ACCORDION HEALTH RELATED QUALITY OF LIFE FORM

Participant ID: ___ ___ ___ ___ ___ ___ ___ ___ ___
Acrostic: ___ ___ ___ ___ ___ ___
Visit Date: ___ ___ / ___ ___ / 20 ___ ___
Form Completed By: ___ ___
Date Entered: ___ ___ / ___ ___ / 20 ___ ___
Data Entered by: _____

DUMMY BARCODE:

B0000000

Over the last 2 WEEKS, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly Every day
1 Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2 Feeling down, depressed or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3 Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4 Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5 Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6 Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7 Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8 Moving or speaking so slowly that other people could have noticed or the opposite - being so fidgety or restless that you have been moving around a lot more	0 ☐	1 ☐	2 ☐	3 ☐
9 Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐
10 In the past 30 days, how many times did you visit your physician or receive treatment as outpatient		☐☐ (number of times) Insert "0" for no visits		

ACCORDION HEALTH UTILITIES INDEX FORM

Participant ID:	___ ___ ___ ___ ___ ___ ___ ___ ___
Acrostic:	___ ___ ___ ___ ___ ___
Visit Date:	___ ___ / ___ ___ / 20 ___ ___
Form Completed By:	___ ___
Date Entered:	___ ___ / ___ ___ / 20 ___ ___
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B0000000

Instructions: This questionnaire contains a set of questions which ask about various aspects of your health. When answering these questions, please think about your health and your ability to do things on a day-to-day basis, during the past 4 weeks. To define the 4-week period, please think about what the date was 4 weeks ago and recall the major events that you have experienced during this period. Please focus your answers on your overall abilities, disabilities and how you felt during the past 4 weeks.

You may feel that some of these questions do not apply to you, but it is important that we ask the same questions of everyone. Also, a few questions are similar; please excuse the apparent overlap and answer each question independently.

Please read each question and consider your answers carefully. For each question, please select one answer that best describes your level of ability or disability during the past 4 weeks. Please indicate the selected answer by checking the box beside the answer.

All information you provide is confidential. There are no right or wrong answers; what we want is your opinion about your abilities and feelings.

1. Which one of the following best describes your ability, during the past 4 weeks, to see well enough to read ordinary newsprint?

   1 ☐ a. Able to see well enough without glasses or contact lenses.

   2 ☐ b. Able to see well enough with glasses or contact lenses.

   3 ☐ c. Unable to see well enough even with glasses or contact lenses.

   4 ☐ d. Unable to see at all.

2. Which one of the following best describes your ability, during the past 4 weeks, to see well enough to recognize a friend on the other side of the street?

   1 ☐ a. Able to see well enough without glasses or contact lenses.

   2 ☐ b. Able to see well enough with glasses or contact lenses.

   3 ☐ c. Unable to see well enough even with glasses or contact lenses.

   4 ☐ d. Unable to see at all.

3. Which one of the following best describes your ability, during the past 4 weeks, to hear what was said in a group conversaton with at least three other people?

   1 ☐ a. Able to hear what was said without a hearing aid.

   2 ☐ b. Able to hear what was said with a hearing aid.

   3 ☐ c. Unable to hear what was said even with a hearing aid.

   4 ☐ d. Unable to hear what was said, but did not wear a hearing aid.

   5 ☐ e. Unable to hear at all.

4. Which one of the following best describes your ability, during the past 4 weeks, to hear what was said in a group conversaton with one other person in a quiet room?

   1 ☐ a. Able to hear what was said without a hearing aid.

   2 ☐ b. Able to hear what was said with a hearing aid.

   3 ☐ c. Unable to hear what was said even with a hearing aid.

   4 ☐ d. Unable to hear what was said, but did not wear a hearing aid.

   5 ☐ e. Unable to hear at all.

5. Which one of the following best describes your ability, during the past 4 weeks, to be understood when speaking your own language with people who do not know you?

   1 ☐ a. Able to be understood completely.

   2 ☐ b. Able to be understood partially.

   3 ☐ c. Unable to be understood.

   4 ☐ d. Unable to speak at all.

6. Which one of the following best describes your ability, during the past 4 weeks, to be understood when speaking with people who know you well?

   1 ☐ a. Able to be understood completely.

   2 ☐ b. Able to be understood partially.

   3 ☐ c. Unable to be understood.

   4 ☐ d. Unable to speak at all.

7. Which one of the following best describes how you have been feeling during the past 4 weeks?

   1 ☐ a. Happy and interested in life.

   2 ☐ b. Somewhat happy.

   3 ☐ c. Somewhat unhappy.

   4 ☐ d. Very unhappy.

   5 ☐ e. So unhappy that life was not worthwhile.

8. Which one of the following best describes the pain and discomfort you have experienced during the past 4 weeks?

   1 ☐ a. Free of pain and discomfort.

   2 ☐ b. Mild to moderate pain or discomfort that prevented no activities.

   3 ☐ c. Moderate pain or discomfort that prevented a few activities.

   4 ☐ d. Moderate to severe pain or discomfort that prevented some activities.

   5 ☐ e. Severe pain or discomfort that prevented most activities.

9. Which one of the following best describes your ability, during the past 4 weeks, to walk? (Note: Walking equipment refers to mechanical supports such as braces, a cane, crutches or a walker.)

   1 ☐ a. Able to walk around the neighborhood without difficulty, and without walking equipment.

   2 ☐ b. Able to walk around the neighborhood with difficulty; but did not require walking equipment or the help of another person .

   3 ☐ c. Able to walk around the neighborhood with walking equipment, but without the help of another person.

   4 ☐ d. Able to walk only short distances with walking equipment, and required a wheelchair to get around the neighborhood.

   5 ☐ e. Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and required a wheelchair to get around the neighborhood.

   6 ☐ f. Unable to walk at all.

10. Which one of the following best describes your ability, during the past 4 weeks, to use your hands and fingers? (Note: Special tools refers to hooks for bottoning clothes, gripping devices for opening jar or lifting small items, and other devices to compensate for limitations of hand or fingers.)

    1 ☐ a. Full use of hands and ten fingers.

    2 ☐ b. Limitations in the use of hand or fingers, but did not require special tools or the help of another person.

    3 ☐ c. Limitations in the use of hands or fingers, independent with use of special tools (did not require the help of another person).

    4 ☐ d. Limitations in the use of hands or fingers, required the help of another person for some tasks (not independent even with use of special tools).

    5 ☐ e. Limitations in the use of hands or fingers, required the help of another person for most tasks(not independent even with use of special tools).

    6 ☐ f. Limitations in the use of hands or fingers, required the help of another person for all tasks (not independent even with use of special tools).

11. Which one of the following best describes your ability, during the past 4 weeks, to remember things?

- 1 ☐ a. Able to remember most things.
- 2 ☐ b. Somewhat forgetful.
- 3 ☐ c. Very forgetful.
- 4 ☐ d. Unable to remember anything at all.

12. Which one of the following best describes your ability, during the past 4 weeks, to think and solve day to day problems?

- 1 ☐ a. Able to think clearly and solve day to day problems.
- 2 ☐ b. Had a little difficulty when trying to think and solve day to day problems.
- 3 ☐ c. Had some difficulty when trying to think and solve day to day problems.
- 4 ☐ d. Had great difficulty when trying to think and solve day to day problems.
- 5 ☐ e. Unable to think or solve day to day problems.

13. Which one of the following best describes your ability, during the past 4 weeks, to perform basic activities?

- 1 ☐ a. Eat, bathe, dress and use the toilet normally.
- 2 ☐ b. Eat, bathe, dress and use the toilet independently, with difficulty.
- 3 ☐ c. Required mechanical equipment to eat, bathe, dress and use the toilet independently.
- 4 ☐ d. Required the help of another person to eat, bathe, dress or use the toilet.

14. Which one of the following best describes how you have been feeling during the past 4 weeks?

- 1 ☐ a. Generally happy, free from worry.
- 2 ☐ b. Occasionally fretful, angry, irritable, anxious or depressed.
- 3 ☐ c. Often fretful, angry, irritable, anxious or depressed.
- 4 ☐ d. Extremely fretful, angry, irritable, anxious or depressed; to the point of needing professional help.

15. Which one of the following best describes the pain or discomfort you have experienced during the past 4 weeks?

- 1 ☐ a. Free of pain and discomfort.
- 2 ☐ b. Occasional pain or discomfort. Discomfort relieved by non-prescription drugs or self-control activity without disruption of normal activities..
- 3 ☐ c. Frequent pain or discomfort. Discomfort relieved by oral medicines with occasional disruption of normal activities.
- 4 ☐ d. Frequent pain or discomfort; frequent disruption of normal activities. Discomfort required prescription narcotis for relief.
- 5 ☐ e. Severe pain or discomfort. Pain not relieved by drugs and constantly disrupted normal activities.

ACCORDION IN-CLINIC FOLLOW-UP FORM

Participant ID: ___ ___ ___ ___ ___ ___ ___ ___ ___
Acrostic: ___ ___ ___ ___ ___ ___
Visit Date: ___ ___ / ___ ___ / 20 ___ ___
Form Completed By: ___ ___
Date Entered: ___ ___ / ___ ___ / 20 ___ ___
Data Entered by: _____

DUMMY BARCODE:

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Remember to update the PARTICIPANT CONTACT INFORMATION FORM at this visit.

Contact Information Status

* Has the participant's contact information changed?

1 ☐ Yes ➡ If "Yes", update the PARTICIPANT CONTACT INFORMATION FORM

2 ☐ No

Contact Type

1. Indicate below the setting of this participant contact.

1 ☐ Phone/Fax/Email

2 ☐ In person visit (in clinic)

3 ☐ Alternate Contact (specify) ➡

2. Is this participant alive?

1 ☐ Yes

2 ☐ No ➡ Date of Death: ____ ____ / ____ ____ / ____ ____ ____ ____ **(Complete Death Report Form)**

3 ☐ Unknown

Follow-Up Events Ascertainment

Date of last events ascertainment ____ ____ / ____ ____ / ____ ____ ____ ____ *(Refer to this date when inquiring below about events that have occurred or procedures that were performed since the last time event data were collected.)*

3. Since **[date of last events ascertainment]**, have you had any of the following events or procedures with or without being admitted to a hospital?

(a) MI (Heart Attack) 1 ☐ Yes ➡
Date of Event: First Occurence ____ ____ / ____ ____ / ____ ____ ____ ____
Date of Event: Second Occurence ____ ____ / ____ ____ / ____ ____ ____ ____
Date of Event: Third Occurence ____ ____ / ____ ____ / ____ ____ ____ ____
Complete an MI REPORT FORM for each event

2 ☐ No

(b) Stroke 1 ☐ Yes ➡
Date of Event: First Occurence ____ ____ / ____ ____ / ____ ____ ____ ____
Date of Event: Second Occurence ____ ____ / ____ ____ / ____ ____ ____ ____
Date of Event: Third Occurence ____ ____ / ____ ____ / ____ ____ ____ ____
Complete a STROKE REPORT FORM for each event

2 ☐ No

(c) Unstable Angina

1 ☐ Yes ➡ Date of Event: First Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

2 ☐ No Date of Event: Second Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

Date of Event: Third Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

Complete an UNSTABLE ANGINA REPORT FORM for each event

(d) Revascularization Procedures including CABG,Coronary (PTCA),

Carotid, or peripheral artery angioplasty(with or without stent)

1 ☐ Yes ➡ Date of Event: First Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

2 ☐ No Date of Event: Second Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

Date of Event: Third Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

Complete a MISCELLANEOUS CARDIOVASCULAR OUTCOME REPORT FORM for each event

(e) Congestive Heart Failure (CHF)

