

Affix patient label within this box

**Edmonton Symptom Assessment System  
Revised Renal (ESAS-r: Renal)**

**Please circle the number that best describes  
how you feel NOW:**

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness <i>(Tiredness = lack of energy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness <i>(Drowsiness = feeling sleepy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression <i>(Depression = feeling sad)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety <i>(Anxiety = feeling nervous)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing <i>(Wellbeing = how you feel overall)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No Itching	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Itching
No Problem Sleeping	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Problem Sleeping
No Restless Legs	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Restless Legs
No _____	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____
Other Problem <i>(For example constipation)</i>												

Patient Name		Completed by <i>(check one)</i> <input type="checkbox"/> Patient <input type="checkbox"/> Family Caregiver <input type="checkbox"/> Health Care Professional Caregiver <input type="checkbox"/> Caregiver-assisted <b>Body Diagram on Reverse</b>
Date <i>(yyyy-Mon-dd)</i>	Time <i>(hh:mm)</i>	

Please mark on these pictures where it is that you hurt:

