

VACS PATIENT QUESTIONNAIRE General Medicine Clinic



Thank you for agreeing to participate in our study. The following survey should take about 40 minutes to complete. Please answer all of the questions to the best of your ability. If you have any questions, please ask the Study Coordinator who gave you this survey. When finished, return the survey to the Research Coordinator.

Study ID:

Last Name:

First Name:

SSN:

DOB: / /

Month:

Day:

Year:

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

Date of Visit: / / Study ID:

1. What is the name of your primary care provider in this clinic?

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PRE-EXISTING CONDITIONS

2. Has your doctor ever told you that you have any of the following?

YES NO

a. Anemia or "low blood"	0	0
b. Angina or Coronary Heart Disease	0	0
c. Heart Attack or Myocardial Infarction	0	0
d. Congestive Heart Failure, also called weak heart or fluid on the lungs	0	0
e. Dementia or "Alzheimer's"	0	0
f. Diabetes or high blood sugar or "sugar"	0	0
g. Liver Disease or a bad liver or Cirrhosis	0	0
h. Hepatitis C	0	0
i. Chronic Hepatitis B	0	0
j. High cholesterol, lipids, or triglycerides	0	0
k. Hypertension or high blood pressure	0	0
l. Pancreatitis	0	0
m. Bad nerves in your feet causing pain and numbness (neuropathy)	0	0
n. Bad circulation in your legs or feet	0	0
o. Chronic lung disease (emphysema, asthma, chronic bronchitis or chronic obstructive lung disease)	0	0
p. Kidney Failure (or bad kidneys)	0	0
q. Stroke or "mini" stroke (Transient Ischemic Attack)	0	0
r. Pneumonia	0	0
s. Shingles	0	0
t. TB or Tuberculosis	0	0
u. Depression	0	0
v. Post-Traumatic Stress Disorder	0	0
w. Schizophrenia (hearing voices or seeing things that others don't)	0	0
x. Any kind of Cancer (please list below)	0	0

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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HEALTH HABITS

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

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

4. How tall are you without shoes on? (fill in feet (ft.) and inches (in.)) (If 1/2" please round up)

- 5 ft 00 in or less 5 ft 04 in 5 ft 08 in 6 ft 00 in
- 5 ft 01 in 5 ft 05 in 5 ft 09 in 6 ft 01 in
- 5 ft 02 in 5 ft 06 in 5 ft 10 in 6 ft 02 in
- 5 ft 03 in 5 ft 07 in 5 ft 11 in 6 ft 03 in or more

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

- NEVER
- LESS THAN ONCE A WEEK
- 1 - 2 TIMES A WEEK
- 3 - 4 TIMES A WEEK
- 5 OR MORE TIMES A WEEK

6. Have you used any of the following therapies in the past year? YES NO

a. Acupuncture/Acupressure	<input type="radio"/>	<input type="radio"/>																				
b. Chiropractic	<input type="radio"/>	<input type="radio"/>																				
c. Herbs/Herbal Medicine	<input type="radio"/>	<input type="radio"/>																				
d. Homeopathy	<input type="radio"/>	<input type="radio"/>																				
e. Imagery	<input type="radio"/>	<input type="radio"/>																				
f. Massage	<input type="radio"/>	<input type="radio"/>																				
g. Meditation/Prayer/Spiritual Healing	<input type="radio"/>	<input type="radio"/>																				
h. Relaxation/Breathing Exercises	<input type="radio"/>	<input type="radio"/>																				
i. Self-help/Support Groups	<input type="radio"/>	<input type="radio"/>																				
j. Special Diet	<input type="radio"/>	<input type="radio"/>																				
k. St. John's Wort	<input type="radio"/>	<input type="radio"/>																				
l. Vitamins/Minerals	<input type="radio"/>	<input type="radio"/>																				
m. Other	<table border="1" style="width: 100%; border-collapse: collapse; height: 20px;"> <tr> <td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td> </tr> </table>																					



7. In the past 4 weeks have you been concerned about having enough food for you or your family?

YES

NO

8. In the past 4 weeks, have you been without a permanent address that you call home?

YES

NO

9. Have you ever been without a permanent address that you call home?

YES

NO

10. In the past 4 weeks, have you stayed one or more nights
in a shelter, on the street, in a park, or an abandoned building?

YES

NO

11. Have you ever stayed one or more nights in a shelter,
on the street, in a park or an abandoned building?

YES

NO

12. Do you now smoke cigars or pipes?

- YES
 NO

13. Do you now smoke cigarettes (i.e. within the last week)?

- YES
 NO

14. Have you ever smoked cigarettes for as long as a year?

- YES (if YES answer a, b, & c)
 NO (If NO, skip to #15)

a. How many years have you smoked/did you smoke cigarettes? years

b. How many cigarettes do/did you smoke a day? cigarettes

c. If you no longer smoke cigarettes, when did you quit?

- LESS THAN 4 WEEKS AGO
 MORE THAN 4 WEEKS AGO

15. Do you think HIV causes AIDS?

- NO, HIV DOES NOT CAUSE AIDS UNSURE I AM SURE HIV DOES CAUSE AIDS

16. Have you ever been tested for HIV?

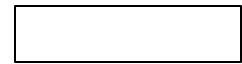
- YES
 NO

17. Do you think you are at risk for HIV infection?

- NOT AT RISK MODERATE RISK HIGH RISK

18. Have you ever had a drink containing alcohol?

- YES (If YES, please continue on the next page)
 NO, NEVER (If NO, please skip to question #51 on page 11)



19. When was the last time you had a drink?

- IN THE LAST 30 DAYS
- IN THE LAST 12 MONTHS
- MORE THAN 12 MONTHS AGO

20. When you are drinking, how often do you have a drink containing alcohol?

- NEVER
- MONTHLY OR LESS
- 2 TO 4 TIMES A MONTH
- 2 TO 3 TIMES A WEEK
- 4 OR MORE TIMES A WEEK

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

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

22. When you are drinking, how often do you have 6 or more drinks on one occasion?

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

23. 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

24. Here are a number of events that drinkers sometimes experience.

Read each one carefully and complete the circle that indicates if this ever happened to you and how often it has happened to you during the past 3 months.

	HAS THIS EVER HAPPENED TO YOU?		DURING THE PAST 3 MONTHS, ABOUT HOW OFTEN HAS THIS HAPPENED TO YOU?			
	<u>YES</u>	<u>NO</u>	<u>NEVER</u>	<u>ONCE OR A FEW TIMES</u>	<u>ONCE OR TWICE A WEEK</u>	<u>DAILY OR ALMOST DAILY</u>
a. I have been unhappy because of my drinking.	0	0	0	0	0	0
b. Because of my drinking, I have not eaten properly.	0	0	0	0	0	0
c. I have failed to do what is expected of me because of my drinking.	0	0	0	0	0	0
d. I have felt guilty or ashamed because of my drinking.	0	0	0	0	0	0
e. I have taken foolish risks when I have been drinking.	0	0	0	0	0	0
f. When drinking, I have done impulsive things that I regret later.	0	0	0	0	0	0
g. My physical health has been harmed by my drinking.	0	0	0	0	0	0
h. I have had money problems because of my drinking.	0	0	0	0	0	0
i. My physical appearance has been harmed by my drinking.	0	0	0	0	0	0
j. My family has been hurt by my drinking.	0	0	0	0	0	0
k. A friendship or close relationship has been damaged by my drinking.	0	0	0	0	0	0
l. My drinking has gotten in the way of my growth as a person.	0	0	0	0	0	0
m. My drinking has damaged my social life, popularity, or reputation.	0	0	0	0	0	0
n. I have spent too much or lost a lot of money because of my drinking.	0	0	0	0	0	0
o. I have had an accident while drinking or intoxicated.	0	0	0	0	0	0

The following questions refer to any drinking you have done in your lifetime.

25. How much did you drink the last time you drank?

- ENOUGH TO GET HIGH OR LESS
- ENOUGH TO GET DRUNK
- ENOUGH TO PASS OUT

26. Have you often had hangovers on Sunday or Monday mornings?

- NO
- YES

27. Have you had the "shakes" when sobering up (hands tremble, shake inside)?

- NO
- SOMETIMES
- OFTEN

28. Have you gotten physically sick (e.g. vomit, stomach cramps) as a result of drinking?

- NO
- SOMETIMES
- ALMOST EVERY TIME I DRINK

29. Have you had the "DTs" (delirium tremens) - that is, seen, felt or heard things not really there; felt very anxious, restless, and over-excited?

