

# ***EQ - 5D***

**Health Questionnaire**  
**English version for the US**

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Collection of this information is authorized under 42 USC 285b. The primary use of this information is to provide **unidentified** information to National Institutes of Health, Food and Drug Administration and Centers for Medicare and Medicaid Services. This information may be disclosed to researchers for research purposes. Submission of this information is voluntary, there is no penalty for not providing the information.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

By placing a checkmark in one box in each group below, please indicate which statements best describe your own health state today.

**Mobility**

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

**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

**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

**Pain/Discomfort**

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

**Anxiety/Depression**

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

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 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

**Your own  
health state  
today**

Best  
imaginable  
health state

100

90

80

70

60

50

40

30

20

10

0

90

80

70

60

50

40

30

20

10

0

90

80

70

60

50

40

30

20

10

0

90

80

70

60

50

40

30

20

10

0

90

80

70

60

50

40

30

20

10

0

Worst  
imaginable  
health state

Because all replies are anonymous, it will help us to understand your answers better if we have a little background data from everyone, as covered in the following questions.

- |    |                                       |                          |                          |                                      |
|----|---------------------------------------|--------------------------|--------------------------|--------------------------------------|
| 1. | Have you experienced serious illness? | Yes                      | No                       |                                      |
|    | <i>in you yourself</i>                | <input type="checkbox"/> | <input type="checkbox"/> | PLEASE CHECK<br>APPROPRIATE<br>BOXES |
|    | <i>in your family</i>                 | <input type="checkbox"/> | <input type="checkbox"/> |                                      |
|    | <i>in caring for others</i>           | <input type="checkbox"/> | <input type="checkbox"/> |                                      |

2. What is your age in years ?

- |    |          |                          |                          |                                    |
|----|----------|--------------------------|--------------------------|------------------------------------|
| 3. | Are you: | Male                     | Female                   |                                    |
|    |          | <input type="checkbox"/> | <input type="checkbox"/> | PLEASE CHECK<br>APPROPRIATE<br>BOX |

- |    |                         |                          |  |                                    |
|----|-------------------------|--------------------------|--|------------------------------------|
| 4. | Are you:                |                          |  |                                    |
|    | <i>a current smoker</i> | <input type="checkbox"/> |  |                                    |
|    | <i>an ex-smoker</i>     | <input type="checkbox"/> |  | PLEASE CHECK<br>APPROPRIATE<br>BOX |
|    | <i>a never smoker</i>   | <input type="checkbox"/> |  |                                    |

- |    |   |                          |                          |                                    |
|----|---|--------------------------|--------------------------|------------------------------------|
| 5. | Do you now, or did you ever, work in health or social services? | Yes                      | No                       |                                    |
|    |   | <input type="checkbox"/> | <input type="checkbox"/> | PLEASE CHECK<br>APPROPRIATE<br>BOX |

If so, in what capacity? .....

- |    |   |                          |       |                                    |
|----|---|--------------------------|-------|------------------------------------|
| 6. | Which of the following best describes your main activity? |                          |       |                                    |
|    | <i>employed (including self employment)</i>               | <input type="checkbox"/> |       |                                    |
|    | <i>retired</i>  | <input type="checkbox"/> |       |                                    |
|    | <i>keeping house</i>                                      | <input type="checkbox"/> |       | PLEASE CHECK<br>APPROPRIATE<br>BOX |
|    | <i>student</i>  | <input type="checkbox"/> |       |                                    |
|    | <i>seeking work</i>                                       | <input type="checkbox"/> |       |                                    |
|    | <i>other (please specify)</i>                             | <input type="checkbox"/> | ..... |                                    |

- |    |  |                          |  |                                    |
|----|--|--------------------------|--|------------------------------------|
| 7. | What is the highest level of education you have completed? |                          |  |                                    |
|    | <i>some high school or less</i>                            | <input type="checkbox"/> |  |                                    |
|    | <i>high school graduate or GED</i>                         | <input type="checkbox"/> |  |                                    |
|    | <i>vocational college or some college</i>                  | <input type="checkbox"/> |  | PLEASE CHECK<br>APPROPRIATE<br>BOX |
|    | <i>college degree</i>                                      | <input type="checkbox"/> |  |                                    |
|    | <i>professional or graduate degree</i>                     | <input type="checkbox"/> |  |                                    |

8. If you know your zip code, please write it here