



PVDOMICS STUDY

EmPHasis-10 Quality of Life Form #172

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1. Identification Number

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2. Alphacode

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

This questionnaire is designed to determine how pulmonary hypertension (PH) affects your life. Please answer every question by placing an “X” over the ONE NUMBER that best describes your recent experience of living with PH.

For each item below, place an “X” in the box that best describes your experience.

I am not frustrated by my breathlessness	0 1 2 3 4 5	I am very frustrated by my breathlessness
Being breathless never interrupts my conversations	0 1 2 3 4 5	Being breathless always interrupts my conversations
I do not need to rest during the day	0 1 2 3 4 5	I always need to rest during the day
I do not feel exhausted	0 1 2 3 4 5	I always feel exhausted
I have lots of energy	0 1 2 3 4 5	I have no energy at all
When I walk up one flight of stairs I am not breathless	0 1 2 3 4 5	When I walk up one flight of stairs I am very breathless
I am confident out in public places/crowds despite my PH	0 1 2 3 4 5	I am not confident at all in public places/crowds because of my PH
PH does not control my life	0 1 2 3 4 5	PH completely controls my life
I am independent	0 1 2 3 4 5	I am completely dependent
I never feel like a burden	0 1 2 3 4 5	I always feel like a burden



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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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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 _____