St. Jude Children's Research Hospital
ALSAC • Danny Thomas, Founder
Finding cures. Saving children.

SJLIFE
Health Habits Survey

The questions in this booklet relate to:

Person completing this questionnaire is:

Your relationship:

☐ Self ☐ Parent ☐ Other: _____

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
m m d d y y y y

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Please! Do not mark below this line

Survey #221

3231152254

01/31/2018 08:21:28 AM

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging.
2. When marking boxes, make an x inside the box (see examples below).
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided:

CORRECT

Grape

INCORRECT

MARKING EXAMPLES

Below are some examples of how to fill out this questionnaire. Please look these over before you begin.

1. During the past month, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, bicycling, swimming, wheelchair basketball, or walking for exercise?

☐ No ☒ Yes

2. Have you ever taken. . .

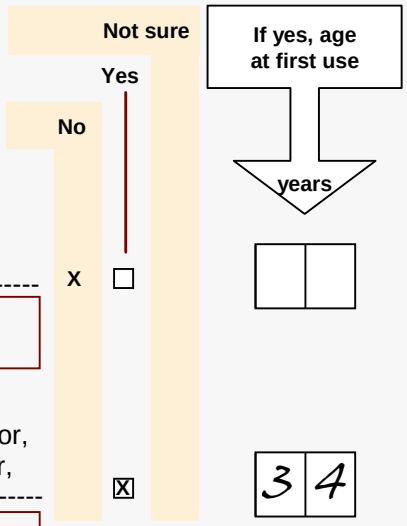
a. BIRTH CONTROL PILLS such as Demulen, Lo-Ovral, Loestrin, Norinyl, Norplant, Ortho-Novum, Ovral, Triphasil----------

If yes, specify the name of the drug(s) or indicate you do not know the specific name

b. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES, such as Zocor, Pravachol, Lipitor, Colestid (colestipol), Tricor, Lescol, Lopid (gemfibrozil), Mevacor, niacin, or Lorelco----------

If yes, specify the name of the drug(s) or indicate you do not know the specific name

mevacor



3. When was this condition diagnosed?

0 4 Month (mm)

1 9 9 5 Year (yyyy)

Please! Do not mark below this line

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SUN SENSITIVITY

A1. How would you describe your natural skin color on parts of your body not exposed to the sun?

- ☐ Pale or milky white
- ☐ Very light brown, sometimes freckles
- ☐ Light tan, brown, or olive
- ☐ Brown, dark brown, or black

A2. What color are your eyes?

- ☐ Blue
- ☐ Blue-grey
- ☐ Hazel
- ☐ Green
- ☐ Light brown
- ☐ Dark brown/black
- ☐ Mixed/other

A3. What is your natural adult hair color? *(check only one)*

- ☐ Light blond
- ☐ Blond
- ☐ Light brown
- ☐ Medium brown
- ☐ Red-brown
- ☐ Strawberry (reddish) blond
- ☐ Red
- ☐ Dark brown/black
- ☐ Jet black

Sunburn is a reddening of the skin that lasts at least 12 hours after you have been outdoors in the sun.

A4. Suppose that after several months of not being in the sun, you went out in the sun without a hat, sunscreen, or protective clothing for an hour. Would you . . . *(check only one)*

- ☐ Never tan, always burn
- ☐ Sometimes tan, usually burn
- ☐ Usually tan, sometimes burn
- ☐ Always tan, rarely burn

A5. Thinking back when you were a child/adolescent (less than 21 years old), how often have you had a severe, painful sunburn on each of these areas of the body?

	Never	1-2 times	3-5 times	6+ times
Back and shoulders	☐	☐	☐	☐
Lower limbs	☐	☐	☐	☐
Face or arms	☐	☐	☐	☐
All over	☐	☐	☐	☐

If you are under 21: → *Go to Question A7.*

A6. As an adult (age 21 or older), how often have you had a severe, painful sunburn on each of these areas of the body?

Back and shoulders	☐	☐	☐	☐
Lower limbs	☐	☐	☐	☐
Face or arms	☐	☐	☐	☐
All over	☐	☐	☐	☐

A7. Have you ever sunbathed or sat outside by the water?

- ☐ No → *Go to Question A9.*
- ☐ Yes

A8. If yes, how many days in the last 12 months have you sunbathed or sat outside by the water?

