



15366

·Please check any of the following conditions you have or have had in the past.
·If you are unsure, please ask a staff member to assist you in filling out this form.

You may check more than one condition.

Medical Condition History Check this box if you have **no** medical problems no medical problems

- Alcoholism
- Anemia
- Anxiety
- Asthma
- Arthritis - rheumatoid (verified with blood test)
- Arthritis - osteo, degenerative
- Blood Clot Year
- Blood Transfusion Year
- Bowel disease
- Cancer (specify) _____
- Cardiac Arrhythmia (Abnormal heart rate)
- Congestive Heart Failure
- Coronary Artery Disease (Angina)
- Cerebrovascular Disease (Stroke)
- COPD (Chronic Obstructive Pulmonary Disease)
- Diabetes
- Depression
- Fibromyalgia
- GERD
- Gout
- Heart Attack Year
- Hypertension (High Blood Pressure)
- Hypercholesterolemia (Elevated Cholesterol)
- Hypothyroidism
- Kidney Disease
- Liver Disorder - Cirrhosis
- Liver Disorder - Hepatitis
- Lung Disease
- Osteomyelitis
- Parkinson's
- Ulcer Disease
- Other (specify all other) _____

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? Yes No

Ear, Nose, Throat Surgeries

- Deviated Septum
- Sinus Repair
- Tonsillectomy
- Tracheostomy
- Vocal Cord Surgery

Gastrointestinal Surgeries

- Appendectomy
- Cholecystectomy (Gallbladder removed)
- Colon Resection
- Exploratory Laparoscopy
- Hernia
- Femoral Incisional Inguinal Umbilical
- Liver Resection
- Small Bowel Obstruction Repair
- Splenectomy

Gynecologic Surgeries

- Hysterectomy
- Oophorectomy
- Ruptured ectopic
- Laprascopy
- C-Section

Urologic Surgeries

- Bladder Suspension
- Bladder Removed
- Lithotripsy (Stone Machine)
- Prostatectomy (Prostate Removed)
- Vasectomy

General Surgeries

- Breast Biopsy Right Left Bilateral
- Mastectomy Right Left Bilateral
- Thyroid Surgery
- Whipple

Heart (Cardiac) Surgeries

- CABG_ # arteries 1 2 3 4 4+
- Valve Aortic Mitral Tricuspid
- Angioplasty
- Defibrillator
- Pace Maker

Vascular Surgeries

- Bypass Graft - Legs
- Vascular Access
- AAA
- Thoracic Aneurysm

Thoracic Surgeries

- Chest Tube
- Pulmonary
- Pectus

Neurosurgeries

- Brain Tumor Malignant Benign
- Brain Aneurysm
- Chiari Decompression
- Spinal Cord Tumor Malignant Benign
- Epidural Injection
- Abscess
- Stent



15366

Orthopaedic Surgery/ Procedures

Please check any procedures you have had and give the year.

Most Recent Year

Previous Surgery Year

(if same surgery performed more than once)

Broken Bones/Fracture Repair Surgeries

<input type="checkbox"/> Fracture Repair - Finger -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Hand -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Wrist -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Arm -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Elbow -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Shoulder -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Hip/Pelvis -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Femur -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Knee -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Lower Leg -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Ankle/Foot -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Ankle/Foot Surgeries

<input type="checkbox"/> Ankle Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ankle Fusion -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Tendon Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Toe Surgery specify _____ -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Elbow, Wrist, Hand Surgeries

<input type="checkbox"/> Biceps Repair -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Carpal Tunnel Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Ligament Reconstruction -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Hand Tendon Repair -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Nail Bed Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Tennis Elbow Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Trigger Finger Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Wrist Ligament Reconstruction -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Knee Surgeries

<input type="checkbox"/> Knee Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Cartilage surgery/meniscus surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Knee replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ligament reconstruction - ACL -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ligament reconstruction - other -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Hip Surgeries

<input type="checkbox"/> Hip replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> AVN Surgery <input type="radio"/> Core Decompression <input type="radio"/> Fibular Graft -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Shoulder Surgeries

<input type="checkbox"/> Shoulder Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Rotator cuff surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Shoulder replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Shoulder stabilization -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Spine Surgeries

<input type="checkbox"/> Laminectomy -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Anterior Fusion -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Posterior Fusion -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Posterior Discectomy -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Other (List all other surgeries) _____

Drug Allergy and Medication Information

Have you ever had problems with anesthesia? Yes No *If yes, describe* _____

Are you allergic to latex? Yes No

Are you allergic to any medications? Yes No *If yes, please write the name of the drug in the boxes below and check the reaction you experienced. Please write only one drug in each space provided. If you have more than 3 drug allergies list the others in the space provided.*

Specify Drug:

[Grid for drug name]

Describe: shock breathing problems rash nausea other _____

Specify Drug:

[Grid for drug name]

Describe: shock breathing problems rash nausea other _____

Specify Drug:

[Grid for drug name]

Describe: shock breathing problems rash nausea other _____

Please list additional drug allergies here: _____

Please list the medications you are currently taking - Please include prescription and non-prescription medication

Please check any anti-inflammatory medication listed below which you have taken in the past. Please include all prescription, non-prescription and samples

- Advil
- Arthrotec
- Bextra
- Celebrex
- Daypro
- Ibuprofen
- Indocin
- Lodine
- Naprelan
- Naproxen
- Oruval/Orudis
- Tylenol
- Ultram
- Vioxx
- Other (specify) _____

Please check any of the following side effects you experienced while taking any of the above anti-inflammatory medications.

- nausea
- diarrhea
- gastric ulcers
- upset stomach
- vomiting
- other _____

Please check any of the following medications you take on a regular basis.

- Aspirin
- Axid
- Coumadin
- Cytotec
- Heparin
- Maalox
- Mylanta
- Pepcid
- Prevacid
- Prilosec
- Tagamet
- Zantac

Family Medical History

Please check all diseases for which you have a family history:

- Cancer - Breast
- Cancer - Prostate
- Cancer - Other
- Diabetes
- Heart Disease
- Stroke
- Rheumatoid Arthritis
- Arthritis - osteo, degenerative
- Gout
- Lupus

If you know your parents' health history please provide the information below. Otherwise, please leave blank.

Father alive deceased *Age (current age or age deceased)* [] [] [] **Health history**

- cancer
- heart disease
- stroke
- diabetes
- rheumatoid arthritis
- osteoarthritis
- gout
- lupus

Cause of death (if deceased)

[Grid for father's health history]

Mother alive deceased *Age (current age or age deceased)* [] [] [] **Health history**

- cancer
- heart disease
- stroke
- diabetes
- rheumatoid arthritis
- osteoarthritis
- gout
- lupus

Cause of death (if deceased)

[Grid for mother's health history]



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Hand Dominance: Right Left Use both equally**Dash Questionnaire - Hand and Upper Extremity**How would you rate your hand today as a percentage of normal (0% - 100%, with 100% being normal)? %

Instructions: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer **every question** based on your condition during the **past week**. If you did not have the opportunity to perform an activity in the past week, please make your **best guess** as to which response would be the most accurate. It does not matter which hand or arm you use to perform the activity, please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the **past week**.
Circle one response for each line.

	<u>No Difficulty</u>	<u>Mild Difficulty</u>	<u>Moderate Difficulty</u>	<u>Severe Difficulty</u>	<u>Unable to do</u>
Open a tight or new jar.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Write.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Turn a key.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Prepare a meal.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Push open a heavy door.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Place an object on a shelf above your head.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Do heavy household chores (e.g., wash walls, wash floors).	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Garden or do yard work.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Make a bed.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Carry a shopping bag or briefcase.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Carry a heavy object (over 10lbs.).	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Change a lightbulb overhead.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Wash or blow dry your hair.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Wash your back.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Put on a pullover sweater.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Use a knife to cut food.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Recreational activities which require little effort (e.g., card playing, knitting, ect.).	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, ect.).	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, ect.).	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Manage transportation needs (getting from one place to another).	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Sexual activities	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5



15366

SF-12 - Check ONLY ONE answer for each question

Instructions: 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. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

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

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

(#2 and #3) The following items are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

- | | <u>Yes,</u>
Limited
A Lot | <u>Yes,</u>
Limited
A Little | <u>No, Not</u>
Limited
At All |
|--|---------------------------------|------------------------------------|-------------------------------------|
| 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Climbing several flights of stairs | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

(#4 and #5) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 4. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 5. Were limited in the kind of work or other activities | <input type="radio"/> 1 | <input type="radio"/> 2 |

(#6 and #7) During the past 4 weeks, 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)?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 6. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 7. Didn't do work or perform other activities as carefully as usual | <input type="radio"/> 1 | <input type="radio"/> 2 |

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

(#9, #10 and #11) 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

- | | <u>All</u>
of the
<u>time</u> | <u>Most</u>
of the
<u>time</u> | <u>A good</u>
bit of
<u>time</u> | <u>Some</u>
of the
<u>time</u> | <u>A little</u>
of the
<u>time</u> | <u>None</u>
of the
<u>time</u> |
|---|-------------------------------------|--------------------------------------|--|--------------------------------------|--|--------------------------------------|
| 9. Have you felt calm and peaceful? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 10. Did you have a lot of energy? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 11. Have you felt downhearted and blue? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |

12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?

- | <u>All</u>
of the
<u>time</u> | <u>Most</u>
of the
<u>time</u> | <u>Some</u>
of the
<u>time</u> | <u>A little</u>
of the
<u>time</u> | <u>None</u>
of the
<u>time</u> |
|-------------------------------------|--------------------------------------|--------------------------------------|--|--------------------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |

PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW