

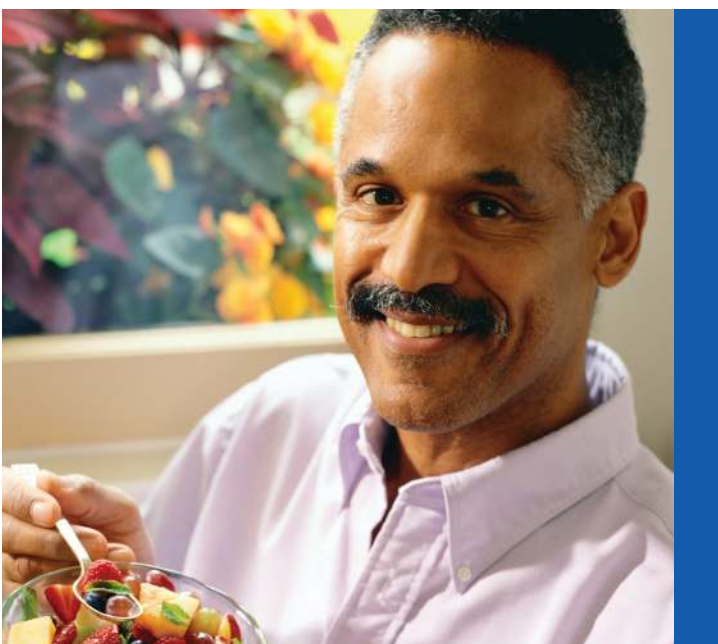


Health Information

National Trends Survey



National Institutes of Health
U.S. Department of Health and Human Services



40769.0614.88610402

Annotated Form
Cycle1, Next-Birthday, Full-Content, English Version

HV-CI

START HERE:

1. Is there more than one person age 18 or older living in this household?

AdultsInHH

1 Yes

2 No → **GO TO A1 on the next page**

2. Including yourself, how many people age 18 or older live in this household?

MailHHAdults

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3. **The adult with the next birthday should complete this questionnaire.**

This way, across all households, HINTS will include responses from adults of all ages.

4. Please write the first name, nickname, or initials of the adult with the next birthday. This is the person who should complete the questionnaire.

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Si prefiere recibir la encuesta en español, por favor llame 1-888-738-6812



A: Looking For Health Information

A1. Have you ever looked for information about health or medical topics from any source?

- SeekHealthInfo
- 1 Yes
- 2 No → **GO TO A5 in the next column**

A2. The most recent time you looked for information about health or medical topics, where did you go first? WhereSeekHealthInfo

Mark **only one.**

- 1 Books
- 2 Brochures, pamphlets, etc.
- 3 Cancer organization
- 4 Family
- 5 Friend/Co-worker
- 6 Doctor or health care provider
- 7 Internet
- 8 Library
- 9 Magazines
- 10 Newspapers
- 11 Telephone information number
- 12 Complementary, alternative, or unconventional practitioner
- WhereSeekHealthInfo_IMP

A3. The most recent time you looked for information about health or medical topics, who was it for?

- WhoLookingFor
- 1 Myself
- 2 Someone else
- 3 Both myself and someone else

A4. Based on the results of your most recent search for information about health or medical topics, how much do you agree or disagree with each of the following statements?

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
a. It took a lot of effort to get the information you needed.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
LotOfEffort				
b. You felt frustrated during your search for the information.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Frustrated				
c. You were concerned about the quality of the information.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
ConcernedQuality				
d. The information you found was hard to understand.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
TooHardUnderstand				

A5. Overall, how confident are you that you could get advice or information about health or medical topics if you needed it?

- ConfidentGetHealthInf
- 1 Completely confident
- 2 Very confident
- 3 Somewhat confident
- 4 A little confident
- 5 Not confident at all

A6. In general, how much would you trust information about health or medical topics from each of the following?

	Not at all	A little	Some	A lot
a. A doctor.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
TrustDoctor				
b. Family or friends.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
TrustFamily				
c. Newspapers or magazines.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
TrustNewsMag				
d. Radio.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
TrustRadio				
e. Internet.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
TrustInternet				
f. Television.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
TrustTelevision				
g. Government health agencies...	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
TrustGov				
h. Charitable organizations.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
TrustCharities				
i. Religious organizations and leaders.....	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
TrustReligiousOrgs				



A7. Imagine that you had a strong need to get information about health or medical topics. Where would you go first?

Mark only one. StrongNeedHealthInfo

- 1 Books
- 2 Brochures, pamphlets, etc.
- 3 Cancer organization
- 4 Family
- 5 Friend/Co-worker
- 6 Doctor or health care provider
- 7 Internet
- 8 Library
- 9 Magazines
- 10 Newspapers
- 11 Telephone information number
- 12 Complementary, alternative, or unconventional practitioner
- 91 Other-Specify → StrongNeedHealthInfo_OS

StrongNeedHealthInfo_IMP

A8. Have you ever looked for information about cancer from any source?

- 1 Yes SeekCancerInfo
- 2 No

A9. In the past 12 months, have you used the Internet to look for information about cancer for yourself?

- 1 Yes InternetCancerInfoSelf
- 2 No

B: Using the Internet to Find Information

B1. Do you ever go on-line to access the Internet or World Wide Web, or to send and receive e-mail?

- 1 Yes UseInternet
- 2 No → GO TO B4 on the next page

B2. When you use the Internet, do you access it through...

	Yes	No
a. A regular dial-up telephone line..... Internet_DialUp	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Broadband such as DSL, cable, or FiOS..... Internet_BroadBnd	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. A cellular network (i.e., phone, 3G/4G)..... Internet_Cell	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. A wireless network (Wi-Fi)..... Internet_Wifi	<input type="checkbox"/> 1	<input type="checkbox"/> 2

B3. How often do you access the Internet through each of the following?

	Daily	Sometimes	Never	Not applicable
a. Computer at home..... WhereUseInternet_Home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b. Computer at work..... WhereUseInternet_Work	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c. Computer at school..... WhereUseInternet_School	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d. Computer in a public place (library, community center, other)..... WhereUseInternet_PublicPlace	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e. On a mobile device (cell phone/smart phone/tablet)..... WhereUseInternet_MobileDevice	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f. On a gaming device/ "Smart TV"..... WhereUseInternet_GamingDevice	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4



B4. In the past 12 months, have you used a computer, smartphone, or other electronic means to do any of the following...

	Yes	No
a. Looked for health or medical information for yourself..... <i>Electronic_SelfHealthInfo</i>	1	2
b. Looked for health or medical information for someone else..... <i>Electronic_HealthInfoSE</i>	1	2
c. Bought medicine or vitamins online..... <i>Electronic_BuyMedicine</i>	1	2
d. Looked for a health care provider..... <i>Electronic_HCPSearch</i>	1	2
e. Used e-mail or the Internet to communicate with a doctor or a doctor's office..... <i>Electronic_TalkDoctor</i>	1	2
f. Made appointments with a health care provider..... <i>Electronic_MadeAppts</i>	1	2
g. Track health care charges and costs..... <i>Electronic_TrackedHealthCosts</i>	1	2
h. Filled out forms or paperwork related to your health care..... <i>Electronic_CompletedForms</i>	1	2
i. Look up test results..... <i>Electronic_TestResults</i>	1	2

B5. Please indicate if you have each of the following.

	Yes	No
a. Tablet computer like an iPad, Samsung Galaxy, Motorola Xoom, or Kindle Fire..... <i>HaveDevice_Tablet</i>	1	2
b. Smartphone, such as an iPhone, Android, Blackberry, or Windows phone..... <i>HaveDevice_SmartPh</i>	1	2
c. Basic cell phone only..... <i>HaveDevice_CellPh</i>	1	2

B6. On your tablet or smartphone, do you have any "apps" related to health and wellness?

TabletHealthWellnessApps

- 1 Yes
- 2 No
- 3 Don't know
- 4 Do not have a tablet or smartphone → **GO TO B8 in the next column**

B7. Has your tablet or smartphone...

Yes No

a. Helped you track progress on a health-related goal such as quitting smoking, losing weight, or increasing physical activity?..... <i>Tablet_AchieveGoal</i>	1	2
b. Helped you make a decision about how to treat an illness or condition?..... <i>Tablet_MakeDecision</i>	1	2
c. Helped you in discussions with your health care provider?..... <i>Tablet_DiscussionsHCP</i>	1	2

B8. Other than a tablet or smartphone, have you used an electronic device to monitor or track your health within the last 12 months? Examples include Fitbit, blood glucose meters, and blood pressure monitors.

OtherDevTrackHealth

- 1 Yes
- 2 No

B9. Have you shared health information from either an electronic monitoring device or smartphone with a health professional within the last 12 months?

SharedHealthDeviceInfo

- 1 Yes
- 2 No
- 3 Not Applicable

B10. Sometimes people use the Internet to connect with other people online through social networks like Facebook or Twitter. This is often called "social media".

In the last 12 months, have you used the Internet for any of the following reasons?

Yes No

a. To visit a social networking site, such as Facebook or LinkedIn..... <i>IntRSN_VisitedSocNet</i>	1	2
b. To share health information on social networking sites, such as Facebook or Twitter..... <i>IntRSN_SharedSocNet</i>	1	2
c. To write in an online diary or blog (i.e., Web log)..... <i>IntRSN_WroteBlog</i>	1	2
d. To participate in an online forum or support group for people with a similar health or medical issue..... <i>IntRSN_SupportGroup</i>	1	2
e. To watch a health-related video on YouTube..... <i>IntRSN_YouTube</i>	1	2

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B11. Have you sent or received a text message from a doctor or other health care professional within the last 12 months?

TextFromDoctor

- 1 Yes
- 2 No
- 3 Don't know

C: Your Health Care

C1. Not including psychiatrists and other mental health professionals, is there a particular doctor, nurse, or other health professional that you see most often?

RegularProvider

- 1 Yes
- 2 No

C2. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

MostRecentCheckup2

- 1 Within the past year
- 2 1-2 years ago
- 3 3-5 years ago
- 4 More than 5 years ago
- 5 Never
- 6 Don't know

C3. In the past 12 months, not counting times you went to an emergency room, how many times did you go to a doctor, nurse, or other health professional to get care for yourself?

GO TO C7 on the next page

FreqGoProvider

- 0 None
- 1 1 time
- 2 2 times
- 3 3 times
- 4 4 times
- 5 5-9 times
- 6 10 or more times

C4. The following questions are about your communication with all doctors, nurses, or other health professionals you saw during the past 12 months.

How often did they do each of the following:

Always Usually Sometimes Never

a. Give you the chance to ask all the health-related questions you had.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
ChanceAskQuestions				
b. Give the attention you needed to your feelings and emotions.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
FeelingsAddressed				
c. Involve you in decisions about your health care as much as you wanted.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
InvolvedDecisions				
d. Make sure you understood the things you needed to do to take care of your health.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
UnderstoodNextSteps				
e. Explain things in a way you could understand.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
ExplainedClearly				
f. Spend enough time with you.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
SpentEnoughTime				
g. Help you deal with feelings of uncertainty about your health or health care.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
HelpUncertainty				

C5. Overall, how would you rate the quality of health care you received in the past 12 months?

QualityCare

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor



C6. In the past 12 months, when getting care for a medical problem, was there a time when you...

Yes No

- a. Had to bring an X-ray, MRI, or other type of test result with you to the appointment?..... 1 2
ProbCare_BringTest
- b. Had to wait for test results longer than you thought reasonable?..... 1 2
ProbCare_WaitLong
- c. Had to redo a test or procedure because the earlier test results were not available?..... 1 2
ProbCare_RedoTest
- d. Had to provide your medical history again because your chart could not be found?..... 1 2
ProbCare_ProvideHist

C7. Are you currently covered by any of the following types of health insurance or health coverage plans?

Yes No

- a. Insurance through a current or former employer or union..... 1 2
HealthIns_InsuranceEMP
 - b. Insurance purchased directly from an insurance company..... 1 2
HealthIns_InsurancePriv
 - c. Medicare, for people 65 and older, or people with certain disabilities..... 1 2
HealthIns_Medicare
 - d. Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability..... 1 2
HealthIns_Medicaid
 - e. TRICARE or other military health care..... 1 2
HealthIns_Tricare
 - f. VA (including those who have ever used or enrolled for VA health care)..... 1 2
HealthIns_VA
 - g. Indian Health Service..... 1 2
HealthIns_IHS
 - h. Any other type of health insurance or health coverage plan (specify)..... 1 2
HealthIns_Other
- HealthIns_Other_OS

D: Medical Records

Next, we are going to ask you some questions about your medical records. Medical records are defined as medical history, such as laboratory test results, clinical notes, and current list of medications.

D1. Do any of your doctors or other health care providers maintain your medical records in a computerized system?

ProviderMaintainEMR2

- 1 Yes
- 2 No
- 3 Don't know

D2. Have you ever been offered online access to your medical records by your...

Yes No Don't know

- a. health care provider?..... 1 2 3
OfferedAccessHCP2
- b. health insurer?..... 1 2 3
OfferedAccessInsurer2

D3. Have any of your health care providers, including doctors, nurses, or office staff ever encouraged you to use an online medical record?

HCPEncourageOnlineRec

- 1 Yes
- 2 No




D4. How many times did you access your online medical record in the last 12 months? *AccessOnlineRecord*

- 0
 - 1 1 to 2 times
 - 2 3 to 5 times
 - 3 6 to 9 times
 - 4 10 or more times
- } **GO TO D6 in the next column**

D5. Why have you not accessed your medical records online? Is it because...

	Yes	No
a. You prefer to speak to your health care provider directly?..... <i>NotAccessed_SpeakDirectly</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. You do not have a way to access the website?..... <i>NotAccessed_NoInternet</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. You did not have a need to use your online medical record?..... <i>NotAccessed_NoNeed</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. You were concerned about the privacy or security of the website that had your medical records?..... <i>NotAccessed_ConcernedPrivacy</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. You don't have an online medical record.... <i>NotAccessed_NoRecord</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f. Other (specify).....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
<i>NotAccessed_Other</i> <i>NotAccessed_Other_OS</i>		



If you have not accessed any medical records in the last 12 months, go to D12 on the next page.

Otherwise, go to D6 in the next column

D6. Do any of your online medical records include the following types of medical information?

	Yes	No	Don't know
a. Laboratory test results..... <i>RecordsOnline_Labs</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. Current list of medications..... <i>RecordsOnline_Meds</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. List of health/medical problems..... <i>RecordsOnline_HealthProbs</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. Allergy list..... <i>RecordsOnline_Allergies</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. Summaries of your office visit..... <i>RecordsOnline_VisitSummary</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. Clinical notes..... <i>RecordsOnline_ClinNotes</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. Immunization or vaccination history.. <i>RecordsOnline_Immunizations</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

D7. In the past 12 months, have you used your online medical record to...

	Yes	No
a. Make appointments with a health care provider?..... <i>RecordsOnline_MakeAppt</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Request refill of medications?..... <i>RecordsOnline_RefillMeds</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Fill out forms or paperwork related to your health care?..... <i>RecordsOnline_Paperwork</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Request correction of inaccurate information?..... <i>RecordsOnline_RequestCorrection</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2

D8. In the past 12 months, have you used your online medical record to...

	Yes	No
a. Securely message health care provider and staff (e.g., e-mail)..... <i>RecordsOnline_MessageHCP</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Look up test results..... <i>RecordsOnline_ViewResults</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Monitor your health..... <i>RecordsOnline_MonitorHealth</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Download your health information to your computer or mobile device, such as a cell phone or tablet..... <i>RecordsOnline_DownloadHealth</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. Add health information to share with your health care provider, such as health concerns, symptoms, and side-effects..... <i>RecordsOnline_AddHealthInfo</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f. Help you make a decision about how to treat an illness or condition..... <i>RecordsOnline_MakeDecision</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2



D9. Have you electronically sent your medical information to....?

	Yes	No
a. Another health care provider?..... <i>ESent_AnotherHCP</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. A family member or another person involved with your care?..... <i>ESent_Family</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. A service or app that can help manage and store your health information?..... <i>ESent_HealthApp</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2

D10. How easy or difficult was it to understand the health information in your online medical record?

UnderstandOnlineMedRec

<input type="checkbox"/> 1	Very easy
<input type="checkbox"/> 2	Somewhat easy
<input type="checkbox"/> 3	Somewhat difficult
<input type="checkbox"/> 4	Very difficult

D11. In general, how useful is your online medical record for monitoring your health?

