

Alfred Sandringham Caulfield

OVERALL HEALTH STATUS (EQ-5D-5L)

Last name*		First name/s*	
Date of birth*		Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other

*mandatory fields

Thank you for completing this questionnaire.

(Save questionnaire to your computer to complete electronically)

Date questionnaire completed _____

Under each heading, **tick ONE box** that best described your health TODAY

MOBILITY
<input type="checkbox"/> I have no problems with walking around
<input type="checkbox"/> I have slight problems with walking around
<input type="checkbox"/> I have moderate problems with walking around
<input type="checkbox"/> I have severe problems with walking around
<input type="checkbox"/> I am unable to walk around
PERSONAL CARE
<input type="checkbox"/> I have no problems with washing or dressing myself
<input type="checkbox"/> I have slight problems with washing or dressing myself
<input type="checkbox"/> I have moderate problems with washing or dressing myself
<input type="checkbox"/> I have severe problems with washing or dressing myself
<input type="checkbox"/> I am unable to wash or dress myself
USUAL ACTIVITIES <i>(eg, work, study, housework, family or leisure activities)</i>
<input type="checkbox"/> I have no problems doing my usual activities
<input type="checkbox"/> I have slight problems doing my usual activities
<input type="checkbox"/> I have moderate problems doing my usual activities
<input type="checkbox"/> I have severe problems doing my usual activities
<input type="checkbox"/> I am unable to do my usual activities
PAIN / DISCOMFORT
<input type="checkbox"/> I have no pain or discomfort
<input type="checkbox"/> I have slight pain or discomfort
<input type="checkbox"/> I have moderate pain or discomfort
<input type="checkbox"/> I have severe pain or discomfort
<input type="checkbox"/> I have extreme pain or discomfort
ANXIETY / DEPRESSION
<input type="checkbox"/> I am not anxious or depressed
<input type="checkbox"/> I am slightly anxious or depressed
<input type="checkbox"/> I am moderately anxious or depressed
<input type="checkbox"/> I am severely anxious or depressed
<input type="checkbox"/> I am extremely anxious or depressed



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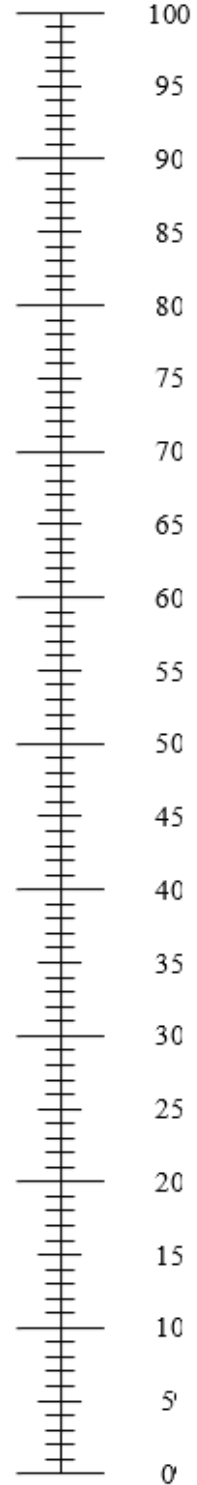
OVERALL HEALTH STATUS (EQ-5D-5L)

Last Name*		First Name/s*	
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- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY

- Now, please write the number you marked on the scale in the box below.

The best health you can imagine



The worst health you can imagine

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