OARS Comorbidity

Instructions: We would like to ask you a few questions about any health problems you might have. Do you have any of the following illnesses at the present time?

Please mark the box with an **"X"** for the appropriate response (yes or no).

If you choose **YES** please tell us how much the illness interferes with your activities.

				IF YOU HAVE THIS ILLNESS: How much does it interfere with your activities?		
Illness	**No**	**Yes**		**Not At All**	**Somewhat**	**A Great Deal**
1. Other cancer or leukemia	☐	☐	**If Yes →**	☐	☐	☐
2. Arthritis or rheumatism	☐	☐	**If Yes →**	☐	☐	☐
3. Glaucoma	☐	☐	**If Yes →**	☐	☐	☐
4. Emphysema or chronic bronchitis	☐	☐	**If Yes →**	☐	☐	☐
5. High blood pressure	☐	☐	**If Yes →**	☐	☐	☐
6. Heart disease	☐	☐	**If Yes →**	☐	☐	☐
7. Circulation trouble in arms or legs	☐	☐	**If Yes →**	☐	☐	☐
8. Diabetes	☐	☐	**If Yes →**	☐	☐	☐
9. Stomach or intestinal disorders	☐	☐	**If Yes →**	☐	☐	☐
10. Osteoporosis	☐	☐	**If Yes →**	☐	☐	☐
11. Chronic liver or kidney disease	☐	☐	**If Yes →**	☐	☐	☐
12. Stroke	☐	☐	**If Yes →**	☐	☐	☐
13. Depression	☐	☐	**If Yes →**	☐	☐	☐

For Clinic Use Only:
Number of Conditions (Sum) = ☐☐

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14. How is your eyesight (with glasses or contacts)?

☐ Totally Blind ☐ Poor ☐ Fair ☐ Good ☐ Excellent

14a. (If Fair to Totally Blind): How much does it interfere with your activities?

☐ Not At All ☐ Somewhat ☐ A Great Deal

15. How is your hearing (with a hearing aid, if needed)?

☐ Deaf ☐ Poor ☐ Fair ☐ Good ☐ Excellent

15a. (If Fair to Deaf): How much does it interfere with your activities?

☐ Not At All ☐ Somewhat ☐ A Great Deal