UsefulOnlineMedRec

<input type="checkbox"/> 1	Very useful
<input type="checkbox"/> 2	Somewhat useful
<input type="checkbox"/> 3	Not very useful
<input type="checkbox"/> 4	Not at all useful
<input type="checkbox"/> 5	I do not use my online medical record to monitor my health

D12. How confident are you that safeguards (including the use of technology) are in place to protect your medical record from being seen by people who aren't permitted to see them? *ConfidentInfoSafe*

<input type="checkbox"/> 1	Very confident
<input type="checkbox"/> 2	Somewhat confident
<input type="checkbox"/> 3	Not confident

D13. Have you ever kept information from your health care provider because you were concerned about the privacy or security of your medical record?

WithheldInfoPrivacy

<input type="checkbox"/> 1	Yes
<input type="checkbox"/> 2	No

D14. If your medical information is sent electronically – that is, by computer – from one health care provider to another, how concerned are you that an unauthorized person would see it?

ElectInfoSafe

<input type="checkbox"/> 1	Very concerned
<input type="checkbox"/> 2	Somewhat concerned
<input type="checkbox"/> 3	Not concerned

D15. How many times did you access a family member or close friend's online medical record in the last 12 months?

AccessFamilyMedRec

<input type="checkbox"/> 0	None → GO TO E1 below
<input type="checkbox"/> 1	1 to 2 times
<input type="checkbox"/> 2	3 to 5 times
<input type="checkbox"/> 3	6 to 9 times
<input type="checkbox"/> 4	10 or more times

D16. How did you access a family member or close friend's personal health information?

	Yes	No
a. Used family member's login and password..... <i>AccessedFamRec_TheirPwd</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Used a login and password assigned to me to access their record..... <i>AccessedFamRec_MyPwd</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2

E: Caregiving

E1. Are you currently caring for or making health care decisions for someone with a medical, behavioral, disability, or other condition?

Mark **all that apply.**

<input type="checkbox"/> 1	Yes, a child/children <i>Caregiving_Child</i>
<input type="checkbox"/> 1	Yes, a spouse/partner <i>Caregiving_Spouse</i>
<input type="checkbox"/> 1	Yes, a parent/parents <i>Caregiving_Parent</i>
<input type="checkbox"/> 1	Yes, a close family member, <i>Caregiving_Family</i>
<input type="checkbox"/> 1	Yes, a friend or other non-relative <i>Caregiving_Friend</i>
<input type="checkbox"/> 1	No → GO TO F1 on the next page <i>Caregiving_No</i> <i>CaregivingWho_Cat</i>



E2. Please check all conditions for which you have provided care for this person.

If you selected more than one person in E1, please think about the individual for whom you have provided the most care.

Mark all that apply.

- Cancer** Caregiving_Cancer
- Alzheimer's, confusion, dementia, forgetfulness** Caregiving_Alzheimers
- Orthopedic/Musculoskeletal Issues** (examples: back problems, broken bones, arthritis, mobility problems, can't get around, feeble, unsteady, falling) Caregiving_OrthoMusc
- Mental Health/Behavioral/Substance Abuse Issues** (examples: mental illness, emotional problems, depression, anxiety, substance/drug/alcohol abuse) Caregiving_MentalHealth
- Chronic Conditions** (examples: high blood pressure/hypertension, diabetes, heart disease, heart attack, lung disease, emphysema, Chronic Obstructive Pulmonary Disease (COPD), Parkinson's) Caregiving_ChronicCond
- Neurological/Developmental Issues** (examples: brain damage or injury, developmental or intellectual disorder, mental retardation, Down syndrome, stroke) Caregiving_NeuroDev
- Acute Conditions** (examples: surgery, wounds/injuries) Caregiving_AcuteCond
- Aging/Aging related health issues** Caregiving_Aging
- Other (specify)** →

<small>Caregiving_Other</small>
<small>Caregiving_Other_OS</small>
- Not sure/Don't know** Caregiving_NotSure
CaregivingCond_Cat

E3. Thinking of all of the kinds of help you provide for this person or persons, about how many hours do you spend in an average week providing care?

- Less than 5 hours per week
- 5-14 hours per week
- 15-20 hours per week
- 21-34 hours per week
- 35 or more hours per week

F: Medical Research

F1. Doctors use DNA tests to analyze someone's DNA for health reasons. Have you heard or read about this type of genetic test?

- Yes HeardDNATest
- No → **GO TO G1 on the next page**

F2. Which of the following uses of a genetic test have you heard of?

Mark all that apply.

- Determining risk or likelihood of getting a particular disease GeneticTestUse_DetermineRisk
- Determining how a disease should be treated after diagnosis GeneticTestUse_DetermineTx
- Determining which drug(s) may or may not work for an individual GeneticTestUse_DetermineMed
- Determining the likelihood of passing an inherited disease to your children GeneticTestUse_DeterminePass
GeneticTestUse_Cat

F3. Have you ever had any of the following type(s) of genetic tests?

Mark all that apply.

- Paternity testing:** To determine if a man is the father of a child HadTest_Paternity
- Ancestry testing:** To determine the background or geographic/ethnic origin of an individual's ancestors HadTest_Ancestry
- DNA fingerprinting:** To distinguish between or match individuals using hair, blood, or other biological material HadTest_DNAFing
- Cystic Fibrosis (CF) carrier testing:** To determine if a person is at risk of having a child with cystic fibrosis HadTest_CFCarrier
- BRCA 1/2 testing:** To determine if a person has more than an average chance of developing breast cancer or ovarian cancer HadTest_BRCA
- Lynch syndrome testing:** To determine if a person has more than an average chance of developing colon cancer HadTest_Lynch
- None of the above HadTest_None
- Not sure HadTest_NotSure
- Other-Specify →

<small>HadTest_Other, HadTest_Other_OS</small>
<small>HadTest_Cat</small>



G: Your Overall Health

G1. In general, would you say your health is...

