Appendix D: Data Collection Forms, Part 4: Special Study Forms — Active Adipose Study

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Demographic Information

Study ID #: ☐-☐☐-☐☐☐

1. Date of consent (mm/dd/yyyy) _____ Date

2. Do you describe yourself as Hispanic?
2 ○ No 1 ○ Yes 9 ○ Refuse

3. What is the highest education level you have completed?
1 ○ 0 - 6 years
2 ○ 7 - 9 years
3 ○ Some high school
4 ○ High school diploma or GED
5 ○ Vocational school or some college
6 ○ College degree
7 ○ Professional or graduate degree
8 ○ Other
9 ○ Refuse

3a. If highest education is marked "Other", please specify: _____

4. Have you smoked at least 100 cigarettes in your entire life?
2 ○ No
1 ○ Yes
3 ○ Not sure
9 ○ Refuse

5. Have you ever been on peritoneal dialysis?
2 ○ No 1 ○ Yes 3 ○ Not sure

6. Have you ever had a kidney transplant?
2 ○ No 1 ○ Yes 3 ○ Not sure

Patient Questionnaire

Study ID #: ☐-☐☐-☐☐☐

Reason if data are not available ☐

1. In the past 12 months, have you lost more than 10 pounds unintentionally? (i.e. not due to dieting or exercise) ○ Yes (1) ○ No (2) ○ Not sure (3) ○ Refuse (9)

2. Do you now smoke cigarettes everyday, some days or not at all? (1) ○ Everyday (3) ○ Not at all (9) ○ Refuse (2) ○ Some days (4) ○ Don't know

3. Are you living alone? (1) ○ Yes (2) ○ No (9) ○ Refuse

4. Are you living in a nursing home, assisted living facility or personal care home? (1) ○ Yes (2) ○ No (9) ○ Refuse

5a. Are you now able to work for pay? (1) ○ Yes full-time (3) ○ No (4) ○ Don't know (2) ○ Yes part-time (9) ○ Refuse

5b. Are you now working for pay (receiving taxable wages)? (1) ○ Yes full-time (3) ○ No (2) ○ Yes part-time (9) ○ Refuse

6. Thinking of all the activity you get in a non-dialysis day, would you say that you are moving around, being active for: (1) ○ Less than 30 minutes on most or all days (2) ○ About 30 minutes on most or all days (3) ○ More than 30 minutes on most or all days (9) ○ Refuse

6a. If more than 30 mins, ☐ minutes / day *or* ☐ hours / day

7. In the past 12 months, have you received:

a. Physical therapy services? (1) ○ Yes (2) ○ No (3) ○ Not sure (9) ○ Refuse
If YES, for what: ☐

b. Occupational therapy services? (1) ○ Yes (2) ○ No (3) ○ Not sure (9) ○ Refuse
If YES, for what: ☐

c. Cardiac rehabilitation? (1) ○ Yes (2) ○ No (3) ○ Not sure (9) ○ Refuse

Patient Questionnaire

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8. In the past 12 months, have you had a fall (a fall is defined as unintentionally coming to rest on the ground, floor or other lower level)?

1 ○ Yes 2 ○ No 3 ○ Not sure 9 ○ Refuse

If YES, number of falls in the past year: _____

9. In the past 12 months, have you had any fractures (broken bones)?

1 ○ Yes 2 ○ No 3 ○ Not sure 9 ○ Refuse

If YES, please describe: _____

10. Have you had to stay overnight in the hospital during the past 12 months?

1 ○ No hospitalizations in the past 12 months
2 ○ one or more in the past 12 months

***if 'one or more'**, please complete hospitalization information below*

Hospitalization 1

Month/Year _____ Reason _____

Approximate number of nights _____

Hospitalization 2

Month/Year _____ Reason _____

Approximate number of nights _____

Hospitalization 3

Month/Year _____ Reason _____

Approximate number of nights _____

Hospitalization 4

Month/Year _____ Reason _____

Approximate number of nights _____

Hospitalization 5

Month/Year _____ Reason _____

Approximate number of nights _____

Attach separate page(s) for additional **Hospitalizations**

Patient Questionnaire

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11. At the present time, do you need help from another person...

1. To bathe (wash and dry your whole body)? 2 ○ No 1 ○ Yes 3 ○ Unable to do 9 ○ Refuse

If you need help or are unable to do, what is the main symptom or condition that causes you to have difficulty or prevents you from doing the activity?

