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

- 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

**IF YOU HAVE NEVER SMOKED, PLEASE SKIP TO QUESTION #8**

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

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

Cigarettes per day

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

Cigarettes per day

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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

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

Age in years

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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  
 THINKING ABOUT QUITTING  
 NOT READY TO QUIT  
 NOT SURE  
 NOT THINKING ABOUT QUITTING

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.

	<u>ALMOST EVERY DAY</u>	<u>SEVERAL DAYS A WEEK</u>	<u>A FEW DAYS A MONTH</u>	<u>ONLY WITH LUNG/RESPIRATORY INFECTIONS</u>	<u>NOT AT ALL</u>
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  
 DOCTOR  
 PHYSICIAN'S ASSISTANT  
 DIETICIAN  
 OTHER HEALTH PROFESSIONAL

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

- UNDERWEIGHT  
 ABOUT THE RIGHT WEIGHT  
 SOMEWHAT OVERWEIGHT  
 EXTREMELY OVERWEIGHT

9D. IN THE PAST 12 MONTHS, has your health care provider suggested you should see a dietician or nutritionist?

- YES  
 NO

9E. IN THE PAST 12 MONTHS, did you see a dietician or nutritionist?

- YES  
 NO

**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).**

**IF YOU HAVE NEVER HAD A DRINK, PLEASE SKIP TO QUESTION #24A**

10A. Have you ever had problems with alcohol?

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

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

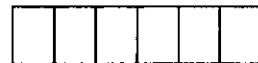
- YES  
 NO

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

Age in years

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

Age in years



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

- YES
- NO, NEVER (If No, skip to #24A)

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

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

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

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

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

- NEVER
- LESS THAN MONTHLY
- MONTHLY
- WEEKLY
- DAILY OR ALMOST DAILY

15. How often during the last 12 months have you found that you were not able to stop drinking once you had started?

- NEVER
- LESS THAN MONTHLY
- MONTHLY
- WEEKLY
- DAILY OR ALMOST DAILY

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16. How often during the last 12 months have you failed to do what was normally expected from you because of drinking?
- NEVER
  - LESS THAN MONTHLY
  - MONTHLY
  - WEEKLY
  - DAILY OR ALMOST DAILY
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
  - LESS THAN MONTHLY
  - MONTHLY
  - WEEKLY
  - DAILY OR ALMOST DAILY
18. How often during the last 12 months have you had a feeling of guilt or remorse after drinking?
- NEVER
  - LESS THAN MONTHLY
  - MONTHLY
  - WEEKLY
  - DAILY OR ALMOST DAILY
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
  - LESS THAN MONTHLY
  - MONTHLY
  - WEEKLY
  - DAILY OR ALMOST DAILY
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 bubble to indicate how you might agree or disagree with each statement.

	<b>NO STRONGLY DISAGREE</b>	<b>NO DISAGREE</b>	<b>UNDECIDED OR UNSURE</b>	<b>YES AGREE</b>	<b>YES STRONGLY AGREE</b>
22A. I really want to make changes in my drinking:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22B. Sometimes I wonder if I'm an alcoholic:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22C. If I don't change my drinking soon, my problems are going to get worse:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22D. I have already started making some changes in my drinking:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22E. I was drinking too much at one time, but I've managed to change my drinking:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22F. Sometimes I wonder if my drinking is hurting other people:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22G. I am a problem drinker:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22H. I'm not just thinking about changing my drinking, I'm already doing something about it:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22I. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22J. I have serious problems with drinking:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



	<b>NO STRONGLY DISAGREE</b>	<b>NO DISAGREE</b>	<b>UNDECIDED OR UNSURE</b>	<b>YES AGREE</b>	<b>YES STRONGLY AGREE</b>
22K. 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

24A. Have you ever had problems with drugs?

- YES
- NO
- NEVER USED DRUGS (If never used, skip to question #30)

24B. If you no longer use drugs, did you stop using drugs because of these problems?

- YES
- NO

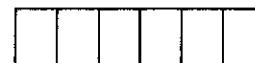


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27. In the past 12 months, were you ever under the influence of a drug in a situation where you could get hurt - like when driving a car or boat, using knives or guns or machinery, or anything else?
- YES
- NO
28. In the past 12 months, have you ever used a needle to inject any drug? DO NOT include anything you took under a doctor's order.
- YES
- NO
29. Look at the scale below. Each statement below represents where various people are in thinking about changing their drug use/habits. Please pill 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