- ☐ None
- ☐ 1-5 days
- ☐ 6-10 days
- ☐ 11 or more days

A9. Have you ever used artificial tanning devices such as a sunlamp, or gone to a tanning booth?

- ☐ No → *Go to Question A11, next page.*
- ☐ Yes

Please! Do not mark below this line

A10. If yes, how many days in the last 12 months have you used any artificial tanning devices such as a sunlamp, or gone to a tanning booth?

- ☐ None
- ☐ 1-5 days
- ☐ 6-10 days
- ☐ 11 or more days

A11. When you were outside last summer for more than 15 minutes, how often did you protect yourself from the sun by . . .

	Never	Rarely	Sometimes	Often	Always
Applying a sunscreen with a sun protection factor (SPF) of 15 or more on all sun exposed skin areas.	☐	☐	☐	☐	☐
Wearing protective clothing such as long-sleeved shirts and long pants.	☐	☐	☐	☐	☐
Wearing a hat.	☐	☐	☐	☐	☐
Limiting exposure to the sun during the mid-day hours.	☐	☐	☐	☐	☐
Staying in the shade.	☐	☐	☐	☐	☐

A12. Has a medical doctor or nurse ever examined all or most of your skin for signs of skin cancer, not just looked at a certain spot?

- ☐ No
- ☐ Yes
- ☐ Don't know

A13. Have you ever had a health care professional remove a skin growth?

- ☐ No
- ☐ Yes

A14. Have you ever been told that you had skin cancer? This includes basal cell, squamous cell, and melanoma.

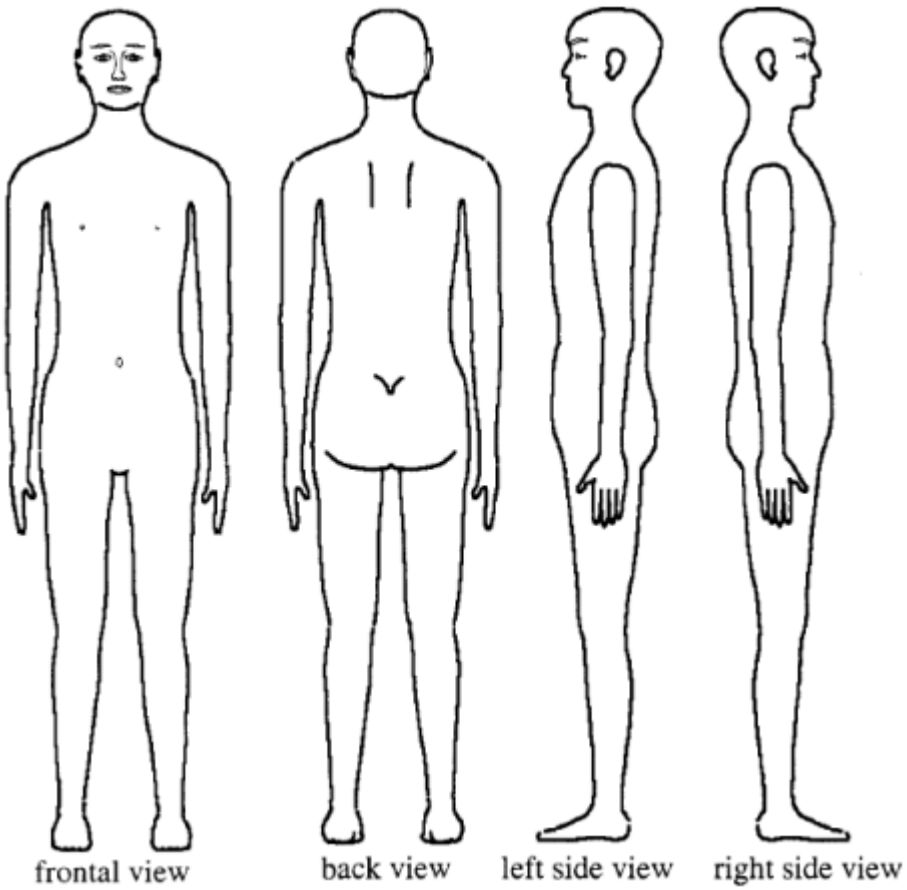
- ☐ No → *Go to Question B1, page 7.*
- ☐ Yes

What was the name of the disease?

