



SF 36 Communication Partner

ID NUMBER:

FORM CODE:

DATE: 10/09/2017
Version 1.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: / /
Month Day Year

0b. Staff ID:

Instructions: Enter the answer given by the participant for each response. The questions are asked to the communication partner.

“This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can. Please consider your hearing as part of your physical health.”

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

Excellent 1 Very good 2 Good 3 Fair 4 Poor 5

2. Compared to one year ago, how would you rate your health in general now?

- 1= Much better now than one year ago
- 2= Somewhat better now than one year ago
- 3= About the same
- 4= Somewhat worse now than one year ago
- 5= Much worse now than one year ago

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?

| | Yes, limited a lot | Yes, limited a little | No, not limited all |
|--|----------------------------|-----------------------------|----------------------------|
| a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| c. Lifting or carrying groceries | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| d. Climbing several flights of stairs | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| e. Climbing one flight of stairs | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| f. Bending, kneeling, or stooping | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| g. Walking more than a mile | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| h. Walking several blocks | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| i. Walking one block | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| j. Bathing or dressing yourself | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |

4. 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?

- | | Yes | No |
|--|----------------------------|----------------------------|
| a. Cut down the amount of time you spent on work or other activities | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b. Accomplished less than you would like | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| c. Were limited in the kind of work or other activities | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| d. Had difficulty performing the work or other activities (for example, it took extra effort) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

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 any emotional problems (such as feeling depressed or anxious)?

- | | Yes | No |
|--|----------------------------|----------------------------|
| a. Cut down the amount of time you spent on work or other activities | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b. Accomplished less than you would like | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| c. Didn't do work or other activities as carefully as usual | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- 1= Not at all
- 2= Slightly
- 3= Moderately
- 4= Quite a bit
- 5= Extremely

7. How much bodily pain have you had during the past 4 weeks?

- 1= None
- 2= Very mild
- 3= Mild
- 4= Moderate
- 5= Severe
- 6= Very severe

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. 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 | A good bit of the time | Some of the time | A little of the time | None of the time |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Did you feel full of pep? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| b. Have you been a very nervous person? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| c. Have you felt so down in the dumps that nothing could cheer you up? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| d. Have you felt calm and peaceful? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| e. Did you have a lot of energy? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| f. Have you felt downhearted and blue? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| g. Did you feel worn out? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| h. Have you been a happy person? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| i. Did you feel tired? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |

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

- 1= All of the time
- 2= Most of the time
- 3= Some of the time
- 4= A little of the time
- 5= None of the time

11. How TRUE or FALSE is each of the following statements for you.

| | Definitely true | Mostly true | Don't know | Mostly false | Definitely false |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. I seem to get sick a little easier than other people | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| b. I am as healthy as anybody I know | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| c. I expect my health to get worse | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| d. My health is excellent | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |