QUALITY OF LIFE (Q1) - Day 0

Patient Study ID #: ☐☐☐—☐☐☐☐ Patient Initials: ☐☐☐

Date: ___ ___ / ___ ___ ___ / ___ ___ ___ ___

dd mmm yyyy

We are interested in some things about you and your health. Please answer all the questions yourself by checking the box that best applies to you **SINCE LAST VISIT**. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

	Yes	No
1. Can you do hard activities, like moving heavy furniture?	◯	◯
2. If you wanted to, could you run a short distance?	◯	◯
3. Do you have any trouble taking a long walk?	◯	◯
4. Do you have any trouble walking a short distance?	◯	◯
5. Are you in bed or a chair most of the day?	◯	◯
6. Do you have to stay indoors most of the day?	◯	◯
7. Do you need help with eating, dressing, washing yourself or using the toilet?	◯	◯
8. Are you limited in any way in doing your work or household jobs?	◯	◯
9. Are you completely unable to work at a job or do household jobs?	◯	◯

	Not at all	A little	Quite a bit	Very much
10. Were you short of breath?	◯	◯	◯	◯
11. Have you had pain?	◯	◯	◯	◯
12. Did you need to rest?	◯	◯	◯	◯
13. Have you felt ill?	◯	◯	◯	◯
14. Have you had trouble sleeping?	◯	◯	◯	◯
15. Have you felt weak?	◯	◯	◯	◯
16. Have you lacked appetite?	◯	◯	◯	◯
17. Have you felt nauseated?	◯	◯	◯	◯
18. Have you vomited?	◯	◯	◯	◯
19. Have you been constipated?	◯	◯	◯	◯
20. Have you had diarrhea?	◯	◯	◯	◯
21. Were you tired?	◯	◯	◯	◯

QUALITY OF LIFE (Q1) - Day 0

Patient Study ID #: ☐☐☐—☐☐☐☐ Patient Initials: ☐☐☐

	Not at all	A little	Quite a bit	Very much
22. Have you had difficulty in concentrating or remembering things?	◯	◯	◯	◯
23. Could you sit at ease and feel relaxed?	◯	◯	◯	◯
24. Have you lost interest in your appearance?	◯	◯	◯	◯
25. Have you felt restless as if you had to be on the move?	◯	◯	◯	◯
26. Did you look forward with enjoyment to things?	◯	◯	◯	◯
27. Did you get sudden feelings of panic?	◯	◯	◯	◯
28. Could you enjoy a good book or radio or television program?	◯	◯	◯	◯
29. Have you felt tense or "wound up"?	◯	◯	◯	◯
30. Could you laugh and see the funny side of things?	◯	◯	◯	◯
31. Were you physically well?	◯	◯	◯	◯
32. Has your condition interfered with your family or social life?	◯	◯	◯	◯
33. Has your medical treatment interfered with your family or social life?	◯	◯	◯	◯
34. Has your condition or treatment caused you financial difficulties?	◯	◯	◯	◯
35. Have you had a high temperature?	◯	◯	◯	◯
36. Have you had bouts of sweating?	◯	◯	◯	◯
37. Has your stomach felt bloated?	◯	◯	◯	◯
38. Have your arms or legs felt numb?	◯	◯	◯	◯
39. Have you had any difficulties moving your arms and legs?	◯	◯	◯	◯
40. Have you had pain when moving around?	◯	◯	◯	◯
41. Have you had pain when resting?	◯	◯	◯	◯
42. Have you taken any painkillers? ◯ 1) Yes ◯ 2) No				
If yes, did they help?	◯	◯	◯	◯
43. Have you noticed swelling on your body?	◯	◯	◯	◯
If not 1, where? _____				
44. Have you had any difficulties finding the right word?	◯	◯	◯	◯
45. Has your hearing been impaired?	◯	◯	◯	◯

For the following questions please check the number between 1 and 7 that best applies to you.

46. How would you rate your overall physical condition during the past week?

Very poor ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 Excellent

47. How would you rate your overall quality of life during the past week?

Very poor ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 Excellent

MOS Health Survey Day 0 (page 1 of 2)

Patient Study ID ☐☐☐-☐☐☐☐ Initials ☐☐☐

Date of Visit __ __/__ __ __/__ __ __ __ (dd/mmm/yyyy)

1. In general, would you say your health is: (check one)

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. In general, compared to one year ago, how would you rate your present health? (check one)

☐ Much better now than one year ago
☐ Some what better now than one year ago
☐ About the same as one year ago
☐ Somewhat worse than one year ago
☐ Much worse than one year ago

3. The following items are activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Check one box for each item)

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
a. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports.			
b. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.			
c. Lifting or carrying groceries			
d. Climbing **several** flights of stairs			
e. Climbing **one** flight of stairs			
f. Bending, kneeling, or stooping			
g. Walking **more than a mile**			
h. Walking **several blocks**			
i. Walking **one block**			
j. Bathing or dressing yourself			

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Check one box for each item.)

	Yes	No
a. Cut down on the *amount of time* you spent on work or other activities.		
b. *Accomplished less* than you like		
c. Were limited in the *kind* of work or other activities		
d. Had *difficulty* performing the work or other activities (for example, it took extra effort)		

MOS Health Survey Day 0 (Page 2 of 2)

Patient Study ID ☐☐☐-☐☐☐☐ Date of Visit __ __/__ __ __/__ __ __ __ (dd/mmm/yyyy)

5. During the past 4 weeks, had you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (Check one box for each item).

	Yes	No
a. Cut down the *amount of time* you spent on work or other activities.		
b. *Accomplished less* than you would like		
c. Didn't do work or other activities as *carefully* as usual		

6. How true or false is each of the following statements for you? (Check one box for each item.)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than people.					
b. I am as healthy as anybody I know.					
c. I expect my health to get worse.					
d. My health is excellent.					

7. These questions are about how things have been with you during the past 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks (Check one box for each item.)

	None of the Time	A Little of the Time	Some of the Time	A Good Bit of the Time	Most of the Time	All of the Time
a. Have you felt tense or high strung?						
b. Have you felt you had nothing to look forward to?						
c. Have you generally enjoyed the things you do?						
d. Have you been in low or very low spirits?						
e. Have you felt cheerful, lighthearted?						