# Cholesterol Drugs* and Adverse Events Study Questionnaire

**---This data will be used for research purposes only. Your personal information will not be released.---**

**Personal profile:**

**Last Name:**_____ **Today's Date:**_____
**First Name:**_____ **Date of Birth:**_____
**Phone:**_____ **Age:**_____
**Address:**_____ **Sex: Male__ Female__**
**City/State/Zip:**_____
_____ **Height:**_____
**E-mail:**_____ **Weight:**_____
**Most recent occupation:**_____
**Currently retired? Yes_____ No_____**
**Highest level of education:**_____

**May we have your permission to contact you in the future?**
**Yes_____ No_____**

**Please indicate one or more answers to each of the questions below using a check mark:**

1. **Relationship Status:**
   **Single__/ Unmarried relationship__/ Married__/ Separated__/ Divorced__**
2. **Ethnicity:**
   **Caucasian__/ Hispanic__/ African American__/ Native American__/ Asian-Pacific Islander__/ Other__**
3. **Where did you hear of us: Magazine/Newspaper__/ Internet__/ Television__/Radio__/Physician/Healthcare Provider__/Friend/Relative__/ Other__ If other, please specify:_____**

**Health History**

4. **Your other medications (including vitamins and over-the-counter medications):**

| **MEDICATION** (e.g. *Vitamin E*) | **DOSAGE** (*200 mg*) | **USAGE PERIOD** (*4/15/92—present*) | **FREQUENCY** (*2/day*) | **TOOK WHILE ON STATINS?** |
|---|---|---|---|---|
| | | | | **Y ___ N___** |
| | | | | **Y ___ N___** |
| | | | | **Y ___ N___** |
| | | | | **Y ___ N___** |
| | | | | **Y ___ N___** |
| | | | | **Y ___ N___** |

*Statins, a class of cholesterol-lowering medications, include: **Lipitor** (atorvastatin), **Zocor** (simvastatin), **Pravachol** (pravastatin), **Mevacor** (lovastatin), **Lescol** (fluvastatin), **Baycol** (cerivastatin), **Crestor** (rosuvastatin). Other cholesterol drugs include, among others: Ezetimibe (**Zetia**); Cholestyramine (**Cholybar, Questran, Questran Light, Prevalite, LoCHOLEST, LoCHOLEST Light)**; Colesevelam **(WelChol)**; Colestipol **(Colestid, Colestid Flavored)**; Gemfibrozil **(Lobid, Lipidil Micro)**; Clofibrate **(Atromid-S)**; Fenofibrate **(Tricor)**; Advicor **(Lovastatin + Niacin)**; Vytorin (**Simvastatin + Ezetimibe**); Caduet (**Atorvastatin + Amlodipine**); Pravigard **(Pravastatin + Buffered Aspirin)**; Omega-3 fatty acid (fish oil: **Promega, Cardio-Omega 3, Sea-Omega, Marine Lipid Concentrate, Super EPA1200).**

**5. <u>Please check all that apply:</u>**

**a. Have you had any of the following conditions: Heart attack__/ Stroke__/ Diabetes__/ Chronic hypertension__/Peripheral artery disease or claudication__**

**b. Have you had any of the following procedures done: Bypass__/ Angioplasty__/ Stent__**

**c. What is your cigarette smoking history? Never smoked__/ Quit smoking__/ Still smoke__**

***If you answered "Never smoked", go on to "5d".***

**i. How many years have you smoked/did you smoke?_____**

**ii. During the years you smoked, what was your average number of cigarettes per day? _____**

**d. Have you ever consumed alcoholic beverages?**

**Yes___ No___**

***If you answered "No", please go on to "5e"***

**i. In an average week *this year*, how many days per week do you drink? ____**

**ii. How many days of last week did you drink? ____**

**iii. During last year, what is the highest number of drinks you drank in a given day?___**

**iv. Have you ever had an alcohol problem? (Including self-perceived problem with alcohol, alcohol treatment, DUI, or alcohol-related legal, work or family problems.)**

**Yes (current) ___ Yes (previously) ___ No___**

**e. Have any first-degree relatives (biological parent/sibling/child) had premature heart disease (heart attack or sudden death) (i.e. men younger than 55/women younger than 65)?**

**Yes___ No___**

**f. Have any first-degree relatives had a history of high blood pressure?**

**Yes_____ No_____**

**g. Have any first-degree relatives had a history of diabetes?**

**Yes_____ No_____**

**6. Blood pressure (if known):**

| **DATE OF MEASUREMENTS** (***e.g. 5/16/03***) | **BLOOD PRESSURE** (e.g. ***125/80***) | **PULSE/HEART RATE** (e.g. ***70 beats/minute***) |
|---|---|---|
| | | |
| | | |
| | | |



**Please go on to next page →**

**7. Cholesterol (chol.) values and drugs used at time of measurement. If possible, please list values and drugs from first drug taken through most recent drug taken, and time after if applicable. Please include values between drugs as well, if these are available. If you do not know exact dates, please give your best estimate of time period (e.g. "for 2 months"). Please use next two pages for additional space.**

| Status of Cholesterol Drug Use | Dose | Date or Duration of Use | Problems on this Drug | Date or Duration of: * Onset of problems, *or* * Resolution of problems after chol. drug use | Other Comments | Date chol. Measured | TC[1] mg/dL | LDL[2] mg/dL | HDL[3] mg/dL | TRG[4] mg/dL |
|---|---|---|---|---|---|---|---|---|---|---|
| ***FOR EXAMPLE:*** | | | | | | | | | | |
| ***Before chol drugs*** | ***N/A*** | ***N/A*** | ***N/A*** | ***N/A*** | | ***12/01/01*** | ***230*** | ***155*** | ***45*** | ***155*** |
| ***FOR EXAMPLE:*** | | | | | | | | | | |
| ***On Lipitor*** | ***10mg*** | ***1/06/02 – 4/18/03 (For~ 15 months)*** | ***Memory Loss*** | ***Onset 4/02/02*** | | ***11/02/02*** | ***180*** | ***120*** | ***56*** | ***154*** |
| ***Switched to Zocor*** | ***20 mg*** | ***4/18/03- 12/04/03*** | ***Muscle Pain*** | ***Onset Muscle Pain ~7/03 Memory loss resolved after two weeks*** | ***Recovered Memory*** | ***08/03/03*** | ***177*** | ***130*** | ***57*** | ***140*** |
| ***Off chol drugs*** | ***N/A*** | ***N/A*** | ***N/A*** | ***Resolved: 4/06/04 (Abated after 2 months Resolved after 4 months)*** | ***Recovered Memory*** | ***6/03/04*** | ***200*** | ***140*** | ***55*** | ***155*** |
| **Status of Cholesterol Drug Use** | **Dose** | **Date or Duration of Use** | **Problems on this Drug** | **Date or Duration of: * Onset of problems, *or* * Resolution of problems after chol. drug use** | **Other Comments** | **Date of Measurement** | **TC[1] mg/dL** | **LDL[2] mg/dL** | **HDL[3] mg/dL** | **TRG[4] mg/dL** |
| Before chol. drugs | N/A | N/A | N/A | N/A | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

[1] TC = Total Cholesterol Level Value (in mg/dL)
[2] LDL = Low-density lipoprotein Cholesterol Level Value (in mg/dL)
[3] HDL = High-density lipoprotein Cholesterol Level Value (in mg/dL)
[4] TRG = Triglyceride Level Value (in mg/dL)



**Please go on to next page →**

**7. Cholesterol (chol.) values and drugs used at time of measurement. If possible, please list values and drugs from first drug taken through most recent drug taken, and time after if applicable. Please include values between drugs as well, if these are available. If you do not know exact dates, please give your best estimate of time period (e.g. "for 2 months"). Please continue to the next page for additional space. (Continued)**

| Status of Cholesterol Drug Use | Dose | Date or Duration of Use | Problems on this Drug | Date or Duration of: * Onset of problems, *or* * Resolution of problems after chol. drug use | Other Comments | Date chol. Measured | TC[1] mg/dL | LDL[2] mg/dL | HDL[3] mg/dL | TRG[4] mg/dL |
|---|---|---|---|---|---|---|---|---|---|---|
| ***FOR EXAMPLE:*** | | | | | | | | | | |
| ***On Lipitor*** | ***10mg*** | ***1/06/02 – 4/18/03 (For~ 15 months)*** | ***Memory Loss*** | ***Onset 4/02/02*** | | ***11/02/02*** | ***180*** | ***120*** | ***56*** | ***154*** |
| ***Switched to Zocor*** | ***20 mg*** | ***4/18/03- 12/04/03*** | ***Muscle Pain*** | ***Onset Muscle Pain ~7/03 Memory loss resolved after two weeks*** | ***Recovered Memory*** | ***08/03/03*** | ***177*** | ***130*** | ***57*** | ***140*** |
| ***Off chol drugs*** | ***N/A*** | ***N/A*** | ***N/A*** | ***Resolved: 4/06/04 (Abated after 2 months Resolved after 4 months)*** | ***Recovered Memory*** | ***6/03/04*** | ***200*** | ***140*** | ***55*** | ***155*** |
| **Status of Cholesterol Drug Use** | **Dose** | **Date or Duration of Use** | **Problems on this Drug** | **Date or Duration of: * Onset of problems, *or* * Resolution of problems after chol. drug use** | **Other Comments** | **Date of Measurement** | **TC[1] mg/dL** | **LDL[2] mg/dL** | **HDL[3] mg/dL** | **TRG[4] mg/dL** |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

[1] TC = Total Cholesterol Level Value (in mg/dL)
[2] LDL = Low-density lipoprotein Cholesterol Level Value (in mg/dL)
[3] HDL = High-density lipoprotein Cholesterol Level Value (in mg/dL)
[4] TRG = Triglyceride Level Value (in mg/dL)



**Please go on to next page →**

**7. Cholesterol (chol.) values and drugs used at time of measurement. If possible, please list values and drugs from first drug taken through most recent drug taken, and time after if applicable. Please include values between drugs as well. If you do not know exact dates, please give your best estimate of time period (e.g. "for 2 months"). If needed, please request for additional formatted sheets from the UCSD Statin Study ((858) 558-4950 x215). (Continued)**

| Status of Cholesterol Drug Use | Dose | Date or Duration of Use | Problems on this Drug | Date or Duration of: * Onset of problems, *or* * Resolution of problems after chol. drug use | Other Comments | Date chol. Measured | TC[1] mg/dL | LDL[2] mg/dL | HDL[3] mg/dL | TRG[4] mg/dL |
|---|---|---|---|---|---|---|---|---|---|---|
| ***FOR EXAMPLE:*** | | | | | | | | | | |
| ***On Lipitor*** | ***10mg*** | ***1/06/02 – 4/18/03 (For~ 15 months)*** | ***Memory Loss*** | ***Onset 4/02/02*** | | ***11/02/02*** | ***180*** | ***120*** | ***56*** | ***154*** |
| ***Switched to Zocor*** | ***20 mg*** | ***4/18/03- 12/04/03*** | ***Muscle Pain*** | ***Onset Muscle Pain ~7/03 Memory loss resolved after two weeks*** | ***Recovered Memory*** | ***08/03/03*** | ***177*** | ***130*** | ***57*** | ***140*** |
| ***Off chol drugs*** | ***N/A*** | ***N/A*** | ***N/A*** | ***Resolved: 4/06/04 (Abated after 2 months Resolved after 4 months)*** | ***Recovered Memory*** | ***6/03/04*** | ***200*** | ***140*** | ***55*** | ***155*** |
| **Status of Cholesterol Drug Use** | **Dose** | **Date or Duration of Use** | **Problems on this Drug** | **Date or Duration of: * Onset of problems, *or* * Resolution of problems after chol.drug use** | **Other Comments** | **Date of Measurement** | **TC[1] mg/dL** | **LDL[2] mg/dL** | **HDL[3] mg/dL** | **TRG[4] mg/dL** |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

[1] TC = Total Cholesterol Level Value (in mg/dL)
[2] LDL = Low-density lipoprotein Cholesterol Level Value (in mg/dL)
[3] HDL = High-density lipoprotein Cholesterol Level Value (in mg/dL)
[4] TRG = Triglyceride Level Value (in mg/dL)



