

The questions below concern your daily activities. Please try to answer even if you do not think it is related to you or the condition you may have. There are no right or wrong answers. Please answer exactly as you think or feel.

PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES:

AT THIS MOMENT YOU ARE ABLE TO:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
1. Dress yourself, including tying shoes laces and doing buttons?				
2. Get in and out of bed?				
3. Lift a full cup or glass to your mouth?				
4. Walk outdoors on flat ground?				
5. Wash and dry your entire body?				
6. Bend down to pick up clothing from the floor?				
7. Turn regular faucets on and off?				
8. Get in and out of a car, bus, train or airplane?				
9. Walk two miles?				
10. Participate in sports and games as you like?				
11. Get a good night's sleep?				
12. Deal with feelings of anxiety or being nervous?				
13. Deal with feelings of depression or feeling blue?				
14. Optional: Able to perform sexual activity?				

1. How do you feel today compared to one month ago?
Please check only one:

- _____ Much better today than one month ago
- _____ Better today than one month ago
- _____ The same today as one month ago
- _____ Worse today than one month ago

2. When you get up in the morning, do you feel stiff?
_____ YES _____ NO

3. If you answered "YES", how long is it until you are as limber as you will be for that day?
_____ minutes or _____ hours

4. Do you get enough sleep at night? ___ YES ___ NO

5. Do wake up feeling rested? ___ YES ___ NO

6. Considering all the ways in which illness and health conditions may affect you at this time, please make below to show how you are doing:

VERY WELL _____ VERY POORLY

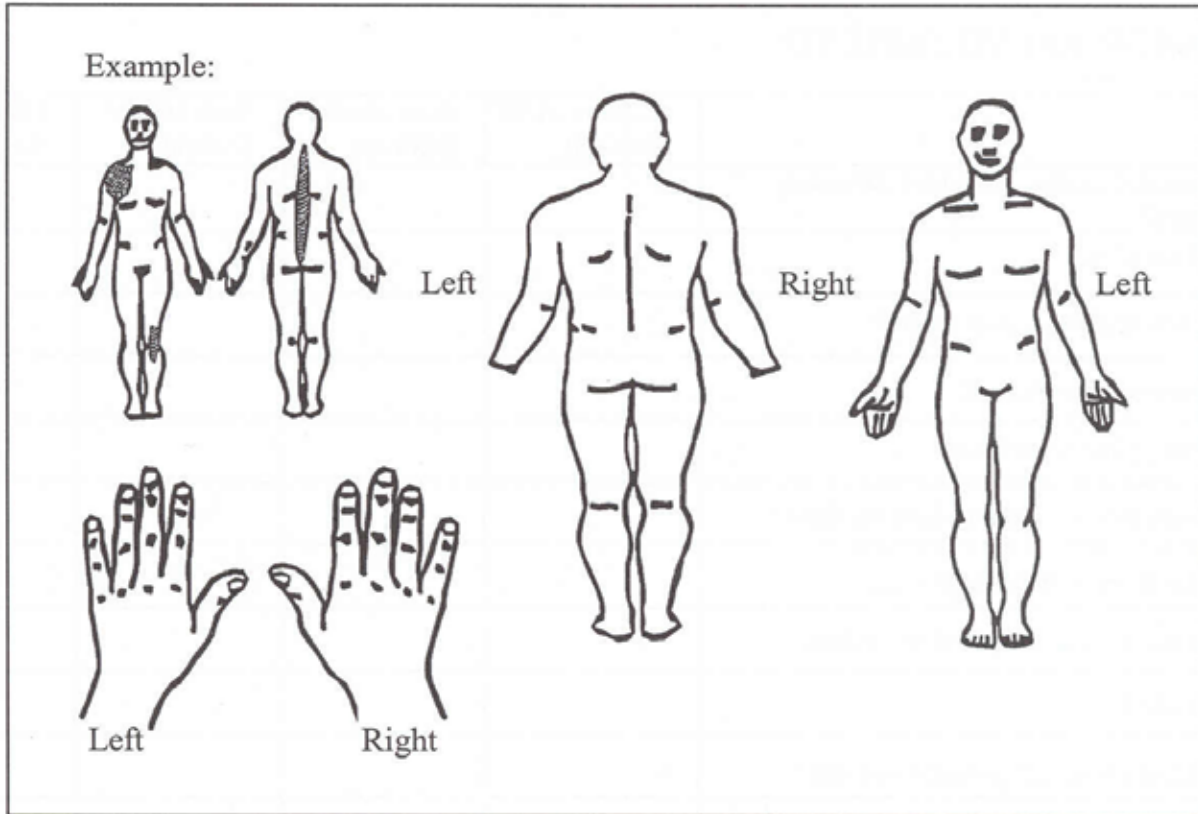
7. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

FATIGUE IS _____ FATIGUE IS A
NO PROBLEM MAJOR PROBLEM

7. How much pain have you had because of your condition over the past week? Place a mark below to indicate how your pain has been?

NO _____ PAIN AS BAD
PAIN AS IT COULD BE

Please shade all the location of your pain OVER THE PAST WEEK on the body figures and hands.



Please list below all the drugs or medicines taken OVER THE LAST WEEK (include birth control pills, aspirin, and any kind of drug or medicine bought without a prescription).