

3. How much do you weigh? (in pounds) (Fill in one circle)

- 90 lbs. or less
 131 - 140 lbs.
 181 - 190 lbs.
 231 - 240 lbs.
 281 - 290 lbs.
 91 - 100 lbs.
 141 - 150 lbs.
 191 - 200 lbs.
 241 - 250 lbs.
 291 - 300 lbs.
 101 - 110 lbs.
 151 - 160 lbs.
 201 - 210 lbs.
 251 - 260 lbs.
 301 - 310 lbs.
 111 - 120 lbs.
 161 - 170 lbs.
 211 - 220 lbs.
 261 - 270 lbs.
 311 - 320 lbs.
 121 - 130 lbs.
 171 - 180 lbs.
 221 - 230 lbs
 271 - 280 lbs.
 321 lbs. or more

4. How often do you engage in regular activities (e.g., brisk walking, jogging, bicycling, etc.) long enough to work up a sweat?

- NEVER
 LESS THAN ONCE A WEEK
 1 - 2 TIMES A WEEK
 3 - 4 TIMES A WEEK
 5 OR MORE TIMES A WEEK

5. Have you smoked at least 100 cigarettes in your ENTIRE LIFE?

- YES
 NO (If No, skip to # 8)

6A. Do you now smoke cigarettes (as of 1 month ago)?

- YES
 NO

6B. How old were you when you FIRST started to smoke fairly REGULARLY?

Age in years

--	--

6C. On average of the ENTIRE TIME you smoked, how many cigarettes did you smoke per day?

Cigarettes per day

--	--	--

6D. How many cigarettes do you smoke per day NOW?

Cigarettes per day

--	--	--

6E. During the PAST 12 MONTHS, have you stopped smoking for more than one day because you were trying to quit?

- YES
 NO
 Does not apply

6F. If you have stopped smoking cigarettes in the last 12 months, did you stop because of health problems?

- YES
 NO
 Does not apply

--	--	--	--	--	--

9	2	0	0	0	0
---	---	---	---	---	---

6G. If you stopped smoking cigarettes completely for at least 12 months, how old were you when you STOPPED?

Age in years

--	--	--

7. Please look at the scale below. Each statement represents where various people are in thinking about quitting smoking. Fill in the circle next to the statement that best indicates where you are now.

- HAVE ALREADY QUIT NOT SURE
 THINKING ABOUT QUITTING NOT THINKING ABOUT QUITTING
 NOT READY TO QUIT

8. These are questions about how often your lung/respiratory problems have affected you over the past 12 months. Please fill in one circle for each question.

	ALMOST EVERY DAY	SEVERAL DAYS A WEEK	A FEW DAYS A MONTH	ONLY WITH LUNG/RESPIRATORY INFECTIONS	NOT AT ALL
8A. Over the last year, I have coughed:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8B. Over the last year, I have brought up phlegm (sputum):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8C. Over the last year, I have had shortness of breath:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8D. Over the last year, I have had episodes of wheezing:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9A. Have you received counseling concerning exercise or weight loss?

- YES (If Yes, please answer #9B)
 NO (If No, please skip to #9C)

9B. If yes, who counseled you on weight loss? Check all that apply.

- NURSE DIETICIAN
 DOCTOR OTHER HEALTH PROFESSIONAL
 PHYSICIAN'S ASSISTANT

9C. IN THE PAST 12 MONTHS, would you generally describe yourself as:

- UNDERWEIGHT
 ABOUT THE RIGHT WEIGHT
 SOMEWHAT OVERWEIGHT
 EXTREMELY OVERWEIGHT

NOTE: For answering these questions, one "drink" is equal to 12 ounces of beer (1 can), or 4 ounces of wine (1 glass), or 1 ounce of liquor (1 shot).

10A. Have you EVER had a drink of alcohol?

- YES
 NO (If No, skip to question #24)

10B. Have you EVER had problems with alcohol?

- YES
 NO (If No, skip to question #10D)

10C. Did you stop drinking because of these problems?

- YES
 NO

10D. How old were you when you first started to drink?

Age in years

10E. If you have stopped drinking completely, how old were you when you stopped?

