

Anti-Clot Treatment Scale

We are interested in your experiences of anti-clot treatment. We would be grateful if you could help us by filling out this questionnaire. The questions below ask about your experiences of anti-clot treatment during the past 4 weeks. All of the information you provide is COMPLETELY CONFIDENTIAL. Please be sure to answer all questions.

INSTRUCTIONS: We are interested in your experiences of anti-clot treatment during the past 4 weeks. Please circle the number in the box that best describes your views.

During the <u>past 4 weeks</u> ...	Not at all	A little	Moderately	Quite a bit	Extremely
1. How much does the possibility of <u>bleeding</u> as a result of your anti-clot treatment limit you from taking part in <u>vigorous physical activities</u> (e.g. exercise, sports, dancing, etc.)?	1	2	3	4	5
2. How much does the possibility of <u>bleeding</u> as a result of your anti-clot treatment limit you from taking part in your <u>usual activities</u> (e.g. work, shopping, housework etc.)?	1	2	3	4	5
3. How bothered are you by the possibility of <u>bruising</u> as a result of your anti-clot treatment?	1	2	3	4	5
4. How bothered are you by having to <u>avoid other medicines</u> (e.g. aspirin) as a result of your anti-clot treatment?	1	2	3	4	5
5. How much does your anti-clot treatment <u>limit what you eat and drink</u> (including alcohol)?	1	2	3	4	5
6. How much of a hassle (inconvenience) are the <u>daily</u> aspects of your anti-clot treatment (e.g. remembering to take your medicine at a certain time, taking the correct dose of your medicine, limiting what you eat and drink (including alcohol), etc.)?	1	2	3	4	5
7. How much of a hassle (inconvenience) are the <u>occasional</u> aspects of your anti-clot treatment (e.g. the need for blood tests, going to or contacting the hospital/doctor, making arrangements for treatment while travelling etc.)?	1	2	3	4	5

Now I want to ask you about daily and occasional aspects of your anti-clot treatment during the past 4 weeks...

	Not at all	A little	Moderately	Quite a bit	Extremely
8. How <u>difficult</u> is it to <u>follow</u> your anti-clot treatment?	1	2	3	4	5
9. How <u>time-consuming</u> is your anti-clot treatment?	1	2	3	4	5
10. How much do you <u>worry</u> about your anti-clot treatment?	1	2	3	4	5
11. How <u>frustrating</u> is your anti-clot treatment?	1	2	3	4	5
12. How much of a <u>burden</u> is your anti-clot treatment?	1	2	3	4	5
13. Overall , how much of a <u>negative impact</u> has your anti-clot treatment had on your life?	1	2	3	4	5
14. How <u>confident</u> are you that your anti-clot treatment will protect your health (e.g. prevent blood clots, stroke, heart attack, DVT, embolism)?	1	2	3	4	5
15. How <u>reassured</u> do you feel because of your anti-clot treatment?	1	2	3	4	5
16. How <u>satisfied</u> are you with your anti-clot treatment?	1	2	3	4	5
17. Overall , how much of a <u>positive impact</u> has your anti-clot treatment had on your life?	1	2	3	4	5

THANK YOU FOR YOUR HELP