

The first set of questions asks for some general information about you.

1. What type of dialysis treatment are you on, hemodialysis or peritoneal dialysis?

Hemodialysis ▼ <input type="checkbox"/> ₁ ▼	Peritoneal dialysis ▼ <input type="checkbox"/> ₂ Skip to question 6
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2. How many DAYS a week do you dialyze? _____

3. How many HOURS do you dialyze each time? _____ (e.g. 1.50, 2.00, 2.25)

**4. What time of day do you START your dialysis treatments? _____ AM
or _____ PM**

5. What type of access do you have?

- Catheter ₁
- Graft ₂
- Fistula ₃
- Don't know ₄

6. Where do you usually dialyze?

- At home ₁
- In a dialysis clinic ₂

7. How do you describe yourself? (Please mark the one best answer)

- White 1
- Black or African American 2
- American Indian or Alaska Native 3
- Asian 4
- Native Hawaiian or other Pacific Islander . . . 5
- Other 6

8. Do you describe yourself as Hispanic or Latino?

- Yes 1
- No 2

9. What is the highest education level you have completed? (Please mark one)

- 0 – 6 years 1
- 7 – 9 years 2
- Some high school 3
- High school diploma or GED 4
- Vocational school or some college . . . 5
- College degree 6
- Professional or graduate degree 7

Yes	No
▼	▼

10. Are you living alone? ₁ ₂

11. Are you living in a nursing home, assisted living facility or personal care home? ₁ ₂

12. Have you smoked at least 100 cigarettes in your ENTIRE LIFE ?

Yes	No	Don't know
▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

13. Do you NOW smoke cigarettes every day, some days or not at all?

Every day	Some days	Not at all	Don't know
▼	▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

These next questions ask about your health.

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

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 questions are about activities you might do during a typical day. **Does your health now limit you in these activities?**

Yes, I am limited a lot	Yes, I am limited a little	No, I am not limited at all
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15. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf 1 2 3
16. Climbing several flights of stairs 1 2 3

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

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

17. Accomplished less than you would like. 1 2 3 4 5
18. Were limited in the kind of work or other activities. 1 2 3 4 5

During the **past 4 weeks**, how much of the time 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)?

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

19. Accomplished less than you would like. 1 2 3 4 5
20. Did work or other activities less carefully than usual. 1 2 3 4 5

21. 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...

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

22. Have you felt calm and peaceful? 1 2 3 4 5

23. Did you have a lot of energy? 1 2 3 4 5

24. Have you felt downhearted and depressed? 1 2 3 4 5

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

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

These questions are about your mood. Over the last 2 weeks, how often have you been bothered by...

Not at all bothered	Bothered several days	Bothered more than half the days	Bothered nearly every day
▼	▼	▼	▼

26. Little interest or pleasure in doing things? 1 2 3 4

27. Feeling down, depressed, or hopeless? 1 2 3 4

These questions are about how things have been going. How much of the time during the past 4 weeks...

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

28. Did you react slowly to things that were said or done? 1 2 3 4 5 6

29. Did you have difficulty concentrating or thinking? 1 2 3 4 5 6

30. Did you become confused? 1 2 3 4 5 6

31. How many hours of sleep do you usually get at night? _____ hours

32. How often do you have trouble falling asleep?

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

33. How often do you have trouble with waking up during the night?

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

34. How often do you have trouble with waking up too early and not being able to fall asleep again?

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

35. How often do you get so sleepy during the day or evening that you have to take a nap?

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

36. Do you have creepy-crawly feelings in your legs that make you want to move your legs?

Yes	No
▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
▼	

If Yes, please answer both of these questions:

If No, skip to question 39

37. Do these feelings happen mainly when you stay still and get better when you move?

Yes	No
▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

38. Are these feelings in your legs worse in the evening or at night than in the morning?

Yes	No
▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

The next questions ask about 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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39. My kidney disease interferes too much with my life. 1 2 3 4 5

40. Too much of my time is spent dealing with my kidney disease. 1 2 3 4 5

41. I feel frustrated dealing with my kidney disease. 1 2 3 4 5

42. 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 ▼
43. Soreness in your muscles?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
44. Chest pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
45. Cramps?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
46. Itchy skin?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
47. Dry skin?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
48. Shortness of breath?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
49. Faintness or dizziness?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
50. Washed out or drained?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
51. 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
52. Nausea or upset stomach?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
53. Headaches?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
54. Muscle weakness?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
55. <i>Peritoneal dialysis patients please answer:</i> 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

Then go to Question 60.

Questions 56 -59 are for Hemodialysis patients only.

(Continued) During the past 4 weeks, to what extent were you bothered by the following?

