

**LEAVE
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DATE _____

ID _____

WSID _____

WSTYP _____

DOB _____

SEX _____

DIAB2 _____

DIAB1 _____

ASTH _____

COPD _____

LUNG _____

HTN _____

HEART _____

ARTH _____

CANC _____

DEPR _____

MH _____

O1 _____

O2 _____

O3 _____

MAR _____

HISP _____

RACE _____

Name _____

Address _____

City, state, zip _____

Telephone: day _____ Date of Birth _____

eve _____ Sex (circle) Female Male

Email _____

Background

1. Please indicate below which chronic condition(s) you have (*check all that apply*)

- None
- Type 2 diabetes/high blood sugar
- Type 1 diabetes/high blood sugar
- Asthma
- Chronic bronchitis, emphysema or COPD
- Other lung disease *describe* _____
- High blood pressure
- Heart disease *describe*: _____
- Arthritis or other rheumatic disease *describe*: _____
- Cancer *describe*: _____
- Depression
- Anxiety or other emotional/mental health condition
- Other chronic condition *describe*: _____

2. Are you currently married, or living as married?

- No
- Yes

3. Are you Hispanic/Latino?

- No
- Yes

4. What is your race?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Two or more races
- Other *describe*: _____

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5. Please circle the **highest** year of school completed:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23+
(primary) (high school) (college/university) (graduate school)

EDU

6. What type of health insurance do you currently have? (check all that apply)

None

Medicare

Medicaid (provided by government for low income individuals)

SSI (federal disability benefits)

Veterans benefits

Private insurance (through employer or purchased)

Other describe: _____

INS1

INS2

INS3

INS4

INS5

TAW

General Health

1. In general, would you say your health is: (circle one)

Excellent 1

Very good..... 2

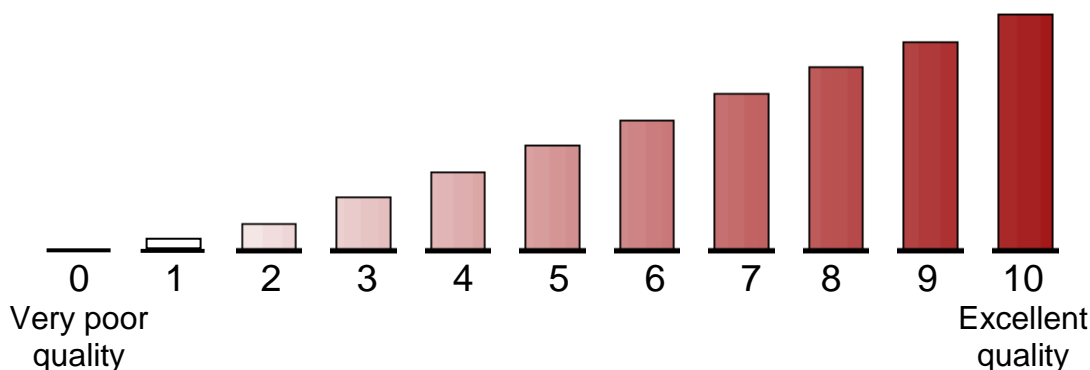
Good 3

Fair..... 4

Poor 5

GH

2. How would you rate your overall **quality of life**? Please circle the number below that describes your **quality of life** in the **past week**:



VNSQOL

Daily Activities

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During the **past week**, how much...

(circle ONE)

- | | Not
at all | Slightly | Moder-
ately | Quite
a bit | Almost
totally |
|---|---------------|----------|-----------------|----------------|-------------------|
| 1. Has your health interfered with your normal activities with family, friends, neighbors or groups?..... | 0 | 1 | 2 | 3 | 4 |
| 2. Has your health interfered with your hobbies or recreational activities? | 0 | 1 | 2 | 3 | 4 |
| 3. Has your health interfered with your household chores? | 0 | 1 | 2 | 3 | 4 |
| 4. Has your health interfered with your errands and shopping?..... | 0 | 1 | 2 | 3 | 4 |

DA1 _____

DA2 _____

DA3 _____

DA4 _____

Physical Activity

During the past week, even if it was not a typical week for you, how much **total** time (for the **entire week**) did you spend on each of the following? *(Please circle one number for each question.)*

- | | None | Less than
30 min/wk | 30-60
min/wk | 1-3 hrs
/week | More than
3 hrs/wk |
|--|------|------------------------|-----------------|------------------|-----------------------|
| 1. Stretching or strengthening exercises (range of motion, using weights, etc.)..... | 0 | 1 | 2 | 3 | 4 |
| 2. Walk for exercise..... | 0 | 1 | 2 | 3 | 4 |
| 3. Swimming or aquatic exercise..... | 0 | 1 | 2 | 3 | 4 |
| 4. Bicycling (including stationary exercise bikes) | 0 | 1 | 2 | 3 | 4 |
| 5. Other aerobic exercise equipment (Stairmaster, rowing, skiing machine, etc.)..... | 0 | 1 | 2 | 3 | 4 |
| 6. Other aerobic exercise | 0 | 1 | 2 | 3 | 4 |

STR _____

WALK _____

AQUA _____

CYCL _____

EQUIP _____

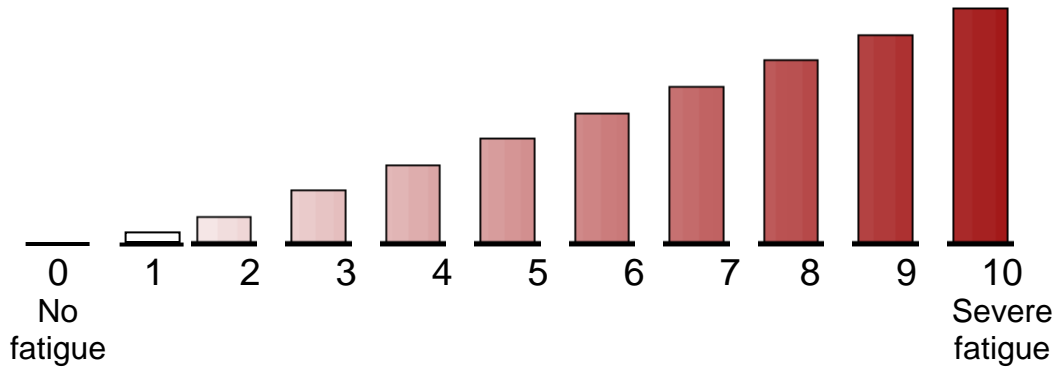
OAER _____

Describe other _____

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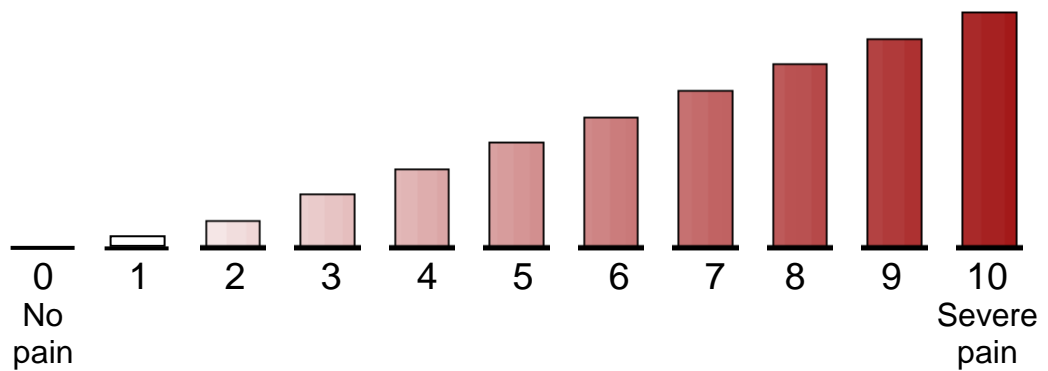
Symptoms

1. We are interested in learning whether or not you are affected by fatigue. Please **circle** the number below that describes your **fatigue** in the **past week**:



