The first section is about your specific health and ability to return to work as it relates to your recent surgery or procedure. Please provide one answer for each question. Fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best. You may skip questions you wish not to answer.

1. How would you rate your quality of life now?

- Better than before your procedure
- The same as before your procedure
- Worse than before your procedure

2. Since your procedure, have you been able to return to work ***(job or studies or housework)***?

- Yes
- No (**Skip to question #6**)
- Does not apply **(Skip to question #6)**

3. After how many weeks since your procedure did you return to work?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐

4. If your ability to perform work is **ten when you are at your best** and **zero when you are unable to work**, circle the number that represents your ability to work currently.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

5. Does your health limit you in your current work ***(job or studies or housework)?***

- I am not limited by my health
- I am able to do my work with difficulty
- I sometimes have to work slowly
- I often have to work slowly
- I am only able to do my work part time
- I am entirely unable to do my work-

6. How long did it take you to return to your normal life activities (other than work) after your procedure?

- less than 1 week,
- 1-4 weeks
- >4 weeks
- I have yet fully recovered

This next section is about your specific health as it relates to your hospital stay after your surgery. Please fill in the circle next to those that apply.

7. While still in the hospital after your recent procedure, did you have **PROBLEMS WITH YOUR HEART: (Fill in all that apply)**

- Heart attack?
- Your heart stopped beating (cardiac arrest)?
- Heart failure (congestive heart failure)?
- Abnormal heart rhythm such as atrial fibrillation?
- Severe pain coming from your heart (angina)?
- None

8. While still in the hospital after your recent procedure, did you have **PROBLEMS WITH BLOOD CLOTS**: **(Fill in all that apply)**

- Blood clot in your leg (Deep Vein Thrombosis)?
- Blood clot in your lung (Pulmonary Embolism)?
- None

9. While still in the hospital after your recent procedure, did you have **PROBLEMS WITH YOUR LUNGS & BREATHING**: **(Fill in all that apply)**

- You stopped breathing (respiratory arrest)?
- You were placed on a breathing machine because you were struggling to breathe on your own (respiratory failure)?
- An infection in your lungs (pneumonia)?
- None

10. While still in the hospital after your recent procedure, did you have **PROBLEMS WITH YOUR KIDNEYS STOMACH OR INTESTINE**: **(Fill in all that apply)**

- Kidney failure and you needed kidney dialysis?
- GI bleed (internal bleeding from your stomach or intestine)?
- Stomach or intestinal ulcer?
- None

11. While still in the hospital after your recent procedure, did you **suffer from severe PAIN that required treatment?**

- Yes
- No
- Don't know

12. While still in the hospital after your recent procedure, did you have **ANY OTHER PROBLEMS**: **(Fill in all that apply)**

- A fall, including a slip or trip in which you lost your balance and landed on the floor or ground or lower level.
- Delirium (temporary confusion with problems paying attention or thinking clearly)?
- Stroke (for example, weakness on one side of the body or difficulty speaking)?
- Nerve injury/paralysis related to your procedure?
- Infection in the surgical wound?
- Other (specify):_____
- None

This next section is about your specific health related to your surgery after you left the hospital. Please fill in the circle next to those that apply.

13. After leaving the hospital following your procedure, did you receive medical care in any of the following locations? **(Fill in all that apply)**

- Outpatient clinic
- Urgent care center
- Emergency room
- A hospital where you were admitted
- A long-term care hospital or inpatient rehabilitation facility
- An operating room where you had another surgery
- Other location
- I did not receive any care **(Skip to question #20)**

14. After leaving the hospital, did you receive medical treatment **FOR PROBLEMS WITH YOUR HEART**? **(Fill in all that apply)**

- Heart attack?
- Your heart stopped beating (cardiac arrest)?
- Heart failure (congestive heart failure)?

- Abnormal heart rhythm such as atrial fibrillation?
- Severe pain coming from your heart (angina)?
- None

15. After leaving the hospital, did you receive medical treatment **FOR PROBLEMS WITH BLOOD CLOTS**? **(Fill in all that apply)**

- Blood clot in your leg (Deep Vein Thrombosis)?
- Blood clot in your lung (Pulmonary Embolism)?
- None

16. After leaving the hospital, did you receive medical treatment **FOR PROBLEMS WITH YOUR LUNGS OR BREATHING**? **(Fill in all that apply)**

- You stopped breathing (respiratory arrest)?
- You were placed on a breathing machine because you were struggling to breathe on your own (respiratory failure)?
- An infection in your lungs (pneumonia)?
- None

17. After leaving the hospital, did you receive medical treatment **FOR PROBLEMS WITH YOUR KIDNEYS STOMACH OR INTESTINE**? **(Fill in all that apply)**

- Kidney failure and you needed kidney dialysis?
- GI bleed (internal bleeding from your stomach or intestine)?
- Stomach or intestinal ulcer?
- None

18. After leaving the hospital**,** did you receive medical treatment **FOR SEVERE PAIN?**

- Yes
- No

19. After leaving the hospital, did you receive medical treatment **FOR ANY OTHER PROBLEMS**? **(Fill in all that apply)**

- Stroke (for example, weakness on one side of the body or difficulty speaking)?
- Nerve injury/paralysis related to your procedure?
- Infection in the surgical wound?
- Other (specify):_____

- None

This next section has to do with falls after your surgery. Please provide one answer for each question. Fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best.

20. Since your surgery, how many times have you had a **fall, including a slip or trip** in which you lost your balance and landed on the floor or ground or lower level?

- Zero (0) (**Skip to question #22**)
- Once (1)
- Twice (2)
- Three or more (>2)

21. Did any of your falls result in any of the following? (**Fill in all that apply**)

- No injury
- Bruising, sprains or cuts
- Reduced mobility
- A fear of falling
- Severe pain
- Injury causing you to seek medical treatment
- Broken bone
- Head injury
- A change from independent living to assisted living

This next section has to do with your anesthesia experience during your procedure. Anesthesia is a combination of drugs or medicines used to either put patients to sleep or to sedate them to keep them from feeling pain during surgery and invasive medical procedures.

22. Did you have general anesthesia for your surgical procedure?

- Yes
- No (**Skip to question #25**)
- I'm not sure

23. Do you remember anything in between going to sleep and waking up from your anesthesia?

- Yes
- No (**Skip to question #25**)

24. Was this experience distressing to you?

- Yes
- No

The last few questions asked about remembering events during general anesthesia and experiencing distress. If you would like to discuss this, you can call Dr. Michael Avidan, telephone: 314-286-1768.

The next section is about your general health. These questions do not necessarily relate to your recent procedure. Please provide one answer for each question. Fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best.

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

- Excellent
- Very good
- Good
- Fair
- Poor

26. Does **your health now limit you** in **moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? If so, how much?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

27. Does **your health now limit you** in climbing **several** flights of stairs? If so, how much?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

28. As a result of your physical health, during the past 4 weeks, have **you accomplished less** than you would like with your work or other regular daily activities?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time

- Yes, all of the time

29. As a result of your physical health, during the past 4 weeks, were you limited in the **kind** of work or other activities?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

30. As a result of any emotional problems (such as feeling depressed or anxious), during the past 4 weeks, have **you accomplished less** than you would like with your work or other regular daily activities?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

31. As a result of any emotional problems (such as feeling depressed or anxious), during the past 4 weeks, have you not done work or other activities as **carefully** as usual?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

32. During the past 4 weeks, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

33. How much of the time during the past 4 weeks have you felt **calm and peaceful**?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little bit of the time
- None of the time

34. How much of the time during the past 4 weeks did you have **a lot of energy**?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little bit of the time
- None of the time

35. How much of the time during the past 4 weeks have you felt **downhearted and blue**?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little bit of the time
- None of the time

36. How much of the time during the past 4 weeks has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little bit of the time
- None of the time

37. Compared to one year ago, how would you rate your **physical health** in general now?

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

38. Compared to one year ago, how would you rate your **emotional problems** now? (Such as feeling anxious, depressed or irritable)

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

The next section is about your use of pain medications and pain. These questions relate to your recent procedure. Please fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best.

39. How does your **current use of pain medications** compare to your use **before** your procedure?

- I take **less** pain medication than before my procedure
- I take **more** pain medication than before my procedure
- I take the **same** amount of pain medication as I did before my procedure
- I **take pain medications now**, but did not before my procedure
- I am **not taking pain medications now**, and did not before my procedure

40. Currently, do you have **any pain** in your surgical incision or related area to your surgery?

- Yes
- No **(Skip to question #44)**

41. Did the pain start after surgery?

- Yes
- No

42. On a scale of zero to ten, with **zero being no pain** and **ten being the worst pain**, please fill in your average pain level during the past week.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

43. Do you have any of the following symptoms in the surgical area (**Fill in all that apply**)

- Numbness
- Decrease sensation to cold or touch
- Increased sensation to cold or touch

The next section has to do with the changes in your life due to problems with memory and thinking. Please fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best.

