MULTIDIMENSIONAL HEALTH STATUS ASSESSMENT
(FOR CMV RETINITIS)

NIAID AIDS CLINICAL TRIALS GROUP

Patient Number ☐☐ ☐☐☐☐ ☐   Date of Patient Visit ☐☐☐ ☐☐ ☐☐☐☐ (mmm dd yyyy)

Protocol Number ☐☐☐☐☐☐   Institution Code ☐☐☐☐☐☐

Form Week ☐☐☐   * Seq No. ☐   ** Step No. ☐   Key Operator Code ☐☐☐

* Enter a “1” if this is the first of this form for this date. Designate subsequent forms on the same date with a 2, 3, etc.

**Enter the subject's current study step number. Enter '1' if the study does not have multiple steps.

FOR OFFICE USE ONLY - TEAR OFF SHEET
MODULE B

INSTRUCTIONS TO THE STUDY NURSE:

The following should always be used in conjunction with MODULE A, OVERALL HEALTH STATUS ASSESSMENT. MODULE B asks the patient about many aspects of his/her health and health care. It should be given to the patient prior to the clinical exam and preferably in a quiet secluded area (e.g., exam room or other office). The patient must be able to read at the sixth-grade level at a minimum to complete the questionnaire without additional assistance.

It is important to be familiar with the content and format of the questionnaire before giving it to study participants. At the first visit, please begin by telling the participant:

> “We would like you to answer some questions about how you are feeling and the kinds of things you are able to do. Your answers will help us understand the effects of the medication you are taking. We appreciate your filling out this questionnaire.”

You should then briefly go over the format of the questions and how to complete them. Have the participant complete the questionnaire before vital signs, history, and physical are completed.

The questionnaire is very brief and should take no more than 10 minutes to complete. Before giving the patient the questionnaire, please fill out the header(s) and DETACH THIS PAGE.

Each question is in the same general format and contains several items. Note that the patient is always asked to make a “✓“ next to the appropriate category. All questions refer to the PAST 4 WEEKS.

Collect the completed questionnaire before the clinical exam. Before going on, review the questionnaire for omissions. If the participant missed any of the questions, point this out and have him/her complete the omissions.

PLEASE COMPLETE THE FOLLOWING ITEMS AFTER PATIENT COMPLETES THE QUESTIONNAIRE OR AFTER YOU ASCERTAIN THAT THIS IS NOT POSSIBLE:

1. How was the questionnaire completed? .... ☐
   1-Self administered by the study participant
   2-Face-to-face interview that you conducted
   3-Phone interview
   4-Not completed
   9-Other

   If Other, specify [30]: ______________________

   a. If you answered “4-Not completed,” please indicate the reason why : ☐
      1-Patient refused initially
      2-Patient missed clinic visit
      3-There was not enough time
      9-Other reason

      If Other, specify [30]: ______________________

2. What was the quality of this interview? .... ☐
   1-Good
   2-Fair
   3-Poor
   -1-Not applicable

   If Poor, explain [30]: ______________________

Date form reviewed (mmm/dd/yyyy):.. ☐☐☐ ☐☐ ☐☐☐☐

Clinician Signature (include degrees): ______________________

11-17-95   Date Form Keyed (DO NOT KEY): ________ / ________ / ________

Pt. No. ☐☐ ☐☐☐☐ ☐ * Seq. No. ☐ ** Step No. ☐ Date ☐☐☐ ☐☐ ☐☐☐☐
mmm dd yyyy

INSTRUCTIONS:
Please answer the following questions by placing a "✓" in the appropriate box.

1. During the past 4 weeks, has your health kept you from working at a job, doing work around the house, or going to school?

   Check (✓) one
   - Yes, for all of the time .... 1 ☐
   - Yes, for some of the time .... 2 ☐
   - No .... 3 ☐

2. During the past 4 weeks, how much bodily pain have you had?

   Check (✓) one
   - None .... 1 ☐
   - Very mild .... 2 ☐
   - Mild .... 3 ☐
   - Moderate .... 4 ☐
   - Severe .... 5 ☐
   - Very severe .... 6 ☐

3. During the past 4 weeks, have you been unable to do certain kinds or amounts of work, housework, or schoolwork because of your health?

   Check (✓) one
   - Yes, for all of the time .... 1 ☐
   - Yes, for some of the time .... 2 ☐
   - No .... 3 ☐

Pt. No. ☐☐ ☐☐☐☐ ☐ * Seq. No. ☐ ** Step No. ☐ Date ☐☐☐ (mmm) ☐☐ (dd) ☐☐☐☐ (yyyy)

4. How much, if at all, does your health now limit you in the following activities?

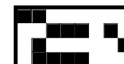
Please check (✓) one box for each question.

	YES Limited A Lot	**YES Limited A Little**	**NO Not Limited At All**	
a. The kind or amounts of vigorous activities you can do, like lifting heavy objects, running or participating in strenuous sports.	☐ 1	☐ 2	☐ 3	☐
b. The kind or amounts of moderate activities you can do, like moving a table or carrying groceries.	☐ 1	☐ 2	☐ 3	☐
c. Walking uphill or climbing a few flights of stairs.	☐ 1	☐ 2	☐ 3	☐
d. Bending, lifting or stooping	☐ 1	☐ 2	☐ 3	☐
e. Walking one block	☐ 1	☐ 2	☐ 3	☐
f. Eating, dressing, bathing, or using the toilet.	☐ 1	☐ 2	☐ 3	☐

5. For **each** of the following questions, please check the box for the **one** answer that comes **closest** to the way you have been feeling **during the past 4 weeks**.
How much of the time during the past 4 weeks . . .

Please check (✓) one box for each question.

	All of the Time	**Most of the Time**	**A Good Bit of Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**	
a. Has your health limited your social activities, like visiting with family and friends?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
b. Did you have trouble keeping your attention on any activity for long?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
c. Did you forget things that happened recently? (ex., where you put things)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
d. Did you have difficulty reasoning and solving problems?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐



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mmm dd yyyy

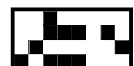
(Continued)

5. For **each** of the following questions, please check the box for the **one** answer that comes **closest** to the way you have been feeling **during the past 4 weeks**.
How much of the time during the past 4 weeks . . .

Please check (✓) one box for each question

	All of the Time	Most of the Time	A Good Bit of Time	Some of the Time	A Little of the Time	None of the Time	
e. Did you have difficulty doing activities involving concentration and thinking?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
f. Have you been a very nervous person?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
g. Have you felt calm and peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
h. Have you felt down-hearted and blue?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
i. Did you feel full of pep?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
j. Did you feel worn out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
k. Did you feel tired?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
l. Did you have enough energy to do the things you wanted to do?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
m. Have you been a happy person?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐
n. Have you felt so down in the dumps that nothing could cheer you up?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐

Turn Over ➔



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

6. How have you been feeling during the past four weeks?

Check (✓) one

- Very sick .... 1 ☐
- Pretty sick .... 2 ☐
- A little sick .... 3 ☐
- Not bad .... 4 ☐
- Pretty well .... 5 ☐
- Very well .... 6 ☐

7. During the past four weeks, how much were bothered by your illness?

Check (✓) one

- Not at all..................................... 1 ☐
- A little .... 2 ☐
- Somewhat .... 3 ☐
- Quite a lot .... 4 ☐
- A great deal............................... 5 ☐

8. During the past four weeks, how much have you been concerned, worried or fearful about your health?

Check (✓) one

- Not at all..................................... 1 ☐
- A little .... 2 ☐
- Somewhat .... 3 ☐
- Quite a lot .... 4 ☐
- A great deal............................... 5 ☐

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9. How often, during the past four weeks, did you feel healthy enough to do the things you wanted to do or had to do?

Check (✓) one

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

10. How has the quality of your life been during the past four weeks? That is, how have things been going for you?

Check (✓) one

- Very well, could hardly be better 1 ☐
- Pretty good .... 2 ☐
- Good and bad parts, about equal 3 ☐
- Pretty bad.................................. 4 ☐
- Very bad, could hardly be worse 5 ☐

11. How would you rate your physical health and emotional condition now, compared to four weeks ago?

Check (✓) one

- Much better................................. 1 ☐
- A little better................................ 2 ☐
- About the same........................... 3 ☐
- A little worse................................ 4 ☐
- Much worse................................. 5 ☐

12. How much trouble do you now have with your eyesight?

Check (✓) one

- No trouble.................................. 1 ☐
- A little trouble.............................. 2 ☐
- A moderate amount of trouble ..... 3 ☐
- A lot of trouble .... 4 ☐

Turn Over ➔

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

Please check (✓) one box for each question.

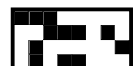
13. Do you have difficulty (even with glasses) in doing any of the following activities:

	No Difficulty	A Little	A Moderate Amount	Unable to do This	Don't do for Other Reasons
a. Reading small print such as labels on medicine bottles, a telephone book, food labels:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. Reading a newspaper or book:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Driving during the day:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. Driving at night:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. Reading traffic signs, street signs, store signs:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. Doing writing such as making lists, writing notes or letters:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g. Watching television:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

14. During the past month, how much have you been bothered by:

	Not at All	A Little	Somewhat	Quite a Lot	A Great Deal
a. Blurred or distorted vision:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. Spots floating in front of your eyes:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Blind spots or blurry spots:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. Trouble seeing to one side or the other:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. Bumping into people or things:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Excellent	Very Good	Good	Fair	Poor
15. In general, would you say your eyesight is:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5



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Getting treatment for your CMV eye infection can be inconvenient, especially because the medicine needs to be given in your veins.

Please check (✓) one box for each question.

16. During the past four weeks, how much has the treatment for your eyes . . .	Not at All	A Little	Somewhat	Quite a Lot	A Great Deal
a. Interfered with your social activities with family, friends, neighbors or groups?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. Interfered with your daily activities like bathing, dressing, shopping, preparing meals?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Made you concerned about how you look?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. Made you embarrassed to go out in public?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

17. How many hours a day . . .

a. Do you spend on treatment for your eyes (hours)? .... ☐☐.☐

b. Does treatment for your eyes keep you from doing the things you want to do? ☐☐.☐

18. Is the amount of time you have to spend everyday on your treatment:

Check (✓) one

- Much too long............................. 1 ☐
- Too long..................................... 2 ☐
- About right.................................. 3 ☐

The final questions ask about work and other activities.

19. Have you had a job or business during the past four weeks? .... Yes................... 1 ☐
No .... 2 ☐

20. How do you spend most of your time?

Check (✓) one

- a. Working full time... 1 ☐
- b. Working part time....................................... 2 ☐
- c. Keeping house or taking care of family....... 3 ☐
- d. Attending school... 4 ☐
- e. Not working because of your health............ 5 ☐
- f. Not working for other reasons..................... 6 ☐

21. During the past week did your illness, treatment or a personal problem (like feeling depressed) cause you to do any of the following things:

a. Stay in bed for a half or more days?.................................... Yes .... 1 ☐
No .... 2 ☐

b. Cut down on your usual activities (such as work, housework, school, leisure activities) for half a day or more (days): .... Yes .... 1 ☐
No.................... 2 ☐

Language: English ☐