

APPENDIX A

Pt. Initials: _____

Pt. ID: _____

Date: _____

UTERINE FIBROID SYMPTOM AND HEALTH-RELATED QUALITY OF LIFE
QUESTIONNAIRE (UFS-QOL)

Listed below are symptoms experienced by women who have uterine fibroids. Please consider each symptom as it relates to your uterine fibroids or menstrual cycle. Each question asks how much distress you have experienced from each symptom during the previous 3 months.

There are no right or wrong answers. Please be sure to answer every question by checking (✓) the most appropriate box. If a question does not apply to you, please mark "not at all" as a response.

During the previous 3 months, how distressed were you by...	Not at all	A little bit	Some-what	A great deal	A very great deal
1. Heavy bleeding during your menstrual period	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2. Passing blood clots during your menstrual period	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3. Fluctuation in the duration of your menstrual period compared to your previous cycle	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4. Fluctuation in the length of your monthly cycle compared to your previous cycles	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5. Feeling tightness or pressure in your pelvic area	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6. Frequent urination during the daytime hours	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7. Frequent nighttime urination	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8. Feeling fatigued	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

The following questions ask about your feelings and experiences regarding the impact of uterine fibroid symptoms on your life. Please consider each question as it relates to your experiences with uterine fibroids during the previous 3 months.

There are no right or wrong answers. Please be sure to answer every question by checking (✓) the most appropriate box. If the question does not apply to you, please check “none of the time” as your option.

During the previous 3 months, how often have your symptoms related to uterine fibroids...	None of the time	A little of the time	Some of the time	Most of the time	All of the time
9. Made you feel anxious about the unpredictable onset or duration of your periods?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. Made you anxious about traveling?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11. Interfered with your physical activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
12. Caused you to feel tired or worn out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
13. Made you decrease the amount of time you spent on exercise or other physical activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
14. Made you feel as if you are not in control of your life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
15. Made you concerned about soiling underclothes?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
16. Made you feel less productive?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
17. Caused you to feel drowsy or sleepy during the day?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
18. Made you feel self-conscious of weight gain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
19. Made you feel that it was difficult to carry out your usual activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
20. Interfered with your social activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
21. Made you feel conscious about the size and appearance of your stomach?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
22. Made you concerned about soiling bed linen?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

During the previous 3 months, how often have your symptoms related to uterine fibroids...	None of the time	A little of the time	Some of the time	Most of the time	All of the time
23. Made you feel sad, discouraged, or hopeless?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
24. Made you feel down hearted and blue?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
25. Made you feel wiped out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
26. Caused you to be concerned or worried about your health?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
27. Caused you to plan activities more carefully?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
28. Made you feel inconvenienced about always carrying extra pads, tampons, and clothing to avoid accidents?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
29. Caused you embarrassment?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
30. Made you feel uncertain about your future?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
31. Made you feel irritable?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
32. Made you concerned about soiling outer clothes?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
33. Affected the size of clothing you wear during your periods?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
34. Made you feel that you are not in control of your health?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
35. Made you feel weak as if energy was drained from your body?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
36. Diminished your sexual desire?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
37. Caused you to avoid sexual relations?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

APPENDIX B
UFS-QoL Scoring Manual

To calculate a symptom score for symptom severity, create a summed score from the items listed below and then use the formula below the table to transform the value. This will provide symptom scores where higher score values are indicative of greater symptom severity or bother and lower scores will indicate minimal symptom severity (high scores = bad).

Scale	Sum Item Values	Lowest and Highest Possible Raw Scores	Possible Raw Score Range
Symptom Severity	Sum 1 – 8	8, 40	32

Transformation for Symptom Severity raw scores ONLY:

$$\text{Transformed Score} = \frac{(\text{Actual raw score} - \text{lowest possible raw score})}{\text{Possible raw score range}} \times 100$$

For the HRQL subscales (concern, activities, energy/mood, control, self-conscious, and sexual function), create summed scores of the items listed below for each individual subscale. To calculate the HRQL total score, sum the value of each individual subscale (do not sum individual items). Use the formula below the table to transform all values. Higher scores will be indicative of better HRQL (high = good).

Scale	Sum Item Values	Lowest and Highest Possible Raw Scores	Possible Raw Score Range
Concern	9+15+22+28+32	5, 25	20
Activities	10+11+13+19+20+27+29	7, 35	28
Energy/mood	12+17+23+24+25+31+35	7, 35	28
Control	14+16+26+30+34	5, 25	20
Self-conscious	18+21+33	3, 15	12
Sexual function	36+37	2, 10	8
HRQL TOTAL	Sum of 6 Subscale Scores	29, 145	116

Formula for transformation of HRQL raw scores ONLY:

$$\text{Transformed Score} = \frac{(\text{Highest possible score} - \text{Actual raw score})}{\text{Possible raw score range}} \times 100$$

Missing Items

For the subscale analyses, if < 50% of the scale items are missing, the scale should be retained with the mean scale score of the items present used to impute a score for the missing items. If ≥ 50% of the items are missing, no scale score should be calculated, the subscale score should be considered missing. If a subscale score is missing, the HRQL total cannot be calculated.