44. In the past 7 days, has your **thinking** been slow?

- Never
- Rarely (Once)
- Sometimes (Two or three times)
- Often (About once a day)
- Very often (Several times a day)

45. In the past 7 days, has it seemed like **your brain was not working** as well as usual?

- Never
- Rarely (Once)
- Sometimes (Two or three times)
- Often (About once a day)
- Very often (Several times a day)

46. In the past 7 days, have you had to **work harder** than usual to keep track of what you were doing?

- Never
- Rarely (Once)
- Sometimes (Two or three times)
- Often (About once a day)
- Very often (Several times a day)

47. In the past 7 days, have you had trouble **shifting back and forth** between different activities that require thinking?

- Never
- Rarely (Once)
- Sometimes (Two or three times)
- Often (About once a day)
- Very often (Several times a day)

48. In the past 7 days, has your **mind** been as sharp as usual?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

49. In the past 7 days, has your **memory** been as good as usual?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

50. In the past 7 days, has your **thinking** been as fast as usual?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

51. In the past 7 days, have you been able to **keep track** of what you are doing, even if you are interrupted?

- Not at all
- A little bit
- Somewhat

- Quite a bit
- Very much

The following questions are about your ability to care for yourself independently now. To be dependent means you need help with the task. To be independent means you can complete the task without help.

52. In relation to **feeding yourself**, you are…

- Unable
- Needing some help (i.e. cutting, spreading butter)
- Independent

53. In relation to **bathing/showering**, you are…

- Dependent
- Independent

54. In relation to **grooming**, you are…

- Needing some help with personal care
- Independent (i.e. brushing hair, brushing teeth, shaving)

55. In relation to **dressing**, you are…

- Dependent
- Needing some help, but can do about half unaided
- Independent (including buttons, zips, laces, etc.)

56. In relation to your **bowels** (defecation), you are…

- Incontinent/unable to control bowels (or need to be given enemas)
- Having occasional accidents
- Continent/able to control bowels

57. In relation to your **bladder** (urination), you are…

- Incontinent/unable to control bladder (or catheterized and unable to manage alone)
- Having occasional accidents
- Continent/able to control bladder

58. In relation to using the **toilet**, you are…

- Dependent
- Needing some help, but can do some things alone
- Independent (on and off the toilet, dressing, wiping)

59. In relation to **transferring from a bed to a chair** and back, you are…

- Unable (no sitting balance)
- Needing major help but are able to sit (one or two people physically helping)
- Needing minor help (verbal encouragement or physical help)
- Independent

60. In relation to your **mobility** (walking) on level surfaces, you are…

- Immobile (unable to walk or move about) for less than 50 yards
- Wheelchair independent, including corners, greater than 50 yards
- Walking with the help of one person (either verbal encouragement or physical help) greater than 50 yards
- Independent (with or without a cane or walker) greater than 50 yards

61. In relation to **climbing** a flight of stairs, you are…

- unable
- Needing help (verbal encouragement, physical help, carrying aid)
- Independent

Thank you for your participation.

The first section is about your specific health and ability to return to work as it relates to your surgery or procedure from about 1 year ago. Please provide one answer for each question. Fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best. You may skip questions you wish not to answer.

1. How would you rate your quality of life **now?**

- Better than before your procedure
- The same as before your procedure
- Worse than before your procedure

2. Since your surgical procedure (about one year ago), have you been able to return to work **(job or studies or housework)**?

- Yes
- No ***(Skip to Question #6)***
- Does not apply ***(Skip to Question #6)***

3. After how many months since your procedure did you return to work?

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. If your ability to perform work is **ten when you are at your best** and **zero when you are unable to work**, circle the number that represents your ability to work currently.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Does your health limit you in your current work **(job or studies or housework)**?

