

QUALITY OF LIFE

Under each heading, please tick the ONE box that best describes your health TODAY

Mobility

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

Self Care

- I have no problems with washing or dressing myself
- I have slight problems with washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems with washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problem doing my usual activities
- I have a slight problem doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

Pain/Discomfort

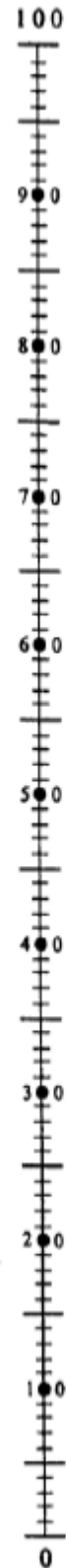
- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

- We would like to know how good or bad your health is **TODAY**.
- This scale is numbered from 0 to 100.
- 100 means the best health you can **imagine**.
- 0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is **TODAY**.
- Now, please write the number you marked on the scale in the box below.

The best health you
can imagine



The worst health you
can imagine

COVID-19

The COVID-19 pandemic has affected many people worldwide and we would like to know how many have been affected in this trial:

A. Do you think you have had COVID-19?

No Yes

B. If **YES**, and you think you have had COVID-19, was this confirmed with a test?

No Yes

MOBILE APP

Would you like to complete your future follow-up questionnaires using a mobile app?

No Yes

Thank you for completing this questionnaire.

If you are likely to change your contact details in the next two months, please fill out the “Change of Contact Details Form” on the following page.

Please return this booklet to the RACER Trial Office in the Freepost envelope provided.

Site Code: Participant TNO:

Please let us know about any changes to your contact details, or your additional contacts, please complete the below form and return with your completed questionnaire or contact RACER@warwick.ac.uk

Please note that we will use all contact information you provide to attempt to reach you, unless you specify otherwise.

Your Contact Details:

Date changes effective from: - -

Title: First Name: Surname:

1st Line of Address :

2nd Line of Address:

Town/City: Postcode:

Telephone: Mobile:

Email: Preferred time of contact:

To help us stay in touch with you for the duration of the study, please could you to provide us with updated additional contacts. We will only make contact with these people if we cannot reach you directly. You only need to update these details if the information previously provided is now incorrect.

Please only provide contact information which you have prior permission to share with us.

Additional Contact 1:

Title:

First Name:

Surname:

Email:

Telephone:

Mobile:

Relationship:

Additional Contact 2:

Title:

First Name:

Surname:

Email:

Telephone:

Mobile:

Relationship:

GP Details: *(If changed since entering the Trial)*

Doctors Surgery Name:

Address:

For information on how your, and your additional contacts, identifiable information is handled please contact the RACER Team on the above email address or visit the trial website: <https://warwick.ac.uk/fac/sci/med/research/ctu/trials/current/racer/>