
Health-Related Quality of Life Survey: CDC HRQOL-14

Please circle your answers and fill in the blanks about yourself or your child. If at any point you would like to skip a question or opt out of the survey, you may do so.

I. Healthy Days Core Module (CDC HRQOL-4)

1. Would you say that in general your health is
 - a. Excellent
 - b. Very good
 - c. Good
 - d. Fair
 - e. Poor
 - f. Don't know/not sure
 - g. Refused

2. Now thinking about your physical health, which includes physical illness and injury, for how many days **during the past 30 days** was your physical health not good?
 - a. Number of days: _____
 - b. None*
 - c. Don't know/not sure
 - d. Refused

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days **during the past 30 days** was your mental health not good?
 - a. Number of days: _____
 - b. None*
 - c. Don't know/not sure
 - d. Refused

II. Activity Limitations Module

1. Are you LIMITED in any way in any activities because of any impairment or health problem?
 - a. Yes
 - b. No
 - c. Don't know/not sure
 - d. Refused

2. What is a MAJOR impairment or health problem that limits your activities? Circle answers.

| | |
|------------------------|---------------------|
| Arthritis/rheumatism | Stroke problem |
| Back or neck problem | High blood pressure |
| Bone/joint injury | Diabetes |
| Walking problem | Cancer |
| Lung/breathing problem | Depression/anxiety |
| Hearing problem | Other impairment |
| Eye/vision problem | Unsure |
| Heart problem | Refused |

3. For HOW LONG have your activities been limited because of your major impairment or health problem?
 - a. Days
 - b. Weeks
 - c. Months
 - d. Years
 - e. Don't know/not sure
 - f. Refused

***If both Q2 and Q3= "None", skip question 4**

4. **During the past 30 days**, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
 - a. Number of days: _____
 - b. None
 - c. Don't know/not sure
 - d. Refused

Continue from Activity Limitations Module:

4. Because of any impairment or health problem, do you need the help of other persons with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?

- a. Yes
- b. No
- c. Don't know/not sure
- d. Refused

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

- a. Yes
- b. No
- c. Don't know/not sure
- d. Refused

III. Healthy Days Symptoms Module

1. **During the past 30 days**, for about how many days did PAIN make it hard for you to do your usual activities, such as self-care, work, or recreation?

- a. Number of Days: ____
- b. None
- c. Don't know/not sure
- d. Refused

2. **During the past 30 days**, for about how many days have you felt SAD, BLUE, or DEPRESSED?

- a. Number of Days: ____
- b. None
- c. Don't know/not sure
- d. Refused

3. **During the past 30 days**, for about how many days have you felt WORRIED, TENSE, or ANXIOUS?

- a. Number of days: ____
- b. None
- c. Don't know/not sure
- d. Refused

4. **During the past 30 days**, for about how many days have you felt you did NOT get ENOUGH REST or SLEEP?

- a. Number of Days: ____
- b. None
- c. Don't know/not sure
- d. Refused

5. **During the past 30 days**, for about how many days have you felt VERY HEALTHY AND FULL OF ENERGY?

- a. Number of days: ____
- b. None
- c. Don't know/not sure
- d. Refused