GeneralHealth

- 1 Excellent,
- 2 Very good,
- 3 Good,
- 4 Fair, or
- 5 Poor?

G2. Overall, how confident are you about your ability to take good care of your health?

OwnAbilityTakeCareHealth

- 1 Completely confident
- 2 Very confident
- 3 Somewhat confident
- 4 A little confident
- 5 Not confident at all

G3. Has a doctor or other health professional ever told you that you had any of the following medical conditions:

Yes No

- | | Yes | No |
|--|----------------------------|----------------------------|
| a. Diabetes or high blood sugar?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| MedConditions_Diabetes | | |
| b. High blood pressure or hypertension?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| MedConditions_HighBP | | |
| c. A heart condition such as heart attack, angina, or congestive heart failure?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| MedConditions_HeartCondition | | |
| d. Chronic lung disease, asthma, emphysema, or chronic bronchitis?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| MedConditions_LungDisease | | |
| e. Arthritis or rheumatism?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| MedConditions_Arthritis | | |
| f. Depression or anxiety disorder?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| MedConditions_Depression | | |

G4. About how tall are you without shoes?

Feet **and**
 Inches
Height_Feet, Height_Inches

G5. About how much do you weigh, in pounds, without shoes?

Weight

Pounds

G6. Over the past 2 weeks, how often have you been bothered by any of the following problems?

Nearly every day More than half the days Several days Not at all

- | | | | | |
|---|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Little interest or pleasure in doing things..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| LittleInterest | | | | |
| b. Feeling down, depressed, or hopeless..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| Hopeless | | | | |
| c. Feeling nervous, anxious, or on edge..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| Nervous | | | | |
| d. Not being able to stop or control worrying..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| Worrying | | | | |

G7. Is there anyone you can count on to provide you with emotional support when you need it - such as talking over problems or helping you make difficult decisions?

EmotionalSupport

- 1 Yes
- 2 No

G8. Do you have friends or family members that you talk to about your health?

TalkHealthFriends

- 1 Yes
- 2 No

G9. If you needed help with your daily chores, is there someone who can help you?

HelpDailyChores

- 1 Yes
- 2 No

G10. Are you deaf or do you have serious difficulty hearing?

Deaf

- 1 Yes
- 2 No



H: Health and Nutrition

H1. When available, how often do you use menu information on calories in deciding what to order? UseMenuCalorieInfo

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Rarely
- 5 Never

H2. About how many cups of fruit (including 100% pure fruit juice) do you eat or drink each day?

- Fruit
- 0 None
 - 1 ½ cup or less
 - 2 ½ cup to 1 cup
 - 3 1 to 2 cups
 - 4 2 to 3 cups
 - 5 3 to 4 cups
 - 6 4 or more cups

1 cup of fruit could be:

- 1 small apple
- 1 large banana
- 1 large orange
- 8 large strawberries
- 1 medium pear
- 2 large plums
- 32 seedless grapes
- 1 cup (8 oz.) fruit juice
- ½ cup dried fruit
- 1 inch-thick wedge of watermelon

H3. About how many cups of vegetables (including 100% pure vegetable juice) do you eat or drink each day?

- Vegetables
- 0 None
 - 1 ½ cup or less
 - 2 ½ cup to 1 cup
 - 3 1 to 2 cups
 - 4 2 to 3 cups
 - 5 3 to 4 cups
 - 6 4 or more cups

1 cup of vegetables could be:

- 3 broccoli spears
- 1 cup cooked leafy greens
- 2 cups lettuce or raw greens
- 12 baby carrots
- 1 medium potato
- 1 large sweet potato
- 1 large ear of corn
- 1 large raw tomato
- 2 large celery sticks
- 1 cup of cooked beans

H4. Which of the following health conditions do you think can result from drinking too much alcohol?

	Yes ↓	No ↓	Don't know ↓
a. Cancer..... <small>AlcoholConditions_Cancer</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. Heart Disease..... <small>AlcoholConditions_HeartDisease</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. Diabetes..... <small>AlcoholConditions_Diabetes</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. High cholesterol..... <small>AlcoholConditions_Cholesterol</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. Liver disease..... <small>AlcoholConditions_LiverDisease</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. Being overweight or obese..... <small>AlcoholConditions_Overweight</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

H5. How much do you agree or disagree with each of the following statements?

	Strongly agree ↓	Somewhat agree ↓	Somewhat disagree ↓	Strongly disagree ↓
a. Alcohol increases your risk of cancer..... <small>AlcoholIncreaseCancer</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b. Drinking alcohol in moderation reduces your risk of heart disease..... <small>AlcoholReduceHeart</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4



I: Physical Activity, Exercise, and UV Exposure

11. In a typical week, how many days do you do any physical activity or exercise of at least moderate intensity, such as brisk walking, bicycling at a regular pace, and swimming at a regular pace?

- 0 None → **GO TO I4 in the next column**
- 1 1 day per week TimesModerateExercise
- 2 2 days per week
- 3 3 days per week
- 4 4 days per week
- 5 5 days per week
- 6 6 days per week
- 7 7 days per week

12. On the days that you do any physical activity or exercise of at least moderate intensity, how long do you typically do these activities?

Write a number in one box below.

		Minutes			Hours
--	--	---------	--	--	-------

HowLongModerateExerciseMn
HowLongModerateExerciseHr

13. In a typical week, outside of your job or work around the house, how many days do you do leisure-time physical activities specifically designed to strengthen your muscles such as lifting weights or circuit training (do not include cardio exercise such as walking, biking, or swimming)?

- 0 None TimesStrengthTraining
- 1 1 day per week
- 2 2 days per week
- 3 3 days per week
- 4 4 days per week
- 5 5 days per week
- 6 6 days per week
- 7 7 days per week

14. How many times in the past 12 months have you used a tanning bed or booth?

- 0 0 times TanningBed
- 1 1 to 2 times
- 2 3 to 10 times
- 3 11 to 24 times
- 4 25 or more times

15. Do you ever have your skin examined by a health professional for signs of skin cancer?

- 2 No SkinCancerHPEExam
- 1 Yes, but not regularly
- 3 Yes, regularly
- 4 I don't know

16. Do you ever check your skin for signs of skin cancer?

- 2 No SkinCancerSelfCheck
- 1 Yes, but not regularly
- 3 Yes, regularly

J: Tobacco Products

J1. Have you smoked at least 100 cigarettes in your entire life? Smoke100

- 1 Yes
- 2 No → **GO TO J5 on the next page**

J2. How often do you now smoke cigarettes?

- 1 Every day SmokeNow
- 2 Some days
- 3 Not at all → **GO TO J5 on the next page**

J3. At any time in the past year, have you stopped smoking for one day or longer because you were trying to quit?

- 1 Yes TriedQuit
- 2 No



J4. Are you seriously considering quitting smoking in the next six months?

ConsiderQuit

- 1 Yes
- 2 No

J5. New types of cigarettes are now available called electronic cigarettes (also known as e-cigarettes or personal vaporizers). These products deliver nicotine through a vapor. Compared to smoking cigarettes, would you say that electronic cigarettes are ...

ElectCigLessHarm

- 1 Much less harmful,
- 2 Less harmful,
- 3 Just as harmful,
- 4 More harmful,
- 5 Much more harmful, or
- 6 I've never heard of electronic cigarettes. → **GO TO J8 below**

J6. Have you ever used an e-cigarette, even one or two times?

UsedECigEver

- 1 Yes
- 2 No → **GO TO J8 below**

J7. Do you now use an e-cigarette every day, some days, or not at all?

UseECigNow

- 1 Every day
- 2 Some days
- 3 Not at all

J8. At any time in the past year, have you talked with your doctor or other health professional about having a test to check for lung cancer?

DrTalkLungTest

- 1 Yes
- 2 No
- 3 Don't know

J9. In your opinion, do you think that some smokeless tobacco products, such as chewing tobacco, snus, and snuff are less harmful to a person's health than cigarettes?

SmokelessLessHarm

- 1 Yes
- 2 No
- 3 Don't know

J10. A hookah pipe (or shisha) is a large water pipe. People smoke tobacco using hookah pipes in groups at cafes or bars. Compared to smoking cigarettes, would you say that smoking tobacco using a hookah is...

HookahLessHarm

- 1 Much less harmful,
- 2 Less harmful,
- 3 Just as harmful,
- 4 More harmful,
- 5 Much more harmful, or
- 6 I've never heard of Hookah.

K: Screening for Cancer

K1. Are you male or female?

GenderC

- 1 Male → **GO TO K4 below**
- 2 Female

K2. How long ago did you have your most recent Pap test to check for cervical cancer?

WhenPapTest

- 1 A year ago or less
- 2 More than 1, up to 2 years ago
- 3 More than 2, up to 3 years ago
- 4 More than 3, up to 5 years ago
- 5 More than 5 years ago
- 6 I have never had a Pap test

K3. When did you have your most recent mammogram to check for breast cancer, if ever?

WhenMammogram

- 1 A year ago or less
- 2 More than 1, up to 2 years ago
- 3 More than 2, up to 3 years ago
- 4 More than 3, up to 5 years ago
- 5 More than 5 years ago
- 6 I have never had a mammogram

Females GO TO L1 on the next page

K4. A PSA test is used to check for prostate cancer.

Have you ever had a PSA test?

EverHadPSATest

- 1 Yes
- 2 No



L: HPV Awareness

L1. Have you ever heard of HPV? HPV stands for Human Papillomavirus. It is not HIV, HSV, or herpes.

- HeardHPV
- 1 Yes
 2 No → **GO TO L5 below**

L2. Do you think HPV can cause...

	Yes	No	Not sure
a. Cervical Cancer?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HPVCauseCancer_Cervical			
b. Penile Cancer?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HPVCauseCancer_Penile			
c. Anal Cancer?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HPVCauseCancer_Anal			
d. Oral Cancer?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HPVCauseCancer_Oral			

L3. Do you think that HPV is a sexually transmitted disease (STD)?

- HPVSTD
- 1 Yes
 2 No
 3 Not sure

L4. Do you think HPV requires medical treatment or will it usually go away on its own without treatment?

- HPVMedicalTreatment
- 1 Requires medical treatment
 2 Will usually go away on its own

L5. A vaccine to prevent HPV infection is available and is called the HPV shot, cervical cancer vaccine, GARDASIL®, or Cervarix®.

Before today, have you ever heard of the cervical cancer vaccine or HPV shot?

- HeardHPVvaccine2
- 1 Yes
 2 No

L6. In your opinion, how successful is the HPV vaccine at preventing cervical cancer?

- HPVShotPrevent
- 1 Not at all successful
 2 A little successful
 3 Pretty successful
 4 Very successful
 5 Don't know

L7. Including yourself, is anyone in your immediate family between the ages of 9 and 27 years old?

- FamBetween9and27
- 1 Yes
 2 No → **GO TO M1 on the next page**

L8. In the last 12 months, has a doctor or health care professional ever talked with you or an immediate family member about the HPV shot or vaccine?

