PASC Symptoms

ERROR! You must complete the enrollment form and the visit form before you can start this form.

Date of PASC Symptoms collection: _____

Check this box if the coordinator is entering data: ☐ Coordinator data entry

	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is	◯	◯	◯	◯	◯
In general, would you say your quality of life is	◯	◯	◯	◯	◯
In general, how would you rate your physical health?	◯	◯	◯	◯	◯
In general, how would you rate your mental health, including your mood and your ability to think?	◯	◯	◯	◯	◯
In general, how would you rate your satisfaction with your social activities and relationships?	◯	◯	◯	◯	◯
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	◯	◯	◯	◯	◯

To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

◯ Completely
◯ Mostly
◯ Moderately
◯ A little
◯ Not at all

In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?

◯ Never
◯ Rarely
◯ Sometimes
◯ Often
◯ Always

In the past 7 days, how would you rate your fatigue on average?

◯ None
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe

In the past 7 days, how would you rate your pain on average?

◯ 0 (No pain)
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5
◯ 6
◯ 7
◯ 8
◯ 9
◯ 10 (Worst Imaginable Pain)

Over the past two weeks, how often have you been bothered by the following problems:

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things:	◯	◯	◯	◯
Feeling down, depressed, or hopeless:	◯	◯	◯	◯
Trouble falling or staying asleep, or sleeping too much:	◯	◯	◯	◯
Feeling tired or having little energy:	◯	◯	◯	◯
Poor appetite or overeating:	◯	◯	◯	◯
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down:	◯	◯	◯	◯
Trouble concentrating on things, such as reading the newspaper or watching television:	◯	◯	◯	◯
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 than usual:	◯	◯	◯	◯

Thoughts that you would be better off dead, or of hurting yourself:	◯	◯	◯	◯

You indicated that you are experiencing thoughts you are better off dead or thoughts of hurting yourself in some way. If you feel you may act on these thoughts there are crisis services that can help including calling 911, going to your local emergency room, or contacting a dedicated suicide prevention resource such as the services listed below and contact your own mental health provider if you are in care:24/7 Crisis Hotline: National Suicide Prevention Lifeline Network
http://www.suicidepreventionlifeline.org
or 1-800-273-TALK (8255) (Veterans, press 1)Crisis Text Line
http://www.crisistextline.org
Text TALK to 741-741 to text with a trained crisis counselor from the Crisis Text Line for free, 24/7Veterans Crisis Line
https://www.veteranscrisisline.net
Send a text to 838255Please note a member of the study team may call you to follow up in the coming days but this is not a replacement for clinical care or emergency services.

Over the past two weeks, how often have you been bothered by the following problems:

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge:	◯	◯	◯	◯
Not being able to stop or control worrying:	◯	◯	◯	◯
Worrying too much about different things:	◯	◯	◯	◯
Trouble relaxing:	◯	◯	◯	◯
Being so restless that it is hard to sit still:	◯	◯	◯	◯
Becoming easily annoyed or irritable:	◯	◯	◯	◯
Feeling afraid as if something awful might happen:	◯	◯	◯	◯

Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury or sexual violence to you or someone else?

☐ No
☐ Yes before [stem_my]
☐ Yes after [stem_my]

In [stem_the], have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury or sexual violence to you or someone else?

◯ Yes
◯ No
◯ I prefer not to answer

In the past month, have you had nightmares about the event(s) or thought about the event(s) when you did not want to?

◯ Yes
◯ No

In the past month, have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

◯ Yes
◯ No

In the past month, have you been constantly on guard, watchful, or easily startled?

◯ Yes
◯ No

In the past month, have you felt numb or detached from people, activities, or your surroundings?

◯ Yes
◯ No

In the past month, have you felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

◯ Yes
◯ No

Have you lost someone significant to you [stem_sincein]?

◯ Yes
◯ No

Was it due to COVID?

◯ Yes
◯ No

What was your relationship to the person who died?

◯ Parent
◯ Child
◯ Significant other
◯ Sibling
◯ Friend/colleague or acquaintance
◯ Other

How many months has it been since the death?

_____
(Months)

Have you been experiencing persistent distressing grief with yearning and/or feeling life is empty since the death?

