

CLEVER

Patient Functioning and Quality of Life Questionnaire: Baseline

Instructions

This questionnaire 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.

Any information that would permit you to be identified as a member of the study will be regarded as strictly confidential and will be used only for this study.

Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

The Research Coordinator will hand you this Questionnaire. Please complete to the best of your ability since the Research Coordinator is not permitted to answer any questions during your completion time.

Now: pageno FLOAT,
NUMBER (6, 2)

was:
pageno (f, 5)

visno (vc, 20)

subid (VC,15)

PS: Context
Panel: Context

Form to be completed by the Research Coordinator:

Site ID	Site (F,3)	Date of Survey	survmm/survdd/survyv	survdt()
Patient No.	Patient (VC,4)	Before start of treatment?	<input type="checkbox"/> (1) YES	
Patient Initials	PATINIT (VC,3)		pretx <yesno>	<input type="checkbox"/> (2) NO

This form was completed: (1) By the Patient
 (2) By Research Coordinator via interview
 (3) By Proxy

formcmpl<contact3>

PS: QOLBas01
PT: QOLBas01
Panel: QOLBas01

By circling one number in each group below, please indicate which statements best describe your own health state today.

PS: QOLBas02
PT: QOLBas02
Panel: QOLBas02

1. Mobility (Circle one) mobility <qolwalk>

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

2. Self-Care (Circle one) selfcare <qolselfcare>

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

3. Usual Activities (Circle one) uslactv <qolactiv>

(e.g. work, study, housework, family or leisure activities)

- 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

4. Pain/Discomfort (Circle one) discmfrt <discom>

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

5. Anxiety/Depression (Circle one) anxiety <anx>

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

Your Health and Well-Being

PS: QOLBas03
 PT: QOLBas03
 Panel: QOLBas03

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. *Thank you for completing this survey!*

For each of the following questions, please mark an in the one box that best describes your answer.

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

Excellent	Very good	Good	Fair	Poor	
▼	▼	▼	▼	▼	
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	health <health1>

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Yes, limited a lot	Yes, limited a little	No, not limited at all
▼	▼	▼

- a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf..... modactv <limit> 1..... 2..... 3
- b. Climbing several flights of stairs ... sevstair <limit> 1..... 2..... 3

3. 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 your physical health?

	Yes	No	
	▼	▼	
a. <u>Accomplished less</u> than you would like.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	phyaccmp <yesno>
b. Were limited in the <u>kind</u> of work or other activities.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	physkind <yesno>

4. 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)?

	Yes	No	
	▼	▼	
a. <u>Accomplished less</u> than you would like.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	emoaccmp <yesno>
b. Did work or other activities <u>less carefully</u> than usual.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	emotcare <yesno>

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely	workpain <pain2>
▼	▼	▼	▼	▼	
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	

6. 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...

PS: QOLBas05
PT: QOLBas05
Panel: QOLBas05

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
▼	▼	▼	▼	▼	▼

a. Have you felt calm and peaceful? 1 2 3 4 5 6

peace
<QOLstate>

b. Did you have a lot of energy? 1 2 3 4 5 6

energy
<QOLstate>

c. Have you felt downhearted and blue? 1 2 3 4 5 6

down
<QOLstate>

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

social <active>

The Peripheral Artery Questionnaire(PAQ)

The following questions refer to blockages in the arteries of your body, particularly your legs, and how that might affect your life. Please read and complete the following questions. There are no right or wrong answers. Please mark the answer that best applies to you.

PS: QOLBas06
PT: QOLBas06
Panel: QOLBas06

1. Blockages in the arteries, often referred to as **peripheral vascular disease**, affect different people in different ways. Some feel cramping or aching while others feel fatigue. Which leg (or buttock) causes you the most severe **discomfort, fatigue, pain, aching, or cramps**?

the **Right** leg
(buttock)

the **Left** leg
(buttock)

Both are the same

Neither

leg
<PAQleg>

2. Please review the list below and indicate how much limitation you have due to **your peripheral vascular disease** (discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)) over the past 4 weeks.

Place an **X** in one box on each line

Activity	Extremely Limited	Quite a bit Limited	Moderately Limited	Slightly Limited	Not at all Limited	Limited for other reasons or did not do the activity
Walking around your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> home <limit2>
Walking 1-2 blocks on level ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> levgrdtwo <limit2>
Walking 1-2 blocks up a hill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> uphill <limit2>
Walking 3-4 blocks on level ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> levgrdfour <limit2>
Hurrying or jogging (as if to catch a bus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> jogging <limit2>
Vigorous work or exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> vigwork <limit2>

3. Compared with 4 weeks ago, have your symptoms of **peripheral vascular disease** (discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)) changed?

My symptoms have become...

PS: QOLBas07
PT: QOLBas07
Panel: QOLBas07

Much worse	Slightly worse	Not changed	Slightly better	Much better	I have had no symptoms over the past 4 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

sympchx
<PAQsympchx>

4. Over the past 4 weeks, how many times did you have **discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)**?

painfreq
<PAQpainfreq>

All of the time	Several times per day	At least once a day	3 or more times per week but not every day	1-2 times per week	Less than once a week	Never over the past 4 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Over the past 4 weeks, how much has **discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)** bothered you?

painbother
<PAQpainbother>

It has been ...

Extremely bothersome	Moderately bothersome	Somewhat bothersome	Slightly bothersome	Not at all bothersome	I've had no leg discomfort
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Over the past 4 weeks, how often have you been awakened with **pain, aching, or cramps in your legs or feet**?

painawake
<PAQpainawake>

Every night	3 or more times per week but not every night	1-2 times per week	Less than once a week	Never over the past 4 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. How satisfied are you that everything possible is being done to treat your **peripheral vascular disease**?

Not satisfied at all	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAQsatisfied
<PAQsatisfied>

8. How satisfied are you with the explanations your doctor has given you about your **peripheral vascular disease**?

Not satisfied at all	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

explanation
<PAQsatisfied>

9. Overall, how satisfied are you with the current treatment of your **peripheral vascular disease**?

Not satisfied at all	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

treatment
<PAQsatisfied>

10. Over the past 4 weeks, how much has your **peripheral vascular disease** limited your enjoyment of life?

It has extremely limited my enjoyment of life	It has limited my enjoyment of life quite a bit	It has moderately limited my enjoyment of life	It has slightly limited my enjoyment of life	It has limited my enjoyment of life at all
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

enjoyllife <PAQlimit>

11. If you had to spend the rest of your life with your **peripheral vascular disease** the way it is right now, how would you feel about this?

Not at all satisfied	Mostly dissatisfied	Somewhat satisfied	Mostly satisfied	Completely satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

forlife <PAQfeel>

12. Over the past 4 weeks, how often have you felt discouraged or down in the because of your **peripheral vascular disease**?

I felt that way all of the time	I felt that way most of the time	I occasionally felt that way	I rarely felt that way	I never felt that way
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

down <PAQdown>

13. How much does your **peripheral vascular disease** affect your lifestyle? Please indicate how your **discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)** may have limited your participation in the following activities over the past 4 weeks.

PS: QOLBas09
PT: QOLBas09
Panel: QOLBas09

Please place an **X** in one box on each line

Activity	Severely limited	Limited quite a bit	Moderately limited	Slightly limited	Did not limit at all	Does not apply or did not do for other reasons
recreactv <limit4> Hobbies, recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
visitactv <limit4> Visiting family or friends out of your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
workactv <limit4> Working or doing household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employment

In order to compare your experiences with other patients, we would like to know a little more about you as a person. By answering the following questions, we will be better able to evaluate your experiences. **If you feel that any question is too personal, please skip it and go on to the next question.**

PS: QOLBas10
PT: QOLBas10
Panel: QOLBas10

1. Which term best describes your most recent main job? *(Circle one)*

employ <employ>

- Professional or technical (lawyer, teacher, social worker, scientist, nurse, doctor, state police, computer programmer)..... 1
- Clerical worker (secretary, receptionist, data entry, cashier)..... 2
- Service worker (janitor, cook, waitress/waiter, nurse's aide, security guard, driver, road crew worker, subway conductor)..... 3
- Craftsman or tradesman (carpenter, electrician, mechanic) 4
- Other (please describe) employsp (vc, 200) 5

2. What was your total family income last year before taxes? *(Circle one)*

income <income>

- Less than \$10,000 1
- \$10,000 to \$20,000..... 2
- \$20,000 to \$40,000..... 3
- \$40,000 to \$60,000..... 4
- \$60,000 to \$80,000..... 5
- \$80,000 to \$100,000..... 6
- More than \$100,000 7

3. Which of the following statements best describes your work situation for the past month? (*Circle one*)

worksitn <situation>

PS: QOLBas11
PT: QOLBas11
Panel: QOLBas11

- Working 1
- Unemployed (but seeking work)..... 2
- On disability..... 3
- Retired 4
- On sick leave..... 5

Personal Information

4. What is the highest grade of school you completed? (*Circle one*)

schling <schooling>

- Grade eight or less 1
- Some high school 2
- Graduated from high school 3
- Some college or did not attend college, but had additional special training.. 4
- Graduated from college 5
- Post-graduate work 6

5. How many people, including yourself, live in your household? hshold (f, 5) people

6. Are you presently: (*Circle one*)

marital <marital>

- Married or living as married 1
- Divorced or separated 2
- Widowed..... 3
- Never Married 4

Thank you for participating in this study!

CLEVER

Patient Functioning and Quality of Life Questionnaire: Follow up

Instructions

This questionnaire 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.

Any information that would permit you to be identified as a member of the study will be regarded as strictly confidential and will be used only for this study.

Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

Now: pageno FLOAT,
NUMBER (6, 2)

was:
pageno (f, 5)

Complete to the best of your ability.

PS: Context
Panel: Context

visno (vc, 20)

subid (VC,15)

Completed by the Research Coordinator:

Site ID	<input type="text" value="Site (F,3)"/>	Date of Survey	<input type="text" value="survmm/survdd/survy"/>	<input type="text" value="survdt()"/>
Patient No.	<input type="text" value="Patient (VC,4)"/>			
Patient Initials	<input type="text" value="PATINIT (VC,3)"/>			

Time Point: 6 Month 18 Month

This form was completed:

(1) By the Patient

(2) By the Proxy

(3) Via HCRI Patient Interviewer

PS: QOLAnn01
PT: QOLAnn01
Panel: QOLAnn01

By circling one number in each group below, please indicate which statements best describe your own health state today.

PS: QOLAnn02
PT: QOLAnn02
Panel: QOLAnn02

1. Mobility (Circle one)

mobility <qolwalk>

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

2. Self-Care (Circle one)

selfcare <qolselfcare>

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

3. Usual Activities (Circle one)

uslactv <qolactiv>

(e.g. work, study, housework, family or leisure activities)

- 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

4. Pain/Discomfort (Circle one)

discmfrt <discom>

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

5. Anxiety/Depression (Circle one)

anxiety <anx>

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

Your Health and Well-Being

PS: QOLAnn03
 PT: QOLAnn03
 Panel: QOLAnn03

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. *Thank you for completing this survey!*

For each of the following questions, please mark an in the one box that best describes your answer.

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

Excellent	Very good	Good	Fair	Poor	
▼	▼	▼	▼	▼	
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	health <health1>

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Yes, limited a lot	Yes, limited a little	No, not limited at all
▼	▼	▼

a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf 1 2 3 modactv <limit>

b. Climbing several flights of stairs 1 2 3 sevstair <limit>

3. 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 your physical health?

	Yes	No	
	▼	▼	
a. <u>Accomplished less</u> than you would like.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	physaccmp <yesno>
b. Were limited in the <u>kind</u> of work or other activities.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	physkind <yesno>

4. 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)?

	Yes	No	
	▼	▼	
a. <u>Accomplished less</u> than you would like.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	emoaccmp <yesno>
b. Did work or other activities <u>less carefully</u> than usual.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	emotcare <yesno>

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely	
▼	▼	▼	▼	▼	
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	workpain <pain2>

6. 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
▼	▼	▼	▼	▼	▼

a. Have you felt calm and peaceful? 1 2 3 4 5 6

peace
<QOLstate>

b. Did you have a lot of energy? 1 2 3 4 5 6

energy
<QOLstate>

c. Have you felt downhearted and blue? 1 2 3 4 5 6

down
<QOLstate>

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

social <active>

The Peripheral Artery Questionnaire(PAQ)

PS: QOLAnn06
PT: QOLAnn06
Panel: QOLAnn06

The following questions refer to blockages in the arteries of your body, particularly your legs, and how that might affect your life. Please read and complete the following questions. There are no right or wrong answers. Please mark the answer that best applies to you.

- Blockages in the arteries, often referred to as **peripheral vascular disease**, affect different people in different ways. Some feel cramping or aching while others feel fatigue. Which leg (or buttock) causes you the most severe discomfort, fatigue, pain, aching, or cramps?

the **Right** leg
(buttock)

the **Left** leg
(buttock)

Both are the same

Neither

leg
<PAQleg>

- Please review the list below and indicate how much limitation you have due to **your peripheral vascular disease** (discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)) over the past 4 weeks.

Place an **X** in one box on each line

Activity	Extremely Limited	Quite a bit Limited	Moderately Limited	Slightly Limited	Not at all Limited	Limited for other reasons or did not do the activity
Walking around your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking 1-2 blocks on level ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking 1-2 blocks up a hill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking 3-4 blocks on level ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hurrying or jogging (as if to catch a bus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vigorous work or exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

home
<limit2>

levgrdtwo
<limit2>

uphill
<limit2l>

levgrdfour
<limit2>

jogging
<limit2>

vigwork
<limit2>

3. Compared with 4 weeks ago, have your symptoms of **peripheral vascular disease** (discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)) changed?