- DiscussHPVvaccination12m
- 1 Yes
 2 No
 3 Don't know

L9. In the last 12 months, has a doctor or health care professional recommended that you or someone in your immediate family get an HPV shot or vaccine?

- RecommendHPVShot
- 1 Yes
 2 No
 3 Don't know



M: Your Cancer History

M1. Have you ever been diagnosed as having cancer? EverHadCancer

- 1 Yes
 2 No → **GO TO N1 on the next page**

M2. What type of cancer did you have?

Mark all that apply.

- 1 Bladder cancer CaBladder
 1 Bone cancer CaBone
 1 Breast cancer CaBreast
 1 Cervical cancer (cancer of the cervix) CaCervical
 1 Colon cancer CaColon
 1 Endometrial cancer (cancer of the uterus) CaEndometrial
 1 Head and neck cancer CaHeadNeck
 1 Hodgkin's lymphoma CaHodgkins
 1 Leukemia/Blood cancer CaLeukemia
 1 Liver cancer CaLiver
 1 Lung cancer CaLung
 1 Melanoma CaMelanoma
 1 Non-Hodgkin lymphoma CaNonHodgkin
 1 Oral cancer CaOral
 1 Ovarian cancer CaOvarian
 1 Pancreatic cancer CaPancreatic
 1 Pharyngeal (throat) cancer CaPharyngeal
 1 Prostate cancer CaProstate
 1 Rectal cancer CaRectal
 1 Renal (kidney) cancer CaRenal
 1 Skin cancer, non-melanoma CaSkin
 1 Stomach cancer CaStomach
 1 Other-Specify →
Cancer_Cat

M3. At what age were you first told that you had cancer? WhenDiagnosedCancer

Age

M4. Did you ever receive any treatment for your cancer? UndergoCancerTreatment

- 1 Yes
 2 No → **GO TO M8 in the next column**

M5. Which of the following cancer treatments have you ever received?

	Yes	No
a. Chemotherapy (IV or pills) <small>CancerTx_Chemo</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Radiation..... <small>CancerTx_Radiation</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Surgery..... <small>CancerTx_Surgery</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Other..... <small>CancerTx_Other</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2

M6. About how long ago did you receive your last cancer treatment? HowLongFinishTreatment_Cat

- 5 Still receiving treatment → **GO TO M10 on the next page**
 1 Less than 1 year ago
 2 1 year ago to less than 5 years ago
 3 5 years ago to less than 10 years ago
 4 10 or more years ago

M7. Did you ever receive a summary document from your doctor or other health care professional that listed all of the treatments you received for your cancer? CancerTxSummary

- 1 Yes
 2 No

M8. Were you ever denied health insurance coverage because of your cancer? CancerDeniedCoverage

- 1 Yes
 2 No

M9. Looking back, since the time you were first diagnosed with cancer, how much, if at all, has cancer and its treatment hurt your financial situation? CancerHurtFinances

- 1 Not at all
 2 A little
 3 Some
 4 A lot



M10. At any time since you were first diagnosed with cancer, did any doctor or other health care provider ever discuss with you the impact of cancer or its treatment on your ability to work? *CancerAbilityToWork*

- 1 Discussed it with me in detail
- 2 Briefly discussed it with me
- 3 Did not discuss it at all
- 4 I don't remember
- 5 I was not working at the time of my diagnosis

M11. Clinical trials are research studies that involve people. They are designed to test the safety and effectiveness of new treatments and to compare new treatments with the standard care that people currently get. Have you ever participated in a clinical trial for treatment of your cancer?

- 1 Yes *ClinicalTrialCancerTx*
- 2 No
- 3 Don't know

M12. Has a doctor or other member of your medical team discussed clinical trials as a treatment option for your cancer?

- 1 Yes *DiscussedClinicalTrial*
- 2 No

N: Beliefs About Cancer

Think about cancer in general when answering the questions in this section.

N1. How likely are you to get cancer in your lifetime? *ChanceGetCancer*

- 1 Very unlikely
- 2 Unlikely
- 3 Neither unlikely nor likely
- 4 Likely
- 5 Very likely

N2. How much do you agree or disagree with each of the following statements?

	<i>Strongly agree</i>	<i>Somewhat agree</i>	<i>Somewhat disagree</i>	<i>Strongly disagree</i>
a. It seems like everything causes cancer..... <i>EverythingCauseCancer</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b. There's not much you can do to lower your chances of getting cancer..... <i>PreventNotPossible</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c. There are so many different recommendations about preventing cancer, it's hard to know which ones to follow..... <i>TooManyRecommendations</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d. In adults, cancer is more common than heart disease..... <i>CancerMoreCommon</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e. When I think about cancer, I automatically think about death..... <i>CancerFatal</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

N3. How much do you agree or disagree with this statement: "I'd rather not know my chance of getting cancer." *RatherNotKnowChance*

- 1 Strongly agree
- 2 Somewhat agree
- 3 Somewhat disagree
- 4 Strongly disagree

N4. How worried are you about getting cancer?

- 1 Not at all *FreqWorryCancer*
- 2 Slightly
- 3 Somewhat
- 4 Moderately
- 5 Extremely



N5. Have any of your family members ever had cancer? *FamilyEverHadCancer*

- 1 Yes
- 2 No
- 4 Not sure

O: You and Your Household

O1. What is your age?

Age
Years old

O2. What is your current occupational status?

