QUALITY OF LIFE ASSESSMENT - REVISED

(For Ages 6 Months - 4 Years) QL4003(000)/00-00-00

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 ☐☐☐

* Enter a "1" if this is the first of this form for this date. Designate subsequent forms on same date with a 2, 3, etc.
**Enter the subject's current study step number. Enter '1' if the study does not have multiple steps.

INSTRUCTIONS TO THE STUDY COORDINATOR:

- The following questionnaire should be given to the parent/guardian prior to the clinical exam and preferably in a quiet secluded area (i.e., exam room or other office). The parent/guardian must be able to read at the sixth-grade level at a minimum to complete the form herself/himself. If not, the Study Nurse should complete the form with the individual, using the QUALITY OF LIFE SCALES provided in the CRF Notebook. This questionnaire should only be given to parent/guardian whose children are between 6 months and 4 years of age.
- **Pages 1 - 2 of this clinic form must be completed by the Study Nurse.** DO NOT SHOW PAGES 1 - 2 OF THIS FORM TO THE PATIENT. Pages 3 - 8 are completed by the parent/guardian. Before giving the questionnaire to the parent/guardian, please fill out the header(s) and DETACH PAGES 1 - 2.
- 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 explaining to the parent/guardian the format of the questions and how to complete them.
- Each question is in the same general format and contains several items. Note that the patient is always asked to CIRCLE a number or make an "X" or "✓" next to the appropriate category.
- 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 omission.

CLINIC SECTION:

QUESTIONS 1 TO 7 ARE TO BE COMPLETED BY THE STUDY NURSE:
*COMPLETE QUESTION 1 AND 2 WITH THE HELP OF THE PARENT/GUARDIAN, **PRIOR** TO GIVING THE QUESTIONNAIRE.*

1. Since the last visit, have any of the following occurred? (1-Yes, 2-No,
   At Entry: Have any of the following occurred within the last 12 months 3-Not Known)

a.	Parent lost job:	☐
b.	Family member left home:	☐
c.	Loss of housing or had to move:	☐
d.	Loss of entitlement: (food stamps, AFDC, etc.)	☐
e.	Loss of health insurance:	☐
f.	Family member hospitalized:	☐
g.	Family member very sick:	☐
h.	Change of caretaker:	☐
i.	Separation of parents:	☐
j.	Divorce of parents:	☐
k.	Jail sentence of parent:	☐
l.	Marriage of parent:	☐
m.	Birth of sibling:	☐
n.	Mother starting to work:	☐
o.	Beginning school or moving to new school:	☐
p.	Change in financial status of parents:	☐
q.	Loss of close friend(to child):	☐
r.	Death in family:	☐

If Death in family, who died? .....

1-Mother
2-Father
3-Brother or sister (stepbrother, or stepsister)
4-Grandparent
9-Other family member

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(1-Yes, 2-No)

2. Is the subject HIV-infected? ..... ☐
   If No, go to question 4.
   a. Does the subject know he/she is infected? ..... ☐
      If Yes, complete 'a1.'
      a1. Age when subject first knew their infection status: *(Enter -1 if unknown)*..... ☐☐
   b. Is the subject in school? ..... ☐
      If No, go to question 3.
   c. Does the school know the diagnosis? ..... ☐

NOTE: The following questions should not be asked of the parent/guardian. (1-Yes, 2-No, 3-Not Known)

3. Has the parent/guardian signed a DNR order on this subject? ..... ☐

4. Has the subject enrolled or been enrolled in hospice care? ..... ☐

*ANSWER THE FOLLOWING ITEMS **AFTER** PARENT/GUARDIAN COMPLETES THE QUESTIONNAIRE OR **AFTER** YOU ASCERTAIN THAT THIS IS NOT POSSIBLE:*

5. How was the questionnaire completed? ..... ☐
   If "4", complete 'a' and STOP.
   1 - Self Administered by the parent/guardian
   2 - Face-to-face interview that you conducted
   3 - Phone interview
   4 - Not completed
   9 - Other, specify

   If Other, specify: [30] _____

   a. If **"4"** - Not completed, indicate the reason: ..... ☐
      1 - Parent/guardian refused
      2 - Patient missed clinic visit
      3 - There was not enough time at this visit
      9 - Other reason

      If Other, specify: [30] _____

6. Who responded to the questions? ..... ☐
   1 - Biological Mother
   2 - Biological Father
   3 - Other Relative, specify
   4 - Adoptive Parent
   5 - Foster Parent
   9 - Other, specify

   If Other or Other Relative, specify: [30] _____

7. What language was the questionnaire given in? ..... ☐
   1-English
   2-Spanish
   3-French
   4-Creole
   9-Other

   If Other, specify: [30] _____

   a. What is the primary language spoken at home? ..... ☐
      1-English
      2-Spanish
      3-French
      4-Creole
      9-Other

      If Other, specify: [30] _____

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

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* Enter a "1" if this is the first of this form for this date. Designate subsequent forms on same date with a 2, 3, etc.

**Enter the subject's current study step number. Enter '1' if the study does not have multiple steps.

INSTRUCTIONS TO PARENT/GUARDIAN:

Please answer the following questions by circling the best response. There are no right or wrong answers. If you don't know what a particular question means do not hesitate to ask the study nurse. Please do your best to answer all questions.

I. General Health Ratings. These statements ask about the health and behavior of your child.

A. On a scale from 1 to 10: (1 being the very worst, and 10 being the very best) HOW HAS YOUR CHILD BEEN FEELING, ON THE AVERAGE, DURING THE PAST 3 MONTHS?

(Please circle one number for each question)

	The Very Worst He/She Ever Felt ↓									The Very Best He/She Ever Felt ↓
1. Overall, in general?	1	2	3	4	5	6	7	8	9	10
2. Physically?	1	2	3	4	5	6	7	8	9	10
3. Emotionally?	1	2	3	4	5	6	7	8	9	10

B. As you read the following statements, decide which phrase best describes your child's health over the past 3 months, then circle the number that goes with the answer you choose.

DURING THE PAST 3 MONTHS ... *(Please circle one number for each question)*

	Never or Rarely	Some of the Time	Almost Always
1. My child's health is excellent:	1	2	3
2. My child seems to resist illness very well:	1	2	3
3. My child seems less healthy than other children I know:....	1	2	3
4. When there is something going around, my child usually catches it:	1	2	3
5. My child is somewhat clumsy:	1	2	3
6. My child seems accident-prone:	1	2	3
7. When my child is sick or injured, he/she usually recovers quickly:	1	2	3

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II. Functional Status

Here are some statements that parents/guardians have made to describe their children. As you read these statements, decide which phrase best describes your child's behavior over the past 3 months, then circle the number that goes with the answer you choose.

Thinking about your child, DURING THE PAST 3 MONTHS, did your child...

(Please circle one number for each question)

		Never or Rarely	Some of the Time	Almost Always
1.	Eat well?.....	1	2	3
2.	Sleep well?.....	1	2	3
3.	Seem contented and cheerful?.....	1	2	3
4.	Act moody?.....	1	2	3
5.	Communicate what he/she wanted?.....	1	2	3
6.	Seem to feel sick and tired?.....	1	2	3
7.	Occupy him/herself?.....	1	2	3
8.	Seem lively and energetic?.....	1	2	3
9.	Seem unusually irritable or cross?.....	1	2	3
10.	Sleep through the night?.....	1	2	3
11.	Respond to your attention?.....	1	2	3
12.	Seem unusually difficult?.....	1	2	3
13.	Seem interested in what was going on around him/her?.....	1	2	3
14.	React to little things by crying?.....	1	2	3
15.	Depend on any special medical equipment or appliance in daily living?.....	1	2	3

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III. Social and Role Functioning *(Place an "X" or "✓" on the line next to your answer)*

A. DURING THE PAST 4 WEEKS, HOW MANY DAYS...

1. Did your child stay in bed (most or all of the day) due to any illness or injury?

0 ____ (1)	1-2 ____ (2)	3-5 ____ (3)	6-10 ____ (4)	11-15 ____ (5)	>16 ____ (6)

2. Did illness or injury keep your child from school? (If during a vacation period, refer to the last month school was open.)

Not In School ____ (-1)	0 ____ (1)	1-2 ____ (2)	3-5 ____ (3)	6-10 ____ (4)	11-15 ____ (5)	>16 ____ (6)

B. Please check only one answer for each question:

	(Check One)	
1. DURING THE PAST 4 WEEKS, did illness or injury limit or prevent your child from doing usual childhood activities such as playing with other children or participating in games or sports?	Yes ☐ 1	No ☐ 2
2. In general, is your child able to take part at all in ordinary play with other children?	Yes ☐ 1	No ☐ 2
3. In general, is your child limited in the kind of play he/she can do because of his/her health?	Yes ☐ 1	No ☐ 2
4. In general, is your child limited in the amount of play because of his/her health?	Yes ☐ 1	No ☐ 2
5. Is your child enrolled in an early intervention program because of his/her health?	Yes ☐ 1	No ☐ 2

6. DURING THE PAST 4 WEEKS, who took care of your child for the most daytime hours during a typical weekday? **(Check One)**

Yourself	11	☐
Other parent/stepparent	12	☐
Child's grandparent	13	☐
Child's brother or sister	14	☐
Non-relative of child	15	☐
A daycare center	16	☐
A nursery school/preschool	17	☐
A Head Start program	18	☐
Early Intervention program	19	☐
Special Education program	20	☐
Someone else	21	☐

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IV. Health Care Utilization *(Place an "X" or "✓" on the line next to your answer)*

A. DURING THE PAST 4 WEEKS...

1. HOW MANY NIGHTS did your child stay in a hospital?

0 ____	1-2 ____	3-5 ____	6-10 ____	11-20 ____	>20 ____
(1)	(2)	(3)	(4)	(5)	(6)

2. HOW MANY VISITS did your child make to a clinic, office or emergency room to see a doctor, nurse or other specialist?

0 ____	1-2 ____	3-5 ____	6-10 ____	11-20 ____	>20 ____
(1)	(2)	(3)	(4)	(5)	(6)

3. HOW MANY TIMES was your child visited by a nurse or other health care provider at your home?

0 ____	1-2 ____	3-5 ____	6-10 ____	11-20 ____	>20 ____
(1)	(2)	(3)	(4)	(5)	(6)

4. HOW MANY TIMES did you call a clinic, physician, nurse, or other health care provider for a medical consultation over the telephone about your child?

0 ____	1-2 ____	3-5 ____	6-10 ____	11-20 ____	>20 ____
(1)	(2)	(3)	(4)	(5)	(6)

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B. Please check only one box for each question:

(Check One)

DURING THE PAST 4 WEEKS, did illness or injury make it necessary for your child to use any medicine, other than vitamins, that a doctor prescribed? ..... Yes ☐ 1 No ☐ 2

If No, go to "C".
If Yes, which of the following prescription medications did your child use?

Was it necessary for your child to use...

1. Prescription pain medicine? ..... Yes ☐ 1 No ☐ 2
2. Prescription antibiotics? ..... Yes ☐ 1 No ☐ 2
3. Prescription cold medicine? ..... Yes ☐ 1 No ☐ 2
4. Prescription medicine for wheezing? ..... Yes ☐ 1 No ☐ 2
5. Prescription topical cream? ..... Yes ☐ 1 No ☐ 2
6. Prescription anti-diarrhea medicine? ..... Yes ☐ 1 No ☐ 2

C. "The following are a list of alternative treatments that you may have provided for your child. These are treatments other than traditional medicines. Since the last clinic visit, has your child had or taken any of the following?"

a. Taking any over the counter herbs? ..... Yes ☐ 1 No ☐ 2
b. Taking any over the counter vitamins? ..... Yes ☐ 1 No ☐ 2
c. Had any acupuncture treatments? ..... Yes ☐ 1 No ☐ 2
d. Taken any yoga? ..... Yes ☐ 1 No ☐ 2
e. Used aromatherapy? ..... Yes ☐ 1 No ☐ 2
f. Practiced any specific form of spiritual activity? ..... Yes ☐ 1 No ☐ 2
g. Used chiropractic care? ..... Yes ☐ 1 No ☐ 2
h. Used any massage therapy? ..... Yes ☐ 1 No ☐ 2

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V. Symptoms

The following questions ask about SYMPTOMS OR FEELINGS your child might have had during the past 4 weeks. Please answer HOW DISTRESSING the following symptoms have been for your child DURING THE PAST 4 WEEKS.

HOW MUCH WAS YOUR CHILD DISTRESSED BY THIS SYMPTOM OR FEELING?

(Please circle one answer for each question)

	Not at all	Very Mildly	Mildly	Moderately	Very Much	Extremely
1. Physical or bodily pain?	1	2	3	4	5	6
2. Coughing, wheezing?	1	2	3	4	5	6
3. Nausea, vomiting, abdominal/stomach pain?	1	2	3	4	5	6
4. Diarrhea	1	2	3	4	5	6
5. Rash, itching, or other skin problems?	1	2	3	4	5	6
6. Fatigue, weakness?	1	2	3	4	5	6
7. Feeling dizzy or lightheaded?	1	2	3	4	5	6
8. Fever, night sweats, shaking, chills?	1	2	3	4	5	6
9. Loss of appetite?	1	2	3	4	5	6
10. Trouble sleeping?	1	2	3	4	5	6
11. Eye trouble, problem with vision?	1	2	3	4	5	6
12. Headache?	1	2	3	4	5	6
13. Dry or painful mouth, trouble swallowing?	1	2	3	4	5	6
14. Chest pain or tightness?	1	2	3	4	5	6
15. Difficulty breathing or catching breath?	1	2	3	4	5	6
16. Runny nose, sinus trouble?	1	2	3	4	5	6
17. Muscle aches, joint bone pain?	1	2	3	4	5	6
18. Pain, numbness, or tingling in hands or feet?	1	2	3	4	5	6
19. Earaches?	1	2	3	4	5	6
20. Overall discomfort?	1	2	3	4	5	6

THANK YOU VERY MUCH FOR YOUR TIME.
Your efforts will be very valuable in evaluating new therapies.

Language: English [E]

11-15-02