



Participant ID: _____

Pin # _____

Discovery Site: _____

Clinical Center _____

CRF Date: ____/____/____

Visit #: ____

SF-12 – Health Status Questionnaire®

Participant completes at Baseline, Bi-monthly, Six-month, and Twelve-month contacts.

Your Health and Well Being

This survey asks 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. *Thank you for completing this survey!*

For each of the following questions, please mark an ☒ in the one box that best describes your answer.

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

Excellent	Very good	Good	Fair	Poor
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

2. 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. Moderate activities, such as moving a table,
pushing a vacuum cleaner, bowling, or playing golf.

<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---------------------------------------	---------------------------------------	---------------------------------------

b. Climbing several flights of stairs

<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
---------------------------------------	---------------------------------------	---------------------------------------

3. 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. Accomplished less than you would
like

<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

b. Were limited in the kind of work or
other activities

<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

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 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. Accomplished less than you would
like

<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

b. Did work or other activities less
carefully than usual

<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

5. 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
------------	--------------	------------	-------------	-----------

<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------



Participant ID: _ _ _ _ _

Pin # _ _ _ _ _

Discovery Site: _ _ _

Clinical Center _ _ _

CRF Date: _ _ / _ _ / _ _ _ _

Visit #: _ _ _

SF-12 – Health Status Questionnaire®

Participant completes at Baseline, Bi-monthly, Six-month, and Twelve-month contacts.

6. 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
a. Have you felt calm and peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
b. Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
c. Have you felt downhearted and depressed?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

7. 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
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