

PHYSICAL FUNCTIONING AND HEALTH SURVEY

POMP 4 - Version: February 26, 2003

These next few questions are about your health.

1. In general, would you say your health is:

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

We would like to ask you about difficulties with some common activities of everyday life and whether you need assistance performing these activities. Please exclude the effects of temporary conditions. If an aid is used, please indicate your difficulty when using the aid.

- | | <u>YES</u> | <u>NO</u> |
|---|----------------------------|----------------------------|
| 2. Because of a physical or mental health condition, do you have difficulty getting around INSIDE the home? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 2A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 3. Because of a physical or mental health condition, do you have difficulty going OUTSIDE the home, for example to shop or visit a doctor's office? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 3A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 4. Because of a physical or mental health condition, do you have difficulty getting in or out of a bed or a chair? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 4A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 5. Because of a physical or mental health condition, do you have difficulty when taking a bath or shower? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 5A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 6. Because of a physical or mental health condition, do you have difficulty when dressing? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 6A. If YES, do you need the help of another person | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 7. Because of a physical or mental health condition, do you have difficulty when walking? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 7A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |

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Client ID: _____ Date: _____

Interview was: Phone In Person Mail Other _____

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- | | <u>YES</u> | <u>NO</u> |
|---|----------------------------|----------------------------|
| 8. Because of a physical or mental health condition, do you have difficulty eating? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 8A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 9. Because of a physical or mental health condition, do you have difficulty using or getting to the toilet? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 9A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 10. Because of a physical or mental health condition, do you have difficulty keeping track of money or bills? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 9A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 11. Because of a physical or mental health condition, do you have difficulty preparing meals? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 11A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 12. Because of a physical or mental health condition, do you have difficulty doing light housework, such as washing dishes or sweeping a floor? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 12A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 13. Because of a physical or mental health condition, do you have difficulty taking the right amount of prescribed medicine at the right time? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 13A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 14. Because of a physical or mental health condition, do you have difficulty using the telephone? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 14A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 15. Because of a physical or mental health condition, do you have difficulty driving an automobile? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 15A. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 16. Is local bus, transit bus, or city bus service available within three quarters (3/4) of a mile from your home? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 16A. IF YES, because of a physical or mental health condition, do you have difficulty using this transportation? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| 16B. If YES, do you need the help of another person? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |

Thank you.

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Comments: