

Clinic: Participant ID: Nickname: Outcome Visit: Month: Day: Year:

Quality of Well-Being Scale, Self-Administered (QWB-SA), V1.04

This survey asks about health problems that you have experienced in the last 3 days, not including today. Please answer all questions by filling in the appropriate circle completely with blue or black ink. Please do not use check marks or felt tip pens. Thank you.

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

Do you have...	YES	NO
a. blindness or severely impaired vision in both eyes?	<input type="radio"/>	<input type="radio"/>
blindness or severely impaired vision in only one eye?	<input type="radio"/>	<input type="radio"/>
b. speech problems such as stuttering, or being unable to speak clearly?	<input type="radio"/>	<input type="radio"/>
c. missing or paralyzed hands, feet, arms, or legs?	<input type="radio"/>	<input type="radio"/>
missing or paralyzed fingers or toes?	<input type="radio"/>	<input type="radio"/>
d. any <u>deformity</u> of the face, fingers, hand or arm, foot or leg, or back (e.g. severe scoliosis)?	<input type="radio"/>	<input type="radio"/>
e. general fatigue, tiredness, or weakness?	<input type="radio"/>	<input type="radio"/>
f. a problem with unwanted weight gain or weight loss?	<input type="radio"/>	<input type="radio"/>
g. a problem with being under or over weight?	<input type="radio"/>	<input type="radio"/>
h. problems chewing your food adequately?	<input type="radio"/>	<input type="radio"/>
i. any hearing loss or deafness?	<input type="radio"/>	<input type="radio"/>
j. any noticeable skin problems, such as bad acne or large burns or scars on face, body, arms, or legs?	<input type="radio"/>	<input type="radio"/>
k. eczema or burning/itching rash?	<input type="radio"/>	<input type="radio"/>
Which of the following health aides do you use/have?	YES	NO
a. dentures?	<input type="radio"/>	<input type="radio"/>
b. oxygen tank?	<input type="radio"/>	<input type="radio"/>
c. prosthesis?	<input type="radio"/>	<input type="radio"/>
d. eye glasses or contact lenses?	<input type="radio"/>	<input type="radio"/>
e. hearing aide?	<input type="radio"/>	<input type="radio"/>
f. magnifying glass?	<input type="radio"/>	<input type="radio"/>
g. neck, back, or leg brace?	<input type="radio"/>	<input type="radio"/>

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 fill in which of the days you had it; if you experienced it on more than one of the days, please fill in all days that apply.

	No days	Yester-day	2 days ago	3 days ago
For example, if you had a headache yesterday and the day before that, you would mark for a headache:	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
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)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. any eye pain, irritation, discharge, or excessive sensitivity to light?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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<input type="text"/>						