My symptoms have become...

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| Much worse | Slightly worse | Not changed | Slightly better | Much better | I have had no symptoms over the past 4 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

sympchx
<PAQsympchx>

4. Over the past 4 weeks, how many times did you have **discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)**?

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------------------------|
| All of the time | Several times per day | At least once a day | 3 or more times per week but not every day | 1-2 times per week | Less than once a week | Never over the past 4 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

painfreq
<PAQpainfreq>

5. Over the past 4 weeks, how much has **discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)** bothered you?

It has been ...

- | | | | | | |
|-----------------------------|------------------------------|----------------------------|----------------------------|------------------------------|----------------------------|
| Extremely bothersome | Moderately bothersome | Somewhat bothersome | Slightly bothersome | Not at all bothersome | I've had no leg discomfort |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

painbother
<PAQpainbother>

6. Over the past 4 weeks, how often have you been awakened with **pain, aching, or cramps in your legs or feet**?

- | | | | | |
|--------------------------|--|--------------------------|--------------------------|-----------------------------|
| Every night | 3 or more times per week but not every night | 1-2 times per week | Less than once a week | Never over the past 4 weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

painawake
<PAQpainawake>

7. How satisfied are you that everything possible is being done to treat your **peripheral vascular disease**?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not satisfied at all | Mostly dissatisfied | Somewhat satisfied | Mostly satisfied | Completely satisfied |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PAQsatisfied
<PAQsatisfied>

8. How satisfied are you with the explanations your doctor has given you about your **peripheral vascular disease**?

- | | | | | |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not
satisfied at
all | Mostly
dissatisfied | Somewhat
satisfied | Mostly
satisfied | Completely
satisfied |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

explanation
<PAQsatisfied>

9. Overall, how satisfied are you with the current treatment of your **peripheral vascular disease**?

- | | | | | |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not
satisfied at
all | Mostly
dissatisfied | Somewhat
satisfied | Mostly
satisfied | Completely
satisfied |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

treatment
<PAQsatisfied>

10. Over the past 4 weeks, how much has your **peripheral vascular disease** limited your enjoyment of life?

- | | | | | |
|--|--|--|--|--|
| It has
extremely
limited my
enjoyment of
life | It has limited
my enjoyment
of life quite a
bit | It has
moderately
limited my
enjoyment of life | It has slightly
limited my
enjoyment of
life | It has
limited my
enjoyment of life
at all |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

enjoylife <PAQlimit>

11. If you had to spend the rest of your life with your **peripheral vascular disease** the way it is right now, how would you feel about this?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all
satisfied | Mostly
dissatisfied | Somewhat
satisfied | Mostly
satisfied | Completely
satisfied |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

forlife <PAQfeel>

12. Over the past 4 weeks, how often have you felt discouraged or down in the because of your **peripheral vascular disease**?

- | | | | | |
|---|--|---|----------------------------------|---------------------------------|
| I felt that way
all of the
time | I felt that way
most of the
time | I
occasionally
felt that way | I rarely felt
that way | I never felt
that way |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

down <PAQdown>

13. How much does your **peripheral vascular disease** affect your lifestyle? Please indicate how your **discomfort, fatigue, pain, aching, or cramps in your calves (or buttocks)** may have limited your participation in the following activities over the past 4 weeks.

Please place an **X** in one box on each line

Activity	Severely limited	Limited quite a bit	Moderately limited	Slightly limited	Did not limit at all	Does not apply or did not do for other reasons
recreactv <limit4> Hobbies, recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
visitactv <limit4> Visiting family or friends out of your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
workactv <limit4> Working or doing household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employment

PS: QOLAnn10
PT: QOLAnn10
Panel: QOLAnn10

In order to compare your experiences with other patients, we would like to know a little more about your work life. By answering the following questions, we will be better able to evaluate your experiences. **If you feel that any question is too personal, please skip it and go on to the next question.**

1. During the last week, have you been working outside of the home?

working <yesno>

1. Yes
2. No **(IF NO, SKIP TO QUESTION 5)**

2. On average, how many hours are you currently working per week?

wkhours (f, 5)

3. Have you resumed working since you were last contacted by the CLEVER study?

resumewk<yesno>

1. Yes **(IF YES, ANSWER QUESTION 4)**
2. No

4. To the best of your recollection, when did you resume working outside of the home?

____/____/____ workmm/workdd/workyy workdt()
Month Day Year

(IF YOU ARE UNEMPLOYED, PLEASE ANSWER QUESTION 5)

5. Are you not working because of your health?

umempl <yesno>

1. Yes
2. No

Thank you for participating in this study!