Name sticker

Pineal Cyst Questionnaire – AFTER OPERATION
at 12 months

The information that you provide will remain strictly confidential.

As compared to before the operation, overall, I am:

☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

Are you currently at work/school? ☐ yes ☐ no

Your weight …… kg

Medications you currently take

	Name	Started	Stopped
HRT			
Contraceptive pill			
Hormonal supplements			
Vitamins			
Painkillers			

Headache

Please tick the box that best describes this symptom after the operation when compared to how it was before the operation.

☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom ☐ I have never had this symptom

Vision

Please tick the box that best describes this symptom after the operation when compared to how it was before the operation.

☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom ☐ I have never had this symptom

Hearing

Please tick the box that best describes this symptom after the operation when compared to how it was before the operation.

☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom ☐ I have never had this symptom

Dizziness/balance problems

Please tick the box that best describes this symptom after the operation when compared to how it was before the operation.

☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom ☐ I have never had this symptom

Memory

Please tick the box that best describes this symptom after the operation when compared to how it was before the operation.

☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom ☐ I have never had this symptom

Speaking

Please tick the box that best describes this symptom after the operation when compared to how it was before the operation.

☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom ☐ I have never had this symptom

Concentration

Please tick the box that best describes this symptom after the operation when compared to how it was before the operation.

☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom ☐ I have never had this symptom

Sleep problems

Please tick the box that best describes this symptom after the operation when compared to how it was before the operation.

☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom ☐ I have never had this symptom

Other symptoms that I had before the operation

Please tick the box that best describes this symptom after the operation when compared to how it was before the operation. Please name the symptom and use one of the descriptions from below:

Symptom 1:
☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom

Symptom 2:
☐ better ☐ worse ☐ no different

☐ much better ☐ much worse

☐ I no longer have this symptom

Symptom 3:
☐ better ☐ worse ☐ no different
☐ much better ☐ much worse

☐ I no longer have this symptom

New symptoms that appeared after the operation
Please tick the box that best describes this symptom after the operation when compared to how it was before the operation.

☐ I have the following problems after the operation that I did not have before the operation

Problem/symptom	score: 1-10*

*Please indicate the degree of the symptom, i.e. score it based on how much of a problem it is to you. "1" – it is there, but it is hardly a problem; "10" – it has made my life unbearable

☐ I have no problems that I can relate to the operation