ANESTHESIA AWARENESS REGISTRY

Adult Eligibility Requirements Cover Sheet

The goal of this Registry is to study general anesthetics where the patient was aware of events occurring during surgery. Follow these steps to determine your eligibility for this Registry of awareness during general anesthesia.

STEP 1: Are you 18 years or older?

- Yes, I am 18 years or older.
  You are eligible for this Registry. Continue to Step 2.
- If you are age 13 to less than age 18 you may not use this packet. Call us or use the link on the website to access the Teenager Survey Packet.
- No, I am under 13 years of age.
  You are <u>not</u> eligible for this Registry. We can only survey patients who are 13 years or older.

STEP 2: Did you have general anesthesia for your surgery?

- Yes, I had general anesthesia.
  You are eligible for this Registry. Continue to Step 3.
- No, I did not have general anesthesia.
  You are <u>not</u> eligible for this Registry. Our Registry can only examine surgeries for general anesthesia. Awareness of events will occur if general anesthesia was not administered. The Anesthesia Awareness Registry website, www.awaredb.org, has more information.
- I'm not sure if I had general anesthesia.
  Contact your anesthesiologist or the Anesthesia Awareness Registry Offices (206-616-2673) for help. Do <u>not</u> proceed to Step 4 until you know for sure you had general anesthesia.

STEP 3: Read the Consent Form carefully. Sign and date where it asks for the "Subject's Signature"

STEP 4: Complete the one-page Enrollment Form.

STEP 5: Complete the Anesthesia Awareness Registry Surveys 1 and 2.

STEP 6: Mail these documents to the Anesthesia Awareness Registry.

- Signed and dated Consent Form
- Completed Enrollment Form & Anesthesia Awareness Registry Survey

Notice: We will send confirmation of receipt of these documents to the mailing address you listed on the Enrollment form. A copy of your signed Consent Form, co-signed by a researcher of the Registry will be mailed to this same address.

STEP 7: Medical Records.

- Some people will be requested to submit copies of their medical records. PLEASE DO NOT REQUEST COPIES OF MEDICAL RECORDS UNTIL REQUESTED BY RESEARCH STAFF. You may participate in this survey even if your medical records are not available.
- If you are asked for copies of your medical records, we will send you information on the specific records we request and the reimbursement procedures.

Anesthesia Awareness Registry
c/o (Research Coordinator Name & Title)
Anesthesiology, Box 356540, University of Washington, Seattle, WA 98195-6540

awaredb@uw.edu

Please remember that we cannot guarantee the confidentiality of any information sent by e-mail.

Enrollment Form

Anesthesia Awareness Registry

Please fill out this contact information so we may send you confirmation of receipt of your documents and send you your copy of the signed consent form. We may use this information to contact you if we need further information concerning your care.

The Anesthesia Awareness Registry will only use this contact information for correspondence that is directly related to the research for this Registry. We will not share or sell this contact information to any other party, company or research organization.

Patient's Address for Correspondence

Name: _____

Mailing Address

_____

_____

_____

_____

Phone numbers

Daytime: (_____) _____ - _____ ☐ *Preferred*

Evening: (_____) _____- _____ ☐ *Preferred*

Cell: (_____) _____- _____ ☐ *Preferred*

Best time to call: _____

E-mail Address

_____

Please remember that we cannot guarantee the confidentiality of any information sent by e-mail.

University of Washington
Consent Form
Anesthesia Awareness Registry

Researchers

Karen B. Domino, MD, MPH	Professor, Anesthesiology	206-616-2673
Shawn L. Mincer, MSW	Research Coordinator, Anesthesiology	206-616-2673

Researcher's Statement

INTRODUCTION

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in this study. Please read this form carefully. You may ask questions about what we will ask you to do, the risks, the benefits, your rights as a volunteer, or anything else about the research or this form that is not clear. When we have answered all of your questions, you can decide if you want to be in this study or not. This process is called "informed consent."