1 ☐ Yes ➡ Date of Event: First Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

2 ☐ No Date of Event: Second Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

Date of Event: Third Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

Complete a MISCELLANEOUS CARDIOVASCULAR OUTCOME REPORT FORM for each event

(f) Lower Extremity Amputation for Ischema

1 ☐ Yes ➡ Date of Event: First Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

2 ☐ No Date of Event: Second Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

Date of Event: Third Occurence ____ ____ / ____ ____ / ____ ____ ____ ____

Complete a MISCELLANEOUS CARDIOVASCULAR OUTCOME REPORT FORM for each event

4. Have you been admitted to the hospital since **[date of last events ascertainment]** including for any events mentioned above?

a. 1 ☐ Yes ➡ How many times were you admitted to the hospital? ____ ____ (number of times)

2 ☐ No **(Go to Question 5)**

b. Were you hospitalized for, or did any of the following occur during hospitalization(s)?

1 ☐ Yes ➡ 1 ☐ Aneurysm Repair 1 ☐ Motor vehicle accident in which you were the driver

2 ☐ No 1 ☐ Other Accident or injury (specify) ➡ ____

1 ☐ Other (specify) ➡ ____

5. Have you had dialysis since **[date of last events ascertainment]**?

1 ☐ Yes ➡

1 ☐ Hemodialysis ➡ Ongoing Hemodialysis? 1 ☐ Yes 2 ☐ No

1 ☐ Peritoneal Dialysis

2 ☐ No

6. Since **[date of last events ascertainment]**, have you had any hypoglycemic events that were so severe that they required medical or paramedical attention and either 1)had a documented plasma glucose <50 mg/dl (2.9 mmol/L) or 2) symptoms that promptly recovered with oral carbohydrate, intravenous glucose or glucagon? (Does not include events treated by self or non-medical personnel).

1 ☐ Yes ➡ Enter the number of hypoglycemic events ➡ ____ ____

Enter the month and year for each event below. Start with the most recent event and end with most distant:

#1 ____ / ____ #4 ____ / ____
#2 ____ / ____ #5 ____ / ____
#3 ____ / ____

2 ☐ No

7. Have you smoked cigarettes in the last 30 days? 1 ☐ Yes 2 ☐ No

8. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

9. Compared to one year ago, how would you rate your health in general <u>now</u>:

Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

10. Which of the following best describes your living situation?

Living Independently 0 ☐

Assisted Living or Receiving Home Care of any kind 1 ☐

Alzheimer's or memory care, including day care 2 ☐

Nursing Home or Care Center 3 ☐

Other 4 ☐ _____

Self-management of diabetes management

11. How much help from others do you receive in order to follow your Doctor's plan for managing your disease?

0 ☐ A lot 1 ☐ Some 2 ☐ A little 3 ☐ None

12. How much help from others do you receive to remember to take your diabetes medicine?

0 ☐ A lot 1 ☐ Some 2 ☐ A little 3 ☐ None

13. How much help from others do you receive to remember to check your blood sugar levels?

0 ☐ A lot 1 ☐ Some 2 ☐ A little 3 ☐ None

Insurance Status

14. Which of the following best describes your current type of insurance coverage? (mark all that apply)

1 ☐ Medicare 1 ☐ Medicaid 1 ☐ VA 1 ☐ Tricare/CHAMPVA 1 ☐ Provincial Health Insurance Plan

1 ☐ Private/Commercial 1 ☐ HMO 1 ☐ Don't know 1 ☐ Uninsured

15. Do you have full or partial drug benefits under your insurance or Provincial health plan?

1 ☐ Yes 2 ☐ No 3 ☐ Don't know 4 ☐ Uninsured

Concomitant Medications

16. Indicate all ***prescribed*** medications that the participant is currently taking ***on a regular basis*** by marking the appropriate boxes.

