

Subject ID: _____

Date (MM/DD/YY): ___/___/___

Time (HH:MM): ___/___ am/pm

**EQ-5D-Y #1: Administered on the day of the clinic visit
 (before the baseline of the cognition testing)**

Health Questionnaire

Describing your health today	
Under the heading, mark the ONE box that best describes your health TODAY	
A. Mobility (walking about)	
I have <u>no</u> problems walking about	1 <input type="checkbox"/>
I have <u>some</u> problems walking about	2 <input type="checkbox"/>
I have <u>a lot</u> of problems walking about	3 <input type="checkbox"/>
B. Looking after myself	
I have <u>no</u> problems with washing or dressing myself	1 <input type="checkbox"/>
I have <u>some</u> problems with washing or dressing myself	2 <input type="checkbox"/>
I have <u>a lot</u> of problems with washing or dressing myself	3 <input type="checkbox"/>
C. Doing Usual Activities (for example, going to school, hobbies, sport, playing, doing things with family or friends)	
I have <u>no</u> problems doing my usual activities	1 <input type="checkbox"/>
I have <u>some</u> problems doing my usual activities	2 <input type="checkbox"/>
I have <u>a lot</u> of problems doing my usual activities	3 <input type="checkbox"/>
D. Having pain or discomfort	
I have <u>no</u> pain or discomfort	1 <input type="checkbox"/>
I have <u>some</u> pain or discomfort	2 <input type="checkbox"/>
I have <u>a lot</u> of pain or discomfort	3 <input type="checkbox"/>
E. Feeling worried, sad or unhappy	
I am <u>not</u> worried, sad or unhappy	1 <input type="checkbox"/>
I am <u>a bit</u> worried, sad or unhappy	2 <input type="checkbox"/>
I am <u>very</u> worried, sad or unhappy	3 <input type="checkbox"/>

~ The end of EQ-5D-Y #1 ~

Public reporting burden of this collection of information is estimated to average 6 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX

EQ-5D-Y #2: Administered on the first day after the clinic visit

(~24 hours after the admission to this study)

Health Questionnaire

Describing your health today	
Under the heading, mark the ONE box that best describes your health TODAY	
A. Mobility (walking about)	
I have <u>no</u> problems walking about	1 <input type="checkbox"/>
I have <u>some</u> problems walking about	2 <input type="checkbox"/>
I have <u>a lot</u> of problems walking about	3 <input type="checkbox"/>
B. Looking after myself	
I have <u>no</u> problems with washing or dressing myself	1 <input type="checkbox"/>
I have <u>some</u> problems with washing or dressing myself	2 <input type="checkbox"/>
I have <u>a lot</u> of problems with washing or dressing myself	3 <input type="checkbox"/>
C. Doing Usual Activities (<i>for example, going to school, hobbies, sport, playing, doing things with family or friends</i>)	
I have <u>no</u> problems doing my usual activities	1 <input type="checkbox"/>
I have <u>some</u> problems doing my usual activities	2 <input type="checkbox"/>
I have <u>a lot</u> of problems doing my usual activities	3 <input type="checkbox"/>
D. Having pain or discomfort	
I have <u>no</u> pain or discomfort	1 <input type="checkbox"/>
I have <u>some</u> pain or discomfort	2 <input type="checkbox"/>
I have <u>a lot</u> of pain or discomfort	3 <input type="checkbox"/>
E. Feeling worried, sad or unhappy	
I am <u>not</u> worried, sad or unhappy	1 <input type="checkbox"/>
I am <u>a bit</u> worried, sad or unhappy	2 <input type="checkbox"/>
I am <u>very</u> worried, sad or unhappy	3 <input type="checkbox"/>

~ The end of EQ-5D-Y #2 ~

EQ-5D-Y #3: Administered on the 2nd day after the clinic visit**(~48 hours after the admission to this study)****Health Questionnaire**

Describing your health today	
Under the heading, mark the ONE box that best describes your health TODAY	
A. Mobility (walking about)	
I have <u>no</u> problems walking about	1 <input type="checkbox"/>
I have <u>some</u> problems walking about	2 <input type="checkbox"/>
I have <u>a lot</u> of problems walking about	3 <input type="checkbox"/>
B. Looking after myself	
I have <u>no</u> problems with washing or dressing myself	1 <input type="checkbox"/>
I have <u>some</u> problems with washing or dressing myself	2 <input type="checkbox"/>
I have <u>a lot</u> of problems with washing or dressing myself	3 <input type="checkbox"/>
C. Doing Usual Activities (for example, going to school, hobbies, sport, playing, doing things with family or friends)	
I have <u>no</u> problems doing my usual activities	1 <input type="checkbox"/>
I have <u>some</u> problems doing my usual activities	2 <input type="checkbox"/>
I have <u>a lot</u> of problems doing my usual activities	3 <input type="checkbox"/>
D. Having pain or discomfort	
I have <u>no</u> pain or discomfort	1 <input type="checkbox"/>
I have <u>some</u> pain or discomfort	2 <input type="checkbox"/>
I have <u>a lot</u> of pain or discomfort	3 <input type="checkbox"/>
E. Feeling worried, sad or unhappy	
I am <u>not</u> worried, sad or unhappy	1 <input type="checkbox"/>
I am <u>a bit</u> worried, sad or unhappy	2 <input type="checkbox"/>
I am <u>very</u> worried, sad or unhappy	3 <input type="checkbox"/>
F. Compared to the day before the clinic visit, how would you rate your level of function now?	
About the same as the day before the clinic visit	1 <input type="checkbox"/>
Somewhat worse now than the day before the clinic visit	2 <input type="checkbox"/>
Much worse now than the day before the clinic visit	3 <input type="checkbox"/>

~ The end of EQ-5D-Y #3 ~

EQ-5D-Y #4: Administered on the 4th-day after the clinic visit**(~96 hours after the admission to this study)****Health Questionnaire**

Describing your health today	
Under the heading, mark the ONE box that best describes your health TODAY	
A. Mobility (walking about)	
I have <u>no</u> problems walking about	1 <input type="checkbox"/>
I have <u>some</u> problems walking about	2 <input type="checkbox"/>
I have <u>a lot</u> of problems walking about	3 <input type="checkbox"/>
B. Looking after myself	
I have <u>no</u> problems with washing or dressing myself	1 <input type="checkbox"/>
I have <u>some</u> problems with washing or dressing myself	2 <input type="checkbox"/>
I have <u>a lot</u> of problems with washing or dressing myself	3 <input type="checkbox"/>
C. Doing Usual Activities (for example, going to school, hobbies, sport, playing, doing things with family or friends)	
I have <u>no</u> problems doing my usual activities	1 <input type="checkbox"/>
I have <u>some</u> problems doing my usual activities	2 <input type="checkbox"/>
I have <u>a lot</u> of problems doing my usual activities	3 <input type="checkbox"/>
D. Having pain or discomfort	
I have <u>no</u> pain or discomfort	1 <input type="checkbox"/>
I have <u>some</u> pain or discomfort	2 <input type="checkbox"/>
I have <u>a lot</u> of pain or discomfort	3 <input type="checkbox"/>
E. Feeling worried, sad or unhappy	
I am <u>not</u> worried, sad or unhappy	1 <input type="checkbox"/>
I am <u>a bit</u> worried, sad or unhappy	2 <input type="checkbox"/>
I am <u>very</u> worried, sad or unhappy	3 <input type="checkbox"/>
F. Compared to the day before the clinic visit, how would you rate your level of function now?	
About the same as the day before the clinic visit	1 <input type="checkbox"/>
Somewhat worse now than the day before the clinic visit	2 <input type="checkbox"/>
Much worse now than the day before the clinic visit	3 <input type="checkbox"/>
G. In general, how many days take you back to your usual level of function after physical or mental exertion?	
	_____ Days

~ The end of EQ-5D-Y #4 ~