Clinic: | Participant ID: | Nickname: | Outcome Visit: | Month: | Day: | Year:

Quality of Well-Being Scale, Self-Administered (QWB-SA), V1.04

This survey asks about health problems that you have experienced in the last 3 days, not including today. Please answer all questions by filling in the appropriate circle completely with blue or black ink. Please do not use check marks or felt tip pens. Thank you.

1. Please indicate whether you currently experience each of the following health symptoms or problems:

Do you have	**YES**	**NO**
a. blindness or severely impaired vision in both eyes?	O	O
blindness or severely impaired vision in only one eye?	O	O
b. speech problems such as stuttering, or being unable to speak clearly?	O	O
c. missing or paralyzed hands, feet, arms, or legs?	O	O
missing or paralyzed fingers or toes?	O	O
d. any deformity of the face, fingers, hand or arm, foot or leg, or back (e.g. severe scoliosis)?	O	O
e. general fatigue, tiredness, or weakness?	O	O
f. a problem with unwanted weight gain or weight loss?	O	O
g. a problem with being under or over weight?	O	O
h. problems chewing your food adequately?	O	O
i. any hearing loss or deafness?	O	O
j. any noticeable skin problems, such as bad acne or large burns or scars on face, body, arms, or legs?	O	O
k. eczema or burning/itching rash?	O	O
Which of the following health aides do you use/have?	**YES**	**NO**
a. dentures?	O	O
b. oxygen tank?	O	O
c. prosthesis?	O	O
d. eye glasses or contact lenses?	O	O
e. hearing aide?	O	O
f. magnifying glass?	O	O
g. neck, back, or leg brace?	O	O

2. For the following list of problems, indicate which days (if any) over the past 3 days, not including today, you had the problem. If you have not had the symptom in the past 3 days, do not leave the question blank, please fill in "no days." If you have experienced the symptom in the past 3 days, please fill in which of the days you had it; if you experienced it on more than one of the days, please fill in all days that apply.

	No days	**Yester-day**	**2 days ago**	**3 days ago**
For example, if you had a headache yesterday and the day before that, you would mark for a headache:	O	●	●	O
Did you have (please fill in all days that apply) a. any problems with your vision not corrected with glasses or contact lenses (such as double vision, distorted vision, flashes, or floaters)?	O	O	O	O
b. any eye pain, irritation, discharge, or excessive sensitivity to light?	O	O	O	O

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Did you have (please fill in all days that apply)	No days	Yester–day	2 days ago	3 days ago
c. a headache?	O	O	O	O
d. dizziness, earache, or ringing in your ears?	O	O	O	O
e. difficulty hearing, or discharge, or bleeding from an ear?	O	O	O	O
f. stuffy or runny nose, or bleeding from the nose?	O	O	O	O
g. a sore throat, difficulty swallowing, or hoarse voice?	O	O	O	O
h. a tooth ache or jaw pain?	O	O	O	O
i. sore or bleeding lips, tongue, or gums?	O	O	O	O
j. coughing or wheezing?	O	O	O	O
k. shortness of breath or difficulty breathing?	O	O	O	O
l. chest pain, pressure, palpitations, fast or skipped heart beat, or other discomfort in the chest?	O	O	O	O
m. an upset stomach, abdominal pain, nausea, heartburn, or vomiting?	O	O	O	O
n. difficulty with bowel movements, diarrhea, constipation, rectal bleeding, black tar-like stools, or any pain or discomfort in the rectal area?	O	O	O	O
o. pain, burning, or blood in urine?	O	O	O	O
p. loss of bladder control, frequent night-time urination, or difficulty with urination?	O	O	O	O
q. genital pain, itching, burning, or abnormal discharge, or pelvic cramping or abnormal bleeding (does not include normal menstruation)?	O	O	O	O
r. a broken arm, wrist, foot, leg, or any other broken bone (other than in the back)?	O	O	O	O
s. pain, stiffness, cramps, weakness, or numbness *in the neck or back*?	O	O	O	O
t. pain, stiffness, cramps, weakness, or numbness *in the hips or sides*?	O	O	O	O
u. pain, stiffness, cramps, weakness, or numbness in any *of the joints or muscles of the hand, feet, arms, or legs*?	O	O	O	O
v. swelling of ankles, hands, feet, or abdomen?	O	O	O	O
w. fever, chills, or sweats?	O	O	O	O
x. loss of consciousness, fainting, or seizures?	O	O	O	O
y. difficulty with your balance, standing, or walking?	O	O	O	O

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Did you have (please fill in all days that apply)	No days	Yester-day	2 days ago	3 days ago
3. The following symptoms are about your feelings, thoughts, and behaviors. Please fill in which days (if any) over the past 3 days, not including today, you have had				
a. trouble falling asleep or staying asleep?	O	O	O	O
b. spells of feeling nervous or shaky?	O	O	O	O
c. spells of feeling upset, downhearted, or blue?	O	O	O	O
d. excessive worry or anxiety?	O	O	O	O
e. feelings that you had little or no control over events in your life?	O	O	O	O
f. feelings of being lonely or isolated?	O	O	O	O
g. feelings of frustration, irritation, or close to losing your temper?	O	O	O	O
h. a hangover?	O	O	O	O
i. any decrease of sexual interest or performance?	O	O	O	O
j. confusion, difficulty understanding the written or spoken word, or significant memory loss?	O	O	O	O
k. thoughts or images you could not get out of your mind?	O	O	O	O
l. to take any medication including over-the-counter remedies (aspirin/tylenol, allergy medications, insulin, hormones, estrogen, thyroid, prednisone)?	O	O	O	O
m. to stay on a medically prescribed diet for health reasons?	O	O	O	O
n. a loss of appetite or over-eating?	O	O	O	O
4. In the last 3 days did you have any symptoms, health complaints, or pains that have not been mentioned? O Yes O No If yes, what were they and on which days did you have them?				
Symptom A:_____	O	O	O	O
Symptom B:_____	O	O	O	O

Over the last 3 days (please fill in all days that apply)	No days	Yester-day	2 days ago	3 days ago
5a. did you spend any part of the day or night as a patient in a hospital, nursing home, or rehabilitation center?	O	O	O	O
5b. because of any impairment or health problem, did you need help with your personal care needs, such as eating, dressing, bathing, or getting around your home?	O	O	O	O
6a. which days did you drive a motor vehicle?	O	O	O	O
6b. which days did you use public transportation such as a bus, subway, Medi-van, train, or airplane?	O	O	O	O
6c. which days did you either not drive a motor vehicle or not use public transportation because of your health, or need help from another person to use?	O	O	O	O

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Over the last three days, did you (please fill in all days that apply)	**No days**	**Yester-day**	**2 days ago**	**3 days ago**
7a. have trouble climbing stairs or inclines or walking off the curb?	O	O	O	O
7b. avoid walking, have trouble walking, or walk more slowly than other people your age?	O	O	O	O
7c. limp or use a cane, crutches, or walker?	O	O	O	O
7d. avoid or have trouble bending over, stooping, or kneeling?	O	O	O	O
7e. have any trouble lifting or carrying everyday objects such as books, a briefcase, or groceries?	O	O	O	O
7f. have any other limitations in physical movements?	O	O	O	O
7g. spend all or most of the day in a bed, chair, or couch because of health reasons?	O	O	O	O
7h. spend all or most of the day in a wheelchair?	O	O	O	O
If in a wheelchair, on which days did someone else control its movement?	O	O	O	O
8a. because of any physical or emotional health reasons, on which days did you avoid, need help with, or were limited in doing some of your usual activities, such as work, school, or housekeeping?	O	O	O	O
8b. because of physical or emotional health reasons, on which days did you avoid or feel limited in doing some of your usual activities, such as visiting family or friends, hobbies, shopping, recreational, or religious activities?	O	O	O	O
8c. on which days did you have to change any of your plans or activities because of your health? (Consider only activities that you did not report in the last 2 questions.)	O	O	O	O

9a. Would you say that your health is:
- O Excellent
- O Very Good
- O Good
- O Fair
- O Poor

9b. Compared to a year ago, how would you rate your health in general now?
- O Much better now than a year ago
- O Somewhat better now than one year ago
- O About the same as a year ago
- O Somewhat worse than a year ago
- O Much worse than a year ago

9c. Think about a scale of 0 to 100, with zero being the least desirable state of health that you could imagine and 100 being perfect health. What number from 0 to 100 would you give to the state of your health, on average, over the last 3 days?

0	10	20	30	40	50	60	70	80	90	100
O	O	O	O	O	O	O	O	O	O	O

10a. Sex: O Male O Female

10b. Age in Years: ☐☐☐

10c. What is your ethnicity?
- O African American
- O Asian/Pacific Islander
- O Caucasian – Non Hispanic
- O Hispanic
- O Native American
- O Other

10d. Which of the following best describes your educational background?
- O 8th Grade Graduate
- O High School Graduate
- O Some College
- O College Graduate (B.S. or B.A. degree)
- O Some Graduate School
- O Completed Post-Graduate (M.A.,M.D.,Ph.D.)