VACS PATIENT QUESTIONNAIRE - GM
FOLLOW-UP 6

FOR ADMINISTRATIVE USE ONLY. TO BE COMPLETED BY STUDY COORDINATOR.

Date of Visit: ☐☐ / ☐☐ / ☐☐☐☐ **Study ID** ☐☐☐☐☐☐

PRE-EXISTING CONDITIONS

1. Has your doctor ever told you that you have any of the following?	YES	NO
a. Angina or Coronary Heart Disease	O	O
b. Heart Attack or Myocardial Infarction	O	O
c. Congestive Heart Failure, also called weak heart or fluid on the lungs	O	O
d. Bad circulation in your legs or feet	O	O
e. Stroke or "mini" stroke (Transient Ischemic Attack)	O	O

2. Has your doctor ever told you that you have any of the following lung or breathing conditions?	YES	NO
a. Asthma	O	O
b. Emphysema	O	O
c. Chronic bronchitis	O	O
d. Chronic Obstructive Pulmonary Disease (COPD)	O	O
e. IPF (idiopathic pulmonary fibrosis) or lung fibrosis	O	O
f. Sarcoidosis	O	O
g. Pulmonary hypertension or high blood pressure in the lungs	O	O
h. A blood clot in your lungs or a pulmonary embolism	O	O
i. Sleep apnea	O	O

3. Have you ever been diagnosed with any of the following types of cancer?	YES	NO
a. Skin: Basal Cell	O	O
b. Skin: Melanoma	O	O
c. Kaposi's Sarcoma	O	O
d. Lymphoma: Non-Hodgkins	O	O
e. Lymphoma: Hodgkins	O	O
f. Lung	O	O
g. Mouth or Throat	O	O
h. Stomach	O	O
i. Colon	O	O
j. Liver	O	O
k. Rectal	O	O
l. Anal	O	O
m. Bladder	O	O
n. Testicular	O	O
o. Prostate	O	O
p. Breast	O	O
q. Cervical	O	O
r. Leukemia	O	O
s. Multiple Myeloma	O	O

4. Has your doctor ever told you that you have any of the following heart or cardiac conditions?	YES	NO
a. Intermittent claudication or pain in legs from blockage of the arteries	O	O
b. Deep vein thrombosis (DVT) blood clot in legs	O	O
c. A blood clot in your lungs or a pulmonary embolism	O	O

5. Have you ever had any of the following procedures in or out of the hospital?	YES	NO
a. Angioplasty, PTCA, coronary artery bypass graft for CABG or any procedure to open up arteries in your heart	O	O
b. Cardiac catheterization or coronary angiography	O	O
c. Any procedure to open up arteries in your legs	O	O

6. Did your mother, ever have a heart attack or myocardial infarction?

○ YES (If Yes, answer #6a) ○ NO (skip to #7) ○ DON'T KNOW (skip to #7)

6a How old was your mother when the first heart attack occurred?

○ LESS THAN 55 ○ 55 - 64 ○ 65 OR OLDER ○ DON'T KNOW AGE

7. Did your father, ever have a heart attack or myocardial infarction?

○ YES (If Yes, answer #7a) ○ NO (skip to #8) ○ DON'T KNOW (skip to #8)

7a. How old was your father when the first heart attack occurred?

○ LESS THAN 55 ○ 55 - 64 ○ 65 OR OLDER ○ DON'T KNOW AGE

8. Did your mother, father, full-blooded sisters, full-blooded brothers, daughters, or sons ever have a stroke?

○ YES (If Yes, answer #8a) ○ NO (skip to #9) ○ DON'T KNOW (skip to #9)

8a. How many of these relatives had a stroke?

○ 1 ○ 2 ○ 3 ○ 4 OR MORE

9. Have you ever broken a bone?

○ YES ○ NO (skip to #12)

10. If yes, what bones have you broken? (please check all that apply)

○ HIP ○ UPPER ARM

○ SPINE ○ OTHER

○ WRIST

11. How did you break the bone? (please check all that apply).

○ I TRIPPED/SLIPPED.

○ I FELL DOWN STAIRS/OFF A LADDER.

○ I WAS IN A CAR ACCIDENT/MOTOR VEHICLE ACCIDENT.

○ I WAS IN A FIGHT.

○ I WAS PLAYING A SPORT.

○ OTHER

12. Have either of your parents ever broken a hip?

○ YES ○ NO ○ DON'T KNOW

13. Have you ever taken orally (by mouth) or inhaled steroid medications such as cortisol/hydrocortisone, prednisone, prednisolone, dexamethasone?

○ YES ○ NO

14.Have you ever taken testosterone supplements by mouth, injection, patch or gel?

0 YES 0 NO

15.Have you ever taken calcium and/or vitamin D supplements?

0 YES 0 NO

HEALTH HABITS

16. How much do you weigh? (in pounds) (Fill in one circle)

0 90 lbs. or less	0 131 - 140 lbs.	0 181 - 190 lbs.	0 231 - 240 lbs.	0 281 - 290 lbs.
0 91 - 100 lbs.	0 141 - 150 lbs.	0 191 - 200 lbs.	0 241 - 250 lbs.	0 291 - 300 lbs.
0 101 - 110 lbs.	0 151 - 160 lbs.	0 201 - 210 lbs.	0 251 - 260 lbs.	0 301 - 310 lbs.
0 111 - 120 lbs.	0 161 - 170 lbs.	0 211 - 220 lbs.	0 261 - 270 lbs.	0 311 - 320 lbs
0 121 - 130 lbs.	0 171 - 180 lbs.	0 221 - 230 lbs	0 271 - 280 lbs.	0 321 lbs. or more

17. How much did you weigh at age 20? (in pounds) (Fill in one circle)

0 90 lbs. or less	0 131 - 140 lbs.	0 181 - 190 lbs.	0 231 - 240 lbs.	0 281 - 290 lbs.
0 91 - 100 lbs.	0 141 - 150 lbs.	0 191 - 200 lbs.	0 241 - 250 lbs.	0 291 - 300 lbs.
0 101 - 110 lbs.	0 151 - 160 lbs.	0 201 - 210 lbs.	0 251 - 260 lbs.	0 301 - 310 lbs.
0 111 - 120 lbs.	0 161 - 170 lbs.	0 211 - 220 lbs.	0 261 - 270 lbs.	0 311 - 320 lbs
0 121 - 130 lbs.	0 171 - 180 lbs.	0 221 - 230 lbs	0 271 - 280 lbs.	0 321 lbs. or more

18. How often do you engage in regular activities (e.g., brisk walking, jogging, bicycling, etc.) long enough to work up a sweat?

0 NEVER 0 1 - 2 TIMES A WEEK 0 5 OR MORE TIMES A WEEK

0 LESS THAN ONCE A WEEK 0 3 - 4 TIMES A WEEK

19. Have you smoked at least 100 cigarettes (5 packs) in your ENTIRE LIFE?

0 YES 0 NO (If No, skip to # 25)

20. Do you now smoke cigarettes (as of 1 month ago)?

0 YES 0 NO

21. How old were you when you FIRST started to smoke fairly REGULARLY?

Age in years

22. How long has it been since you last smoked cigarettes?

○ LESS THAN ONE MONTH	○ 1-5 YEARS
○ 1-5 MONTHS	○ MORE THAN 5 YEARS
○ 6-11 MONTHS	○ STILL SMOKING

23. How many cigarettes do you smoke per day NOW?

Cigarettes per day

24. Please look at the scale below. Each statement represents where various people are in thinking about quitting smoking. Fill in the circle next to the statement that best indicates where you are now.

○ HAVE ALREADY QUIT	○ NOT SURE
○ THINKING ABOUT QUITTING	○ NOT THINKING ABOUT QUITTING
○ NOT READY TO QUIT	

25. These are questions about how often your lung/respiratory problems have affected you over the past 12 months. Please fill in one circle for each question.

