
Your Health and Well-Being

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 this survey!*

For each of the following questions, please mark an in the one box that best describes your answer.

1. 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

2. Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
▼	▼	▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Yes, limited a lot	Yes, limited a little	No, not limited at all
▼	▼	▼

- a Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports ₁ ₂ ₃
- b Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf ₁ ₂ ₃
- c Lifting or carrying groceries ₁ ₂ ₃
- d Climbing several flights of stairs..... ₁ ₂ ₃
- e Climbing one flight of stairs..... ₁ ₂ ₃
- f Bending, kneeling, or stooping..... ₁ ₂ ₃
- g Walking more than a mile ₁ ₂ ₃
- h Walking several hundred yards ₁ ₂ ₃
- i Walking one hundred yards ₁ ₂ ₃
- j Bathing or dressing yourself..... ₁ ₂ ₃

4. 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
▼	▼	▼	▼	▼

- a Cut down on the amount of time you spent on work or other activities ₁ ₂ ₃ ₄ ₅
- b Accomplished less than you would like ₁ ₂ ₃ ₄ ₅
- c Were limited in the kind of work or other activities ₁ ₂ ₃ ₄ ₅
- d Had difficulty performing the work or other activities (for example, it took extra effort) ₁ ₂ ₃ ₄ ₅

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
▼	▼	▼	▼	▼

- a Cut down on the amount of time you spent on work or other activities ₁ ₂ ₃ ₄ ₅
- b Accomplished less than you would like ₁ ₂ ₃ ₄ ₅
- c Did work or other activities less carefully than usual ₁ ₂ ₃ ₄ ₅

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	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

7. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very Severe
▼	▼	▼	▼	▼	▼
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

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

9. 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
▼	▼	▼	▼	▼

- a Did you feel full of life? ₁ ₂ ₃ ₄ ₅
- b Have you been very nervous? ₁ ₂ ₃ ₄ ₅
- c Have you felt so down in the dumps that nothing could cheer you up? ₁ ₂ ₃ ₄ ₅
- d Have you felt calm and peaceful? ₁ ₂ ₃ ₄ ₅
- e Did you have a lot of energy? ₁ ₂ ₃ ₄ ₅
- f Have you felt downhearted and depressed? ₁ ₂ ₃ ₄ ₅
- g Did you feel worn out? ₁ ₂ ₃ ₄ ₅
- h Have you been happy? ₁ ₂ ₃ ₄ ₅
- i Did you feel tired? ₁ ₂ ₃ ₄ ₅

10. 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

11. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
	▼	▼	▼	▼	▼
a I seem to get sick a little easier than other people.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b I am as healthy as anybody I know	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c I expect my health to get worse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d My health is excellent	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

THANK YOU FOR COMPLETING THESE QUESTIONS!

Monthly Update Medical Questionnaire

Please print clearly or type:

Date: _____

Questionnaire# _____

Section 1: Customer Information

Customer Name: _____

Date of Birth (MM/DD/YR) _____ - _____ - _____ Present Weight: _____

Section 1B: (please complete only the information that has changed from last month)

Address: _____

City: _____ State: _____ Country _____ Zip _____

Home Phone # _____ Work Phone # _____ Other Ph # _____

Please answer the following questions as they pertain to the past 30 days:

Section 3: NEW Metastases Cancer Diagnosis

Metastasized Cancer Type: _____ Date of Diagnosis: _____

Metastasized Cancer Location(s): _____

Diagnosed By (Physician's name): _____

Name of Hospital/Clinic/Office: _____

Other Information: _____

Section 4: NEW Surgery

Surgery? Y / N

If Yes please complete this section. If No, please go to Section 5.

Date of surgery: _____ Surgeon's Name: _____

Name of Hospital/Clinic/Office: _____

Outcome of Surgery: _____

Other Information: _____

Section 5: NEW Chemotherapy

Chemotherapy? Y / N

If Yes please complete this section. If No, please go to Section 6.

Type of Chemotherapy: _____ Oncologist: _____

Name of Hospital/Clinic/Office: _____

Date Started: _____ Date Ended: _____ Treatment # _____

Section 6: NEW Radiation

Radiation? Y / N

If Yes please complete this section. If No, please go to Section 7.

Date Started: _____ Date Ended: _____

Radiologist: _____

Radiation Absorbed Dose (RADS): _____

Section 7: NEW Alternative/ Other Therapies

Please list individually;

1. Name of Other therapy/ drug/ medications: _____

Date Started: _____ Date Ended: _____

Description/Purpose: _____

Reason for discontinuing: _____

2. Name of Other therapy/ drug/ medications: _____

Date Started: _____ Date Ended: _____

Description/Purpose: _____

Reason for discontinuing: _____

3. Name of Other therapy/ drug/ medications: _____

Date Started: _____ Date Ended: _____

Description/Purpose: _____

Reason for discontinuing: _____

4. Name of Other therapy/ drug/ medications: _____

Date Started: _____ Date Ended: _____

Description/Purpose: _____

Reason for discontinuing: _____

5. Name of Other therapy/ drug/ medications: _____

Date Started: _____ Date Ended: _____

Description/Purpose: _____

Reason for discontinuing: _____

Section 8: Present Condition

Karnofsky Rating (see below): _____

- 100 Normal; no complaints; no evidence of disease
- 90 Able to carry on normal activity; minor symptoms of disease
- 80 Normal activity with effort; some symptoms of disease
- 70 Cares for self; unable to carry on normal activity or active work
- 60 Requires occasional assistance but is able to care for needs
- 50 Requires considerable assistance and frequent medical care
- 40 Disabled; requires special care and assistance
- 30 Severely disabled; hospitalization is indicated death not imminent
- 20 Very sick; hospitalization necessary; active treatment is necessary
- 10 Moribund; fatal processes progressing rapidly
- 0 Dead

POLY-MVA CONSUMPTION LOG FOR QUALITY OF LIFE STUDY

Demographic Data				
Name of Consumer	Date of Birth	Age	Sex	Today's Date
Log Submitted By	Product Used Poly-MVA		Manufacturer Garnett/McKeen Labs. Inc	
<p>Please list all the care providers (attending physician, specialists, alternative medicine practitioner, nurse(s) [NP, PA, LVN, RN]). And the duration of their care.</p> <p><i>Example: Jan Smith MD, Oncologist, Dec 1995-present</i> <i>Jos. Klein, NP, Clinical Care, Jan 1992-Nov 1998</i></p>				

1. Please document and describe the time from the diagnosis of any pre-existing condition to the starting of your Poly-MVA intervention:

Example: *Diagnosis: Biopsy confirmed Prostate Cancer on Dec 15th, 1996. Started Poly-MVA Mar 5, 1997*

2. Regarding Your Compliance: Have you been taking Poly-MVA on a regular basis according to the dose and duration described above? No Yes

If **No**, please describe:

3. Please comment on your ability to ingest, tolerate and comply with your Poly-MVA treatment program:

4. Are your medical health care provider(s) such as attending physician, specialist(s), or nurse(s)[NP, PA, RN, LVN] informed about your use of Poly-MVA? If **YES**, please explain when they were informed and list who. If **NO** please explain your reason(s) for not disclosing your Poly-MVA use:

5. Have you ever used Poly-MVA while undergoing chemotherapy and/or radiation? No Yes

If **Yes**, please list all dates and type of chemotherapy and/or radiation previously and/or currently undergoing:

6. Have you ever or are currently taking medications with your Poly-MVA? No Yes

If **Yes**, please list all dates and types of medications taken and/or currently taking with Poly-MVA:

7. Have you ever or currently taking supplements such as vitamins, micronutrients, or herbs with your Poly-MVA?

No Yes

If **Yes**, please list all dates and types of supplements taken and/or currently taking with Poly-MVA:

8. Are you currently using Poly-MVA? No Yes

If **NO**, please explain why:

If **YES**, please continue to monitor and record your use and forward along your log of Poly-MVA consumption.

Thank-you for your participation, cooperation, prompt response and support in this effort. As always, your information submitted to us is **CONFIDENTIAL** and guarded by unique identifiers when presented to colleagues in the area of this study. Please send the completed document to our Research Coordinator, Jorge LLamas MD in the enclosed envelope. Should you want to speak with him directly, call at (866)-522-6237

Jorge LLamas MD
research@polymva.com

Client Safety Profile

DATE: _____ Questionnaire # _____

Name of client _____

If filled out by other than client, whom and what relation: _____

Since your last report, have you experienced any of the following?

See below for instructions and rating scale

	Severity, Yes or No If yes Rate 1-3	Relatedness If yes 0-4	Researcher's notes
Headache			
Nausea			
Vomiting			
Diarrhea			
Itchiness			
Constipation			
Rash			
Difficulty Sleeping			
Numbness/Tingling			
Chest Pain			
Palpitations			
Shortness of breath			
Difficulty breathing			
Nervousness/Anxiety			
Weakness			
Change in weight			
Any other symptoms			

Please write as clear and cleanly as possible

*Column 1- **Interpretation:**

Severity of Event: 1=mild 2=moderate 3=severe

*Column 2- **Likelihood of Relatedness:**

0=Definitely Unrelated 1=Remotely Related 2=Possibly Related 3=Probably Related 4=Definitely Related

If so, is this a new symptom, or does this represent a chronic condition, from either current or past conditions? _____

Do you attribute any of the above symptoms to POLY-MVA? _____

If not, alternative explanation: _____

Have had any changes in your general medication regimen? _____

List Current Medications: _____