- I am not limited by my health
- I am able to do my work with difficulty
- I sometimes have to work slowly
- I often have to work slowly
- I am only able to do my work part time
- I am entirely unable to do my work

6. How long did it take you to return to your **normal life activities** (other than work) **after your procedure**?

- less than 1 week,
- 1-4 weeks
- 1-3 months
- 3-6 months
- More than 6 months
- I have yet fully recovered

This next section is about your specific health related to your surgery since you completed the last survey about a month after your surgery. Please fill in the circle next to those that apply.

7. Since completing the previous Health & Well-being Survey (about a year ago), did you receive medical care in any of the following locations? **(Fill in all that apply)**

- Outpatient clinic
- Urgent care center
- Emergency room
- A hospital where you were admitted
- A long-term care hospital or inpatient rehabilitation facility
- An operating room where you had another surgery
- Other location
- I did not receive any care **(Skip to question #13)**

8. Since completing the previous survey, did you receive medical treatment **FOR PROBLEMS WITH YOUR HEART**? **(Fill in all that apply)**

- Heart attack?
- Your heart stopped beating (cardiac arrest)?
- Heart failure (congestive heart failure)?
- Abnormal heart rhythm such as atrial fibrillation?
- Severe pain coming from your heart (angina)?
- None

9. Since completing the previous survey, did you receive medical treatment **FOR PROBLEMS WITH BLOOD CLOTS**? **(Fill in all that apply)**

- Blood clot in your leg (Deep vein thrombosis)?
- Blood clot in your lung (Pulmonary embolism)?
- None

10. Since completing the previous survey, did you receive medical treatment **FOR PROBLEMS WITH YOUR LUNGS OR BREATHING**? **(Fill in all that apply)**

- You stopped breathing (respiratory arrest)?
- You were placed on a breathing machine because you were struggling to breathe on your own (respiratory failure)?
- An infection in your lungs (pneumonia)?
- None

11. Since completing the previous survey, did you receive medical treatment **FOR PROBLEMS WITH YOUR KIDNEYS, STOMACH OR INTESTINE**? **(Fill in all that apply)**

- Kidney failure and you needed kidney dialysis?
- GI bleed (internal bleeding from your stomach or intestine)?
- Stomach or intestinal ulcer?
- None

12. Since completing the previous survey, did you receive medical treatment **FOR ANY OTHER PROBLEMS**? **(Fill in all that apply)**

- Stroke (for example, weakness on one side of the body or difficulty speaking)?
- Nerve injury/paralysis related to your procedure?
- Other (specify):_____
- None

This next section has to do with falls since completing the previous survey. Please provide one answer for each question. Fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best.

13. Since completing the previous survey, how many times have you had a **fall, including a slip or trip** in which you lost your balance and landed on the floor or ground or lower level?

- Zero (0) **(Skip to question #15)**
- Once (1)
- Twice (2)
- Three or more (>2)

14. Did any of your **falls** result in any of the following? (**Fill in all that apply**)

- No injury
- Bruising, sprains or cuts
- Reduced mobility
- A fear of falling
- Severe pain
- Injury causing you to seek medical treatment
- Broken bone
- Head injury
- A change from independent living to assisted living

The next section is about your CURRENT general health. These questions do not necessarily relate to your procedure from about 1 year ago. Please provide one answer for each question. Fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best.

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

- Excellent
- Very good

- Good
- Fair
- Poor

16. Does **your health now limit you** in **moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? If so, how much?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

17. Does **your health now limit** you in climbing **several** flights of stairs? If so, how much?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

18. As a result of your physical health, during the past 4 weeks, have you **accomplished less** than you would like with your work or other regular daily activities?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

19. As a result of your physical health, during the past 4 weeks, were you limited in the **kind** of work or other activities?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

20. As a result of any emotional problems (such as feeling depressed or anxious), during the past 4 weeks, have **you accomplished less** than you would like with your work or other regular daily activities?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

21. As a result of any emotional problems (such as feeling depressed or anxious), during the past 4 weeks, have you not done work or other activities as **carefully** as usual?

- No, none of the time
- Yes, a little of the time
- Yes, some of the time

- Yes, most of the time
- Yes, all of the time

22. During the past 4 weeks, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

23. How much of the time during the past 4 weeks have you felt **calm and peaceful**?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little bit of the time
- None of the time

24. How much of the time during the past 4 weeks did you have **a lot of energy**?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little bit of the time
- None of the time

25. How much of the time during the past 4 weeks have you felt **downhearted and blue**?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little bit of the time
- None of the time

26. How much of the time during the past 4 weeks has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little bit of the time
- None of the time

27. Compared to one year ago, how would you rate your **physical health** in general **now**?

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

28. Compared to one year ago, how would you rate your **emotional problems** now? (Such as feeling anxious, depressed or irritable)

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

The next section is about your use of pain medication and pain. These questions relate to your recent procedure. Please fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best.

29. How does your **current** use of pain medications compare to your use **before** your procedure about one year ago?

- I take **less** pain medication than I did one year ago
- I take **more** pain medication than I did one year ago
- I take the **same** amount of pain medication than I did one year ago
- I **take pain medications now**, but did not one year ago
- I am **not taking pain medications** now, and did not one year ago

30. Currently, do you have **any pain** in your surgical incision or in the area related to your surgery?

- Yes
- No **(Skip to question #34)**

31. Did the pain start after the surgery?

- Yes
- No

32. On a scale of zero to ten, with **zero being no pain** and **ten being the worst pain**, please fill in your average pain level during the past week.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

33. Do you have any of the following symptoms in the surgical area (**Fill in all that apply**)

- Numbness
- Decrease sensation to cold or touch
- Increased sensation to cold or touch

The next section has to do with the changes in your life due to problems with memory and thinking. Please fill in the circle next to your answer. If you are unsure how to answer a question, please choose the one that fits best.

34. In the past 7 days, has your **thinking** been slow?
- Never
- Rarely (Once)
- Sometimes (Two or three times)
- Often (About once a day)
- Very often (Several times a day)

35. In the past 7 days, has it seemed like your **brain was not working** as well as usual?
- Never
- Rarely (Once)
- Sometimes (Two or three times)
- Often (About once a day)
- Very often (Several times a day)

36. In the past 7 days, have you had to **work harder** than usual to keep track of what you were doing?
- Never
- Rarely (Once)
- Sometimes (Two or three times)
- Often (About once a day)
- Very often (Several times a day)

37. In the past 7 days, have you had trouble **shifting back and forth** between different activities that require thinking?
- Never
- Rarely (Once)
- Sometimes (Two or three times)
- Often (About once a day)
- Very often (Several times a day)

38. In the past 7 days, has your **mind** been as sharp as usual?
- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

39. In the past 7, days has your **memory** been as good as usual?
- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

40. In the past 7 days, has your **thinking** been as fast as usual?
- Not at all

- A little bit
- Somewhat
- Quite a bit
- Very much

41. In the past 7 days, have you been able to **keep track** of what you are doing, even if you are interrupted?
- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

The following questions are about your ability to care for yourself independently now. To be dependent means you need help with a task. To be independent means you can complete a task without help.

42. In relation to **feeding** yourself, you are…
- Unable
- Needing some help (i.e. cutting, spreading butter)
- Independent

43. In relation to **bathing/showering**, you are…
- Dependent
- Independent

44. In relation to **grooming**, you are…
- Needing some help with personal care
- Independent (i.e. brushing hair, brushing teeth, shaving)

45. In relation to **dressing**, you are…
- Dependent
- Needing some help, but can do about half unaided
- Independent (including buttons, zips, laces, etc.)

46. In relation to your **bowels** (defecation), you are…
- Incontinent/unable to control bowels (or need to be given enemas)
- Having occasional accidents
- Continent/able to control bowels

47. In relation to your **bladder** (urination), you are…
- Incontinent/unable to control bladder (or catheterized and unable to manage alone)
- Having occasional accidents
- Continent/able to control bladder

48. In relation to **using the toilet**, you are…
- Dependent
- Needing some help, but can do some things alone
- Independent (on and off the toilet, dressing, wiping)

49. In relation to **transferring from a bed to a chair** and back, you are…
- Unable (no sitting balance)
- Needing major help but are able to sit (one or two people physically helping)
- Needing minor help (verbal encouragement or physical help)
- Independent

50. In relation to your **mobility** (walking) on level surfaces, you are…
- Immobile (unable to walk or move about) for less than 50 yards
- Wheelchair independent, including corners, greater than 50 yards
- Walking with the help of one person (either verbal encouragement or physical help) greater than 50 yards
- Independent (with or without a cane or walker) greater than 50 yards

51. In relation to **climbing** a flight of stairs, you are…
- Unable
- Needing help (verbal encouragement, physical help, carrying aid)
- Independent

Thank you for your participation.