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# HCHS/SOL SF-12v2™ Health Survey

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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FORM CODE: SFE  
VERSION: A  
4/30/07

Contact Occasion	<input type="text"/>	<input type="text"/>	SEQ #	<input type="text"/>	<input type="text"/>
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Acrostic: \_\_\_\_\_

## ADMINISTRATIVE INFORMATION

0a. Completion Date:   /   /      
Month Day Year

0b. Staff ID:

**Instructions:** Mark the appropriate box for the response. Unless instructed, mark **ONLY** one response.

*This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.*

1. In general, would you say your health is:

Excellent 1       Very good 2       Good 3       Fair 4       Poor 5

2. 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?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Climbing <b>several</b> flights of stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Were limited in the kind of work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Didn't do work or activities as carefully as usual	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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

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

6. 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...

- |   | All of<br>the time         | Most of<br>the time        | Some of<br>the time        | A little of<br>the time    | None of<br>the time        |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Have you felt calm and peaceful?         | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| b. Did you have a lot of energy?            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| c. Have you felt downhearted and depressed? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

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

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