

# Health Survey

## Question set

This document includes a list of the Health Survey's complete question set. Since the Health Survey is a dynamic and interactive system, most people only see a small fraction of these questions, while some automatically appear based on a response in real time. The questions based on branching logic are in italics.

### About You:

Which door would you go into?  Men  Women

How old are you? \_\_\_\_\_ Years

What is your height and weight? \_\_\_\_\_ Feet/Inches \_\_\_\_\_ Pounds

What is your waist size? \_\_\_\_\_ (inches) \_\_\_\_\_ I don't know.

*Tooltip: Measure at your natural waist – bend sideways to find it, or measure halfway between your hip bone and lowest rib.*

Where do you live?  Rural area  Urban area  Suburb

What is your relationship status?

Married or in a committed relationship  Separated or divorced  Widowed  Single

What's your living situation?  Alone  With a spouse or partner  With roommates  Other

*Are you currently pregnant?*  Yes  No

Do you have children?  Yes  No

How would you describe your outlook?  Pretty happy  Up and down  Often blue

How do you feel about exercise?  It's too hard for me  It's too much time  I do it whenever I can  I love it!

Do you have a doctor or clinic you go to for care?  Yes  No

### Life:

What is your employment status?

Working full or part-time  Looking for work  Retired or Not working by choice

*In the past month, how many days of work did you miss because you were sick?* \_\_\_\_\_ days

*How's your work life?*  I love my job!  Things are pretty good  It's a paycheck  I need a new job

On average, how many hours of sleep do you get at night?

Less than 6  About 6 to 7  About 8 to 9  9 or more

How often do you wake up refreshed in the morning?

All or most of the time  Some of the time  Rarely or never

How often do you feel overwhelmed with stress?  Rarely  Sometimes  Often

*Do you feel that stress is affecting your health?*  Big time!  A little  No

How often do you worry about making ends meet?  Rarely  Sometimes  Often

Do you have supportive family and friends?

I have a great network  I have some friends  I'm a little lonely  Not sure

In the past 12 months, how many times have you missed work, school, or other obligations due to personal or family health issues?  Three or fewer  Four to six  Seven to nine  10 or more

Are you exposed to chemical fumes or dust in your daily activities?  Yes  No

How often are you exposed to secondhand smoke?  Rarely  Sometimes  Often

## Habits:

How would you rate your diet on most days?  Terrible!  Not so good  OK  Good  Excellent

Tooltip: Fruits, veggies, beans, and whole grains are good for you, so the more you eat the better your diet. Not so good: refined or white flour, added sugars, soda, fast food, fatty or fried foods, and most processed or packaged foods.

How often do you eat fast food in a week?

Never  Once or twice  Three or four times  Five or more times

How many servings of fruits and vegetables do you eat in a day?

What's a vegetable?  One or two  Three or four  Five or more

How often do you eat foods high in fat or cholesterol (meat, eggs, cheese)?

Rarely or never  A few times a week  Daily  Several times a day

How often do you cook at home?

Never  Twice or three times a week  Four or five times a week  Most of the time

Are you comfortable following a recipe when cooking?  Yes  No

How many alcoholic drinks do you have in an average week? \_\_\_\_\_ drinks  I rarely or never drink

Tooltip: One drink is a 12-ounce beer, 5-ounce glass of wine, 1.5-ounce shot of liquor or small cocktail

*Do you have any plans to change your drinking habits?*  No  Plan to drink less  Started drinking less

How many days a week do you exercise for at least 30 minutes?

None  One or two  Three or four  Five or more

How much of these activities do you do in a typical week?

Vigorous Examples: running, hiking, biking uphill \_\_\_\_\_ hours \_\_\_\_\_ minutes

Moderate Examples: fast walking, dancing \_\_\_\_\_ hours \_\_\_\_\_ minutes

Light Examples: standing, easy bicycling or walking \_\_\_\_\_ hours \_\_\_\_\_ minutes

How many days a week do you do weight-bearing exercise (weights, bodyweight)?

Once  Two to three times  Never

How confident are you that you're able to make healthy changes (like eat better, exercise more, or lose weight)?

I'm very confident  I think I can  Not sure I can  Not at all confident

What would motivate you to try and be healthier?

To live longer  To have more energy or strength  To feel better or happier  To save money  Other

What are your biggest hurdles to making healthy changes?

Not the right time  Money  Motivation  Need help or guidance  Other

How would you describe your cigarette smoking habits?

I smoke every day  I smoke sometimes  I used to smoke  I've never smoked

*How long have you smoked cigarettes?* \_\_\_\_\_ years

*On average, how many cigarettes do you smoke in a day?* \_\_\_\_\_ cigarettes a day

*How long ago did you stop smoking cigarettes* \_\_\_\_\_ years

On average, how many cigarettes a day did you use to smoke? \_\_\_\_\_ cigarettes a day

Do you use other forms of tobacco?  Chewing tobacco  Pipes or cigars  Both  No

Have you been thinking about cutting down or quitting tobacco?  All the time  Sometimes  Not really

What are your plans to cut down or quit using tobacco?

I plan to soon  I've started a program  I've cut down already  No plans

Do you ever use drugs (street or prescription) for fun or for coping with stress?  No  Rarely  Regularly

## Health:

How many prescription medicines do you take daily or regularly?  None  1  2  3  4+

Tooltip: Only count the medicines your doctors have prescribed for you and you have to fill at the pharmacy.

How many over-the-counter medicines and supplements do you take regularly?  None  1  2  3  4+

Tooltip: Count everything that your health insurance doesn't cover, whether your doctor recommended it or Not -- herbs, vitamins, supplements.

