

Your Health and Well-Being (SF36)

Name: _____ Today's Date: _____

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. *Thank you for completing this survey!*

For each of the following questions, please mark an X in the one box that best describes your answer.

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

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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

Much better than one year ago.	Somewhat better now than one year ago	About the same as one year ago.	Somewhat worse now than one year ago.	Much worse now than one year ago.
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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

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 <u>amount of time</u> you spent on work or other activities? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ |
| b <u>Accomplished less</u> than you would like? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ |
| c Were limited in the <u>kind</u> of work or other activities? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ |
| d Had <u>difficulty</u> performing the work or other activities (for example it took extra effort)? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ |

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 <u>amount of time</u> you spent on work or other activities? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ |
| b <u>Accomplished less</u> than you would like? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ |
| c Didn't do work or other activities as <u>carefully</u> as usual? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ |

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?

- | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Not at all | Slightly | Moderately | Quite a bit | Extremely |
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

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

- | | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| None | Very mild | Mild | Moderate | Severe | Very severe |
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ | <input type="checkbox"/> ₆ |

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

- | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Not at all | A little bit | Moderately | Quite a bit | Extremely |
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |

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**.

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

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.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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

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

Thank you for completing these questions!

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