The following questions refer to difficulties arising from a HEALTH PROBLEM that you may experience when performing certain activities. 

1. Do(es) [you/he/she] have/has difficulty seeing, [even when wearing glasses]?
2. Do(es) [you/he/she] have/has difficulty hearing, [even when wearing hearing aids]?
3. Do(es) [you/he/she] have/has difficulty walking or climbing steps?
4. Do(es) [you/he/she] have/has difficulty to remember or to concentrate?
5. Do(es) [you/he/she] have/has difficulty with self-care, such as washing or dressing?
6. When using your usual language, do[es][you/he/she] have/has difficulty communicating, e.g., understanding others or being understood?

Now I am going to ask you about permanent limitations to carry out activities.

44. Given your physical and mental condition, and without any kind of help, . . . In your daily life do you have difficulties in performing activities such as: hearing, speaking, seeing, moving your body, walking, grasping objects with your hands, understanding, learning or remembering, eating or dressing yourself, and interacting with others?

1. Yes
44.1 What activities are you unable or have difficulty performing?
(Explain to the person that he/she should indicate the degree of difficulty he/she has in performing each of the activities listed):
1. Cannot do it
2. Yes, with great difficulty
3. Yes, with some difficulty
4. Can do it without difficulty
1. Hearing the voice or the sounds?
2. Talking or conversing?
3. Seeing near, far or around?
4. Move your body, walk or go up and down stairs?
5. Grasp or move objects with hands?
6. Understand, learn, remember, or make decisions for self?
7. Eat, dress, or bathe him/herself?
8. Relate to or interact with other people?
9. Do daily activities without heart or respiratory problems?

The degree of difficulty you have in performing each of the activities listed:
1. Cannot do it
2. Yes, with great difficulty
3. Yes, with some difficulty
4. Can do it without difficulty

You will now be asked about abilities and skills to perform some activities of daily living that may be affected by physical or mental difficulties.

16. Given your physical and mental condition, and without any assistance, can you . . . :
1. Hearing the voice or the sounds?
2. Talking or conversing?
3. Seeing near, far or around?
4. Move your body, walk or go up and down stairs?
5. Grasp or move objects with hands?
6. Understand, learn, remember, or make decisions for self?
7. Eat, dress, or bathe him/herself?
8. Relate to or interact with other people?
9. Do daily activities without heart or respiratory problems?

The degree of difficulty you have in performing each of the activities listed:
1. Cannot do it
2. Yes, with great difficulty
3. Yes, with some difficulty
4. Can do it without difficulty