Quality of Well-Being Scale, Self-Administered, QWB-SA, V1.04

DPP FORM Q 11.1

This survey asks about health problems that you have experienced in the last 3 days, not including today. Please answer all questions by filling in the appropriate circle with blue or black ink. Please do not use check marks or use felt tip pens. Thank you.

Today's date: ☐☐ / ☐☐ / ☐☐ (MM / DD / YY)

Part I - Acute and Chronic Symptoms

1. Please indicate whether you currently experience each of the following health symptoms or problems

Do you have....

a. blindness or severely impaired vision in both eyes? Y○ N○
   blindness or severely impaired vision in only one eye? Y○ N○
b. speech problems such as stuttering, or being unable to speak clearly? Y○ N○
c. missing or paralyzed hands, feet, arms, or legs? Y○ N○
   missing or paralyzed fingers or toes? Y○ N○
d. any deformity of the face, fingers, hand or arm, foot or leg, or back (e.g. severe scoliosis)? Y○ N○
e. general fatigue, tiredness, or weakness? Y○ N○
f. a problem with unwanted weight gain or weight loss? Y○ N○
g. a problem with being under or over weight? Y○ N○
h. problems chewing your food adequately? Y○ N○
i. any hearing loss or deafness? Y○ N○
j. any noticeable skin problems, such as bad acne or large burns or scars on face, body, arms, or legs? Y○ N○
k. eczema or burning/itching rash? Y○ N○

Which of the following health aides do you use/have?

dentures? Y○ N○
oxygen tank? Y○ N○
prosthesis? Y○ N○
eye glasses or contact lenses? Y○ N○
hearing aide? Y○ N○
magnifying glass? Y○ N○
neck, back, or leg brace? Y○ N○

2. For the following list of problems indicate which days (if any) over the past 3 days, not including today, you had the problem. If you have not had the symptom in the past 3 days, do not leave the question blank, please fill in "no days." If you have experienced the symptom in the past 3 days, please check which of the days you had it; if you experienced it on more than one of the days, fill in all days that apply.

For example, if you had a headache yesterday and the day before that:
A headache?
○ No Days ● Yesterday ● 2 days ago ○ 3 days ago

Did you have.... (please fill in all days that apply)

a. any problems with your vision not corrected with glasses or contact lenses (such as double vision, distorted vision, flashes, or floaters)?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

b. any eye pain, irritation, discharge, or excessive sensitivity to light?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

c. a headache?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

d. dizziness, earache, or ringing in your ears?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

e. difficulty hearing, or discharge, or bleeding from an ear?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

f. stuffy or runny nose, or bleeding from the nose?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

g. a sore throat, difficulty swallowing, or hoarse voice?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

h. a tooth ache or jaw pain?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

i. sore or bleeding lips, tongue, or gums?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

j. coughing or wheezing?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

k. shortness of breath or difficulty breathing?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

Did you have.... (please fill in all days that apply)

l. chest pain, pressure, palpitations, fast or skipped heart beat, or other discomfort in the chest?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

m. an upset stomach, abdominal pain, nausea, heartburn, or vomiting?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

n. difficulty with bowel movements, diarrhea, constipation, rectal bleeding, black tar-like stools, or any pain or discomfort in the rectal area?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

o. pain, burning, or blood in urine?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

p. loss of bladder control, frequent night-time urination, or difficulty with urination?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

q. genital pain, itching, burning, or abnormal discharge, or pelvic cramping or abnormal bleeding? (does not include normal menstruation)
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

r. a broken arm, wrist, foot, leg, or any other broken bone (other than in the back)?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

s. pain, stiffness, cramps, weakness, or numbness *in the neck or back?*
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

t. pain, stiffness, cramps, weakness, or numbness *in the hips or sides?*
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

u. pain, stiffness, cramps, weakness, or numbness in any *of the joints or muscles of the hand, feet, arms, or legs?*
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

v. swelling of ankles, hands, feet or abdomen?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

w. fever, chills, or sweats?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

x. loss of consciousness, fainting, or seizures?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

y. difficulty with your balance, standing, or walking?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

3. The following symptoms are about your feelings, thoughts, and behaviors. Please fill in which days (if any) over the past 3 days, not including today, you have had ...

a. trouble falling asleep or staying asleep?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

b. spells of feeling nervous or shaky?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

c. spells of feeling upset, downhearted, or blue?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

d. excessive worry or anxiety?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

e. feelings that you had little or no control over events in your life?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

f. feelings of being lonely or isolated?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

g. feelings of frustration, irritation, or close to losing your temper?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

h. a hangover?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

i. any decrease of sexual interest or performance?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

j. confusion, difficulty understanding the written or spoken word, or significant memory loss?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

k. thoughts or images you could not get out of your mind?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

l. to take any medication including over-the-counter remedies (aspirin/tylenol, allergy medications, insulin, hormones, estrogen, thyroid, prednisone)?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

Please continue on other side.

