

STUDY #: \_\_\_\_\_

# **COMPREHENSIVE CARE SURVEY**

## **Patient Questionnaire**

**UCSF General Medicine Practice  
400 Parnassus, 4<sup>th</sup> Floor  
San Francisco, CA 94143**

**Michael Rabow, M.D.  
Principal Investigator**

**SECTION 1: INFORMATION ABOUT YOU**

- 1. Your sex:            M or F
  
- 2. Your birthdate: \_\_\_\_\_  
                          (Mo / Day / Yr)
  
- 3. Your height:        \_\_\_\_\_ ft.    inches
  
- 4. Your weight:        \_\_\_\_\_ lbs.
  
- 5. Circle the one number that corresponds to the highest grade or year you completed in regular school, vocational school, college, or graduate professional training.

Grade School	High School
_____	_____
1   2   3   4   5   6   7   8	9   10   11   12
College	Graduate School
_____	_____
13   14   15   16	17   18   19   20   21   22   >22

- 6. Circle the letters that best describe your ethnic group(s):
  - A. American Indian
  - B. Asian American
  - C. Black/African-American
  - D. Caucasian/white
  - E. Latino/Latina
  - F. Mixed Ethnic Background
  - G. Pacific Islander
  - H. Other: \_\_\_\_\_  
(specify)

**DEMOGRAPHIC INFORMATION (continued)**

7. Were you born a United States citizen? \_\_\_\_\_Yes \_\_\_\_\_No

8. Circle the letter(s) that best describe your current employment status.

- A. Full-time
- B. Part-time
- C. Self-employed
- D. Retired
- E. Unemployed
- F. Disability / Sick Leave
- G. Student
- H. Other: \_\_\_\_\_  
(specify)

9. Marital Status

- A. Married/Partnered
- B. Single
- C. Widowed
- D. Divorced
- E. Other: \_\_\_\_\_  
(specify)

10. Do you live alone? \_\_\_\_\_Yes \_\_\_\_\_No

11. If no, with whom do you live? And what is their relationship to you?

Name	Relationship

## SECTION 2: HEALTH CARE ASSESSMENT

Thinking about your own health care in the General Medicine Practice *during the past year*, how would you rate the following? Please circle one number on each line.

- 1 = Poor
- 2 = Fair
- 3 = Good
- 4 = Very Good
- 5 = Excellent

	Poor	Fair	Good	Very Good	Excellent
1. Overall quality of care and services.....	1	2	3	4	5
2. Access to specialty care if needed.....	1	2	3	4	5
3. Access to hospital care if needed.....	1	2	3	4	5
4. Access to emergency medical care.....	1	2	3	4	5
5. Availability of medical information or advice by phone.....	1	2	3	4	5
6. Access to medical care when needed.....	1	2	3	4	5
7. Thoroughness of examinations and accuracy of diagnoses.....	1	2	3	4	5
8. Skill, experience, and training of doctors.....	1	2	3	4	5
9. Thoroughness of treatment.....	1	2	3	4	5
10. Explanations of medical procedures and tests.....	1	2	3	4	5
11. Attention given to what you have to say.....	1	2	3	4	5
12. Advice you received about ways to avoid illness and to stay healthy.....	1	2	3	4	5
13. Number of doctors you have to choose from.....	1	2	3	4	5
14. Friendliness and courtesy shown to you by your doctors.....	1	2	3	4	5

**HEALTH CARE ASSESSMENT (continued)**

	Poor	Fair	Good	Very Good	Excellent
15. Personal interest in you and your medical problems.....	1	2	3	4	5
16. Respect shown to you; attention to your privacy.....	1	2	3	4	5
17. Reassurance and support offered to you by your doctors and staff.....	1	2	3	4	5
18. Friendliness and courtesy shown to you by the staff.....	1	2	3	4	5
19. Amount of time you have with doctors and staff during a visit.....	1	2	3	4	5
20. The outcomes of your medical care; how much you are helped.....	1	2	3	4	5

**Below are some things that people say about their medical care. Please read each one carefully, keeping in mind your health care in the General Medicine Practice. Although the statements may look similar, please answer each one separately. Please circle one number on each line.**

- 1 = Strongly Disagree**
- 2 = Disagree**
- 3 = Not Sure**
- 4 = Agree**
- 5 = Strongly Agree**

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
22. I am very satisfied with the medical care I receive.....	1	2	3	4	5
23. There are some things about the medical care I receive that could be better.....	1	2	3	4	5
24. The medical care I have been receiving is just about perfect.....	1	2	3	4	5
25. I am dissatisfied with some things about the medical care I receive.....	1	2	3	4	5

### SECTION 3: ACTIVITIES ASSESSMENT

Do you need help with the following activities? Please circle the appropriate selection.

1. Eating	None	A little	A lot	Spoon fed or IV
	None	A little	A lot	Do not walk
2. Walking (with cane or walker if applicable)	None	A little	A lot	Am housebound
3. Mobility (going outside, getting about -- with wheelchair, etc. if applicable)	None	A little	A lot	Must be bathed
4. Bathing (with help getting supplies, etc. if applicable)	None	A little	A lot	Must be dressed
5. Dressing (with help selecting clothing if applicable)	None	A little	A lot	Use bedpan or unable to care for ostomy/catheter
6. Toileting (with help disrobing, cleaning, handling ostomy/ catheter if applicable)	None	A little	A lot	Must be groomed
7. Grooming (combing hair; clipping nails; brushing teeth; shaving for men)	None	A little	A lot	Cannot manage
8. Adaptive tasks (managing money/ possessions; using telephone; buying newspapers, toilet articles, snacks)	None	A little	A lot	

**ACTIVITIES ASSESSMENT (continued)**

**Do you have disability with the following functions? Please circle the appropriate selection.**

9. Communication (expressing yourself)	None	A Little	A Lot	Do not communicate
	None	A Little	A Lot	Do not hear
10. Hearing (with aid if applicable)	None	A Little	A Lot	Do not see
11. Sight (with glasses if applicable)	None	A Little	A Lot	Fed by IV tube
12. Diet (deviation from normal)	None	A Little	A Lot	Most/all of the time
13. In bed during day (either ordered or self-initiated)		(Less than 3 hours)		
14. Incontinence (urine/feces with catheter or prosthesis if applicable)	None	A Little	Frequently (Weekly+)	Do not control
15. Medication	None	Sometimes	Daily (Taken orally)	Daily Injection

**Do you have the following problems? Please circle the appropriate selection.**

16. Mental confusion	None	A little	A lot	Extreme
	None	A little	A lot	Extreme
17. Uncooperativeness (combats efforts to help with care)				
18. Depression	None	A little	A lot	Extreme



**PAIN ASSESSMENT (continued)**

8. Please circle the one number that best describes how, during the **past 24 hours, pain has interfered** with your:

A. General Activity

Does not interfere    0   1   2   3   4   5   6   7   8   9   10    Completely interferes

B. Mood

Does not interfere    0   1   2   3   4   5   6   7   8   9   10    Completely interferes

C. Walking Ability

Does not interfere    0   1   2   3   4   5   6   7   8   9   10    Completely interferes

D. Normal Work (includes both housework and work outside the home)

Does not interfere    0   1   2   3   4   5   6   7   8   9   10    Completely interferes

E. Relations with Other People

Does not interfere    0   1   2   3   4   5   6   7   8   9   10    Completely interferes

F. Sleep

Does not interfere    0   1   2   3   4   5   6   7   8   9   10    Completely interferes

G. Enjoyment of Life

Does not interfere    0   1   2   3   4   5   6   7   8   9   10    Completely interferes

## SECTION 5: SHORTNESS OF BREATH ASSESSMENT

For each activity listed below, please rate your shortness of breath on a scale between 0 and 5, where 0 is not at all short of breath and 5 is maximally short of breath or too short of breath to do the activity. If the activity is one which you do not perform, please give your best estimate of shortness of breath. Your responses should be for an *“average” day during the past week*. Please respond to all items. Read the 2 examples below, then begin the questionnaire.

**0 = Not at all short of breath**

**1 = Slightly short of breath**

**2 = Mildly short of breath**

**3 = Moderately short of breath**

**4 = Severely short of breath**

**5 = Maximally or unable to do because of shortness of breath**

### Example 1:

How short of breath do you get while:

1. Brushing teeth..... 0      1      2      3      4      5

Harry has felt moderately short of breath during the past week while brushing his teeth and so circles a 3 for his activity.

### Example 2:

How short of breath do you get while:

2. Mowing the lawn..... 0      1      2      3      4      5

Anne has never mowed the lawn before but estimates that she would have been too short of breath to do this activity during the past week. She circles a 5 for this activity.

**1. Do you ever experience shortness of breath?    Yes    or    No**

**(If no, please skip to SECTION 6.)**

**2. How short of breath do you get:**

	Not at all	Slightly	Mildly	Moderately	Severely	Maximally
a. At rest.....	0	1	2	3	4	5
b. Walking on a level at your own pace.....	0	1	2	3	4	5
c. Walking on a level with others your age....	0	1	2	3	4	5

## SHORTNESS OF BREATH ASSESSMENT (continued)

	Not at all	Slightly	Mildly	Moderately	Severely	Maximally
d. Walking up a hill.....	0	1	2	3	4	5
e. Walking up stairs.....	0	1	2	3	4	5
f. While eating.....	0	1	2	3	4	5
g. Standing up from a chair.....	0	1	2	3	4	5
h. Brushing teeth.....	0	1	2	3	4	5
i. Shaving and/or brushing hair.....	0	1	2	3	4	5
j. Showering/bathing.....	0	1	2	3	4	5
k. Dressing.....	0	1	2	3	4	5
l. Picking up and straightening things.....	0	1	2	3	4	5
m. Doing dishes.....	0	1	2	3	4	5
n. Sweeping/vacuuming.....	0	1	2	3	4	5
o. Making bed.....	0	1	2	3	4	5
p. Shopping.....	0	1	2	3	4	5
q. Doing laundry.....	0	1	2	3	4	5
r. Washing car.....	0	1	2	3	4	5
s. Mowing lawn.....	0	1	2	3	4	5
t. Watering the lawn.....	0	1	2	3	4	5
u. Sexual activities.....	0	1	2	3	4	5
<b>How much do these limit you in your daily life?</b>						
v. Shortness of breath.....	0	1	2	3	4	5
w. Fear of "hurting myself" by overexerting.....	0	1	2	3	4	5
x. Fear of shortness of breath.....	0	1	2	3	4	5

## SECTION 6: SLEEP ASSESSMENT

1. How long did it usually take you to fall asleep during the **past four weeks**? Please circle one selection.

- A. 0 - 15 minutes
- B. 16 - 30 minutes
- C. 31 - 45 minutes
- D. 46 - 60 minutes
- E. More than 60 minutes

2. On average, how many hours did you sleep **each night during the past four weeks**?

Please write in the **average number of hours per night**: \_\_\_\_\_

3. During the **past four weeks**, how often did you: (Using the scale below, please circle one number on each line.)

- 0 = None of the time**
- 1 = A little of the time**
- 2 = Some of the time**
- 3 = A good bit of the time**
- 4 = Most of the time**
- 5 = All of the time**

	None	A Little	Some	A Good Bit	Most	All
A. Feel that your sleep was not quiet (you moved restlessly, felt tense, talked, etc. while sleeping)?	0	1	2	3	4	5
B. Get enough sleep to feel rested upon waking in the morning?	0	1	2	3	4	5
C. Awaken during your sleep time and have trouble falling asleep again?	0	1	2	3	4	5
D. Get the amount of sleep you needed?	0	1	2	3	4	5

## SECTION 7: MOOD ASSESSMENT

Below is a list of ways you might have felt or behaved. How often have you felt this way *during the past week*? (Please circle the number that best applies for each item.)