Antihypertensive Agents

1 ☐ Loop diuretics
1 ☐ Thiazide diuretics
1 ☐ ACE inhibitors
1 ☐ Potassium supplements
1 ☐ Angiotensin type 2 antagonists (ARB)
1 ☐ Peripheral alpha-blockers
1 ☐ Any dihydropyridine calcium-channel blocker (CCB)
1 ☐ Any non-dihydropyridine calcium-channel blocker (CCB)
1 ☐ Direct Renin Inhibitors (Aliskiren)
1 ☐ Central alpha-adrenergic agonists
1 ☐ Beta-Blockers
1 ☐ ARB
1 ☐ Reserpine
1 ☐ K-sparing diuretic agents
1 ☐ Vasodialtors
1 ☐ Other antihypertensive agents

Cardiovascular Drugs

1 ☐ Digitalis preparations
1 ☐ Anti-arrhythmics
1 ☐ Nitrates
1 ☐ Other cardiovascular drugs

Diabetes Treatments

1 ☐ Sulfonylureas
1 ☐ Biguanides
1 ☐ Thiazolidinediones
1 ☐ Alpha-glucosidase inhibitors
1 ☐ Long-acting Insulin (e.g. Glargine, Detemir, NPH, Other)
1 ☐ Amylin-mimetics
1 ☐ Regular Insulins
1 ☐ Rapid-acting Insulins (e.g. Lispro, Aspart, Glulisine)
1 ☐ Incretin Agonists
1 ☐ Premixed Insulins
1 ☐ Meglitinides
1 ☐ DPP-4 Inhibitors
1 ☐ Bromocriptine
1 ☐ SGLT-2 inhibitors
1 ☐ Other diabetes treatments

Lipid-Lowering Drugs

1 ☐ Bile-acid sequestrants
1 ☐ HMG CoA reductace inhibitors (statins)
1 ☐ Fibrates
1 ☐ Other lipid-lowering drugs
1 ☐ Cholesterol absorption inhibitors
1 ☐ Niacin and nicotinic acid

Miscellaneous Prescribed Therapies

1 ☐ Oral anticoagulants (warfarin, coumadin, anisindione)
1 ☐ Non-steroidal anti-inflammatory agents (excluding aspirin)
1 ☐ Inhibitors of platelet aggregation (except aspirin)
1 ☐ Cox-2 inhibitors
1 ☐ Heparins
1 ☐ Aspirin
1 ☐ Progestins
1 ☐ Estrogens (excluding vaginal creams)
1 ☐ Thyroid agents
1 ☐ Oral asthma drugs (except steroids)
1 ☐ Inhaled steroids for asthma
1 ☐ Oral steroids
1 ☐ Any antidepressant
1 ☐ Any antipsychotic
1 ☐ Weight loss drugs
1 ☐ Erectile dysfunction drugs
1 ☐ Drugs for Osteoperosis
1 ☐ Diuretic for fluid retention
1 ☐ Any medicine for memory loss
1 ☐ Any other (prescribed) medication not listed above

17. Indicate **Non-Prescibed** medications that the participant is currently taking ***on a regular basis*** by marking the appropriate boxes.

1 ☐ Vitamins and/or nutritional supplements
1 ☐ Over-the-counter medications
1 ☐ Herbal/alternative medication therapies

18. a. Is the participant currently participating in another intervention trial? 1 ☐ Yes 2 ☐ No **(Go to Question 19)**

b. Is the participant taking any drug(s) associated with this intervention trial? 1 ☐ Yes 2 ☐ No

19. Participant Weight: ____ ____ ____ . ____ Measurement recorded in: 1 ☐ pounds 2 ☐ kilograms

20. Participant Height: ____ ____ ____ . ____ Measurement recorded in: 1 ☐ inches 2 ☐ centimeters

21. Waist Circumference: ____ ____ ____ . ____ Measurement recorded in: 1 ☐ inches 2 ☐ centimeters

Sitting Blood Pressure and Heart Rate

22. **Systolic BP** (average of 3) ____ ____ ____ mm Hg

23. **Diastolic BP** (average of 3) ____ ____ ____ mm Hg

24. **Heart Rate** (average of 3) ____ ____ ____ bpm

Eye Disease During Past Year

25. Has the participant had eye surgery, including laser photocoagulation, since the last study visit?

1 ☐ Yes ➡ Please indicate type below

2 ☐ No

Right Eye	**Left Eye**
1 ☐ Cataract removal	1 ☐ Cataract removal
1 ☐ Retinal laser photocoagulation for diabetic retinopathy	1 ☐ Retinal laser photocoagulation for diabetic retinopathy
1 ☐ Yag laser for cataract capsule	1 ☐ Yag laser for cataract capsule
1 ☐ Vitrectomy for diabetic retinopathy	1 ☐ Vitrectomy for diabetic retinopathy
1 ☐ Other ☐	1 ☐ Other ☐

26. Has the participant experienced any of the following vision problems since the last study clinic visit?

(a) Retinopathy 1 ☐ Yes ➡ Indicate Eye ➡ 1 ☐ Left 1 ☐ Right
2 ☐ No

(b) Vision Loss 1 ☐ Yes ➡ Indicate Eye ➡ 1 ☐ Left 1 ☐ Right
2 ☐ No

(c) Blindness 1 ☐ Yes ➡ Indicate Eye ➡ 1 ☐ Left 1 ☐ Right
2 ☐ No

27. Eye Injections

a. Has the participant had injections in or around the eye since the start of ACCORD?

Right Eye	**Left Eye**
1 ☐ Yes ➡ If "Yes", answer question b and c.	1 ☐ Yes ➡ If "Yes", answer question b and c.
2 ☐ No	2 ☐ No

b. Has the participant had injections in the eye (Intraocular) since the start of ACCORD:

Right Eye	**Left Eye**
1 ☐ Yes ➡ If "Yes", please indicate all that apply below	1 ☐ Yes ➡ please indicate all that apply below
2 ☐ No	2 ☐ No
i. ☐ Lucentis (ranibizumab)	i. ☐ Lucentis (ranibizumab)
ii. ☐ Avastin (bevacizumab)	ii. ☐ Avastin (bevacizumab)
iii. ☐ VEGF-Trap Eye (Aflibercept)	iii. ☐ VEGF-Trap Eye (Aflibercept)
iv. ☐ Steroids (triamcinolone acetonide)	iv. ☐ Steroids (triamcinolone acetonide)
v. ☐ Other ____	v. ☐ Other ____
vi. ☐ Not known	vi. ☐ Not known

c. Has the participant had injections around the eye (subconjunctival/periocular) since the start of ACCORD:

Right Eye	**Left Eye**
1 ☐ Yes ➡ If "Yes", please indicate all that apply below	1 ☐ Yes ➡ please indicate all that apply below
2 ☐ No	2 ☐ No
i. ☐ Steroids (triamcinolone acetonide)	i. ☐ Steroids (triamcinolone acetonide)
ii. ☐ Other ____	ii. ☐ Other ____

Foot Exam

28. Right Foot

Amputation/Foot Inspection: Document amputation history and assess foot characteristics as outlines below.

Has participant ever had amputation of a lower extremity on the right side?

1 ☐ Yes (complete box for amputation description) 2 ☐ No (skip to part (a) below)

Amputation Description (mark one only)

1 ☐ Toe 2 ☐ Ray (metatarsal)

3 ☐ Forefoot 4 ☐ Foot

5 ☐ Below knee 6 ☐ Above knee

Stop here, do not complete (a) - (e) below.

(a) Appearance:

0 ☐ Normal

1 ☐ Abnormal (complete table below, mark all that apply)

1 ☐ Deformities 1 ☐ Infection

1 ☐ Dry skin, callus 1 ☐ Fissure

1 ☐ Other(specify below)

(b) Ulceration:

0 ☐ Absent 1 ☐ Present

(c) Ankle Reflexes

0 ☐ Present 0.5 ☐ Present/Reinforcement

1 ☐ Absent

(d) Vibration (perception at great toe)

0 ☐ Present (≤10 sec) 0.5 ☐ Reduced (>10 sec)

1 ☐ Absent

(e) 10gm Filament (number of applications detected)

0 ☐ Present (≥ 8) 0.5 ☐ Reduced (1 - 7) 1 ☐ Absent

28. Left Foot

Amputation/Foot Inspection: Document amputation history and assess foot characteristics as outlines below.

