

SF36

Today's Date: _____

Name: Last: _____ First: _____ Date of Birth: _____

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer these questions by "check-marking" your choice. Please select only one choice for each item.

1- In general, would you say your health is:

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

2- Compared to ONE YEAR AGO, how would you rate your health in general NOW?

1. MUCH BETTER than one year ago.
 2. Somewhat BETTER now than one year ago.
 3. About the SAME as one year ago.
 4. Somewhat WORSE now than one year ago.
 5. MUCH WORSE now than one year ago.

3- The following items are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

Activities	1. Yes, Limited A Lot	2. Yes, Limited A Little	3. No, Not Limited At All
a) <u>Vigorous activities</u> , such as running, lifting heavy objects, participating in strenuous sports?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all
b) <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all
c) Lifting or carrying groceries?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all
d) Climbing several flights of stairs?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all
e) Climbing one flight of stairs?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all
f) Bending, kneeling or stooping?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all
g) Walking more than a mile ?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all
h) Walking several blocks?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all
i) Walking one block?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all
j) Bathing or dressing yourself?	<input type="checkbox"/> 1. Yes, limited a lot	<input type="checkbox"/> 2. Yes, limited a little	<input type="checkbox"/> 3. No, not limited at all

4- During the **past 4 weeks**, have you had any of the following problems with your work or other regular activities *as a result of your physical health?*

	Yes	No
a) Cut down on the amount of time you spent on work or other activities?	<input type="checkbox"/> 1. yes	<input type="checkbox"/> 2. No
b) Accomplished less than you would like?	<input type="checkbox"/> 1. yes	<input type="checkbox"/> 2. No
c) Were limited in the kind of work or other activities?	<input type="checkbox"/> 1. yes	<input type="checkbox"/> 2. No
d) Had difficulty performing the work or other activities (for example it took extra effort)?	<input type="checkbox"/> 1. yes	<input type="checkbox"/> 2. No

5. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
a) Cut down on the amount of time you spent on work or other activities?	<input type="checkbox"/> 1. yes	<input type="checkbox"/> 2. No
b) Accomplished less than you would like?	<input type="checkbox"/> 1. yes	<input type="checkbox"/> 2. No
c) Didn't do work or other activities as carefully as usual?	<input type="checkbox"/> 1. yes	<input type="checkbox"/> 2. No

6. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

1. Not at all 2. Slightly 3. Moderately 4. Quite a bit 5. Extremely

7. How much **bodily pain** have you had during the **past 4 weeks**?

1. None 2. Very mild 3. Mild 4. Moderate 5. Severe 6. Very severe

8. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

9. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question , please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks...**

	1. All of the time	2. Most of the time	3. A good bit of the time	4. Some of the time	5. A little of the time	6. None of the time
a) Did you feel full of pep?	<input type="checkbox"/> 1. All of the time	<input type="checkbox"/> 2. Most of the time	<input type="checkbox"/> 3. A good bit of the time	<input type="checkbox"/> 4. Some of the time	<input type="checkbox"/> 5. A little of the time	<input type="checkbox"/> 6. None of the time
b) Have you been a very nervous person?	<input type="checkbox"/> 1. All of the time	<input type="checkbox"/> 2. Most of the time	<input type="checkbox"/> 3. A good bit of the time	<input type="checkbox"/> 4. Some of the time	<input type="checkbox"/> 5. A little of the time	<input type="checkbox"/> 6. None of the time
c) Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> 1. All of the time	<input type="checkbox"/> 2. Most of the time	<input type="checkbox"/> 3. A good bit of the time	<input type="checkbox"/> 4. Some of the time	<input type="checkbox"/> 5. A little of the time	<input type="checkbox"/> 6. None of the time
d) Have you felt calm and peaceful?	<input type="checkbox"/> 1. All of the time	<input type="checkbox"/> 2. Most of the time	<input type="checkbox"/> 3. A good bit of the time	<input type="checkbox"/> 4. Some of the time	<input type="checkbox"/> 5. A little of the time	<input type="checkbox"/> 6. None of the time
e) Did you have a lot of energy?	<input type="checkbox"/> 1. All of the time	<input type="checkbox"/> 2. Most of the time	<input type="checkbox"/> 3. A good bit of the time	<input type="checkbox"/> 4. Some of the time	<input type="checkbox"/> 5. A little of the time	<input type="checkbox"/> 6. None of the time
f) Have you felt downhearted and blue?	<input type="checkbox"/> 1. All of the time	<input type="checkbox"/> 2. Most of the time	<input type="checkbox"/> 3. A good bit of the time	<input type="checkbox"/> 4. Some of the time	<input type="checkbox"/> 5. A little of the time	<input type="checkbox"/> 6. None of the time
g) Do you feel worn out?	<input type="checkbox"/> 1. All of the time	<input type="checkbox"/> 2. Most of the time	<input type="checkbox"/> 3. A good bit of the time	<input type="checkbox"/> 4. Some of the time	<input type="checkbox"/> 5. A little of the time	<input type="checkbox"/> 6. None of the time
h) Have you been a happy person?	<input type="checkbox"/> 1. All of the time	<input type="checkbox"/> 2. Most of the time	<input type="checkbox"/> 3. A good bit of the time	<input type="checkbox"/> 4. Some of the time	<input type="checkbox"/> 5. A little of the time	<input type="checkbox"/> 6. None of the time
i) Did you feel tired?	<input type="checkbox"/> 1. All of the time	<input type="checkbox"/> 2. Most of the time	<input type="checkbox"/> 3. A good bit of the time	<input type="checkbox"/> 4. Some of the time	<input type="checkbox"/> 5. A little of the time	<input type="checkbox"/> 6. None of the time

10. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- 1. All of the time
- 2. Most of the time.
- 3. Some of the time
- 4. A little of the time.
- 5. None of the time.

11. How TRUE or FALSE is **each** of the following statements for you?

	1. Definitely true	2. Mostly true	3. Don't know	4. Mostly false	5. Definitely false
a) I seem to get sick a little easier than other people?	<input type="checkbox"/> 1. Definitely true	<input type="checkbox"/> 2. Mostly true	<input type="checkbox"/> 3. Don't know	<input type="checkbox"/> 4. Mostly false	<input type="checkbox"/> 5. Definitely false
b) I am as healthy as anybody I know?	<input type="checkbox"/> 1. Definitely true	<input type="checkbox"/> 2. Mostly true	<input type="checkbox"/> 3. Don't know	<input type="checkbox"/> 4. Mostly false	<input type="checkbox"/> 5. Definitely false
c) I expect my health to get worse?	<input type="checkbox"/> 1. Definitely true	<input type="checkbox"/> 2. Mostly true	<input type="checkbox"/> 3. Don't know	<input type="checkbox"/> 4. Mostly false	<input type="checkbox"/> 5. Definitely false
d) My health is excellent?	<input type="checkbox"/> 1. Definitely true	<input type="checkbox"/> 2. Mostly true	<input type="checkbox"/> 3. Don't know	<input type="checkbox"/> 4. Mostly false	<input type="checkbox"/> 5. Definitely false

Thank you!