PURPOSE OF THE STUDY

We want to learn about factors that may be associated with awareness during general anesthesia. We will use two sets of surveys to find out about memories patients have of their surgery and the emotional impact of the awareness experience. We also need information from medical records from patients who may have been awake during general anesthesia. We hope that the results of this study will help anesthesiologists care for patients better in the future.

STUDY PROCEDURES

If you choose to be in this study, we will ask you to complete two written surveys. **Each survey can take from 30-45 minutes to complete and each will need to be completed in one session. You will not need to take both surveys in one sitting.** You will have the opportunity to go back and review all of your responses before you complete the surveys. You will have the opportunity to discuss your experiences by phone with a member of the study team for the Anesthesia Awareness Registry. If you are requested to obtain copies of your medical records, you will be given 3 options for obtaining copies of your medical records: 1. You can request copies from the hospital/clinic and send them to us, 2. You can request the hospital/clinic to send the copies of the medical records directly to the Registry, 3. You can sign a HIPAA authorization to request researchers on the team to request copies of the medical records. You will have the opportunity to discuss your experiences by phone with a member of the study team for the Awareness Registry. The first survey and optional discussion will ask you to describe any memories that you have of the procedure. It will also ask whether you were upset, if you told your doctor, and if you were satisfied with your care. The second survey will ask about the emotional impact of awareness under anesthesia. It includes questions about past traumatic events, such as whether you have experienced sexual assault, physical assault, or other very stressful events. Survey 2 will ask about how you are currently feeling, and includes questions about, for example, feeling as if your future will somehow be cut short. You are free to not answer any question. We would also like to obtain the following information from your medical record: health status, medical conditions, medications, type of anesthesia used, type of surgery, monitoring information, age, and gender. All health information that we collect during the study will be kept as study data.

RISKS, STRESS, OR DISCOMFORT

Although we will make every effort to keep your information confidential, no system for protecting your confidentiality can be completely secure. It is still possible that someone could find out you were in this study and could find out information about you. The survey may also bring up unpleasant memories. You may refuse to answer any of the questions in the survey or optional discussion. You can ask questions now and later by contacting Shawn Mincer at 206-616-2673 or any other member of the research team.

We have a Certificate of Confidentiality from the federal National Institutes of Health. This helps us protect your privacy. The Certificate means that we do not have to give out identifying information about you even if we are asked to by a court of law. We will use the Certificate to resist any demands for identifying information.

We can't use the Certificate to withhold your research information if you give your written consent to give it to an insurer, employer, or other person. Also, you or a member of your family can share information about yourself or your part in this research if you wish.

There are some limits to this protection. We will voluntarily provide the information to:

- a member of the federal government who needs it in order to audit or evaluate the research;
- individuals at the University of Washington, the funding agency, and other groups involved in the research, if they need the information to make sure the research is being done correctly;

BENEFITS OF THE STUDY

You will not directly benefit from taking part in this research. We hope that the results of this study will benefit future patients by preventing awareness during general anesthesia and helping patients if it does happen.

OTHER INFORMATION

Being in this study is voluntary. You may choose not to be in this study, and you may withdraw from the study at any time without penalty or loss of benefits to which you are otherwise entitled. Whether you choose to take part in the study, or choose not to take part, will not affect your health care. Information about you is confidential. We will code your survey responses and medical information. The link between your name and the code will be kept in a secured location, separate from the study information. We will keep the link between your name and the code until January 1, 2022, and then we will destroy the link. We will not pay you for being in this study. We will reimburse you for charges to obtain copies of your medical records up to $500.

You may want to get an estimate of charges to make sure the costs will not exceed $500 before you request copies of your medical records. An original receipt will be required for reimbursement.

Government or university staff sometimes review studies such as this one to make sure they are being done safely and legally. If a review of this study takes place, your records may be examined. The reviewers will protect your privacy. The study records will not be used to put you at legal risk of harm.

The link between your name and your study data will not be kept beyond January 1, 2022. If you are eligible to participate in other studies before that time, we will contact you. You will be asked to sign a separate consent for any future studies and may choose not to participate at any time.

We will release your name and other identifying information to the appropriate officials, if we find or suspect intent to harm yourself or others.

All study data will be confidential. We will not release study data or copies of your medical records to you once they have been given to us. The only document we will return to you is a copy of this consent form.

Signature of Researcher	*Printed Name*	*Date*

Subject's Statement

This study has been explained to me, and I voluntarily consent to participate. I have had an opportunity to ask questions. If I have questions about the research, I can ask one of the researchers listed above. If I have questions about my rights as a research subject, I may call the University of Washington Human Subjects Division at 206-543-0098. I give the researchers permission to use my medical records as described in this consent form. I will receive a copy of this consent form.

Subject's Signature	*Printed Name*	*Date*

Copies to: Subject, Researcher's file

Anesthesia Awareness Registry Survey 1

Today's date _____

In this first section, we would like to collect some general information about your surgery and some specific details about your anesthesia experience.

1. What was your surgical procedure? _____
2. In what month and year did you have your surgery? _____
3. Age at time of surgery? _____
4. Did you stay overnight at the hospital AFTER your surgery?
   - ☐ Yes
   - ☐ No
5. Did any of your doctors mention the possibility of awareness during general anesthesia BEFORE you had your surgery?
   - ☐ Yes
   - ☐ No
   - ☐ I don't remember
6. What is the last thing you remember before going to sleep? Please describe.

7. What is the first thing you remember when waking up after the procedure or surgery? Please describe.

8. What do you remember between going to sleep and the end of the surgery? Please describe in detail.

Do you recall any of these things during your surgery? *Check all that apply.*

Feeling something in your mouth or your throat?
Yes ☐ No ☐

Feeling unable to move, as if you were paralyzed?
Yes ☐ No ☐

Feeling pressure or tugging near your surgery site?
Yes ☐ No ☐

Feeling burning sensation near your surgery site?
Yes ☐ No ☐

Feeling burning sensation NOT near your surgery site?
Yes ☐ No ☐

Feeling pain near your surgery site?
Yes ☐ No ☐

Feeling pain NOT near your surgery site?
Yes ☐ No ☐

Feeling anxious or fearful?
Yes ☐ No ☐

Feeling panic?
Yes ☐ No ☐

Having an out-of-body experience?
Yes ☐ No ☐

Thinking you were dying/had died?

Yes ☐ No ☐

Any other feelings?

Yes ☐ No ☐

Please describe anything you felt: (physical or emotional)

Do you recall any of these other things during your surgery? *Check all that apply.*

	Yes	No
Hearing people talking?	☐	☐
Any other sounds?	☐	☐

Please describe what you heard:

	Yes	No
Seeing light or lights?	☐	☐

Please describe what you saw:

	Yes	No
Did you dream or have nightmares?	☐	☐

Please describe your dreams or nightmares:

	Yes	No
Tasting or smelling things?	☐	☐
Any other experiences?	☐	☐

Please describe in detail, including any conscious memories or anything else you felt, heard, or were thinking.

9. Which of the following statements best describes the timing of the events you have described?

- ☐ These events occurred before surgery had started.
- ☐ These events occurred as surgery was just starting.
- ☐ These events occurred in the middle of surgery.
- ☐ These events occurred when surgery was over.
- ☐ Not sure when these events happened.
- ☐ Other (specify) _____

Next we would like to ask you a set of questions about any past discussion/s you might have had about what happened to you during surgery.