**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.**

30. During the past 12 months, have you had sex?
- YES
- NO (if no, SKIP to question #46A)
31. Thinking back about the last time you had sex, did you or your partner use a condom?
- YES
- NO
32. During the past 12 months, have you had sex with only males, only females, or with both males and females?
- ONLY MALES
- ONLY FEMALES
- BOTH MALES AND FEMALES
33. How many sexual partners have you had in the last 12 months?
- 00 01 02 03 04 05 06 07 0>8



34. In the past 12 months, have you ever exchanged money or drugs for sex?
- NO
- YES, AND I HAD PROTECTED SEX
- YES, AND I HAD UNPROTECTED SEX
- YES, AND I HAD BOTH PROTECTED AND UNPROTECTED SEX
- I PREFER NOT TO ANSWER THIS QUESTION
35. In the past 12 months, have you had sex with anyone that you did not know ahead of time (anonymous/casual sex)?
- YES
- NO
- I PREFER NOT TO ANSWER THIS QUESTION
36. In the past 12 months, how often have you practiced safe sex (used a male or female condom)?
- EVERY TIME I HAVE SEX WITH EVERY PARTNER
- WITH EACH PARTNER, I SOMETIMES PRACTICE SAFER SEX, BUT NOT ALWAYS
- WITH SOME PARTNERS, I ALWAYS PRACTICE SAFER SEX, AND WITH OTHER PARTNERS I DO NOT
- I AM SEXUALLY ACTIVE BUT I NEVER PRACTICE SAFER SEX
- I DO NOT HAVE TO PRACTICE SAFER SEX SINCE I AM NOT AT RISK FOR HIV OR OTHER STDS
- I AM NOT SEXUALLY ACTIVE
- I PREFER NOT TO ANSWER THIS QUESTION
- 37A. In the past 12 months, has your primary health care provider asked you anything about your sexual behavior?
- YES
- NO
- 37B. In the past 12 months, have you used any prescription drug to improve sexual performance, such as Viagra, Cialis or Levitra?
- YES, If Yes, please check below to indicate how you get your medication)
- NO (If No, skip to question #37C)
- |                            |                           |                          |
|----------------------------|---------------------------|--------------------------|
| VA PROVIDER                | <input type="radio"/> YES | <input type="radio"/> NO |
| OTHER HEALTH CARE PROVIDER | <input type="radio"/> YES | <input type="radio"/> NO |
| INTERNET                   | <input type="radio"/> YES | <input type="radio"/> NO |
| TV / NEWSPAPER             | <input type="radio"/> YES | <input type="radio"/> NO |
| FRIEND / ACQUAINTANCE      | <input type="radio"/> YES | <input type="radio"/> NO |
| OTHER                      | <input type="radio"/> YES | <input type="radio"/> NO |

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37C. In the past year, have you used any other type of medication specifically to improve sexual performance (such as testosterone or herbal supplements)?.

YES

NO

37D. What is your sexual orientation?

HETEROSEXUAL / STRAIGHT

GAY OR LESBIAN

BISEXUAL

OTHER

**If you have not had a drink in the past 12 months, skip to question #42**

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?

YES

NO

41. In the past 12 months, have you had unprotected sex (not used a condom) because you were drinking?

YES

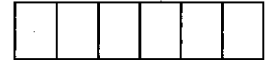
NO

**SKIP if you have not used drugs in the last 12 months. Go on to question #46A**

42. Thinking back about the last time you had sex, were you using drugs?

YES

NO



43. In the last 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

MIGHT HAVE

46A. 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

46B. 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



47. 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

48. 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



49. If you received care outside the VA, what were your reasons? (please fill ovals)

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

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

- VA PROVIDER  
 NON-VA PROVIDER

51. 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?	<input type="radio"/>	<input type="radio"/>
b. For drugs?	<input type="radio"/>	<input type="radio"/>

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

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

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

	YES	NO
a. To prevent you from drinking.	<input type="radio"/>	<input type="radio"/>
b. To help you detoxify/come off alcohol.	<input type="radio"/>	<input type="radio"/>
c. To help you stabilize or change your use of drugs other than alcohol.	<input type="radio"/>	<input type="radio"/>
d. For your psychological or emotional problems.	<input type="radio"/>	<input type="radio"/>



Many people have many pills to take at different times during the day and find it hard to always remember their pills. Please tell us what you are doing. Don't worry about telling us that you don't take all your doses. We need to know what is really happening, not what you think we "want to hear."

Please fill in the oval of the one response that best describes how you take your medications.

If you do not take medications please SKIP to question #63A

54. In the past 12 months, when you take your prescription medications, how often do you take all the medications you're supposed to?

