

Brief Fatigue Inventory

STUDY ID# _____

HOSPITAL# _____

Date: ____ / ____ / ____

Time: _____

Name: _____
Last
First
Middle Initial

Throughout our lives, most of us have times when we feel very tired or fatigued. Have you felt unusually tired or fatigued in the last week? Yes No

1. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your fatigue right NOW.

0	1	2	3	4	5	6	7	8	9	10
No										As bad as
Fatigue										you can imagine

2. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your USUAL level of fatigue during past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No										As bad as
Fatigue										you can imagine

3. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your WORST level of fatigue during past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No										As bad as
Fatigue										you can imagine

4. Circle the one number that describes how, during the past 24 hours, fatigue has interfered with you:

A. General Activity	0	1	2	3	4	5	6	7	8	9	10
Does not Interfere											Completely Interferes
B. Mood	0	1	2	3	4	5	6	7	8	9	10
Does not Interfere											Completely Interferes
C. Walking ability	0	1	2	3	4	5	6	7	8	9	10
Does not Interfere											Completely Interferes
D. Normal work (includes both work outside the home and daily chores)	0	1	2	3	4	5	6	7	8	9	10
Does not Interfere											Completely Interferes
E. Relations with other people	0	1	2	3	4	5	6	7	8	9	10
Does not Interfere											Completely Interferes
F. Enjoyment of life	0	1	2	3	4	5	6	7	8	9	10
Does not Interfere											Completely Interferes

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