



SLEEP HEART HEALTH STUDY

Quality of Life Survey (SF 36)

ID#: **PPTID**

Field Center: **SITE25**

Today's date: **DATE25**
month day year

This survey asks you for your views about your health. Answer every question by checking the appropriate response. If you are unsure about how to answer a question, please give the best answer you can and make a comment in the left margin.

1 In general, would you say your health is: (Check one box.) GENH25

- | | | | | | |
|-----------|--------------------------|---|------|--------------------------|---|
| Excellent | <input type="checkbox"/> | 1 | Fair | <input type="checkbox"/> | 4 |
| Very good | <input type="checkbox"/> | 2 | Poor | <input type="checkbox"/> | 5 |
| Good | <input type="checkbox"/> | 3 | | | |

2 Compared to one year ago, how would you rate your health in general now? (Check one box.) CMP1YR25

- | | | | | | |
|---------------------|--------------------------|---|--------------------|--------------------------|---|
| Much better now | <input type="checkbox"/> | 1 | Somewhat worse now | <input type="checkbox"/> | 4 |
| Somewhat better now | <input type="checkbox"/> | 2 | Much worse now | <input type="checkbox"/> | 5 |
| About the same | <input type="checkbox"/> | 3 | | | |

3 The following questions 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 for each question.)

		Yes, limited a lot	Yes, limited a little	No, not limited at all
VIGACT25	a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
MODACT25	b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LIFT25	c. Lifting or carrying groceries.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
CLIMBS25	d. Climbing several flights of stairs.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
CLIMB125	e. Climbing one flight of stairs.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
BEND25	f. Bending, kneeling, or stooping.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
WK1ML25	g. Walking more than a mile.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
WKSBLK25	h. Walking several blocks.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
WL1BLK25	i. Walking one block.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
BATHE25	j. Bathing and dressing yourself.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

4 During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (Please check either YES or NO for each question.)

		Yes	No
PHCTDN25	a. Cut down on the amount or time you spent on work or other activities.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
PHACLS25	b. Accomplished less than you would like.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
LIMIT25	c. Were limited in the kind of work or other activities you were able to do.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
EXEFRT25	d. Had difficulty performing the work or other activities. (For example, it took extra effort.)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀

5 During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of emotional problems (such as feeling depressed or anxious)? (Please check either YES or NO for each question.)

		Yes	No
EMCTDN25	a. Cut down on the amount or time you spent on work or other activities.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
EMACLS25	b. Accomplished less than you would like.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
CARFUL25	c. Didn't do work or other activities as carefully as usual.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀

6 During the past four weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Check one box.) **PROBSA25**

Not at all	<input type="checkbox"/> ₁	Quite a bit	<input type="checkbox"/> ₄
Slightly	<input type="checkbox"/> ₂	Extremely	<input type="checkbox"/> ₅
Moderately	<input type="checkbox"/> ₃		

7 How much bodily pain have you had during the past four weeks? (Check one box.) **BDPAIN25**

None	<input type="checkbox"/> ₁	Moderate	<input type="checkbox"/> ₄
Very mild	<input type="checkbox"/> ₂	Severe	<input type="checkbox"/> ₅
Mild	<input type="checkbox"/> ₃	Very severe	<input type="checkbox"/> ₆

8 During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework? (Check one box.) **PAININ25**

Not at all	<input type="checkbox"/> ₁	Quite a bit	<input type="checkbox"/> ₄
Slightly	<input type="checkbox"/> ₂	Extremely	<input type="checkbox"/> ₅
Moderately	<input type="checkbox"/> ₃		

9 These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, check the box for the one answer that comes closest to the way you have been feeling.

During the past 4 weeks, how much of the time...

		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
PEP25	a. Did you feel full of pep?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
NRVOUS25	b. Have you been a very nervous person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
DOWN25	c. Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
CALM25	d. Have you felt calm and peaceful?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
ENERG25	e. Did you have a lot of energy?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
BLUE25	f. Have you felt downhearted and blue?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
WORN25	g. Did you feel worn out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
HAPPY25	h. Have you been a happy person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
TIRED25	i. Did you feel tired?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

10 During the past 4 weeks, how much of the time has your health limited your social activities (like visiting with friends or close relatives)? (Check one box.) HLTHLM25

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

11 Please choose the answer that best describes how true or false each of the following statements is for you. (Check one box for each statement.)

		Definitely true	Mostly true	Not sure	Mostly false	Definitely false
SICKEZ25	a. I seem to get sick a little easier than other people.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
HLTHY25	b. I am as healthy as anybody I know.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
WORSE25	c. I expect my health to get worse.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EXCLNT25	d. My health is excellent.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Field Center Use Only 0 Self administered WHOADM25 1 Interviewer administered
 Interviewer or Reviewer INTID25 _____ Date: RDATE25 _____
 month day year