	ALMOST EVERY DAY	SEVERAL DAYS A WEEK	A FEW DAYS A MONTH	ONLY WITH LUNG/RESPIRATORY INFECTIONS	NOT AT ALL
A. Over the last year, I have coughed:	○	○	○	○	○
B. Over the last year, I have brought up phlegm (sputum):	○	○	○	○	○
C. Over the last year, I have had shortness of breath:	○	○	○	○	○
D. Over the last year, I have had episodes of wheezing:	○	○	○	○	○

26. In the last 12 months have you spent at least one night in any of the following places? (Mark all that apply): (If No, skip to question # 32)

○ A SHELTER FOR HOMELESS PERSONS

○ ON THE STREET OR IN A PUBLIC PLACE NOT INTENDED FOR SLEEPING (E.G.ABANDONED BUILDING, SUBWAY, OR CAR)

○ IN A WELFARE HOTEL OR SRO

○ IN ANY EMERGENCY, TEMPORARY, OR TRANSITIONAL HOUSING PROGRAM, OR A HALFWAY HOUSE

○ DOUBLED UP WITH OTHERS, IN SOMEONE ELSE'S HOUSE/APARTMENT

○ IN DRUG TREATMENT, DETOX, OR DRUG PROGRAM HOUSING

27. Are you currently living in any of the places listed above?

- ○ YES
- ○ NO (If No, skip to #30)

28. How many months have you lived there?

- ○ LESS THAN A MONTH
- ○ 1-2 MONTHS
- ○ 3-4 MONTH
- ○ 5-6 MONTHS
- ○ 6 MONTHS OR MORE

29. How many months ago did you FIRST start living in one of the places listed above?

- ○ LESS THAN A MONTH
- ○ 1-2 MONTHS
- ○ 3-4 MONTH
- ○ 5-6 MONTHS
- ○ 6 MONTHS OR MORE

30. Do you currently live in VA subsidized housing (paid for by VASH vouchers or other VA funds)?

- ○ YES
- ○ NO (If No, skip to #32)

31. How long have you lived here?

- ○ LESS THAN A MONTH
- ○ 1-2 MONTHS
- ○ 3-4 MONTH
- ○ 5-6 MONTHS
- ○ 6 MONTHS OR MORE

The following questions are related to incarceration (time spent in a jail, prison, detention center, or juvenile correctional facility). Your responses will be kept completely confidential.

32. Have you ever spent any time in a jail, prison, detention center, or juvenile correctional facility?

○ YES ○ NO (skip to #37) ○ DON'T KNOW (skip to #37)

33. How old were you when you first spent time in a jail, prison, detention center, or juvenile correctional facility?

- ○ 18 YEARS OLD
- ○ 19-30 YEARS OLD
- ○ 31-50 YEARS OLD
- ○ GREATER THAN 50 YEARS OLD
- ○ DON’T KNOW

34. How many times have you been in a jail, prison, detention center, or juvenile correctional facility?

- 0 1
- 0 2-5
- 0 6-10
- 0 GREATER THAN 10
- 0 DON'T KNOW

35. In your entire life, how much time total have you been in a jail, prison, detention center, or juvenile correctional facility?

- 0 LESS THAN A MONTH
- 0 LESS THAN YEAR
- 0 BETWEEN 1-5 YEARS
- 0 MORE THAN 5 YEARS
- 0 DON'T KNOW

36. In the past year, how much time have you spent in a jail, prison, or detention center?

- 0 0 DAYS
- 0 <7 DAYS
- 0 8-30 DAYS
- 0 1-3 MONTHS
- 0 >3 MONTHS

NOTE: For answering these questions, one "drink" is equal to 12 ounces of beer (1can), or 4 ounces of wine (1 glass), or 1 ounce of liquor (1 shot).

37. Have you EVER had a drink of alcohol?

- 0 YES
- 0 NO (If No, skip to #54)

38. Have you EVER had problems with alcohol?

- 0 YES
- 0 NO (If No, skip to #40)

39. Did you stop drinking because of these problems?

- 0 YES
- 0 NO

40. In the last 12 months have you had a drink containing alcohol?

- ○ YES
- ○ NO (If No, skip to #53)

