AVID

Patient Quality of Life: Half Yearly

Year, 6 Month

Date completed: ☐☐/☐☐/☐☐☐☐ (month / day / year) days44

☐☐-☐☐☐-☐ ☐☐☐☐ Affix Patient ID # Here seqnum44

The information in this questionnaire is extremely important. Thank you very much for taking the time to fill it out.

INSTRUCTIONS: This form is to be completed by the AVID patient without help from others (for example, with reading or translation). If this is not possible, please check this box ☐ and return the form in the envelope provided.

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. Place a √ in the box of your choice, like this: ☑. If you are unsure about how to answer a question, please give the best answer you can. If you make a mistake, erase it completely.

Did you complete this form during your clinic visit? yes ☐ no ☐ clinic44

Section A

1. In general, would you say your health is: Place a √ in one box.

Excellent	☐ 1
Very Good	☐ 2
Good	☐ 3
Fair	☐ 4
Poor	☐ 5

pa144

2. Compared to one year ago, how would you rate your health in general <u>now</u>? Place a √ in one box.

Much better now than one year ago	☐ 1
Somewhat better now than one year ago	☐ 2
About the same as one year ago	☐ 3
Somewhat worse now than one year ago	☐ 4
Much worse now than one year ago	☐ 5

pa244

rtnum44

3. The following items are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much? Place a √ in one box in each row.

Activities		Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	pa3a44	☐ 1	☐ 2	☐ 3
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	pa3b44	☐ 1	☐ 2	☐ 3
Lifting or carrying groceries	pa3c44	☐ 1	☐ 2	☐ 3
Climbing **several** flights of stairs	pa3d44	☐ 1	☐ 2	☐ 3
Climbing **one** flight of stairs	pa3e44	☐ 1	☐ 2	☐ 3
Bending, kneeling, or stooping	pa3f44	☐ 1	☐ 2	☐ 3
Walking **more than a mile**	pa3g44	☐ 1	☐ 2	☐ 3
Walking **several blocks**	pa3h44	☐ 1	☐ 2	☐ 3
Walking **one block**	pa3i44	☐ 1	☐ 2	☐ 3
Bathing or dressing yourself	pa3j44	☐ 1	☐ 2	☐ 3

4. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>? Place a √ in one box on each line.

	Yes	No	
Cut down the **amount of time** you spent on work or other activities	☐ 1	☐ 2	pa4a44
Accomplished less than you would like	☐ 1	☐ 2	pa4b44
Were limited in the **kind** of work or other activities	☐ 1	☐ 2	pa4c44
Had **difficulty** performing the work or other activities (for example, it took extra effort)	☐ 1	☐ 2	pa4d44

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? Place a √ in one box on each line.

	Yes	No	
Cut down the **amount of time** you spent on work or other activities	☐ 1	☐ 2	pa5a44
Accomplished less than you would like	☐ 1	☐ 2	pa5b44
Didn't do work or other activities as **carefully** as usual	☐ 1	☐ 2	pa5c44

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? Place a √ in one box.

- Not at all ☐ 1
- Slightly ☐ 2
- Moderately ☐ 3 pa644
- Quite a bit ☐ 4
- Extremely ☐ 5

7. How much bodily pain have you had during the past 4 weeks? Place a √ in one box.

- None ☐ 1
- Very mild ☐ 2
- Mild ☐ 3
- Moderate ☐ 4 pa744
- Severe ☐ 5
- Very severe ☐ 6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework) ? Place a √ in one box.

- Not at all ☐ 1
- A little bit ☐ 2
- Moderately ☐ 3 pa844
- Quite a bit ☐ 4
- Extremely ☐ 5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time	
Did you feel full of pep?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	pa9a44
Have you been a very nervous person?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	pa9b44
Have you felt so down in the dumps that nothing could cheer you up?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	pa9c44
Have you felt calm and peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	pa9d44
Did you have a lot of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	pa9e44
Have you felt downhearted and blue?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	pa9f44
Did you feel worn out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	pa9g44
Have you been a happy person?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	pa9h44
Did you feel tired?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	pa9i44

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interefered with social activities (like visiting with friends, relatives, etc.)?
Place a √ in one box.

All of the time	☐ 1	
Most of the time	☐ 2	
Some of the time	☐ 3	pa1044
A little of the time	☐ 4	
None of the time	☐ 5	

11. How TRUE or FALSE is each of the following statements for you?
Place a √ in one box on each line.

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
I seem to get sick a little easier than other people.	pa11a44	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I am as healthy as anybody I know.	pa11b44	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I expect my health to get worse.	pa11c44	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My health is excellent.	pa11d44	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

SECTION B

1. In the past 3 months, have you experienced:

Cardiovascular	Yes	No	
Fast pulse (>100 bpm) or heart racing	☐ 1	☐ 2	pc144
Palpitations or flip-flopping of heart	☐ 1	☐ 2	pc244
Dizziness or near fainting	☐ 1	☐ 2	pc344
Passing out	☐ 1	☐ 2	pc444
Angina	☐ 1	☐ 2	pc544
Shortness of breath	☐ 1	☐ 2	pc644
Difficulty walking	☐ 1	☐ 2	pcdw44

