



Attention - DO NOT enter patient data on this form if the header does not contain preprinted CRISP ID number, clinical center ID, and visit number.

Participant ID: \_\_\_\_\_ pkdid

Clinical Center: \_\_\_\_\_ pccn

visit:

## Quality of Life Questionnaire (SF-36v2 Health Survey)

This survey asks for your views about your health, how you feel and how well you are able to do your usual activities. Answer every question by checking the appropriate response. There are no right or wrong answers. If you are unsure about how to answer a question, please give the best answer you can.

Date of visit <i>dvdate</i>		<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>1. In general, would you say your health is:</b> <i>health</i>											
Excellent	Very Good	Good	Fair	Poor							
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>							
<b>2. Compared to one year ago, how would you rate your health in general now?</b> <i>rthlth</i>											
Much better	Somewhat better	About the same	Somewhat worse	Much worse							
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>							
<b>3. The following questions are about activities you might do during a typical day. <u>Does your health now limit you in these activities?</u> If so, how much?</b>											
			Yes, limited a lot	Yes, limited a little	No, not limited at all						
<b>a. <u>Vigorous activities</u>, such as running, lifting heavy objects, participating in strenuous activities.</b> <i>vgract</i>			1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>						
<b>b. <u>Moderate activities</u>, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf</b> <i>mdract</i>			1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>						
<b>c. Lifting or carrying groceries</b> <i>lccroc</i>			1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>						
<b>d. Climbing <u>several</u> flights of stairs</b> <i>cmstair</i>			1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>						
<b>e. Climbing <u>one</u> flight of stairs</b> <i>csstair</i>			1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>						
<b>f. Bending, kneeling, or stooping</b> <i>bdknstp</i>			1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>						
<b>g. Walking <u>more than a mile</u></b> <i>wlkm1</i>			1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>						
<b>h. Walking <u>several hundred yards</u></b> <i>wlkyd</i>			1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>						



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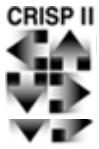
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	Yes, limited a lot	Yes, limited a little	No, not limited at all		
i. Walking <u>one hundred yards</u> <i>wlkoyd</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		
j. Bathing or dressing yourself <i>bthdrs</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		
<b>4. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities as a <u>result of your physical health</u> ?</b>					
	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 <u>amount of time</u> you spent on work or other activities <i>cuttm</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. <u>Accomplished less</u> than you would have liked <i>dolss</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Were limited in the <u>kind of work or other activities</u> <i>lmtknd</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort) <i>dffwrk</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>5. During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities as a <u>result of any emotional problems</u> (such as feeling depressed or anxious)?</b>					
	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down the <u>amount of time</u> you spent on work or other activities <i>ecuttm</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. <u>Accomplished less</u> than you would like <i>edolss</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Did your work or activities <u>less carefully than usual</u> <i>elsscr</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>6. During the <u>past 4 weeks</u>, to what <u>extent</u> has your <u>physical health or emotional problems</u> interfered with your normal social activities with family, friends, neighbors, or groups? <i>extent</i></b>					
Not at all 1 <input type="checkbox"/>	Slightly 2 <input type="checkbox"/>	Moderately 3 <input type="checkbox"/>	Quite a bit 4 <input type="checkbox"/>	Extremely 5 <input type="checkbox"/>	



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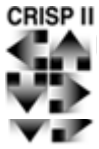
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<b>7. How much <u>bodily</u> pain have you had during the <u>past 4 weeks</u>? <i>pnxtnt</i></b>					
None 1 <input type="checkbox"/>	Very mild 2 <input type="checkbox"/>	Mild 3 <input type="checkbox"/>	Moderate 4 <input type="checkbox"/>	Severe 5 <input type="checkbox"/>	Very severe 6 <input type="checkbox"/>
<b>8. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)? <i>pnintf</i></b>					
Not at all 1 <input type="checkbox"/>	Slightly 2 <input type="checkbox"/>	Moderately 3 <input type="checkbox"/>	Quite a bit 4 <input type="checkbox"/>	Extremely 5 <input type="checkbox"/>	
<b>9. These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling.</b>					
<b>How much of the time during the Past 4 weeks....</b>	All of the time	Most of the time	Some of the time	A little of the time	None of the time
<b>a. Did you feel full of life?</b> <i>flife</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>b. Have you been very nervous?</b> <i>nervs</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>c. Have you felt so down in the dumps that nothing could cheer you up?</b> <i>edown</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>d. Have you felt calm and peaceful?</b> <i>ecalm</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>e. Did you have a lot of energy?</b> <i>fenrgy</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>f. Have you felt downhearted and depressed?</b> <i>edprss</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>g. Did you feel worn out?</b> <i>wrnout</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>h. Have you been happy?</b> <i>ehppy</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>i. Did you feel tired?</b> <i>etred</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>10. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)? <i>sinterf</i></b>					
All of the time 1 <input type="checkbox"/>	Most of the time 2 <input type="checkbox"/>	Some of the time 3 <input type="checkbox"/>	A little of the time 4 <input type="checkbox"/>	None of the time 5 <input type="checkbox"/>	



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11. How TRUE or FALSE is each of the following statements for you?					
	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
<b>a. I seem to get sick a little easier than other people</b> <i>esysck</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>b. I am as healthy as anybody I know</b> <i>hlthy</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>c. I expect my health to get worse</b> <i>hlthwrs</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
<b>d. My health is excellent</b> <i>hlthgd</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

CRISP Member completing this form \_\_\_\_\_  
*cdidnum*

Date Form Completed \_\_\_/\_\_\_/\_\_\_  
*cddate*

Data Entry Status: Please check to indicate that the above information has been entered

Primary Entered by: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
*deidnum* *dedate*

Secondary Entered by: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_