

Frank R. Noyes, MD	Michelle Andrews, MD	G. James Sammarco, MD
Mark G. Siegel, MD	Marc T. Galloway, MD	V. James Sammarco, MD
Thomas N. Lindenfeld, MD	Samer S. Hasan, MD, PhD	Matthew L. Busam, MD



Cincinnati SportsMedicine and Orthopaedic Center

Health Status Questionnaire

Patient Name _____ Today's Date _____

Dear Patient,

As your partner in health management, we are most interested in understanding your overall health status and the impact of our management on it. The questions below are from a standardized health status questionnaire that has been shown to be most helpful in health management. Please take time to complete each of these questions as accurately as you can.

Thank you.

The Staff at Cincinnati SportsMedicine

Instructions: this survey asks for your views about your health. This information will be summarized in your medical record and will help us keep track of how you feel and how well you are able to do your usual activities. Answer every question by checking the appropriate box. If you are unsure about how to answer a question, please give the best answer you can.

In general, would you say your health is: Excellent Very Good Good Fair Poor

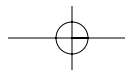
Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago Somewhat better now than one year ago About the same as one year ago
 Much worse than one year ago Somewhat worse than one year ago

The following questions are about activities you might do during a typical day. Does **your health** limit you in these activities? If so, how much? (*only check one box per line*)

Activities:	Yes, limited a lot	Yes, limited a little	No, not limited at all
<i>Vigorous</i> activities such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Moderate</i> activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing <i>several</i> flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing <i>one</i> flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending, kneeling, or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking <i>more than a mile</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking <i>several blocks</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking <i>one block</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing and dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Montgomery 10663 Montgomery Road 513/347-9999 (513) 792-3239 Fax	Tri-County 12115 Sheraton Lane 513/347-9999 (513) 346-7299 Fax	Western Hills 6350 Glenway Ave, Ste 415 513/347-9999 (513) 347-3999 Fax	Mason 7423 Mason-Montgomery Rd 513/347-9999 (513) 573-9178 Fax	Northern Kentucky 328 Thomas More Parkway 859/331-9700 (859) 344-4153 Fax
--	--	---	--	---



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?* (only check one box per line)

	Yes	No
Cut down the <i>amount of time</i> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Were limited to the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
Had <i>difficulty</i> performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>

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)? (only check one box per line)

	Yes	No
Cut down on the <i>amount of time</i> you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
<i>Accomplished less</i> than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Didn't do work or other activities as <i>carefully</i> as usual	<input type="checkbox"/>	<input type="checkbox"/>

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

Not at all
 Slightly
 Moderately
 Quite a bit
 Extremely

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

None
 Very mild
 Mild
 Moderate
 Severe
 Very severe

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

These questions are about how you feel and how things have been with you *during the past month*. For each question, please give the *one* answer that comes closest to the way you have been feeling. (only check one box per line)

How much of the time during the past month...

	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
Did you feel full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt so "down in the dumps" that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your health limited your social activities (like visiting with friends or close relatives)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

