

## Quality of Life Monthly Questionnaire

Date: \_\_\_\_\_ Questionnaire# \_\_\_\_\_

Name \_\_\_\_\_

### 1.-Present Condition:

Karnofsky Rating (based on values listed here): \_\_\_\_\_

- 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

### 2.-Are you currently taking Poly-MVA?

YES. If yes, please describe consumption: (Ex: 2 tsp. 2 times a day after meals for 30 days)

NO. If no, please explain.

**3.-Since you started using Poly-MVA, would you say your health is:**

Much Better	Better	Same	Worse
▼	▼	▼	▼
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**4.-Are you using Poly-MVA while undergoing chemotherapy and/or radiation?**

**YES** (please see below)  **NO**

If **YES**, please list all dates and type of chemotherapy and/or radiation since last questionnaire.

**5.-Have you undergone surgery since your last questionnaire?**

**YES** (please see below)  **NO**

If **YES**, please describe the date, type, goal and outcome of the surgery.

**6.-Have you had any scans, tests or other procedures since your last questionnaire?**

**YES** (please see below)  **NO**

If **YES**, please describe and list known results.

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

Symptom	Yes or No	Symptom	Yes or No
Headache		Numbness/Tingling	
Nausea		Pain Level Decreasing	
Vomiting		Palpitations	
Diarrhea		Shortness of breath	
Itchiness		Difficulty breathing	
Constipation		Nervousness/Anxiety	
Rash		Weakness	
Difficulty sleeping		Change in weight	
Any other symptoms <i>*attach separate sheet if more room is needed</i>			

8.-Do you and/or your practitioner attribute any of the above symptoms to Poly-MVA?

YES  NO

9.-Has Poly-MVA improved your quality of life?

YES (please see below)  NO

If YES, please explain.

**The space below is provided for any additional comments or information.  
Attach a separate sheet if more room is needed.**