

SECTION 2: YOUR WELL-BEING

2.1 In General, would you say your health is...

	Poor	Fair	Good	Very Good	Excellent
Please TICK ONE box	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

2.2 This is a list of common long-term medical conditions. For each condition please tell me whether you have this condition or not. If you DO have it, please tell me how much it limits your daily activities from 1 (NOT AT ALL) to 5 (A LOT).

	Do you have this condition?		I DO have this condition and it limits my daily activities...				
	NO	YES	NOT AT ALL.....	ALOT			
High blood pressure	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Heart problem e.g. heart disease, angina, heart failure, atrial fibrillation (<i>irregular heartbeat</i>)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Chest or lung problem e.g. asthma, COPD, chronic bronchitis, emphysema	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Diabetes	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Chronic Kidney Disease	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Stroke or TIA (<i>mini stroke</i>)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Cancer during the last 5 years (<i>not including small skin cancers</i>)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Thyroid disorder	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Chronic back pain or sciatica	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Osteoarthritis (<i>"regular" arthritis, not rheumatoid arthritis</i>)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Rheumatoid arthritis or other rheumatology condition (<i>e.g. lupus</i>)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Osteoporosis (<i>thinning of the bones</i>)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

	Do you have this condition?		I DO have this condition and it limits my daily activities...				
	NO	YES	NOT AT ALL.....				A LOT
Fibromyalgia, chronic fatigue syndrome or ME	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Stomach problems (e.g. indigestion, ulcer)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Bowel problems (e.g. IBS, diverticulitis, inflammatory bowel disease, constipation)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Overweight / Obesity	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Poor blood circulation in your legs including leg ulcers	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Skin condition	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Deafness or other severe problem with ears (e.g. tinnitus)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Blindness or severe problem with vision	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Anxiety or Depression	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Severe mental health problems (Schizophrenia, psychotic illness)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Dementia or severe memory problems	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Learning disability	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Neurological problem (e.g. multiple sclerosis, Parkinson's, epilepsy)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Alcohol / drug problems	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Urinary problems (e.g. incontinence, enlarged prostate)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Do you have any other long-term medical conditions that were not mentioned above? If so, please list them here:			It limits my daily activities...				
			NOT AT ALL.....A LOT				
			<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
			<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

SECTION 3: YOUR MOOD

3.1 Please choose one response from the four given which comes closest to how you have been feeling in the past week.

The HADS instrument was used with permission.