

Last Name

First Name

Date of Visit

MRN

ICD9-1

ICD9-2

The SF-36v2 Health Survey

Instructions for Completing the Questionnaire

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your response.

EXAMPLE

This is for your review. Do not answer this question. The questionnaire begins with the section *Your Health in General* below.

For each question you will be asked to fill in a bubble in each line:

1. How strongly do you agree or disagree with each of the following statements?

	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree
a) I enjoy listening to music.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I enjoy reading magazines	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please begin answering your questions now.

Your Health in General

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

Excellent	Very Good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Much better now 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please turn the page and continue.

Office use only

- | | |
|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> pre-op | <input type="checkbox"/> 1 year |
| <input type="checkbox"/> 6 weeks | <input type="checkbox"/> 2 years |
| <input type="checkbox"/> 3 months | |
| <input type="checkbox"/> 6 months | <input type="checkbox"/> Office visit |

3. The following questions 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
--------------------------	-----------------------------	------------------------------

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| a) Vigorous activities , such as running, lifting heavy objects participating in strenuous sports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Lifting or carrying groceries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Climbing several flights of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Climbing one flight of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Bending, kneeling, or stooping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Walking more than a mile | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Walking several hundred yards | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Walking one hundred yards | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Bathing or dressing yourself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

All of the time	Most of the time	Some of the time	A little of the time	None of the time
-----------------	------------------	------------------	----------------------	------------------

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

5. During the **past 4 weeks**, how much of the time 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)?

All of the Time	Most of The time	Some of The time	A little of The time	None of The time
-----------------	------------------	------------------	----------------------	------------------

- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) Cut down on the amount of time you spent on work or other activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Accomplished less than you would like | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Did work or other activities less carefully than usual | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

None Very Mild Mild Moderate Severe 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)?

Not at all A little bit Moderately Quite a bit 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**...

All of the time	Most of the time	Some of the time	A little of the time	None of the time
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- a) did you feel full of life?
- b) have you been very nervous?
- c) have you felt so down in the dumps nothing could cheer you up?
- d) have you felt calm and peaceful?
- e) did you have a lot of energy?
- f) have you felt downhearted and depressed?
- g) did you feel worn out?
- h) have you been happy?
- i) did you feel tired?

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 friends, relatives, etc.)?

All of the time Most of the time Some of the time A little of the time None of the time

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

Definitely true	Mostly true	Don't know	Mostly false	Definitely false
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- a) I seem to get sick a little easier than other people
- b) I am as healthy as anybody I know
- c) I expect my health to get worse
- d) My health is excellent

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

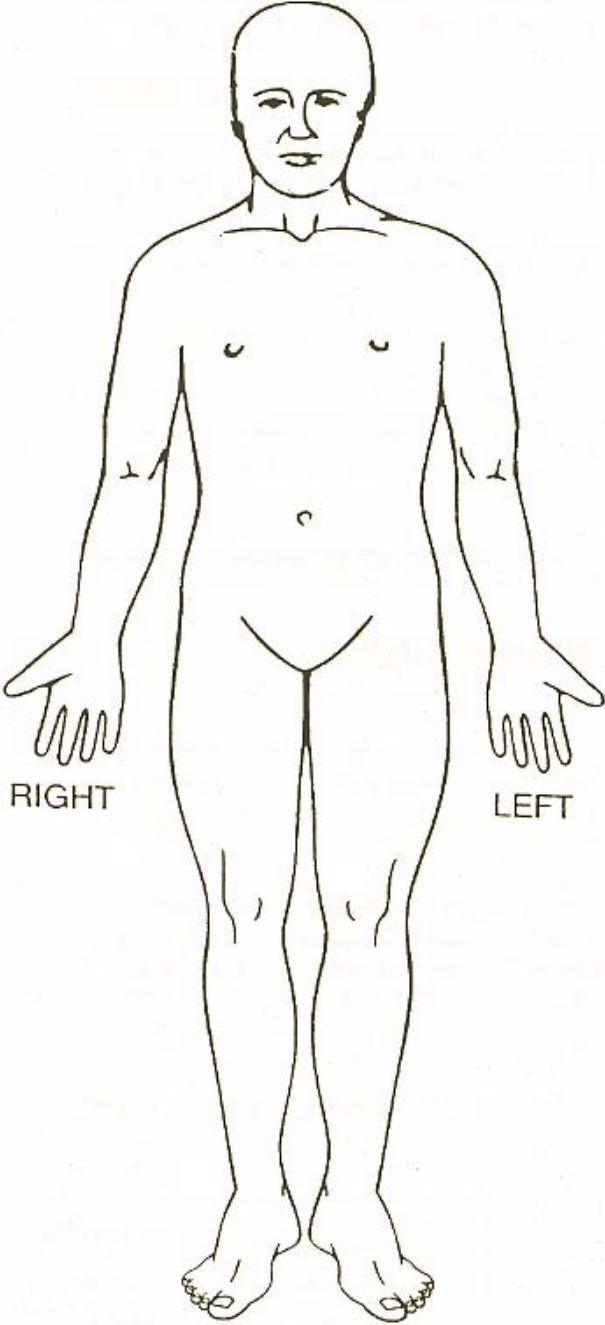
Please fill in the pain drawing. This will help us understand what your pain is like and where it is now.

