



*The following questions are about activities you might do during a typical day.*

Card #0	
1	Yes, limited a lot
2	Yes, limited a little
3	No, not limited

START CARD #0

Use card #0 for item 8.

8. Does your **health now limit** you in these activities? If so, how much?

a. The kinds or amount of **vigorous** activities you can do, like lifting heavy objects, running or participating in strenuous sports:

- Yes, limited alot ( 1 )
- Yes, limited a little ( 2 )
- No, not limited ( 3 )

b. The kinds or amount of **moderate** activities you can do, like moving a table, carrying groceries or bowling:

- Yes, limited alot ( 1 )
- Yes, limited a little ( 2 )
- No, not limited ( 3 )

c. Walking uphill or climbing a few flights of stairs:

- Yes, limited alot ( 1 )
- Yes, limited a little ( 2 )
- No, not limited ( 3 )

d. Bending, lifting or stooping:

- Yes, limited alot ( 1 )
- Yes, limited a little ( 2 )
- No, not limited ( 3 )

e. Walking one block:

- Yes, limited alot ( 1 )
- Yes, limited a little ( 2 )
- No, not limited ( 3 )

f. Eating, dressing, bathing or using the toilet:

- Yes, limited alot ( 1 )
- Yes, limited a little ( 2 )
- No, not limited ( 3 )

STOP CARD #0

9. Does **your health** keep you from working at a job, doing work around the house or going to school?

- ( Yes ) ( No )
- ( 1 ) ( 2 )

10. Have you been unable to do **certain kinds or amounts** of work, housework or schoolwork because of your health?

- ( Yes ) ( No )
- ( 1 ) ( 2 )

Card #1	
1	All of the time
2	Most of the time
3	A good bit of the time
4	Some of the time
5	A little of the time
6	None of the time

START CARD #1

Use card #1 for items 11-13.

11. How much of the time during the past 4 weeks...

a. Has your **health limited your social activities** (like visiting with friends or close relatives)? \_\_\_\_\_

(1-6)

b. Have you been a **very nervous person**? \_\_\_\_\_

(1-6)

c. Have you felt **calm and peaceful**? \_\_\_\_\_

(1-6)

d. Have you felt **downhearted and blue**? \_\_\_\_\_

(1-6)

e. Have you been a **happy person**? \_\_\_\_\_

(1-6)

f. Have you felt so **down in the dumps** that nothing could cheer you up? \_\_\_\_\_

(1-6)

- 12.** How often during the last 4 weeks...
- a. Did you feel full of pep? \_\_\_\_\_  
(1-6)
  - b. Did you feel worn out? \_\_\_\_\_  
(1-6)
  - c. Did you feel tired? \_\_\_\_\_  
(1-6)
  - d. Did you have enough energy to do the things you wanted to do? \_\_\_\_\_  
(1-6)

- 13.** How much of the time, during the past 4 weeks...
- a. Did you have difficulty reasoning and solving problems, for example, making plans, making decisions, learning new things? \_\_\_\_\_  
(1-6)
  - b. Did you forget things that happened recently, for example, where you put things, appointments? \_\_\_\_\_  
(1-6)
  - c. Did you have trouble keeping your attention on any activity for long? \_\_\_\_\_  
(1-6)
  - d. Did you have difficulty doing activities involving concentration and thinking? \_\_\_\_\_  
(1-6)

*STOP CARD #1*

***These questions are about how you have been feeling and how things have been with you during the past four weeks. For each question, please indicate the response that comes closest to the way you have been feeling.***

- 14.** How have you been feeling during the past 4 weeks? (*check only one*):
- Very sick ( 1 )
  - Pretty sick ( 2 )
  - A little sick ( 3 )
  - Not bad ( 4 )
  - Pretty well ( 5 )
  - Very well ( 6 )

- 15.** During the past 4 weeks, how much were you bothered by your illness? (*check only one*):
- Not at all ( 1 )
  - A little ( 2 )
  - Somewhat ( 3 )
  - Quite a lot ( 4 )
  - A great deal ( 5 )

- 16.** During the past 4 weeks, how much have you been concerned, worried, or fearful about your health? (*check only one*):
- Not at all ( 1 )
  - A little ( 2 )
  - Somewhat ( 3 )
  - Quite a lot ( 4 )
  - A great deal ( 5 )

- 17.** How often, during the past 4 weeks, did you feel healthy enough to do the things you wanted to do or had to do? (*check only one*):
- All of the time ( 1 )
  - Most of the time ( 2 )
  - Some of the time ( 3 )
  - A little of the time ( 4 )
  - None of the time ( 5 )

- 18.** How has the quality of your life been during the past 4 weeks? That is, how have things been going for you? (*check only one*):
- Very well, could hardly be better ( 1 )
  - Pretty good ( 2 )
  - Good and bad parts about equal ( 3 )
  - Pretty bad ( 4 )
  - Very bad, could hardly be worse ( 5 )

- 19.** How would you rate your physical health and emotional condition now compared to 4 weeks ago? (*check only one*):
- Much better ( 1 )
  - A little better ( 2 )
  - About the same ( 3 )
  - A little worse ( 4 )
  - Much worse ( 5 )

**C. Visual**

*Next, we would like to ask you some questions about your eyesight.*

Card #3	
1	Not at all
2	A little
3	Somewhat
4	Quite a lot
5	A great deal

**20.** How much trouble do you now have with your eyesight? (*check only one*):

- No trouble ( 1 )
- A little trouble ( 2 )
- A moderate amount of trouble ( 3 )
- A lot of trouble ( 4 )

Card #2	
1	No difficulty
2	A little
3	A moderate amount
4	Unable to do this
5	Don't do for other reasons

*START CARD #2*

*Use card #2 for item 21.*

*The following questions ask about problems with your eyesight you might have had during the past 4 weeks.*

**21.** Do you have difficulty (even with glasses) in doing any of the following activities?

- a.** Reading small print such as labels on medicine bottles, a telephone book, food labels: \_\_\_\_\_  
(1-5)
- b.** Reading a newspaper or book: \_\_\_\_\_  
(1-5)
- c.** Driving during the day: \_\_\_\_\_  
(1-5)
- d.** Driving at night: \_\_\_\_\_  
(1-5)
- e.** Reading traffic signs, street signs, store signs: \_\_\_\_\_  
(1-5)
- f.** Doing writing such as making lists, writing notes or letters: \_\_\_\_\_  
(1-5)
- g.** Watching television: \_\_\_\_\_  
(1-5)

*STOP CARD #2*

*START CARD #3*

*Use card #3 for items 22 and 25.*

**22.** During the past 4 weeks, how much have you been bothered by...

- a.** Blurred or distorted vision: \_\_\_\_\_  
(1-5)
- b.** Spots floating in front of your eyes: \_\_\_\_\_  
(1-5)
- c.** Blind spots or blurry spots: \_\_\_\_\_  
(1-5)
- d.** Trouble seeing to one side or the other: \_\_\_\_\_  
(1-5)
- e.** Bumping into people or things: \_\_\_\_\_  
(1-5)

*STOP CARD #3*

**23.** In general, would you say your eyesight is (*check only one*):

- Excellent ( 1 )
- Very good ( 2 )
- Good ( 3 )
- Fair ( 4 )
- Poor ( 5 )

**24.** Did you receive treatment for an eye problem related to AIDS in the past 4 weeks (*including patients with an active implant for no longer than 7 months*):

- Yes ( 1 )
- No ( 2 )

If "No", skip to item 27 (do not answer items 25 and 26)

*START CARD #3*

***Getting treatment for an eye problem can be inconvenient.***

**25.** During the past 4 weeks how much has the treatment for your eyes...

**a.** Interfered with your social activities with family, friends, neighbors, or groups? \_\_\_\_\_  
(1-5)

**b.** Interfered with your daily activities like bathing, dressing, shopping or preparing meals? \_\_\_\_\_  
(1-5)

**c.** Made you concerned about how you look? \_\_\_\_\_  
(1-5)

**d.** Made you embarrassed to go out in public? \_\_\_\_\_  
(1-5)

*STOP CARD #3*

**26.** During the past 4 weeks...

**a.** Was the amount of time you had to spend on treatment for your eyes (*check only one*):

- Much too long ( 1 )
- Too long ( 2 )
- About right ( 3 )
- Not applicable ( N )

**b.** How much did treatment for your eyes keep you from doing the things you wanted to do (*check only one*):

- Not at all ( 1 )
- A little ( 2 )
- Somewhat ( 3 )
- A lot ( 4 )
- A great deal ( 5 )

***The final questions ask about work and other activities.***

**27.** Have you had a job or business during the past 4 weeks:

- Yes ( 1 )
- No ( 2 )

**28.** How do you spend most of your time? (*check only one*):

- Working full time ( 1 )
- Working part time ( 2 )
- Keeping house or taking care of family ( 3 )
- Attending school ( 4 )
- Not working because of your health ( 5 )
- Not working for other reasons ( 6 )

**29.** How many days during the past week did your illness, treatment or a personal problem (like feeling depressed) cause you to do any of the following things?

**a.** Stay in bed for a half a day or more: \_\_\_\_\_  
days

**b.** Cut down on your usual activities (such as your work, housework, school, leisure activities) for half a day or more: \_\_\_\_\_  
days

**D. EuroQol**

**30. Mobility**

*(check only one):*

- I have no problems in walking about ( 1 )
- I have some problems in walking about ( 2 )
- I am confined to bed ( 3 )

**31. Self-Care**

*(check only one):*

- I have no problems with self-care ( 1 )
- I have some problems washing and dressing myself ( 2 )
- I am unable to wash or dress myself ( 3 )

**32. Usual Activities (e.g. work, study, housework, family or leisure activities)**

*(check only one):*

- I have no problems with performing my usual activities ( 1 )
- I have some problems with performing my usual activities ( 2 )
- I am unable to perform my usual activities ( 3 )

**33. Pain/Discomfort**

*(check only one):*

- I have no pain or discomfort ( 1 )
- I have moderate pain or discomfort ( 2 )
- I have extreme pain or discomfort ( 3 )

**34. Anxiety/Depression**

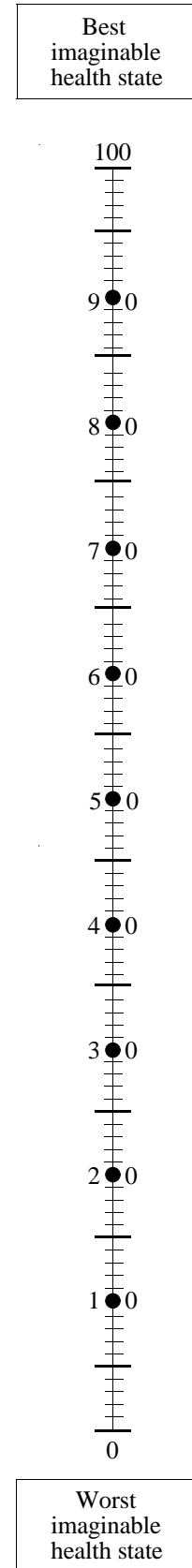
*(check only one):*

- I am not anxious or depressed ( 1 )
- I am moderately anxious or depressed ( 2 )
- I am extremely anxious or depressed ( 3 )

**35. Health state:**

*To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) to the right. The best health state you can imagine is marked 100 and the worst state you can imagine is marked 0.*

*We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box that reads "Your own health state today" to whatever place on the scale indicates how good or bad your health state is.*



Your own health state today

**E. Administrative information**

*(Section E should be completed by the Clinic Coordinator)*

**36. Health state scale**

a. Did the patient complete item #35:

Yes ( 1 )      No ( 2 )

*If no, specify why not and skip to item #37:*

\_\_\_\_\_ specify why not

b. Record value indicated on scale in item #35:

\_\_\_\_\_

**37. How was the questionnaire completed (check only one):**

- Self-administered by patient ( 1 )
- In-person interview ( 2 )
- Telephone interview ( 3 )
- Other (*specify*): ( 4 )

\_\_\_\_\_  
\_\_\_\_\_

**38. QL form used (check only one):**

- Standard print ( 1 )
- Large print ( 2 )

**39. What was the quality of this interview (check only one):**

- Good ( 1 )
- Fair ( 2 )
- Poor (*explain*): ( 3 )

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Not applicable ( N )

**40. Date form reviewed:**

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
day month year

**41. Clinic coordinator ID:** \_\_\_\_\_

**42. Clinic coordinator signature:**  
\_\_\_\_\_