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OMB #0925-0414 Exp: 4/06

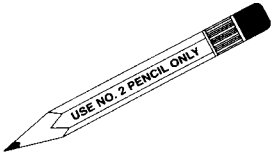
WOMEN'S HEALTH INITIATIVE

Form 38 - Daily Life

This booklet contains questions about the experiences of your daily life. Please answer each question as honestly as you can. Make sure you look at both sides of the page. No one will see your answers except for the scientists and staff at your clinic. Your answers will be kept secret and will never be put with your name in a report. Please answer using your first thoughts about each question. Do not go back later to "figure out" answers. Your answers will help us to understand the health of women like you. Thank you for your help.

MARKING INSTRUCTIONS

- **Use a No. 2 pencil only.**
- **Darken the oval completely next to the answer you choose.**
- **Erase cleanly any marks you wish to change.**
- **Do not make any stray marks on this form.**



CORRECT MARK ●

INCORRECT MARKS ✓ ✗ ▬ •

- **For questions where you write in a number, write the number in the box provided. Then mark the corresponding oval to the right.**

Example: If your age is 59:

[| 5 | 9]

100
10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

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OFFICE USE ONLY

S_____

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

1. Date Received:

[| |]-[| |]-[| |]
Month Day Year

M 1 2 3 4 5 6 7 8 9 10 11 12
D 10 20 30
1 2 3 4 5 6 7 8 9
Y 94 95 96 97 98 99 00 01 02 03 04 05 06 07

2. Reviewed By:

[| | |]

100 200 300
10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

3. Contact Type:

1 Phone
2 Mail
3 Visit
8 Other

4. Visit Type:

1 Screening 0 1 2 3 11
2 Semi-Annual 1 2 3 4 5 6 7 8 9 10
3 Annual 1 2 3 4 5 6 7 8 9 10
4 Non Routine 11

5. Form Administration:

1 Self 2 Group 3 Interview 4 Assistance

PLEASE MAKE NO MARKS IN THIS AREA

521403

1. Overall, how would you rate your quality of life? **(Mark one oval in the box below.)**

0	1	2	3	4	5	6	7	8	9	10
Worst					Halfway					Best

As bad or worse than being dead — Best quality of life

2. How satisfied are you with your current quality of life? **(Mark one oval in the box below.)**

0	1	2	3	4	5	6	7	8	9	10
Dissatisfied					Halfway					Satisfied

Not at all happy with quality of life now — Very happy with quality of life now

	Excellent	Very good	Good	Fair	Poor
3. In general, would you say your health is **(Mark one oval.):**	1	2	3	4	5

4. Compared to one year ago, how would you rate your health in general now? **(Mark one oval.)**

1 Much better now than 1 year ago

2 Somewhat better now than 1 year ago

3 About the same

4 Somewhat worse now than 1 year ago

5 Much worse than 1 year ago

The following are questions about a typical (or usual) day's activities. Does your health now limit you in these activities and, if so, how much? (Mark one oval for each question.)

	No, not limited at all	Yes, limited a little	Yes, limited a lot
5. Vigorous activities, such as running, lifting heavy objects, or strenuous sports	3	2	1
6. Moderate activities, such as moving a table, vacuuming, bowling, or golfing	3	2	1
7. Lifting or carrying groceries	3	2	1
8. Climbing several flights of stairs	3	2	1
9. Climbing one flight of stairs	3	2	1
10. Bending, kneeling, stooping	3	2	1
11. Walking more than a mile	3	2	1
12. Walking several blocks	3	2	1
13. Walking one block	3	2	1
14. Bathing or dressing yourself	3	2	1

	Not at all	Slightly	Moderately (Medium)	Quite a bit	Extremely (A lot)
15. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, neighbors, friends, or groups? **(Mark one oval.)**	1	2	3	4	5

	None	Very mild	Mild	Moderate (Medium)	Severe
16. During the past 4 weeks, how much bodily pain have you had? **(Mark one oval.)**	0	2	3	4	5

	None at all	A little bit	Moderately (Medium)	Quite a bit	Extremely (A lot)
17. During the past 4 weeks, how much did pain interfere with your normal work (both outside your home and at home)? **(Mark one oval.)**	1	2	3	4	5

PLEASE MAKE NO MARKS IN THIS AREA

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The next questions are about your regular daily activities like work, child care, or community activities. As a result of your physical health, have any of the following problems occurred during the past 4 weeks?

	No	Yes
18. You cut down on the amount of time you spent on work or other activities	0	1
19. You accomplished less than you would have liked	0	1
20. You were limited in the kind of work or other activities you did	0	1
21. You had difficulty performing work or other activities (it took extra effort)	0	1

In the past 4 weeks, as a result of any emotional problem (feeling depressed or anxious), have any of the following occurred?

	No	Yes
22. You cut down on the amount of time you spent on work or other activities	0	1
23. You accomplished less than you would have liked	0	1
24. You did work or other things less carefully than usual	0	1

Of these statements, how true or false is each for you?

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
25. I seem to get sick a little easier than other people	1	2	3	4	5
26. I am as healthy as anybody I know	1	2	3	4	5
27. I expect my health to get worse	1	2	3	4	5
28. My health is excellent	1	2	3	4	5

29. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends and relatives)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
1	2	3	4	5

These questions are about how you feel and how things have been during the past 4 weeks. Give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . .

	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
30. Did you feel full of pep?	1	2	3	4	5	6
31. Have you been a very nervous person?	1	2	3	4	5	6
32. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
33. Have you felt calm and peaceful?	1	2	3	4	5	6
34. Did you have a lot of energy?	1	2	3	4	5	6
35. Have you felt downhearted and blue?	1	2	3	4	5	6
36. Did you feel worn out?	1	2	3	4	5	6
37. Have you been happy?	1	2	3	4	5	6
38. Did you feel tired?	1	2	3	4	5	6

39. Can you eat:

1 Without help (able to feed yourself completely)
2 With some help (need help with cutting, etc.)
3 Or are you completely unable to feed yourself?

40. Can you dress and undress yourself:

1 Without help (able to pick out clothes, dress and undress yourself)
2 With some help
3 Or are you completely unable to dress and undress yourself?

41. Can you get in and out of bed:

1 Without any help or aids
2 With some help (either from a person or with the aid of some device)
3 Or are you totally dependent on someone else to lift you?

42. Can you take a bath or shower:

1 Without help
2 With some help (need help getting in and out of the tub, or need special attachments on the tub)
3 Or are you completely unable to bathe yourself?

PLEASE MAKE NO MARKS IN THIS AREA

521403

Below is a list of symptoms people sometimes have. For each item, mark the one oval that best describes how bothersome the symptom was during the past 4 weeks for you. Be sure to mark one oval on each line.

If you did not have the problem, please mark the oval under "symptom did not occur." If you had the symptom, use the following key to indicate how bothersome it was:

Mild = symptom did not interfere with usual activities.
Moderate = symptom interfered somewhat with usual activities.
Severe = symptom was so bothersome that usual activities could not be performed.

		Symptom did not occur	Symptom occurred and was: Mild	Moderate	Severe
43.1.	Bloating or gas	0	1	2	3
43.2.	Constipation (difficulty having bowel movements)	0	1	2	3
43.3.	Night sweats	0	1	2	3
43.4.	General aches or pains	0	1	2	3
43.5.	Breast tenderness	0	1	2	3
43.6.	Hot flashes	0	1	2	3
43.7.	Diarrhea	0	1	2	3
43.8.	Mood swings	0	1	2	3
43.9.	Nausea	0	1	2	3
43.10.	Dizziness	0	1	2	3
43.11.	Feeling tired	0	1	2	3
43.12.	Forgetfulness	0	1	2	3
43.13.	Increased appetite	0	1	2	3
43.14.	Heart racing or skipping beats	0	1	2	3
43.15.	Tremors (shakes)	0	1	2	3
43.16.	Heartburn	0	1	2	3
43.17.	Restless or fidgety	0	1	2	3
43.18.	Low back pain	0	1	2	3
43.19.	Neck pain	0	1	2	3
43.20.	Skin dryness or scaling	0	1	2	3

		Symptom did not occur	Symptom occurred and was: Mild	Moderate	Severe
43.21.	Headaches or migraines	0	1	2	3
43.22.	Clumsiness	0	1	2	3
43.23.	Any trouble seeing that is uncorrected by lenses	0	1	2	3
43.24.	Vaginal or genital irritation or itching	0	1	2	3
43.25.	Difficulty concentrating	0	1	2	3
43.26.	Joint pain or stiffness	0	1	2	3
43.27.	Decreased appetite	0	1	2	3
43.28.	Hearing loss	0	1	2	3
43.29.	Swelling of hands or feet	0	1	2	3
43.30.	Vaginal or genital dryness	0	1	2	3
43.31.	Upset stomach or belly pain or discomfort	0	1	2	3
43.32.	Pain or burning while urinating	0	1	2	3
43.33.	Cough or wheezing	0	1	2	3
43.34.	Vaginal or genital discharge	0	1	2	3

Below are some hard things that sometimes happen to people. Please try to think back over the past year to remember if any of these things happened. Mark the answer that seems best.

Over the past year:		**No**	**Yes,** and it upset me: Not too much	Moderately (Medium)	Very much
44.1.	Did your spouse or partner die?	0	1	2	3
44.2.	Did your spouse or partner have a serious illness?	0	1	2	3
45.	Did a close friend or family member die or have a serious illness (other than your spouse or partner)?	0	1	2	3
46.	Did you have any major problems with money?	0	1	2	3
47.	Did you have a divorce or break-up with a spouse or partner?	0	1	2	3
48.	Did a family member or close friend have a divorce or break-up?	0	1	2	3
49.	Did you have a major conflict with children or grandchildren?	0	1	2	3
50.	Did you have any major accidents, disasters, muggings, unwanted sexual experiences, robberies, or similar events?	0	1	2	3

Over the past year:

		No	Yes, and it upset me: Not too much	Moderately (Medium)	Very much
51.	Did you or a family member or close friend lose their job or retire?	0	1	2	3
52.	Were you physically abused by being hit, slapped, pushed, shoved, punched or threatened with a weapon by a family member or close friend?	0	1	2	3
53.	Were you verbally abused by being made fun of, severely criticized, told you were a stupid or worthless person, or threatened with harm to yourself, your possessions, or your pets, by a family member or close friend?	0	1	2	3
54.	Did a pet die?	0	1	2	3

These questions are about your feeling during the past week. For each of the statements, please indicate the choice that tells how often you felt that way.

		Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
55.1.	You felt depressed (blue or down)	0	1	2	3
55.2.	Your sleep was restless	0	1	2	3
55.3.	You enjoyed life	0	1	2	3
55.4.	You had crying spells	0	1	2	3
55.5.	You felt sad	0	1	2	3
55.6.	You felt that people disliked you	0	1	2	3

56. In the past year, have you had two weeks or more during which you felt sad, blue, or depressed, or lost pleasure in things that you usually cared about or enjoyed?

0 No 1 Yes

57. Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

0 No 1 Yes

57.1. Have you felt depressed or sad much of the time in the past year?

0 No 1 Yes

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA

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These next questions are about your sleep habits. Please mark one of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the past 4 weeks.

	No, not in past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 times a week	Yes, 5 or more times a week
58. Did you take any kind of medication or alcohol at bedtime to help you sleep?	1	2	3	4	5
59. Did you fall asleep during quiet activities like reading, watching TV, or riding in a car?	1	2	3	4	5
60. Did you nap during the day?	1	2	3	4	5
61. Did you have trouble falling asleep?	1	2	3	4	5
62. Did you wake up several times at night?	1	2	3	4	5
63. Did you wake up earlier than you planned to?	1	2	3	4	5
64. Did you have trouble getting back to sleep after you woke up too early?	1	2	3	4	5
65. Did you snore? 9 Don't know	1	2	3	4	5

66. Overall, was your typical night's sleep during the past 4 weeks:

Very sound or restful	Sound or restful	Average quality	Restless	Very restless
5	4	3	2	1

67. About how many hours of sleep did you get on a typical night during the past 4 weeks?

5 or less hours	6 hours	7 hours	8 hours	9 hours	10 or more hours
1	2	3	4	5	6

Many women report that they leak urine (or pee). The next questions are about problems you may have had with leaking urine.

68. Have you ever leaked even a very small amount of urine involuntarily and you couldn't control it?

0 No 1 Yes

(If you answered "No," go to question 75.)

69. How often does this leaking urine occur? **(Mark one oval.)**

Not once during the past year	Less than once a month	More than once a month but less than once a week	One or more times a week but less than every day	Daily
1	2	3	4	5

70. When do you usually leak urine? **(Mark all that apply.)**

No longer leak urine	When I cough, laugh, sneeze, lift, stand up, or exercise	When I feel the need to urinate and can't get to a toilet fast enough	When I am sleeping	Other _____ (Please describe)
0	1	2	3	8

(If you "no longer leak urine," go to question 75.)

71. How much urine do you usually lose when it leaks? **(Mark one oval.)**

None	Barely noticeable on underpants	Soaked underpants	Soaked through to outer clothing
1	2	3	4

72. What protection do you wear in case you leak urine? **(Mark all that apply.)**

None	Mini-pad, tissue or paper towel	Mentrual pad or sheild	Diaper, towel, Attends, Depends	Other
1	2	3	4	8

73. How often does the leakage of urine limit your daily activities? **(Mark one oval.)**

Never	Almost never	Sometimes	Fairly often	Very often
1	2	3	4	5

74. How much does the leakage of urine bother or disturb you? **(Mark one oval.)**

Not at all disturbing	A little disturbing	Somewhat disturbing	Very disturbing	Extremely disturbing
1	2	3	4	5

PLEASE MAKE NO MARKS IN THIS AREA

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The last questions in this booklet ask about some personal topics. Although the following questions are sensitive and personal, they are important. Your answers will help us understand the health of women and may help us find better treatments for their health problems. Please be assured that your responses to these questions will remain confidential.

		No	Yes
75.	Are you currently married or in an intimate relationship with at least one person?	0	1

		No	Yes	Don't want to answer
76.	Did you have any sexual activity with a partner in the last year?	0	1	9

		Very unsatisfied	A little unsatisfied	Somewhat satisfied	Very satisfied	Don't want to answer
77.	How satisfied are you with your current sexual activities, either with a partner or alone? **(Mark one oval.)**	1	2	3	4	9

		Less often	Satisfied with current frequency	More often	Don't want to answer
78.	Are you satisfied with the frequency of your sexual activity, or would you like to have sex more or less often? **(Mark one oval.)**	1	2	3	9

		Not at all worried	A little worried	Somewhat worried	Very worried	Don't want to answer
79.	Are you worried that sexual activities will affect your health? **(Mark one oval.)**	1	2	3	4	9

Thank you. Feel free to write any comments here or notes about things to ask your clinic staff.

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