Quality of Life

POST IMPLANT FORM
Please answer questions #1-9 below to provide some additional information.

1. Which one of the following best describes your “one” main activity? (select one)
   - Too sick to work (disabled)
   - Actively working
   - Keeping house
   - Student
   - Unknown
   - Retired
   - Seeking work
   - Other please specify: ___________

   Is this “one” main activity considered:  Full time   or  Part time or Unknown

2. How many of your close friends or relatives do you see in person, speak to on the telephone or contact via the internet at least once a month? __________ (please count each person 1 time).  ST= Unknown.

3. Have you unintentionally lost more than 10 pounds in the last year?  □ Yes □ No □ Unknown

4. Do you currently smoke cigarettes?  □ Yes □ No □ Unknown

   If YES, how many cigarettes are you currently smoking, on average?
   - Half a pack or less per day
   - 1 to 2 packs per day
   - More than half to 1 pack per day
   - 2 or more packs per day

5. Do you currently smoke e-cigarettes?  □ Yes □ No □ Unknown

   Please circle a number, to respond to the questions below.  ST= Unknown.

6. How much stress related to your health issues do you feel you’ve been under during the past 1 month?
   1               2              3              4              5              6              7              8              9              10
   No stress                                                                                                                                   Very much stress

7. How well do you feel you’ve been coping with or handling your stress related to your health issues during the past 1 month?
   1               2              3              4              5              6              7              8              9              10
   Coping very poorly                                                                                                                              Coping very well

8. How confident are you that you can do the tasks and activities needed to manage your ventricular assist device so as to reduce how much having a ventricular assist device affects your everyday life?
   1               2              3              4              5              6              7              8              9              10
   Not at all confident                                           Totally confident

9. How satisfied are you with the outcome of your ventricular assist device surgery, during the past 3 months?
   1               2              3              4              5              6              7              8              9              10
   Not satisfied                                           Very satisfied
10. If you had to do it all over again, would you decide to have a ventricular assist device knowing what you know now?

1. Definitely No
2. Probably No
3. Not Sure
4. Probably Yes
5. Definitely Yes