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# Your Health – *and* – Well-Being

## Kidney Disease and Quality of Life (KDQOL™-36)

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.



***Thank you for completing these questions!***

# **Study of Quality of Life For Patients on Dialysis**

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## **What is the purpose of the study?**

This study is being carried out in cooperation with physicians and their patients. The purpose is to assess the quality of life of patients with kidney disease.

## **What will I be asked to do?**

For this study, we want you to complete a survey today about your health, how you feel and your background.

## **Confidentiality of information?**

We do not ask for your name. Your answers will be combined with those of other participants in reporting the findings of the study. Any information that would permit identification of you will be regarded as strictly confidential. In addition, all information collected will be used only for purposes of the study, and will not be disclosed or released for any other purpose without your prior consent.

## **How will participation benefit me?**

The information you provide will tell us how you feel about your care and further understanding about the effects of medical care on the health of patients. This information will help to evaluate the care delivered.

## **Do I have to take part?**

You do not have to fill out the survey and you can refuse to answer any question. Your decision to participate will not affect your opportunity to receive care.

# Your Health

This survey includes a wide variety of questions about your health and your life. We are interested in how you feel about each of these issues.

1. In general, would you say your health is: [Mark an  in the one box that best describes your answer.]

Excellent	Very good	Good	Fair	Poor
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? [Mark an  in a box on each line.]

Yes, limited a lot	Yes, limited a little	No, not limited at all
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2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf .....  1..... 2..... 3

3. Climbing several flights of stairs .....  1..... 2..... 3

**During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

Yes	No
▼	▼

4. Accomplished less than you would like.....  1..... 2

5. Were limited in the kind of work or other activities .....  1..... 2

**During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

Yes	No
▼	▼

6. Accomplished less than you would like.....  1..... 2

7. Didn't do work or other activities as carefully as usual .....  1..... 2

**8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?**

Not at all	A little bit	Moderately	Quite a bit	Extremely
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.**

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

		A good			
All	Most	bit	Some	A little	None
of the	of the	of the	of the	of the	of the
time	time	time	time	time	time
▼	▼	▼	▼	▼	▼

9. Have you felt calm and peaceful?.....  1..... 2..... 3..... 4..... 5..... 6
10. Did you have a lot of energy? .....  1..... 2..... 3..... 4..... 5..... 6
11. Have you felt downhearted and blue? .  1..... 2..... 3..... 4..... 5..... 6

**12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?**

All	Most	Some	A little	None
of the	of the	of the	of the	of the
time	time	time	time	time
▼	▼	▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

# Your Kidney Disease

How true or false is each of the following statements for you?

Definitely true ▼	Mostly true ▼	Don't know ▼	Mostly false ▼	Definitely false ▼
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13. My kidney disease interferes too much with my life .....

1 .....  2 .....  3 .....  4 .....  5

14. Too much of my time is spent dealing with my kidney disease .....

1 .....  2 .....  3 .....  4 .....  5

15. I feel frustrated dealing with my kidney disease .....

1 .....  2 .....  3 .....  4 .....  5

16. I feel like a burden on my family .....

1 .....  2 .....  3 .....  4 .....  5

**During the past 4 weeks, to what extent were you bothered by each of the following?**

Not at all bothered	Somewhat bothered	Moderately bothered	Very much bothered	Extremely bothered
▼	▼	▼	▼	▼

- |   |                            |       |                            |       |                            |       |                            |       |                            |
|---|----------------------------|-------|----------------------------|-------|----------------------------|-------|----------------------------|-------|----------------------------|
| <b>17.</b> Soreness in your muscles?.....                 | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>18.</b> Chest pain? .....                              | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>19.</b> Cramps?.....                                   | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>20.</b> Itchy skin?.....                               | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>21.</b> Dry skin?.....                                 | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>22.</b> Shortness of breath?.....                      | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>23.</b> Faintness or dizziness?.....                   | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>24.</b> Lack of appetite?...                           | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>25.</b> Washed out or drained?.....                    | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>26.</b> Numbness in hands or feet?.....                | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>27.</b> Nausea or upset stomach?.....                  | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>28<sup>a</sup>.</b> (Hemodialysis patient only)        |                            |       |                            |       |                            |       |                            |       |                            |
| Problems with your access site? ...                       | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |
| <b>28<sup>b</sup>.</b> (Peritoneal dialysis patient only) |                            |       |                            |       |                            |       |                            |       |                            |
| Problems with your catheter site?..                       | <input type="checkbox"/> 1 | ..... | <input type="checkbox"/> 2 | ..... | <input type="checkbox"/> 3 | ..... | <input type="checkbox"/> 4 | ..... | <input type="checkbox"/> 5 |

# Effects of Kidney Disease on Your Daily Life

Some people are bothered by the effects of kidney disease on their daily life, while others are not. How much does kidney disease bother you in each of the following areas?

Not at all bothered    Somewhat bothered    Moderately bothered    Very much bothered    Extremely bothered

▼                      ▼                      ▼                      ▼                      ▼

29. Fluid restriction?....     1 .....  2 .....  3 .....  4 .....  5
30. Dietary restriction?     1 .....  2 .....  3 .....  4 .....  5
31. Your ability to work around the house? .....  1 .....  2 .....  3 .....  4 .....  5
32. Your ability to travel? .....  1 .....  2 .....  3 .....  4 .....  5
33. Being dependent on doctors and other medical staff?.....  1 .....  2 .....  3 .....  4 .....  5
34. Stress or worries caused by kidney disease? .....  1 .....  2 .....  3 .....  4 .....  5
35. Your sex life? .....  1 .....  2 .....  3 .....  4 .....  5
36. Your personal appearance? .....  1 .....  2 .....  3 .....  4 .....  5

*Thank you for completing these questions!*