2. To dress (like putting on a shirt or shoes, buttoning, and zipping)? 2 ○ No 1 ○ Yes 3 ○ Unable to do 9 ○ Refuse

If you need help or are unable to do, what is the main symptom or condition that causes you to have difficulty or prevents you from doing the activity?

3. To get in and out of a chair? 2 ○ No 1 ○ Yes 3 ○ Unable to do 9 ○ Refuse

If you need help or are unable to do, what is the main symptom or condition that causes you to have difficulty or prevents you from doing the activity?

4. To walk around your home or apartment 2 ○ No 1 ○ Yes 3 ○ Unable to do 9 ○ Refuse

If you need help or are unable to do, what is the main symptom or condition that causes you to have difficulty or prevents you from doing the activity?

12. I am going to read a list of activities. Please tell me which activities you have done in the past two weeks:

	Select a choice below (Yes; No; Not Sure / Refuse)	How often have you *name activity* in the last two weeks?	What is the average amount of time that you spent per session? (hours and/or minutes)		How many months per year do you *name activity*?
a. walking for exercise?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr	☐☐ min	☐☐ months
b. moderately strenuous household chores? (for example, scrubbing or vacuuming?)	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr	☐☐ min	☐☐ months
c. mowing the lawn?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr	☐☐ min	☐☐ months
d. raking the lawn?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr	☐☐ min	☐☐ months

Patient Questionnaire

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12. *continued...*

I am going to read a list of activities. Please tell me which activities you have done in the past two weeks:

	Select a choice below (Yes; No; Not Sure / Refuse)	How often have you *name activity* in the last two weeks?	What is the average amount of time that you spent per session? (hours and/or minutes)	How many months per year do you *name activity*?
e. gardening?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr ☐☐ min	☐☐ months
f. hiking?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr ☐☐ min	☐☐ months
g. jogging?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr ☐☐ min	☐☐ months
h. biking?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr ☐☐ min	☐☐ months
i. exercise cycle?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr ☐☐ min	☐☐ months
j. dancing?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr ☐☐ min	☐☐ months
k. aerobics/aerobic dance?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr ☐☐ min	☐☐ months
l. bowling?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr ☐☐ min	☐☐ months
m. golf?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	☐☐ times	☐☐ hr ☐☐ min	☐☐ months

Patient Questionnaire

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12. *continued...*

I am going to read a list of activities. Please tell me which activities you have done in the past two weeks:

	Select a choice below (Yes; No; Not Sure / Refuse)	How often have you *name activity* in the last two weeks?	What is the average amount of time that you spent per session? (hours and/or minutes)	How many months per year do you *name activity*?
n. swimming?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	____ times	____ hr ____ min	____ months
o. calisthenics/general exercise?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	____ times	____ hr ____ min	____ months
p. singles tennis?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	____ times	____ hr ____ min	____ months
q. doubles tennis?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	____ times	____ hr ____ min	____ months
r. racquetball?	1 ○ Yes 2 ○ No 9 ○ Not sure / Refuse	____ times	____ hr ____ min	____ months

13. How many hours of sleep do you usually get at night? (hours) ____ (XX.X hours)

14. How often do you have trouble falling asleep? 1 ○ All or most of the time 3 ○ A little of the time 9 ○ Refuse 2 ○ Some of the time 4 ○ None of the time

15. How often do you have trouble with waking up during the night? 1 ○ All or most of the time 3 ○ A little of the time 9 ○ Refuse 2 ○ Some of the time 4 ○ None of the time

16. How often do you have trouble with waking up too early and not being able to fall asleep again? 1 ○ All or most of the time 3 ○ A little of the time 9 ○ Refuse 2 ○ Some of the time 4 ○ None of the time

17. Do you have creepy-crawly feelings in your legs that make you want to move your legs? 1 ○ Yes 2 ○ No 3 ○ Not sure 9 ○ Refuse

if yes,

a. Do these feelings happen mainly when you stay still and get better when you move? 1 ○ Yes 2 ○ No 3 ○ Not sure 9 ○ Refuse

b. Are these feelings in your legs worse in the evening or at night than in the morning? 1 ○ Yes 2 ○ No 3 ○ Not sure 9 ○ Refuse

c. How often do you experience these feelings? 1 ○ Once a month or less 3 ○ 5 to 15 times a month 2 ○ 2 to 4 times a month 4 ○ 16 or more times a month 9 ○ Refuse

