

General Patient History

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42632

Medical Record Number

Grid for Medical Record Number

Date of Visit

Grid for Date of Visit

First Name

Grid for First Name

Middle

Grid for Middle

Last Name

Grid for Last Name

Suffix Sr. Jr. III IV M.D. PhD

Date of Birth

Grid for Date of Birth with labels: month, day, year (4 digit ex. 1922)

Gender

Female Male

Race

African American Asian Caucasian Hispanic Native American Other _____

Marital Status

Single Married Living with significant other Divorced Separated Widowed

Location of Injury or Problem; Reason for visit (example: left knee, right shoulder)

Grid for Location of Injury or Problem

Please describe your current problem (If you are seeing the doctor for multiple problems, answer for the most severe)

- New Injury or problem (less than 6 weeks duration)
 Subacute problem (began slowly with no identifiable cause and progressively worsened)
 Chronic problem (problem has been present over time period of more than 3 months and never been restored to normal)
 Re-injury (you injured this same area before, received treatment, had no problems until this new injury occurred)

Date problem began (approximate if unsure)

Grid for Date problem began

Date of re-injury

Grid for Date of re-injury

Is your problem a result of an injury? Yes No

ANSWER THE QUESTIONS IN THIS BOX ONLY IF YOUR PROBLEM IS THE RESULT OF AN INJURY

If your problem is the result of an injury, where did it occur? (check one answer only)

Home Work Motor vehicle accident Exercise Sport Competition Other (specify) _____

What caused your injury?

- Fall Fighting
 Lifting Twisting
 Throwing Collision/Contact
 Reaching Other (specify) _____
 Pulling

Check any of the following that happened at the time of your injury

Felt pain Heard popping Had swelling Dislocation Fracture Other (specify) _____

Have you talked to a lawyer about today's problem? Yes No

Are you receiving or have you applied for workers compensation concerning your injury? Yes No

Have you received previous treatment for your current problem? Yes No

If yes, please specify treatment type (check all that apply) and provide the # of the procedures or weeks of physical therapy you have had for the specific problem you are seeing the doctor for today

- ER Visit chiropractic
 oral medicine massage therapy
 physical therapy # of weeks [] [] acupuncture
 surgical # of surgeries [] [] other _____
 injections # of injections [] [] (specify)

Please tell us your height and weight

Height

Grid for Height in feet and inches

Weight

Grid for Weight in pounds



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·Please check any of the following conditions you have or have had in the past.
·If you are unsure, please ask a staff member to assist you in filling out this form.

You may check more than one condition.

Medical Condition History Check this box if you have **no** medical problems no medical problems

- Alcoholism
- Anemia
- Anxiety
- Asthma
- Arthritis - rheumatoid (verified with blood test)
- Arthritis - osteo, degenerative
- Blood Clot Year
- Blood Transfusion Year
- Bowel disease
- Cancer (specify) _____
- Cardiac Arrhythmia (Abnormal heart rate)
- Congestive Heart Failure
- Coronary Artery Disease (Angina)
- Cerebrovascular Disease (Stroke)
- COPD (Chronic Obstructive Pulmonary Disease)
- Diabetes
- Depression
- Fibromyalgia
- GERD
- Gout
- Heart Attack Year
- Hypertension (High Blood Pressure)
- Hypercholesterolemia (Elevated Cholesterol)
- Hypothyroidism
- Kidney Disease
- Liver Disorder - Cirrhosis
- Liver Disorder - Hepatitis
- Lung Disease
- Osteomyelitis
- Parkinson's
- Ulcer Disease
- Other (specify all other) _____

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? Yes No

Year
Ear, Nose, Throat Surgeries
<input type="checkbox"/> Deviated Septum
<input type="checkbox"/> Sinus Repair
<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Tracheostomy
<input type="checkbox"/> Vocal Cord Surgery

Gastrointestinal Surgeries
<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Cholecystectomy (Gallbladder removed)
<input type="checkbox"/> Colon Resection
<input type="checkbox"/> Exploratory Laparoscopy
<input type="checkbox"/> Hernia <input type="radio"/> Femoral <input type="radio"/> Incisional <input type="radio"/> Inguinal <input type="radio"/> Umbilical
<input type="checkbox"/> Liver Resection
<input type="checkbox"/> Small Bowel Obstruction Repair
<input type="checkbox"/> Splenectomy

Gynecologic Surgeries
<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Oophorectomy
<input type="checkbox"/> Ruptured ectopic
<input type="checkbox"/> Laparoscopy
<input type="checkbox"/> C-Section

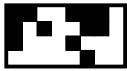
Urologic Surgeries
<input type="checkbox"/> Bladder Suspension
<input type="checkbox"/> Bladder Removed
<input type="checkbox"/> Lithotripsy (Stone Machine)
<input type="checkbox"/> Prostatectomy (Prostate Removed)
<input type="checkbox"/> Vasectomy

Year
General Surgeries
<input type="checkbox"/> Breast Biopsy <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral
<input type="checkbox"/> Mastectomy <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral
<input type="checkbox"/> Thyroid Surgery
<input type="checkbox"/> Whipple

Heart (Cardiac) Surgeries
<input type="checkbox"/> CABG # arteries <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 4+
<input type="checkbox"/> Valve <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral <input type="checkbox"/> Tricuspid
<input type="checkbox"/> Angioplasty
<input type="checkbox"/> Defibrillator
<input type="checkbox"/> Pace Maker

Vascular Surgeries
<input type="checkbox"/> Bypass Graft - Legs
<input type="checkbox"/> Vascular Access
<input type="checkbox"/> AAA
<input type="checkbox"/> Thoracic Aneurysm
Thoracic Surgeries
<input type="checkbox"/> Chest Tube
<input type="checkbox"/> Pulmonary
<input type="checkbox"/> Pectus

Neurosurgeries
<input type="checkbox"/> Brain Tumor <input type="radio"/> Malignant <input type="radio"/> Benign
<input type="checkbox"/> Brain Aneurysm
<input type="checkbox"/> Chiari Decompression
<input type="checkbox"/> Spinal Cord Tumor <input type="radio"/> Malignant <input type="radio"/> Benign
<input type="checkbox"/> Epidural Injection
<input type="checkbox"/> Abscess
<input type="checkbox"/> Stent



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Orthopaedic Surgery/ Procedures

Please check any procedures you have had and give the year.

Most Recent Year

Previous Surgery Year

(if same surgery performed more than once)

Broken Bones/Fracture Repair Surgeries

<input type="checkbox"/> Fracture Repair - Finger -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Hand -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Wrist -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Arm -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Elbow -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Shoulder -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Hip/Pelvis -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Femur -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Knee -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Lower Leg -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Ankle/Foot -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Ankle/Foot Surgeries

<input type="checkbox"/> Ankle Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ankle Fusion -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Tendon Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Toe Surgery specify _____	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Elbow, Wrist, Hand Surgeries

<input type="checkbox"/> Biceps Repair -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Carpal Tunnel Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Ligament Reconstruction -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Hand Tendon Repair -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Nail Bed Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Tennis Elbow Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Trigger Finger Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Wrist Ligament Reconstruction -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Knee Surgeries

<input type="checkbox"/> Knee Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Cartilage surgery/meniscus surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Knee replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ligament reconstruction - ACL -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ligament reconstruction - other -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Hip Surgeries

<input type="checkbox"/> Hip replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> AVN Surgery <input type="radio"/> Core Decompression <input type="radio"/> Fibular Graft	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

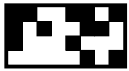
Shoulder Surgeries

<input type="checkbox"/> Shoulder Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Rotator cuff surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Shoulder replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Shoulder stabilization -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Spine Surgeries