◯ Yes
◯ No

Is grief currently your most distressing problem?

◯ Yes
◯ No
◯ Prefer not to answer

Have you had a period in the last 3 months?

◯ Yes
◯ No

Why have you not had a period in the last 3 months?

◯ I am in menopause
◯ I had a hysterectomy
◯ I am pregnant
◯ I am taking a medication or using an IUD that stops my period
◯ My periods come infrequently
◯ Some other reason

Please tell us at what time(s) you have had any of the following symptoms. Check all that apply.

	No, I have NOT had this symptom	Yes, I DID have it in the YEAR BEFORE [stem_my]	Yes, I DID have it AROUND the time of [stem_my]	Yes, I have it NOW	I don't know or prefer not to answer
Fatigue (being very tired)	☐	☐	☐	☐	☐
Post-exertional malaise (Symptoms worse after even minor physical or mental effort)	☐	☐	☐	☐	☐
Weakness in arms or legs	☐	☐	☐	☐	☐
Fever, chills, sweats or flushing	☐	☐	☐	☐	☐
Loss of or change in smell or taste	☐	☐	☐	☐	☐
Pain in any part of your body	☐	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐	☐
Persistant (chronic) cough	☐	☐	☐	☐	☐
Palpitations, racing heart, arrhythmia, skipped beats	☐	☐	☐	☐	☐
Swelling of your legs	☐	☐	☐	☐	☐
Gastrointestinal (belly) symptoms (feeling full or vomiting after eating, diarrhea, constipation)	☐	☐	☐	☐	☐
Bladder problems (incontinence, trouble passing urine or emptying bladder)	☐	☐	☐	☐	☐
Nerve problems (tremor, shaking, abnormal movements, numbness, tingling, burning, can't move part of body, new seizures)	☐	☐	☐	☐	☐

Problems with anxiety, depression, stress, or trauma-related symptoms like nightmares or grief	☐	☐	☐	☐	☐	
Problems thinking or concentrating ("brain fog")	☐	☐	☐	☐	☐	
Stopping breathing during sleep or sleep problems (such as snoring, trouble falling asleep, nighttime awakenings, or trouble staying awake during the day) 3 or more times a week	☐	☐	☐	☐	☐	
Feeling faint, dizzy, "goofy"; difficulty thinking soon after standing up from a sitting or lying position	☐	☐	☐	☐	☐	
Color changes in your skin, such as red, white or purple	☐	☐	☐	☐	☐	
Skin rash	☐	☐	☐	☐	☐	
Excessively dry mouth	☐	☐	☐	☐	☐	
Excessive thirst	☐	☐	☐	☐	☐	
Vision problems (blurry, light sensitivity, difficulty reading or focusing, floaters, flashing lights, "snow")	☐	☐	☐	☐	☐	
Problems with hearing (hearing loss, ringing in ears)	☐	☐	☐	☐	☐	
Hair loss	☐	☐	☐	☐	☐	
Problems with teeth	☐	☐	☐	☐	☐	
Changes to menstrual cycle	☐	☐	☐	☐	☐	
Changes to menopause symptoms (such as hot flashes)	☐	☐	☐	☐	☐	
Changes in fertility or difficulty getting pregnant	☐	☐	☐	☐	☐	
Changes in desire for, comfort with or capacity for sex	☐	☐	☐	☐	☐	

	No, I have NOT had this symptom	Yes, I DID have it in the YEAR BEFORE [stem_my]	Yes, I DID have it AROUND the time of [stem_my]	Yes, I DID have it BETWEEN 30 DAYS AFTER [stem_my] AND NOW	Yes, I have it NOW	I don't know or prefer not to answer
Fatigue (being very tired)	☐	☐	☐	☐	☐	☐

