Initials: ☐☐☐☐ **Subject ID:** ☐☐☐☐☐
First name Surname Interviewer to complete

Date of birth: ☐☐ / ☐☐ / ☐☐☐☐ **Time of day:** ☐☐ : ☐☐
Day Month Year Please use 24hr time

Today's date: ☐☐ / ☐☐ / ☐☐☐☐ **Sex:** male female
Day Month Year Circle one

Brief Disability Questionnaire

The following questions concern daily activities that are sometimes affected by your health. We would like to know whether your health problems have recently limited you in any of these areas. For each question please tick, cross or colour the circle that most closely matches your response. There are no right or wrong answers. Please answer all questions.

In the past week:	**No, not at all**	**Yes, sometimes or a little**	**Yes, moderately or definitely**
1. Have your health problems limited you in any of the following activities:			
a. The kinds or amount of vigorous activity you can do, like lifting heavy objects, running, or sports?	○	○	○
b. Walking long distances (that is 1-2 Km)?	○	○	○
c. The kinds or amount of moderate activity you can do, like moving a table, or carrying groceries?	○	○	○
d. Climbing stairs or walking uphill?	○	○	○
e. Bending, lifting or stooping?	○	○	○
f. Eating, dressing, bathing or using the toilet?	○	○	○
2. Have you had to cut down or stop any activity you used to do, such as a hobby, because of your illness?	○	○	○
3. Have you been unable to do something that your family (or household) expected from you as part of your daily routine?	○	○	○
4. Have your personal problems decreased your motivation to work?	○	○	○
5. Have your personal problems decreased your personal efficiency at home, school or work?	○	○	○
6. Has there been a deterioration in your social relations with friends, workmates, or other people?	○	○	○

7. During the past week how many days in total were you unable to carry out your usual daily activities fully? _____days (0-7)

8. During the past week how many days in total did you stay in bed all or most of the day because of your illness? _____days (0-7)