Has participant ever had amputation of a lower extremity on the left side?

1 ☐ Yes (complete box for amputation description) 2 ☐ No (skip to part (a) below)

Amputation Description (mark one only)

1 ☐ Toe 2 ☐ Ray (metatarsal)

3 ☐ Forefoot 4 ☐ Foot

5 ☐ Below knee 6 ☐ Above knee

Stop here, do not complete (a) - (e) below.

(a) Appearance:

0 ☐ Normal

1 ☐ Abnormal (complete table below, mark all that apply)

1 ☐ Deformities 1 ☐ Infection

1 ☐ Dry skin, callus 1 ☐ Fissure

1 ☐ Other(specify below)

(b) Ulceration:

0 ☐ Absent 1 ☐ Present

(c) Ankle Reflexes

0 ☐ Present 0.5 ☐ Present/Reinforcement

1 ☐ Absent

(d) Vibration (perception at great toe)

0 ☐ Present (≤10 sec) 0.5 ☐ Reduced (>10 sec)

1 ☐ Absent

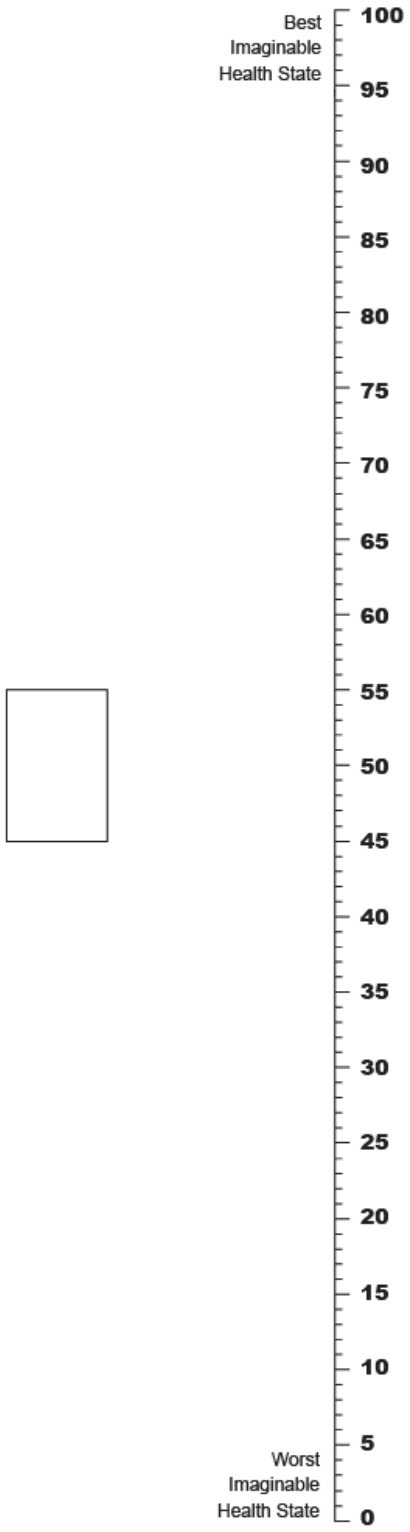
(e) 10gm Filament (number of applications detected)

0 ☐ Present (≥ 8) 0.5 ☐ Reduced (1 - 7) 1 ☐ Absent

TO BE COMPLETED BY THE PARTICIPANT

Feeling Thermometer: To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked by 100 and the worst state you can imagine is marked by 0.

We would like for you to indicate on this scale, in your opinion, how good or bad your own health is **TODAY**. Please do this by drawing a line from the center of the box below to whichever point on the scale indicates how good or bad your current health state is.



