MULTIDIMENSIONAL HEALTH STATUS ASSESSMENT

NIAID AIDS CLINICAL TRIALS GROUP

Patient Number [ ][ ] [ ][ ][ ][ ] [ ] Date of Patient Visit [ ][ ][ ] [ ][ ] [ ][ ][ ][ ]
mmm dd yyyy

Protocol Number [ ][ ][ ][ ][ ][ ] Institution Code [ ][ ][ ][ ][ ][ ]

Form Week [ ][ ][ ] Seq No. [ ] Step No. [ ] Key Operator Code [ ][ ][ ]

FOR OFFICE USE ONLY - TEAR OFF SHEET
MODULE B

INSTRUCTIONS TO THE STUDY NURSE:

The following should always be used in conjunction with MODULE A, OVERALL HEALTH STATUS ASSESSMENT. MODULE B asks the patient about many aspects of his/her health and health care. It should be given to the patient prior to the clinical exam and preferably in a quiet secluded area (e.g., exam room or other office). The patient must be able to read at the sixth-grade level at a minimum to complete the questionnaire without additional assistance.

It is important to be familiar with the content and format of the questionnaire before giving it to study participants. At the first visit, please begin by telling the participant:

> "We would like you to answer some questions about how you are feeling and the kinds of things you are able to do. Your answers will help us understand the effects of the medication you are taking. We appreciate your filling out this questionnaire."

You should then briefly go over the format of the questions and how to complete them. Have the participant complete the questionnaire before vital signs, history, and physical are completed.

The questionnaire is very brief and should take no more than 10 minutes to complete. Before giving the patient the questionnaire, please fill out the header(s) and DETACH THIS PAGE.

Each question is in the same general format and contains several items. Note that the patient is always asked to make a "✓" next to the appropriate category. All questions refer to the PAST 4 WEEKS.

Collect the completed questionnaire before the clinical exam. Before going on, review the questionnaire for omissions. If the participant missed any of the questions, point this out and have him/her complete the omissions.

PLEASE COMPLETE THE FOLLOWING ITEMS AFTER PATIENT COMPLETES THE QUESTIONNAIRE OR AFTER YOU ASCERTAIN THAT THIS IS NOT POSSIBLE:

1. How was the questionnaire completed? .....1-Self administered by the study participant
   2-Face-to-face interview that you conducted
   3-Phone interview
   4-Not completed
   9-Other, specify [ ]

   If Other, specify [30]: _____

   a. If you answered "4-Not completed," please indicate the reason why :
      1-Patient refused initially
      2-Patient missed clinic visit
      3-There was not enough time
      9-Other reason, specify [ ]

      If Other, specify [30]: _____

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Patient Number | | | | | | | | Date of Patient Visit | | | | | | | (mmm dd yy)

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INSTRUCTIONS: Please answer the following questions by placing a "✓" in the appropriate box.

1. During the past 4 weeks, has your health kept you from working at a job, doing work around the house, or going to school?

(Check one)

- Yes, for all of the time ..... 1 ☐
- Yes, for some of the time ..... 2 ☐
- No ..... 3 ☐

2. During the past 4 weeks, how much bodily pain have you had?

(Check one)

- None ..... 1 ☐
- Very Mild ..... 2 ☐
- Mild ..... 3 ☐
- Moderate ..... 4 ☐
- Severe ..... 5 ☐
- Very severe ..... 6 ☐

3. During the past 4 weeks, how much has your physical health or emotional problems interfered with your normal social activities?

(Check one)

- Not at all ..... 1 ☐
- A little bit ..... 2 ☐
- Moderately ..... 3 ☐
- Quite a bit ..... 4 ☐
- Extremely..... 5 ☐

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mmm dd yyyy

4. During the past 4 weeks, have you been unable to do certain kinds or amounts of work, housework, or schoolwork because of your health?

(Check one)

Yes, for all of the time ..... 1 ☐
Yes, for some of the time ..... 2 ☐
No ..... 3 ☐

5. During the past 4 weeks, how much did pain interfere with your normal work (including housework)?

(Check one)

Not at all ..... 1 ☐
A little bit ..... 2 ☐
Moderately ..... 3 ☐
Quite a bit ..... 4 ☐
Extremely..... 5 ☐

6. How much, if at all, does your health now limit you in the following activities?

Please check one box for each question.	**YES Limited A Lot**	**YES Limited A Little**	**NO Not Limited At All**
a. The kind or amounts of vigorous activities you can do, like lifting heavy objects, running or participating in strenuous sports.	☐ 1	☐ 2	☐ 3
b. The kind or amounts of moderate activities you can do, like moving a table or carrying groceries.	☐ 1	☐ 2	☐ 3
c. Walking uphill or climbing a few flights of stairs.	☐ 1	☐ 2	☐ 3
d. Eating, dressing, bathing, or using the toilet.	☐ 1	☐ 2	☐ 3

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7. For **each** of the following questions, please check the box for the **one** answer that comes **closest** to the way you have been feeling **during the past 4 weeks**.
How much of the time during the past 4 weeks...

Please check one box for each question.	**All of the Time**	**Most of the Time**	**A Good Bit of Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
a. Has your health limited your social activities, like visiting with family and friends?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b. Did you have trouble keeping your attention on any activity for long?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c. Did you have difficulty reasoning and solving problems?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d. Have you felt calm and peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e. Have you felt down-hearted and blue?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f. Did you feel tired?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g. Did you have enough energy to do the things you wanted to do?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h. Have you been a happy person?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
I. Have trouble remembering things?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

8. Please check the box that best describes whether each of the following statements is true or false for you.

Please check one box for each question.	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
a. My health is excellent.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. I have been feeling bad lately.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Language: English ☐ E

Date Form Keyed: (DO NOT KEY)___/___/___