Post-exertional malaise (Symptoms worse after even minor physical or mental effort)	☐	☐	☐	☐	☐	☐
Weakness in arms or legs	☐	☐	☐	☐	☐	☐
Fever, chills, sweats or flushing	☐	☐	☐	☐	☐	☐
Loss of or change in smell or taste	☐	☐	☐	☐	☐	☐
Pain in any part of your body	☐	☐	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐	☐	☐
Persistant (chronic) cough	☐	☐	☐	☐	☐	☐
Palpitations, racing heart, arrhythmia, skipped beats	☐	☐	☐	☐	☐	☐
Swelling of your legs	☐	☐	☐	☐	☐	☐
Gastrointestinal (belly) symptoms (feeling full or vomiting after eating, diarrhea, constipation)	☐	☐	☐	☐	☐	☐
Bladder problems (incontinence, trouble passing urine or emptying bladder)	☐	☐	☐	☐	☐	☐
Nerve problems (tremor, shaking, abnormal movements, numbness, tingling, burning, can't move part of body, new seizures)	☐	☐	☐	☐	☐	☐
Problems with anxiety, depression, stress, or trauma-related symptoms like nightmares or grief	☐	☐	☐	☐	☐	☐
Problems thinking or concentrating ("brain fog")	☐	☐	☐	☐	☐	☐
Stopping breathing during sleep or sleep problems (such as snoring, trouble falling asleep, nighttime awakenings, or trouble staying awake during the day) 3 or more times a week	☐	☐	☐	☐	☐	☐
Feeling faint, dizzy, "goofy"; difficulty thinking soon after standing up from a sitting or lying position	☐	☐	☐	☐	☐	☐
Color changes in your skin, such as red, white or purple	☐	☐	☐	☐	☐	☐
Skin rash	☐	☐	☐	☐	☐	☐
Excessively dry mouth	☐	☐	☐	☐	☐	☐

Excessive thirst	☐	☐	☐	☐	☐	☐
Vision problems (blurry, light sensitivity, difficulty reading or focusing, floaters, flashing lights, "snow")	☐	☐	☐	☐	☐	☐
Problems with hearing (hearing loss, ringing in ears)	☐	☐	☐	☐	☐	☐
Hair loss	☐	☐	☐	☐	☐	☐
Problems with teeth	☐	☐	☐	☐	☐	☐
Changes to menstrual cycle	☐	☐	☐	☐	☐	☐
Changes to menopause symptoms (such as hot flashes)	☐	☐	☐	☐	☐	☐
Changes in fertility or difficulty getting pregnant	☐	☐	☐	☐	☐	☐
Changes in desire for, comfort with or capacity for sex	☐	☐	☐	☐	☐	☐

Did you have any of the following symptoms in [stem_psfu]?

	No	Yes, but I NO LONGER have it	Yes, and I STILL HAVE it	I prefer not to answer
Fatigue (being very tired)	○	○	○	○
Post-exertional malaise (Symptoms worse after even minor physical or mental effort)	○	○	○	○
Weakness in arms or legs	○	○	○	○
Fever, chills, sweats or flushing	○	○	○	○
Loss of or change in smell or taste	○	○	○	○
Pain in any part of your body	○	○	○	○
Shortness of breath	○	○	○	○
Persistant (chronic) cough	○	○	○	○
Palpitations, racing heart, arrhythmia, skipped beats	○	○	○	○
Swelling of your legs	○	○	○	○
Gastrointestinal (belly) symptoms (feeling full or vomiting after eating, diarrhea, constipation)	○	○	○	○
Bladder problems (incontinence, trouble passing urine or emptying bladder)				

Nerve problems (tremor, shaking, abnormal movements, numbness, tingling, burning, can't move part of body, new seizures)	○	○	○	○
Problems with anxiety, depression, stress, or trauma-related symptoms like nightmares or grief	○	○	○	○
Problems thinking or concentrating ("brain fog")	○	○	○	○
Stopping breathing during sleep or sleep problems (such as snoring, trouble falling asleep, nighttime awakenings, or trouble staying awake during the day) 3 or more times a week	○	○	○	○
Feeling faint, dizzy, "goofy"; difficulty thinking soon after standing up from a sitting or lying position	○	○	○	○
Color changes in your skin, such as red, white or purple	○	○	○	○
Skin rash	○	○	○	○
Excessively dry mouth	○	○	○	○
Excessive thirst	○	○	○	○
Vision problems (blurry, light sensitivity, difficulty reading or focusing, floaters, flashing lights, "snow")	○	○	○	○
Problems with hearing (hearing loss, ringing in ears)	○	○	○	○
Hair loss	○	○	○	○
Problems with teeth	○	○	○	○
Changes to menstrual cycle	○	○	○	○
Changes to menopause symptoms (such as hot flashes)	○	○	○	○
Changes in fertility or difficulty getting pregnant	○	○	○	○
Changes in desire for, comfort with or capacity for sex	○	○	○	○

Other symptoms:

Have you experienced any other symptoms [stem_attribute]?