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if yes, *continued..*

d. Overall, how severe were these feelings over the last month?
1 ○ Very severe
2 ○ Severe
3 ○ Moderate
4 ○ Mild
5 ○ Not bothersome at all
9 ○ Refuse

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

1. Did you react slowly to things that were said or done?
1 ○ None of the time
2 ○ A little of the time
3 ○ Some of the time
4 ○ A good bit of the time
5 ○ Most of the time
6 ○ All of the time
9 ○ Refuse

2. Did you have difficulty concentrating or thinking?
1 ○ None of the time
2 ○ A little of the time
3 ○ Some of the time
4 ○ A good bit of the time
5 ○ Most of the time
6 ○ All of the time
9 ○ Refuse

3. Did you become confused?
1 ○ None of the time
2 ○ A little of the time
3 ○ Some of the time
4 ○ A good bit of the time
5 ○ Most of the time
6 ○ All of the time
9 ○ Refuse

19. *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?*

1. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports
1 ○ Yes limited a lot
2 ○ Yes limited a little
3 ○ No not limited at all
9 ○ Refused

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

3. Lifting or carrying groceries
1 ○ Yes limited a lot
2 ○ Yes limited a little
3 ○ No not limited at all
9 ○ Refused

4. Climbing several flights of stairs
1 ○ Yes limited a lot
2 ○ Yes limited a little
3 ○ No not limited at all
9 ○ Refused

5. Climbing one flight of stairs
1 ○ Yes limited a lot
2 ○ Yes limited a little
3 ○ No not limited at all
9 ○ Refused

6. Bending, kneeling, or stooping
1 ○ Yes limited a lot
2 ○ Yes limited a little
3 ○ No not limited at all
9 ○ Refused

7. Walking more than a mile
1 ○ Yes limited a lot
2 ○ Yes limited a little
3 ○ No not limited at all
9 ○ Refused

8. Walking several hundred yards
1 ○ Yes limited a lot
2 ○ Yes limited a little
3 ○ No not limited at all
9 ○ Refused

9. Walking one hundred yard
1 ○ Yes limited a lot
2 ○ Yes limited a little
3 ○ No not limited at all
9 ○ Refused

10. Bathing or dressing yourself
1 ○ Yes limited a lot
2 ○ Yes limited a little
3 ○ No not limited at all
9 ○ Refused

Patient Questionnaire

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20. *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...***

1. Did you feel full of life?	1 ○ All of the time 2 ○ Most of the time 3 ○ Some of the time	4 ○ A little of the time 5 ○ None of the time 9 ○ Refuse
2. Did you have a lot of energy?	1 ○ All of the time 2 ○ Most of the time 3 ○ Some of the time	4 ○ A little of the time 5 ○ None of the time 9 ○ Refuse
3. Did you feel worn out?	1 ○ All of the time 2 ○ Most of the time 3 ○ Some of the time	4 ○ A little of the time 5 ○ None of the time 9 ○ Refuse
4. Did you feel tired?	1 ○ All of the time 2 ○ Most of the time 3 ○ Some of the time	4 ○ A little of the time 5 ○ None of the time 9 ○ Refuse

21. *Below is a list of the ways you might have felt or behaved.*

Please tell me how often you have felt this way during the past week.

1. I was bothered by things that usually don't bother me.
   - 0 ○ Rarely or none of the time (less than 1 day)
   - 1 ○ Some or little of the time (1-2 days)
   - 2 ○ Occasionally or a moderate amount of time (3-4 days)
   - 3 ○ Most or all of the time (5-7 days)
   - 9 ○ Refuse

2. I did not feel like eating; my appetite was poor.
   - 0 ○ Rarely or none of the time (less than 1 day)
   - 1 ○ Some or little of the time (1-2 days)
   - 2 ○ Occasionally or a moderate amount of time (3-4 days)
   - 3 ○ Most or all of the time (5-7 days)
   - 9 ○ Refuse

3. I felt that I could not shake off the blues even with help from my family or friends.
   - 0 ○ Rarely or none of the time (less than 1 day)
   - 1 ○ Some or little of the time (1-2 days)
   - 2 ○ Occasionally or a moderate amount of time (3-4 days)
   - 3 ○ Most or all of the time (5-7 days)
   - 9 ○ Refuse

4. I felt I was just as good as other people.
   - 0 ○ Rarely or none of the time (less than 1 day)
   - 1 ○ Some or little of the time (1-2 days)
   - 2 ○ Occasionally or a moderate amount of time (3-4 days)
   - 3 ○ Most or all of the time (5-7 days)
   - 9 ○ Refuse

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21. *continued... Please tell me how often you have felt this way during the past week.*

5. I had trouble keeping my mind on what I was doing.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

6. I felt depressed.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

7. I felt that everything I did was an effort.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

8. I felt hopeful about the future.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

9. I thought my life had been a failure.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

10. I felt fearful.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

11. My sleep was restless.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

12. I was happy.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

13. I talked less than usual.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all the time (5-7 days)
9 ○ Refuse

14. I felt lonely.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

15. People were unfriendly.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

16. I enjoyed life.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

17. I had crying spells.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

18. I felt sad.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

Patient Questionnaire

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21. *continued... Please tell me how often you have felt this way during the past week.*

19. I felt that people disliked me.
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

20. I could not get "going."
0 ○ Rarely or none of the time (less than 1 day)
1 ○ Some or little of the time (1-2 days)
2 ○ Occasionally or a moderate amount of time (3-4 days)
3 ○ Most or all of the time (5-7 days)
9 ○ Refuse

22. *We are interested in knowing if any of these reasons may limit your participation in physical activity.* I am going to read a list of possible reasons. Please tell me if a reason limits your physical activity. (If necessary, ask after each: "Is this a reason you limit your physical activity?")

a. You feel too sick	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
b. You feel too tired	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
c. You feel sad	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
d. You don't have time	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
e. You are just not motivated	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
f. You don't have any place to exercise or any exercise equipment	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
g. You don't know what to do	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
h. You don't think it is good for you	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
i. You are in too much pain	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
j. You are afraid of getting hurt	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
k. Your family doesn't think you should	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse
l. Your doctor doesn't think you should	1 ○ Yes	2 ○ No	3 ○ Not sure	9 ○ Refuse

23. Is there anything that we haven't asked that you think would be helpful for the researchers to know?

Physical Measures

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Are data collected for this assessment? 1 ○ Yes 2 ○ No

Reason if data are not available ____

if no, quit this form but enter the above information into the database
if yes, proceed with this form

GRIP STRENGTH

1. Have you had a recent worsening of pain or of arthritis in your wrist, or do you have tendonitis? 1 ○ Yes 2 ○ No 3 ○ Unknown

2. Have you had any surgery on your hands or arms during the last 13 weeks? 1 ○ Yes 2 ○ No 3 ○ Unknown

3. Was a grip strength test done? 1 ○ Yes 2 ○ No

***if 'no'**, skip to Question 12*

***if 'yes'**, continue below*

4. Circle which hand is being tested. 1 ○ Right 2 ○ Left 3 ○ Unable/discontinued

(Begin with dominant hand.)

5. First try ____ (XX kg)

6. Second try ____ (XX kg)

7. Third try ____ (XX kg)

Repeat for opposite hand.

8. Circle which hand is being tested. 1 ○ Right 2 ○ Left 3 ○ Unable/discontinued

9. First try ____ (XX kg)

10. Second try ____ (XX kg)

11. Third try ____ (XX kg)

MEASURED WALK

12. *OBSERVE: Does this participant use an assistive device for walking?* 1 ○ Yes 2 ○ No 3 ○ Unknown

***if 'no' or not assessed**, skip to Question 13*

*12a. **If 'yes'**, what type of device?*

1 ○ Standard cane 2 ○ Wheelchair
3 ○ Quad cane 4 ○ White cane
5 ○ Walker 6 ○ Crutches (1 or 2)
7 ○ Electric wheelchair/scooter
8 ○ Cane & electric wheelchair/scooter
9 ○ Cane & wheelchair 10 ○ Wheelchair & walker
11 ○ Cane & walker 12 ○ Cane, wheelchair & walker

Physical Measures

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13. Does the participant use a lower extremity orthosis? (plastic or metal leg brace at or above the ankle) / ○ Yes 2 ○ No 3 ○ Unknown

