(For Internal Use Only)

Patient Study Number	Completed By:_____ Clinic:_____
Visit Date (MM/DD/YY) __ __ / __ __ / __ __	Visit Schedule *(check appropriate box)* ☐ Preop ☐ 3 mo ☐ 6 mo ☐ 12 mo ☐ 24 mo

S.O.L.V.E.D

SF-12v2™ Health Survey

(SF-12 v2 Standard, US Version 2.0)

To be completed by the PATIENT

Directions: *This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. If you are unsure about how to answer a question, please give the best answer you can.* ***Mark only one answer for each question unless otherwise instructed. Shade circles like this:*** ●

		Excellent	Very Good	Good	Fair	Poor
01.	**In general, would you say your health is:**	○	○	○	○	○

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?		Yes, limited a lot	Yes, limited a little	No, not limited at all
02.	**Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf**	○	○	○
03.	**Climbing several flights of stairs**	○	○	○

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?		All of the time	Most of the time	Some of the time	A little of the time	None of the time
04.	**Accomplished less than you would like**	○	○	○	○	○
05.	**Were limited in the kind of work or other activities**	○	○	○	○	○

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)?		All of the time	Most of the time	Some of the time	A little of the time	None of the time
06.	**Accomplished less than you would like**	○	○	○	○	○
07.	**Did work or activities less carefully than usual**	○	○	○	○	○

		Not at all	A little bit	Moderately	Quite a bit	Extremely
08.	**During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?**	○	○	○	○	○

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give 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
09.	**Have you felt calm and peaceful?**	○	○	○	○	○
10.	**Did you have a lot of energy?**	○	○	○	○	○
11.	**Have you felt downhearted and depressed?**	○	○	○	○	○

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
12.	**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.)?**	○	○	○	○	○

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S.O.L.V.E.D

EuroQol EQ-5D

To be completed by the PATIENT

Directions: *Answer every question by shading in the circle or writing in the information. If you are unsure about how to answer a question, please give the best answer you can.* **Mark only one answer for each question. Shade circles like this: ●**

By filling in one circle in each group below, please indicate which statement best describes your own health state today. Do not fill more than one circle in each group.

01. Mobility

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

02. 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

03. 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

04. Pain / Discomfort

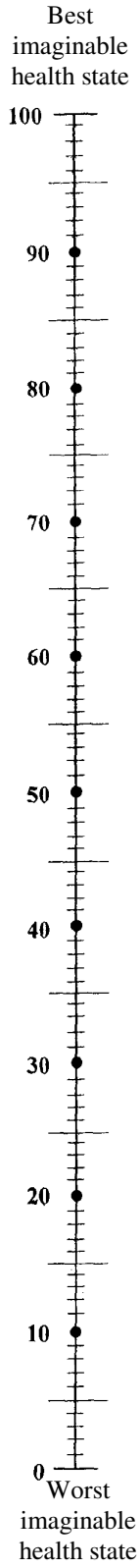
- ○ I have no pain or discomfort
- ○ I have moderate pain or discomfort
- ○ I have extreme pain or discomfort

05. Anxiety / Depression

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

06. ***To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked by 0.***

We would like you to indicate on this scale how good or bad your own health is today. Mark a line across the scale to show how good or bad you think your health is today.



PHYSICIAN USE ONLY:

07. ____ ____ ____
SCORE

ver.022107BMC

CONFIDENTIAL

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S.O.L.V.E.D

Short Musculoskeletal Function Assessment

To be completed by the PATIENT

Directions*: We are interested in finding out how you are managing with your injury or arthritis this week. We would like to know about any problems you may be having with your daily activities because of your injury or arthritis. Please answer each question by shading in the circle corresponding to the choice that best describes you..* **Mark only one answer for each question unless otherwise instructed. Shade circles like this: ●**

These questions are about how much difficulty you may be having <u>this week</u> with your daily activities because of your injury or arthritis.

		Not at all <u>difficult</u>	A little <u>difficult</u>	Moderately <u>difficult</u>	Very <u>difficult</u>	Unable <u>to do</u>
01.	**How difficult is it for you to get in or out of a low chair?**	○	○	○	○	○
02.	**How difficult is it for you to open medicine bottles or jars?**	○	○	○	○	○
03.	**How difficult is it for you to shop for groceries or other things?**	○	○	○	○	○
04.	**How difficult is it for you to climb stairs?**	○	○	○	○	○
05.	**How difficult is it for you to make a tight fist?**	○	○	○	○	○
06.	**How difficult is it for you to get in or out of the bathtub or shower?**	○	○	○	○	○
07.	**How difficult is it for you to get comfortable to sleep?**	○	○	○	○	○
08.	**How difficult is it for you to bend or kneel down?**	○	○	○	○	○
09.	**How difficult is it for you to use buttons, snaps, hooks, or zippers?**	○	○	○	○	○
10.	**How difficult is it for you to cut your own fingernails?**	○	○	○	○	○
11.	**How difficult is it for you to dress yourself?**	○	○	○	○	○
12.	**How difficult is it for you to walk?**	○	○	○	○	○
13.	**How difficult is it for you to get moving after you have been sitting or lying down?**	○	○	○	○	○
14.	**How difficult is it for you to go out by yourself?**	○	○	○	○	○
15.	**How difficult is it for you to drive?**	○	○	○	○	○
16.	**How difficult is it for you to clean yourself after going to the bathroom?**	○	○	○	○	○
17.	**How difficult is it for you turn knobs or levers, for example, open doors, roll down car windows?**	○	○	○	○	○
18.	**How difficult is it for you to write or type?**	○	○	○	○	○
19.	**How difficult is it for you to pivot?**	○	○	○	○	○
20.	**How difficult is it for you to do your usual physical recreational activities, such as bicycling, jogging, or walking?**	○	○	○	○	○
21.	**How difficult is it for you to do your usual leisure activities, such as hobbies, crafts, gardening, card playing, going out with friends?**	○	○	○	○	○
22.	**How much difficulty are you having with sexual activity?**	○	○	○	○	○
23.	**How difficult is it for you to do <u>light</u> housework <u>or</u> yardwork, such as dusting, washing dishes, or watering plants?**	○	○	○	○	○
24.	**How difficult is it for you to do <u>heavy</u> housework <u>or</u> yardwork, such as washing floors, vacuuming, or mowing lawns?**	○	○	○	○	○
25.	**How difficult is it for you to do your usual work, such as a paid job, housework, volunteer activities?**	○	○	○	○	○

Please continue on next page

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S.O.L.V.E.D

Short Musculoskeletal Function Assessment

To be completed by the PATIENT

These next questions ask how often you are experiencing problems <u>this week</u> because of your injury or arthritis

		None of <u>the time</u>	A little of <u>the time</u>	Some of <u>the time</u>	Most of <u>the time</u>	All of the <u>time</u>
26.	**How often do you walk with a limp?**	○	○	○	○	○
27.	**How often do you avoid using your painful limb(s) or back?**	○	○	○	○	○
28.	**How often does your leg lock or give-way?**	○	○	○	○	○
29.	**How often do you have problems with concentration?**	○	○	○	○	○
30.	**How often does doing too much in one day affect what you do the next day?**	○	○	○	○	○
31.	**How often do you act irritable toward those around you, for example, snap at people, give sharp answers, or criticize easily?**	○	○	○	○	○
32.	**How often are you tired?**	○	○	○	○	○
33.	**How often do you feel disabled?**	○	○	○	○	○
34.	**How often do you feel angry or frustrated that you have this injury or arthritis?**	○	○	○	○	○

These next questions are about how much you are bothered by problems you are having <u>this week</u> due to your injury or arthritis

How much are you bothered by:		Not bothered <u>at all</u>	A little <u>bothered</u>	Moderately <u>bothered</u>	Very <u>bothered</u>	Extremely <u>bothered</u>
35.	**Problems using your hands?**	○	○	○	○	○
36.	**Problems using your back?**	○	○	○	○	○
37.	**Problems doing work around your home?**	○	○	○	○	○
38.	**Problems with bathing, dressing, toileting or other personal care?**	○	○	○	○	○
39.	**Problems with sleep and rest?**	○	○	○	○	○
40.	**Problems with leisure or recreational activities?**	○	○	○	○	○
41.	**Problems with your friends, family or other important people in your life?**	○	○	○	○	○
42.	**Problems with thinking, concentrating or remembering?**	○	○	○	○	○
43.	**Problems adjusting or coping with your injury or arthritis?**	○	○	○	○	○
44.	**Problems doing your usual work?**	○	○	○	○	○
45.	**Problems with feeling dependent on others?**	○	○	○	○	○
46.	**Problems with stiffness and pain?**	○	○	○	○	○

Reproduced from: Marc F. Swiontkowski, M.D.; Ruth Engelberg, Ph.D.; Diane P. Martin, Ph.D.; and Julie Agel, M.A. Short Musculoskeletal Function Assessment Questionnaire: Validity, Reliability, Responsiveness. J Bone Joint Surg AM 81:1245-60, 1999.