Age in years

11. In the last 12 months have you had a drink containing alcohol?

- YES
 NO (If No, skip to #22A)

12. How often do you have a drink containing alcohol?

- NEVER TWO TO THREE TIMES A WEEK
 MONTHLY OR LESS FOUR OR MORE TIMES A WEEK
 TWO TO FOUR TIMES A MONTH

13. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 OR 2 7 TO 9
 3 OR 4 10 OR MORE
 5 OR 6

14. How often do you have six or more drinks on one occasion?

- NEVER WEEKLY
 LESS THAN MONTHLY DAILY OR ALMOST DAILY
 MONTHLY

15. How often during the last 12 months have you found that you were not able to stop drinking once you had started?
- NEVER WEEKLY
 LESS THAN MONTHLY DAILY OR ALMOST DAILY
 MONTHLY
16. How often during the last 12 months have you failed to do what was normally expected from you because of drinking?
- NEVER WEEKLY
 LESS THAN MONTHLY DAILY OR ALMOST DAILY
 MONTHLY
17. How often during the last 12 months have you needed a first drink in the morning to get yourself going after a heavy drinking session?
- NEVER WEEKLY
 LESS THAN MONTHLY DAILY OR ALMOST DAILY
 MONTHLY
18. How often during the last 12 months have you had a feeling of guilt or remorse after drinking?
- NEVER WEEKLY
 LESS THAN MONTHLY DAILY OR ALMOST DAILY
 MONTHLY
19. How often during the last 12 months have you been unable to remember what happened the night before because you had been drinking?
- NEVER WEEKLY
 LESS THAN MONTHLY DAILY OR ALMOST DAILY
 MONTHLY
20. Have you or someone else been injured as a result of your drinking?
- NEVER
 YES, BUT NOT IN THE LAST YEAR
 YES, DURING THE LAST YEAR
21. Has a relative or friend or doctor or other health care worker been concerned about your drinking or suggested you cut down?
- NO
 YES, BUT NOT IN THE LAST YEAR
 YES, DURING THE LAST YEAR

For each statement below, fill in one circle to indicate how you might agree or disagree with each statement.	NO	NO	UNDECIDED	YES	YES
	<u>STRONGLY</u> <u>DISAGREE</u>	<u>DISAGREE</u>	<u>OR</u> <u>UNSURE</u>	<u>AGREE</u>	<u>STRONGLY</u> <u>AGREE</u>
22A. I really want to make changes in my drinking:	0	0	0	0	0
22B. Sometimes I wonder if I'm an alcoholic:	0	0	0	0	0
22C. If I don't change my drinking soon, my problems are going to get worse:	0	0	0	0	0
22D. I have already started making some changes in my drinking:	0	0	0	0	0
22E. I was drinking too much at one time, but I've managed to change my drinking:	0	0	0	0	0
22F. Sometimes I wonder if my drinking is hurting other people:	0	0	0	0	0
22G. I am a problem drinker:	0	0	0	0	0
22H. I'm not just thinking about changing my drinking, I'm already doing something about it:	0	0	0	0	0
22I. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern:	0	0	0	0	0
22J. I have serious problems with drinking:	0	0	0	0	0
23K. Sometimes I wonder if I am in control of my drinking:	0	0	0	0	0
22L. My drinking is causing a lot of harm:	0	0	0	0	0
22M. I am actively doing things now to cut down or stop drinking:	0	0	0	0	0
22N. I want help to keep from going back to the drinking problems that I had before:	0	0	0	0	0
22O. I know that I have a drinking problem:	0	0	0	0	0
22P. There are times when I wonder if I drink too much:	0	0	0	0	0
22Q. I am an alcoholic:	0	0	0	0	0
22R. I am working hard to change my drinking:	0	0	0	0	0
22S. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink:	0	0	0	0	0

23. Look at the scale below. Each statement represents where various people are in thinking about changing their drinking. Please fill in the circle next to the statement that best indicates where you are now.

- HAVE ALREADY CHANGED
- THINKING ABOUT CHANGING
- NOT READY
- NOT SURE
- NOT THINKING ABOUT CHANGING

24. Have you ever used prescription drugs only for the experience or feeling they caused?

- YES
- NO (If NO, please skip to #27)

25. Have you ever, even once, used one of the medications listed below that was NOT prescribed for you or that you took only for the experience or feeling it caused?

(These questions are about the use of pain relievers. We are NOT interested in your use of "over the counter" pain medications such as aspirin, Tylenol or Advil.)

Please check all that apply.

	<u>EVER USED</u>	<u>USED IN THE PAST 12 MONTHS</u>																				
Buprenorphine	0	0																				
Codeine	0	0																				
Darvocet	0	0																				
Darvon	0	0																				
Demerol	0	0																				
Dilaudid	0	0																				
Fioricet	0	0																				
Fiorinal	0	0																				
Hydrocodone	0	0																				
Methadone	0	0																				
Morphine	0	0																				
Oxycontin	0	0																				
Percocet	0	0																				
Percodan	0	0																				
Propoxyphene	0	0																				
Talwin	0	0																				
Tylenol with codeine	0	0																				
Tylox	0	0																				
Ultram	0	0																				
Vicodin	0	0																				
Other	0	0																				
please specify	<table border="1" style="width: 100%;"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																					

26. Now think only about the past 12 months. On average, how many days each week in the past 12 months did you use any prescription pain reliever that was not prescribed for you or that you took only for the experience or feeling that it caused?

Average number of days per week

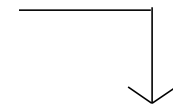
27. For each of the following drugs, please fill in the circle that best indicates how often in the past 12 months you used each drug.

IN THE LAST 12 MONTHS

	HAVE NEVER TRIED	NO USE IN THE LAST YEAR	LESS THAN ONCE A MONTH	1 - 3 TIMES A MONTH	1 - 3 TIMES A WEEK	4 - 6 TIMES A WEEK	EVERY DAY
a. Marijuana or Hashish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Cocaine or Crack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Prescription benzodiazepines (Valium, Deastat, Ativan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Other (please specify):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>						

28. In the past 12 months, did your use of drugs ever interfere with your work at school, or a job, or at home?

- YES (If YES, please answer #28a)
- NO (If NO, please skip to #32)
- DID NOT USE DRUGS (Please skip to #32)



28a. How often in the past 12 months did drugs interfere with your work at school, or a job, or at home?

<input type="radio"/> ONCE OR TWICE	<input type="radio"/> BETWEEN 11 AND 20 TIMES
<input type="radio"/> BETWEEN 3 AND 5 TIMES	<input type="radio"/> MORE THAN 20 TIMES
<input type="radio"/> BETWEEN 6 AND 10 TIMES	

29. In the past 12 months, were you ever under the influence of a drug in a situation where you could get hurt - like when driving a car or boat, using knives or guns or machinery, or anything else?

- YES
- NO

30. In the past 12 months, have you ever used a needle to inject any drug? DO NOT include anything you took under a doctor's order.
- YES
 NO
31. Look at the scale below. Each statement below represents where various people are in thinking about changing their drug use/habits. Please fill in the circle next to the statement that best indicates where you are now.
- HAVE ALREADY CHANGED NOT SURE
 THINKING ABOUT CHANGING NOT THINKING ABOUT CHANGING
 NOT READY

The next questions are about your sexual behavior. We recognize the following questions may be personal. We ask that you complete them to the best of your ability. By sex we mean oral, vaginal, or anal sex, but NOT masturbation. When we talk about condoms, we mean both male as well as female condoms.

32. During the past 12 months, have you had sex?
- YES
 NO (If NO, skip to question #50)
33. Thinking back about the last time you had sex, did you or your partner use a condom?
- YES
 NO
34. During the past 12 months, have you had sex with only males, only females, or with both males and females?
- ONLY MALES BOTH MALES AND FEMALES
 ONLY FEMALES
35. How many sexual partners have you had in the last 12 months?
- 0 1 2 3 4 5 6 7 >8
36. Of these people, how many of them were new partners, that is, people you had oral, anal, or vaginal sex with for the first or only time in the last 12 months?
- 0 1 2 3 4 5 6 7 >8
37. In the past 12 months, have you used any prescription drug to improve sexual performance, such as Viagra, Cialis or Levitra?
- YES
 NO
38. Thinking back about the last time you had sex, had you been drinking alcohol?
- YES
 NO

39. In the past 12 months, have you used alcohol to help you feel more comfortable with a sexual partner?
- YES
- NO
40. In the past 12 months, have you done more sexually than you had planned because you were drinking alcohol?
- YES
- NO
41. In the past 12 months, have you had unprotected sex (not used a condom) because you were drinking alcohol?
- YES
- NO
42. Thinking about the last time you had sex, were you using drugs?
- YES
- NO
43. In the past 12 months, have you used drugs to help you feel more comfortable with a sexual partner?
- YES
- NO
44. In the past 12 months, have you done more sexually than you had planned because you were using drugs?
- YES
- NO
45. In the past 12 months, have you had unprotected sex (not used a condom) because you were using drugs?
- YES
- NO
46. In the past 12 months, have you been diagnosed with any of the following sexually transmitted diseases (STDs)? Please fill in all those that apply.
- | | |
|---------------------------------------|--|
| <input type="radio"/> chlamydia | <input type="radio"/> herpes |
| <input type="radio"/> gonorrhea | <input type="radio"/> non-specific urethritis/ non-gonococcal urethritis |
| <input type="radio"/> syphilis | <input type="radio"/> genital warts |
| <input type="radio"/> trichomonas | <input type="radio"/> another sexually transmitted disease |
| <input type="radio"/> chancroid | <input type="radio"/> None of these infections |
| <input type="radio"/> lice or scabies | <input type="radio"/> I prefer not to answer this question |

47. During the past 12 months, on average, how often have you had sex?

- DID NOT HAVE SEX A FEW TIMES A MONTH EVERY DAY
 ABOUT ONCE A MONTH OR LESS A FEW TIMES A WEEK

48. During the past 12 months when you had sex, how often did you use a condom?

- DID NOT HAVE SEX SOMETIMES ALWAYS
 NEVER USUALLY

49. During the past 12 months, did you ever, even once, have unprotected vaginal or anal sex (sex without a condom) with any of the following types of partners?

	Yes (unprotected sex at least once)	No (always used a condom)
a. A main partner (spouse or long-term lover)	0	0
b. Any other partner (date, fling, someone you just met)	0	0
c. Any partner who was HIV positive	0	0
d. Any partner who was HIV negative	0	0
e. Any partner whose HIV status was unknown	0	0

50. In the past 12 months, has your primary health care provider asked you anything about your sexual behavior?

- YES
 NO

51. Have you been tested for HIV?

- NO, I HAVE NEVER BEEN TESTED
 YES, AND MY LAST TEST WAS NEGATIVE
 YES, AND MY LAST TEST WAS POSITIVE
 YES, AND MY LAST TEST WAS INDETERMINATE
 YES, I WAS TESTED BUT HAVE NOT RETURNED FOR MY RESULTS
 I PREFER NOT TO ANSWER THIS QUESTION

52. Please indicate whether you AGREE or DISAGREE or DON'T KNOW with each statement below:

	AGREE	DISAGREE	DON'T KNOW
a. Condoms do not always prevent HIV infection	0	0	0
b. I do not like using condoms	0	0	0
c. I sometimes did not use a condom because I was drinking or using drugs	0	0	0
d. I sometimes did not use a condom because I did not have one	0	0	0
e. My sexual partners do not like me to use condoms	0	0	0
f. I don't need to use condoms with my main partner	0	0	0
g. HIV infection is not as serious as it used to be	0	0	0
h. A person with HIV cannot transmit HIV if his/her viral load is undetectable	0	0	0
i. I am not at risk for getting HIV or sexually transmitted diseases	0	0	0
j. I am not at risk of transmitting HIV or STDs	0	0	0

53. In the past 4 weeks, have you stayed one or more nights in the following? Mark all that apply.

- ON THE STREET, AT A PARK, AN ABANDONED BUILDING OR IN A CAR
- A SHELTER OR AN EMERGENCY SHELTER
- A SUBSIDIZED APARTMENT OR HOME AWAITING PERMANENT HOUSING
- WITH FAMILY OR FRIENDS TEMPORARILY AWAITING PERMANENT HOUSING
- NONE OF THE ABOVE

54. Do you have health insurance outside the VA? YES (If yes, please answer below)
 NO

	YES	NO
a. Do you have private health insurance?	0	0
b. Do you have Medicaid?	0	0
c. Do you have Medicare?	0	0
d. Do you have other forms of public health insurance?	0	0

