MOUNT SINAI SCHOOL OF MEDICINE

The Lilian and Benjamin Hertzberg Palliative Care Institute
Brookdale Department of Geriatrics & Adult Development
One Gustave L. Levy Place – Box 1070
New York, NY 10029-6574
Phone (212) - 241-1446
Fax (212) 426-5054

OUTPATIENT PALLIATIVE CARE

Condensed Memorial Symptom Assessment Scale (CMSAS)

Patient Name: _____ Date: _____
Last First MI

Instructions: Below is a list of symptoms. **Please circle either Y or N** to indicate whether or not you have experienced the symptom during the last week. **If YES**, please circle the number that best describes how much this symptom has bothered or distressed you in the past 7 days.

Symptom	Present	If the symptom is present, please indicate how much the symptom bothered you.				
		Not at all = 0	A little bit = 1	Somewhat = 2	Quite a bit = 3	Very much = 4
Lack of energy	Y N	0	1	2	3	4
Lack of appetite	Y N	0	1	2	3	4
Pain	Y N	0	1	2	3	4
Dry Mouth	Y N	0	1	2	3	4
Weight Loss	Y N	0	1	2	3	4
Feeling Drowsy	Y N	0	1	2	3	4
Shortness of Breath	Y N	0	1	2	3	4
Constipation	Y N	0	1	2	3	4
Difficulty Sleeping	Y N	0	1	2	3	4
Difficulty Concentrating	Y N	0	1	2	3	4
Nausea	Y N	0	1	2	3	4

How frequently did the following symptoms occur?

Symptom	Present	Rarely = 1	Occasionally = 2	Frequently = 3	Almost Constantly = 4
Worrying	Y N	1	2	3	4
Feeling sad	Y N	1	2	3	4
Feeling nervous	Y N	1	2	3	4

PLEASE RETURN THIS FORM TO THE PALLIATIVE CARE TEAM