41. How often do you have a drink containing alcohol?

- ○ NEVER
- ○ MONTHLY OR LESS
- ○ TWO TO FOUR TIMES A MONTH
- ○ TWO TO THREE TIMES A WEEK
- ○ FOUR OR MORE TIMES A WEEK

42. How many drinks containing alcohol do you have on a typical day when you are drinking?

- ○ 1 OR 2
- ○ 3 OR 4
- ○ 5 OR 6
- ○ 7 TO 9
- ○ 10 OR MORE

43. How often do you have six or more drinks on one occasion?

- ○ NEVER
- ○ LESS THAN MONTHLY
- ○ MONTHLY
- ○ WEEKLY
- ○ DAILY OR ALMOST DAILY

44. How often during the last 12 months have you found that you were not able to stop drinking once you had started?

- ○ NEVER
- ○ LESS THAN MONTHLY
- ○ MONTHLY
- ○ WEEKLY
- ○ DAILY OR ALMOST DAILY

45. How often during the last 12 months have you failed to do what was normally expected from you because of drinking?

- ○ NEVER
- ○ LESS THAN MONTHLY
- ○ MONTHLY
- ○ WEEKLY
- ○ DAILY OR ALMOST DAILY

46. How often during the last 12 months have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- ○ NEVER
- ○ LESS THAN MONTHLY
- ○ MONTHLY
- ○ WEEKLY
- ○ DAILY OR ALMOST DAILY

47. How often during the last 12 months have you had a feeling of guilt or remorse after drinking?

○ NEVER ○ WEEKLY
○ LESS THAN MONTHLY ○ DAILY OR ALMOST DAILY
○ MONTHLY

48. How often during the last 12 months have you been unable to remember what happened the night before because you had been drinking?

○ NEVER ○ WEEKLY
○ LESS THAN MONTHLY ○ DAILY OR ALMOST DAILY
○ MONTHLY

49. Have you or someone else been injured as a result of your drinking?

○ NEVER
○ YES, BUT NOT IN THE LAST YEAR
○ YES, DURING THE LAST YEAR

50. Has a relative or friend or doctor or other health care worker been concerned about your drinking or suggested you cut down?

○ NO
○ YES, BUT NOT IN THE LAST YEAR
○ YES, DURING THE LAST YEAR

51. How many drinks of alcohol does it take for you to begin to feel a buzz or high?

○ Have never felt a buzz or high ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ Greater than 8

52. How many drinks of alcohol does it take for you to begin to lose control or feel drunk?

○ Have never felt this way ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ Greater than 10

53. Look at the scale below. Each statement represents where various people are in thinking about changing their drinking. Please fill in the circle next to the statement that best indicates where you are now.

○ HAVE ALREADY CHANGED ○ NOT SURE
○ THINKING ABOUT CHANGING ○ NOT THINKING ABOUT CHANGING
○ NOT READY

OTHER DRUG USE

54. **For each of the following drugs, please fill in the circle that best indicates how often in the <u>past 12 months</u> you used each drug.**

		IN THE LAST 12 MONTHS					
	HAVE NEVER <u>TRIED</u>	**NO USE IN THE LAST <u>YEAR</u>**	**LESS THAN ONCE A <u>MONTH</u>**	**1 - 3 TIMES A <u>MONTH</u>**	**1 - 3 TIMES A <u>WEEK</u>**	**4 - 6 TIMES A <u>WEEK</u>**	**EVERY <u>DAY</u>**
a. Marijuana or Hashish	O	O	O	O	O	O	O
b. Cocaine or Crack	O	O	O	O	O	O	O
c. Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)	O	O	O	O	O	O	O
d. Heroin	O	O	O	O	O	O	O
e. Prescription painkillers (such as Oxycontin, Vicodin, Percocet)	O	O	O	O	O	O	O
f. Prescription benzodiazepines (Valium,Deastat, Ativan)	O	O	O	O	O	O	O
g. Other	O	O	O	O	O	O	O

55. In the <u>past 12 months</u>, did your use of drugs ever interfere with your work at school, or a job, or at home?

O YES (If YES, please answer #56)
O NO (If NO, please skip to #57)
O DID NOT USE DRUGS (Please skip to #60)

56. How often in the <u>past 12 months</u> did drugs interfere with your work at school, or a job, or at home?

O ONCE OR TWICE
O BETWEEN 3 AND 5 TIMES
O BETWEEN 6 AND 10 TIMES
O BETWEEN 11 AND 20 TIMES
O MORE THAN 20 TIMES

57. In the <u>past 12 months</u>, were you ever under the influence of a drug in a situation where you could get hurt - like when driving a car or boat, using knives or guns or machinery, or anything else?