55. During the last 3 months, were you seen in any of the following for these reasons.

	VA	OUTSIDE CARE	DOES NOT APPLY
a. In a hospital for medical problems	0	0	0
b. In a hospital for psychological or emotional problems	0	0	0
c. In a hospital for detoxification	0	0	0
d. In an outpatient program for alcohol treatment	0	0	0
e. In an outpatient program for other drug treatment	0	0	0
f. In a residential program for alcohol treatment	0	0	0
g. In a residential program for other drug treatment	0	0	0
h. In a halfway house	0	0	0
i. In a holding unit; a place where someone can stay while they wait for a bed to open up in a program. (generally no services are provided in the holding unit).	0	0	0

56. During the last 3 months, did you do any of the following.

	VA	OUTSIDE CARE	DOES NOT APPLY
a. Go to an Emergency Room for medical care	0	0	0
b. Fill your prescription medication	0	0	0
c. Call for Telephone Advice	0	0	0

57. If you received care outside the VA, what were your reasons? (Mark all that apply)

- | | |
|--|--|
| <input type="checkbox"/> UNABLE TO GET APPOINTMENT WITH VA CARE | <input type="checkbox"/> LOCATION |
| <input type="checkbox"/> RELATIONSHIP WITH PROVIDER OUTSIDE THE VA | <input type="checkbox"/> INSURANCE |
| <input type="checkbox"/> DISSATISFACTION WITH VA CARE | <input type="checkbox"/> OTHER REASONS |
| <input type="checkbox"/> DID NOT RECEIVE CARE OUTSIDE THE VA | |

58. IN THE LAST 12 MONTHS where did you get your general medical care?

- VA PROVIDER
 NON-VA PROVIDER

59. During the last 3 months, did you go to meetings of Alcoholics Anonymous (AA), self-help, mutual-help, or another 12-step program?

	YES	NO
a. For alcohol?	0	0
b. For drugs?	0	0

60. During the last 3 months, did you receive counseling for alcohol problems from:

- A PRIEST / MINISTER / RABBI OR OTHER CLERGY EMERGENCY ROOM
 AN EMPLOYEE ASSISTANCE PROGRAM OTHER
 ALCOHOLICS ANONYMOUS DID NOT RECEIVE COUNSELING

61. During the last 3 months, have you taken any medications prescribed by a physician:

	YES	NO
a. To prevent you from drinking.	0	0
b. To help you detoxify/come off alcohol.	0	0
c. To help you stabilize or change your use of drugs other than alcohol.	0	0
d. For your psychological or emotional problems.	0	0

62. Do you now take prescription medications?

- YES
 NO (If NO, skip to question #67)

63. Most prescription medications need to be taken on a schedule, such as "2 times a day," or "3 times a day," or "every 8 hours." How closely did you follow your specific schedule over the last four days?

- NEVER ABOUT HALF OF THE TIME ALL OF THE TIME
 SOME OF THE TIME MOST OF THE TIME

64. Did you miss any of your prescription medications last weekend--(last Saturday or Sunday)?

- YES
 NO

65. When was the last time you missed any of your prescription medications?

- WITHIN THE PAST WEEK 1-2 WEEKS AGO 2-4 WEEKS AGO
 1-3 MONTHS AGO OVER 3 MONTHS AGO NEVER MISSED

66. During the past 4 days, on how many days have you missed taking any of your doses?

- NONE ONE DAY TWO DAYS
 THREE DAYS FOUR DAYS

Questions 67a-u are from the *Beck Anxiety Inventory*[®]

The *BAI*[®] is protected by federal copyright law.

68. The following questions ask about symptoms you might have had during the past four weeks.
Please fill in the circle of the one response that best describes this symptom.

