

## Fibromyalgia Impact Questionnaire

Name \_\_\_\_\_

Date \_\_\_\_\_

Directions: For questions 1 through 11, please circle the number that best describes how you did **overall** for the past week. If you don't normally do something that is asked, cross the question out.

Were you able to:	Always	Most	Occasionally	Never
1. Do Shopping?	0	1	2	3
2. Do laundry with a washer and dryer?	0	1	2	3
3. Prepare meals?	0	1	2	3
4. Wash dishes/cooking utensils by hand?	0	1	2	3
5. Vacuum a rug?	0	1	2	3
6. Make beds?	0	1	2	3
7. Walk several blocks?	0	1	2	3
8. Visit friends or relatives?	0	1	2	3
9. Do yard work?	0	1	2	3
10. Drive a car?	0	1	2	3
11. Climb stairs?	0	1	2	3

12. Of the 7 days in the past week, how many days did you feel good?

0      1      2      3      4      5      6      7

13. How many days last week did you miss work, including housework, because of fibromyalgia?

0      1      2      3      4      5      6      7

***PLEASE TURN PAGE OVER AND COMPLETE SIDE 2.***