O YES
O NO

58. In the past 12 months, have you ever used a needle to inject any drug? DO NOT include anything you took under a doctor's order.

    ○ YES ○ NO

59. Look at the scale below. Each statement below represents where various people are in thinking about changing their drug use/habits. Please fill in the circle next to the statement that best indicates where you are now.

    ○ HAVE ALREADY CHANGED
    ○ THINKING ABOUT CHANGING
    ○ NOT READY
    ○ NOT SURE
    ○ NOT THINKING ABOUT CHANGING

The next questions are about your sexual behavior. We recognize the following questions may be personal. We ask that you complete them to the best of your ability. By sex we mean oral, vaginal, or anal sex, but NOT masturbation. When we talk about condoms, we mean both male as well as female condoms.

60. During the past 12 months, have you had sex?

    ○ YES ○ NO (If NO, skip to #79)

61. Thinking back about the last time you had sex, did you or your partner use a condom?

    ○ YES ○ NO

62. During the past 12 months, have you had sex with only males, only females, or with both males and females?

    ○ ONLY MALES ○ ONLY FEMALES ○ BOTH MALES AND FEMALES

63. How many sexual partners have you had in the last 12 months?

    ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 or more

64. Of these people, how many of them were new partners, that is, people you had oral, anal, or vaginal sex with for the first or only time in the last 12 months?

    ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 or more

65. In the past 12 months, have you used any prescription drug to improve sexual performance, such as Viagra, Cialis or Levitra?

    ○ YES ○ NO

66. Thinking back about the last time you had sex, had you been drinking alcohol?

    ○ YES ○ NO

67. In the past 12 months, have you used alcohol to help you feel more comfortable with a sexual partner?

    ○ YES ○ NO

68. In the past 12 months, have you done more sexually than you had planned because you were drinking alcohol?

    ○ YES ○ NO

69. In the past 12 months, have you had unprotected sex (not used a condom) because you were drinking alcohol?

O YES O NO

70. In the past 12 months, have you had unprotected sex (not used a condom) because you were using drugs?

O YES O NO

71. In the past 12 months, have you had unprotected sex (not used a condom) with someone you know has multiple partners?

O YES O NO O Unsure

72. In the past 12 months, have you had unprotected sex (not used a condom) with someone who injects drugs?

O YES O NO O Unsure

73. In the past 12 months have you paid for sex?

O YES O NO

74. In the past 12 months have you been paid for sex ?

O YES O NO

75. In the past 12 months have you been diagnosed with a sexually transmitted disease?

O YES O NO

76. In the past 12 months have you had unprotected sex (not used a condom) with someone who had been diagnosed with a sexually transmitted disease?

O YES O NO O Unsure

77. In the past 12 months have you had unprotected sex (not used a condom) with someone you know who has the HIV virus?

O YES O NO O Unsure

78. During the past 12 months, did you ever, even once, have vaginal or anal sex with any of the following types of partners?

	Yes	No
a. A main partner (spouse or long-term lover)	O	O
If yes, did you use a condom every time?	O	O
b. Any other partner (date, fling, someone you just met)	O	O
If yes, did you use a condom every time?	O	O
c. Any partner who was HIV positive	O	O
If yes, did you use a condom every time?	O	O
d. Any partner who was HIV negative	O	O
If yes, did you use a condom every time?	O	O
e. Any partner whose HIV status was unknown	O	O
If yes, did you use a condom every time?	O	O

79. Have you ever been tested for HIV?

0 NO, I HAVE NEVER BEEN TESTED (if No, skip to #81)
0 YES, AND MY LAST TEST WAS NEGATIVE
0 YES, AND MY LAST TEST WAS POSITIVE
0 YES, AND MY LAST TEST WAS INDETERMINATE
0 YES, I WAS TESTED BUT HAVE NOT RETURNED FOR MY RESULTS
0 I PREFER NOT TO ANSWER THIS QUESTION

80. Have you been tested for HIV in the previous 12 months?

0 YES 0 NO

HEALTH CARE

81. During the last 3 months, were you seen in any of the following for these reasons?

	VA	OUTSIDE CARE	DOES NOT APPLY
a. In a hospital for detoxification	0	0	0
b. In an outpatient program for alcohol treatment	0	0	0
c. In an outpatient program for drug treatment	0	0	0
d. In a residential program for alcohol treatment	0	0	0
e. In a residential program for other drug treatment	0	0	0
f. In a halfway house	0	0	0

82. During the last 3 months, did you do any of the following?

	VA	OUTSIDE CARE	DOES NOT APPLY
a. Go to an Emergency Room for medical care	0	0	0
b. Fill your prescription medication	0	0	0
e. Call for Telephone Advice	0	0	0

83. If you received care outside the VA, what were your reasons? (Mark all that apply)

- ○ UNABLE TO GET APPOINTMENT WITH VA CARE
- ○ RELATIONSHIP WITH PROVIDER OUTSIDE THE VA
- ○ DISSATISFACTION WITH VA CARE
- ○ DID NOT RECEIVE CARE OUTSIDE THE VA
- ○ LOCATION
- ○ INSURANCE
- ○ OTHER REASONS

84. During the last 3 months, did you go to meetings of Alcoholics Anonymous (AA), self-help, mutual-help, or another 12-step program?

	YES	NO
a. For alcohol?	○	○
b. For drugs?	○	○

85. During the last 3 months, did you receive counseling for alcohol problems from: (Mark all that apply)

- ○ A PRIEST / MINISTER / RABBI OR OTHER CLERGY
- ○ AN EMPLOYEE ASSISTANCE PROGRAM
- ○ ALCOHOLICS ANONYMOUS
- ○ EMERGENCY ROOM
- ○ OTHER
- ○ DID NOT RECEIVE COUNSELING

86. In the past 12 months did you make any visits to medical offices, health care clinics, or hospitals for a lung or breathing problem?

- ○ NO
- ○ YES, WITHIN THE VA
- ○ YES, OUTSIDE THE VA
- ○ YES, BOTH WITHIN AND OUTSIDE THE VA

87. The following questions ask about symptoms you might have had during the past four weeks. Please fill in the circle of the one response that best describes this symptom.

	I DO NOT HAVE THIS SYMPTOM	I HAVE THIS SYMPTOM AND…. IT DOESN'T BOTHER ME	IT BOTHERS ME A LITTLE	IT BOTHERS ME	IT BOTHERS ME A LOT
a. Fatigue or loss of energy?	○	○	○	○	○
b. Fevers, chills, or sweats?	○	○	○	○	○
c. Feeling dizzy or lightheaded?	○	○	○	○	○
d. Pain, numbness, or tingling in the hands or feet?	○	○	○	○	○
e. Trouble remembering?	○	○	○	○	○
f. Nausea or vomiting?	○	○	○	○	○

	I DO NOT HAVE THIS SYMPTOM	I HAVE THIS SYMPTOM AND…. IT DOESN'T BOTHER ME	IT BOTHERS ME A LITTLE	IT BOTHERS ME	IT BOTHERS ME A LOT
g. Diarrhea or loose bowel movements?	○	○	○	○	○
h. Felt sad, down, or depressed?	○	○	○	○	○
i. Felt nervous or anxious?	○	○	○	○	○
j. Difficulty falling or staying asleep?	○	○	○	○	○
k. Skin problems, such as rash, dryness, or itching?	○	○	○	○	○
l. Cough or trouble catching your breath?	○	○	○	○	○
m. Headache?	○	○	○	○	○
n. Loss of appetite or change in the taste of food?	○	○	○	○	○
o. Bloating, pain, or gas in your stomach?	○	○	○	○	○
p. Muscle aches or joint pain?	○	○	○	○	○
q. Problems with having sex, such as loss of interest or lack of satisfaction?	○	○	○	○	○
r. Changes in the way your body looks, such as fat deposits or weight gain?	○	○	○	○	○
s. Problems with weight loss or wasting?	○	○	○	○	○
t. Hair loss or changes in the way	○	○	○	○	○

88. Do you think your symptoms from question #87 are caused by the drugs you take to treat your medical condition?

() YES

() NO

() UNSURE

89. Do you think your symptoms from question #87 are caused by drinking alcohol?

() YES

() NO

() UNSURE

90. On a scale of 0 to 10 where 0 means no pain and 10 equals the worst possible pain, what is your current pain level? (If pain equals 0 [zero] please skip to question #100)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

NO PAIN WORST POSSIBLE PAIN

91. In general, how much does your pain problem interfere with your day to day activities? (Please mark one)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

NO INTERFERENCE EXTREME INTERFERENCE

92. Since the time you developed a pain problem how much has your pain changed your ability to work? (Please mark one)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

NO CHANGE EXTREME CHANGE

93. How much has your pain changed the amount of satisfaction or enjoyment you get from participating in social and recreational activities? (Please mark one)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

NO CHANGE EXTREME CHANGE

94. How much has your pain changed your ability to participate in recreational and other social activities? (Please mark one)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

NO CHANGE EXTREME CHANGE

95. How much has your pain changed the amount of satisfaction you get from family-related activities? (Please mark one)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

NO CHANGE EXTREME CHANGE

96. How much has your pain changed your marriage and other family relationships? (Please mark one)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

NO CHANGE EXTREME CHANGE

97. How much has your pain changed the amount of satisfaction or enjoyment you get from work? (Please mark one)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

NO CHANGE EXTREME CHANGE

98. How much has your pain changed your ability to do household chores? (Please mark one)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

NO CHANGE EXTREME CHANGE

99. How much has your pain changed your friendships with people other than your family?(Please mark one)

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6

NO CHANGE EXTREME CHANGE

The next group of questions are about pain or uncomfortable sensations in your feet.

100. In the last 6 months, have you felt pain or an uncomfortable sensation in both of your feet at the same time?

() YES () NO (If No skip to #107)

101. Please use the scale below to tell us how intense your pain feels.

○ 0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

NO PAIN MOST INTENSE PAIN POSSIBLE

102. Please use the scale below to tell us how sharp your pain feels. Sharp can mean 'stabbing,' 'jabbing,' 'like jolts of electricity,' or 'like a knife.'

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○10

NO PAIN MOST SHARP SENSATION IMAGINABLE

103. Please use the scale below to tell us how sensitive your skin is to clothing, bed sheets, or to light touching. Sensitive can mean 'raw skin' or 'feel like they are sunburned.'

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○10

NO PAIN MOST SENSITIVE SENSATION IMAGINABLE

104. Please use the scale below to tell us how dull your pain feels. Dull can mean 'aching,' 'like a bruise,' 'like a dull toothache.'

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○10

NO PAIN MOST DULL SENSATION IMAGINABLE

105. Please use the scale below to tell us how hot your pain feels. Hot can mean 'on fire,' or 'burning.'

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○10

NO PAIN MOST HOT SENSATION IMAGINABLE

106. Please use the scale below to tell us how cold your pain feels. Cold can mean 'freezing,' or 'like ice.'

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

NO PAIN MOST COLD SENSATION IMAGINABLE

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

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
a. Little interest or pleasure in doing things	0	0	0	0
b. Feeling down, depressed, or hopeless	0	0	0	0
c. Trouble falling/staying asleep, sleeping too much	0	0	0	0
d. Feeling tired or having little energy	0	0	0	0
e. Poor appetite or overeating	0	0	0	0
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	0	0	0
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	0	0	0
h. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	0	0	0
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	0	0	0

108. If you checked off any problem listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0 NOT DIFFICULT AT ALL 0 VERY DIFFICULT

0 SOMEWHAT DIFFICULT 0 EXTREMELY DIFFICULT

109. Have you ever seriously thought about committing suicide? 0 YES 0 NO

If YES, have you felt this way in the past 2 weeks? 0 YES 0 NO

110. Have you ever made a plan for committing suicide? 0 YES 0 NO

If YES, have you felt this way in the past 2 weeks? 0 YES 0 NO

111. Have you ever attempted suicide? 0 YES 0 NO

If YES, have you felt this way in the past 2 weeks? 0 YES 0 NO

These questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer each question by filling in the circle. If you are unsure about how to answer, please try your best.