- NEVER  
 SOME OF THE TIME  
 ABOUT HALF OF THE TIME  
 MOST OF THE TIME  
 ALL OF THE TIME (If all of the time, skip to #63A)

55. In the past 12 months, is there a particular medication that you are more likely to miss than the others?

- YES If yes, do any of these reasons explain why?  
 NO

	YES	NO
I have to take it at an inconvenient time	0	0
I have to worry about taking it with or without food	0	0
I don't like the side effects	0	0
The pill is hard to swallow or tastes bad	0	0

56. Do you ever stop taking your medications for a while or take a "drug holiday" that was not recommended by your doctor?

- NEVER  
 LESS THAN MONTHLY  
 MONTHLY  
 WEEKLY  
 MORE THAN WEEKLY

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***If you do stop taking your medications for a while,***

57. How often is this something you do on purpose?

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

58. How long does it last for?

- 2 DAYS  
 3 OR 4 DAYS  
 BETWEEN 5 AND 7 DAYS  
 BETWEEN 1 WEEK AND 1 MONTH  
 MORE THAN 1 MONTH

59. Does it tend to occur around the following times?

**WEEKENDS:**

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

**VACATIONS:**

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

**PAYDAYS** (when you receive employer or government checks):

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

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

- YES  
 NO

61. 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

62. 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



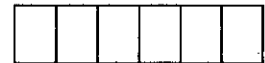
Below is a list of common symptoms of anxiety. Please fill in the bubble to indicate how much you have been bothered by that symptom IN THE PAST MONTH.

	<u>NOT AT ALL</u>	<u>MILDLY BUT IT DIDN'T BOTHER ME MUCH</u>	<u>MODERATELY - IT WASN'T PLEASANT AT TIMES</u>	<u>SEVERELY - IT BOTHERED ME A LOT</u>
63A. Numbness or Tingling	0	0	0	0
63B. Feeling hot	0	0	0	0
63C. Wobbliness in legs	0	0	0	0
63D. Unable to relax	0	0	0	0
63E. Fear of the worst happening	0	0	0	0
63F. Dizzy or Light headed	0	0	0	0
63G. Heart pounding / racing	0	0	0	0
63H. Unsteady	0	0	0	0
63I. Terrified or afraid	0	0	0	0
63J. Nervous	0	0	0	0
63K. Feeling of choking	0	0	0	0
63L. Hands trembling	0	0	0	0
63M. Shaky / unsteady	0	0	0	0
63N. Fear of losing control	0	0	0	0
63O. Difficulty breathing	0	0	0	0
63P. Fear of dying	0	0	0	0
63Q. Scared	0	0	0	0
63R. Indigestion	0	0	0	0
63S. Faint / lightheaded	0	0	0	0
63T. Face flushed	0	0	0	0
63U. Hot / cold sweats	0	0	0	0



64. The following questions ask about symptoms you might have had during the past four weeks.  
Please fill in the oval 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



65A. Do you think your symptoms from question #64 are caused by the drugs you take to treat your medical conditions?

- YES  
 NO  
 UNSURE

65B. Do you think your symptoms from question #64 are caused by drinking alcohol?

- YES  
 NO  
 UNSURE

66. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	<u>NOT AT ALL</u>	<u>SEVERAL DAYS</u>	<u>MORE THAN HALF THE DAYS</u>	<u>NEARLY EVERY DAY</u>
a. Little interest or pleasure in doing things	0	0	0	0
b. Feeling down, depressed, or hopeless	0	0	0	0
c. Trouble falling/staying asleep, sleeping too much	0	0	0	0
d. Feeling tired or having little energy	0	0	0	0
e. Poor appetite or overeating	0	0	0	0
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	0	0	0
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	0	0	0
h. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	0	0	0
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	0	0	0

67. 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  
 SOMEWHAT DIFFICULT  
 VERY DIFFICULT  
 EXTREMELY DIFFICULT



68. These questions are about any physical limitations you might have. For these activities, please indicate which response best describes you by filling in the oval 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 oval. If you are unsure about how to answer, please try your best.**

69. In general, would you say your health is:

- EXCELLENT
- VERY GOOD
- GOOD
- FAIR
- POOR



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?

	<b>YES, LIMITED A LOT</b>	<b>YES, LIMITED A LITTLE</b>	<b>NO, NOT LIMITED AT ALL</b>
70. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	0	0	0
71. 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?

72. Accomplished less than you would like

YES

NO

73. 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)?

74. Accomplished less than you would like

YES

NO

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

YES

NO



76. 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

**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>
77. Have you felt downhearted and blue?	0	0	0	0	0	0
78. Did you have a lot of energy?	0	0	0	0	0	0
79. Have you felt calm and peaceful?	0	0	0	0	0	0

80. 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
- MOST OF THE TIME
- SOME OF THE TIME
- A LITTLE OF THE TIME
- NONE OF THE TIME

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