

Medical Outcomes Study: 20-Item Patient Questionnaire

Choose one option for each questionnaire item.

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

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

2. For how long (if at all) has your **health limited you in each** of the following activities?

	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	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. The kinds or amounts of moderate activities you can do, like moving a table, carrying groceries, or bowling	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. Walking uphill or climbing a few flights of stairs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. Bending, lifting, or stooping	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. Walking one block	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. Eating, dressing, bathing, or using the toilet	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

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3. How much **bodily** pain have you had **during the past 4 weeks**:

- 1- None
- 2- Very mild
- 3- Mild
- 4- Moderate
- 5- Severe
- 6- Very Severe

4. Does your health **keep** you from working at a job, doing work around the house, or going to school?

- 1- YES for more than 3 months
- 2- YES for 3 months or less
- 3- No

5. Have you been unable to do **certain kinds or amounts** of work, housework, or schoolwork because of your health?

- 1- YES for more than 3 months
- 2- YES for 3 months or less
- 3- No

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For **each** of the following questions, please mark the circle for the **one** answer that comes **closest** to the way you have been feeling **during the past month**.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	None of the time
6. How much of the time, during the past month, has your health limited your social activites (like visiting with friends or close relatives)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
7. How much of the time, during the past month, have you been a very nervous person ?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
8. During the past month, how much of the time, have you felt calm and peaceful ?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
9. How much of the time, during the past month, have you felt downhearted and blue ?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
10. During the past month, how much of the time, have you been a happy person ?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
11. How often, during the past month much of the time, during the past month, have you felt downhearted and blue ?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

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12. Please mark the circle that **best** describes whether **each** of the following statements is **true or false** for you

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
a. I am somewhat ill	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. I am as healthy as anybody I know	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. My health is excellent	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. I have been feeling badly today	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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