14. Is participant missing any limb? / ○ Yes 2 ○ No 3 ○ Unknown

***if 'no' or not assessed**, skip to Question 15*

***if 'yes'**, continue below, indicating which limbs are missing*

a. Left arm / ○ Yes 2 ○ No 3 ○ Unknown

b. Right arm / ○ Yes 2 ○ No 3 ○ Unknown

c. Left leg / ○ Yes 2 ○ No 3 ○ Unknown

d. Right leg / ○ Yes 2 ○ No 3 ○ Unknown

15. Does the participant use a prosthesis (artificial limb)? / ○ Yes ○ No 2 ○ Unknown 3

***if 'no' or not assessed**, skip to Question 16*

***if 'yes'**, continue below, indicating which limbs have a prosthesis*

a. Left arm / ○ Yes 2 ○ No 3 ○ Unknown

b. Right arm / ○ Yes 2 ○ No 3 ○ Unknown

c. Left leg / ○ Yes 2 ○ No 3 ○ Unknown

d. Right leg / ○ Yes 2 ○ No 3 ○ Unknown

16. Is the participant able to walk 15 feet? / ○ Yes 2 ○ No ○ Unknown 3

***if 'no' or not assessed**, skip to Question 19*

***if 'yes'**, continue below with the 15-foot walk test*

16a. *Is the participant using an assistive device to perform this walk?* / ○ Yes ○ No 2 ○ Unknown 3

Time, in seconds, to walk 15 feet:

17. First try ☐☐☐☐ (XX.XX) seconds

18. Second try ☐☐☐☐ (XX.XX) seconds

Physical Measures

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19. Is the participant able to do a side-by-side stand (balance unaided for 10 seconds)?

Side-by-side-stand

1 ○ Held for 10 sec
2 ○ Not held for 10 sec
Number of seconds held if less than 10 sec: _____ (X.XX sec)
3 ○ Not attempted

If participant did not attempt test or failed, specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other, specify _____
7 ○ Participant refused

20. Semi-Tandem Stand

1 ○ Held for 10 sec
2 ○ Not held for 10 sec
Number of seconds held if less than 10 sec: _____ (X.XX sec)
3 ○ Not attempted

If participant did not attempt test or failed, specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other, specify _____
7 ○ Participant refused

21. Tandem Stand

1 ○ Held for 10 sec
2 ○ Held for 3 to 9.99 sec
3 ○ Held for less than 3 sec
Number of seconds held if less than 10 sec: _____ (X.XX sec)
4 ○ Not attempted

If participant did not attempt test or failed, specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other, specify _____
7 ○ Participant refused

Physical Measures

Study ID #: ☐-☐☐-☐☐☐

22. CHAIR-STAND

1. Single Chair Stand Test

A. Safe to stand without help — 1 ○ YES 2 ○ NO

if 'no', end test, indicate reason at right and quit this form → specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other (specify below), specify _____
7 ○ Participant refused

if 'yes', continue below

Results:

1 ○ Participant stood without using arms → Go to Repeated Chair Stand Test
2 ○ Participant used arms to stand → End Test
3 ○ Test not completed → End Test

If participant did not attempt test or failed, circle why:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other (specify below), specify _____
7 ○ Participant refused

2. Repeated Chair Stand Test

A. Safe to stand five times — 1 ○ YES 2 ○ NO

if 'no', end test, indicate reason at right and quit this form → specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other (specify below), specify _____
7 ○ Participant refused

if 'yes', continue below. Ask the patient to stand five times and record the time this takes. Stop at 60 seconds.

If five stands done successfully, record time in seconds. _____ (XX.XX sec)

If participant did not attempt test or failed, circle why:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other (specify bellow), specify _____
7 ○ Participant refused

Body Composition

Study ID #: ☐-☐☐-☐☐☐

1. Standing height ☐ (XXX.X cm)

2. Predialysis weight ☐ (XXX.X kg)

3. Waist circumference:

Are waist circumference data collected for this assessment? ○ Yes ○ No

Trial #1 ☐ (XXX.X cm)

Trial #2 ☐ (XXX.X cm)

4. Are BIS data collected for this assessment? 1 ○ Yes 2 ○ No

*4a. **If 'no'**, indicate reason at right and quit this form*

1 ○ Double amputee
2 ○ Measure discontinued (patient started but did not want to continue or not able to continue)
3 ○ Patient refused
4 ○ Patient too sick to participate
5 ○ 4b. Other, Specified reason ☐

***if 'yes'**, continue below*

5. On which side of the body were BIS measurements conducted? 1 ○ Right side 2 ○ Left side

6.Date of patient's most recent dialysis (mmddyy):_____

Medical Record

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HEMODIALYSIS

1. Undernourished or cachectic (malnourished) currently — 0 ○ No 1 ○ Yes 9 ○ Unknown

2. Current pre/post dialysis blood pressure and weight (most recent 3 readings)

a. **Pre** dialysis BP (sitting preferred)

Reading 1	☐☐☐	SBP/	☐☐☐	DBP	☐☐☐	Weight (XXX.X kg)
Reading 2	☐☐☐	SBP/	☐☐☐	DBP	☐☐☐	Weight (XXX.X kg)
Reading 3	☐☐☐	SBP/	☐☐☐	DBP	☐☐☐	Weight (XXX.X kg)

b. **Post** dialysis BP (sitting preferred)

Reading 1	☐☐☐	SBP/	☐☐☐	DBP	☐☐☐	Weight (XXX.X kg)
Reading 2	☐☐☐	SBP/	☐☐☐	DBP	☐☐☐	Weight (XXX.X kg)
Reading 3	☐☐☐	SBP/	☐☐☐	DBP	☐☐☐	Weight (XXX.X kg)

3. Current dialysis clinic ___ - _____

4. What time of day do hemodialysis treatments for this patient START (on date of assessment)? *circle one:*

1 morning (before 12 noon)
2 afternoon (12 noon – before 6 pm)
3 evening or night (6 pm or later)

5. Current hemodialysis prescription:

a. Prescribed hours per treatment: ☐☐☐ (X.XX hours)

b. Prescribed number of dialysis sessions per week ☐☐

c. Blood flow rate* (BFR) ☐☐☐ (XXX ml/min)

* If BFR varies, please enter the prescribed or the most common "high" rate.

d. Patient usually reusing dialyzer — 0 ○ No 1 ○ Yes 9 ○ Unknown

Medical Record

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e. If reuse does not occur, please indicate reason 1 ○ Unit does not reuse 2 ○ Other

f. Vascular access in use:
1 ○ AV Fistula
2 ○ Temporary internal jugular (IJ) catheter
3 ○ AV graft
4 ○ Temporary femoral catheter
5 ○ Tunneled or Permanent catheter
6 ○ Other

g. If a catheter is in use, is there a maturing graft or fistula 0 ○ No 1 ○ AVG 2 ○ AVF 4 ○ Not applicable

h. Number of HD treatments skipped by patients during 30 days prior to current date (do not include time in the hospital): ☐☐ (XX)

6. Is the patient taking EPO (Erythropoietin)? 0 ○ No 1 ○ Yes 9 ○ Unknown

if yes,

How often? ☐☐☐ doses/month

Doses units ○ U. ○ U/kg

Cumulative dose: ☐☐☐☐☐☐ (XXXXXX)

7. Is the patient taking darbepoietin? 0 ○ No 1 ○ Yes 9 ○ Unknown

if yes,

How often? ☐☐☐ doses/month

Doses units ○ mcg ○ mcg/kg

Cumulative dose: ☐☐☐☐ (XXXX)

8. Is the patient receiving maintenance IV iron during dialysis? 0 ○ No

1 ○ sodium ferric gluconate (Ferrlecit)
2 ○ iron dextran (InFed; Dexferrum)
3 ○ iron sucrose (Venofer)
4 ○ other
9 ○ Unknown

How often? ☐☐☐ doses/month

Cumulative dose: ☐☐☐☐ (XXXX mg)

9. Is the patient receiving Vitamin D therapy?

a. Calcitriol (Rocaltrol) 0 ○ No 1 ○ Yes 9 ○ Unknown

b. Paricalcitol (Zemplar) 0 ○ No 1 ○ Yes 9 ○ Unknown

c. Doxercalciferol (Hectorol) 0 ○ No 1 ○ Yes 9 ○ Unknown

d. Other type of Vitamin D therapy 0 ○ No 1 ○ Yes 9 ○ Unknown

Medical Record

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LABORATORY DATA

Complete with information closest to form completion date

1. Cardiomegaly by X-ray — 0 ○ No 1 ○ Yes 9 ○ Unknown

2. Has the patient had echocardiogram(s)? — 0 ○ No 1 ○ Yes 9 ○ Unknown

   ***if 'no' or 'unknown'**, skip to item 3*

   ***if 'yes'**, continue below*

   a. Date of most recent echocardiogram (mm/dd/yyyy) ____ Date

3. Is an estimate of ejection fraction available? — 0 ○ No 1 ○ Yes

   ***if 'no'** skip to item 4*

   ***if 'yes'**, continue below*

   a. Most recent source

   1 ○ Echocardiogram
   2 ○ MUGA (Nuclear medicine study)
   3 ○ Cardiac catheterization
   4 ○ PET scan
   5 ○ Other cardiac test including SPECT
   6 ○ Unknown

   Transcribe the most recent ejection fraction as either a single value or range below.

   b1. Most recent EF ____ (XX.X %)

   OR

   b2. EF range ____ (XX – XX %)

   c. Date of EF (mm/dd/yyyy) ____ Date

4. Left ventricular hypertrophy (LVH):

   a. by EKG — 0 ○ No 1 ○ Yes 9 ○ Unknown

   b. by echocardiography — 0 ○ No 1 ○ Yes 9 ○ Unknown

Medical Record

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5. Total serum calcium – predialysis: ☐☐☐☐ (XX.X mg/dl)

6. Serum phosphate or phosphorus – predialysis: ☐☐☐☐ (XX.X mg/dl)

7. Serum biocarbonate or CO_2 – predialysis: ☐☐☐☐ (XX.X mEq/l)

8. Hematocrit information (*from the lab report*):

   a. Hematocrit (*If transfused, give value before blood transfusion*) ☐☐☐☐ (XX.X %)

   b. Hemoglobin (*If transfused, give value before transfusion*) ☐☐☐☐ (XX.X g/dl)

9. Serum Creatinine: ☐☐☐☐ (XX.XX mg/dl)

10. BUN:

    Nearest to current date (*measurements must be from the same date*)

    a. Predialysis: *(Required)* ☐☐☐☐ (XXX mg/dl)

    b. Postdialysis: *(Required)* ☐☐☐☐ (XXX mg/dl)

11. spKt/V: ☐☐☐☐ (X.XX)

12. Predialysis or random Serum Albumin: ☐☐☐☐ (X.X g/dl)

13. Lipids:

    a. Cholesterol total ☐☐☐☐ (XXX mg/dl)

    b. HDL cholesterol ☐☐☐☐ (XXX mg/dl)

    c. LDL cholesterol ☐☐☐☐ (XXX mg/dl)

    d. Triglycerides ☐☐☐☐ (XXXX mg/dl)

14. Serum intact PTH: ☐☐☐☐ (XXXX pg/ml)

15. Serum 25(OH)D: ☐☐☐☐ (XX.X ng/ml)

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16. ○ No hospitalizations in the past 12 months (1) ○ one or more hospitalizations in the past 12 months (2)

***if 'one or more'**, Please complete hospitalization information below*

Hospitalization 1

Month/Year _____ Reason _____

Approximate number of nights _____

Hospitalization 2

Month/Year _____ Reason _____

Approximate number of nights _____

Hospitalization 3

Month/Year _____ Reason _____

Approximate number of nights _____

Hospitalization 4

Month/Year _____ Reason _____

Approximate number of nights _____

Hospitalization 5

Month/Year _____ Reason _____

Approximate number of nights _____

Attach separate page(s) for additional **Hospitalizations**

Copy and attach patient's current **Medication List**

Physical Measures

Study ID #: ☐-☐☐-☐☐☐

Are data collected for this assessment? 1 ○ Yes 2 ○ No

Reason if data are not available ____

if no, quit this form but enter the above information into the database
if yes, proceed with this form

GRIP STRENGTH

1. Have you had a recent worsening of pain or of arthritis in your wrist, or do you have tendonitis? 1 ○ Yes 2 ○ No 3 ○ Unknown

2. Have you had any surgery on your hands or arms during the last 13 weeks? 1 ○ Yes 2 ○ No 3 ○ Unknown

3. Was a grip strength test done? 1 ○ Yes 2 ○ No

***if 'no'**, skip to Question 12*

***if 'yes'**, continue below*

4. Circle which hand is being tested. 1 ○ Right 2 ○ Left 3 ○ Unable/discontinued

(Begin with dominant hand.)

5. First try ____ (XX kg)

6. Second try ____ (XX kg)

7. Third try ____ (XX kg)

Repeat for opposite hand.