Score ____ ____ ____

ACCORDION VISUAL ACUITY WORKSHEET

Participant ID: ___ ___ ___ ___ ___ ___ ___ ___ ___

Acrostic: ___ ___ ___ ___ ___ ___

Visit Date: ___ ___ / ___ ___ / 20 ___ ___

Form Completed By: ___ ___

Date Entered: ___ ___ / ___ ___ / 20 ___ ___

Data Entered by: _____

DUMMY BARCODE:

B0000000

CIRCLE each letter that the participant identifies correctly, place a slash (/) through any letters identified incorrectly or skipped, write the total correct for each row in the column at the right. Continue the test until the participant cannot identify <u>any</u> letters in a given row. If the total number of letters read correctly is 19 or fewer, move the participant to a distance of 1 meter from the chart and test the acuity at this distance using only the first six rows of test letters.

Row	Snellen Equivalent	Chart R Letters	Number Correct at 4 Meters
1	20/200	H V Z D S	
2	20/160	N C V K D	
3	20/125	C Z S H N	
4	20/100	O N V S R	
5	20/80	K D N R O	
6	20/63	Z K C S V	
7	20/50	D V O H C	
8	20/40	O H V C K	
9	20/32	H Z C K O	
10	20/25	N C K H D	
11	20/20	Z H C S R	
12	20/16	S Z R D N	
13	20/13	H C D R O	
14	20/10	R D O S N	

Total number correct at 4 meters: ____

Row	Snellen Equivalent	Chart R Letters	Number Correct at 1 Meter
1	20/800	H V Z D S	
2	20/640	N C V K D	
3	20/500	C Z S H N	
4	20/400	O N V S R	
5	20/320	K D N R O	
6	20/260	Z K C S V	

Total number correct at 1 meter: ____

Visual Acuity Score - Right Eye

A. Total Number correct at 4 meters ____

B. If A ≥ 20, add 30 + ____

C. Total correct at I meter (if not tested, place a zero + ____

<u>This data is to be entered on the Visual Acuity data entry page</u>

VISUAL ACUITY SCORE - RIGHT EYE (SUM OF A,B, AND C) ____

Approximate Snellen Fraction (lowest line with 1 or fewer mistakes 20/ ____

CIRCLE each letter that the participant identifies correctly, place a slash (/) through any letters identified incorrectly or skipped, write the total correct for each row in the column at the right. Continue the test until the participant cannot identify any letters in a given row. If the total number of letters read correctly is 19 or fewer, move the participant to a distance of 1 meter from the chart and test the acuity at this distance using only the first six rows of test letters.

Row	Snellen Equivalent	Chart R Letters	Number Correct at 4 Meters
1	20/200	H V Z D S	
2	20/160	N C V K D	
3	20/125	C Z S H N	
4	20/100	O N V S R	
5	20/80	K D N R O	
6	20/63	Z K C S V	
7	20/50	D V O H C	
8	20/40	O H V C K	
9	20/32	H Z C K O	
10	20/25	N C K H D	
11	20/20	Z H C S R	
12	20/16	S Z R D N	
13	20/13	H C D R O	
14	20/10	R D O S N	

Total number correct at 4 meters: ____

Row	Snellen Equivalent	Chart R Letters	Number Correct at 1 Meter
1	20/800	H V Z D S	
2	20/640	N C V K D	
3	20/500	C Z S H N	
4	20/400	O N V S R	
5	20/320	K D N R O	
6	20/260	Z K C S V	

Total number correct at 1 meter: ____

Visual Acuity Score - Left Eye

A. Total Number correct at 4 meters ____

B. If A ≥ 20, add 30 + ____

C. Total correct at I meter (if not tested, place a zero + ____

This data is to be entered on the Visual Acuity data entry page

VISUAL ACUITY SCORE - LEFT EYE (SUM OF A,B, AND C) ____

Approximate Snellen Fraction (lowest line with 1 or fewer mistakes 20/ ____