THE QUESTIONS OF HOWSYOURHEALTH GERIATRIC AND SCORING CONVENTIONS 9/06

* ARE USED IN THE CALCULATION SHOWN IN THE CUMULATIVE REPORTS

DAILY ACTIVITIES
During the past 4 weeks how much difficulty have you had doing your usual activities or tasks, both inside and outside the house because of your physical and emotional health?

No difficulty at all
A little bit of difficulty
Some difficulty
Much difficulty*
Could not do*

Continue

DAILY ACTIVITIES

You answered that you had greater than average difficulty doing your usual activities or tasks.

Is your doctor or nurse aware of the problem?

Yes

No

DAILY ACTIVITIES

You answered that you had greater than average difficulty doing your usual activities or tasks.

How would you rate your doctor's or nurse's explanation of the problem(s)?

Excellent*

Very good*

Good

Fair

Poor

DAILY ACTIVITIES

You answered that you had greater than average difficulty doing your usual activities or tasks.

Treatment has made these problems:

No treatment has been given to me for these problems

Much better*

A little better*

No different

A little worse

Much worse

FEELINGS

During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?

Not at all
Slightly
Moderately
Quite a bit*
Extremely*

FEELINGS

You answered that you have been bothered by more than average emotional problems.

Is your doctor or nurse aware of the problem?

Yes

No

FEELINGS

You answered that you have been bothered by more than average emotional problems.

How would you rate your doctor's or nurse's explanation of the problem(s)?

Excellent*

Very good*

Good

Fair

Poor

FEELINGS

You answered that you have been bothered by more than average emotional problems.

Treatment has made these problems:

No treatment has been given to me for these problems

Much better*

A little better*

No different

A little worse

Much worse

SOCIAL ACTIVITIES

During the past 4 weeks, has your physical and emotional health limited your social activities with family friends, neighbors or groups?

Not at all
Slightly
Moderately
Quite a bit*
Extremely*

SOCIAL ACTIVITIES

You answered that your social activities have been limited more than average.

Is your doctor or nurse aware of the problem?

Yes

No

SOCIAL ACTIVITIES

You answered that your social activities have been limited more than average.

How would you rate your doctor's or nurse's explanation of the problem(s)?

Excellent*

Very good*

Good

Fair

Poor

SOCIAL ACTIVITIES

You answered that your social activities have been limited more than average.

Treatment has made these problems:

No treatment has been given to me for these problems

Much better*

A little better*

No different

A little worse

Much worse

PAIN

During the past 4 weeks, how much bodily pain have you generally had?

No pain
Very mild pain
Mild pain
Moderate pain*
Severe pain*

PAIN

You answered that you had greater than average bodily pain.

Is your doctor or nurse aware of the problem?

Yes

No

PAIN

You answered that you had greater than average bodily pain.

How would you rate your doctor's or nurse's explanation of the problem(s)?

Excellent*

Very good*

Good

Fair

Poor

PAIN

You answered that you had greater than average bodily pain.

Treatment has made these problems:

No treatment has been given to me for these problems

Much better*

A little better*

No different

A little worse

Much worse

SOCIAL SUPPORT

During the past 4 weeks, was someone available to help you if you needed and wanted help?

For example, if you: felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself

Yes, as much as I wanted
Yes, quite a bit
Yes, some
Yes, a little*
No, not at all*

SOCIAL SUPPORT

You answered that you had very little or no social support.

Is your doctor or nurse aware of the problem?

Yes

No

SOCIAL SUPPORT

You answered that you had very little or no social support.

How would you rate your doctor's explanation of the problem(s)?

Excellent*

Very good*

Good

Fair

Poor

SOCIAL SUPPORT

You answered that you had very little or no social support.

Treatment has made these problems:

No treatment has been given to me for these problems

Much better*

A little better*

No different

A little worse

Much worse

PHYSICAL FITNESS

During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes

Very heavy
Heavy
Moderate
Light*
Very light*

PHYSICAL FITNESS

You answered that you had greater than average difficulty doing physical activities.

Is your doctor or nurse aware of the problem?

Yes

No

PHYSICAL FITNESS

You answered that you had greater than average difficulty doing physical activities.

How would you rate your doctor's or nurse's explanation of the problem(s)?

Excellent*

Very good*

Good

Fair

Poor

PHYSICAL FITNESS

You answered that you had greater than average difficulty doing physical activities.

Treatment has made these problems:

No treatment has been given to me for these problems

Much better*

A little better*

No different

A little worse

Much worse

How often during the PAST FOUR WEEKS have you been bothered by any of the following problems?

Never Seldom Sometimes Often*Always*

Trouble thinking or remembering
Trouble urinating or wetting
Trouble hearing
Trouble seeing
Falling or dizzy when standing up
Trouble sleeping

Foot problems
Constipation
Trouble eating well

You answered that you had been bothered by one or more problems.

