

Health Psychology Department

The purpose of this questionnaire is to assess your perception of your health and well-being. There are no right or wrong answers. You will have an opportunity to discuss concerns or results later. If possible, please fill out a form for each caregiver you have shared information with. Please use black or blue ink.

Name: _____ Date: _____
Age: _____ Sex: _____ Date of Birth: _____ Grade: _____
Living Alone: _____ Family/Relationship: _____

How do you usually perceive your health? (Please check all that apply)

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Good |
| <input type="checkbox"/> Fair | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Poor | <input type="checkbox"/> Very Poor |
| <input type="checkbox"/> Don't know | <input type="checkbox"/> Other (specify) _____ |

Psychological Status

How satisfied are you with your quality of life? Yes/No

If you have a chronic condition, how satisfied are you with your management? (Please specify)

How often are medical complications when you receive care (specify with you)? Yes/No

If you prefer, explain:

Do you ever receive any of the following during the pregnancy?

- None
- Frequency/Severe
- Other things

Open-Ended

What have you done? What else would you like to do to feel better? (You may use the back)