Not at all bothered ▼	Somewhat bothered ▼	Moderately bothered ▼	Very much bothered ▼	Extremely bothered ▼
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56. Problems with your access site? ₁ ₂ ₃ ₄ ₅

57. How long after dialysis does it take you to recover and be able to do your usual activities?

No time needed. ₁

Less than 1 hour needed ₂

Number of hours needed. ₃
Hours

58. How likely are you to doze off or sleep while on hemodialysis?

Never ▼ <input type="checkbox"/> ₁	Slight chance ▼ <input type="checkbox"/> ₂	Moderate chance ▼ <input type="checkbox"/> ₃	High chance ▼ <input type="checkbox"/> ₄
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If Never, go to
Question 60

If Slight, Moderate, or High chance
▼

59. About how much time do you sleep during your dialysis? Please answer in minutes or hours.

About _____ minutes

or

About _____ hours

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
	▼	▼	▼	▼	▼
60. Fluid restriction?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
61. Dietary restriction?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
62. Your ability to work around the house?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
63. Your ability to travel?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
64. Being dependent on doctors and other medical staff?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
65. Stress or worries caused by kidney disease?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
66. Your sex life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
67. Your personal appearance?	<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.

Often	Occasionally	Rarely	Never
▼	▼	▼	▼

68. How often do you take walks? ₁ ₂ ₃ ₄

69. How often do you work in the garden or yard? ₁ ₂ ₃ ₄

70. How often do you do sports or exercises? ₁ ₂ ₃ ₄

71. **Were you working for pay (receiving taxable wages) at any time DURING THE YEAR BEFORE YOU STARTED DIALYSIS?**

Yes, full-time	Yes, part-time	No
▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

72. **Are you NOW ABLE to work for pay?**

Yes, full-time	Yes, part-time	No
▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

73. Are you **NOW** working for pay (receiving taxable wages)?

Yes, full-time ▼ <input type="checkbox"/> 1 ▼	Yes, part-time ▼ <input type="checkbox"/> 2 ▼	No ▼ <input type="checkbox"/> 3
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If No, skip to question 75

74. If Yes, what kind of work are you doing now?

(For example: food service worker, truck driver, nursing assistant)

75. Are you receiving disability benefits (SSDI, SSI) from Social Security?

Yes ▼ <input type="checkbox"/> 1	No ▼ <input type="checkbox"/> 2	Don't know ▼ <input type="checkbox"/> 3
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If YES,
▼

If NO,
▼

If Don't Know,
go to question 78

76. Did your Social Security disability coverage start before you began dialysis?

Yes ▼ <input type="checkbox"/> 1	No ▼ <input type="checkbox"/> 2
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77. Have you applied for Social Security disability coverage since you began dialysis?

Yes ▼ <input type="checkbox"/> 1	No ▼ <input type="checkbox"/> 2
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These next questions are about medical care before you started dialysis.

78. Were you taking any medicine to lower your cholesterol before you started regular dialysis?

- Yes, 12 months or more before I started regular dialysis 1
- Yes, less than 12 months before I started regular dialysis. 2
- No, I did not take a cholesterol lowering drug before I started regular dialysis. . . . 3
- Not sure. 4

79. Were you taking any medicine to lower your blood pressure before you started regular dialysis?

- Yes, 12 months or more before I started regular dialysis 1
- Yes, less than 12 months before I started regular dialysis. 2
- I did not take medicine for my blood pressure before I started regular dialysis. 3
- Not sure. 4

80. Was peritoneal dialysis discussed with you before you started your regular treatment for kidney failure?

Yes	No	Not sure
▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
▼		

If Yes:

If No or Don't Know,
go to question 82

81. Was this 12 months or more before you started?

Yes	No	Not Sure
▼	▼	▼
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

82. Was kidney transplantation discussed with you before you started your regular treatment for kidney failure?

Yes ▼ <input type="checkbox"/> ₁ ▼	No ▼ <input type="checkbox"/> ₂	Not sure ▼ <input type="checkbox"/> ₃
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If Yes:

If No or Don't Know,
go to question 84

83. Was this 12 months or more before you started?

Yes ▼ <input type="checkbox"/> ₁	No ▼ <input type="checkbox"/> ₂	Not Sure ▼ <input type="checkbox"/> ₃
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The next questions are about your care on dialysis.

84. Think about the care you receive for kidney dialysis. In terms of your satisfaction, how would you rate the friendliness and interest shown in you as a person?

- Very Poor ₁
- Poor ₂
- Fair ₃
- Good ₄
- Very Good ₅
- Excellent ₆
- The Best ₇

Think about the kidney doctor you see most often. In terms of your satisfaction, how would you rate. . .

Excellent	Very Good	Good	Fair	Poor
▼	▼	▼	▼	▼

85. The amount of time your kidney doctor spends with you? ₁ ₂ ₃ ₄ ₅

86. Your kidney doctor's explanations of medical procedures and tests? ₁ ₂ ₃ ₄ ₅

87. Has kidney transplantation been discussed with you since you started dialysis?

Yes	No	Not Sure
▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

The next questions are about common activities that people do in their daily lives. I want to know whether you are still doing the activity, have stopped doing the activity, or never did the activity.