10. Have you told anyone about your experience during your surgery? (Check all that apply.)

	Yes	No	When did you tell them?	How did they respond? If they provided an explanation, what did they tell you?
Family	☐	☐		
Friend(s)	☐	☐		
Anesthesia Provider	☐	☐		
Surgeon	☐	☐		
Nurse(s)	☐	☐		
Other(s)	☐	☐		

11. If your anesthesia provider, surgeon, or nurse offered you an explanation for what happened to you during anesthesia, do you believe the explanation is correct? ☐ Yes ☐ No If not, what do you think happened?

12. Did any of the following people talk to you about your anesthesia awareness experience without being asked first by you? (*Check all that apply.)*

- ☐ My anesthesia provider
- ☐ My surgeon
- ☐ Nurses
- ☐ Others (*specify*) _____
- ☐ None of the above.

13. To your knowledge, are your anesthesia provider or surgeon aware of your experience during surgery?

- ☐ Both are aware of my experience during surgery.
- ☐ Only my anesthesia provider is aware of my experience.
- ☐ Only my surgeon is aware of my experience.
- ☐ To my knowledge, neither my anesthesia provider nor my surgeon is aware of my experience. **(SKIP TO QUESTION 16)**

14. Has your anesthesia provider or your surgeon expressed concern about your experience?

- ☐ Both have expressed concern about my experience.
- ☐ Only my anesthesia provider has expressed concern.
- ☐ Only my surgeon has expressed concern.
- ☐ Neither my anesthesia provider nor my surgeon has expressed concern.

15. Did the doctors or hospital offer to investigate?

☐ Yes ☐ No **(SKIP TO QUESTION 16)**

16. If yes, were you or your family ever informed of the outcome of that investigation?

☐ Yes ☐ No

In this next section, we would like to learn about your feelings since your surgery.

17. In the first few weeks after your awareness experience, how often were you bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

18. In the past 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

19. Have any of the following been harmed as a result of your experience?

	Yes	No	Don't know	I prefer not to answer
My family relationships	☐	☐	☐	☐
My job performance	☐	☐	☐	☐
My friendships	☐	☐	☐	☐

20. Check all of the following statements that might reflect your current feelings about future surgeries?

- ☐ I will have another surgery if it is necessary for my health.
- ☐ I will not have another surgery, unless my life depended on it.
- ☐ I will not have another surgery on the same part of my body.
- ☐ I will not have another surgery at the same hospital.
- ☐ I will not have another surgery with the same surgeon.
- ☐ I will not have another surgery with the same anesthesia provider.
- ☐ I will not have another surgery with the same anesthetic.
- ☐ I will not have another surgery, unless I can have brain activity / function monitoring during surgery.
- ☐ I will never have another surgery.

21. How satisfied are you with the manner in which your concerns about your anesthesia experience were addressed by:

	Very satisfied	Somewhat satisfied	Somewhat unsatisfied	Very unsatisfied
Your anesthesia provider	☐	☐	☐	☐
Your surgeon	☐	☐	☐	☐
Your nurses	☐	☐	☐	☐
Others _____	☐	☐	☐	☐

22. What might have been done differently to address your concerns after your anesthesia awareness experience?

23. Immediately after your surgery, which statement best describes your feelings?

- ☐ I was very upset.
- ☐ I was upset.
- ☐ I was slightly upset.
- ☐ I was not at all upset.

24. Today, which statement best describes your feelings?

- ☐ I am very upset.
- ☐ I am upset.
- ☐ I am slightly upset.
- ☐ I am not at all upset.

25. If you were upset about your anesthesia awareness experience in the past, but are no longer upset about it, when and why did your feelings change?

Finally, we would like to ask a few questions about other resources you may have found useful (or necessary) to understand what happened to you during your surgery.

26. Have you seen a mental health specialist for this experience?

- ☐ Yes, I was referred to a mental health specialist by the healthcare provider at the hospital.
- ☐ Yes, I was referred to a mental health specialist by someone else.
- ☐ Yes, I sought out a mental health specialist by myself (not by referral).
- ☐ No **(SKIP TO QUESTION 29)**
- ☐ I don't remember **(SKIP TO QUESTION 29)**

27. If you have been to a counselor or therapist for this experience, how long have you had counseling or therapy?

28. Are you still receiving counseling or therapy?

- ☐ Yes
- ☐ No

29. Have you been diagnosed with Post Traumatic Stress Disorder (PTSD) as a result of this experience?

- ☐ Yes
- ☐ No
- ☐ I don't know.

30. Is there anything else you want to tell us about your experience? Attach other sheets if necessary.

31. Are you willing to discuss your experiences in more detail with a member of the study team for the Awareness Registry?

- ☐ Yes, a member of the study team for the Awareness Registry may contact me by phone for a discussion.

Please give us a telephone number where you may be reached. ( ) -

- ☐ No, please do not contact me for a discussion of my experiences.

For Office Use only: Coded _____ Dbase _____ Review1 _____ Review2 _____ Review3 _____ Final _____ Verified _____

Anesthesia Awareness Registry Survey 2

Today's date_____

In this first section, we would like to collect some general information about you.

1. In what year were you born? _____

2. Gender
   - ☐ Male
   - ☐ Female

3. Race
   - ☐ Asian/Asian American
   - ☐ Pacific Islander/Native Hawaiian
   - ☐ Black/African American
   - ☐ American Indian/Alaska Native
   - ☐ White/Caucasian

   Other, specify _____

4. Ethnicity
   - ☐ Hispanic or Latina
   - ☐ Non-Hispanic

5. Current marital status
   - ☐ Single, never married
   - ☐ Married, partnered, cohabitating
   - ☐ Separated or divorced
   - ☐ Widowed

   Other, specify _____

6. What is the highest level of education you have completed
   - ☐ High school or less
   - ☐ Some college, trade school, certificate, associate degree
   - ☐ 4-year college
   - ☐ Beyond 4-year degree

7. Prior to your awareness experience, did you ever seek treatment by a mental health professional (**check all that apply**):

☐ Yes ⟶ ☐ Individual therapy

☐ Couples or marriage counseling

☐ Group therapy

☐ Other_____

☐ No

8. Are you currently seeing a mental health professional **(check all that apply):**

☐ Yes ⟶ ☐ Individual therapy

☐ Couples or marriage counseling

☐ Group therapy

☐ Other_____

☐ No

9. Did you take medication for a mental health issue prior to your awareness experience?

☐ Yes ☐ No

10. Are you currently taking any medication for a mental health issue?

☐ Yes ☐ No

11. ***Please think back upon your awareness experience and answer the following questions in an honest and sincere way, by selecting a number from 1 to 5. Please answer each question based on your feelings about your awareness experience <u>in the past week</u>. Use the following scale:***

Totally Disagree				Totally Agree
1	2	3	4	5

		Totally Disagree				Totally Agree
1.	I feel that this event has become part of my identity.	1	2	3	4	5
2.	This event has become a reference point for the way I understand the world.	1	2	3	4	5
3.	I feel that this event has become a central part of my life story.	1	2	3	4	5
4.	This event has colored the way I think and feel about other experiences.	1	2	3	4	5
5.	This event permanently changed my life.	1	2	3	4	5
6.	I often think about the effects this event will have on my future.	1	2	3	4	5
7.	This event was a turning point in my life.	1	2	3	4	5

12. *Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally (b) you witnessed it happen to someone else (c) you're not sure if it fits, or (d) it doesn't apply to you.*

Natural disaster (for example, flood, hurricane, tornado, earthquake).

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Fire or explosion.

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Transportation accident (for example, car accident, boat accident, train wreck, plane crash).

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Serious accident at work, home, or during recreational activity.

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Exposure to toxic substance (for example, dangerous chemicals, radiation).

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Physical assault (for example, being attacked, hit, slapped, kicked, beaten up).

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb).

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm).

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Other unwanted or uncomfortable sexual experience.

