Form 151 – Activities of Daily Life

Ver. 9
OMB #0925-0414 Exp: XX/XXXX

This form has questions about your current experiences. Please answer the questions as honestly as you can, using your first thoughts about each question. You should not go back later to "figure out" answers. Please answer the questions on both sides. Your answers will be kept confidential and will never be put with your name in a published report, but they will help us to understand the health of women like you. Thank you for your help.

1. In general, would you say your health is (**Mark one box only.**)

Excellent	Very good	Good	Fair	Poor
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2. Overall, how would you rate your quality of life? (**Mark one 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

3. Does the place where you live have special services for older people (such as help with meals, medicines, bathing, or transportation)?

☐ 0 No ☐ 1 Yes →

3.1. Are you currently receiving any of these services?

☐ 0 No ☐ 1 Yes

4. In the past year, have you stayed in a nursing home?

☐ 0 No ☐ 1 Yes

Go to next page. →

OFFICE USE ONLY

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

1. Date Received: Month Day Year

2. Reviewed By:

3. Contact Type:
- ○1 Phone
- ○2 Mail
- ○3 Other

4. Language:
●1 E ○2 S

○ FCA ○ OU1 ○ OU2

46999

PLEASE MAKE NO MARKS IN THIS AREA

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		I do not use any aid	I use a cane	I use crutches	I use a walker	I use a wheelchair
5.	What aid, if any, do you usually use to walk on a level surface? **(Mark one.)**	☐1	☐2	☐3	☐4	☐5

6. Are you taking a calcium supplement such as Oscal, Viactiv, or Tums?

☐0 No ☐1 Yes

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 box for each question.)

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

These next questions ask about how much help (if any) you need to do routine activities <u>for yourself</u>. Help can be defined as getting assistance from another person or using a device. (Mark one box for each question)

		I can do this activity:		
		By myself	With some help	Completely unable to do this by myself
17.	Can you feed yourself?	☐1	☐2	☐3
18.	Can you dress and undress yourself?	☐1	☐2	☐3
19.	Can you get in and out of bed yourself?	☐1	☐2	☐3
20.	Can you take a bath or shower?	☐1	☐2	☐3
21.	Can you do your own grocery shopping?	☐1	☐2	☐3
22.	Can you keep track of and take your medicines?	☐1	☐2	☐3

FORM: **151 – ACTIVITIES OF DAILY LIFE**

Version: 9 – March 30, 2007

Description: 1-page, 2-sided form; scanned at CCC.

When used: Mailed annually to Extension Study participants; mailed routinely with the *Form 33 – Medical History Update.*

Purpose: To record information about the impact of disease events on daily functioning and quality of life in aging participants. There is no expectation that the FCs follow-up on information that a participant marks on this form.

GENERAL INSTRUCTIONS

The form is printed in both English (*Form 151*) and Spanish (*Form 151s*) and both are in mark-sense format. For both forms, follow the instructions on the front of the form for marking the answers.

The CCC places the participant barcode label on the front page of the form and mails it with the annual *Form 33 – Medical History Update* and one-time *Form 134 – Addendum to the Medical History Update* to HT participants two months before the randomization anniversary month.

Participants are asked to mail the completed form back to the CCC together with the *Form 33 – Medical History Update* and the *Form 134 – Addendum to the Medical History Update* in the return envelope provided.

Data entry at the CCC. Review the form for comments and mark the FCA box in the Office Use Only box as needed. Scan the form.

Item Instructions

Date received	Date received at FC or date completed by phone interview. Located in *Official Use Only* on page 1. When the CCC mails the form to and receives it back from the participant, this item is left blank and instead the scan date is inserted into WHIX.
Reviewed by	5-digit WHI Extension study employee ID. For forms scanned at the CCC, this item is left blank and instead WHIX inserts the ID of the CCC staff person scanning the form.
Contact type	Mark appropriate box. For forms scanned at the CCC, this item is left blank, and WHIX inserts "2 – Mail" into WHIX.
Visit type	Mark appropriate box. For forms scanned at the CCC, this item is left blank, and WHIX inserts "3 – Annual" into WHIX.
Language	Indication of English (E) or Spanish (S) version of the form. The response to this item is printed on the form.
Field Center Alert (FCA) bubble	Used by CCC to alert the FC that a form has participant comments and the image should be reviewed.
OU1 bubble	Reserved for future use.
OU2 bubble	Reserved for future use.

1.	In general, how is your health?	Mark one box
2.	Overall, rate your quality of life	Mark one box, 0 (worse than being dead) to 10 (best quality of life)
3.	Does your place have special services for older people?	No/Yes
3.1	Currently receiving any of these services?	No/Yes
4.	Stayed in nursing home in past year?	No/Yes
5.	Do you use aids to walk on level surface?	Mark one box (1 – 5)
6.	Taking a calcium supplement such as Oscal, Viactiv, or Tums?	No/Yes
7.	Does your health limit moderate activities?	Mark one box: No (not limite)d/Yes (limited a little)/Yes (limited a lot)
8.	Does your health limit lifting or carrying groceries?	Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)

9.	Does your health limit climbing flights of stairs?	Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
10.	Does your health limit climbing one flight of stairs?	Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
11.	Does your health limit bending, kneeling, stooping?	Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
12.	Does your health limit walking more than a mile?	Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
13.	Does your health limit walking several blocks?	Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
14.	Does your health limit walking one block?	Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
15.	Does your health limit bathing or dressing?	Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
16.	Can you feed yourself?	Mark one box: By myself/With some help/Completely unable to do by myself
17.	Can you dress and undress yourself?	Mark one box: By myself/With some help/Completely unable to do by myself
18.	Can you get in/out of bed by yourself?	Mark one box: By myself/With some help/Completely unable to do by myself
19.	Can you bathe or shower by yourself?	Mark one box: By myself/With some help/Completely unable to do by myself
20.	Can you do your own grocery shopping?	Mark one box: By myself/With some help/Completely unable to do by myself
21.	Can you keep track and take your medication?	Mark one box: By myself/With some help/Completely unable to do by myself

La Mujer y su Salud

Formulario 151S – Actividades de la vida cotidiana

Ver. 9
OMB #0925-0414 Exp:XX/XXXX

Este formulario incluye preguntas acerca de sus experiencias actuales. Responda a las preguntas con la mayor honestidad posible, escribiendo lo primero que piense acerca de cada pregunta. No debe volver a revisar las preguntas más adelante para "descifrar" las respuestas. Responda a las preguntas de ambos lados. Sus respuestas se mantendrán confidenciales y nunca se incluirán con su nombre en un informe publicado, pero nos ayudarán a comprender la salud de mujeres como usted. Gracias por su ayuda.

1. En general, usted diría que su salud es: **(Marque un solo círculo.)**

Excelente	Muy buena	Buena	Regular	Mala
○1	○2	○3	○4	○5

2. Por lo general, ¿qué considera Ud. ser la calidad de su vida? **(Marque un círculo en el recuadro a continuación.)**

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
Peor				Punto medio						Mejor

Tan mala o peor que si estuvie se muerta — La mejor calidad de vida

3. ¿El lugar donde vive (casa, departamento, vivienda con asistencia) tiene servicios especiales para personas mayores (como ayuda con las comidas, los medicamentos, el baño o el transporte)?

○0 No ○1 Sí → 3.1. ¿Está recibiendo alguno de estos servicios en la actualidad? ○0 No ○1 Sí

4. En el ultimo año, ¿estuvo en un hogar de ancianos?
○0 No ○1 Sí

5. Si usa alguna ayuda para caminar sobre una superficie plana, ¿qué ayuda suele usar? **(Marque una opción).**

No uso ninguna ayuda	Uso bastón	Uso muletas	Uso andador	Uso silla de ruedas
○1	○2	○3	○4	○5

AFFIX LABEL BETWEEN LINES
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El informe público por medio de estos datos colectivos se calcula tomar 6 minutos por cada respuesta, incluyendo el tiempo que tarde repasar las instrucciones, investigado las fuentes de datos que existen actualmente, colectando y manteniendo los datos necesarios y completar y repasar el cuestionario. A ninguna agencia se le permitirá llevar ni patrocinar una serie de datos colectivos, a menos que aparezca el número de control OMB válido; y al igual a ninguna persona se le requirere responder a lo mismo. Favor de dirigir sus comentarios sobre esta estimación de labor o cualquier otro aspecto de estos datos colectivos, incluyendo sugerencias para reducir esta labor, al siguiente: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0414). Favor de no enviar estos cuestionarios completados a dichas direcciones.

PARA USO EXCLUSIVO DE LA OFICINA

1. Date Received: Month Day Year
2. Reviewed By:
3. Contact Type: ○1 Phone ○2 Mail ○3 Other ○ FCA ○ OU1 ○ OU2
4. Language: ○1 E ●2 S

SERIAL #
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Formulario 151S – Actividades de la vida cotidiana

OMB #0925-0414 Exp: XX/XXXX

6. ¿Está tomando un suplemento de calcio como Oscal, Viactive o Tums?

○0 No ○1 Sí

A continuación, se incluyen preguntas acerca de las actividades de un día típico (o habitual). ¿Su salud lo limita en estas actividades en la actualidad? En caso afirmativo, ¿en qué medida? (Marque una sola círculo para cada pregunta).

	No, no me limita para nada	Sí, me limita un poco	Sí, me limita mucho
7. Actividades intensas, como correr, levantar objetos pesados o hacer deportes que demanden mucho esfuerzo	○3	○2	○1
8. Actividades moderadas, como mover una mesa, pasar la aspiradora o jugar a los bolos o al golf	○3	○2	○1
9. Levantar objetos o cargar las compras	○3	○2	○1
10. Subir varios pisos por escalera	○3	○2	○1
11. Subir un piso por escalera	○3	○2	○1
12. Inclinarse, arrodillarse, agacharse	○3	○2	○1
13. Caminar más de una milla	○3	○2	○1
14. Caminar varias cuadras	○3	○2	○1
15. Caminar una cuadra	○3	○2	○1
16. Bañarse o vestirse	○3	○2	○1

Las siguientes preguntas hacen referencia a cuánta ayuda necesita (si la necesita) para hacer las actividades de rutina <u>por sí sola</u>. El término "ayuda" puede definirse como obtener asistencia de otra persona o usar un dispositivo. (Marque una sola círculo para cada pregunta).

Puedo hacer esta actividad:	Por mí misma sin ayuda	Con algo de ayuda	Soy completamente incapaz de hacer esta actividad sola
17. ¿Puede alimentarse sola?	○1	○2	○3
18. ¿Puede vestirse o desvestirse sola?	○1	○2	○3
19. ¿Puede acostarse y levantarse de la cama sola?	○1	○2	○3
20. ¿Puede bañarse o ducharse?	○1	○2	○3
21. ¿Puede hacer las compras?	○1	○2	○3
22. ¿Puede llevar un registro de sus medicamentos y tomarlos?	○1	○2	○3