

CRITÉRIOS DE AVALIAÇÃO
DE QUALIDADE DE VIDA

PORTUGAL

SF-12

IQOLA SF-12 Portugal (Portuguese)
Version 1.0

QUESTIONÁRIO DE ESTADO DE SAÚDE SF-12

ACERCA DESTAS PERGUNTAS: As questões que se seguem pedem-lhe opinião sobre a sua saúde, a forma como se sente, e sobre a sua capacidade de desempenhar as actividades habituais.

Pedimos que leia com atenção cada pergunta e que responda a mais honestamente possível. Se não tiver a certeza sobre a resposta a dar, dê-nos a que sonar mais apropriada e, se quiser, acresce um comentário a seguir à pergunta.

1. Em geral, diria que a sua saúde é:

Óptima

Muito boa

Bom

Razoável

Fraca

As perguntas que se seguem são sobre actividades que executa no seu dia-a-dia. Será que a sua saúde o/a limita nestas actividades? Se sim quanto?

	Sim, muito limitado/a	Sim, um pouco limitado/a	Não, nada limitado/a
2. Actividades moderadas, tais como deslocar uma mesa ou aspirar a casa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Subir várias lanchas de escada	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Durante as últimas 4 semanas, teve no seu trabalho ou actividades diárias algum dos problemas apresentados a seguir como consequência do seu estado de saúde físico?

	Sim	Não
4. Fez menos do que queria	<input type="checkbox"/>	<input type="checkbox"/>
5. Sentiu-se limitado/a no tipo de trabalho ou outras actividades	<input type="checkbox"/>	<input type="checkbox"/>

Durante as últimas 4 semanas, teve com o seu trabalho ou com as suas actividades diárias, algum dos problemas apresentados a seguir devido a quaisquer problemas emocionais (tal como sentir-se deprimido/a ou ansioso/a)?

- | | Sim | Não |
|--|--------------------------|--------------------------|
| 6. Fez menos do que queria | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Não executou o trabalho ou outras actividades tão cuidadosamente como era costume | <input type="checkbox"/> | <input type="checkbox"/> |
8. Durante as últimas 4 semanas, de que forma é que a dor interferiu com o seu trabalho normal (tanto o trabalho fora de casa como o trabalho doméstico)?
- | | | | | |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Absolutamente nada | Um pouco | Moderadamente | Bastante | Imenso |

As perguntas que se seguem pretendem avaliar a forma como se sentiu e como lhe correram as coisas nas últimas quatro semanas. Para cada pergunta, coloque por favor um círculo à volta do número que melhor descreva a forma como se sentiu. Quanto tempo, nas últimas 4 semanas....

- | | Sempre | A maior parte do tempo | Bastante tempo | Algum tempo | Pouco tempo | Nunca |
|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 9. se sentiu calmo/a e tranquilo/a? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. se sentiu com muita energia? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. se sentiu triste e em baixo? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

12. Durante as últimas 4 semanas, até que ponto é que a sua saúde física ou problemas emocionais limitaram a sua actividade social (tal como visitar amigos ou familiares próximos)?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sempre	A maior parte do tempo	Algum tempo	Pouco tempo	Nunca

S1 SF36 - General Health Survey

Patient Name _____ Patient ID _____
 _____ Study Name _____ Study
 Number _____ Date ____/____/____ Side Right Left
 Filled in by: Operating Dr. Other MD Research Assistant Questionnaire Other
 Reviewer Name: _____ Next Visit Due ____/____/____

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

- Excellent
- Very Good
- Good
- Fair
- Poor

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

- Much better now than 1 year ago
- Somewhat better now than 1 year ago
- About the same as 1 year ago
- Somewhat worse now than 1 year ago
- Much worse now than 1 year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities?

If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Bending, kneeling or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking more than a mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Walking several hundred yards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Walking one hundred yards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Had difficulty performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Did work or other activities less carefully than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

- Not At All
- Slightly
- Moderately
- Quite a Bit
- Extremely

7. How much bodily pain have you had during the past 4 weeks?

- None
- Very Mild
- Mild
- Moderate
- Severe
- Very Severe

8. 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

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you been very nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you felt downhearted and depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you been happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. During the past 4 weeks, how much of the time 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 of the time
- None of the time

11. How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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