1 = Rarely or none of the time (less than 1 day/week)

2 = Some or a little of the time (1-2 days/week)

3 = Occasionally or a moderate amount of time (3-4 days/week)

4 = Most or all of the time (5-7 days/week)

During the *past week*:

	Rarely or none of the time ( < 1 day/wk)	Some or a little of the time (1-2 days/ wk)	Occasion- ally or a moderate amount of time (3-4 days/wk)	Most or all of the time (5- 7 days/ wk)
1. I was bothered by things that usually don't bother me.....	1	2	3	4
2. I did not feel like eating; my appetite was poor.....	1	2	3	4
3. I felt that I could not shake off the blues even with help from my family or friends.....	1	2	3	4
4. I felt that I was just as good as other people.....	1	2	3	4
5. I had trouble keeping my mind on what I was doing.....	1	2	3	4
6. I felt depressed.....	1	2	3	4
7. I felt that everything I did was an effort.....	1	2	3	4
8. I felt hopeful about the future.....	1	2	3	4
9. I thought my life had been a failure.....	1	2	3	4
10. I felt fearful.....	1	2	3	4
11. My sleep was restless.....	1	2	3	4
12. I was happy.....	1	2	3	4
13. I talked less than usual.....	1	2	3	4
14. I felt lonely.....	1	2	3	4
15. People were unfriendly.....	1	2	3	4
16. I enjoyed life.....	1	2	3	4

## MOOD ASSESSMENT (continued)

	Rarely or none of the time (< 1 day/wk)	Some or a little of the time (1-2 days/wk)	Occasionally or a moderate amount of time (3-4 days/wk)	Most or all of the time (5-7 days/wk)
17. I had crying spells.....	1	2	3	4
18. I felt sad.....	1	2	3	4
19. I felt that people disliked me.....	1	2	3	4
20. I could not get "going".....	1	2	3	4

## SECTION 8: ANXIETY ASSESSMENT

Below is a list of ways you might have felt *during the past week (including today)*. Please circle the number that best applies for each item.

- 0 = Not at all
- 1 = A little bit
- 2 = Moderately
- 3 = Quite a bit
- 4 = Extremely

During the *past week*:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. I felt tense.....	0	1	2	3	4
2. I felt on edge.....	0	1	2	3	4
3. I felt uneasy.....	0	1	2	3	4
4. I felt anxious.....	0	1	2	3	4
5. I felt nervous.....	0	1	2	3	4
6. I felt restless.....	0	1	2	3	4

## SECTION 9: QUALITY OF LIFE ASSESSMENT

Below are a number of questions about your quality of life. Please circle a number to indicate your answer.

1. How is your present state of health?

Extremely poor health    0   1   2   3   4   5   6   7   8   9   10    Excellent health

2. How much enjoyment are you getting out of life?

No enjoyment    0   1   2   3   4   5   6   7   8   9   10    A great deal of enjoyment

3. How useful do you feel?

Not at all useful    0   1   2   3   4   5   6   7   8   9   10    Extremely useful

4. How much happiness do you feel?

Not at all happy    0   1   2   3   4   5   6   7   8   9   10    Extremely happy

5. How satisfying is your life?

Not at all satisfying    0   1   2   3   4   5   6   7   8   9   10    Extremely satisfying

6. Do you receive enough love from your family and friends?

Not enough or too much love    0   1   2   3   4   5   6   7   8   9   10    Just the right amount of love

7. Do you tire easily?

I do not tire easily    0   1   2   3   4   5   6   7   8   9   10    I tire very easily

## QUALITY OF LIFE ASSESSMENT (continued)

8. How much are you able to do the things you like to do, such as watch TV, read, garden, listen to music, take walks, play tennis, play cards, etc.?

Not at all able to do the things I like to do	0	1	2	3	4	5	6	7	8	9	10	Completely able to do the things I like to do
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9. How is your present ability to concentrate on things?

Extremely poor concentration	0	1	2	3	4	5	6	7	8	9	10	Excellent concentration
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10. How much strength do you have?

No strength at all	0	1	2	3	4	5	6	7	8	9	10	A great deal of strength
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11. Are you able to take care of your personal needs (dress, comb hair, toilet, eat, shower, bathe)?

I can't do anything by myself	0	1	2	3	4	5	6	7	8	9	10	I can do everything by myself
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12. How much of an appetite do you have?

No appetite at all	0	1	2	3	4	5	6	7	8	9	10	Excellent appetite
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13. Are you able to get around the way you want to (walk around your room or home, get out of your place, go shopping, drive your car or take public transportation, etc.)?

Completely bed bound	0	1	2	3	4	5	6	7	8	9	10	Can get around on my own
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**QUALITY OF LIFE ASSESSMENT (continued)**

14. Does life have meaning for you?

Life has no meaning	0	1	2	3	4	5	6	7	8	9	10	Life has a great deal of meaning
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15. Do you receive enough emotional support from your family and friends?

Not enough or too much emotional support	0	1	2	3	4	5	6	7	8	9	10	Just the right amount of emotional support
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16. Do you feel you make others happy (family, friends)?

I make others very unhappy	0	1	2	3	4	5	6	7	8	9	10	I make others very happy
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17. How good is your quality of life?

Extremely poor quality of life	0	1	2	3	4	5	6	7	8	9	10	Excellent quality of life
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## SECTION 10: SPIRITUAL WELL-BEING ASSESSMENT

For each of the following statements, circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

- 1 = Strongly Disagree
- 2 = Moderately Disagree
- 3 = Disagree
- 4 = Agree
- 5 = Moderately Agree
- 6 = Strongly Agree

	Strongly Disagree	Moderately Disagree	Disagree	Agree	Moderately Agree	Strongly Agree
1. I don't know who I am, where I came from, or where I'm going.....	1	2	3	4	5	6
2. I feel that life is a positive experience.....	1	2	3	4	5	6
3. I feel unsettled about my future.....	1	2	3	4	5	6
4. I feel very fulfilled and satisfied with life.....	1	2	3	4	5	6
5. I feel a sense of well-being about the direction my life is headed in.....	1	2	3	4	5	6
6. I don't enjoy much about life.....	1	2	3	4	5	6
7. I feel good about my future.....	1	2	3	4	5	6
8. I feel that life is full of conflict and unhappiness.....	1	2	3	4	5	6
9. Life doesn't have much meaning.....	1	2	3	4	5	6
10. I believe there is some real purpose for my life.....	1	2	3	4	5	6

**Do you believe in God or a higher power or purpose in the universe? Yes or No**

**(If yes, please answer the following questions.)  
(If no, please skip to SECTION 11.)**

11. I don't find much satisfaction in private prayer with God.....	1	2	3	4	5	6
11. I believe that God loves me and cares about me.....	1	2	3	4	5	6

**SPIRITUAL WELL-BEING ASSESSMENT (continued)**

	Strongly Disagree	Moderately Disagree	Disagree	Agree	Moderately Agree	Strongly Agree
13. I believe that God is impersonal and not interested in my daily situations.....	1	2	3	4	5	6
14. I have a personally meaningful relationship with God.....	1	2	3	4	5	6
15. I don't get much personal strength and support from my God.....	1	2	3	4	5	6
16. I believe that God is concerned about my problems.....	1	2	3	4	5	6
17. I don't have a personally satisfying relationship with God.....	1	2	3	4	5	6
18. My relationship with God helps me not to feel lonely.....	1	2	3	4	5	6
19. I feel most fulfilled when I'm in close communion with God.....	1	2	3	4	5	6
20. My relationship with God contributes to my sense of well-being.....	1	2	3	4	5	6

21. How often do you attend church services?

\_\_\_\_\_ Never

\_\_\_\_\_ Yearly: \_\_\_\_\_ times / year

\_\_\_\_\_ Monthly: \_\_\_\_\_ times / month

\_\_\_\_\_ Weekly: \_\_\_\_\_ times / week

\_\_\_\_\_ Daily

## SECTION 11: ALTERNATIVE MEDICINE ASSESSMENT

Which of the following things have you tried as part of your treatment for your illness? Please let us know which were helpful.

