# Falls

**PID:** 0 **Acrostic:** 0
**Date Form Completed:** d_form
**Reviewed by:** compby
**Language:** language
**Visit:**
**Administration Type:** admin

## D. Falls

1. In the past year, how many times did you fall and land on the floor or ground? (Do not include falls due to sports activities such as skiing or horseback riding.)

   fallcnt

   1 none
   2 1 time
   3 2 times
   4 3 or more times
   5 don't know

2. Did you see a doctor (or go to the emergency room) because of these falls?

   seedoc

   1 yes
   2 no
   3 don't know

# MY HEALTH, PART B. ANNUAL

| Patient ID | *[affix ID label here]* | Date Form Completed | / / (Month / Day / Year) |
|---|---|---|---|
| Administration Type | | Visit Code | Reviewed by | Language: E |

## A. Complaints

**Below is a list of complaints people sometime have. For each item, check the one that best describes how bothersome the complaint was for you during the past 4 weeks. Be sure to mark one box for each complaint listed. If you did not have the problem, please check the box under "did not occur." If you had the complaint, use the following key to indicate how bothersome it was:**

**Mild = complaint did not interfere with usual activities.**

**Moderate = complaint interfered somewhat with usual activities.**

**Severe = complaint was so bothersome that usual activities could not be performed**

| | Complaint | Did not occur | Complaint occurred and was: Mild | Moderate | Severe |
|---|---|---|---|---|---|
| 1. | Heartburn (burning sensation in chest or upper abdomen) | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 2. | Regurgitation (the involuntary movement of liquids or foods from the stomach up into the throat) | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 3. | Nausea (feeling sick to your stomach as if you were going to throw up or vomit) | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 4. | Abdominal pain above the navel | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 5. | Vomiting | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 6. | Feeling very full after eating only a little bit of a meal | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 7. | Bloating or distention (your abdomen feels swollen or gassy) | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 8. | Constipation | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 9. | Diarrhea | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

## A. Complaints

| Complaint | Did not occur | Complaint occurred and was: Mild | Moderate | Severe |
|---|---|---|---|---|
| 10. Abdominal pain below the navel | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 11. Leg or arm pain during or following exercise | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 12. Swollen or sore joints during or following exercise | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 13. A pulled or strained muscle, tendon, or ligament during or following exercise | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 14. Sores on your feet that heal poorly | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 15. Swelling of the feet or ankles | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 16. Chest pain/angina/heart pain | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 17. Palpitations/Heart racing/Heart skipping beats | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 18. Shortness of breath with exercise | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 19. Shortness of breath lying down or waking you up at night | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 20. Dizzy or lightheaded when you stand up | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 21. Dizzy or lightheaded anytime | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 22. Worsening of your eyesight | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |
| 23. Numbness or weakness of one arm or leg | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ |

## A. Complaints

24. Have you experienced low blood sugar in the last 3 months?

1 ☐ Yes ➔

| | |
|---|---|
| How many times was your low blood sugar so severe that you had to be in the hospital? | ☐☐ (number of times, "00" if none) |
| How many times was your low blood sugar so severe you had to visit the emergency room, but not be admitted to the hospital? | ☐☐ (number of times, "00" if none) |
| How many times was your low blood sugar so severe that you needed someone to help you (but not ER visit or hospitalization)? | ☐☐ (number of times, "00" if none) |
| How many times have you had low blood sugar in the last 7 days? | ☐☐ (number of times, "00" if none) |

| | | |
|---|---|---|
| Did any of these times occur without symptoms? | 1 ☐ Yes | 2 ☐ No |
| Did any of these times result in injury to yourself or to others? | 1 ☐ Yes | 2 ☐ No |
| Did any of these times occur when you were asleep? | 1 ☐ Yes | 2 ☐ No |

2 ☐ No ➔ Go to Section B, "Knees," next page

25. Was your blood sugar checked during the most severe episode of low blood sugar?

1 ☐ Yes ➔ What was the glucose value? ☐☐☐

2 ☐ No

26. Has your medicine for diabetes been changed as a result of these episodes of low blood sugar?

1 ☐ Yes ➔

2 ☐ No

Who changed your diabetes medicines?

1 ☐ Primary Care Physician

2 ☐ Look AHEAD Personnel

3 ☐ Other

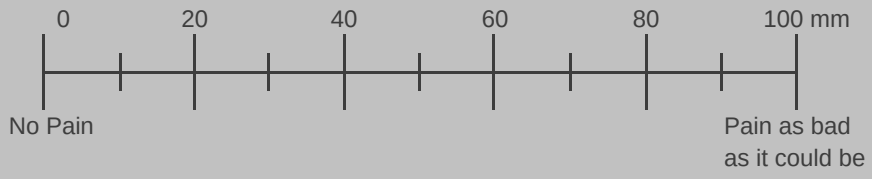
## B. Knees

Have you had any pain or discomfort in your knees in the past month?

1 ☐ Yes ➔ CONTINUE

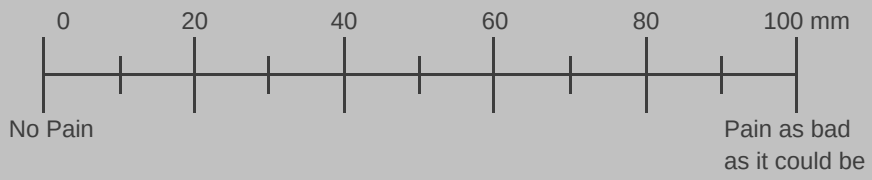
2 ☐ No ➔ Go to Section C, "Urinary History"

1. Please mark an X on the scale for how bad the **pain** in your **right** knee has been in the past 2 weeks.




For office use only: ☐☐☐

2. Please mark an X on the scale for how bad the **pain** in your **left** knee has been in the past 2 weeks.




For office use only: ☐☐☐

**The following questions concern the amount of pain you have experienced in your knee(s). For each situation please enter the amount of pain experienced in the last 2 weeks.**

**QUESTION: How much pain do you have?**

3. Walking on a flat surface.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

4. Going up or down stairs.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

5. At night while in bed.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

6. Sitting or lying.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

7. Standing upright.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

## B. Knees

**The following questions concern the amount of joint stiffness (not pain) you have experienced in the last 2 weeks in your knee(s). Stiffness is a sensation of restriction or slowness in the ease with which you move your joints.**

8. How **severe** is your stiffness **after first wakening** in the morning?

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

9. How **severe** is your stiffness after sitting, lying or resting **later in the day**?

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

**The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last 2 weeks due to arthritis, pain or discomfort in your knee(s).**

**QUESTION: What degree of difficulty do you have?**

10. Descending stairs.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

11. Ascending stairs.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

12. Rising from sitting.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

13. Standing.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

14. Bending to floor.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

15. Walking on flat.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

16. Getting in/out of car.

1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

## B. Knees

17. Going shopping.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

18. Putting on socks/stockings.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

19. Rising from bed.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

20. Taking off socks/stockings.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

21. Lying in bed.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

22. Getting in/out of bath.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

23. Sitting.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

24. Getting on/off toilet.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

25. Heavy domestic duties.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

26. Light domestic duties.
    1 ☐ None 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Extreme

## C. Urinary History

**The following questions are about your urinary or bladder habits. These questions may seem personal or embarrassing, but your answers are important for research on these common health issues.**

1. **In the past 12 months**, have you been told by a doctor that you had an infection of your bladder (urinary tract infection) or kidneys?

   1 ☐ Yes ➔
   a. ☐☐ Number of bladder (urinary tract) infections **in the last year**
   b. ☐☐ Number of kidney infections **in the last year**

   2 ☐ No

   3 ☐ I don't know if it was an infection of my bladder or of my kidneys.

2. In the **past 7 days**, on average, how many times each day have you had **to go to the bathroom to urinate**:

   a. during the day? ☐☐ **times per day**

   b. during the night after going to bed? ☐☐ **times per night**

3. Many people complain that they leak urine or wet themselves accidentally. In the **past 12 months**, have you **leaked even a small amount of urine**? ***(Check one only)***

   1 ☐ None
   2 ☐ Less than once per month
   3 ☐ One or more times per month
   4 ☐ One or more times per week
   5 ☐ Every day

4. Have you leaked even a small amount of urine or wet yourself **in the past 7 days**?

   1 ☐ Yes➔
   2 ☐ No

   In the past 7 days, how many times did you leak urine with . . . **(Mark all that apply)**

   a. ☐ An activity like coughing, sneezing, lifting, or exercise.
   ☐☐ times in the **last week**

   b. ☐ An urge to urinate and couldn't get to the bathroom fast enough.
   ☐☐ times in the **last week**

   c. ☐ Other reasons or don't know.
   ☐☐ times in the **last week**

## D. Falls

1. In the past **year**, how many times did you fall and land on the floor or ground? (Do not include falls due to sports activities such as skiing or horseback riding.)

   Permitted responses:

   1 ☐ None ➔ End of form

   2 ☐ 1 time  3 ☐ 2 times  4 ☐ 3 or more times  5 ☐ Don't know

2. Did you see a doctor (or go to the emergency room) because of these falls?

   Permitted responses:

   1 ☐ Yes  2 ☐ No  3 ☐ Don't know