPY?

CIRCLE ONE: NO YES

IF #13 IS NO, STOP HERE.

14. ARE THE SYMPTOMS PRIMARILY A CONSEQUENCE OF CO-MORBID PSYCHIATRIC DISORDERS SUCH AS MAJOR DEPRESSION, SOMATIZATION DISORDER, SOMATOFORM DISORDER, OR DELIRIUM?

CIRCLE ONE: NO YES

IF #14 IS YES, PATIENT DOES NOT MEET CRITERIA FOR CANCER-RELATED FATIGUE.

IF #14 IS NO, PATIENT DOES MEET CRITERIA FOR CANCER-RELATED FATIGUE.

15. DOES PATIENT MEET CRITERIA FOR CANCER-RELATED FATIGUE?

CIRCLE ONE: NO YES