8. Circle which hand is being tested. 1 ○ Right 2 ○ Left 3 ○ Unable/discontinued

9. First try ____ (XX kg)

10. Second try ____ (XX kg)

11. Third try ____ (XX kg)

MEASURED WALK

12. *OBSERVE: Does this participant use an assistive device for walking?* 1 ○ Yes 2 ○ No 3 ○ Unknown

***if 'no' or not assessed**, skip to Question 13*

*12a. **If 'yes'**, what type of device?*

1 ○ Standard cane 2 ○ Wheelchair
3 ○ Quad cane 4 ○ White cane
5 ○ Walker 6 ○ Crutches (1 or 2)
7 ○ Electric wheelchair/scooter
8 ○ Cane & electric wheelchair/scooter
9 ○ Cane & wheelchair 10 ○ Wheelchair & walker
11 ○ Cane & walker 12 ○ Cane, wheelchair & walker

Physical Measures

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13. Does the participant use a lower extremity orthosis? (plastic or metal leg brace at or above the ankle) / ○ Yes 2 ○ No 3 ○ Unknown

14. Is participant missing any limb? / ○ Yes 2 ○ No 3 ○ Unknown

***if 'no' or not assessed**, skip to Question 15*

***if 'yes'**, continue below, indicating which limbs are missing*

a. Left arm / ○ Yes 2 ○ No 3 ○ Unknown

b. Right arm / ○ Yes 2 ○ No 3 ○ Unknown

c. Left leg / ○ Yes 2 ○ No 3 ○ Unknown

d. Right leg / ○ Yes 2 ○ No 3 ○ Unknown

15. Does the participant use a prosthesis (artificial limb)? / ○ Yes ○ No 2 ○ Unknown 3

***if 'no' or not assessed**, skip to Question 16*

***if 'yes'**, continue below, indicating which limbs have a prosthesis*

a. Left arm / ○ Yes 2 ○ No 3 ○ Unknown

b. Right arm / ○ Yes 2 ○ No 3 ○ Unknown

c. Left leg / ○ Yes 2 ○ No 3 ○ Unknown

d. Right leg / ○ Yes 2 ○ No 3 ○ Unknown

16. Is the participant able to walk 15 feet? / ○ Yes 2 ○ No ○ Unknown 3

***if 'no' or not assessed**, skip to Question 19*

***if 'yes'**, continue below with the 15-foot walk test*

16a. *Is the participant using an assistive device to perform this walk?* / ○ Yes ○ No 2 ○ Unknown 3

Time, in seconds, to walk 15 feet:

17. First try ☐☐☐☐ (XX.XX) seconds

18. Second try ☐☐☐☐ (XX.XX) seconds

Physical Measures

Study ID #: ☐-☐☐-☐☐☐

19. Is the participant able to do a side-by-side stand (balance unaided for 10 seconds)?

Side-by-side-stand

1 ○ Held for 10 sec
2 ○ Not held for 10 sec
Number of seconds held if less than 10 sec: _____ (X.XX sec)
3 ○ Not attempted

If participant did not attempt test or failed, specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other, specify _____
7 ○ Participant refused

20. Semi-Tandem Stand

1 ○ Held for 10 sec
2 ○ Not held for 10 sec
Number of seconds held if less than 10 sec: _____ (X.XX sec)
3 ○ Not attempted

If participant did not attempt test or failed, specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other, specify _____
7 ○ Participant refused

21. Tandem Stand

1 ○ Held for 10 sec
2 ○ Held for 3 to 9.99 sec
3 ○ Held for less than 3 sec
Number of seconds held if less than 10 sec: _____ (X.XX sec)
4 ○ Not attempted

If participant did not attempt test or failed, specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other, specify _____
7 ○ Participant refused

Physical Measures

Study ID #: ☐-☐☐-☐☐☐

22. CHAIR-STAND

1. Single Chair Stand Test

A. Safe to stand without help — 1 ○ YES 2 ○ NO

if 'no', end test, indicate reason at right and quit this form → specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other (specify below), specify _____
7 ○ Participant refused

if 'yes', continue below

Results:

1 ○ Participant stood without using arms → Go to Repeated Chair Stand Test
2 ○ Participant used arms to stand → End Test
3 ○ Test not completed → End Test

If participant did not attempt test or failed, circle why:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other (specify below), specify _____
7 ○ Participant refused

2. Repeated Chair Stand Test

A. Safe to stand five times — 1 ○ YES 2 ○ NO

if 'no', end test, indicate reason at right and quit this form → specify reason:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other (specify below), specify _____
7 ○ Participant refused

if 'yes', continue below. Ask the patient to stand five times and record the time this takes. Stop at 60 seconds.

If five stands done successfully, record time in seconds. _____ (XX.XX sec)

If participant did not attempt test or failed, circle why:

1 ○ Tried but unable
2 ○ Participant could not hold position unassisted
3 ○ Not attempted and you felt unsafe
4 ○ Not attempted and participant felt unsafe
5 ○ Participant unable to understand instructions
6 ○ Other (specify bellow), specify _____
7 ○ Participant refused