Do you have any lung problems like asthma or COPD?  Yes  No

Do you have asthma?  Yes  No

How are you managing your asthma?  Quick-acting inhaler  Long-acting medicines  Both  None

Is your asthma under control?  Usually  Sometimes  Rarely

Tooltip: If it's under control, your asthma is Not affecting your daily activities and you're only out of breach or needing your quick-acting inhaler twice a week or less often.

Do you have chronic bronchitis or emphysema (COPD)?  Yes  No

Tooltip: These are lung conditions that make it harder to breathe over time. They are also called COPD, which is short for chronic obstructive pulmonary disease.

In the past year, have you had your blood sugar level tested?  Yes  No  I don't know

Tooltip: We're looking for a "fasting" glucose level -- this is usually tested first thing in the morning on an empty stomach.

What is your latest blood sugar reading? \_\_\_\_\_ in mg/dL  I don't know

In the past year, have you had a A1C test for diabetes?  Yes  No  I don't know

Tooltip: This gives a three-month "snapshot" of your blood sugar level.

What is your latest A1C reading? \_\_\_\_\_ in mg/dL  I don't know

Have you been diagnosed with diabetes or pre-diabetes?  Yes, diabetes  Yes, pre-diabetes  No

Tooltip: Don't count gestational diabetes or a one-off high blood sugar reading.

How are you managing your diabetes?  Diet only  Oral medication  Insulin injections  Other

Have you had an eye exam and glaucoma test within the last year?  Yes  No  I don't know

Do you have heart disease, or have you had a heart attack or stroke?  Yes  No

What kind of heart problem do you have?  Angina  Atrial fibrillation  Coronary heart disease  
 Other

Have you ever had a heart attack?  Yes  No

Have you ever had a stroke?  Yes  No

Are you under medical treatment or taking medication for your heart problems?

Medical treatment  Taking medication  Both  None

Have you had your blood pressure checked within the past two years?  Yes  No  I don't know

What is your blood pressure? \_\_\_\_\_ values systolic/diastolic in mmHg  I don't know

Has a doctor told you that you have high blood pressure?  Yes  No  I don't know

Are you taking any medicine for blood pressure?  Yes  No

Have you had a cholesterol test within the past five years?  Yes  No  I don't know

*What are your cholesterol numbers?*  values for total, LDL, HDL, triglycerides in md/dL  I don't know

*Has a doctor told you that you have high cholesterol?*  Yes  No  I don't know

Are you taking any medicines for cholesterol (statins)?  Yes  No

Do you have back problems?  Yes  No

*Do your back problems affect your daily work, school, or recreational activities?*

Rarely  Sometimes  Often

*Are you under treatment by a physician for your back problems?*  Yes  No

Do you have any arthritis or pain, aching, or stiffness in your joints?  No  Mild  Moderate  Severe

*Does the pain or stiffness in your joints affect your daily work, school, or recreational activities?*

Rarely  Sometimes  Often

*When was your last screening for breast cancer (mammogram)?*

Never  Past year  One to three years  More than three years

*When was your last screening for cervical cancer? (Pap test)*

Never  Past year  One to three years  More than three years

*Have you ever had breast or cervical cancer?*  Breast  Cervical  Both  No

*Do you have osteoporosis (brittle bones)?*  Yes  No

When was the last time you had a screening for colorectal cancer?

Never  Past year  One to five years  Five or more years

Have you had the latest available flu shot?  Yes  No

Do you have any hearing problems?  Yes  No

*Do you have a hearing aid?*  Yes  No

Do you have any vision problems?  Yes  No

*Do you need to wear glasses or contact lenses?*  Yes  No

In general, would you say your health is\*:  Excellent  Very Good  Good  Fair  Poor

Does your health limit you while doing moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?\*  Yes, limited a lot  Yes, limited a little  No, Not limited at all

Does your health limit you while climbing several flights of stairs?\*

Yes, limited a lot  Yes, limited a little  No, Not limited at all

In the past four weeks, has your physical health affected your work or other regularly daily activities?

(You accomplished less than you'd like)\*

No, None of the time  Yes, a little of the time  Yes, some of the time

Yes, most of the time  Yes, all of the time

In the past four weeks, how often has your physical health limited your work or other activities?\*

No, None of the time  Yes, a little of the time  Yes, some of the time

Yes, most of the time  Yes, all of the time

In the past four weeks, how often have your emotions interfered with getting things done?

(you accomplished less than you'd like)?\*

None of the time  A little of the time  Some of the time  Most of the time  All of the time

In the past four weeks, how often have your emotions affected your work or other activities?

(you were Not as attentive or careful as usual)?\*

None of the time  A little of the time  Some of the time  Most of the time  All of the time

During the past 4 weeks, how much did pain interfere with your Normal work (at your job or at home)?\*

Not at all  A little bit  Moderately  Quite a bit  Extremely

How much of the time during the past 4 weeks, have you felt calm and peaceful?\*

None of the time  A little of the time  Some of the time  Most of the time  All of the time

In the past four weeks, how often have you had a lot of energy?\*

None of the time  A little of the time  Some of the time  Most of the time  All of the time

How much of the time during the past 4 weeks, have you felt downhearted or blue?\*

None of the time  A little of the time  Some of the time  Most of the time  All of the time

In the past four weeks, how often has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?\*

None of the time  A little of the time  Some of the time  Most of the time  All of the time

Compared to one year ago, how would you rate your physical health in general Now?\*

Much better  Slightly better  About the same  Slightly worse  Much worse

Compared to one year ago, how would you rate your emotional health (feeling anxious, depressed, or irritable)?\*

Much better  Slightly better  About the same  Slightly worse  Much worse

Did you think this survey was easy to complete?  Definitely!  Sort of  No

\*Represents VR-12 questions