QUALITY OF LIFE	(Q1)	- Day	0	
Patient Study ID #: Pati	ent Initials:			
Date: /				
dd mmm yyyy				
We are interested in some things about you and your health. Ple	ease answer all the	questions	yourself by c	hecking the
that best applies to you SINCE LAST VISIT. There are no "ri	ght" or "wrong" an	swers. Th	ne information	n that you pr
will remain strictly confidential.				
			Yes	No
1. Can you do hard activities, like moving heavy furniture?			\bigcirc	\bigcirc
2. If you wanted to, could you run a short distance?			\bigcirc	\bigcirc
3. Do you have any trouble taking a long walk?			\bigcirc	\bigcirc
4. Do you have any trouble walking a short distance?				\bigcirc
5. Are you in bed or a chair most of the day?			\circ	\bigcirc
6. Do you have to stay indoors most of the day?			Ö	
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?				\bigcirc
9. Are you completely unable to work at a job or do household jobs?				
	Not at all	A little	Quite a bit	Very mucl
10. Were you short of breath?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
11. Have you had pain?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
12. Did you need to rest?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
13. Have you felt ill?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
14. Have you had trouble sleeping?		\bigcirc		\bigcirc
15. Have you felt weak?		\bigcirc		
16. Have you lacked appetite?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
17. Have you felt nauseated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
18. Have you vomited?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
19. Have you been constipated?				\bigcirc

20. Have you had diarrhea?

21. Were you tired?

(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?	\bigcirc	\bigcirc			
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?	\bigcirc	\bigcirc	\bigcirc	0	
26. Did you look forward with enjoyment to things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
27. Did you get sudden feelings of panic?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
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?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
33. Has your medical treatment interfered with your family or social life?	$\tilde{\bigcirc}$	$\tilde{\bigcirc}$	$\tilde{\bigcirc}$	$\tilde{\bigcirc}$	
34. Has your condition or treatment caused you financial difficulties?	Ŏ	Ŏ	Ŏ	Ŏ	
35. Have you had a high temperature?					
36. Have you had bouts of sweating?	Ö				
37. Has your stomach felt bloated?					
38. Have your arms or legs felt numb?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
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?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
If not 1, where?					
44. Have you had any difficulties finding the right word?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
45. Has your hearing been impaired?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
For the following questions please check the number between	1 and 7 tha	ıt best ap	plies to you.		
46. How would you rate your overall physical condition during the past week?					
Very poor) 4 \(\) 5	0 6 () 7 Exe	cellent	
47. How would you rate your overall quality of life during the past week?					
Very poor \bigcirc 1 \bigcirc 2 \bigcirc 3 \bigcirc) 4 \bigcirc 5	\bigcirc 6 \bigcirc) 7 Ex	cellent	

Patient Study ID #: Patient In	itials:				
Date: / /					
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			Yes	No	
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2. If you wanted to, could you run a short distance?			\bigcirc	\bigcirc	
3. Do you have any trouble taking a long walk?			\bigcirc	$\overline{\bigcirc}$	
4. Do you have any trouble walking a short distance?			\bigcirc	\bigcirc	
5. Are you in bed or a chair most of the day?					
6. Do you have to stay indoors most of the day?			Ō		
7. Do you need help with eating, dressing, washing yourself or using the toi	let?		\bigcirc	\bigcirc	
8. Are you limited in any way in doing your work or household jobs?			\bigcirc	\bigcirc	
9. Are you completely unable to work at a job or do household jobs?			\bigcirc	\bigcirc	
	Not at all	A little	Quite a bit	Very much	
10. Were you short of breath?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
11. Have you had pain?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
12. Did you need to rest?				_	
	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
13. Have you felt ill?				0	
13. Have you felt ill?14. Have you had trouble sleeping?			0	0	
·	000	0000	0		
14. Have you had trouble sleeping?		00000	0000		
14. Have you had trouble sleeping?15. Have you felt weak?	00000	000000	00000		
14. Have you had trouble sleeping?15. Have you felt weak?16. Have you lacked appetite?	000000	0000000	000000		
14. Have you had trouble sleeping?15. Have you felt weak?16. Have you lacked appetite?17. Have you felt nauseated?	0000000	0000000	000000	000000	

21. Were you tired?

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VUAL	/I I I	$\mathbf{O}\mathbf{I}$	

Patient Study ID #: Patient Initi	ials:			
	Not at all	A little	Quite a bit	Very much
22. Have you had difficulty in concentrating or remembering things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
23. Could you sit at ease and feel relaxed?	\bigcirc	\bigcirc	\bigcirc	
24. Have you lost interest in your appearance?	\bigcirc	O	O	O
25. Have you felt restless as if you had to be on the move?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
26. Did you look forward with enjoyment to things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
27. Did you get sudden feelings of panic?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
28. Could you enjoy a good book or radio or television program?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
29. Have you felt tense or "wound up"?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
30. Could you laugh and see the funny side of things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
31. Were you physically well?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
32. Has your condition interfered with your family or social life?		\bigcirc	\bigcirc	\bigcirc
33. Has your medical treatment interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
34. Has your condition or treatment caused you financial difficulties?	\bigcirc			
35. Have you had a high temperature?				
36. Have you had bouts of sweating?	\bigcirc			
37. Has your stomach felt bloated?	\bigcirc	\bigcirc	\bigcirc	
38. Have your arms or legs felt numb?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
39. Have you had any difficulties moving your arms and legs?	Ŏ	Ŏ	Ö	Ö
40. Have you had pain when moving around?	Ö	Ö	Ö	Ö
41. Have you had pain when resting?				
42. Have you taken any painkillers? 1) Yes 2) No				
If yes, did they help?	\bigcirc			
43. Have you noticed swelling on your body?		\bigcirc		
If not 1, where?				
44. Have you had any difficulties finding the right word?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
45. Has your hearing been impaired?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
For the following questions please check the number between	1 and 7 tha	ıt best app	olies to you.	
46. How would you rate your overall physical condition during the past week?				
Very poor 0 1 0 2 0 3 0	4 0 5	O 6 C) 7 Ex	cellent
47. How would you rate your overall quality of life during the past week?				
Very poor 1 2 3 0	4 0 5	O 6 C) 7 Ex	cellent

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2. If you wanted to, could you run a short distance?			\bigcirc	\bigcirc	
3. Do you have any trouble taking a long walk?			\bigcirc	\bigcirc	
4. Do you have any trouble walking a short distance?			\bigcirc	\bigcirc	
5. Are you in bed or a chair most of the day?					
6. Do you have to stay indoors most of the day?				\bigcirc	
7. Do you need help with eating, dressing, washing yourself or using the toil	let?		\bigcirc	\bigcirc	
8. Are you limited in any way in doing your work or household jobs?			\bigcirc	\bigcirc	
9. Are you completely unable to work at a job or do household jobs?			\bigcirc	\bigcirc	
	Not at all	A little	Quite a bit	Very much	
10. Were you short of breath?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
11. Have you had pain?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
12. Did you need to rest?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
13. Have you felt ill?	\circ	\circ	\bigcirc	\circ	
14. Have you had trouble sleeping?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
15. Have you felt weak?		\bigcirc			
16. Have you lacked appetite?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
17. Have you felt nauseated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
18. Have you vomited?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
19. Have you been constipated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
20. Have you had diarrhea?	\bigcirc	\bigcirc	\bigcirc		
21. Were you tired?					

