Body Image Questionnaire for Patients with

Gynecological and Breast Cancer

PART ONE

1) **How old are you?** .....
2) **Marital status:**

Single ☐ Married ☐ Widowed ☐ Divorced ☐

3) **Education level:**

Primary Middle school Secondary school University

4) **Profession :** ……

5) **Socioeconomic level:**

Low ☐ Medium ☐ High ☐

6) **Place of residence:**

Rural area ☐ Urban area ☐

7) **Family history of cancer :** ……
8) **Number of pregnancies:** .....
9) **Number of children :** ……

PART TWO

1) **You have been treated for:**

Breast cancer ☐ Cervical cancer ☐ Endometrial cancer ☐
Ovarian cancer ☐

Other ☐ **:** please specify .....

2) **How long has it been since you finished your treatment?** .....

3) **What type(s) of treatment did you receive?**

Neoadjuvant radiotherapy ☐

Neoadjuvant chemotherapy ☐

Primary surgery ☐ : Specify the surgical procedure and approach
.....

Adjuvant radiotherapy ☐

Adjuvant chemotherapy ☐

Closure surgery ☐

Hormone therapy ☐

Targeted therapy ☐

4) **Hospital were treated:** .....

PART THREE

1) **Are you worried about the physical changes that your illness or its treatment are causing?**

Not at all (0) A little (1) Moderately (2) Very much (3)

2) **Do you have difficulty accepting your physical appearance since your diagnosis or treatment?**

Not at all (0) A little (1) Moderately (2) Very much (3)

3) **Do you avoid looking at your body because of physical changes (scars, hair loss, etc.)?**

Never (0) Sometimes (1) Often (2) Always (3)

4) **Do you feel less attractive than before your diagnosis or treatment?**

Not at all (0) A little (1) Moderately (2) Very much (3)

5) **Do you think that your body is weaker or less capable than it was before?**

Not at all (0) A little (1) Moderately (2) Very much (3)

6) **Since your diagnosis, has your perception of your body evolved?**

Improved (0) Unchanged (1) Worsened(2)

7) **Do you find it difficult to show yourself in public because of your physical appearance?**

Never (0) Sometimes (1) Often (2) Always (3)

8) **Do you feel that others are looking at you or judging you more than before your diagnosis because of your appearance?**

Never (0) Sometimes (1) Often (2) Always (3)

9) **Does your body image affect your participation in social activities (meetings, outings, etc.)?**

Not at all (0) A little (1) Moderately (2) Very much (3)

10) **Have your physical changes affected your sexual desire?**

Not at all (0) A little (1) Moderately (2) Very much (3)

11) **Do you feel embarrassed by the physical changes (scars, stoma, hair loss) during intimate relationships?**

Never (0) Sometimes (1) Often (2) Always (3)

12) **Do you have difficulty feeling desirable for your partner?**

Not at all (0) A little (1) Moderately (2) Very much (3)

13) **Does your body image affect your satisfaction in your intimate relationships?**

Not at all (0) A little (1) Moderately (2) Very much (3)

14) **Does your body image affect your self-confidence?**

Not at all (0) A little (1) Moderately (2) Very much (3)

15) **Do you feel anxious or depressed because of the physical changes related to your illness or treatment?**

Never (0) Sometimes (1) Often (2) Always (3)

16) Do you feel that your quality of life has been affected by changes in your physical appearance?

Not at all (0) A little (1) Moderately (2) Very much (3)

17) Have you received any psychological or aesthetic support (medical makeup, prostheses, etc.) to help you accept the physical changes related to your illness or treatment?

Yes ☐ No ☐

If yes, did you find this support useful? Yes ☐ No ☐

18) Have you discussed your concerns about body image with your care team?

Yes ☐ No ☐

If not, why? (Lack of opportunity, embarrassment, etc.): ……..

19) What types of support would you like to receive to improve your body image? (Several possible answers)

Type of support desired	**Select**
Advice on medical makeup	☐
Advice on medical makeup	☐
Workshops on body image	☐
Support groups	☐
Other (please specify) ……	