Dataset Name: qwbs v2.0

Participant ID pid D000000

Acrostic acrostic ZZZZZ

Interviewer compby V.C. vc YYY

Date of Visit vis_dat

Quality of Well-being Scale ©

CRF 2.0

This survey asks about health problems that you have experienced in the last three days, not including today. Please make sure to answer all questions below. Thank you for your patience and time in carefully completing this survey.

Part I - Acute and Chronic Symptoms

Please mark with an X whether you currently have any of the following health symptoms or problems:

A. Do you have...

1. Blindness or severely impaired vision in both eyes? — blindboth_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

2. Blindness or severely impaired vision in only one eye? — blndone_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

3. Speech problems such as stuttering or being unable to speak clearly? — spchprob_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

4. Missing or paralyzed hands, feet, arms, or legs? — misshfal_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

5. Missing or paralyzed fingers or toes? — missft_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

6. Any deformity of the face, fingers, hand or arm, foot or leg, or back (e.g. severe scoliosis?) — deformty_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

7. General fatigue, tiredness, or weakness? — fatique_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

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8. A problem with unwanted weight gain or weight loss?

wtgnls_qwbs
-9
1 Yes
0 No
-6 Permanently Missing

9. A problem with being under or over weight?

unovwt_qwbs
-9
1 Yes
0 No
-6 Permanently Missing

10. Problems chewing your food adequately?

chewprob_qwbs
-9
1 Yes
0 No
-6 Permanently Missing

11. Any hearing loss or deafness?

hearloss_qwbs
-9
1 Yes
0 No
-6 Permanently Missing

12. Any noticeable skin problems, such as bad acne or large burns or scars on face, body, arms, or legs?

skinprob_qwbs
-9
1 Yes
0 No
-6 Permanently Missing

13. Eczema or burning/itching rash?

eczema_qwbs
-9
1 Yes
0 No
-6 Permanently Missing

B. Which of the following health aids do you use/have?

1. Dentures?

dentures_qwbs
-9
1 Yes
0 No
-6 Permanently Missing

2. Oxygen tank?

oxygentk_qwbs
-9
1 Yes
0 No
-6 Permanently Missing

3. Prosthesis?

prosthss_qwbs
-9
1 Yes
0 No
-6 Permanently Missing

4. Eye glasses or contact lenses? glasses_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

5. Hearing aid? hearaide_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

6. Magnifying glass? magglass_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

7. Neck, back, or leg brace? brace_qwbs

-9
1 Yes
0 No
-6 Permanently Missing

C. For the following list of problems, indicate which days (if any) over the **past 3 days, not including today,** you had the problem. **If you have not had the symptom in the past 3 days, do not just leave the question blank, please check "No days."** If you have experienced the symptom in the **past 3 days** , please check which of the days you had it; if you experienced it on more than one of the days, please **check all days that apply** .

For example, if you had a headache yesterday and the day before that, the following should be checked?	**No days**	**1 day ago**	**2 days ago**	**3 days ago**	**Perm. Missing**
Example: a headache?		x	x		
Did you have? (Please Check All Days That Apply)	**No days**	**1 day ago**	**2 days ago**	**3 days ago**	**Perm. Missing**
1. Any problems with your vision not corrected with glasses or contact lenses (such as double vision, distorted vision.	visprob0_qwbs value ="1" ☐	visprob1_qwbs value ="1" ☐	visprob2_qwbs value ="1" ☐	visprob3_qwbs value ="1" ☐	visprob4_qwbs value ="1" ☐

flashes, or floaters)?					
2. Any eye pain, irritation, discharge, or excessive sensitivity to light?	eyepain0_qwbs value ="1"	eyepain1_qwbs value ="1"	eyepain2_qwbs value ="1"	eyepain3_qwbs value ="1"	eyepain4_qwbs value ="1"
3. A headache?	hdache0_qwbs value ="1"	hdache1_qwbs value ="1"	hdache2_qwbs value ="1"	hdache3_qwbs value ="1"	hdache4_qwbs value ="1"
4. Dizziness, earache, or ringing in your ears?	earache0_qwbs value ="1"	earache1_qwbs value ="1"	earache2_qwbs value ="1"	earache3_qwbs value ="1"	earache4_qwbs value ="1"
5. Difficulty hearing or discharge, or bleeding from an ear?	dffhear0_qwbs value ="1"	dffhear1_qwbs value ="1"	dffhear2_qwbs value ="1"	dffhear3_qwbs value ="1"	dffhear4_qwbs value ="1"
6. Stuffy or runny nose or bleeding from the nose?	nose0_qwbs value=" 1"	nose1_qwbs value=" 1"	nose2_qwbs value=" 1"	nose3_qwbs value=" 1"	nose4_qwbs value=" 1"
7. A sore throat, difficulty swallowing, or hoarse voice?	soretht0_qwbs value ="1"	soretht1_qwbs value ="1"	soretht2_qwbs value ="1"	soretht3_qwbs value ="1"	soretht4_qwbs value ="1"
8. A tooth ache or jaw pain?	tthache0_qwbs value ="1"	tthache1_qwbs value ="1"	tthache2_qwbs value ="1"	tthache3_qwbs value ="1"	tthache4_qwbs value ="1"
9. Sore or bleeding lips, tongue or gums?	sorelip0_qwbs value ="1"	sorelip1_qwbs value ="1"	sorelip2_qwbs value ="1"	sorelip3_qwbs value ="1"	sorelip4_qwbs value ="1"
10. Coughing or wheezing?	cough0_qwbs value= "1"	cough1_qwbs value= "1"	cough2_qwbs value= "1"	cough3_qwbs value= "1"	cough4_qwbs value= "1"
11. Shortness of breath or difficulty breathing?	dffbrth0_qwbs value ="1"	dffbrth1_qwbs value ="1"	dffbrth2_qwbs value ="1"	dffbrth3_qwbs value ="1"	dffbrth4_qwbs value ="1"
12. Chest pain, pressure, palpitations, fast or skipped heart beat, or other discomfort in the chest?	chestds0_qwbs value ="1"	chestds1_qwbs value ="1"	chestds2_qwbs value ="1"	chestds3_qwbs value ="1"	chestds4_qwbs value ="1"
13. An upset stomach, abdominal	upsstom0_qwbs valu e="1"	upsstom1_qwbs valu e="1"	upsstom2_qwbs valu e="1"	upsstom3_qwbs valu e="1"	upsstom4_qwbs valu e="1"

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pain, nausea, heartburn, or vomiting?					
14. Difficulty with bowel movements, diarrhea, constipation, rectal bleeding, black tar-like stools, or any pain or discomfort in the rectal area?	bowel0_qwbs value="1"	bowel1_qwbs value="1"	bowel2_qwbs value="1"	bowel3_qwbs value="1"	bowel4_qwbs value="1"
15. Pain, burning, or blood in urine?	urine0_qwbs value="1"	urine1_qwbs value="1"	urine2_qwbs value="1"	urine3_qwbs value="1"	urine4_qwbs value="1"
16. Loss of bladder control, frequent night-time urination, or difficulty with urination?	bladder0_qwbs value="1"	bladder1_qwbs value="1"	bladder2_qwbs value="1"	bladder3_qwbs value="1"	bladder4_qwbs value="1"
17. Genital pain, itching, burning, abnormal discharge, pelvic cramping, or abnormal bleeding (does not include normal menstruation)?	gnpain0_qwbs value="1"	gnpain1_qwbs value="1"	gnpain2_qwbs value="1"	gnpain3_qwbs value="1"	gnpain4_qwbs value="1"
18. A broken arm, wrist, foot, leg, or any other broken bone (other than in back)?	brkbone0_qwbs valu e="1"	brkbone1_qwbs valu e="1"	brkbone2_qwbs valu e="1"	brkbone3_qwbs valu e="1"	brkbone4_qwbs valu e="1"
19. Swelling of ankles, hands, feet, or abdomen?	swellng0_qwbs value="1"	swellng1_qwbs value="1"	swellng2_qwbs value="1"	swellng3_qwbs value="1"	swellng4_qwbs value="1"
20. Fever, chills, or sweats?	fever0_qwbs value="1"	fever1_qwbs value="1"	fever2_qwbs value="1"	fever3_qwbs value="1"	fever4_qwbs value="1"
21. Loss of consciousnes	losscon0_qwbs value	losscon1_qwbs value	losscon2_qwbs value	losscon3_qwbs value	losscon4_qwbs value

s, fainting, or seizures?	="1"	="1"	="1"	="1"	="1"
22. Pain, stiffness, cramps, weakness, or numbness in the neck or back?	backpn0_qwbs value ="1"	backpn1_qwbs value ="1"	backpn2_qwbs value ="1"	backpn3_qwbs value ="1"	backpn4_qwbs value ="1"
23. Pain, stiffness, cramps, weakness, or numbness in the hip or sides?	hippain0_qwbs value ="1"	hippain1_qwbs value ="1"	hippain2_qwbs value ="1"	hippain3_qwbs value ="1"	hippain4_qwbs value ="1"
24. Pain, stiffness, cramps, weakness, or numbness in any of the joints or muscles of the hand, feet, arms, or legs?	jointpn0_qwbs value ="1"	jointpn1_qwbs value ="1"	jointpn2_qwbs value ="1"	jointpn3_qwbs value ="1"	jointpn4_qwbs value ="1"
25. Difficulty with your balance, standing or walking?	diffbal0_qwbs value= "1"	diffbal1_qwbs value ="1"	diffbal2_qwbs value ="1"	diffbal3_qwbs value ="1"	diffbal4_qwbs value ="1"
D. The following symptoms are about your feelings, thoughts, and behaviors. Please check which days (if any) over the past 3, not including today, you have had?..					
	No days	**1 day ago**	**2 days ago**	**3 days ago**	**Perm. Missing**
26. Trouble falling asleep or staying asleep?	sleep0_qwbs value=" 1"	sleep1_qwbs value=" 1"	sleep2_qwbs value=" 1"	sleep3_qwbs value=" 1"	sleep4_qwbs value=" 1"
27. Spells of feeling nervous or shaky?	nervous0_qwbs value ="1"	nervous1_qwbs value ="1"	nervous2_qwbs value ="1"	nervous3_qwbs value ="1"	nervous4_qwbs value ="1"
28. Spells of feeling upset, downhearted, or blue?	upset0_qwbs value=" 1"	upset1_qwbs value=" 1"	upset2_qwbs value=" 1"	upset3_qwbs value=" 1"	upset4_qwbs value=" 1"
29. Excessive worry or anxiety?	worry0_qwbs value= "1"	worry1_qwbs value= "1"	worry2_qwbs value= "1"	worry3_qwbs value= "1"	worry4_qwbs value= "1"

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30. Feelings that you had little or no control over events in your life?	lossctl0_qwbs value= "1"	lossctl1_qwbs value= "1"	lossctl2_qwbs value= "1"	lossctl3_qwbs value= "1"	lossctl4_qwbs value= "1"
31. Feelings of being lonely or isolated?	lonely0_qwbs value= "1"	lonely1_qwbs value= "1"	lonely2_qwbs value= "1"	lonely3_qwbs value= "1"	lonely4_qwbs value= "1"
32. Feelings of frustration, irritation, or close to losing your temper?	frust0_qwbs value=" 1"	frust1_qwbs value=" 1"	frust2_qwbs value=" 1"	frust3_qwbs value=" 1"	frust4_qwbs value=" 1"
33. A hangover?	hangovr0_qwbs valu e="1"	hangovr1_qwbs valu e="1"	hangovr2_qwbs valu e="1"	hangovr3_qwbs valu e="1"	hangovr4_qwbs valu e="1"
34. Any decrease of sexual interest or performance ?	dcsxint0_qwbs value ="1"	dcsxint1_qwbs value ="1"	dcsxint2_qwbs value ="1"	dcsxint3_qwbs value ="1"	dcsxint4_qwbs value ="1"
35. Confusion, difficulty understandin g the written or spoken word, or significant memory loss?	confusn0_qwbs value ="1"	confusn1_qwbs value ="1"	confusn2_qwbs value ="1"	confusn3_qwbs value ="1"	confusn4_qwbs value ="1"
36. Thoughts or images you could not get out of your mind?	thtimg0_qwbs value= "1"	thtimg1_qwbs value= "1"	thtimg2_qwbs value= "1"	thtimg3_qwbs value= "1"	thtimg4_qwbs value= "1"
37. To take any medication including over-the-counter remedies (aspirin/Tyle nol, allergy medications, insulin, hormones, estrogen, thyroid, prednisone)?	meds0_qwbs value=" 1"	meds1_qwbs value=" 1"	meds2_qwbs value=" 1"	meds3_qwbs value=" 1"	meds4_qwbs value=" 1"
38. To stay on a medically	diet0_qwbs value="1 "	diet1_qwbs value="1 "	diet2_qwbs value="1 "	diet3_qwbs value="1 "	diet4_qwbs value="1 "

prescribed diet for health reasons?					
39. A loss of appetite or over-eating?	lossapp0_qwbs value ="1" ☐	lossapp1_qwbs value ="1" ☐	lossapp2_qwbs value ="1" ☐	lossapp3_qwbs value ="1" ☐	lossapp4_qwbs value ="1" ☐

