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

QUALITY OF LIFE (Q1) - Month 4

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) - Month 4

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

QUALITY OF LIFE (Q1) - Month 12

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) - Month 12

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

QUALITY OF LIFE (Q1) - Month 24

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) - Month 24

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

QUALITY OF LIFE (Q1) - Month 36

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) - Month 36

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

QUALITY OF LIFE (Q1) - Month 48

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) - Month 48

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

QUALITY OF LIFE (Q1) - Month 60

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) - Month 60

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

QUALITY OF LIFE (Q1) - Month 72

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) - Month 72

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

QUALITY OF LIFE (Q1) - Month 84

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) - Month 84

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

QUALITY OF LIFE (Q1) - Month 96

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) - Month 96

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

QUALITY OF LIFE (Q1) - Month 108

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) - Month 108

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

QUALITY OF LIFE (Q1) - Month 120

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) - Month 120

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