**Please go on to next page →**

**8. SYMPTOMS: Answer yes or no to each of the following symptoms. *Answer 'yes' if you noticed it for the first time while on cholesterol-lowering drugs or if it seemed to worsen while on cholesterol drugs.* Provide additional comments about your symptoms at the end of the questionnaire, if you'd like. For the severity scale, 0=not present, 10=most severe.**

| **SYMPTOM (e.g. *Muscle pain*)** | **PRESENT (Y_x_N__)** | **SEVERITY: Rate 0-10** | **DRUG/ DOSE (*Lipitor/ 10mg*)** | **Lessened off cholesterol drugs? (Y_x_N__)** | **Recurred or worsened with drug reintroduction? Which drug/dose? (*Yes, Pravachol, 20mg*)** |
|---|---|---|---|---|---|
| **Muscle pain** | **Y ___N___** | | | **Y ___N___** | |
| **Leg cramps** | **Y ___N___** | | | **Y ___N___** | |
| **Muscle weakness/muscle fatigue** | **Y ___N___** | | | **Y ___N___** | |
| **Joint pain** | **Y ___N___** | | | **Y ___N___** | |
| **Headache** | **Y ___N___** | | | **Y ___N___** | |
| **Abdominal pain** | **Y ___N___** | | | **Y ___N___** | |
| **Diarrhea** | **Y ___N___** | | | **Y ___N___** | |
| **Abdominal bloating** | **Y ___N___** | | | **Y ___N___** | |
| **Nausea/other stomach problems.** | **Y ___N___** | | | **Y ___N___** | |
| **Attention/concentration problems.** | **Y ___N___** | | | **Y ___N___** | |
| **Memory problems** | **Y ___N___** | | | **Y ___N___** | |
| **Sleep change/sleep probs.** | **Y ___N___** | | | **Y ___N___** | |
| **Depression/hopelessness** | **Y ___N___** | | | **Y ___N___** | |
| **Joylessness** | **Y ___N___** | | | **Y ___N___** | |
| **Anxiety** | **Y ___N___** | | | **Y ___N___** | |
| **Fatigue/lack of energy** | **Y ___N___** | | | **Y ___N___** | |
| **Dizziness** | **Y ___N___** | | | **Y ___N___** | |
| **Impatience** | **Y ___N___** | | | **Y ___N___** | |
| **Irritability** | **Y ___N___** | | | **Y ___N___** | |
| **Reduced social activities** | **Y ___N___** | | | **Y ___N___** | |
| **Loss of interest in activities** | **Y ___N___** | | | **Y ___N___** | |
| **Loss of interest in socializing** | **Y ___N___** | | | **Y ___N___** | |
| **Vaginal dryness/atrophic vaginitis** | **Y ___N___** | | | **Y ___N___** | |
| **Changes in sexual function** | **Y ___N___** | | | **Y ___N___** | |
| **Reduced sexual interest** | **Y ___N___** | | | **Y ___N___** | |
| **Weight increase Amount increase: _____lbs** | **Y ___N___** | | | **Y ___N___** | |
| **Weight decrease Amount decrease: _____lbs** | **Y ___N___** | | | **Y ___N___** | |
| **Shortness of breath** | **Y ___N___** | | | **Y ___N___** | |
| **Rash/sores/skin problems** | **Y ___N___** | | | **Y ___N___** | |
| **Dry skin/dry eyes/dry mouth** | **Y ___N___** | | | **Y ___N___** | |
| **Increased upper resp. infections** | **Y ___N___** | | | **Y ___N___** | |
| **Increased infections, other** | **Y ___N___** | | | **Y ___N___** | |
| **Swelling of extremities** | **Y ___N___** | | | **Y ___N___** | |
| **Hair loss** | **Y ___N___** | | | **Y ___N___** | |
| **Mouth ulcers** | **Y ___N___** | | | **Y ___N___** | |



