Part I - Acute and Chronic Symptoms

1. Please indicate whether you currently experience each of the following health symptoms or problems.

   - a. blindness or severely impaired vision in both eyes? ☐ ☐ ☐
   - b. speech problems such as stammering, or being unable to speak clearly? ☐ ☐ ☐
   - c. missing or paralyzed hands, feet, arms, or legs? ☐ ☐ ☐
   - d. any deformity of the face, fingers, hand or arm, foot or leg, or back (e.g. severe scoliosis)? ☐ ☐ ☐
   - e. general fatigue, tiredness, or weakness? ☐ ☐ ☐
   - f. a problem with unwanted weight gain or weight loss? ☐ ☐ ☐
   - g. a problem with being under or overweight? ☐ ☐ ☐
   - h. problems chewing your food adequately? ☐ ☐ ☐
   - i. any hearing loss or deafness? ☐ ☐ ☐
   - j. any noticeable skin problems, such as bad acne or large burns or scars on face, body, arms, or legs? ☐ ☐ ☐
   - k. eczema or burning/itching rash? ☐ ☐ ☐
   - l. any problem with your vision not corrected with glasses or contact lenses? ☐ ☐ ☐
   - m. any sore or bleeding lips, tongue, or gums? ☐ ☐ ☐
   - n. any eye trouble other than vision? ☐ ☐ ☐
   - o. a headache? ☐ ☐ ☐
   - p. chest pain, pressure, palpitations, fast or skipped heart beat, or other discomfort in the chest? ☐ ☐ ☐
   - q. any difficulty in breathing or difficulty with your balance, standing, or walking? ☐ ☐ ☐
   - r. difficulty in swallowing? ☐ ☐ ☐
   - s. any difficulty with urination? ☐ ☐ ☐
   - t. loss of bladder control, frequent night-time urination, or difficulty with urination? ☐ ☐ ☐
   - u. pain, stiffness, cramps, weakness, or numbness in any of the joints or muscles of the hands, feet, arms, or legs? ☐ ☐ ☐
   - v. swelling of ankles, hands, feet or abdomen? ☐ ☐ ☐
   - w. fever, chills, or sweating? ☐ ☐ ☐
   - x. loss of consciousness, fainting, or seizures? ☐ ☐ ☐
   - y. difficulty with your balance, standing, or walking? ☐ ☐ ☐

2. For the following list of problems indicate which days (if any) over the past 3 days, not including today, you had the problem. If you have not had the symptom in the past 3 days, do not leave the question blank, please fill in "no days" if you have experienced the symptom in the past 3 days, please check which of the days you had it; if you experienced it on more than one of the days, fill in all days that apply.

   For example, if you had a headache yesterday and the day before that:
   A headache? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐

Did you have.... (please fill in all days that apply)

   a. any problems with your vision not corrected with glasses or contact lenses (such as double vision, distorted vision, flashes, or floaters)? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   b. any eye trouble other than vision? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   c. a headache? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   d. dizziness, earache, or ringing in your ears? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   e. difficulty hearing, or discography, or bleeding from an ear? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   f. stuffy or runny nose, or bleeding from the nose? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   g. a sore throat, difficulty swallowing, or hoarse voice? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   h. a tooth ache or jaw pain? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   i. sore or bleeding lips, tongue, or gums? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   j. coughing or wheezing? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   k. shortness of breath or difficulty breathing? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   l. any decrease of sexual interest or performance? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   m. any confusion, difficulty understanding the written or spoken word, or other significant memory loss? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐

3. The following symptoms are about your feelings, thoughts, and behaviors. Please fill in which days (if any) over the past 3 days, not including today, you have had:

   a. trouble falling asleep or staying asleep? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   b. spells of feeling nervous or shaky? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   c. spells of feeling upset, downhearted, or blue? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   d. excessive worry or anxiety? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   e. feelings that you had little or no control over events in your life? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   f. feelings of being lonely or isolated? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   g. feelings of frustration, irritation, or close to losing your temper? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   h. a hangover? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   i. any decrease of sexual interest or performance? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   j. confusion, difficulty understanding the written or spoken word, or other significant memory loss? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐
   k. thoughts or images you could not get out of your mind? ☐ ☐ ☐
   - No Days ☐ ☐ ☐
   - Yesterday ☐ ☐ ☐
   - 2 days ago ☐ ☐ ☐
   - 3 days ago ☐ ☐ ☐

Please continue on other side.
Part I - Acute and Chronic Symptoms (continued)

3. Question 3 continued ....

m. to stay on a medically prescribed diet for health reasons?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

n. a loss of appetite or over-eating?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

4. In the last 3 days did you have any symptoms, health complaints, or pains that have not been mentioned?
   - Yes
   - No

If yes, what were they and on which days did you have them?

Symptoms

Days

A.

B.

Part II - Self Care

5. Over the last 3 days ... (please fill in all days that apply)

a. did you spend any part of the day or night as a patient in a hospital, nursing home, or rehabilitation center?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

b. because of any impairment or health problem, did you need help with your personal care needs, such as eating, dressing, bathing, or getting around your home?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

Part III - Mobility

6. Over the last 3 days ... (please fill in all days that apply)

a. which days did you drive a motor vehicle?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

b. which days did you use public transportation such as a bus, subway, Medi-va-i, train, or airplane?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

c. which days did you either not drive a motor vehicle or not use public transportation because of your health, or need help from another person to use?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

Part IV - Physical Activity

7. Over the last 3 days did you ... (please fill in all days that apply)

a. have trouble climbing stairs or inclines or walking off the curb?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

b. avoid walking, have trouble walking, or walk more slowly than other people your age?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

c. limp or use a cane, crutches, or walker?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

d. avoid or have trouble bending over, stooping, or kneeling?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

e. have any trouble lifting or carrying everyday objects such as books, a briefcase, or groceries?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

f. have any other limitations in physical movements?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

g. spend all or most of the day in a bed, chair, or couch because of health reasons?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

h. spend all or most of the day in a wheelchair?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

If in a wheelchair, on which days did someone else control its movement?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

Part V - Usual Activity

8. Over the last 3 days ... (please fill in all days that apply)

a. because of any physical or emotional health reasons, on which days did you avoid, need help with, or were limited in doing some of your usual activities, such as work, school or housekeeping?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

b. because of any physical or emotional health reasons, on which days did you avoid or feel limited in doing some of your usual activities, such as visiting family or friends, hobbies, shopping, recreational, or religious activities?
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

c. on which days did you have to change any of your plans or activities because of your health? (Consider only activities that you did not report in the last 2 questions.)
   - No Days
   - Yesterday
   - 2 days ago
   - 3 days ago

If limited, please describe:

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