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Combat or exposure to a war-zone (in the military or as a civilian).

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war).

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Life-threatening illness or injury.

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Severe human suffering.

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Sudden, violent death (for example, homicide, suicide).

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Sudden, unexpected death of someone close to you.

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Serious injury, harm, or death you caused to someone else.

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

Any other very stressful event or experience.

☐ Happened to me ☐ Witnessed it ☐ Not sure ☐ Doesn't apply

13. ***Below is a list of problems and complaints that people sometimes have in response to awareness under anesthesia. Please read each one carefully, then choose one of the responses to indicate how much you have been bothered by the problem*** *in the last month.*

Repeated, disturbing memories, thoughts or images of awareness experience.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Repeated, disturbing dreams of the awareness experience.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Suddenly acting or feeling as if the awareness experience was happening again (as if you were reliving it).

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Feeling very upset when something reminded you of the awareness experience.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Having physical reactions (e.g. heart pounding, trouble breathing, or sweating) when something reminded you of the awareness experience.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Avoid thinking about or talking about the awareness experience or avoid having feelings related to it.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Avoid activities or situations because they remind you of the awareness experience.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Trouble remembering important parts of the awareness experience.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Loss of interest in things that you used to enjoy.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Feeling distant or cut off from other people.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Feeling emotionally numb or being unable to have loving feelings for those close to you.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Feeling as if your future will somehow be cut short.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Trouble falling or staying asleep.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Feeling irritable or having angry outbursts.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Having difficulty concentrating.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Being "super alert" or watchful or on guard.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Feeling jumpy or easily startled.

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Over the last two weeks, how often have you been bothered by any of the following problems

Little or no interest or pleasure in doing things.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, hopeless.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble falling or staying asleep, or sleeping too much.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling tired or having little energy.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Poor appetite or overeating.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling bad about yourself–or that you are a failure or have let yourself or your family down.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety and restless that you have been moving around a lot more than usual.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Thoughts that you would be better off dead or of hurting yourself in some way.

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

How much are the following statements true for you?

There is a special person who is around when you are in need.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

There is a special person with whom you can share joys and sorrows.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

Your family really tries to help you.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

You get the emotional help and support you need from your family.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

You have a special person who is a real source of comfort to you.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

Your friends really try to help you.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

You can count on your friends when things go wrong.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

You can really talk about your problems with your family.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

You have friends with whom you can share your joys and sorrows.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

There is a special person in your life who cares about your feelings.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

Your family is willing to help you make decisions.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

You can talk about your problems with your friends.

☐ Strongly agree ☐ Agree ☐ Slightly disagree ☐ Disagree ☐ Strongly disagree

14. ***The following questions ask how you feel about your quality of life, health, or other areas of your life. Please choose the answer that appears most appropriate. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life*** *in the last four weeks*.

How would you rate your quality of life.

☐ Very poor ☐ Poor ☐ Neither poor nor good ☐ Good ☐ Very good

How satisfied are you with your health.

☐ Very poor ☐ Poor ☐ Neither poor nor good ☐ Good ☐ Very good

The following questions ask about how much you have experienced certain things in the last four weeks.

To what extent do you feel that physical pain prevents you from doing what you need to do.

☐ Not at all ☐ A little ☐ A moderate amount ☐ Very much ☐ An extreme amount

How much do you need any medical treatment to function in your daily life.

☐ Not at all ☐ A little ☐ A moderate amount ☐ Very much ☐ An extreme amount

How much do you enjoy life.

☐ Not at all ☐ A little ☐ A moderate amount ☐ Very much ☐ An extreme amount

To what extent do you feel your life to be meaningful.

☐ Not at all ☐ A little ☐ A moderate amount ☐ Very much ☐ An extreme amount

How well are you able to concentrate.

☐ Not at all ☐ A little ☐ A moderate amount ☐ Very much ☐ Extremely

How safe do you feel in your daily life.

☐ Not at all ☐ A little ☐ A moderate amount ☐ Very much ☐ Extremely

How healthy is your physical environment.

☐ Not at all ☐ A little ☐ A moderate amount ☐ Very much ☐ Extremely

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

Do you have enough energy for everyday life.

☐ Not at all ☐ A little ☐ Moderately ☐ Mostly ☐ Completely

Are you able to accept your bodily appearance.

☐ Not at all ☐ A little ☐ Moderately ☐ Mostly ☐ Completely

Have you enough money to meet your needs.

☐ Not at all ☐ A little ☐ Moderately ☐ Mostly ☐ Completely

How available to you is the information that you need in your day-to-day life.

☐ Not at all ☐ A little ☐ Moderately ☐ Mostly ☐ Completely

To what extent do you have the opportunity for leisure activities.

☐ Not at all ☐ A little ☐ Moderately ☐ Mostly ☐ Completely

How well are you able to get around.

☐ Very poor ☐ Poor ☐ Neither poor nor good ☐ Good ☐ Very good

How satisfied are you with your sleep.

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

How satisfied are you with your ability to perform your daily living activities.

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

How satisfied are you with your capacity for work.

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

How satisfied are you with yourself.

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

How satisfied are you with your personal relationships.

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

How satisfied are you with your sex life.

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

How satisfied are you with the support you get from your friends?

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

How satisfied are you with the conditions of your living place.

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

How satisfied are you with your access to health services.

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

How satisfied are you with your transport.

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied nor dissatisfied ☐ Satisfied ☐ Very satisfied

The following question refers to how often you have felt or experienced certain things in the last four weeks.

How often do you have negative feelings such as blue mood, despair, anxiety, depression.

☐ Never ☐ Seldom ☐ Quite often ☐ Very often ☐ Always

15. *Several common symptoms or bodily sensations are listed below. Please indicate how frequently you experience each symptom*

	Have never or almost never experienced the symptom	Less than 3 or 4 times per year	Every month or so	Every week or so	More than every week
Eyes water					
Itchy eyes or skin					
Ringing in ears					
Temporary deafness					
Lump in throat					
Choking sensations					
Sneezing spells					
Running nose					
Congested nose					
Bleeding nose					
Asthma or wheezing					
Coughing					
Out of breath					
Swollen ankles					
Chest Pains					

	Have never or almost never experienced the symptom	Less than 3 or 4 times per year	Every month or so	Every week or so	More than every week
Racing heart					
Cold hands or feet even in hot weather					
Leg cramps					
Insomnia or difficulty sleeping					
Toothaches					
Upset stomach					
Indigestion					
Heartburn or gas					
Abdominal pain					
Diarrhea					
Constipation					
Hemorrhoids					
Swollen joints					
Stiff or sore muscles					
Back pain					
Sensitive or tender skin					
Face flushes					

	Have never or almost never experienced the symptom	Less than 3 or 4 times per year	Every month or so	Every week or so	More than every week
Tightness in chest					
Skin breaks out in rash					
Acne or pimples on face					
Acne/pimples other than face					
Boils					
Sweat even in cold weather					
Strong reactions to insect bites					
Headaches					
Feeling pressure in head					
Hot flashes					
Chills					
Dizziness					
Feel faint					
Numbness or tingling in any part of body					
Twitching of eyelid					
Twitching other than eyelid					
Hands tremble or shake					

	Have never or almost never experienced the symptom	Less than 3 or 4 times per year	Every month or so	Every week or so	More than every week
Stiff joints					
Sore muscles					
Sore throat					
Sunburn					
Nausea					

This is the end of our survey. Thank you very much for participating in our study. If you have any questions about this survey or the Anesthesia Awareness Registry, e-mail awaredb@u.washington.edu (please note we cannot guarantee the confidentiality of e-mail communications) or call the Registry at (206) 616-2677.