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25. Have you felt restless as if you had to be on the move?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
26. Did you look forward with enjoyment to things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
27. Did you get sudden feelings of panic?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
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?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
33. Has your medical treatment interfered with your family or social life?		\bigcirc	\bigcirc	\bigcirc
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?		\bigcirc	\bigcirc	\bigcirc
38. Have your arms or legs felt numb?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
39. Have you had any difficulties moving your arms and legs?	\circ	Ö	$\overline{\bigcirc}$	Ö
40. Have you had pain when moving around?				O
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?				
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3. Do you have any trouble taking a long walk?			\bigcirc	\bigcirc	
4. Do you have any trouble walking a short distance?				\bigcirc	
5. Are you in bed or a chair most of the day?					
6. Do you have to stay indoors most of the day?			\bigcirc	\bigcirc	
7. Do you need help with eating, dressing, washing yourself or using the toil	let?		\bigcirc	\bigcirc	
8. Are you limited in any way in doing your work or household jobs?			\bigcirc	\bigcirc	
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	Not at all	A little	Quite a bit	Very much	
10. Were you short of breath?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
11. Have you had pain?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
12. Did you need to rest?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
13. Have you felt ill?	O	O	O	O	
14. Have you had trouble sleeping?					
15. Have you felt weak?	\cup	\cup	\cup	\cup	
	0	0	0	0	
16. Have you lacked appetite?	0	0	0		
	0000	0000	0 0 0	000	
16. Have you lacked appetite?	0000	0000	0000	0000	
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30. Could you laugh and see the funny side of things?	O	O	\bigcirc	O
31. Were you physically well?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
33. Has your medical treatment interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
34. Has your condition or treatment caused you financial difficulties?	\circ	\circ	\circ	\circ
35. Have you had a high temperature?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
36. Have you had bouts of sweating?	\bigcirc	\bigcirc	\bigcirc	\circ
37. Has your stomach felt bloated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
38. Have your arms or legs felt numb?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
39. Have you had any difficulties moving your arms and legs?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
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13. Have you felt ill?	\bigcirc	\bigcirc	\bigcirc		
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16. Have you lacked appetite?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
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32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
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40. Have you had pain when moving around?	Ö	Ö	Ö	Ö
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12. Did you need to rest?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
13. Have you felt ill?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
14. Have you had trouble sleeping?		\bigcirc			
15. Have you felt weak?		\bigcirc			
16. Have you lacked appetite?		\bigcirc			
17. Have you felt nauseated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
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36. Have you had bouts of sweating?							
37. Has your stomach felt bloated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
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			Yes	No	
1. Can you do hard activities, like moving heavy furniture?			\bigcirc		
2. If you wanted to, could you run a short distance?			\bigcirc		
3. Do you have any trouble taking a long walk?			Ŏ		
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?			Ō		
7. Do you need help with eating, dressing, washing yourself or using the toil	let?				
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?			\bigcirc		
	Not at all	A little	Quite a bit	Very much	
10. Were you short of breath?	\bigcirc	\bigcirc	\bigcirc		
11. Have you had pain?	\bigcirc	\bigcirc	\bigcirc		
12. Did you need to rest?	\bigcirc	\bigcirc	\bigcirc		
13. Have you felt ill?	\bigcirc	\bigcirc	\bigcirc		
14. Have you had trouble sleeping?	\bigcirc	\bigcirc	\bigcirc		
15. Have you felt weak?		\bigcirc			
16. Have you lacked appetite?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
17. Have you felt nauseated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
18. Have you vomited?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
19. Have you been constipated?	\bigcirc	\bigcirc	\bigcirc		
20. Have you had diarrhea?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	

Patient Study ID #: Patient Init	ials:						
	Not at all	A little	Quite a bit	Very much			
22. Have you had difficulty in concentrating or remembering things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
23. Could you sit at ease and feel relaxed?	O	O	O	O			
24. Have you lost interest in your appearance?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
25. Have you felt restless as if you had to be on the move?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
26. Did you look forward with enjoyment to things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
27. Did you get sudden feelings of panic?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
28. Could you enjoy a good book or radio or television program?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
29. Have you felt tense or "wound up"?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
30. Could you laugh and see the funny side of things?	\bigcirc	\bigcirc	\bigcirc	O			
31. Were you physically well?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
33. Has your medical treatment interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
34. Has your condition or treatment caused you financial difficulties?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
35. Have you had a high temperature?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
36. Have you had bouts of sweating?	\circ	\bigcirc		\circ			
37. Has your stomach felt bloated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
38. Have your arms or legs felt numb?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
39. Have you had any difficulties moving your arms and legs?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
40. Have you had pain when moving around?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
41. Have you had pain when resting?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
42. Have you taken any painkillers? 1) Yes 2) No							
If yes, did they help?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
43. Have you noticed swelling on your body?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
If not 1, where?							
44. Have you had any difficulties finding the right word?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
45. Has your hearing been impaired?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
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 0 1 0 2 0 3 0) 4) 5	O 6 C) 7 Ex	cellent			
47. How would you rate your overall quality of life during the past week?							
Very poor 1 2 3 C) 4) 5	O 6 C) 7 Ex	cellent			

Patient Study ID #: Patient In	itials:				
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that best applies to you SINCE LAST VISIT . There are no "right" or		-	•	-	
will remain strictly confidential.	-				
			Yes	No	
1. Can you do hard activities, like moving heavy furniture?			\bigcirc	\bigcirc	
2. If you wanted to, could you run a short distance?			\bigcirc	\bigcirc	
3. Do you have any trouble taking a long walk?			\circ	$\tilde{\bigcirc}$	
4. Do you have any trouble walking a short distance?				\bigcirc	
5. Are you in bed or a chair most of the day?			\bigcirc	\bigcirc	
6. Do you have to stay indoors most of the day?			Ō		
7. Do you need help with eating, dressing, washing yourself or using the toil	let?		O	0	
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?			\circ	\circ	
	Not at all	A little	Quite a bit	Very much	
10. Were you short of breath?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
11. Have you had pain?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
12. Did you need to rest?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
13. Have you felt ill?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
14. Have you had trouble sleeping?	\bigcirc	\bigcirc		\bigcirc	
15. Have you felt weak?		\bigcirc			
16. Have you lacked appetite?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
17. Have you felt nauseated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
18. Have you vomited?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
19. Have you been constipated?	\bigcirc	\bigcirc			
20. Have you had diarrhea?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
21. Were you tired?					

Patient Study ID #: Patient Init	ials:						
	Not at all	A little	Quite a bit	Very much			
22. Have you had difficulty in concentrating or remembering things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
23. Could you sit at ease and feel relaxed?	O	O	O	O			
24. Have you lost interest in your appearance?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
25. Have you felt restless as if you had to be on the move?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
26. Did you look forward with enjoyment to things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
27. Did you get sudden feelings of panic?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
28. Could you enjoy a good book or radio or television program?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
29. Have you felt tense or "wound up"?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
30. Could you laugh and see the funny side of things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
31. Were you physically well?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
33. Has your medical treatment interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
34. Has your condition or treatment caused you financial difficulties?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
35. Have you had a high temperature?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
36. Have you had bouts of sweating?	\circ	\bigcirc		\circ			
37. Has your stomach felt bloated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
38. Have your arms or legs felt numb?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
39. Have you had any difficulties moving your arms and legs?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
40. Have you had pain when moving around?		\bigcirc	\bigcirc	\bigcirc			
41. Have you had pain when resting?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
42. Have you taken any painkillers? 1) Yes 2) No							
If yes, did they help?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
43. Have you noticed swelling on your body?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
If not 1, where?							
44. Have you had any difficulties finding the right word?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
45. Has your hearing been impaired?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
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 0 1 0 2 0 3 0) 4) 5	O 6 C) 7 Ex	cellent			
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will remain strictly confidential.					
			Yes	No	
1. Can you do hard activities, like moving heavy furniture?			\bigcirc	\bigcirc	
2. If you wanted to, could you run a short distance?			\bigcirc	\bigcirc	
3. Do you have any trouble taking a long walk?			Ŏ	Ŏ	
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?			$\tilde{\bigcirc}$	$\tilde{\bigcirc}$	
7. Do you need help with eating, dressing, washing yourself or using the toil	et?		$\tilde{\bigcirc}$	$\tilde{\bigcirc}$	
8. Are you limited in any way in doing your work or household jobs?			$\tilde{\bigcirc}$	\bigcirc	
9. Are you completely unable to work at a job or do household jobs?			$\tilde{\bigcirc}$	$\tilde{\bigcirc}$	
	Not at all	A little	Quite a bit	Very much	
10. Were you short of breath?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
11. Have you had pain?	Ö	Ö	$\overline{\bigcirc}$	\circ	
12. Did you need to rest?	Ö	Ŏ	\circ	Ö	
13. Have you felt ill?	Ō	O	Ŏ	Ō	
14. Have you had trouble sleeping?		\bigcirc			
15. Have you felt weak?	\bigcirc	\bigcirc		\bigcirc	
16. Have you lacked appetite?		\bigcirc			
17. Have you felt nauseated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
18. Have you vomited?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
19. Have you been constipated?		\bigcirc			
20. Have you had diarrhea?	\bigcirc	\bigcirc	\bigcirc		
21. Were you tired?	\bigcirc				

