

Outcome Questionnaire

Name of patient: _____ Study Number: _____

INSTRUCTIONS: This form asks about the state of your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please tick the box which best fits your state of health.

Tick only one box

- | | | |
|---|---|--------------------------|
| 0 | no symptoms at all | <input type="checkbox"/> |
| 1 | no significant disability despite symptoms; able to carry out all usual duties and activities | <input type="checkbox"/> |
| 2 | slight disability: unable to carry out all previous activities but able to look after own affairs without assistance | <input type="checkbox"/> |
| 3 | moderate disability; requiring some help, but able to walk without assistance | <input type="checkbox"/> |
| 4 | moderate to severe disability; unable to walk without assistance, and unable to attend to own bodily needs without assistance | <input type="checkbox"/> |
| 5 | severe disability; bedridden, incontinent, requiring constant nursing care and attention | <input type="checkbox"/> |

Name of person completing the form _____

Date when completing form: / / eg 01/JAN/06

Thank you for completing the questionnaire