Neurological	Yes	No	
Tremors or shaking of hands	☐ 1	☐ 2	pc744
Numbness or tingling	☐ 1	☐ 2	pc844
Coldness in hands/feet	☐ 1	☐ 2	pc944
Headaches	☐ 1	☐ 2	pc1044
Restlessness, nervousness	☐ 1	☐ 2	pc1144
Confusion	☐ 1	☐ 2	pc1244
Short-term memory loss	☐ 1	☐ 2	pc1344
Long-term memory loss	☐ 1	☐ 2	pc1444
Ringing in ears	☐ 1	☐ 2	pc1544

	Yes	No	
Visual			
Blurred vision	☐ 1	☐ 2	pc1644
Halo vision or seeing lights around things	☐ 1	☐ 2	pc1744
Sensitivity to light	☐ 1	☐ 2	pc1844
Problems sleeping			
Difficulty falling asleep	☐ 1	☐ 2	pc1944
Interrupted sleep	☐ 1	☐ 2	pc2044
Insomnia	☐ 1	☐ 2	pc2144
Nightmares	☐ 1	☐ 2	pc2244
Gastrointestinal			
Nausea	☐ 1	☐ 2	pc2344
Vomitting	☐ 1	☐ 2	pc2444
Constipation	☐ 1	☐ 2	pc2544
Diarrhea	☐ 1	☐ 2	pc2644
Heartburn	☐ 1	☐ 2	pc2744
Abdominal pain	☐ 1	☐ 2	pc2844
Metallic taste in your mouth	☐ 1	☐ 2	pc2944
Dermatological			
Skin rash	☐ 1	☐ 2	pc3044
Burning or prickling of skin or eyes	☐ 1	☐ 2	pc3144
Genito-urinary			
Difficulty in urinating	☐ 1	☐ 2	pc3244
Reduced sexual activity	☐ 1	☐ 2	pc3344

Feeling fearful about:	Yes	No		
Getting an attack	☐ 1	☐ 2		pc3444
Heart stopping	☐ 1	☐ 2		pc3544
Not being resuscitated	☐ 1	☐ 2		pc3644
Dying	☐ 1	☐ 2		pc3744
ICD firing off	☐ 1	☐ 2	3 ☐ no device	pc3844
ICD not firing off	☐ 1	☐ 2	3 ☐ no device	pc3944

Feeling particularly anxious about situations such as:	Yes	No	
A family problem	☐ 1	☐ 2	pc4044
A financial problem	☐ 1	☐ 2	pc4144
Your health	☐ 1	☐ 2	pc4244
Your future	☐ 1	☐ 2	pc4344

Have you experienced feeling:	Yes	No	
Dependent on others	☐ 1	☐ 2	pc4444
Other people making you feel dependent	☐ 1	☐ 2	pc4544
Sad	☐ 1	☐ 2	pc4644
Hopeless	☐ 1	☐ 2	pc4744
Frustrated	☐ 1	☐ 2	pc4844
Irritable	☐ 1	☐ 2	pc4944
Disinterested in what is going on around you	☐ 1	☐ 2	pc5044
Decreased energy	☐ 1	☐ 2	pc5144
Increased energy	☐ 1	☐ 2	pc5244
Drowsiness	☐ 1	☐ 2	pc5344
Tiredness	☐ 1	☐ 2	pc5444
Feeling anxious in general	☐ 1	☐ 2	pc5544
Increased sense of well-being	☐ 1	☐ 2	pc5644
Improved confidence or outlook	☐ 1	☐ 2	pc5744

If you have experienced any concerns not addressed above, please describe:

_____

_____

_____

Section C

1. How do you feel about your life at the present time? pb144

(Check under the number that best describes your life)

Worst Possible Life										Best Possible Life
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. In the past four weeks, has your heart rhythm problem

- Prevented you from driving ☐ 1
- Reduced the amount of driving you do ☐ 2
- Had no impact on your driving ☐ 3
- Did not drive prior to heart rhythm problem ☐ 4

pb544

3. Over the <u>past 4 weeks</u>, how much has your heart rhythm problem interfered with your enjoyment of life?

- It has severely limited my enjoyment of life ☐ 1
- It has moderately limited my enjoyment of life ☐ 2
- It has slightly limited my enjoyment of life ☐ 3
- It has barely limited my enjoyment of life ☐ 4
- It has not limited my enjoyment of life ☐ 5

pb844

4. If you had to spend the rest of your life with your heart rhythm problem the way it is right now, how would you feel about this?

- Not satisfied at all ☐ 1
- Mostly dissatisfied ☐ 2
- Somewhat satisfied ☐ 3
- Mostly satisfied ☐ 4
- Highly satisfied ☐ 5

pb944

5 How often do you worry that you may die suddenly?

- I can't stop worrying about it ☐ 1
- I often think or worry about it ☐ 2
- I occasionally worry about it ☐ 3
- I rarely think or worry about it ☐ 4
- I never think or worry about it ☐ 5

pb1044

6. Over the <u>past 4 weeks</u>, how much has your heart condition limited your ability to have sexual intercouse?

- I have been severely limited ☐ 1
- I have been moderately limited ☐ 2
- I have been somewhat limited ☐ 3
- I have been a little limited ☐ 4
- I have not been limited ☐ 5
- No opportunity, or did not do for other reasons ☐ 6

pb1144

7. Has your physician asked you to reduce your activities in the following areas?

	Yes	No	
Work	☐ 1	☐ 2	pb13a44
Driving	☐ 1	☐ 2	pb13b44
Amount of physical activity	☐ 1	☐ 2	pb13c44