Clinic ☐☐ Participant/ Screening # ☐☐☐☐☐☐

Part I - Acute and Chronic Symptoms (continued)

3. Question 3 continued .....

m. to stay on a medically prescribed diet for health reasons?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

n. a loss of appetite or over-eating?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

4. In the last 3 days did you have any symptoms, health complaints, or pains that have not been mentioned?

○ Yes ○ No

If yes, what were they and on which days did you have them?

Symptoms	Days
A.	
B.	

Part II - Self Care

5. *Over the last 3 days ... (please fill in all days that apply)*

a. did you spend any part of the day or night as a patient in a hospital, nursing home, or rehabilitation center?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

b. because of any impairment or health problem, did you need help with your personal care needs, such as eating, dressing, bathing, or getting around your home?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

Part III - Mobility

6. Over the last 3 days ... (please fill in all days that apply)

a. which days did you drive a motor vehicle?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

b. which days did you use public transportation such as a bus, subway, Medi-van, train, or airplane?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

c. which days did you either not drive a motor vehicle or not use public transportation because of your health, or need help from another person to use?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

Part IV - Physical Activity

7. Over the last 3 days did you ... (please fill in all days that apply)

a. have trouble climbing stairs or inclines or walking off the curb?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

b. avoid walking, have trouble walking, or walk more slowly than other people your age?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

c. limp or use a cane, crutches, or walker?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

d. avoid or have trouble bending over, stooping, or kneeling?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

e. have any trouble lifting or carrying everyday objects such as books, a briefcase, or groceries?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

f. have any other limitations in physical movements?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

g. spend all or most of the day in a bed, chair, or couch because of health reasons?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

h. spend all or most of the day in a wheelchair?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

If in a wheelchair, on which days did someone else control its movement?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

Part V - Usual Activity

8. *Over the last 3 days ... (please fill in all days that apply)*

a. because of any physical or emotional health reasons, on which days did you avoid, need help with, or were limited in doing some of your usual activities, such as work, school or housekeeping?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

b. because of any physical or emotional health reasons, on which days did you avoid or feel limited in doing some of your usual activities, such as visiting family or friends, hobbies, shopping, recreational, or religious activities?
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

c. on which days did you have to change any of your plans or activities because of your health? (Consider only activities that you did not report in the last 2 questions.)
○ No Days ○ Yesterday ○ 2 days ago ○ 3 days ago

If limited, please describe:

9a. Would you say that your health is: **Q9A**
○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

b. Compared to a year ago, how would you rate your health in general now: **Q9B**
○ Much better than a year ago
○ Somewhat better than one year ago
○ About the same as a year ago
○ Somewhat worse than a year ago
○ Much worse than a year ago

c. Think about a scale of 0 to 100, with zero being the least desirable state of health that you could imagine and 100 being perfect health. What number, from 0 to 100 would you give to the state of your health, on average, over the last 3 days? **Q9C**

0	10	20	30	40	50	60	70	80	90	100
○	○	○	○	○	○	○	○	○	○	○

10. Please complete the following questions:

Sex: ○ Male ○ Female

Age: ☐☐

What is your ethnicity?
○ African American
○ Asian Pacific Islander
○ Caucasian - Non Hispanic
○ Hispanic
○ Native American
○ Other

Which of the following best describes your educational background?
○ 8th Grade Graduate
○ High School Graduate
○ Some College
○ College Graduate (B.S. or B.A. degree)
○ Some Graduate School
○ Completed Post-Graduate (M.A., M.D., Ph.D.)

Program Coordinator:

Affix participant label here

Thank you for completing the QWB SA 1.04 Health Status Survey

VISIT

01A	02A	03A	04A	05A
☐	☐	☐	☐	☐

Clinic ■ ☐☐ Participant ☐☐☐☐☐☐ Nickname ☐☐☐☐☐☐

Rand Date ☐☐ ☐☐ ☐☐ (month day year)

Date of Visit ☐☐ ☐☐ ☐☐ (month day year) ■

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