<input type="checkbox"/> Laminectomy -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Anterior Fusion -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Posterior Fusion -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Posterior Discectomy -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Other (List all other surgeries) _____



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Drug Allergy and Medication Information

Have you ever had problems with anesthesia? Yes No *If yes, describe* _____

Are you allergic to latex? Yes No

Are you allergic to any medications? Yes No *If yes, please write the name of the drug in the boxes below and check the reaction you experienced. Please write only one drug in each space provided. If you have more than 3 drug allergies list the others in the space provided.*

Specify Drug:

[Grid for drug name]

Describe: shock breathing problems rash nausea other _____

Specify Drug:

[Grid for drug name]

Describe: shock breathing problems rash nausea other _____

Specify Drug:

[Grid for drug name]

Describe: shock breathing problems rash nausea other _____

Please list additional drug allergies here: _____

List **all** medications you are currently taking with the correct **dosage** and **frequency** (*prescription and non-prescription medication*)

Please check any medication listed below which you have taken in the past.

- Advil
- Aleve
- Arthrotec
- Bextra
- Celebrex
- Daypro
- Ibuprofen
- Indocin
- Lodine
- Naprelan
- Naproxen
- Oruval/Orudis
- Ultram

Please check any of the following side effects you experienced while taking any of the above anti-inflammatory medications.

- nausea
- diarrhea
- gastric ulcers
- upset stomach
- vomiting
- other _____

Please check any of the following medications you take on a regular basis.

- Aspirin
- Axid
- Coumadin
- Cytotec
- Heparin
- Maalox
- Mylanta
- Pepcid
- Prevacid
- Prilosec
- Tagamet
- Zantac

Family Medical History

Please check all diseases for which you have a family history:

- Cancer - Breast
- Cancer - Prostate
- Cancer - Other
- Diabetes
- Heart Disease
- Stroke
- Rheumatoid Arthritis
- Arthritis - osteo, degenerative
- Gout
- Lupus

If you know your parents' health history please provide the information below. Otherwise, please leave blank.

Father alive deceased Age (current age or age deceased) [] [] [] Health history

- cancer
- heart disease
- stroke
- diabetes
- rheumatoid arthritis
- osteoarthritis
- gout
- lupus

Cause of death (if deceased)

[Grid for father's health history]

Mother alive deceased Age (current age or age deceased) [] [] [] Health history

- cancer
- heart disease
- stroke
- diabetes
- rheumatoid arthritis
- osteoarthritis
- gout
- lupus

Cause of death (if deceased)

[Grid for mother's health history]



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SF-12 - Check ONLY ONE answer for each question

Instructions: This survey 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. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

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

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

(#2 and #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?

- | | <u>Yes,
Limited
A Lot</u> | <u>Yes,
Limited
A Little</u> | <u>No, Not
Limited
At All</u> |
|--|-----------------------------------|--------------------------------------|---------------------------------------|
| 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Climbing several flights of stairs | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

(#4 and #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 your physical health?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 4. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 5. Were limited in the kind of work or other activities | <input type="radio"/> 1 | <input type="radio"/> 2 |

(#6 and #7) 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)?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 6. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 7. Didn't do work or perform other activities as carefully as usual | <input type="radio"/> 1 | <input type="radio"/> 2 |

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

(#9, #10 and #11) 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.

How much of the time during the past 4 weeks

- | | <u>All
of the
time</u> | <u>Most
of the
time</u> | <u>A good
bit of
time</u> | <u>Some
of the
time</u> | <u>A little
of the
time</u> | <u>None
of the
time</u> |
|---|--------------------------------|---------------------------------|-----------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| 9. Have you felt calm and peaceful? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 10. Did you have a lot of energy? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 11. Have you felt downhearted and blue? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |

12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?

- | <u>All
of the
time</u> | <u>Most
of the
time</u> | <u>Some
of the
time</u> | <u>A little
of the
time</u> | <u>None
of the
time</u> |
|--------------------------------|---------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |

PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW