

Assessment:

Centers for Disease Control and Prevention Health-Related Quality-of-Life 14-Item Measure

Scale items:

Healthy Days Core Module (CDC HRQOL-4)

1. Would you say that in general your health is:

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor
6. Don't know
7. Refuse to answer

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

1. Number of days _____
2. None
3. Don't know
4. Refuse to answer

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

1. Number of days _____
2. None
3. Don't know
4. refuse to answer

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

1. Number of days _____
2. None

3. Don't know
4. Refuse to answer

Activity Limitations Module

These next questions are about physical, mental, or emotional problems or limitations you may have in your daily life.

1. Are you LIMITED in any way in any activities because of any impairment or health problem?

1. Number of days _____
2. None
3. Don't know
4. Refuse to answer

2. What is the MAJOR impairment or health problem that limits your activities?

1. Arthritis/rheumatism
2. Back or neck problem
3. Fractures, bone/joint injury
4. Walking problem
5. Lung/breathing problem
6. Hearing problem
7. Eye/vision problem
8. Heart problem
9. Stroke problem
10. Hypertension/high blood pressure
11. Diabetes
12. Cancer
13. Depression/anxiety/emotional problem
14. Other impairment/problem
15. Don't know
16. Refuse to answer

3. For HOW LONG have your activities been limited because of your major impairment or health problem?

1. Days _____
2. Weeks _____
3. Months _____
4. Years _____

- 5. Don't know
- 6. Refuse to answer

4. Because of any impairment or health problem, do you need the help of other persons with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?

- 1. Yes
- 2. No
- 3. Don't know
- 4. Refuse to answer

5. Because of any impairment or health problem, do you need the help of other persons in handling your ROUTINE needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

- 1. Yes
- 2. No
- 3. Don't know
- 4. Refuse to answer

Healthy Days Symptoms Module

1. During the past 30 days, for about how many days did PAIN make it hard for you to do your usual activities, such as self-care, work, or recreation?

- 1. Number of days _____
- 2. None
- 3. Don't know
- 4. Refuse to answer

2. During the past 30 days, for about how many days have you felt SAD, BLUE, or DEPRESSED?

- 1. Number of days _____
- 2. None
- 3. Don't know
- 4. Refuse to answer

3. During the past 30 days, for about how many days have you felt WORRIED, TENSE, or ANXIOUS?

1. Number of days _____
2. None
3. Don't know
4. Refuse to answer

4. During the past 30 days, for about how many days have you felt you did NOT get ENOUGH REST or SLEEP?

1. Number of days _____
2. None
3. Don't know
4. Refuse to answer

5. During the past 30 days, for about how many days have you felt VERY HEALTHY AND FULL OF ENERGY?

1. Number of days _____
2. None
3. Don't know
4. Refuse to answer