◯ Yes
◯ No
◯ I prefer not to answer

Please specify any other symptoms [stem_attribute]:

This set of questions is about your problem with pain.

In the YEAR BEFORE [stem_your], where were you having pain? Check all that apply.

☐ Head pain/headache
☐ Chest pain (including chest tightness, pressure)
☐ Abdomen (belly)
☐ Pelvis or genitals
☐ Joints
☐ Muscles
☐ Back/spine
☐ Skin
☐ Feet
☐ Mouth
☐ Throat

AROUND [stem_your], where were you having pain? Check all that apply.

☐ Head pain/headache
☐ Chest pain (including chest tightness, pressure)
☐ Abdomen (belly)
☐ Pelvis or genitals
☐ Joints
☐ Muscles
☐ Back/spine
☐ Skin
☐ Feet
☐ Mouth
☐ Throat

BETWEEN 30 DAYS AFTER [stem_your] AND NOW where were you having pain? Check all that apply

☐ Head pain/headache
☐ Chest pain (including chest tightness, pressure)
☐ Abdomen (belly)
☐ Pelvis or genitals
☐ Joints
☐ Muscles
☐ Back/spine
☐ Skin
☐ Feet
☐ Mouth
☐ Throat

In [stem_the], where were you having pain that you no longer have? Check all that apply.

- ☐ Head pain/headache
- ☐ Chest pain (including chest tightness, pressure)
- ☐ Abdomen (belly)
- ☐ Pelvis or genitals
- ☐ Joints
- ☐ Muscles
- ☐ Back/spine
- ☐ Skin
- ☐ Feet
- ☐ Mouth
- ☐ Throat

Where are you having pain RIGHT NOW? Check all that apply.

- ☐ Head pain/headache
- ☐ Chest pain (including chest tightness, pressure)
- ☐ Abdomen (belly)
- ☐ Pelvis or genitals
- ☐ Joints
- ☐ Muscles
- ☐ Back/spine
- ☐ Skin
- ☐ Feet
- ☐ Mouth
- ☐ Throat

This set of questions is about your headaches:

	Never	Rarely	Sometimes	Very often	Always
When you have headaches, how often is the pain severe?	○	○	○	○	○
How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?	○	○	○	○	○
When you have a headache, how often do you wish you could lie down?	○	○	○	○	○
In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?	○	○	○	○	○
In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?	○	○	○	○	○

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches	◯	◯	◯	◯	◯

This set of questions is about your chest pain.

The following is a list of activities that people often do during the week. Although for some people with several medical problems it is difficult to determine what it is that limits them, please go over the activities listed below and indicate how much limitation you have had due to chest pain, chest tightness, or angina over the past 4 weeks.

	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 indoors on level ground	◯	◯	◯	◯	◯	◯
Gardening, vacuuming, or carrying groceries	◯	◯	◯	◯	◯	◯
Lifting or moving heavy objects (e.g. furniture, children)	◯	◯	◯	◯	◯	◯

Over the past 4 weeks, on average, how many times have you had chest pain, chest tightness, or angina?

◯ 4 or more times per day
◯ 1-3 times per day
◯ 3 or more times per week but not every day
◯ 1-2 times per week
◯ Less than once a week
◯ None over the past 4 weeks

Over the past 4 weeks, on average, how many times have you had to take nitroglycerin (tablets or spray) for your chest pain, chest tightness, or angina?

◯ 4 or more times per day
◯ 1-3 times per day
◯ 3 or more times per week but not every day
◯ 1-2 times per week
◯ Less than once a week
◯ None over the past 4 weeks

Over the past 4 weeks, how much has your chest pain, chest tightness, or angina 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 not limited my enjoyment of life at all

If you had to spend the rest of your life with your chest pain, chest tightness, or angina the way it is right now, how would you feel about this?

◯ Not satisfied at all
◯ Mostly dissatisfied
◯ Somewhat satisfied
◯ Mostly satisfied
◯ Completely satisfied

This set of questions is about your problem with shortness of breath.

Which of the following best describes your shortness of breath?

◯ I only get breathless with strenuous exercise.
◯ I get short of breath when hurrying on the level or walking up a slight hill.
◯ I walk slower than people of the same age on the level because of breathlessness, or I have to stop for breath when walking on my own pace on the level.
◯ I stop for breath after walking about 100 meters or after a few minutes on the level.
◯ I am too breathless to leave the house or I am breathless when dressing or undressing.

This set of questions is about your nerve problems.

In the YEAR BEFORE [stem_your], which nerve problems did you have? Check all that apply.

☐ Tremor
☐ Abnormal movements
☐ Numbness, tingling, burning
☐ Inability to move part of body
☐ Seizures

AROUND [stem_your], which nerve problems did you have? Check all that apply.

☐ Tremor
☐ Abnormal movements
☐ Numbness, tingling, burning
☐ Inability to move part of body
☐ Seizures

BETWEEN 30 DAY AFTER [stem_your] AND NOW, which nerve problems did you have? Check all that apply.

☐ Tremor
☐ Abnormal movements
☐ Numbness, tingling, burning
☐ Inability to move part of body
☐ Seizures

In [stem_the], which nerve problems did you have that you no longer have? Check all that apply.

☐ Tremor
☐ Abnormal movements
☐ Numbness, tingling, burning
☐ Inability to move part of body
☐ Seizures

Which nerve problems do you have right now? Check all that apply.

- ☐ Tremor
- ☐ Abnormal movements
- ☐ Numbness, tingling, burning
- ☐ Inability to move part of body
- ☐ Seizures

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check yes or no based on how you usually feel. Thank you.

	Yes	No
Are your legs and/or feet numb?	◯	◯
Do you ever have any burning pain in your legs and/or feet?	◯	◯
Are your feet too sensitive to touch?	◯	◯
Do you get muscle cramps in your legs and/or feet?	◯	◯
Do you ever have any prickling feelings in your legs or feet?	◯	◯
Does it hurt when the bed covers touch your skin?	◯	◯
When you get into the tub or shower, are you able to tell the hot water from the cold water?	◯	◯
Have you ever had an open sore on your foot?	◯	◯
Has your doctor ever told you that you have diabetic neuropathy?	◯	◯
Do you feel weak all over most of the time?	◯	◯
Are your symptoms worse at night?	◯	◯
Do your legs hurt when you walk?	◯	◯
Are you able to sense your feet when you walk?	◯	◯
Is the skin on your feet so dry that it cracks open?	◯	◯
Have you ever had an amputation?	◯	◯

This set of questions is about your problems with weakness in your arms or legs, or with numbness and tingling.

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	○	○	○	○	○
Are you able to go up and down stairs at a normal pace?	○	○	○	○	○
Are you able to go for a walk of at least 15 minutes?	○	○	○	○	○
Are you able to run errands and shop?	○	○	○	○	○
Are you able to turn a key in a lock?	○	○	○	○	○
Are you able to brush your teeth?	○	○	○	○	○
Are you able to make a phone call using a touch tone key-pad?	○	○	○	○	○
Are you able to pick up coins from a table top?	○	○	○	○	○
Are you able to write with a pen or pencil?	○	○	○	○	○
Are you able to open and close a zipper?	○	○	○	○	○
Are you able to wash and dry your body?	○	○	○	○	○
Are you able to shampoo your hair?	○	○	○	○	○

This set of questions is about your problems with thinking or concentrating ("brain fog").

In the past 7 days:

	Never	Rarely (once)	Sometimes (2-3 times)	Often (once a day)	Very often (several times a day)
I had to read something several times to understand it:	○	○	○	○	○
My thinking was slow:	○	○	○	○	○
I had to work really hard to pay attention or I would make a mistake:	○	○	○	○	○
I had trouble concentrating:	○	○	○	○	○

How much difficulty do you currently have:

	None	A little	Somewhat	A lot	Cannot do

reading and following complex interactions (e.g., directions for a new medication)?	○	○	○	○	○
planning for and keeping appointments that are not part of your weekly routine (e.g. a therapy or doctor appointment, or a social gather with friends and family)?	○	○	○	○	○
managing your time to do most of your daily activities?	○	○	○	○	○
learning new tasks or instructions?	○	○	○	○	○

Problems with sleep:

This set of questions is about your problems with sleep.

Has anyone ever told you that you have sleep apnea (stopping breathing during sleep) or that you snore 3 or more times a week?

◯ Yes
◯ No
◯ Prefer not to answer

In the past 7 days...

	Very poor	Poor	Fair	Good	Very good
My sleep quality was	◯	◯	◯	◯	◯

In the past 7 days...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
My sleep was refreshing	◯	◯	◯	◯	◯
I had a problem with my sleep	◯	◯	◯	◯	◯
I had difficulty falling asleep	◯	◯	◯	◯	◯
My sleep was restless	◯	◯	◯	◯	◯
I tried hard to get to sleep	◯	◯	◯	◯	◯
I worried about not being able to fall asleep	◯	◯	◯	◯	◯
I was satisfied with my sleep	◯	◯	◯	◯	◯

This set of questions is about your problems with vision.

At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?

◯ Excellent
◯ Good
◯ Fair
◯ Poor
◯ Very Poor
◯ Completely Blind

How much of the time do you worry about your eyesight?

◯ None of the time
◯ A little of the time
◯ Some of the time
◯ Most of the time
◯ All of the time

How much pain or discomfort have you had in and around your eyes (for example, burning, itching, or aching)? Would you say it is:

◯ None
◯ Mild
◯ Moderate
◯ Severe
◯ Very severe

How much difficulty do you have reading ordinary print in newspapers? Would you say you have:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

How much difficulty do you have reading street signs or the names of stores?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have seeing how people react to things you say?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Stopped doing this because of your eyesight
◯ Stopped doing this for other reasons or not interested in doing this

Are you currently driving, at least once in a while?

◯ Yes
◯ No

Have you never driven a car or have you given up driving?

◯ Never drove
◯ Gave up

Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?

◯ Mainly eyesight
◯ Mainly other reasons
◯ Both eyesight and other reasons

How much difficulty do you have driving during the daytime in familiar places? Would you say you have:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty

How much difficulty do you have driving at night? Would you say you have:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Have you stopped doing this because of your eyesight
◯ Have you stopped doing this for other reasons or are you not interested in doing this

How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have:

◯ No difficulty at all
◯ A little difficulty
◯ Moderate difficulty
◯ Extreme difficulty
◯ Have you stopped doing this because of your eyesight
◯ Have you stopped doing this for other reasons or are you not interested in doing this

The next questions are about how things you do may be affected by your vision. For each one, please indicate whether for you the statement is true for you all, most, some, a little, or none of the time.

Do you accomplish less than you would like because of your vision?

◯ All of the time
◯ Most of the time
◯ Some of the time
◯ A little of the time
◯ None of the time

Are you limited in how long you can work or do other activities because of your vision?

◯ All of the time
◯ Most of the time
◯ Some of the time
◯ A little of the time
◯ None of the time

How much does pain or discomfort in or around your eyes, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:

◯ All of the time
◯ Most of the time
◯ Some of the time
◯ A little of the time
◯ None of the time

For each of the following statements, please indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.

I stay home most of the time because of my eyesight

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

I feel frustrated a lot of the time because of my eyesight

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

I have much less control over what I do, because of my eyesight.

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

Because of my eyesight, I have to rely too much on what other people tell me

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

I need a lot of help from others because of my eyesight

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

I worry about doing things that will embarrass myself or others, because of my eyesight

◯ Definitely true
◯ Mostly true
◯ Not sure
◯ Mostly false
◯ Definitely false

This set of questions is about feeling faint, dizzy or goofy.

When standing up, how frequently do you get these feelings or symptoms?

◯ Rarely
◯ Occasionally
◯ Frequently
◯ Almost always

How would you rate the severity of these feelings or symptoms?

◯ Mild
◯ Moderate
◯ Severe

In the past year, have these feelings or symptoms that you have experienced:

◯ Gotten much worse
◯ Gotten somewhat worse
◯ Stayed about the same
◯ Gotten somewhat better
◯ Gotten much better
◯ Completely gone

This set of questions is about changes in skin color.

What parts of your body are affected by these color changes? (check all that apply)

☐ Hands
☐ Feet

Are these changes in your skin color:

◯ Getting much worse
◯ Getting somewhat worse
◯ Staying about the same
◯ Getting somewhat better
◯ Getting much better
◯ Completely gone

In the past 5 years, what changes, if any, have occurred in your general body sweating?

◯ I sweat much more than I used to
◯ I sweat somewhat more than I used to
◯ I haven't noticed any changes in my sweating
◯ I sweat somewhat less than I used to
◯ I sweat much less than I used to

Do your eyes feel excessively dry?

◯ Yes
◯ No

This set of questions is about having an excessively dry mouth.

For the symptom of dry mouth that you had had for the longest period of time, is this symptom:

◯ I have not had any of these symptoms
◯ Getting much worse
◯ Getting somewhat worse
◯ Staying about the same
◯ Getting somewhat better
◯ Getting much better
◯ Completely gone

This set of questions is about belly problems.

In the past year, have you noticed any changes in how quickly you get full when eating a meal?

◯ I get full a lot more quickly than I used to
◯ I get full more quickly than I used to
◯ I haven't noticed any change
◯ I get full less quickly than I used to
◯ I get full a lot less quickly than I used to

In the past year, have you felt excessively full or persistently full (bloated feeling) after a meal?

◯ Never
◯ Sometimes
◯ A lot of the time

In the past year, have you ever vomited after a meal?

◯ Never
◯ Sometimes
◯ A lot of the time

In the past year, have you had a cramping or colicky abdominal pain?

◯ Never
◯ Sometimes
◯ A lot of the time

In the past year, have you had any bouts of diarrhea?

◯ Yes
◯ No

How frequently does this occur?

◯ Rarely
◯ Occasionally
◯ Frequently
◯ Constantly

How severe are these bouts of diarrhea?

◯ Mild
◯ Moderate
◯ Severe

Are your bouts of diarrhea getting:

◯ Much worse
◯ Somewhat worse
◯ Staying the same
◯ Somewhat better
◯ Much better
◯ Completely gone

In the past year, have you been constipated?

◯ Yes
◯ No

How frequently are you constipated?

◯ Rarely
◯ Occasionally
◯ Frequently
◯ Constantly

How severe are these episodes of constipation?

◯ Mild
◯ Moderate
◯ Severe

Is your constipation getting:

◯ Much worse
◯ Somewhat worse
◯ Staying the same
◯ Somewhat better
◯ Much better
◯ Completely gone

This set of questions is about bladder problems.

In the past year, have you ever lost control of your bladder function?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

In the past year, have you had difficulty passing urine?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

In the past year, have you had trouble completely emptying your bladder?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

This set of questions is about vision problems.

In the past year, without sunglasses or tinted glasses, has bright light bothered your eyes?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

How severe is this sensitivity to bright light?

◯ Mild
◯ Moderate
◯ Severe

In the past year, have you had trouble focusing your eyes?

◯ Never
◯ Occasionally
◯ Frequently
◯ Constantly

Is the most troublesome symptom with your eyes (ie, sensitivity to bright light or trouble focusing) getting:

◯ I have not had any of these symptoms
◯ Much worse
◯ Somewhat worse
◯ Staying about the same
◯ Somewhat better
◯ Much better
◯ Completely gone

How severe is this focusing problem?

◯ Mild
◯ Moderate
◯ Severe

This set of questions is about the changes to your menstrual cycle.

Are your periods:

◯ More frequent
◯ Less frequent
◯ About the same frequency

Is the bleeding during your period:

◯ Heavier
◯ Lighter
◯ About the same

This set of questions is about the changes to your menopause symptoms.

Have your hot flashes become more frequent?

◯ Yes
◯ No

This set of questions is about your changes in fertility or difficulty getting pregnant.

Have you had any treatment for infertility including medications or procedures such as IVF?