Part II - Self Care

Over the last 3 days?(Please Check All Days That Apply)	**No days**	**1 day ago**	**2 days ago**	**3 days ago**	**Perm. Missing**
1. Did you spend any part of the day or night as a patient in a hospital, nursing home, or rehabilitation center?	hospitl0_qwbs value= "1" ☐	hospitl1_qwbs value= "1" ☐	hospitl2_qwbs value= "1" ☐	hospitl3_qwbs value= "1" ☐	hospitl4_qwbs value= "1" ☐
2. Because of any impairment or health problem did you need help with your personal care needs, such as eating, dressing, bathing, or getting around your home?	prscare0_qwbs value ="1" ☐	prscare1_qwbs value ="1" ☐	prscare2_qwbs value ="1" ☐	prscare3_qwbs value ="1" ☐	prscare4_qwbs value ="1" ☐

Part III - Mobility

Over the last 3 days?(Please Check All Days That Apply)	**No days**	**1 day ago**	**2 days ago**	**3 days ago**	**Perm. Missing**

1. Which days did you drive a motor vehicle?	motorvh0_qwbs value ="1"	motorvh1_qwbs value ="1"	motorvh2_qwbs value ="1"	motorvh3_qwbs value ="1"	motorvh4_qwbs value ="1"
2. Which days did you use public transportation such as a bus, subway, Medi-van, train, or airplane?	pubtran0_qwbs value ="1"	pubtran1_qwbs value ="1"	pubtran2_qwbs value ="1"	pubtran3_qwbs value ="1"	pubtran4_qwbs value ="1"
3. Which days did you either not drive a motor vehicle or not use public transportation because of your health or need help from another person to use?	notrans0_qwbs value ="1"	notrans1_qwbs value ="1"	notrans2_qwbs value ="1"	notrans3_qwbs value ="1"	notrans4_qwbs value ="1"

Part IV - Physical Activity

Over the last 3 days?(Please check all that apply)	**No days**	**1 day ago**	**2 days ago**	**3 days ago**	**Perm. Missing**
1. Have trouble climbing stairs or inclines or walking off the curb?	stairs0_qwbs value="1"	stairs1_qwbs value="1"	stairs2_qwbs value="1"	stairs3_qwbs value="1"	stairs4_qwbs value="1"
2. Avoid walking, have trouble walking, or walk more slowly than other	trbwalk0_qwbs value ="1"	trbwalk1_qwbs value ="1"	trbwalk2_qwbs value ="1"	trbwalk3_qwbs value ="1"	trbwalk4_qwbs value ="1"

people your age?					
3. Limp or use a cane, crutches, or walker?	walkaid0_qwbs value ="1"	walkaid1_qwbs value ="1"	walkaid2_qwbs value ="1"	walkaid3_qwbs value ="1"	walkaid4_qwbs value ="1"
4. Avoid or have trouble bending over, stooping or kneeling?	trbbend0_qwbs value ="1"	trbbend1_qwbs value ="1"	trbbend2_qwbs value ="1"	trbbend3_qwbs value ="1"	trbbend4_qwbs value ="1"
5. Have any trouble lifting or carrying everyday objects such as books, a briefcase, or groceries?	trblift0_qwbs value=" 1"	trblift1_qwbs value=" 1"	trblift2_qwbs value=" 1"	trblift3_qwbs value=" 1"	trblift4_qwbs value=" 1"
6. Have any other limitations in physical movements?	othlim0_qwbs value= "1"	othlim1_qwbs value= "1"	othlim2_qwbs value= "1"	othlim3_qwbs value= "1"	othlim4_qwbs value= "1"
7. Spend all or most of the day in a bed, chair, or couch because of health reasons?	bedchr0_qwbs value= "1"	bedchr1_qwbs value= "1"	bedchr2_qwbs value= "1"	bedchr3_qwbs value= "1"	bedchr4_qwbs value= "1"
8. Spend all or most of the day in a wheelchair?	whlchr0_qwbs value= "1"	whlchr1_qwbs value= "1"	whlchr2_qwbs value= "1"	whlchr3_qwbs value= "1"	whlchr4_qwbs value= "1"
9. **If you spent all or most of the day in a wheelchair**, on which days did someone else control its movement?	ctrlwc0_qwbs value= "1"	ctrlwc1_qwbs value= "1"	ctrlwc2_qwbs value= "1"	ctrlwc3_qwbs value= "1"	ctrlwc4_qwbs value= "1"

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Part V- Usual Activity

Over the last 3 days?(Please check all that apply)	No days	1 day ago	2 days ago	3 days ago	Perm. Missing
1. Because of any physical or emotional health reasons, on which days did you avoid, need help with, or were limited in doing some of your usual activities, such as work, school, or housekeeping?	trbwork0_qwbs value ="1" ☐	trbwork1_qwbs value ="1" ☐	trbwork2_qwbs value ="1" ☐	trbwork3_qwbs value ="1" ☐	trbwork4_qwbs value ="1" ☐
2. Because of physical or emotional health reasons, on which days did you avoid or feel limited in doing some of your usual activities, such as visiting family/friends, hobbies, shopping, recreational, or religious activities?	trbrec0_qwbs value=" 1" ☐	trbrec1_qwbs value=" 1" ☐	trbrec2_qwbs value=" 1" ☐	trbrec3_qwbs value=" 1" ☐	trbrec4_qwbs value=" 1" ☐
3. On which days did you have to change any of your plans or activities because of	chpln0_qwbs value=" 1" ☐	chpln1_qwbs value=" 1" ☐	chpln2_qwbs value=" 1" ☐	chpln3_qwbs value=" 1" ☐	chpln4_qwbs value=" 1" ☐

your health that you did not report on the previous two questions?					

Please describe:

chplndsc_qwbs

Part VI - General Health

1. Would you say that your health is (Please check one):

hlthrtng_qwbs

-9	
1	Excellent
2	Very Good
3	Good
4	Fair
5	Poor
-6	Permanently Missing

2. Compared to a year ago, how would you rate your health in general now?

hlthcomp_qwbs

-9	
1	a. Much better now than a year ago
2	b. Somewhat better now than one year ago
3	c. About the same as a year ago
4	d. Somewhat worse than a year ago
5	e. Much worse than a year ago
-6	Permanently Missing

3. Think about a scale of 0 to 100, with zero bei

sthlth_qwbs

-9	
0	0
5	5
10	10
15	15
20	20
25	25
30	30
35	35
40	40
45	45
50	50
55	55
60	60
65	65
70	70
75	75
80	80
85	85
90	90
95	95
100	100
-6	Permanently Missing

ng the least desirable state of health that you could imagine and 100 being perfect health. What number from 0 to 100 would you give to the state of yo

Dataset Name: qwbs v2.0

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These are some questions about how you have been feeling. For each of the following statements, please mark with an "X" how often you have been feeling that way during the past week. During the past week?	
1. I felt that everything I did was an effort.	effort_qwbs -9 1 Rarely or never 2 Some of the time 3 Much or most of the time -6 Permanently Missing
2. I could not get "going".	getgoing_qwbs -9 1 Rarely or never 2 Some of the time 3 Much or most of the time

Dataset Name: qwbs v2.0

	-6 Permanently Missing

Source Form Language: lang

-9 -
1 English
2 Spanish

Save

Participant ID

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L I F E

Acrostic

Interviewer

Visit Code

Date of Visit (month / day / year)

Quality of Well-being Scale ©

This survey asks about health problems that you have experienced in the last three days, not including today. Please make sure to answer all questions below. Thank you for your patience and time in carefully completing this survey.

Part I -Acute and Chronic Symptoms

Please mark with an X whether you currently have any of the following health symptoms or problems:

A. Do you have…	**YES**	**NO**
1. Blindness or severely impaired vision in both eyes?	☐	☐
2. Blindness or severely impaired vision in only one eye?	☐	☐
3. Speech problems such as stuttering or being unable to speak clearly?	☐	☐
4. Missing or paralyzed hands, feet, arms, or legs?	☐	☐
5. Missing or paralyzed fingers or toes?	☐	☐
6. Any *deformity* of the face, fingers, hand or arm, foot or leg, or back (e.g. severe scoliosis?)	☐	☐
7. General fatigue, tiredness, or weakness?	☐	☐
8. A problem with unwanted weight gain or weight loss?	☐	☐
9. A problem with being under or over weight?	☐	☐
10. Problems chewing your food adequately?	☐	☐
11. Any hearing loss or deafness?	☐	☐
12. Any noticeable skin problems, such as bad acne or large burns or scars on face, body, arms, or legs?	☐	☐
13. Eczema or burning/itching rash?	☐	☐