**Please go on to next page →**

**8. SYMPTOMS (continued): Answer yes or no to each of the following symptoms. *Answer 'yes' if you noticed it for the first time while on cholesterol-lowering drugs or if it seemed to worsen while on cholesterol drugs.* Provide additional comments about your symptoms at the end of the questionnaire, if you'd like. For the severity scale, 0=not present, 10=most severe.**

| SYMPTOM (e.g. *Muscle pain*) | PRESENT (Y_x_N__) | SEVERITY: Rate 0-10 | DRUG/ DOSE (*Lipitor/ 10mg*) | Lessened off cholesterol drug? (Y_x_N__) | Recurred or worsened with drug reintroduction? Which drug/dose? (*Yes, Pravachol, 20mg*) |
|---|---|---|---|---|---|
| Abnormal bleeding (blood in stool, urine, sperm, etc.) | Y ___N___ | | | Y ___N___ | |
| Tremors | Y ___N___ | | | Y ___N___ | |
| Breast enlargement | Y ___N___ | | | Y ___N___ | |
| Ringing in ears | Y ___N___ | | | Y ___N___ | |
| Falls | Y ___N___ | | | Y ___N___ | |
| Vision changes | Y ___N___ | | | Y ___N___ | |
| Chemical sensitivity (unusual sensitivity to smells) | Y ___N___ | | | Y ___N___ | |
| Coordination/balance probs. | Y ___N___ | | | Y ___N___ | |
| Altered temperature regulation (feel hot/cold/have sweats when others don't) | Y ___N___ | | | Y ___N___ | |
| Peripheral neuropathy (numbness, tingling, burning in extremities or elsewhere) | Y ___N___ | | | Y ___N___ | |
| Change in blood glucose: specify_____ | Y ___N___ | | | Y ___N___ | |
| Change in blood pressure: specify_____ | Y ___N___ | | | Y ___N___ | |
| Other physical symptoms: specify_____ | Y ___N___ | | | Y ___N___ | |

**☐ Check here if you have no adverse effects to report**

**Comment on any of the above symptoms:**

**Quality of Life:**

**9. On a scale from 0 to 10 (0=worst, 10=best), please rate your overall health and physical activity *prior* to cholesterol drug use: Health:_____ Physical activity:_____**

**10. On a scale from 0 to 10 (0=worst, 10=best), please rate your overall health and physical activity *during* cholesterol drug use: Health:_____ Physical activity:_____**

**11. On a scale from 0 to 10 (0=worst, 10=best), please rate your overall health and physical activity *after* cholesterol drug use: Health:_____ Physical activity:_____**



**Please go on to next page →**

**12. On a scale from 0 to 10 (0=worst, 10=best), please rate your satisfaction with your overall quality of life before, during, & after cholesterol drug use:**
**Before:_____ During:_____ After:_____**

**13. On a scale from 0 to 10 (0=worst, 10=best), please rate your enthusiasm for doing activities before, during, & after cholesterol drug use:**
**Before:_____ During:_____ After:_____**

**14. On a scale from 0 to 10 (0=worst, 10=best), please rate your level of social activity before, during, & after cholesterol drug use:**
**Before:_____ During:_____ After:_____**

**15. Please mark the scale with an 'X' according to how much your symptom(s) affected your Relationships or activities.**

| | Maximum Possible Worsening | No effect | Maximum Possible Improvement |
|---|---|---|---|
| **a. Family functions:** **(activity and relationship)** | |----------| | |----------| |
| **b. Social relations:** **(activity and relationship)** | |----------| | |----------| |
| **c. Work function:** | |----------| | |----------| |
| **d. Household function:** | |----------| | |----------| |
| **e. Recreational activities:** | |----------| | |----------| |
| **f. Emotional state/mood:** | |----------| | |----------| |
| **g. Energy:** | |----------| | |----------| |
| **h. Sleep:** **(can refer to affects on quality, quantity, or restfulness of sleep)** | |----------| | |----------| |
| **i. Overall quality of life:** | |----------| | |----------| |

**16. Would you say you feel older or younger than your stated age?**
**a. Before cholesterol drug use: Younger__/ Same__/ Older__**
**b. On cholesterol drug use: Younger__/ Same__/ Older__**
**c. After cholesterol drug use: Younger__/ Same__/ Older__**
**Comments:**

**17. Did you talk to your doctor about any of your symptoms?**
**Yes____ No____**



**Please go on to next page →**

**18. Did you or your doctor bring up the possibility of a link between your cholesterol drug usage and symptoms?**
**Yes____ No____ If yes, who brought it up? You did____ Your doctor did____**
**Comments:**

**19. If cholesterol drugs were discussed in relation to your symptoms, what was your doctor's approach to the possible link between cholesterol drug and your symptoms?**
**Endorsed/Supported_____ Dismissed_____ Was Neutral_____**

**20. Did other people comment on changes in your personality or mental or physical abilities while you took cholesterol drugs?**
**If so, please describe:**

**20. Are there other factors that might have contributed to your health problems?**
**If so, please describe:**


**Please go on to next page →**

## 22. ADDITIONAL COMMENTS

***This part of the questionnaire is very important, and provide the opportunity to add any additional comments about your experience or how it affected you. Include <u>any</u> detail you think may be relevant. We are interested in all you would like to share with us. Please use the additional space provided to attach additional pages if needed. We <u>sincerely</u> thank you for your time and effort.***

**Please send this questionnaire and the consent form to:**
**University of California, San Diego**
**Statin Study**
**9500 Gilman Drive 0995**
**La Jolla, CA 92093-0995**



**End. Thank you.**

## SF36 Health Survey

**INSTRUCTIONS:** This set of questions 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. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

- Excellent ☐
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

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

3. 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? **(Please circle one number on each line.)**

| | **Activities** | **Yes, Limited A Lot** | **Yes, Limited A Little** | **Not Limited At All** |
|---|---|---|---|---|
| 3(a) | **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports | 1 | 2 | 3 |
| 3(b) | **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | 1 | 2 | 3 |
| 3(c) | Lifting or carrying groceries | 1 | 2 | 3 |
| 3(d) | Climbing **several** flights of stairs | 1 | 2 | 3 |
| 3(e) | Climbing **one** flight of stairs | 1 | 2 | 3 |
| 3(f) | Bending, kneeling, or stooping | 1 | 2 | 3 |
| 3(g) | Waling **more than a mile** | 1 | 2 | 3 |
| 3(h) | Walking **several blocks** | 1 | 2 | 3 |
| 3(i) | Walking **one block** | 1 | 2 | 3 |
| 3(j) | Bathing or dressing yourself | 1 | 2 | 3 |

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?

| | **(Please circle one number on each line.)** | **Yes** | **No** |
|---|---|---|---|
| 4(a) | Cut down on the **amount of time** you spent on work or other activities | 1 | 2 |
| 4(b) | Accomplished less than you would like | 1 | 2 |
| 4(c) | Were **limited** in the **kind** of work or other activities | 1 | 2 |
| 4(d) | Had **difficulty** performing the work or other activities (for example, it took extra effort) | 1 | 2 |

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 (e.g. feeling depressed or anxious)?

| | **(Please circle one number on each line.)** | **Yes** | **No** |
|---|---|---|---|
| 5(a) | Cut down on the **amount of time** you spent on work or other activities | 1 | 2 |
| 5(b) | Accomplished less than you would like | 1 | 2 |
| 5(c) | Didn't do work or other activities as **carefully** as usual | 1 | 2 |

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, neighbours, or groups? (Please tick **one** box.)

- Not at all ☐
- Slightly ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

- None ☐
- Very mild ☐
- Mild ☐
- Moderate ☐
- Severe ☐
- 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)? (Please tick **one** box.)

- Not at all ☐
- A little bit ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

| | **(Please circle one number on each line.)** | **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** |
|---|---|---|---|---|---|---|---|
| 9(a) | Did you feel full of life? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(b) | Have you been a very nervous person? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(c) | Have you felt so down in the dumps that nothing could cheer you up? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(d) | Have you felt calm and peaceful? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(e) | Did you have a lot of energy? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(f) | Have you felt downhearted and blue? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(g) | Did you feel worn out? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(h) | Have you been a happy person? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(i) | Did you feel tired? | 1 | 2 | 3 | 4 | 5 | 6 |

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.) (Please tick **one** box.)

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

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

| | **(Please circle one number on each line.)** | **Definitely True** | **Mostly True** | **Don't Know** | **Mostly False** | **Definitely False** |
|---|---|---|---|---|---|---|
| 11(a) | I seem to get sick a little easier than other people | 1 | 2 | 3 | 4 | 5 |
| 11(b) | I am as healthy as anybody I know | 1 | 2 | 3 | 4 | 5 |
| 11(c) | I expect my health to get worse | 1 | 2 | 3 | 4 | 5 |
| 11(d) | My health is excellent | 1 | 2 | 3 | 4 | 5 |

**Thank You!**