



*If you have an Advanced Directive or living will, please bring a copy to your visit *

1	During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue? <input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely		
2	During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups? <input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely		
3	During the past four weeks, how much bodily pain have you generally had? <input type="checkbox"/> No pain <input type="checkbox"/> Very mild pain <input type="checkbox"/> Mild pain <input type="checkbox"/> Moderate pain <input type="checkbox"/> Severe pain		
4	During the past four weeks, was someone available to help you if needed and wanted help? (For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.) <input type="checkbox"/> Yes, as much as I wanted <input type="checkbox"/> Yes, quite a bit <input type="checkbox"/> Yes, some <input type="checkbox"/> Yes, a little <input type="checkbox"/> No		
5	During the past four weeks, what was the hardest physical activity you could do for at least two minutes? <input type="checkbox"/> Very heavy <input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> Very light		
6	Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?) <input type="checkbox"/> Yes <input type="checkbox"/> No		
7	Can you go shopping for groceries or clothes without someone's help? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8	Can you do your own housework without help? <input type="checkbox"/> Yes <input type="checkbox"/> No	9	Can you prepare your own meals? <input type="checkbox"/> Yes <input type="checkbox"/> No
10	Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11	Can you handle your own money without help? <input type="checkbox"/> Yes <input type="checkbox"/> No		
12	During the past four weeks, how would you rate your health in general? <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
13	Are you having difficulties driving your car? <input type="checkbox"/> Yes, often <input type="checkbox"/> Sometimes <input type="checkbox"/> No <input type="checkbox"/> I don't drive		
14	How often during the past four weeks have you been bothered by : Falling/dizzy when standing up <input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always Sexual problems <input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always Trouble eating well <input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always Teeth or denture problems <input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always Problems using the telephone <input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always Tiredness or fatigue <input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always		
15	Have you fallen two or more times in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	16	Are you afraid of falling? <input type="checkbox"/> Yes <input type="checkbox"/> No
17	Do you exercise for about 20 minutes three or more days a week? <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, some of the time <input type="checkbox"/> No, I usually do not exercise this much		
18	Have you been given, at any point by anyone, information to help you with the following? Hazards in your house that might hurt you? <input type="checkbox"/> Yes <input type="checkbox"/> No Keeping track of your medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19	How often do you have trouble taking medicines the way you have been told to take them? <input type="checkbox"/> I do not have to take medicine <input type="checkbox"/> Sometimes I take them as prescribed <input type="checkbox"/> I always take them as prescribed <input type="checkbox"/> I seldom take them as prescribed		
20	How confident are you that you can control and manage most of your health problems? <input type="checkbox"/> Very confident <input type="checkbox"/> Not very confident <input type="checkbox"/> Somewhat confident <input type="checkbox"/> I do not have any health problems		
21	Are you worried about your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No		