Mark only one. *OccupationStatus*

- 1 Employed *Employed*
- 2 Unemployed *Unemployed*
- 3 Homemaker *Homemaker*
- 4 Student *Student*
- 5 Retired *Retired*
- 6 Disabled *Disabled*
- 91 Other-Specify →

OccupationStatus_OS

*OtherOcc
MultiOcc*

O3. Have you ever served on active duty in the U.S. Armed Forces, military Reserves or National Guard? Active duty does not include training in the Reserves or National Guard, but DOES include activation, for example, for the Persian Gulf War.

- 1 Yes, now on active duty *ActiveDutyArmedForces*
 - 2 Yes, on active duty in the last 12 months but not now
 - 3 Yes, on active duty in the past, but not in the last 12 months
 - 4 No, training for Reserves or National Guard only
 - 5 No, never served in the military
- } **GO TO O5 in the next column**

O4. In the past 12 months, have you received some or all of your health care from a VA hospital or clinic? *ReceivedCareVA*

- 1 Yes, all of my health care
- 2 Yes, some of my health care
- 3 No, no VA health care received

O5. What is your marital status?

Mark only one.

MaritalStatus

- 1 Married
- 2 Living as married
- 3 Divorced
- 4 Widowed
- 5 Separated
- 6 Single, never been married

O6. What is the highest grade or level of schooling you completed?

Education

- 1 Less than 8 years
- 2 8 through 11 years
- 3 12 years or completed high school
- 4 Post high school training other than college (vocational or technical)
- 5 Some college
- 6 College graduate
- 7 Postgraduate

O7. Were you born in the United States?

BornInUSA

- 1 Yes → **GO TO O9 below**
- 2 No

O8. In what year did you come to live in the United States? *YearCameToUSA*

Year

O9. How well do you speak English?

SpeakEnglish

- 1 Very well
- 2 Well
- 3 Not well
- 4 Not at all



O10. Are you of Hispanic, Latino/a, or Spanish origin? One or more categories may be selected.

Mark **all that apply.**

- No, not of Hispanic, Latino/a, or Spanish origin
NoHispanic
- Yes, Mexican, Mexican American, Chicano/a
Mexican
- Yes, Puerto Rican
PuertoRican
- Yes, Cuban
Cuban
- Yes, another Hispanic, Latino/a, or Spanish origin
OthHispanic
Hisp_Cat

O11. What is your race? One or more categories may be selected.

Mark **all that apply.**

- White *White*
- Black or African American *Black*
- American Indian or Alaska Native *AmerInd*
- Asian Indian *AsInd*
- Chinese *Chinese*
- Filipino *Filipino*
- Japanese *Japanese*
- Korean *Korean*
- Vietnamese *Vietnamese*
- Other Asian *OthAsian*
- Native Hawaiian *Hawaiian*
- Guamanian or Chamorro *Guamanian*
- Samoan *Samoan*
- Other Pacific Islander *OthPacIsl*
Race_Cat2

O12. Do you think of yourself as...

- Heterosexual, or straight
SexualOrientation
- Homosexual, or gay or lesbian
- Bisexual
- 91 Something else – Specify

↓

SexualOrientation_OS

SexualOrientation_I

O13. Including yourself, how many people live in your household? *TotalHousehold*

--	--

Number of people

O14. Starting with yourself, please mark the sex, and write in the age and month of birth for each adult 18 years of age or older living at this address.

	Sex	Age	Month Born (01-12)
SELF	<input type="checkbox"/> Male	SelfAge	SelfMOB
	<input type="checkbox"/> Female		
Adult 2	<input type="checkbox"/> Male	HHAdultAge2	HHAdultMOB2
	<input type="checkbox"/> Female		
Adult 3	<input type="checkbox"/> Male	HHAdultAge3	HHAdultMOB3
	<input type="checkbox"/> Female		
Adult 4	<input type="checkbox"/> Male	HHAdultAge4	HHAdultMOB4
	<input type="checkbox"/> Female		
Adult 5	<input type="checkbox"/> Male	HHAdultAge5	HHAdultMOB5
	<input type="checkbox"/> Female		

O15. How many children under the age of 18 live in your household?

ChildrenInHH

--	--

Number of children under 18

O16. Do you currently rent or own your home?

- Own *RentOrOwn*
- Rent
- Occupied without paying monetary rent

O17. Does anyone in your family have a working cell phone? *CellPhone*

- Yes
- No

O18. Is there at least one telephone inside your home that is currently working and is not a cell phone? *PhoneInHome*

- Yes
- No



O19. Thinking about members of your family living in this household, what is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?

- IncomeRanges
- 1 \$0 to \$9,999
 - 2 \$10,000 to \$14,999
 - 3 \$15,000 to \$19,999
 - 4 \$20,000 to \$34,999
 - 5 \$35,000 to \$49,999
 - 6 \$50,000 to \$74,999
 - 7 \$75,000 to \$99,999
 - 8 \$100,000 to \$199,999
 - 9 \$200,000 or more

O20. About how long did it take you to complete the survey?

Write a number in one box below.

		Minutes			Hours
--	--	---------	--	--	-------

MailSurveyTimeMin

MailSurveyTimeHrs

O21. At which of the following types of addresses does your household currently receive residential mail?

Mark **all that apply.**

- 1 A street address with a house or building number
TypeOfAddressA
- 1 An address with a rural route number
TypeOfAddressB
- 1 A U.S. post office box (P.O. Box)
TypeOfAddressC
- 1 A commercial mailbox establishment (such as Mailboxes R Us, and Mail Boxes Etc.®)
TypeOfAddressD

Thank you!

▶ Please return this questionnaire in the postage-paid envelope within 2 weeks.

▶ If you have lost the envelope, mail the completed questionnaire to:

HINTS Study, TC 1046F
Westat
1600 Research Boulevard
Rockville, MD 20850