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B. Which of the following health aids do you use/have?	**YES**	**NO**
1. Dentures?	☐	☐
2. Oxygen tank?	☐	☐
3. Prosthesis?	☐	☐
4. Eye glasses or contact lenses?	☐	☐
5. Hearing aid?	☐	☐
6. Magnifying glass?	☐	☐
7. Neck, back, or leg brace?	☐	☐

Go on to page 3 ⟶

Participant ID **FOR STAFF USE ONLY**	***L I F E***	Acrostic ☐☐☐☐☐ Visit Code ☐☐☐

C. For the following list of problems, indicate which days (if any) over the **past 3 days, not including today,** you had the problem. **If you have not had the symptom in the past 3 days**, **do not just leave the question blank, please check "No days."** If you have experienced the symptom in the **past 3 days**, please check which of the days you had it; if you experienced it on more than one of the days, please **check all days that apply**.

For example, if you had a headache yesterday and the day before that, the following should be checked…	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
Example: a headache?	☐	☒	☒	☐
Did you have… (Please Check All Days That Apply)	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
1. Any problems with your vision not corrected with glasses or contact lenses (such as double vision, distorted vision, flashes, or floaters)?	☐	☐	☐	☐
2. Any eye pain, irritation, discharge, or excessive sensitivity to light?	☐	☐	☐	☐
3. A headache?	☐	☐	☐	☐
4. Dizziness, earache, or ringing in your ears?	☐	☐	☐	☐
5. Difficulty hearing or discharge, or bleeding from an ear?	☐	☐	☐	☐
6. Stuffy or runny nose or bleeding from the nose?	☐	☐	☐	☐
7. A sore throat, difficulty swallowing, or hoarse voice?	☐	☐	☐	☐
8. A tooth ache or jaw pain?	☐	☐	☐	☐
9. Sore or bleeding lips, tongue or gums?	☐	☐	☐	☐

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Did you have… **(Please Check All Days That Apply)**	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
10. Coughing or wheezing?	☐	☐	☐	☐
11. Shortness of breath or difficulty breathing?	☐	☐	☐	☐
12. Chest pain, pressure, palpitations, fast or skipped heart beat, or other discomfort in the chest?	☐	☐	☐	☐
13. An upset stomach, abdominal pain, nausea, heartburn, or vomiting?	☐	☐	☐	☐
14. Difficulty with bowel movements, diarrhea, constipation, rectal bleeding, black tar-like stools, or any pain or discomfort in the rectal area?	☐	☐	☐	☐
15. Pain, burning, or blood in urine?	☐	☐	☐	☐
16. Loss of bladder control, frequent night-time urination, or difficulty with urination?	☐	☐	☐	☐
17. Genital pain, itching, burning, abnormal discharge, pelvic cramping, or abnormal bleeding (does not include normal menstruation)?	☐	☐	☐	☐
18. A broken arm, wrist, foot, leg, or any other broken bone (other than in back)?	☐	☐	☐	☐
19. Swelling of ankles, hands, feet, or abdomen?	☐	☐	☐	☐
20. Fever, chills, or sweats?	☐	☐	☐	☐
21. Loss of consciousness, fainting, or seizures?	☐	☐	☐	☐
22. Pain, stiffness, cramps, weakness, or numbness in the neck or back?	☐	☐	☐	☐

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Did you have… (Please Check All Days That Apply)	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
23. Pain, stiffness, cramps, weakness, or numbness in the hip or sides?	☐	☐	☐	☐
24. Pain, stiffness, cramps, weakness, or numbness in any of the joints or muscles of the hand, feet, arms, or legs?	☐	☐	☐	☐
25. Difficulty with your balance, standing or walking?	☐	☐	☐	☐
D. The following symptoms are about your feelings, thoughts, and behaviors. Please check which days (if any) over the past 3, not including today, you have had…..				
26. Trouble falling asleep or staying asleep?	☐	☐	☐	☐
27. Spells of feeling nervous or shaky?	☐	☐	☐	☐
28. Spells of feeling upset, downhearted, or blue?	☐	☐	☐	☐
29. Excessive worry or anxiety?	☐	☐	☐	☐
30. Feelings that you had little or no control over events in your life?	☐	☐	☐	☐
31. Feelings of being lonely or isolated?	☐	☐	☐	☐
32. Feelings of frustration, irritation, or close to losing your temper?	☐	☐	☐	☐
33. A hangover?	☐	☐	☐	☐
34. Any decrease of sexual interest or performance?	☐	☐	☐	☐
35. Confusion, difficulty understanding the written or spoken word, or significant memory loss?	☐	☐	☐	☐
36. Thoughts or images you could not get out of your mind?	☐	☐	☐	☐