◯ Yes
◯ No

This set of questions is about your changes in desire for, comfort with or capacity for sex.

These questions ask about your sexual feelings and responses DURING THE PAST 4 WEEKS. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential.

During the past 4 weeks, how satisfied were you with the frequency of your sexual activity (with or without a partner)?	◯ Very satisfied ◯ Somewhat satisfied ◯ Neither satisfied nor dissatisfied ◯ Somewhat dissatisfied ◯ Very dissatisfied
During the past 4 weeks, how satisfied in general have you been with your ability to have and enjoy sex (with or without a partner)?	◯ Very satisfied ◯ Somewhat satisfied ◯ Neither satisfied nor dissatisfied ◯ Somewhat dissatisfied ◯ Very dissatisfied ◯ I don't have a partner/I don't have sex without a partner
During the past 4 weeks, when you had sexual activity, how much of the time did you experience orgasm?	◯ Never ◯ Rarely ◯ Sometimes ◯ Most of the time ◯ All of the time ◯ I did not have sexual activity
During the past 4 weeks, when you had sexual activity, how much of the time did you feel satisfied after sexual activity?	◯ Never ◯ Rarely ◯ Sometimes ◯ Most of the time ◯ All of the time ◯ I did not have sexual activity
During the past 4 weeks, when you experienced orgasm, how strong or intense was the orgasm on average?	◯ Did not experience any orgasms ◯ Mild ◯ Moderate ◯ Strong
During the past 4 weeks, how much of a problem was difficulty in having an orgasm?	◯ Not a problem ◯ Little of a problem ◯ Somewhat of a problem ◯ Very much of a problem ◯ I did not have sexual activity
During the past 4 weeks, how much of a problem was lack of sexual interest?	◯ Not a problem ◯ Little of a problem ◯ Somewhat of a problem ◯ Very much of a problem ◯ I did not have sexual activity

During the past 4 weeks, how often did you desire sex (with or without a partner?)	◯ Never ◯ Once or twice ◯ 3-4 times ◯ 5-6 times ◯ More than 6 times
During the past 4 weeks, how much of a problem was inability to relax and enjoy sex?	◯ Not a problem ◯ Little of a problem ◯ Somewhat of a problem ◯ Very much of a problem ◯ I did not have sexual activity
During the past 4 weeks, to what extent has your bleeding interfered with your normal or regular sexual activity (with or without a partner)?	◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely
During the past 4 weeks, to what extent has your pelvic pain or discomfort interfered with your normal or regular sexual activity (with or without a partner)?	◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely
During the past 4 weeks, to what extent have your pelvic problems overall interfered with your normal or regular sexual activity (with or without a partner)?	◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely

How would you rate each of the following during the last 4 weeks?

Your level of sexual desire?

◯ Very poor
◯ Poor
◯ Fair
◯ Good
◯ Very good

Your ability to have an erection?

◯ Very poor
◯ Poor
◯ Fair
◯ Good
◯ Very good

Your ability to reach orgasm (climax)?

◯ Very poor
◯ Poor
◯ Fair
◯ Good
◯ Very good

How would you describe the usual quality of your erections?

◯ None at all
◯ Not firm enough for any sexual activity
◯ Firm enough for masturbation and foreplay only
◯ Firm enough for intercourse

How would you describe the frequency of your erections?

◯ I never had an erection when I wanted one
◯ I had an erection less than half the time I wanted one
◯ I had an erection about half the time I wanted one
◯ I had an erection more than half the time I wanted one
◯ I had an erection whenever I wanted one

How often have you awakened in the morning or night with an erection?

◯ Never
◯ Seldom (less than 25% of the time)
◯ Not often (less that half the time)
◯ Often (more than half the time)
◯ Very often (more than 75% of the time)

During the last 4 weeks did you have vaginal or anal intercourse?

◯ No
◯ Yes, once
◯ Yes, more than once

Overall, how would you rate your ability to function sexually during the last 4 weeks?

◯ Very poor
◯ Poor
◯ Fair
◯ Good
◯ Very good

Have you been to the hospital [stem_sincein]? Check all that apply.

☐ Yes, I visited the emergency department
☐ Yes, I was admitted to the hospital
☐ No