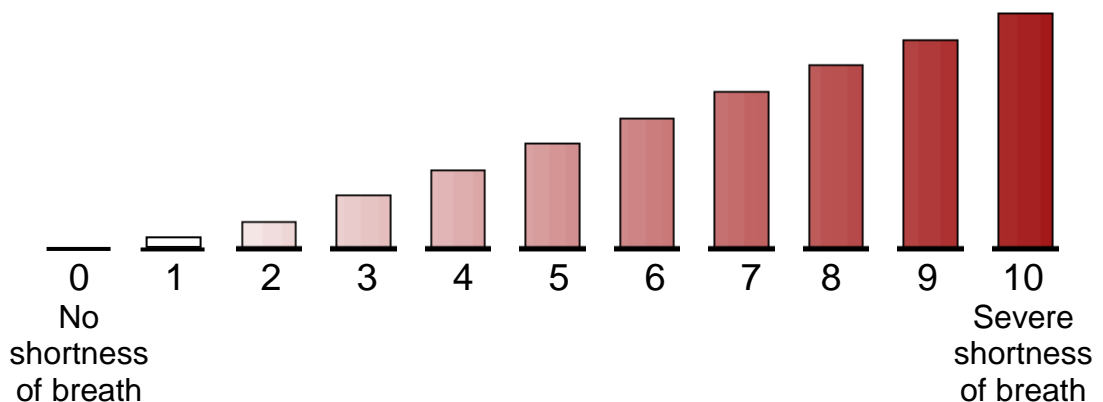
VNSFAT

2. We are interested in learning whether or not you are affected by pain. Please **circle** the number below that describes your **pain** in the **past week**:



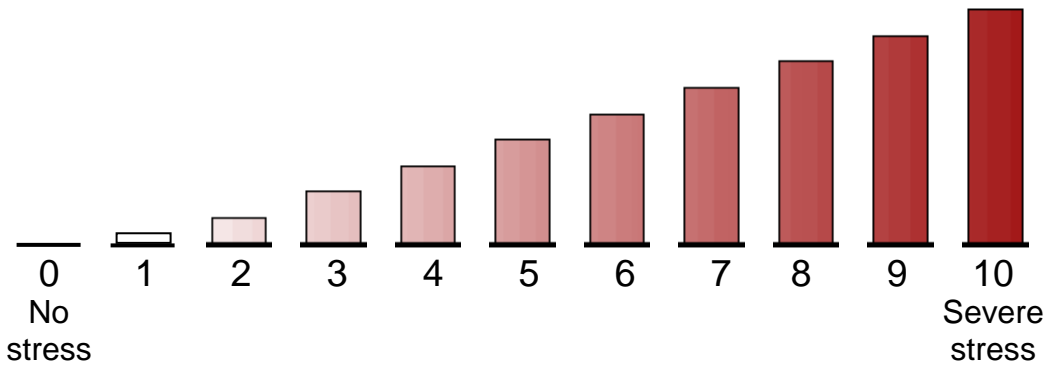
VNSPAIN

3. We are interested in learning whether or not you are affected by shortness of breath. Please **circle** the number below that describes your **shortness of breath** in the **past week**:



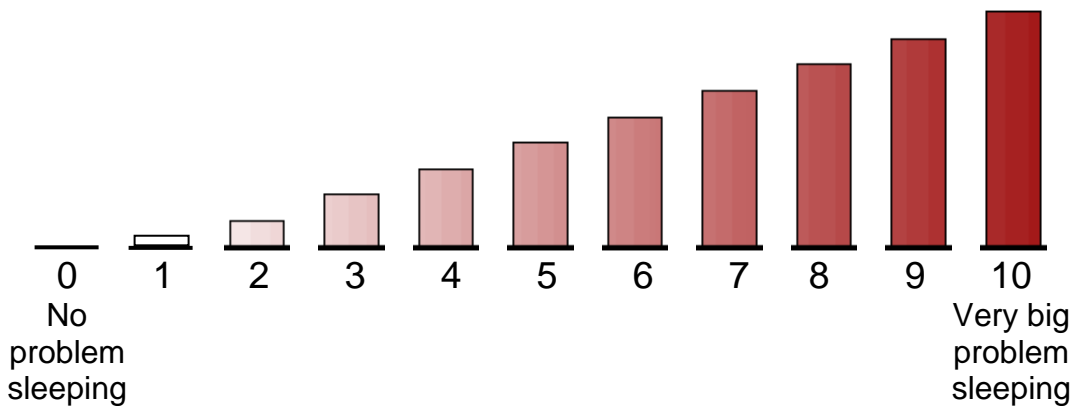
VNSSOB

4. We are interested in learning whether or not you are affected by stress. Please **circle** the number below that describes your **stress** in the **past week**:



VNSSTRS

5. We are interested in learning whether or not you are affected by sleep problems. Please **circle** the number below that describes your **sleep** in the **past week**:



VNSSLP

Recent Health

- Thinking about your **physical** health, which includes physical illness and injury, for how many days during the past **month** was your **physical** health **not** good? _____ days in the month NOT good
- Thinking about your **mental** health, which included stress, depression, and problems with emotions, for how many days during the past **month** was your **mental** health **not** good? _____ days in the month NOT good
- During the **past month**, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? _____ days in the month

HDAY1

HDAY2

HDAY3

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Physical Activities

1. During the past week, other than your regular job, did you participate in any physical activity or exercises, such as brisk walking for exercise, running, dancing, biking, water exercise, etc.? No Yes
2. How many **days** in the past week were you physically active or exercising for at least 30 minutes, such as brisk walking, running, dancing, bicycling, water exercise, etc., that may cause faster breathing or heartbeat, or feeling warmer (it does not have to be all at one time)?..... _____ days / past week
3. How many **TOTAL minutes** in the entire last week were you physically active or exercising at the same level as described above (it does not have to be all at one time)?..... _____ minutes / past week
4. How many **days** in the past week did you do **stretching or strengthening** exercises, such as range of motion, using weights/resistance, yoga, tai chi, Pilates, etc.?..... _____ days / past week

Medical Forms

Circle *one* number:

- | | Extremely | Quite a bit | Some-what | A little bit | Not at all |
|---|-----------|-------------|-----------|--------------|------------|
| 1. How confident are you filling out medical forms by yourself? | 4 | 3 | 2 | 1 | 0 |

_____EX1

_____EX2

_____EX3

_____EX4

_____HL

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Feelings

How much time during the **past week**...

**Not
at all**

**Several
days**

**More than
half
the days**

**Nearly
every
day**

1. Were you bothered by little interest
or pleasure in doing things?0 12..... 3

PHQ1_____

2. Were you bothered by feeling down,
depressed, or hopeless?0 12..... 3

PHQ2_____

3. Were you bothered by trouble falling/
staying asleep, sleeping too much?0 12..... 3

PHQ3_____

4. Were you bothered by feeling tired or
having little energy?0 12..... 3

PHQ4_____

5. Were you bothered by poor appetite
or overeating?0 12..... 3

PHQ5_____

6. Were you bothered by feeling bad
about yourself – or that you are a
failure or have let yourself or
your family down?0 12..... 3

PHQ6_____

7. Were you bothered by trouble
concentrating on things, such as
reading the newspaper or
watching television?0 12..... 3

PHQ7_____

8. Were you bothered by moving or
speaking so slowly that other
people could have noticed -
or the opposite – being so fidgety
or restless that you have been
moving around a lot more than usual?0 12..... 3

PHQ8_____

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Medical Care

1. When you **visit your doctor**, how often do you do the following (*please circle one number for each question*):

Never Almost never Some-times Fairly often Very often Always

a. Prepare a list of questions for your doctor..... 0 1 2 3 4 5

b. Ask questions about the things you want to know and things you don't understand about your treatment..... 0 1 2 3 4 5

c. Discuss any personal problems that may be related to your illness..... 0 1 2 3 4 5

2. **In the past 6 months**, how many times did you visit a physician? *Do not include visits while in the hospital or the hospital emergency department*..... _____ visits

3. **In the past 6 months**, how many times did you go to a **hospital** emergency department?..... _____ times

4. **In the past 6 months**, how many TIMES were you hospitalized for one night or longer? _____ times

5. How many total NIGHTS did you spend in the hospital **in the past 6 months**? _____ nights

Thank you!

_____DOC1

_____DOC2

_____DOC3

_____MD

_____ER

_____HT

_____HN

_____CALLED

_____CODED

_____CHECKED

_____ENTERED

_____VERIFIED

_____ACCESS