Oral Addendum to EORTC-QLQ C30

During the past week:

	Not at all	A Little	Quite a bit	Very much
1. Have you had a painful throat?	1	2	3	4
2. Did you have pain in your face?	1	2	3	4
3. Did you have pain in your mouth?	1	2	3	4
4. Did you have any soreness or burning in the mouth?	1	2	3	4
5. Did you have any soreness or burning in the mouth while eating?	1	2	3	4
6. Did you have pain in your teeth?	1	2	3	4
7. Did you have pain in your teeth with hot or cold foods or drinks?	1	2	3	4
8. Did you have pain in your teeth with biting?	1	2	3	4
9. Did you have difficulty opening your jaw normally?	1	2	3	4
10. Did you have burning, shooting or short-lived pains in your mouth or face?	1	2	3	4
11. Did you have numbness in your face?	1	2	3	4
12. Did you have dryness in your mouth?	1	2	3	4
13. Did you have difficulty with chewing?	1	2	3	4
After completion of radiotherapy:				
14. Did you have increased tooth decay?	1	2	3	4
15. Did you have more difficulty with your dentures than before your cancer treatment?	1	2	3	4