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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 answ 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?

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?

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

1. Dentures?

2. Oxygen tank?

3. Prosthesis?

4. Eye glasses or contact lenses?

5. Hearing aide?

6. Magnifying glass?

7. Neck, back, or leg brace?

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 no 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 **pas** 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**
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**
1. Any problems with your vision not corrected with glasses or contact lenses (such as double vision, distorted vision, flashes, or floaters)?	visprob0_qwbs	visprob1_qwbs	visprob2_qwbs	visprob3_qwbs
2. Any eye pain, irritation, discharge, or excessive sensitivity to light?	eyepain0_qwbs	eyepain1_qwbs	eyepain2_qwbs	eyepain3_qwbs
3. A headache?	hdache0_qwbs	hdache1_qwbs	hdache2_qwbs	hdache3_qwbs
4. Dizziness, earache, or ringing in your ears?	earache0_qwbs	earache1_qwbs	earache2_qwbs	earache3_qwbs
5. Difficulty hearing or discharge, or bleeding from an ear?	dffhear0_qwbs	dffhear1_qwbs	dffhear2_qwbs	dffhear3_qwbs
6. Stuffy or runny nose or bleeding from the nose?	nose0_qwbs	nose1_qwbs	nose2_qwbs	nose3_qwbs
7. A sore throat, difficulty swallowing, or hoarse voice?	soretht0_qwbs	soretht1_qwbs	soretht2_qwbs	soretht3_qwbs
8. A tooth ache or jaw pain?	tthache0_qwbs	tthache1_qwbs	tthache2_qwbs	tthache3_qwbs
9. Sore or bleeding lips, tongue or gums?	sorelip0_qwbs	sorelip1_qwbs	sorelip2_qwbs	sorelip3_qwbs
10. Coughing or wheezing?	cough0_qwbs	cough1_qwbs	cough2_qwbs	cough3_qwbs

11. Shortness of breath or difficulty breathing?	dffbrth0_qwbs	dffbrth1_qwbs	dffbrth2_qwbs	dffbrth3_qwbs
12. Chest pain, pressure, palpitations, fast or skipped heart beat, or other discomfort in the chest?	chestds0_qwbs	chestds1_qwbs	chestds2_qwbs	chestds3_qwbs
13. An upset stomach, abdominal pain, nausea, heartburn, or vomiting?	upsstom0_qwbs	upsstom1_qwbs	upsstom2_qwbs	upsstom3_qwbs
14. Difficulty with bowel movements, diarrhea, constipation, rectal bleeding, black tar-like stools, or any pain or discomfort in the rectal area?	bowel0_qwbs	bowel1_qwbs	bowel2_qwbs	bowel3_qwbs
15. Pain, burning, or blood in urine?	urine0_qwbs	urine1_qwbs	urine2_qwbs	urine3_qwbs
16. Loss of bladder control, frequent night-time urination, or difficulty with urination?	bladder0_qwbs	bladder1_qwbs	bladder2_qwbs	bladder3_qwbs
17. Genital pain, itching, burning, abnormal discharge, pelvic cramping, or abnormal bleeding (does not include normal menstruation)?	gnpain0_qwbs	gnpain1_qwbs	gnpain2_qwbs	gnpain3_qwbs
18. A broken arm, wrist, foot, leg, or any other broken bone (other than in back)?	brkbone0_qwbs	brkbone1_qwbs	brkbone2_qwbs	brkbone3_qwbs
19. Swelling of ankles, hands, feet, or abdomen?	swellng0_qwbs	swellng1_qwbs	swellng2_qwbs	swellng3_qwbs
	No days	**1 day ago**	**2 days ago**	**3 days ago**
20. Fever, chills, or sweats?	fever0_qwbs	fever1_qwbs	fever2_qwbs	fever3_qwbs
21. Loss of consciousness, fainting, or seizures?	losscon0_qwbs	losscon1_qwbs	losscon2_qwbs	losscon3_qwbs
22. Pain, stiffness, cramps, weakness, or numbness in the neck or back?	backpn0_qwbs	backpn1_qwbs	backpn2_qwbs	backpn3_qwbs
23. Pain, stiffness, cramps, weakness, or numbness in the hip or sides?	hippain0_qwbs	hippain1_qwbs	hippain2_qwbs	hippain3_qwbs
24. Pain, stiffness, cramps, weakness, or numbness in any of the joints or muscles of the hand, feet, arms, or legs?	jointpn0_qwbs	jointpn1_qwbs	jointpn2_qwbs	jointpn3_qwbs
25. Difficulty with your balance, standing or walking?	diffbal0_qwbs	diffbal1_qwbs	diffbal2_qwbs	diffbal3_qwbs
D. The following symptoms are about your feelings, thoughts, and behaviors. Please check which days (if any) over the past 3, not incl you have had?..				
26. Trouble falling asleep or staying asleep?	sleep0_qwbs	sleep1_qwbs	sleep2_qwbs	sleep3_qwbs
27. Spells of feeling nervous or shaky?	nervous0_qwbs	nervous1_qwbs	nervous2_qwbs	nervous3_qwbs
28. Spells of feeling upset, downhearted, or blue?	upset0_qwbs	upset1_qwbs	upset2_qwbs	upset3_qwbs
29. Excessive worry or anxiety?	worry0_qwbs	worry1_qwbs	worry2_qwbs	worry3_qwbs
30. Feelings that you had little or no control over events in your life?	lossctl0_qwbs	lossctl1_qwbs	lossctl2_qwbs	lossctl3_qwbs
31. Feelings of being lonely or isolated?	lonely0_qwbs	lonely1_qwbs	lonely2_qwbs	lonely3_qwbs
32. Feelings of frustration, irritation, or close to losing your temper?	frust0_qwbs	frust1_qwbs	frust2_qwbs	frust3_qwbs
33. A hangover?	hangovr0_qwbs	hangovr1_qwbs	hangovr2_qwbs	hangovr3_qwbs
34. Any decrease of sexual interest or performance?	dcsxint0_qwbs	dcsxint1_qwbs	dcsxint2_qwbs	dcsxint3_qwbs
35. Confusion, difficulty understanding the written or spoken word, or significant memory loss?	confusn0_qwbs	confusn1_qwbs	confusn2_qwbs	confusn3_qwbs

36. Thoughts or images you could not get out of your mind?	thtimg0_qwbs	thtimg1_qwbs	thtimg2_qwbs	thtimg3_qwbs
37. To take any medication including over-the-counter remedies (aspirin/Tylenol, allergy medications, insulin, hormones, estrogen, thyroid, prednisone)?	meds0_qwbs	meds1_qwbs	meds2_qwbs	meds3_qwbs
38. To stay on a medically prescribed diet for health reasons?	diet0_qwbs	diet1_qwbs	diet2_qwbs	diet3_qwbs
39. A loss of appetite or over-eating?	lossapp0_qwbs	lossapp1_qwbs	lossapp2_qwbs	lossapp3_qwbs

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
1. Did you spend any part of the day or night as a patient in a hospital, nursing home, or rehabilitation center?	hospitl0_qwbs	hospitl1_qwbs	hospitl2_qwbs	hospitl3_qwbs
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	prscare1_qwbs	prscare2_qwbs	prscare3_qwbs

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
1. Which days did you drive a motor vehicle?	motorvh0_qwbs	motorvh1_qwbs	motorvh2_qwbs	motorvh3_qwbs
2. Which days did you use public transportation such as a bus, subway, Medi-van, train, or airplane?	pubtran0_qwbs	pubtran1_qwbs	pubtran2_qwbs	pubtran3_qwbs
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	notrans1_qwbs	notrans2_qwbs	notrans3_qwbs

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
1. Have trouble climbing stairs or inclines or walking off the curb?	stairs0_qwbs	stairs1_qwbs	stairs2_qwbs	stairs3_qwbs
2. Avoid walking, have trouble walking, or walk more slowly than other people your age?	trbwalk0_qwbs	trbwalk1_qwbs	trbwalk2_qwbs	trbwalk3_qwbs
3. Limp or use a cane, crutches, or walker?	walkaid0_qwbs	walkaid1_qwbs	walkaid2_qwbs	walkaid3_qwbs
4. Avoid or have trouble bending over, stooping or kneeling?	trbbend0_qwbs	trbbend1_qwbs	trbbend2_qwbs	trbbend3_qwbs
5. Have any trouble lifting or carrying everyday objects such as books, a briefcase, or groceries?	trblift0_qwbs	trblift1_qwbs	trblift2_qwbs	trblift3_qwbs
6. Have any other limitations in physical movements?	othlim0_qwbs	othlim1_qwbs	othlim2_qwbs	othlim3_qwbs
7. Spend all or most of the day in a bed, chair, or couch because of health reasons?	bedchr0_qwbs	bedchr1_qwbs	bedchr2_qwbs	bedchr3_qwbs
8. Spend all or most of the day in a wheelchair?	whlchr0_qwbs	whlchr1_qwbs	whlchr2_qwbs	whlchr3_qwbs
9. **If you spent all or most of the day in a wheelchair**, on which days did someone else control its movement?	ctrlwc0_qwbs	ctrlwc1_qwbs	ctrlwc2_qwbs	ctrlwc3_qwbs

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

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	trbwork1_qwbs	trbwork2_qwbs	trbwork3_qwbs
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	trbrec1_qwbs	trbrec2_qwbs	trbrec3_qwbs
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: chplndsc_qwbs	chpln0_qwbs	chpln1_qwbs	chpln2_qwbs	chpln3_qwbs

Part VI - General Health

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

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

-9
1 a. Much better now than
2 b. Somewhat better now
3 c. About the same as a y
4 d. Somewhat worse than
5 e. Much worse than a ye
-6 f. Not on form

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?

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