



Name: _____

Date: _____

SF – 12 Health Survey

This questionnaire asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

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

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> |
| Excellent | Very good | Good | Fair | Poor |

The following items 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 |
|-----------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------|---------------------------------------|
| 2. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling or playing golf | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Climbing several flights of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | Yes | No |
|----------------------------------------------------------------|--------------------------|--------------------------|
| 4. Accomplished less than you would like | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Were limited in the kind of work or other activities | <input type="checkbox"/> | <input type="checkbox"/> |

During the past 4 weeks, 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)?

- | | Yes | No |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 6. Accomplished less than you would like | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Didn't do work or other activities as carefully as usual | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. During the <u>past 4 weeks</u> , how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)? | | |

<input type="checkbox"/>				
Not at all	A little bit	Moderately	Quite a bit	Extremely

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 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 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------|---------------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| 9. Have you felt calm and peaceful? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Did you have a lot of energy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you felt downhearted and blue? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. During the <u>past 4 weeks</u> , how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)? | | | | | | |

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All of the time	Most of the time	A Good Bit of the time	Some of the time	A little of the time	None the time