<u>Treatments</u>	<u>Did You Try?</u>		<u>Was It Helpful?</u>	
Acupressure	Yes	No	Yes	No
Acupuncture	Yes	No	Yes	No
Chiropractic	Yes	No	Yes	No
Massage	Yes	No	Yes	No
Physical Therapy	Yes	No	Yes	No
Homeopathy	Yes	No	Yes	No
Herbs	Yes	No	Yes	No
Relaxation	Yes	No	Yes	No
Visualization	Yes	No	Yes	No
Meditation	Yes	No	Yes	No
Prayer	Yes	No	Yes	No
Yoga	Yes	No	Yes	No
Support Group	Yes	No	Yes	No
Psychotherapy	Yes	No	Yes	No
Other: _____	Yes	No	Yes	No

If you have tried any of the above treatments, what was the *combined average monthly cost* for the treatment(s)? \$ \_\_\_\_\_

**SECTION 12: ADVANCE CARE PLANNING ASSESSMENT**

1. Have you completed an advance directive?..... Yes No

- Durable Power of Attorney:\_\_\_\_\_
- Living Will:\_\_\_\_\_
- Do Not Resuscitate order:\_\_\_\_\_

2. If not, have you thought about it?..... Yes No

3. If not, do you intend to complete an advance directive?..... Yes No

4. Have you decided what do with your possessions at the end of your life?..... Yes No

5. If not, have you thought about it?..... Yes No

6. If not, do you intend to decide what to do with your possessions at the end of your life?..... Yes No

7. Have you made funeral arrangements?..... Yes No

Arrangements:\_\_\_\_\_

8. If not, have you thought about it?..... Yes No

9. If not, do you intend to make funeral arrangements?..... Yes No

10. At the end of your life, where would you hope to die? Home  
Hospital  
Nursing Home  
Institutional Hospice  
Other: \_\_\_\_\_

11. What is your greatest fear at the end of life?\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## SECTION 13: ADDITIONAL DEMOGRAPHIC INFORMATION

**We strongly encourage you to answer the questions below. Your answers will be kept strictly confidential.**

1. What is **your** annual income before taxes?

- |   |  |
|---|--|
| <input type="checkbox"/> less than \$10,000 | <input type="checkbox"/> \$60,000-69,999   |
| <input type="checkbox"/> \$10,000-19,999    | <input type="checkbox"/> \$70,000-79,999   |
| <input type="checkbox"/> \$20,000-29,999    | <input type="checkbox"/> \$80,000-89,999   |
| <input type="checkbox"/> \$30,000-39,999    | <input type="checkbox"/> \$90,000-99,999   |
| <input type="checkbox"/> \$40,000-49,999    | <input type="checkbox"/> \$100,000 or more |
| <input type="checkbox"/> \$50,000-59,999    |  |

2. What is your **spouse/partner's** annual income before taxes?

- |   |  |
|---|--|
| <input type="checkbox"/> no spouse/partner  | <input type="checkbox"/> \$50,000-59,999   |
| <input type="checkbox"/> don't know         | <input type="checkbox"/> \$60,000-69,999   |
| <input type="checkbox"/> less than \$10,000 | <input type="checkbox"/> \$70,000-79,999   |
| <input type="checkbox"/> \$10,000-19,999    | <input type="checkbox"/> \$80,000-89,999   |
| <input type="checkbox"/> \$20,000-29,999    | <input type="checkbox"/> \$90,000-99,999   |
| <input type="checkbox"/> \$30,000-39,999    | <input type="checkbox"/> \$100,000 or more |
| <input type="checkbox"/> \$40,000-49,999    |  |

3. Sexual Orientation?

- A. Bisexual
- B. Heterosexual
- C. Gay or Lesbian
- D. Other: \_\_\_\_\_

(specify)