- NO
- SOMETIMES
- SEVERAL TIMES

30. When you drink, do you stumble about, stagger, and weave?

- NO
- SOMETIMES
- OFTEN

31. As a result of drinking, have you felt overly hot and sweaty (feverish)?

- NO
- ONCE
- SEVERAL TIMES

32. As a result of drinking, have you seen things that were not really there?

- NO
- ONCE
- SEVERAL TIMES

33. Have you panicked because you feared you may not have a drink when you need it?

- NO
- YES

34. Have you had blackouts ("loss of memory" without passing out) as a result of drinking?

- NO, NEVER
- SOMETIMES
- OFTEN
- ALMOST EVERY TIME I DRINK

35. Have you carried a bottle with you or kept one close at hand?

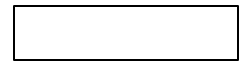
- NO
- SOME OF THE TIME
- MOST OF THE TIME

36. After a period of abstinence (not drinking), have you ended up drinking heavily again?

- NO
- SOMETIMES
- ALMOST EVERY TIME I DRINK

37. Have you passed out as a result of drinking?

- NO
- ONCE
- MORE THAN ONCE



38. Have you had a convulsion (fit) following a period of drinking?

NO

YES

SEVERAL TIMES

39. Do you drink throughout the day?

NO

YES

40. After drinking heavily, has your thinking been fuzzy or unclear?

NO

YES, BUT ONLY FOR A FEW HOURS

YES, FOR ONE OR TWO DAYS

YES, FOR MANY DAYS

41. As a result of drinking, have you felt your heart beating rapidly?

NO

YES

SEVERAL TIMES

42. Do you almost constantly think about drinking and alcohol?

NO

YES

43. As a result of drinking, have you heard "things" that were not really there?

NO

YES

SEVERAL TIMES

44. Have you had weird and frightening sensations when drinking?

NO

ONCE OR TWICE

OFTEN

45. As a result of drinking, have you "felt things" crawling on you that were not really there (e.g., bugs, spiders)?

- NO
- YES
- SEVERAL TIMES

46. With respect to blackouts (loss of memory)

- HAVE NEVER HAD A BLACKOUT
- HAVE HAD BLACKOUTS THAT LAST LESS THAN AN HOUR
- HAVE HAD BLACKOUTS THAT LAST FOR SEVERAL HOURS
- HAVE HAD BLACKOUTS THAT LAST FOR A DAY OR MORE

47. Have you tried to cut down on your drinking and failed?

- NO
- ONCE
- SEVERAL TIMES

48. Do you gulp drinks (drink quickly)?

- NO
- YES

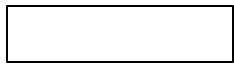
49. After taking one or two drinks, can you usually stop?

- NO
- YES

50. Have you had any of the following symptoms in the last 12 months?

Mark all that apply. (Please note this question refers only to the last 12 months.)

- | | |
|--|--|
| <input type="radio"/> THE SHAKES | <input type="radio"/> NAUSEA OR VOMITING |
| <input type="radio"/> BEING UNABLE TO SLEEP | <input type="radio"/> HEADACHES |
| <input type="radio"/> FEELING VERY NERVOUS OR RESTLESS | <input type="radio"/> WEAKNESS |
| <input type="radio"/> SWEATING | <input type="radio"/> SEEING OR HEARING THINGS THAT OTHERS COULD NOT SEE OR HEAR |
| <input type="radio"/> YOUR HEART BEATING FAST | <input type="radio"/> FITS OR SEIZURES |



51. For each of the following drugs, please mark the box that best indicates how often in the past year you used each drug.

	HAVE NEVER TRIED	NO USE IN THE LAST YEAR	LESS THAN ONCE A MONTH	1 - 3 TIMES A MONTH	1 - 3 TIMES A WEEK	4 - 6 TIMES A WEEK	EVERY DAY																				
a. Marijuana or Hashish	0	0	0	0	0	0	0																				
b. Cocaine or Crack	0	0	0	0	0	0	0																				
c. Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)	0	0	0	0	0	0	0																				
d. Opioids (heroin, morphine, codeine, opium)	0	0	0	0	0	0	0																				
e. Other (please specify):	<table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																										

If you have used any of the drugs listed above, please answer questions 52 through 58; if you have not used any of the drugs, please skip to question #59 on page 13.

52. In the past 12 months, did your use of drugs ever interfere with your work at school, or a job, or at home?

- YES (If YES, please answer #52a)
- NO (If NO, please skip to #53 on the next page)

52a. How often in the past 12 months, did drugs interfere with your work at school, or a job, or at home?

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

53. During the past 12 months, 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?

YES

NO

54. During the past 12 months, did you have any emotional or psychological problems from using drugs - such as feeling uninterested in things, feeling depressed, suspicious of people, paranoid, or having strange ideas?

YES

NO

55. During the past 12 months, did you have a strong desire or urge to use a drug that you could not keep from using it?

YES

NO

56. During the past 12 months, did you have a period of a month or more when you spent a great deal of time using drugs or getting over its/their effects?

YES

NO

57. During the past 12 months, did you ever use much larger amounts of drugs than you intended to or did you use it/them for a longer period of time than you intended to?

YES (If YES, please answer #57a)

NO (If NO, please skip to #58)

57a. How often in the past 12 months, did you use a much larger amount of drugs than you intended to or use it/them for a longer period of time than you intended to?

ONCE OR TWICE

BETWEEN 3 AND 5 TIMES

BETWEEN 6 AND 10 TIMES

BETWEEN 11 AND 20 TIMES

MORE THAN 20 TIMES

58. During the past 12 months, was there ever a time when you had to use more of a drug than you used to get the same effect you wanted?

YES

NO

BEHAVIOR

59. In order to compare our study with the results of other studies, we'd like to know if you have ever done any of the following things.

Have you:	<u>YES</u>	<u>NO</u>	<u>DON'T KNOW</u>
a. Had sex with a man?	0	0	0
b. Had sex with a woman?	0	0	0
c. Injected drugs?	0	0	0
d. Had sex with someone you know or believe to have been an IV or injected drug user?	0	0	0
e. Had sex with someone you know or believe to have been bisexual?	0	0	0
f. Received clotting factor for hemophilia or other blood clotting disorder?	0	0	0
g. Received transfusion of blood components other than clotting factor?	0	0	0

The next questions are about your sexual behavior. 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 (If YES, please answer #61 - 64 below)
- NO (If NO, skip to #65 on the next page)

61. During the past 12 months, with how many people have you had sex?

people

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

- YES
- NO

64. Thinking back about the last time you had sex, were you under the influence of alcohol or drugs?

- YES
- NO

65. Have you ever, even once, used a needle to inject any drug?
DO NOT include anything you took under a doctor's orders.

YES

NO [SKIP to #74 on page 16]

66. In the past 12 months, have you ever used a needle to inject any drug?

YES

NO [SKIP to #74 on page 16]

67. The last time that you used a needle to inject a drug, what drug did you inject?
(Check all that apply)

HEROIN

POWDER COCAINE

CRACK COCAINE

METHAMPHETAMINE

OTHER, specify

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

68. The last time you used a needle to inject a drug, was it a new sterile needle?
By sterile, we mean that it had never been used before, not even by you?

YES

NO

DON'T KNOW

69. The last time you used a needle to inject a drug, did you use cottons, a cooker,
or rinse water that you knew or suspected someone else had used before?

YES

NO

DON'T KNOW

70. The last time you used a needle to inject a drug, did someone else use the needle after you?

- YES
- NO
- DON'T KNOW

71. The last time you used a needle to inject a drug, did someone else use the cottons, cooker, or rinse water after you?

- YES
- NO
- DON'T KNOW

72. The last time you used a needle to inject a drug, did someone use their syringe to squirt the drug into your syringe? This is sometimes called "backloading," "frontloading," or "splitting."

