

SF-36 Health Survey (part 1)
(Patient to Complete)

Name _____ Hospital # _____

Joint _____ Side _____ Date _____

1. In general, would you say your health is ____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

2. Compared to 1 year ago, how would you rate your health in general now?

- ____ Much better now than 1 year ago
- ____ Somewhat better now than 1 year ago
- ____ About the same
- ____ Somewhat worse than 1 year ago
- ____ Much worse now than 1 year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

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

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?

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

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 (such as feeling depressed or anxious)?

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

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, neighbors, or groups?

- Not at all Slightly Moderately Quite a bit Extremely

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

- 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)?

- Not at all Slightly 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. For each question, please give the one answer that comes closest to the way you have been feeling.

		None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
a. Did you feel full of pep?	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you been a very nervous person?	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt so down in the dumps nothing could cheer you up?	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you felt calm and peaceful?	d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Did you have a lot of energy?	e.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you felt downhearted and blue?	f.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Do you feel worn out?	g.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you been a happy person?	h.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Did you feel tired?	i.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.)?

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

11. How true or false is each of the following statements for you?

		Definitely true	Mostly true	Mostly false	Definitely false	Not sure
a. I seem to get sick a little easier than other people.	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I am as healthy as anybody I know.	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I expect my health to get worse.	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My health is excellent	d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How severe is your pain? Place a vertical mark on the line below to indicate how bad your pain is today.

NO PAIN _____ VERY SEVERE PAIN