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Hip/Knee Replacement, Arthroscopy, Minimally Invasive Surgery, Sports Medicine, Fracture Care

Health Status Questionnaire

Name: _____ Date of Birth: _____ Date: _____

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

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: (Check one box on each line.)

- | | <u>Limited a lot</u> | <u>Limited a little</u> | <u>Not limited at all</u> |
|--|--------------------------|--------------------------|---------------------------|
| 2. Moderate Activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Climbing several flights of stairs: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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? (Check one box on each line.)

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

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)? (Check one box on each line.)

- | | | |
|---|------------------------------|-----------------------------|
| 6. Accomplished less than you would like: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Did not do work or other activities as carefully as usual: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- | | | | | |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> A little bit | <input type="checkbox"/> Moderately | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Extremely |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|

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.....(Check one box on each line.)

- | | All
of the
Time | Most
of the
Time | A Good
Bit of
the Time | Some
of the
Time | A Little
of the
Time | None
of the
Time |
|---|--------------------------------|---------------------------------|---------------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| 9. Have you felt calm and peaceful? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Did you have a lot of energy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you felt downhearted and blue? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with you visiting friends, relative, etc.? (Check one box.)

- | | | |
|---|---|---|
| <input type="checkbox"/> All of the time | <input type="checkbox"/> Most of the time | <input type="checkbox"/> Some of the time |
| <input type="checkbox"/> A little of the time | <input type="checkbox"/> None of the time | |