Patient Study ID #: Patient Initials:							
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24. Have you lost interest in your appearance?							
25. Have you felt restless as if you had to be on the move?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
26. Did you look forward with enjoyment to things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
27. Did you get sudden feelings of panic?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
28. Could you enjoy a good book or radio or television program?	\bigcirc	\bigcirc					
29. Have you felt tense or "wound up"?							
30. Could you laugh and see the funny side of things?		\bigcirc					
31. Were you physically well?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
33. Has your medical treatment interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
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?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
38. Have your arms or legs felt numb?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
39. Have you had any difficulties moving your arms and legs?							
40. Have you had pain when moving around?							
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3. Do you have any trouble taking a long walk?			\bigcirc	
4. Do you have any trouble walking a short distance?			\bigcirc	\bigcirc
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10. Were you short of breath?	\bigcirc	\bigcirc	\bigcirc	
11. Have you had pain?	\bigcirc	\bigcirc	\bigcirc	
12. Did you need to rest?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
13. Have you felt ill?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
14. Have you had trouble sleeping?	\bigcirc	\bigcirc	\bigcirc	
15. Have you felt weak?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
16. Have you lacked appetite?	\bigcirc	\bigcirc	\bigcirc	
17. Have you felt nauseated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc
18. Have you vomited?	\bigcirc	\bigcirc	\circ	\bigcirc
19. Have you been constipated?	\bigcirc	\bigcirc	\bigcirc	
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25. Have you felt restless as if you had to be on the move?	\bigcirc	\bigcirc	\bigcirc	\bigcirc		
26. Did you look forward with enjoyment to things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc		
27. Did you get sudden feelings of panic?	\bigcirc	\bigcirc	\bigcirc	\bigcirc		
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32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc		
33. Has your medical treatment interfered with your family or social life?		\bigcirc	\bigcirc	\bigcirc		
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39. Have you had any difficulties moving your arms and legs?	\circ	Ö	$\overline{\bigcirc}$	Ö		
40. Have you had pain when moving around?				O		
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			Yes	No]
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	Not at all	A little	Quite a bit	Very much	
10. Were you short of breath?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
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12. Did you need to rest?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
13. Have you felt ill?	\bigcirc	\circ	\bigcirc	\circ	
14. Have you had trouble sleeping?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
15. Have you felt weak?		\bigcirc			
16. Have you lacked appetite?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
17. Have you felt nauseated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
18. Have you vomited?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
19. Have you been constipated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
20. Have you had diarrhea?	\bigcirc	\bigcirc	\bigcirc	\bigcirc	
21. Were you tired?					

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Patient Study ID #: Patient Init	ials:						
	Not at all	A little	Quite a bit	Very much			
22. Have you had difficulty in concentrating or remembering things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
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26. Did you look forward with enjoyment to things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
27. Did you get sudden feelings of panic?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
28. Could you enjoy a good book or radio or television program?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
29. Have you felt tense or "wound up"?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
30. Could you laugh and see the funny side of things?	\bigcirc	\bigcirc	\bigcirc	O			
31. Were you physically well?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
33. Has your medical treatment interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
34. Has your condition or treatment caused you financial difficulties?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
35. Have you had a high temperature?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
36. Have you had bouts of sweating?	\circ	\bigcirc		\circ			
37. Has your stomach felt bloated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
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12. Did you need to rest?	\bigcirc	\bigcirc	\bigcirc	\bigcirc					
13. Have you felt ill?	\circ	\circ	\circ	\bigcirc					
14. Have you had trouble sleeping?	\bigcirc	\bigcirc	\bigcirc	\bigcirc					
15. Have you felt weak?		\bigcirc		\bigcirc					
16. Have you lacked appetite?	\bigcirc	\bigcirc	\bigcirc	\bigcirc					
17. Have you felt nauseated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc					
18. Have you vomited?	\bigcirc	\bigcirc	\bigcirc	\bigcirc					
19. Have you been constipated?		\bigcirc	\bigcirc						
20. Have you had diarrhea?	\bigcirc	\bigcirc	\bigcirc	\bigcirc					
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QUALITY OF LIFE	(Q1) - I	Month	120	rage 2 C			
Patient Study ID #: Patient Init	tials:						
	Not at all	A little	Quite a bit	Very much			
22. Have you had difficulty in concentrating or remembering things?	\circ	\bigcirc	\circ				
23. Could you sit at ease and feel relaxed?	O	\bigcirc	O	O			
24. Have you lost interest in your appearance?	O	O	\bigcirc	\bigcirc			
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27. Did you get sudden feelings of panic?	\bigcirc	\bigcirc	\circ	\bigcirc			
28. Could you enjoy a good book or radio or television program?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
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30. Could you laugh and see the funny side of things?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
31. Were you physically well?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
32. Has your condition interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
33. Has your medical treatment interfered with your family or social life?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
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37. Has your stomach felt bloated?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
38. Have your arms or legs felt numb?	\bigcirc	$\overline{\bigcirc}$	\bigcirc	\bigcirc			
39. Have you had any difficulties moving your arms and legs?	$\tilde{\bigcirc}$	$\tilde{\bigcirc}$	\bigcirc	\bigcirc			
40. Have you had pain when moving around?	Ŏ	Ŏ	$\tilde{\bigcirc}$	$\tilde{\bigcirc}$			
41. Have you had pain when resting?	Ŏ	Ŏ	Ŏ	Ŏ			
42. Have you taken any painkillers? 1) Yes 2) No	O	<u> </u>	<u> </u>				
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?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
45. Has your hearing been impaired?	\bigcirc	\bigcirc	\bigcirc	\bigcirc			
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?							

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