SAMPLE QUESTIONNAIRE

CHRONIC DISEASE

August 2007

You may use all or parts of the questionnaire at no charge without permission

Stanford Patient Education Research Center
1000 Welch Road, Suite 204
Palo Alto CA 94304
(650) 723-7935 voice • (650) 725-9422 fax
http://patienteducation.stanford.edu
self-management@stanford.edu
Name: _______________________________  Today's date: _______________

Address: __________________________________________________________

City, state, zip: ______________________________________________________

Telephone: home (___) _____ - ____________  Date of birth: ______________

work (___) _____ - ____________  Sex (circle):  Female  Male

### Background

1. Ethnic origin (check only one):
   - [ ] White not Hispanic
   - [ ] Black not Hispanic
   - [ ] Hispanic
   - [ ] Asian or Pacific Islander
   - [ ] Filipino
   - [ ] American Indian/Alaskan Native
   - [ ] Other: __________________________

2. 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+
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(primary)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(high school)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(college/university)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(graduate school)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Are you currently (check only one):
   - [ ] Married
   - [ ] Single
   - [ ] Separated
   - [ ] Divorced
   - [ ] Widowed

4. Please indicate below which chronic condition(s) you have:
   - [ ] Diabetes
   - [ ] Asthma
   - [ ] Emphysema or COPD
   - [ ] Other lung disease  Type of lung disease: __________________________
   - [ ] Heart disease  Type of heart disease: ________________________________
   - [ ] Arthritis or other rheumatic disease  Specify type: ____________________
   - [ ] Cancer  Type of cancer: ____________________________________________
   - [ ] Other chronic condition  Specify: ____________________________________
General Health

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

   (Circle one)
   
   Excellent ..................................1
   Very good...................................2
   Good........................................3
   Fair.........................................4
   Poor...........................................5

Symptoms

How much time during the **past 2 weeks**...

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A good bit of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
</table>

1. Were you discouraged by your health problems? ..............................0 1 2 3 4 5

2. Were you fearful about your future health? ..........................................0 1 2 3 4 5

3. Was your health a worry in your life? ..................................................0 1 2 3 4 5

4. Were you frustrated by your health problems? ......................................0 1 2 3 4 5
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 2 weeks:

2. 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 2 weeks:

3. 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 2 weeks.
**Physical Activities**

**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.)*

<table>
<thead>
<tr>
<th>Activity</th>
<th>none</th>
<th>less than 30 min/wk</th>
<th>30-60 min/week</th>
<th>1-3 hrs per week</th>
<th>more than 3 hrs/wk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stretching or strengthening exercises <em>(range of motion, using weights, etc.)</em></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Walk for exercise</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Swimming or aquatic exercise</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Bicycling <em>(including stationary exercise bikes)</em></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Other aerobic exercise equipment <em>(Stairmaster, rowing, skiing machine, etc.)</em></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Other aerobic exercise</td>
<td>Specify</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Confidence About Doing Things**

For each of the following questions, please circle the number that corresponds with your confidence that you can do the tasks regularly at the present time.

**How confident are you that you can...**

1. Keep the fatigue caused by your disease from interfering with the things you want to do?
   - not at all confident
   - totally confident

2. Keep the physical discomfort or pain of your disease from interfering with the things you want to do?
   - not at all confident
   - totally confident

3. Keep the emotional distress caused by your disease from interfering with the things you want to do?
   - not at all confident
   - totally confident

4. Keep any other symptoms or health problems you have from interfering with the things you want to do?
   - not at all confident
   - totally confident
How confident are you that you can...

5. Do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?  
   [Scale: not at all | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | totally confident]

6. Do things other than just taking medication to reduce how much your illness affects your everyday life?  
   [Scale: not at all | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | totally confident]

### Daily Activities

During the **past 2 weeks**, how much...  

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Almost totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your health interfered</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>with your normal social</td>
<td>activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>activities with family,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>friends, neighbors or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>groups?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your health interfered</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>with your hobbies or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>recreational activities?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your health interfered</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>with your household chores?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your health interfered</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>with your errands and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>shopping?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Almost never</th>
<th>Sometimes</th>
<th>Fairly often</th>
<th>Very often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Prepare a list of questions for your doctor</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Ask questions about the things you want to know and things you don’t understand about your treatment</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Discuss any personal problems that may be related to your illness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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
   a. How many total NIGHTS did you spend in the hospital in the past 6 months?...__________________________________________ nights
   b. Were any of these hospitalizations at a skilled nursing facility, convalescent hospital, or other minimum care facility? (circle) Yes No

Thank you for your help!