

**PVDOMICS STUDY**
MINNESOTA LIVING WITH HEART FAILURE[®]
QUESTIONNAIRE Quality of Life Form #171

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1. Identification Number

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2. Alphacode

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3. Date questionnaire completed (mm/dd/yyyy)

Instructions: The following questions ask how much your heart failure (heart condition) affected your life during the past month (4 weeks). After each question, circle the 0, 1, 2, 3, 4 or 5 to show how much your life was affected. If a question does not apply to you, circle the 0 after that question.

<u>Did your heart failure prevent you from living as you wanted during the past month (4 weeks) by:</u>	No	Very Little				Very Much
1. Causing swelling in your ankles or legs?	0	1	2	3	4	5
2. Making you sit or lie down to rest during the day?	0	1	2	3	4	5
3. Making your walking about or climbing stairs difficult?	0	1	2	3	4	5
4. Making your working around the house or yard difficult?	0	1	2	3	4	5
5. Making your going places away from home difficult?	0	1	2	3	4	5
6. Making your sleeping well at night difficult?	0	1	2	3	4	5
7. Making your relating to or doing things with your friends or family difficult?	0	1	2	3	4	5
8. Making your working to earn a living difficult?	0	1	2	3	4	5
9. Making your recreational pastimes, sports or hobbies difficult?	0	1	2	3	4	5
10. Making your sexual activities difficult?	0	1	2	3	4	5

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	No	Very Little			Very Much	
11. Making you eat less of the foods you like?	0	1	2	3	4	5
12. Making you short of breath?	0	1	2	3	4	5
13. Making you tired, fatigued, or low on energy?	0	1	2	3	4	5
14. Making you stay in a hospital?	0	1	2	3	4	5
15. Costing you money for medical care?	0	1	2	3	4	5
16. Giving you side effects from treatments?	0	1	2	3	4	5
17. Making you feel you are a burden to your family or friends?	0	1	2	3	4	5
18. Making you feel a loss of self-control in your life?	0	1	2	3	4	5
19. Making you worry?	0	1	2	3	4	5
20. Making it difficult for you to concentrate or remember things?	0	1	2	3	4	5
21. Making you feel depressed?	0	1	2	3	4	5



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Coordinator Instructions: If this form is being completed (self-administered) by the participant, please remove this page from the form while the participant has the form. Re-attach this page prior to data entry.

Make sure to label this page with identifying patient and visit information.

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1. Identification Number

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2. Alphacode

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3. Date questionnaire completed (mm/dd/yyyy)

100. a. How was this survey administered?
1=Self-administered, 2=Interview-administered in person, 3=Interview by telephone

b. If Q100a = 2 or 3, enter the username of the person administering the form.....

101. Setting where this form was completed?
1=At clinic visit, 2=Other clinical setting, 3=At home

102. In what language was this instrument completed?
1=English, 2=Spanish

200. Date this form completed (mm/dd/yyyy)..... / /

201. Username of person completing/reviewing completeness of this form

Clinical Center Use Only

Date Form Entered (mm/dd/yyyy) ____/____/____

Username of person entering this form _____