I am going to read a list of activities. For each activity please tell me whether you are still doing the activity, have stopped doing the activity, or never did the activity.

	<i>Still Doing This Activity</i>	<i>Have Stopped Doing This Activity</i>	<i>Never Did This Activity</i>
1. Getting in and out of chairs or bed (without assistance)			
2. Listening to the radio			
3. Reading books, magazines, or newspapers			
4. Writing (letters, notes)			
5. Working at a desk or table			
6. Standing (for more than 1 minute)			
7. Standing (more than 5 minutes)			
8. Dressing or undressing (without assistance)			
9. Getting clothes from drawers or closets			
10. Getting in or out of a car			
11. Dining at a restaurant			
12. Playing cards/table games			
13. Taking a bath (without assistance)			
14. Putting on shoes, stockings, or socks (no rest or break needed)			
15. Attending a movie, play, church event, or sports activity			
16. Walking 30 yards (27 meters)			
17. Walking 30 yards (non-stop)			
18. Dressing/undressing (no rest or break needed)			

	<i>Still Doing This Activity</i>	<i>Have Stopped Doing This Activity</i>	<i>Never Did This Activity</i>
19. Using public transportation or driving a car (99 miles or less)			
20. Using public transportation or driving a car (100 miles or more)			
21. Cooking your own meals			
22. Washing or drying dishes			
23. Putting groceries on shelves			
24. Ironing or folding clothes			
25. Dusting/polishing furniture or polishing a car			
26. Showering			
27. Climbing 6 steps			
28. Climbing 6 steps (non-stop)			
29. Climbing 9 steps			
30. Climbing 12 steps			
31. Walking 1/2 block on level ground			
32. Walking 1/2 block on level ground (non-stop)			
33. Making a bed (not changing sheets)			
34. Cleaning windows			
35. Kneeling, squatting to do light work			
36. Carrying a light load of groceries			
37. Climbing 9 steps (non-stop)			

	<i>Still Doing This Activity</i>	<i>Have Stopped Doing This Activity</i>	<i>Never Did This Activity</i>
38. Climbing 12 steps (non-stop)			
39. Walking 1/2 block uphill			
40. Walking 1/2 block uphill (non-stop)			
41. Shopping (by yourself)			
42. Washing clothes (by yourself)			
43. Walking 1 block on level ground			
44. Walking 2 blocks on level ground			
45. Walking 1 block on level ground (non-stop)			
46. Walking 2 blocks on level ground (non-stop)			
47. Scrubbing (floors, walls, or cars)			
48. Making a bed (changing sheets)			
49. Sweeping			
50. Sweeping (5 minutes non-stop)			
51. Carrying a large suitcase or bowling (one game)			
52. Vacuuming carpets			
53. Vacuuming carpets (5 minutes non-stop)			
54. Painting (interior/exterior)			
55. Walking 6 blocks on level ground			
56. Walking 6 blocks on level ground (non-stop)			

	<i>Still Doing This Activity</i>	<i>Have Stopped Doing This Activity</i>	<i>Never Did This Activity</i>
57. Carrying out the garbage			
58. Carrying a heavy load of groceries			
59. Climbing 24 steps			
60. Climbing 36 steps			
61. Climbing 24 steps (non-stop)			
62. Climbing 36 steps (non-stop)			
63. Walking 1 mile			
64. Walking 1 mile (non-stop)			
65. Running 110 yards (100 meters) or playing softball/baseball			
66. Dancing (social)			
67. Doing calisthenics or aerobic dancing (5 minutes non-stop)			
68. Mowing the lawn (power mower, but not a riding mower)			
69. Walking 2 miles			
70. Walking 2 miles (non-stop)			
71. Climbing 50 steps (2 1/2 floors)			
72. Shoveling, digging, or spading			
73. Shoveling, digging, or spading (5 minutes non-stop)			
74. Climbing 50 steps (non-stop)			
75. Walking 3 miles or golfing 18 holes without a riding cart			
76. Walking 3 miles (non-stop)			

	<i>Still Doing This Activity</i>	<i>Have Stopped Doing This Activity</i>	<i>Never Did This Activity</i>
77. Swimming 25 yards			
78. Swimming 25 yards (non-stop)			
79. Bicycling 1 mile			
80. Bicycling 2 miles			
81. Bicycling 1 mile (non-stop)			
82. Bicycling 2 miles (non-stop)			
83. Running or jogging 1/4 mile			
84. Running or jogging 1/2 mile			
85. Playing tennis or racquetball			
86. Playing basketball/soccer (game play)			
87. Running or jogging 1/4 mile (non-stop)			
88. Running or jogging 1/2 mile (non-stop)			
89. Running or jogging 1 mile			
90. Running or jogging 2 miles			
91. Running or jogging 3 miles			
92. Running or jogging 1 mile in 12 minutes or less			
93. Running or jogging 2 miles in 20 minutes or less			
94. Running or jogging 3 miles in 30 minutes or less			