

POMP Final: Physical Functioning and Health Module

(Mail Version)

These next questions are about your health.

PF1. In general, would you say your health is:

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

PF2. Do you use any of the following aids?

			If "Yes," have you used them for 6 months or longer?	
	Yes	No	Yes	No
PF2a. A cane, crutches, or a walker	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2
PF2b. A wheelchair, electric scooter, etc.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2
PF2c. A hearing aid	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2
PF2d. Other (e.g., grab bar, shower chair, shower bench, etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 2

PF3. About how many different prescription medications do you take every day?

|__| |__|

PF4. In the past 12 months, did you have to stay overnight in a nursing home or rehabilitation center?

- Yes..... 1
- No..... 2

PF5. In the past 12 months, did you have to stay overnight in a hospital?

- Yes..... 1
- No..... 2

PF6. In the past 12 months, did you receive treatment in an emergency room?

- Yes..... 1
- No..... 2

Office Use Only: Client ID: _____ Service Enrollment Date: _____ Date of Survey Administration: _____
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This question asks about common activities of daily life and whether you usually need assistance with them. This does not include the effects of temporary conditions. If you use an aid or assistive device, please indicate if you still have difficulty when using the aid.

Because of a physical or mental health condition, do you have difficulty...

	<u>Yes</u>	<u>No</u>	If "Yes," do you need the help of another person?	
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
PF7. Getting around INSIDE the home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF8. Getting around OUTSIDE the home, for example to shop or visit a doctor's office	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF9. Getting in or out of a bed or a chair	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF10. Taking a bath or shower	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF11. Dressing	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF12. Walking	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF13. Eating	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF14. Using or getting to the toilet	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF15. Keeping track of money or bills	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF16. Preparing meals	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF17. Doing light housework, such as washing dishes or sweeping a floor	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF18. Doing heavy housework, such as scrubbing floors and washing windows	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF19. Taking the right amount of prescribed medicine at the right time	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
PF20. Using the telephone	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

PF21. Have you ever been told by a doctor, nurse, or other health care professional that you have...

	<u>Yes</u>	<u>No</u>
a. Arthritis or rheumatism.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. High blood pressure or hypertension	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. A heart attack, coronary heart disease, angina, congestive heart failure, or other heart problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. High cholesterol	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. Diabetes or high blood sugar	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f. Allergies, asthma, emphysema, chronic bronchitis, or other breathing or lung problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2
g. Cancer or a malignant tumor, excluding minor skin cancer.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
h. Stroke	<input type="checkbox"/> 1	<input type="checkbox"/> 2
i. Anemia	<input type="checkbox"/> 1	<input type="checkbox"/> 2
j. Osteoporosis	<input type="checkbox"/> 1	<input type="checkbox"/> 2
k. Kidney disease	<input type="checkbox"/> 1	<input type="checkbox"/> 2
l. Eye or vision conditions such as glaucoma, cataracts, macular degeneration or other medical conditions [Does not include only wears glasses or contacts.]....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
m. Oral health/tooth or mouth problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2
n. Hearing problems.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
o. Emotional, nervous, or psychiatric problems.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
p. Memory related disease such as Alzheimer's or dementia	<input type="checkbox"/> 1	<input type="checkbox"/> 2
q. Seizures or epilepsy	<input type="checkbox"/> 1	<input type="checkbox"/> 2
r. Parkinson's	<input type="checkbox"/> 1	<input type="checkbox"/> 2
s. Persistent pain, aching, stiffness or swelling around a joint? [Includes broken bones and sprained muscles, and bad backs, knees, shoulders, etc.]	<input type="checkbox"/> 1	<input type="checkbox"/> 2
t. Multiple Sclerosis	<input type="checkbox"/> 1	<input type="checkbox"/> 2
u. A serious problem with urinary incontinence.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
v. Something else?	<input type="checkbox"/> 1	<input type="checkbox"/> 2

Please describe: _____