Has your doctor treated the problem(s)?

Yes, the doctor has treated the problem(s)*

Yes, the doctor has treated some of these problems*

No, the doctor has not treated the problem(s)

You answered that the doctor has treated one or more of these problems.

Treatment has made these problems:

Much better*

A little better*

No different

A little worse

Much worse

Do you use any of the following:
(Please mark all that apply)*

A cane, wheelchair, or walker
Brace(s) or prosthesis
A hearing aid
Dentures
Reading glasses
Raised toilet seat, bathtub bars, toilet bars
Devices for dressing, eating, or bathing
Emergency Alert System

If you became too sick to speak for yourself, who would decide about medical treatment for you?

I am not sure

Family members*

Friends*

My doctor*

Other*

You answered that you knew who would decide about medical treatment for you:

Do they know what you would want?

Yes*

No

I am not sure

Is what you want in writing?

Yes*

No

I am not sure

Have you ever had a shot to prevent pneumonia(Pneumovax), in the past five years?

Yes*

No

I am not sure

Do you have a flu shot to prevent flu every year?

Yes*

No

I am not sure

Have you had a tetanus shot in the past 10 years?

Yes*

No

I am not sure

In the past two years, have you had a test for cancer of the bowel?

Yes *

No

Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

Yes*

No

Keeping track of your medications?

Yes*

No

During the PAST FOUR WEEKS, have you seen any of the following health care workers?
(Please mark all that apply)

I have not seen any other health care workers
Your own or another doctor
Home health aid or a nurse in your home
Social worker
Podiatrist (foot doctor)
Chiropractor
Mental health worker or psychiatrist or psychologist or counselor
Physical therapist or occupational therapist
Nurse practitioner or physician's assistant

Can you get to places out of walking distance without help? (for example, can you travel alone on buses, taxis, or drive your own car)

Yes

No*

Can you go shopping for groceries or clothes without someone's help?

Yes

No*

Can you prepare your own meals?

Yes

No*

Can you do your housework without help?

Yes

No*

Can you handle your own money without help?

Yes

No*

Do you have enough money to buy the things that you need to live everyday such as food, clothing, or housing?

Yes, usually

Yes, sometimes*

No*

Are you having difficulties driving your car?

Yes, often*

Sometimes*

No

Not applicable, I do not use a car

Are you a smoker?

No

Yes, and I might quit*

Yes, but I'm not ready to quit*

During the PAST 4 WEEKS, how many drinks of wine, beer or other alcoholic beverages did you have?

10 or more per week *

6-9 per week*

2-5 per week

1 drink or less per week

No alcohol at all

How many dollars do your prescription medications cost you each month?

less than $25

$26 - $59

$60 - $100

more than $100

Do you believe any of your medications are making you ill?

Yes*

No

Maybe, I am not sure*

I am not taking any medications

How many different prescription medications are you currently taking more than three days a week?

None

1-2

3-5

More than 5*

OVERALL HEALTH

During the past 4 weeks, how would you rate your health in general?

Excellent
Very good
Good
Fair*
Poor*

QUALITY OF LIFE

How have things been going for you during the past four weeks?

Very well - could hardly be better
Pretty good
Good and bad parts about equal*
Pretty bad*
Very bad - could hardly be worse*

Has a doctor told you that you have any of these problems:
(Please mark all that apply)

High blood pressure
Heart trouble or hardening of the arteries
(Sugar) Diabetes
Arthritis
Asthma, bronchitis or emphysema
Serious obesity (more than 15% overweight)

You checked that you have high blood pressure, heart trouble, diabetes, or breathing problems.

In the past year have you been in the hospital or visited an emergency room because of any of these problems?

Yes *

No

You checked that you have high blood pressure, heart trouble, diabetes, or breathing problems.

In general, how would you rate the information given to you about these problem(s) by your doctor or a nurse?

Excellent*

Very Good*

Good

Fair

Poor

I do not remember receiving any information

You checked that you have high blood pressure, heart trouble, diabetes, or breathing problems.

In general, how much have any of the doctors or nurses helped you live with these problems?

A lot*

Some

A little

Not much

I have not needed any help

You checked that you have high blood pressure, heart trouble, diabetes, or breathing problems.

What is your weight in pounds (kilograms)?

less than 100 (45)
100-120 (46-55)
121-140 (56-64)
141-160 (65-73)
161-180 (74-82)
181-200 (83-91)
201-220 (92-100)
221-240 (101-109)
240 or more (>110)

What is your height in inches (within 2 inches)?

Feet: Inches:

In the PAST 3 MONTHS did you have an illness or injury that kept you in bed for all or most of the day?

Yes

No

In the PAST YEAR did you stay in a hospital overnight or longer?

Yes

No

Do you have one person you think of as your personal doctor or nurse?

Yes

No

Are there things about your medical care that could be better?

No, my care is perfect

Yes, some things

Yes, a lot of things

How easy is it for you to get medical care when you need it?

Very Easy*
Easy
Somewhat Difficult
Very Difficult
I have not needed medical care

You indicated earlier that you have breathing problems.

How would you rate the information your doctor or a nurse gave you about:
Excellent* Very Good* Good Fair Poor I do not remember receiving any information
How to adjust medicines for your shortness of breath?

How to use inhaled medicines?

Do you use an inhaled steroid?

Yes*

No

Not sure

You indicated earlier that you have diabetes.

How often do you keep your blood sugar (glucose) in normal range (between 80 and 150)?

I do not test my blood sugar

*All of the time

*Often

Sometimes

Rarely

Never

How would you rate the information your doctor or a nurse gave you about:

*Excellent

*Very Good

Good

Fair

Poor

I do not remember receiving any information

Having your eyes checked?

How to check feet and choose proper shoes?

How to adjust medicines for diabetes and recognize when to call a doctor or nurse for help?

If your blood sugar level before eating was checked in the past four weeks, what was it?
Less than 100

101-120

121-140

141-160

161-180

181-200

201-250

Over 250

How would you rate the blood pressure information your doctor or nurse has given you?

*Excellent

*Very Good

Good

Fair

Poor

I do not remember receiving any information

What to do if you miss a dose of your medicine?

The effect of weight and salt on our blood pressure?

The problems blood pressure medications might cause you?

Do you check your own blood pressure?

*Yes, often

Yes, sometimes

Almost never

Never

What was your last blood pressure?
High Number (systolic)

Under 100

100-120

121-130

131-140

141-150

151-160

161-170

Over 171

I don't know

Low Number (diastolic)

Less than 60

60-70

71-80

81-90

91-100

101-110

Over 110

I don't know

What was your last total cholesterol level?

Less than 100
101-130
131-160
161-180
181-200
201-220
221-240
Over 240
I don't know

You indicated earlier that you have heart trouble.

Have you ever had a heart attack?

Yes

No

If you answered yes, are you taking aspirin and a "beta blocker" such as propanolol (Inderal), or other "beta blocker" drugs that end with a 'lol'?

Yes

No

I am not sure

Have you had a stroke, paralysis or "shock"?

Yes

No

If yes, are you now taking a "blood thinner" each day like aspirin or warfarin?

Yes

No

In the last month, have you used nitroglycerin for chest pain, tightness or angina?

Yes

No

If you answered yes, how satisfied are you that everything is being done for your chest pain, tightness or angina?

*Completely satisfied

*Mostly satisfied

Somewhat satisfied

Mostly dissatisfied

Not satisfied at all

Have you been told that you have heart failure?

Yes
No

If you answered yes, how would you rate the information your doctor or a nurse gave you about

*Excellent

*Very Good

Good

Fair

Poor

I do not remember receiving any information

The effect of weight and salt on your heart failure?

How to adjust medicines for your weight, shortness of breath and leg swelling?

Describe here any medical errors (mistakes) that you or your family have experienced. Errors include such things as mixed up medications or poor treatment that result in harm or additional problems. If possible, be sure to tell us the cause of the error and how it might have been avoided. Your response will help us to improve future care delivery.

If you wrote in an error or harm, please help us by choosing ANY of the following categories for this error.
(Please mark all that apply) *ALL MUST BE PRESENT TO BE CODED A HARM

*It caused harm, hurt or injury

*It happenend within the last year

*It happened to me

How confident are you that you can control and manage most of your health problems?

*Very confident
Somewhat confident
Not very confident
I do not have any health problems.

Do you exercise for about 20 minutes 3 or more days a week?

*Yes, most of the time

Yes, some of the time

No, I usually do not exercise this much.

When you visit your doctor's office, how often is it well organized, efficient, and does not waste your time?

*Most of the time

Some of the time

Almost never is it efficient. It often wastes my time.

Does not apply to me. I seldom visit a doctor's office.

I receive exactly the help I want and need exactly when I want and need it. (qexact)

Strongly Agree*   Agree   Disagree   Strongly   Disagree

****
****

For the summary scores at the end:

domain: Your Health Habits

Health Habits (Adult only)
Smoking
Drinking
qExercise
BMI calculation

domain Your Health Care and Self Care
Perfect Care
Confidence

domain Your Number of Health Problems and Risks
Diseases
Symptoms
Emotions
Pain
ED/Hospital Use or Hosp
Medication Problems
Medications

The cutoffs from these three summative categories were made on a sample of about 30,000 persons so that approximately 15% are in the "best" group; 35% in the middle group, and the remaining 50% in the lowest or "at risk" group.