Where was the skin cancer located on your body? (Example: upper right arm, left ear)

Please! Do not mark below this line

Please mark an "X" at the location(s) of your skin cancer(s). We are interested in the most exact location(s) you can provide so please be as specific as possible.



When was this diagnosed?

Month (mm) Year (yyyy)

If you don't remember the date when the skin cancer was diagnosed, please give your approximate age at the time, or a time period when it happened (*for example*, between 1980 and 1983).

Please! Do not mark below this line

A14. (Cont.) Where was this diagnosed?

Doctor's name
Hospital or clinic
Address
City, State, Zip code

If you had more than one occurrence of skin cancer, please use a separate sheet of paper.

Continue on next page.

Smoking

B1. Have you smoked cigarettes in the last month?

☐ No

☐ Yes

B2. Have you used smokeless tobacco in the last month?

☐ No

☐ Yes

B3. Have you smoked at least 100 cigarettes in your entire life?

☐ No → *Go to Question B9.*

☐ Yes

B4. How old were you when you started smoking?

☐☐ **Years**

B5. Do you smoke cigarettes now?

☐ No

☐ Yes

B6. On average, how many cigarettes a day do/did you smoke?

☐☐

B7. How many years, in total, have you smoked?

☐☐

B8. If you currently smoke, how many times in the past 12 months have you tried to quit smoking and not smoked for at least 24 hours?

☐☐

B9. In the past year, have you ever used any of these tobacco products? *(Mark all that apply)*

	Never used	No longer use	Occasionally use	Regularly use
Chewing tobacco	☐	☐	☐	☐
Snuff tobacco	☐	☐	☐	☐
Pipes	☐	☐	☐	☐
Cigars	☐	☐	☐	☐
E-Cigarettes	☐	☐	☐	☐

B10. For any of those that you have used or are currently using, how long have you used it?

	Less than 1 year	1 - 2 years	3 - 4 years	5 - 10 years	11+ years
Chewing tobacco	☐	☐	☐	☐	☐
Snuff tobacco	☐	☐	☐	☐	☐
Pipes	☐	☐	☐	☐	☐
Cigars	☐	☐	☐	☐	☐
E-Cigarettes	☐	☐	☐	☐	☐

B11. If you are no longer using the listed tobacco products, how long ago did you quit? Mark one.

☐☐ ☐ **Days** ☐ **Months** ☐ **Years**

Continue on next page.

Please! Do not mark below this line

Drug Use

B12. During your life, how many times have you used…

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 - 99 times	100 or more times
Marijuana/Hashish/Cannabis	☐	☐	☐	☐	☐	☐	☐
Cocaine/Crack/Freebase	☐	☐	☐	☐	☐	☐	☐
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy	☐	☐	☐	☐	☐	☐	☐
Sniffing glue/breathing aerosol spray cans/inhaling paints	☐	☐	☐	☐	☐	☐	☐
Heroin/Smack/Junk/White China	☐	☐	☐	☐	☐	☐	☐
Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms	☐	☐	☐	☐	☐	☐	☐

B13. During your life, how many times have you used without a doctor's prescription. . .

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 - 99 times	100 or more times
Steroid Pills or Shots	☐	☐	☐	☐	☐	☐	☐
Prescription Drugs (OxyContin/Percocet/Vicodin/ Codeine/Adderall/Ritalin/ Xanax)	☐	☐	☐	☐	☐	☐	☐

B14. During the past 30 days, how many times did you use…

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 or more
Marijuana/Hashish/Cannabis	☐	☐	☐	☐	☐	☐
Cocaine/Crack/Freebase	☐	☐	☐	☐	☐	☐
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy	☐	☐	☐	☐	☐	☐
Sniffing glue/breathing aerosol spray cans/inhaling paints	☐	☐	☐	☐	☐	☐
Heroin/Smack/Junk/White China	☐	☐	☐	☐	☐	☐
Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms	☐	☐	☐	☐	☐	☐

B15. During the past 30 days, how many times did you use without a doctor's prescription. . .

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 or more
Steroid Pills or Shots	☐	☐	☐	☐	☐	☐
Prescription Drugs (OxyContin/Percocet/Vicodin/ Codeine/Adderall/Ritalin/ Xanax)	☐	☐	☐	☐	☐	☐

Please! Do not mark below this line

B16. How old were you when you tried _____ for the first time?

Never tried		Age at first use
☐	Marijuana/Hashish/Cannabis	
☐	Cocaine/Crack/Freebase	
☐	Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy	
☐	Sniffing glue/breathing aerosol spray cans/inhaling paints	
☐	Heroin/Smack/Junk/White China	
☐	Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms.	

B17. How old were you when you tried _____ for the first time without a doctor's prescription?

Never tried		Age at first use
☐	Steroid Pills or Shots	
☐	Prescription Drugs (OxyContin/Percocet/Vicodin/ Codeine/Adderall/Ritalin/Xanax)	

If Never for all, Go to Question B20.

B18. In total, how many years have you/did you use…?

	Number of years	Avg # times used per year
Marijuana/Hashish/Cannabis		
Cocaine/Crack/Freebase		
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy		
Sniffing glue/breathing aerosol spray cans/inhaling paints		
Heroin/Smack/Junk/White China . . .		
Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms.		

B19. In total, how many years have you/did you use without a doctor's prescription…?

	Number of years	Avg # times used per year
Steroid Pills or Shots		
Prescription Drugs (OxyContin/Percocet/Vicodin/ Codeine/Adderall/Ritalin/Xanax) . . .		

B20. Have you ever been prescribed medical marijuana by your medical doctor?

☐ No → *Go to Question B21.*

☐ Yes

B20a. If yes, have you only used marijuana for medical purposes?

☐ No

☐ Yes

B21. During your life, how many times have you used a needle to inject any illegal drug into your body?

Please! Do not mark below this line

Alcohol

B22. In your entire life, have you ever had at least 2 drinks of any kind of alcoholic beverage?

☐ No → *Go to Question B28, next page.*

☐ Yes

B23. How old were you when you first started drinking alcohol?

☐☐ **Years**

B24. During the last 12 months, how many alcoholic drinks did you have on a typical day when you drank alcohol? *(If less than one per day, enter 0.)*

Wine (4 oz. glass):	Beer (12 oz. can):	Mixed drink (1 shot):
☐☐	☐☐	☐☐
Glasses a day	Cans a day	Drinks a day

B25. During the last 12 months, what is the largest number of drinks you had on any single day? Was it. . .

☐ 24+ drinks

☐ 12-23 drinks

☐ 8-11 drinks

☐ 5-7 drinks

☐ 4 drinks

☐ 3 drinks

☐ 2 drinks

☐ 1 drink

☐ 0 drinks → *Go to Question B28, next page.*

B26. During the last 12 months, how often did you usually have any kind of drink containing alcohol?

☐ Every day

☐ 5 to 6 times a week

☐ 3 to 4 times a week

☐ twice a week

☐ once a week

☐ 2 to 3 times a month

☐ once a month

☐ 3 to 11 times in the past year

☐ 1 or 2 times in the past year

☐ Never in the past year

B27. During the last 12 months, how often did you have 5 or more (males) or 4 or more (females) drinks containing any kind of alcohol in a single day?

☐ Every day

☐ 5 to 6 days a week

☐ 3 to 4 days a week

☐ two days a week

☐ one day a week

☐ 2 to 3 days a month

☐ one day a month

☐ 3 to 11 days in the past year

☐ 1 or 2 days in the past year

☐ Never in the past year

Please! Do not mark below this line

Physical Activity

Examples of physical activity intensity levels:

Light activities • your heart beats slightly faster than normal • you can talk and sing	 Walking Leisurely  Stretching  Vacuuming or Light Yard Work
Moderate activities • your heart beats faster than normal • you can talk but not sing	 Fast Walking  Aerobics Class  Strength Training  Swimming Gently
Vigorous activities • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths	 Stair Machine  Jogging or Running  Tennis, Racquetball, Badminton

For questions B28 through B36b, refer to the activity graphic above.

Do the following statements accurately describe your level of physical activity?	**No**	**Yes**
B28. I rarely or never do any physical activities	☐	☐
B29. I do some light or moderate physical activities, but not every week	☐	☐
B30. I do some light physical activity every week . . .	☐	☐
B31. I do activities to increase muscle strength, such as lifting weights or aerobics, once a week or more	☐	☐
B32. I do activities to improve flexibility, such as stretching or yoga, once a week or more	☐	☐

For questions B33 through B36b, continue to refer to the activity graphic.

B33. On how many of the <u>past 7 days</u> did you exercise or do sports for at least 20 minutes that made you sweat or breathe hard (e.g., dancing, jogging, basketball, etc.)?

☐ 0 days
☐ 1 day
☐ 2 days
☐ 3 days
☐ 4 days
☐ 5 days
☐ 6 days
☐ 7 days

B34. Now thinking about the <u>vigorous physical activities</u> you do in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, wheelchair basketball, heavy yard work, or anything else that causes large increases in breathing or heart rate?

☐ No → *Go to Question B35.*

☐ Yes

B34a. How many days per week do you do these <u>vigorous activities</u> for at least 10 minutes at a time?

☐ **days per week**

B34b. On days when you do <u>vigorous activities</u> for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

☐☐☐ **minutes per day**

Please! Do not mark below this line

Examples of physical activity intensity levels:

Light activities • your heart beats slightly faster than normal • you can talk and sing	 Walking Leisurely  Stretching  Vacuuming or Light Yard Work
Moderate activities • your heart beats faster than normal • you can talk but not sing	 Fast Walking  Aerobics Class  Strength Training  Swimming Gently
Vigorous activities • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths	 Stair Machine  Jogging or Running  Tennis, Racquetball, Pickleball or Badminton

B35. Now thinking about <u>moderate physical activities</u> you do in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, gardening, manual operation of a wheelchair, or anything else that causes small increases in breathing or heart rate?

☐ No → *Go to Question B36.*

☐ Yes

B35a. How many days per week do you do these <u>moderate activities</u> for at least 10 minutes at a time?

☐ **days per week**

B35b. On days when you do <u>moderate activities</u> for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

☐☐☐ **minutes per day**

B36. Now thinking about <u>light physical activities</u> you do in a usual week, do you do light activities for at least 10 minutes at a time, such as a slow casual walk, or anything else that does not cause an increase in your breathing or heart rate?

☐ No → *Go to Question B37.*

☐ Yes

B36a. How many days per week do you do these <u>light activities</u> for at least 10 minutes at a time?

☐ **days per week**

B36b. On days when you do <u>light activities</u> for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

☐☐☐ **minutes per day**

B37. Over the <u>last 2 years</u>, how long (if at all) has your health limited you in each of the following activities? *(Mark one box for each item.)*

	Limited for more than 3 months	Limited for 3 months or less	Not limited at all
a. The kinds or amounts of vigorous activities you can do, like lifting heavy objects, running or participating in strenuous sports.	☐	☐	☐
b. The kinds or amounts of moderate activities you can do, like moving a table, carrying groceries or bowling	☐	☐	☐
c. Walking uphill or climbing a few flights of stairs.	☐	☐	☐
d. Bending, lifting, or stooping	☐	☐	☐
e. Walking one block	☐	☐	☐
f. Eating, dressing, bathing, or using the toilet	☐	☐	☐

Please! Do not mark below this line

Please indicate which statements best describe your own health state today. *(Check only one for each group)*

B38a. Mobility

- ☐ I have no problems in walking about
- ☐ I have some problems walking about
- ☐ I am confined to bed

B38b. Self-Care

- ☐ I have no problems with self-care
- ☐ I have some problems washing or dressing myself
- ☐ I am unable to wash or dress myself

B38c. Usual Activities (e.g. work, study, housework, family, or leisure activities)

- ☐ I have no problems with performing my usual activities
- ☐ I have some problems with performing my usual activities
- ☐ I am unable to perform my usual activities

B38d. Pain/Discomfort

- ☐ I have no pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have extreme pain or discomfort

B38e. Anxiety/Depression

- ☐ I am not anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am extremely anxious or depressed

Continue on next page.

Daily Activity

B39. Which statement best describes your usual daily activities?

- ☐ I mostly sit during the day and do not walk about very much
- ☐ I stand or walk about quite a lot during the day, but do not have to carry or lift things very often
- ☐ I carry light loads, or have to climb stairs or hills often
- ☐ I do heavy work or carry heavy loads

B40. Over the past 30 days, on a typical day how much time altogether did you spend sitting and watching TV or videos or using a computer or other electronic portable device outside of work? Would you say ...

- ☐ Don't watch TV or videos or use a computer or electronic portable device
- ☐ <1 hour
- ☐ 1 - 2 hours
- ☐ 3 - 4 hours
- ☐ 5 - 6 hours
- ☐ 7 - 8 hours
- ☐ 9 hours or more

B41. Because of any impairment or health problems, do you need the help of other persons with personal care needs, such as eating, bathing, dressing, or getting around your home?

- ☐ No
- ☐ Yes

B42. Because of any impairment or health problems, do you need the help of other persons in handling routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

- ☐ No
- ☐ Yes

B43. Does any impairment or health problem keep you from holding a job or attending school?

- ☐ No
- ☐ Yes

B44. Do you currently have a driver's license?

- ☐ No
- ☐ Yes

HEALTH STATUS

C1. Would you rate yourself as being:

- ☐ Completely disabled
- ☐ Severely disabled
- ☐ Moderately disabled
- ☐ Mildly disabled
- ☐ Not at all disabled

C2. In general, would you say your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

C3. Compared to one year ago, how would you rate your health in general now?

- ☐ Much better now than one year ago
- ☐ Somewhat better now than one year ago
- ☐ About the same as one year ago
- ☐ Somewhat worse now than one year ago
- ☐ Much worse now than one year ago

Continue on next page.

C4. 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?

	No, not limited at all	Yes, limited a little	Yes, limited a lot
a. Vigorous Activities, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b. Moderate Activities, such as moving a table, bowling, or playing golf	☐	☐	☐
c. Lifting or carrying groceries	☐	☐	☐
d. Climbing several flights of stairs	☐	☐	☐
e. Climbing one flight of stairs	☐	☐	☐
f. Bending, kneeling, or stooping	☐	☐	☐
g. Walking more than a mile	☐	☐	☐
h. Walking several hundred yards	☐	☐	☐
i. Walking one hundred yards	☐	☐	☐
j. Bathing or dressing yourself	☐	☐	☐

C5. 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?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Cut down on the amount of time you spent on work or other activities	☐	☐	☐	☐	☐
b. Accomplished less than you would like	☐	☐	☐	☐	☐
c. Were limited in the kind of work or other activities	☐	☐	☐	☐	☐
d. Had difficulty performing the work or other activities (for example, it took extra effort)	☐	☐	☐	☐	☐

C6. 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)?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Cut down on the amount of time you spent on work or other activities	☐	☐	☐	☐	☐
b. Accomplished less than you would like	☐	☐	☐	☐	☐
c. Did work or activities less carefully than usual	☐	☐	☐	☐	☐

C7. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

Continue on next page.

Please! Do not mark below this line

C8. How much bodily pain have you had during the past 4 weeks?

- ☐ None
- ☐ Very mild
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Very severe

C9. 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
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

C10. For pain that you have had during the past 4 weeks, where has this pain been located? ***(Check all that apply)***

- ☐ Head
- ☐ Neck
- ☐ Chest
- ☐ Hands/Arms
- ☐ Abdomen
- ☐ Back
- ☐ Pelvis
- ☐ Legs/Feet
- ☐ Other

Specify

C11. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please mark 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	Some of the time	A little of the time	None of the time
a. Did you feel full of life?	☐	☐	☐	☐	☐
b. Have you been very nervous? . . .	☐	☐	☐	☐	☐
c. Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐
d. Have you felt calm and peaceful?.	☐	☐	☐	☐	☐
e. Did you have a lot of energy?	☐	☐	☐	☐	☐
f. Have you felt downhearted and depressed?	☐	☐	☐	☐	☐
g. Did you feel worn out?	☐	☐	☐	☐	☐
h. Have you been happy?	☐	☐	☐	☐	☐
i. Did you feel tired?	☐	☐	☐	☐	☐

C12. 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
- ☐ A little of the time
- ☐ Most of the time
- ☐ None of the time
- ☐ Some of the time

C13. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people	☐	☐	☐	☐	☐
b. I am as healthy as anybody I know	☐	☐	☐	☐	☐
c. I expect my health to get worse . . .	☐	☐	☐	☐	☐
d. My health is excellent	☐	☐	☐	☐	☐

Please! Do not mark below this line