



# The Veterans Rand 12 Item Health Survey (VR-12)

eform v 3.1

Patient Name: \_\_\_\_\_

Side:  Left (Ignore for Spine)  
 Right

Patient ID: \_\_\_\_\_

Date of review:         (complete either the date of review or the follow up period below)

Follow up period: Pre Op OR \_\_\_\_\_ Weeks / Months / Years (add the delay and circle one)

**Patients - please place an X in one box on each line to indicate your response to that question.**

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

Excellent  Very good  Good  Fair  Poor

2. 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. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Climbing several flights of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities.....

.....as a result of your physical health ?

	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
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. 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"/>

4. ...as a result of any emotional problems (such as feeling depressed or anxious)

	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
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. 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



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6. 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	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful ?	<input type="checkbox"/>					
b. Did you have a lot of energy ?	<input type="checkbox"/>					
c. Have you felt downhearted and blue ?	<input type="checkbox"/>					

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
7. 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) ?	<input type="checkbox"/>				

Now, we'd like to ask you some questions about how your health may have changed.

	Much better	Slightly better	About the same	Slightly worse	Much worse
8. Compared to one year ago, how would you rate your physical health in general now?	<input type="checkbox"/>				
9. Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed or irritable) now?	<input type="checkbox"/>				