112. In general, would you say your health is:

O EXCELLENT O VERY GOOD O GOOD O FAIR O POOR

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	YES, LIMITED A LOT	YES, LIMITED A LITTLE	NO, NOT LIMITED AT ALL
113. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	O	O	O
114. Climbing several flights of stairs	O	O	O

During the past 4 weeks, have you had any of the following problems with your work or other daily activities as a result of your physical health?

115. Accomplished less than you would like O YES O NO

116. Were limited in the kind of work or other activities O YES O NO

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

117. Accomplished less than you would like O YES O NO

118. Didn't do work or other activities as carefully as usual O YES O NO

119. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

O NOT AT ALL O MODERATELY O EXTREMELY
O A LITTLE BIT O QUITE A BIT

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks -

	ALL OF THE TIME	MOST OF THE TIME	A GOOD BIT OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
120. Have you felt downhearted and blue?	0	0	0	0	0	0
121. Did you have a lot of energy?	0	0	0	0	0	0
122. Have you felt calm and peaceful?	0	0	0	0	0	0

123. During the past 4 weeks, how much of the time have your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

0 ALL OF THE TIME
0 MOST OF THE TIME
0 SOME OF THE TIME
0 A LITTLE OF THE TIME
0 NONE OF THE TIME

124. Do you take any medicine to treat your health problems?

0 YES 0 NO (If No, skip to #126)

125. For some people it is difficult to always take medications as the doctor prescribes. Thinking back on the last month, on average how would you rate your ability to take ALL of your medications as your doctor prescribed them?

0 EXCELLENT
0 VERY GOOD
0 GOOD
0 FAIR
0 POOR
0 VERY POOR

126. The following questions ask about your perceptions of alcohol use and your health.

	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE
a. People are more likely to miss taking their medications if they have been drinking.	0	0	0	0	0
b. Alcohol and medications should never be mixed.	0	0	0	0	0
c. Drinking in moderation can have health benefits.	0	0	0	0	0
d. A person should stop taking their medications if they are going to be drinking.	0	0	0	0	0

The next set of questions are about your experiences with the internet.

127. In the last 12 months did you use the Internet for any purpose?

O YES O NO (If No, skip to the end of the survey)

128. In the last 12 months, about how often did you look on the Internet for information or advice about health or health care?

O MORE THAN ONCE A WEEK
O ABOUT ONCE A WEEK
O ONCE A MONTH
O EVERY 2-3 MONTHS
O LESS THAN EVERY 2-3 MONTHS
O NEVER (If Never, skip to the end of the survey)

129. In the last 12 months, did you use the Internet to obtain information about your medications for any health problems?

O YES
O NO
O NOT CURRENTLY TAKING MEDICATIONS

130. In the last 12 months, did you use the Internet to obtain information about your medical conditions?

O YES O NO

131. Thinking about all of the times in the last year that you used the Internet for things related to health or health care, to what extent do you agree or disagree with the following statement, "Using the Internet improved my ability to manage my health care needs."

STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE
O	O	O	O	O

MyHealtheVet (www.myhealth.va.gov) is a VA website that veterans can use to find health information and do things like ordering VA prescription refills

132. In the last 12 months, about how often did you use the MyHealtheVet website for information or advice about health or health care, or to refill prescriptions?

- ○ MORE THAN ONCE A WEEK
- ○ ABOUT ONCE A WEEK
- ○ ONCE A MONTH
- ○ EVERY 2-3 MONTHS
- ○ LESS THAN EVERY 2-3 MONTHS
- ○ NEVER (If Never, skip to the end of the survey)

133. Thinking about all of the times in the last year that you used the MyHealtheVet website, to what extent do you agree or disagree with the following statement, "Using the MyHealtheVet website improved my ability to manage my health care needs."

STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE
○	○	○	○	○

Thank you for completing our questionnaire.