Using the appropriate symbol, fill in the affected areas.

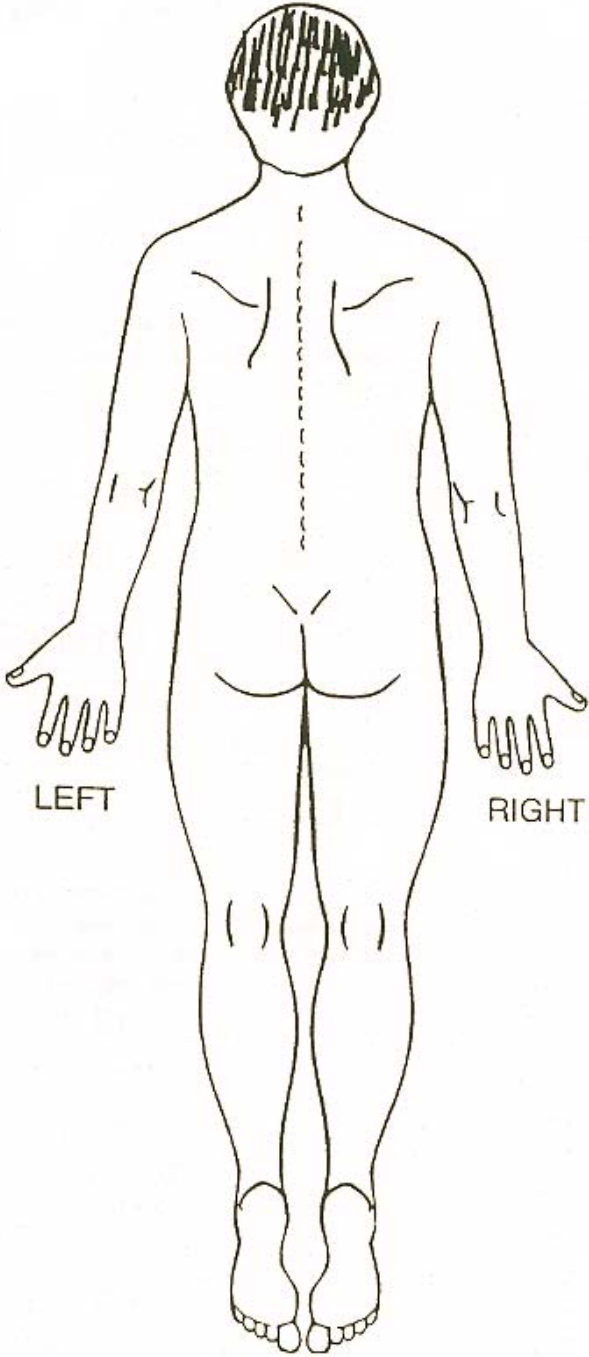
Numbness, tingling, pins/ needles: ooooooo

Pain, aching: xxxxxxxxx

NO PAIN



FRONT



BACK