**Supplementary Materials.** Questionnaire on oral problems in oncology patients undergoing chemotherapy for solid tumors.

Patient ID (compiled by operators): ____________________

Compilation date (compiled by operators): ___ / ___ / ___

**Patient’s general and medical information**

Please select your gender  □ Male  □ Female  □ I prefer not to answer

Please report your date of birth: __________

Select your tumor diagnosis:

- □ Lung and pleura
- □ Gastrointestinal
- □ Pancreas and hepatobiliary
- □ Prostate
- □ Breast
- □ Ovarian
- □ Uterus
- □ Testis
- □ Kidney and urinary tract
- □ Melanoma
- □ Soft tissue
- □ Central nervous system
- □ Unknown origin

Select your tumor stage:

- □ Stage I
- □ Stage II
- □ Stage III
- □ Stage IV
To the best of your knowledge, has the tumour generated metastases (localisation of the tumour to other sites)?

☐ Yes
☐ No

Please report the name of the chemotherapy you are undergoing (this information can be found on the informed consent given by your oncologist):

__________________________________________________________________________________________
__________________________________________________________________________________________

This cycle of chemotherapy you are starting today is number ________________

**Self-reported oral problems**

After the last CT cycle have you ever had:

ORAL PAIN  Yes ☐ No ☐

If yes, please tick the maximum intensity of oral pain you experienced:

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (the worst pain you can imagine)

If yes, how many times have you felt oral pain from the last CT cycle?

☐ Always present
☐ 3 weeks
☐ 2 weeks
☐ 1 week
☐ Twice/month
☐ Once/month
☐ Rarely

ORAL MUCOSITIS (acute inflammation and/or ulceration of the oral mucosa)  ☐ Yes  ☐ No

If yes, please tick the maximum intensity of pain related to oral mucositis you experienced:

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (the worst pain you can imagine)

If yes, how many times have you felt pain related to oral mucositis from the last CT cycle?

☐ Always present
☐ 3 weeks
☐ 2 weeks
☐ 1 week
☐ Twice/month
☐ Once/month
☐ Rarely
SALIVARY GLAND HYPOFUNCTION (dry, doughy mouth)  ☐ Yes  ☐ No

If yes, please tick the maximum intensity of discomfort associated to dry/doughy mouth you experienced:
0 (no discomfort)  1  2  3  4  5  6  7  8  9  10 (the worst discomfort you can imagine)
If yes, how many times have you felt discomfort associated to dry/doughy mouth from the last CT cycle?
☐ Always present  ☐ 3 weeks  ☐ 2 weeks  ☐ 1 week  ☐ Twice/month  ☐ Once/month  ☐ Rarely

DYSPHAGIA (difficulty in swallowing)  ☐ Yes  ☐ No

If yes, please tick the maximum intensity of pain associated to dysphagia you experienced:
0 (no pain)  1  2  3  4  5  6  7  8  9  10 (the worst pain you can imagine)
If yes, how many times have you felt pain associated to dysphagia from the last CT cycle?
☐ Always present  ☐ 3 weeks  ☐ 2 weeks  ☐ 1 week  ☐ Twice/month  ☐ Once/month  ☐ Rarely

DYSPHONIA (voice alteration)  ☐ Yes  ☐ No

If yes, how many times have you felt a voice alteration from the last CT cycle?
☐ Always present  ☐ 3 weeks  ☐ 2 weeks  ☐ 1 week  ☐ Twice/month  ☐ Once/month  ☐ Rarely

LABIAL PAIN  ☐ Yes  ☐ No

If yes, please tick the maximum intensity of labial pain you experienced:
0 (no pain)  1  2  3  4  5  6  7  8  9  10 (the worst pain you can imagine)
If yes, how many times have you felt labial pain from the last CT cycle?
☐ Always present  ☐ 3 weeks  ☐ 2 weeks  ☐ 1 week  ☐ Twice/month  ☐ Once/month  ☐ Rarely
From the last CT cycle, have you ever felt a reduced sensitivity or a sense of anesthesia (like after dental procedures) in your lip and/or chin?  

Yes ☐  No ☐

If yes, the sensitivity was reduced (paresthesia) ☐ or completely absent (anesthesia)? ☐

If yes, was one side involved ☐ or both sides? ☐

If yes, please indicate with a cross the area or areas involved by this sensation in the figure below:

![Face Diagram]

How did you treat these oral problems?
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Who recommended you these treatments?

☐ Oncologist and Nurse staff  
☐ General Practitioner and/or dentist  
☐ Other healthcare figures  
☐ They are homemade treatment  
☐ Other, specify ____________________________

If they are homemade treatments, who recommended them to you?

☐ Myself  
☐ Pharmacist or herbalist  
☐ Relatives, friends, other patents  
☐ Other, specify ____________________________

Were you aware that oral problems could arise after chemotherapy?

Yes ☐  No ☐