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Did you have… (Please Check All Days That Apply)	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
37. To take any medication including over-the-counter remedies (aspirin/Tylenol, allergy medications, insulin, hormones, estrogen, thyroid, prednisone)?	☐	☐	☐	☐
38. To stay on a medically prescribed diet for health reasons?	☐	☐	☐	☐
39. A loss of appetite or over-eating?	☐	☐	☐	☐

Part II – Self Care

Over the last 3 days… (Please Check All Days That Apply)	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
1. Did you spend any part of the day or night as a patient in a hospital, nursing home, or rehabilitation center?	☐	☐	☐	☐
2. Because of any impairment or health problem did you need help with your personal care needs, such as eating, dressing, bathing, or getting around your home?	☐	☐	☐	☐

Part III – Mobility

Over the last 3 days… (Please Check All Days That Apply)	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
1. Which days did you drive a motor vehicle?	☐	☐	☐	☐
2. Which days did you use public transportation such as a bus, subway, Medi-van, train, or airplane?	☐	☐	☐	☐
3. Which days did you either not drive a motor vehicle or not use public transportation because of your health or need help from another person to use?	☐	☐	☐	☐

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Part IV – Physical Activity

Over the last 3 days… (Please Check All Days That Apply)	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
1. Have trouble climbing stairs or inclines or walking off the curb?	☐	☐	☐	☐
2. Avoid walking, have trouble walking, or walk more slowly than other people your age?	☐	☐	☐	☐
3. Limp or use a cane, crutches, or walker?	☐	☐	☐	☐
4. Avoid or have trouble bending over, stooping or kneeling?	☐	☐	☐	☐
5. Have any trouble lifting or carrying everyday objects such as books, a briefcase, or groceries?	☐	☐	☐	☐
6. Have any other limitations in physical movements?	☐	☐	☐	☐
7. Spend all or most of the day in a bed, chair, or couch because of health reasons?	☐	☐	☐	☐
8. Spend all or most of the day in a wheelchair?	☐	☐	☐	☐
9. **If you spent all or most of the day in a wheelchair**, on which days did someone else control its movement?	☐	☐	☐	☐

Part V- Usual Activity

Over the last 3 days… (Please Check All Days That Apply)	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
1. Because of any physical or emotional health reasons, on which days did you avoid, need help with, or were limited in doing some of your usual activities, such as work, school, or housekeeping?	☐	☐	☐	☐
2. Because of physical or emotional health reasons, on which days did you avoid or feel limited in doing some of your usual activities, such as visiting family/friends, hobbies, shopping, recreational, or religious activities?	☐	☐	☐	☐

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Over the past 3 days… (Please Check All Days That Apply)	**No days**	**Yesterday**	**2 days ago**	**3 days ago**
3. On which days did you have to change any of your plans or activities because of your health that you did not report on the previous two questions? Please describe: _____ _____	☐	☐	☐	☐

PART VI – General Health

1. Would you say that your health is (Please check one):

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Compared to a year ago, how would you rate your health in general now? (Please check one):

a. Much better now than a year ago	☐
b. Somewhat better now than one year ago	☐
c. About the same as a year ago	☐
d. Somewhat worse than a year ago	☐
e. Much worse than a year ago	☐

3. Think about a scale of 0 to 100, with zero being the least desirable state of health that you could imagine and 100 being perfect health. What number from 0 to 100 would you give to the state of your health, on average, over the past 3 days? (Please check one.)

0 10 20 30 40 50 60 70 80 90 100

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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These are some questions about how you have been feeling. For each of the following statements, please mark with an "X" how often you have been feeling that way <u>during the past week</u>. **During the <u>past week</u>…**	**Rarely or never**	**Some of the time**	**Much or most of the time**
1. I felt that everything I did was an effort.	☐	☐	☐
2. I could not get "going".	☐	☐	☐