

FR DA.Frankfurt

Familiäres Risiko für Darmkrebs

Questionnaire 4

(The following boxes were filled out at the trial coordination center)

Date	
Patient-ID	

Dear participant,

Thank-you very much for taking the time to answer the following questions. The questionnaire will only take a few minutes to fill in. Please observe the following instructions:

- Please clearly tick the appropriate box. If you make a mistake, cross out the corresponding box and tick the correct one.
- **Please answer every question.** If you are in any doubt, you should tick the box which is most appropriate.
- Your answers will of course be treated in **strict confidence**. Only pseudonymized data will be used in the analysis.

If you have any questions, please do not hesitate to contact us. You will find contact details below. **Thank-you!**

<p>1. Following the consultation with your family doctor, did you participate in bowel cancer screening by having an occult blood test?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p>2. Following the consultation with your family doctor, did you participate in bowel cancer screening by having a colonoscopy?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p>Please answer one of the following questions, depending on whether you participated in bowel cancer screening or not</p>	
<div style="text-align: center;">  <p>If you underwent bowel cancer screening</p>  </div> <p>3a. I regret having undergone bowel cancer screening.</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<div style="text-align: center;">  <p>If you did <u>not</u> undergo bowel cancer screening</p>  </div> <p>3b. I regret not having undergone bowel cancer screening.</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>

Questions about your thoughts and feelings

<p>4. Over the last two weeks, how often have you been bothered by any of the following problems?</p> <p><i>Please tick the appropriate answer with „✓“</i></p> <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Over the last two weeks</th> <th style="text-align: center; border-bottom: 1px solid black;">Not at all</th> <th style="text-align: center; border-bottom: 1px solid black;">Several days</th> <th style="text-align: center; border-bottom: 1px solid black;">More than half the days</th> <th style="text-align: center; border-bottom: 1px solid black;">Nearly every day</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;">1. Feeling nervous, anxious or on edge</td> <td style="text-align: center; border-bottom: 1px solid black;">0</td> <td style="text-align: center; border-bottom: 1px solid black;">1</td> <td style="text-align: center; border-bottom: 1px solid black;">2</td> <td style="text-align: center; border-bottom: 1px solid black;">3</td> </tr> <tr> <td style="border-bottom: 1px solid black;">2. Not being able to stop or control worrying</td> <td style="text-align: center; border-bottom: 1px solid black;">0</td> <td style="text-align: center; border-bottom: 1px solid black;">1</td> <td style="text-align: center; border-bottom: 1px solid black;">2</td> <td style="text-align: center; border-bottom: 1px solid black;">3</td> </tr> </tbody> </table>	Over the last two weeks	Not at all	Several days	More than half the days	Nearly every day	1. Feeling nervous, anxious or on edge	0	1	2	3	2. Not being able to stop or control worrying	0	1	2	3
Over the last two weeks	Not at all	Several days	More than half the days	Nearly every day											
1. Feeling nervous, anxious or on edge	0	1	2	3											
2. Not being able to stop or control worrying	0	1	2	3											

5. Over the last two weeks, how often have you been bothered by any of the following problems?

Please tick the appropriate answer with „✓“

Over the last two weeks	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Thank-you for your participation

Sources:

Frage 4: GAD-2: Kroenke K, Spitzer RL, Williams JBW. The PHQ-9. Validity of a brief depression severity measure. J Gen Intern Med 2001; 16: 606–613

Frage 5: PHQ-9:Kroenke K, Spitzer RL, Williams JBW, Monahan PO, Löwe B. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Ann Intern Med 2007; 146: 317-325