



HPTN 052 (096)

IQL-1 (171)

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Index ID

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Site Number Index Number Partner Chk

Index Quality of Life

Visit Date

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Instructions: This is an interviewer-administered form. Complete form for Enrollment, Quarterly, and Yearly visits.

I am now going to ask you some questions about your health, how you've been feeling and the support you get from family and friends. I will first ask the question and then show you a card with the answer choices. Select the choice that best describes how you feel. Remember that there are no right or wrong answers.

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?.....  
yes, for all of the time    yes, for some of the time    no  
                                           

Show Card #1.

2. During the **past 4 weeks**, how much pain have you had (for example, headache, muscle pain, back pain, stomach ache)?

Show Card #2.

- none
- very mild
- mild
- moderate
- severe
- very severe

3. During the **past 4 weeks**, how much has your physical health or emotional problems interfered with your normal social activities (for example, socializing with friends or family)?

Show Card #3.

- not at all
- a little bit
- moderately
- quite a bit
- extremely

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

Show Card #1.

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## **Index Quality of Life (IQL-1)**

No further instructions.

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

**Show Card #3.**

- not at all
- a little bit
- moderately
- quite a bit
- extremely

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

**Show Card #4.**

	<i>yes, limited a lot</i>	<i>yes, limited a little</i>	<i>no, not limited at all</i>
6a. The kind or amounts of vigorous activities you can do, like lifting heavy objects or running .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6b. The kind or amounts of moderate activities you can do, like going to the market .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6c. Walking uphill or climbing a few flights of stairs .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6d. Eating, dressing, bathing or toileting .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**Show Card #5.**

- excellent
- very good
- good
- fair
- poor

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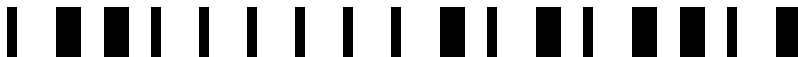
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## **Index Quality of Life (IQL-2)**

No further instructions.

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8. How much of the time during the past 4 weeks...

**Show Card #6.**

	<i>all of the time</i>	<i>most of the time</i>	<i>a good bit of the time</i>	<i>some of the time</i>	<i>a little of the time</i>	<i>none of the time</i>
8a. has your health limited your social activities, like visiting with family and friends? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8b. did you have trouble keeping your attention on any activity for long? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8c. did you have difficulty reasoning and solving problems? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8d. have you been nervous? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8e. have you felt very sad or depressed? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8f. did you feel tired or fatigued? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8g. did you have enough energy to do the things you wanted to do? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8h. have you been a happy person? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8i. have you had trouble remembering things? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. My health is excellent. ....

**Show Card #7.**

*definitely true*    *mostly true*    *don't know*    *mostly false*    *definitely false*

10. I have been feeling bad lately. ....

**Show Card #7.**

11. In general, how satisfied are you with the overall support you get from your friends and family members? .....

**Show Card #8.**

*very dissatisfied*    *somewhat dissatisfied*    *somewhat satisfied*    *very satisfied*

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## **Index Quality of Life (IQL-3)**

No further instructions.

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12. To what extent do your friends and family members help you remember to take your medication? ... not at all a little somewhat a lot N/A

Show Card #9.

People have various health habits. The following questions ask about your alcohol and drug use, past and current.

13. During the past 30 days how often have you had five or more drinks of alcohol (e.g., fermented beverages, beer, wine or spirits) in a row within a couple of hours (e.g., 2-4 hours)?

Show Card #10.

daily nearly every day 3 or 4 times a week once or twice a week 2 or 3 times a month once a month never

14. In the past 30 days have you used any of the following substances?

14a. Marijuana yes no
14b. Cocaine (powder, crack, freebase injections) yes no
14c. Heroin yes no
14d. Amphetamines (speed) yes no
14e. Sniffing organic solvents, glues or thinners yes no
14f. other, specify: yes no

If no to all, end of form.

14g. For the substance used most often, indicate how often it was used in the past 30 days.

Show Card #10.

daily nearly every day 3 or 4 times a week once or twice a week 2 or 3 times a month once a month never

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## **Index Quality of Life (IQL-4)**

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