Did you have... (please fill in all days that apply)	No days	Yester-day	2 days ago	3 days ago
c. a headache?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. dizziness, earache, or ringing in your ears?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. difficulty hearing, or discharge, or bleeding from an ear?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. stuffy or runny nose, or bleeding from the nose?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. a sore throat, difficulty swallowing, or hoarse voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. a tooth ache or jaw pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. sore or bleeding lips, tongue, or gums?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. coughing or wheezing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. shortness of breath or difficulty breathing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. chest pain, pressure, palpitations, fast or skipped heart beat, or other discomfort in the chest?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. an upset stomach, abdominal pain, nausea, heartburn, or vomiting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. difficulty with bowel movements, diarrhea, constipation, rectal bleeding, black tar-like stools, or any pain or discomfort in the rectal area?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. pain, burning, or blood in urine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. loss of bladder control, frequent night-time urination, or difficulty with urination?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. genital pain, itching, burning, or abnormal discharge, or pelvic cramping or abnormal bleeding (does not include normal menstruation)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
r. a broken arm, wrist, foot, leg, or any other broken bone (other than in the back)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
s. pain, stiffness, cramps, weakness, or numbness <i>in the neck or back</i> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
t. pain, stiffness, cramps, weakness, or numbness <i>in the hips or sides</i> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
u. pain, stiffness, cramps, weakness, or numbness in any of <i>the joints or muscles of the hand, feet, arms, or legs</i> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
v. swelling of ankles, hands, feet, or abdomen?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
w. fever, chills, or sweats?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
x. loss of consciousness, fainting, or seizures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
y. difficulty with your balance, standing, or walking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Did you have... (please fill in all days that apply)	No days	Yester-day	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. spells of feeling nervous or shaky?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. spells of feeling upset, downhearted, or blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. excessive worry or anxiety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. feelings that you had little or no control over events in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. feelings of being lonely or isolated?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. feelings of frustration, irritation, or close to losing your temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. a hangover?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. any decrease of sexual interest or performance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. confusion, difficulty understanding the written or spoken word, or significant memory loss?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. thoughts or images you could not get out of your mind?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. to take any medication including over-the-counter remedies (aspirin/tylenol, allergy medications, insulin, hormones, estrogen, thyroid, prednisone)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. to stay on a medically prescribed diet for health reasons?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. a loss of appetite or over-eating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>4. In the last 3 days did you have any symptoms, health complaints, or pains that have not been mentioned?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>If yes, what were they and on which days did you have them?</p>				
Symptom A: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Symptom B: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Over the last 3 days...(please fill in all days that apply)	No days	Yester-day	2 days ago	3 days ago
5a. did you spend any part of the day or night as a patient in a hospital, nursing home, or rehabilitation center?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5b. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6a. which days did you drive a motor vehicle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6b. which days did you use public transportation such as a bus, subway, Medi-van, train, or airplane?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6c. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Over the last three days, did you... (please fill in all days that apply)	No days	Yester-day	2 days ago	3 days ago
7a. have trouble climbing stairs or inclines or walking off the curb?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7b. avoid walking, have trouble walking, or walk more slowly than other people your age?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7c. limp or use a cane, crutches, or walker?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7d. avoid or have trouble bending over, stooping, or kneeling?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7e. have any trouble lifting or carrying everyday objects such as books, a briefcase, or groceries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7f. have any other limitations in physical movements?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7g. spend all or most of the day in a bed, chair, or couch because of health reasons?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7h. spend all or most of the day in a wheelchair?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If in a wheelchair , on which days did someone else control its movement?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8a. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8b. because of 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8c. 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<p>9a. Would you say that your health is:</p> <p><input type="radio"/> Excellent</p> <p><input type="radio"/> Very Good</p> <p><input type="radio"/> Good</p> <p><input type="radio"/> Fair</p> <p><input type="radio"/> Poor</p>	<p>9b. Compared to a year ago, how would you rate your health in general now?</p> <p><input type="radio"/> Much better now than a year ago</p> <p><input type="radio"/> Somewhat better now than one year ago</p> <p><input type="radio"/> About the same as a year ago</p> <p><input type="radio"/> Somewhat worse than a year ago</p> <p><input type="radio"/> Much worse than a year ago</p>
<p>9c. Think about a scale of 0 to 100, with zero being the least desirable state of health that you could imagine and 100 being perfect health. What number from 0 to 100 would you give to the state of your health, on average, over the last 3 days?</p> <p style="text-align: center;"> <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 40 <input type="radio"/> 50 <input type="radio"/> 60 <input type="radio"/> 70 <input type="radio"/> 80 <input type="radio"/> 90 <input type="radio"/> 100 </p>	

<p>10a. Sex: <input type="radio"/> Male <input type="radio"/> Female</p>	<p>10c. What is your ethnicity?</p> <p><input type="radio"/> African American</p> <p><input type="radio"/> Asian/Pacific Islander</p> <p><input type="radio"/> Caucasian – Non Hispanic</p> <p><input type="radio"/> Hispanic</p> <p><input type="radio"/> Native American</p> <p><input type="radio"/> Other</p>	<p>10d. Which of the following best describes your educational background?</p> <p><input type="radio"/> 8th Grade Graduate</p> <p><input type="radio"/> High School Graduate</p> <p><input type="radio"/> Some College</p> <p><input type="radio"/> College Graduate (B.S. or B.A. degree)</p> <p><input type="radio"/> Some Graduate School</p> <p><input type="radio"/> Completed Post-Graduate (M.A.,M.D.,Ph.D.)</p>
<p>10b. Age in Years:</p> <input type="text"/> <input type="text"/> <input type="text"/>		