



MPN Symptom Form

A measurement tool for symptoms of myeloproliferative neoplasms (MPNs)

Whether you've received this information from your doctor or obtained it directly, using it may help you discuss your symptoms with your doctor more easily. MPNs make up a group of diseases that includes myelofibrosis.

The enclosed MPN Symptom Form lists 10 symptoms:

- Early satiety
(early feeling of fullness after eating)
- Abdominal discomfort
- Inactivity
- Problems with concentration
(compared with concentration prior to my myeloproliferative disorder)
- Numbness/tingling (in hands/feet)
- Night sweats
- Itching (pruritus)
- Bone pain
(diffuse, not joint pain or arthritis)
- Fever (>100°F)
- Unintentional weight loss
in the last 6 months

Using this form can help you track your symptoms and monitor how they are affecting you over time, so you can discuss how you're feeling with your doctor.



Myeloproliferative Neoplasm Symptom Assessment Form

Total Symptom Score (MPN-SAF TSS)

Symptom	1 to 10 (0 if absent) ranking 1 is most favorable and 10 least favorable
Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your WORST level of fatigue during past 24 hours*	(No Fatigue) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)

Circle the one number that describes how, during the past week how much difficulty you have had with each of the following symptoms	
Filling up quickly when you eat (Early satiety)	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)
Abdominal discomfort	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)
Inactivity	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)
Problems with concentration – Compared to prior to my MPD	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)
Numbness/Tingling (in my hands and feet)	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)
Night sweats	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)
Itching (pruritus)	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)
Bone pain (diffuse not joint pain or arthritis)	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)
Fever (>100 F)	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Daily)
Unintentional weight loss last 6 months	(Absent) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)

* Question used with permission from the MD Anderson Cancer Center Brief Fatigue Inventory ©

About this form

The article describes the development and use of this form as published in the November 20, 2012 edition of the *Journal of Clinical Oncology*.



Additional Information

Fill out this form, thinking back on how you have felt during the past week.
Also answer the question below:

Check the one box that describes the worst level of interference you had with performing activities during the past week				
No interference with activities				Unable to perform activities at all
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

Notes

After filling out this form, share your responses with your doctor or other healthcare professional.