	I DO NOT HAVE THIS SYMPTOM	I HAVE THIS SYMPTOM AND...			
		IT DOESN'T BOTHER ME	IT BOTHERS ME A LITTLE	IT BOTHERS ME	IT BOTHERS ME A LOT
a. Fatigue or loss of energy?	0	0	0	0	0
b. Fevers, chills, or sweats?	0	0	0	0	0
c. Feeling dizzy or light headed?	0	0	0	0	0
d. Pain, numbness, or tingling in the hands or feet?	0	0	0	0	0
e. Trouble remembering?	0	0	0	0	0
f. Nausea or vomiting?	0	0	0	0	0
g. Diarrhea or loose bowel movements?	0	0	0	0	0
h. Felt sad, down, or depressed?	0	0	0	0	0
i. Felt nervous or anxious?	0	0	0	0	0
j. Difficulty falling or staying asleep?	0	0	0	0	0
k. Skin problems, such as rash, dryness, or itching?	0	0	0	0	0
l. Cough or trouble catching your breath?	0	0	0	0	0
m. Headache?	0	0	0	0	0
n. Loss of appetite or change in the taste of food?	0	0	0	0	0
o. Bloating, pain, or gas in your stomach?	0	0	0	0	0
p. Muscle aches or joint pain?	0	0	0	0	0
q. Problems with having sex, such as loss of interest or lack of satisfaction?	0	0	0	0	0
r. Changes in the way your body looks, such as fat deposits or weight gain?	0	0	0	0	0
s. Problems with weight loss or wasting?	0	0	0	0	0
t. Hair loss or changes in the way your hair looks?	0	0	0	0	0

74. If you checked off any problem listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
- NOT DIFFICULT AT ALL VERY DIFFICULT
- SOMEWHAT DIFFICULT EXTREMELY DIFFICULT

75. These questions are about any physical limitations you might have. For these activities, please indicate which response best describes you by filling in the circle under the appropriate response after each statement.

	<u>YES, I CAN DO THIS</u>	<u>YES, BUT ONLY SLOWLY</u>	<u>NO, I CANNOT DO THIS</u>
a. Can you do heavy work at home, like scrubbing floors, lifting or moving heavy furniture?	0	0	0
b. Can you do moderate work at home like moving a chair or table, or pushing a vacuum cleaner?	0	0	0
c. Can you do light work around the house like dusting or washing dishes?	0	0	0
d. If you want to, can you participate in active sports such as swimming, tennis, basketball, volleyball or rowing a boat?	0	0	0
e. If you want to, can you run a short distance?	0	0	0
f. Can you walk uphill or upstairs?	0	0	0
g. Can you walk a block or more?	0	0	0
h. Can you walk around inside the house?	0	0	0
i. Can you walk to a table for meals?	0	0	0
j. Can you dress yourself?	0	0	0
k. Can you eat without help?	0	0	0
l. Can you use the bathroom without help?	0	0	0

These questions ask 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 each question by filling in the circle. If you are unsure about how to answer, please try your best.

76. In general, would you say your health is:
- EXCELLENT FAIR
- VERY GOOD POOR
- GOOD

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?

	YES, LIMITED A LOT	YES, LIMITED A LITTLE	NO, NOT LIMITED AT ALL
77. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	0	0	0
78. Climbing several flights of stairs	0	0	0

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

79. Accomplished less than you would like

YES

NO

80. Were limited in the kind of work or other activities

YES

NO

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)?

81. Accomplished less than you would like

YES

NO

82. Didn't do work or other activities as carefully as usual

YES

NO

83. 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

QUITE A BIT

A LITTLE BIT

EXTREMELY

MODERATELY

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:

	<u>ALL OF THE TIME</u>	<u>MOST OF THE TIME</u>	<u>A GOOD BIT OF THE TIME</u>	<u>SOME OF THE TIME</u>	<u>A LITTLE OF THE TIME</u>	<u>NONE OF THE TIME</u>
84. Have you felt downhearted and blue?	0	0	0	0	0	0
85. Did you have a lot of energy?	0	0	0	0	0	0
86. Have you felt calm and peaceful?	0	0	0	0	0	0

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

- ALL OF THE TIME
 A LITTLE OF THE TIME
 MOST OF THE TIME
 NONE OF THE TIME
 SOME OF THE TIME

88. Do you have an email address?

- YES
 NO

89A. Do you have access to the internet?

- YES
 NO

89B. If yes, where do you have access to the internet?

- HOME
 LIBRARY
 WORK
 OTHER

**Thank you for completing our questionnaire.
Please return this to the Survey coordinator who gave it to you.**