Stroke Oxygen Study
6 Months follow-up Questionnaire

Name: _____ **Date of birth:**_____ **Trial No:**_____

This questionnaire can be completed by a relative, friend or carer on your behalf.

Date of discharge from hospital after the stroke, if known/applicable:
_____DD-MON-YYYY

Where do you live now? Please tick the box which applies to you
☐ In my own home
☐ In the home of a relative
☐ In a residential home
☐ In a nursing home
☐ In a continuing care hospital; name of hospital ----------
☐ I have not yet left hospital after my stroke

Who do you live with? Please tick the box which applies to you
☐ I live alone
☐ I live with a spouse/partner
☐ I live with family/friends

Have you been admitted to hospital again for any reason after you were discharged?
☐ Yes (once)
☐ Yes (more than once)
☐ No

Are you left with any symptoms or problems after your stroke?
Please tick **one box** next to the statement which best describes your present state

☐ I have no symptoms at all.

☐ I have a few symptoms, but I am able to carry out all previous activities and duties.

☐ I am unable to carry out all previous activities, but am able to look after my own affairs without assistance.

☐ I need some help with looking after my own affairs, but am able to walk without assistance.

☐ I am unable to walk without assistance and unable to attend to my own bodily needs without assistance, but I do not need constant care and attention.

☐ I have major symptoms which severely handicap me. I am bedridden and incontinent and I need constant attention day and night.

This page contains some more specific questions on how the stroke has affected your day to day life and physical functioning

Please circle the number for the statement that best describes each activity

Bowel control	0 Incontinent (or needs to be given an enema) 1 Occasional accident (once a week) 2 Continent
Bladder control	0 Incontinent or catheterised and unable to manage alone 1 Occasional accident (max. once per 24h) 2 Continent (for more than seven days)
Grooming	0 Needs help with personal care 1 Independent: face, hair, teeth, shaving (implements provided)
Toilet use	0 Dependent 1 Needs some help but can do some things alone 2 Independent (on and off, wiping, dressing)
Feeding	0 Unable 1 Needs help in cutting, spreading butter etc. 2 Independent (food provided in reach)
Transfer from bed to chair	0 Unable – no sitting balance 1 Major help (physical, one or two people), can sit 2 Minor help (verbal or physical) 3 Independent (but may use any aid)
Mobility	0 Immobile 1 Wheelchair independent, including corners etc 2 Walks with help of 1 person (verbal or physical help) 3 Independent (but may use any aid)
Ability to dress	0 Dependent 1 Needs help but can do about half unaided 2 Independent (including buttons, laces, zips etc)
Ability to climb stairs	0 Unable 1 Needs help (verbal, physical, carrying aid) 2 Independent, up and down
Bathing	0 Dependent 1 Independent (Bath: must get in & out unsupervised and wash self or Shower: unsupervised/unaided)

The following questions will help us to find whether your wellbeing is affected by any of your medical problems. Some questions may address similar topics to the previous pages, but this will help us to get more specific information about how well you are

Mobility
Please tick the box which best describes your level of mobility

☐ I have no problems walking
☐ I have some problems walking
☐ I am confined to bed

Self care
Please tick the box which best describes your ability to care for yourself

☐ I have no problems with self care
☐ I have some problems washing and dressing
☐ I am unable to wash or dress myself

Usual activities
Please tick one box next to the statement which best describes your ability to perform your usual activities

☐ I am able to perform my usual activities
☐ I have some problems performing my usual activities
☐ I am unable to perform my usual activities

Pain or discomfort
Please tick one box next to the statement which best describes your level of pain or discomfort

☐ I have no pain or discomfort
☐ I have moderate pain or discomfort
☐ I have extreme pain or discomfort

Anxiety and depression
Please tick one box next to the statement which best your level of anxiety and depression

☐ I am not anxious or depressed
☐ I am moderately anxious or depressed
☐ I am extremely anxious or depressed

To help to say how good (or bad) your health is we have drawn a scale (rather like a thermometer) on which the best health you can imagine is marked by 100 and the worst health you can imagine is marked by 0.

We would like you to indicate on this scale how good or bad your health is in your own opinion today.

Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your current health is.

Best imaginable health state

100

Your own health today is:

0

Score: _____%

Worst imaginable health state

This is a long list of questions designed to find out if and how your medical condition has affected your ability to do day to day activities and to pursue work and leisure interests

Please tick the option that describes best which you actually do

	Alone easily	Alone with difficulty	With help	Not at all
Mobility:				
Do you walk around outside?				
Do you climb stairs?				
Do you get in and out of the car?				
Do you walk on uneven ground?				
Do you cross roads?				
Do you travel on public transport?				
Eating and Drinking:				
Do you manage to feed yourself?				
Do you manage to make a hot drink?				
Do you take hot drinks from one room to another?				
Do you do the washing up?				
Do you make yourself a hot snack?				
Domestic tasks:				
Do you manage your own money when out?				
Do your own shopping?				
Do you wash small items of clothing?				
Do you do a full clothes wash?				
Leisure and communication:				
Do you read newspapers and books?				
Use the telephone?				
Do you write letters?				
Go out socially?				
Do you manage your own garden?				
Drive a car?				

Memory
Please tick one box next to the statement which best describes your memory
☐ My memory is as good as before the stroke
☐ My memory has deteriorated since the stroke
☐ My memory has improved since the stroke

Sleep
Please tick one box next to the statement which best describes your sleep
☐ I sleep as well as before the stroke
☐ I sleep better since my stroke
☐ I find it more difficult to sleep after my stroke

Eyesight
Please tick one box next to the statement which best describes your eyesight
☐ My eyesight is as good as before the stroke
☐ My eyesight has deteriorated since the stroke
☐ My eyesight has improved since the stroke

Speech
Please tick one box next to the statement which best describes your ability to communicate verbally
☐ I have no speech problems
☐ I have some speech problems, but usually manage a conversation
☐ I frequently have problems in communication
☐ I can only say a few words
☐ I cannot speak at all

Can you remember which of the treatments you were given as part of this trial?
☐ Oxygen for 3 days and nights
☐ Oxygen for 3 nights
☐ Oxygen only if needed
☐ No oxygen
☐ I don't know

Have you taken part in any other clinical trials since the start of this study?
☐ No
☐ I don't know
☐ Yes
If YES, please state name of trial :

Who completed the form? [tick what applies to you]
☐ I completed the form on my own
☐ I completed the form with some help from a relative, friend or carer
☐ A relative, friend or carer completed the form for me
☐ The form was completed by the researcher over the telephone
☐ The form was completed by the researcher in a hospital clinic
☐ Other_____

Date: _____ DD- MMM –YYYY
Thank you very much for taking the time to complete this form.