- YES
- NO
- DON'T KNOW

73. The last time you used a needle to inject a drug, did you use your syringe to squirt the drug into the syringe of someone else? This is sometimes called "frontloading," "backloading," or "splitting."

- YES
- NO
- DON'T KNOW

SOCIAL ASPECTS OF HEALTH

74. For each of the following statements, fill in the circle if you strongly agree, agree, disagree, or strongly disagree.

	<u>STRONGLY AGREE</u>	<u>AGREE</u>	<u>DISAGREE</u>	<u>STRONGLY DISAGREE</u>
a. I want to take an active role in the medical management of my disease and its complications	0	0	0	0
b. It is better to trust a doctor or nurse in charge of a medical procedure than to question what they are doing	0	0	0	0
c. I want to know as much as I can about the medical aspects of my disease and treatment	0	0	0	0
d. I'd rather have doctors and nurses make decisions about what's best rather than for them to give me a lot of choices	0	0	0	0

75. How often do you see or hear from relatives or close friends? Would you say less than once a month, about once a month, a few times a month, a few times a week, every day?

	<u>LESS THAN ONCE A MONTH</u>	<u>MONTHLY</u>	<u>A FEW TIMES A MONTH</u>	<u>A FEW TIMES A WEEK</u>	<u>DAILY</u>
a. Relatives?	0	0	0	0	0
b. Close friends?	0	0	0	0	0

76. How many close friends or family do you have with whom you feel at ease, can talk about private matters, or can call on for help?

0 NONE

0 ONE

0 TWO

0 THREE OR FOUR

0 FIVE TO EIGHT

0 NINE OR MORE

77. In response to having a medical illness, how often during the past four weeks have you done each of the following? Would you say all of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time?

	ALL OF THE TIME	MOST OF THE TIME	A GOOD BIT OF THE TIME	SOME OF THE TIME	LITTLE OF THE TIME	NONE OF THE TIME
a. Used my situation to change or grow as a person?	0	0	0	0	0	0
b. Avoided being with people in general?	0	0	0	0	0	0
c. Kept yourself from thinking too much about it?	0	0	0	0	0	0
d. Asked other people for advice and information?	0	0	0	0	0	0
e. Criticized or lectured yourself?	0	0	0	0	0	0
f. Tried to keep yourself from worrying about it?	0	0	0	0	0	0
g. Talked to someone about how you were feeling about having it?	0	0	0	0	0	0
h. Tried to keep it from bothering you?	0	0	0	0	0	0
i. Involved yourself in volunteer work or a community organization?	0	0	0	0	0	0

78. Are you an official member of a church or other place of worship?

YES

NO

79. How religious do you consider yourself?

NOT AT ALL RELIGIOUS

NOT VERY RELIGIOUS

SOMEWHAT RELIGIOUS

RELIGIOUS

VERY RELIGIOUS

80. During the past year, how often did you attend religious services?

- NEVER
- LESS THAN TWICE A YEAR
- SEVERAL TIMES A YEAR
- ABOUT ONCE A MONTH
- TWO TO THREE TIMES A MONTH
- EVERY WEEK
- SEVERAL TIMES A WEEK
- EVERYDAY

81. How frequently do you pray?

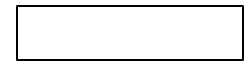
- NEVER
- LESS THAN TWICE A YEAR
- SEVERAL TIMES A YEAR
- ABOUT ONCE A MONTH
- TWO TO THREE TIMES A MONTH
- EVERY WEEK
- SEVERAL TIMES A WEEK
- EVERY DAY

82. How important is religion to you?

- VERY IMPORTANT
- IMPORTANT
- SOMEWHAT IMPORTANT
- NOT VERY IMPORTANT
- NOT AT ALL IMPORTANT

83. When you have problems or difficulties in your life,
how often do you seek spiritual comfort and support?

- ALMOST ALWAYS
- OFTEN
- SOMETIMES
- RARELY
- NEVER



HEALTH CARE UTILIZATION

84. How many times have you used VA health care in the last 4 months?

a. For overnight stays in a hospital or nursing home

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

b. For outpatient care

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

85. How many times have you used health care outside the VA in the last 4 months?

a. For overnight stays in a hospital or nursing home

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

b. For outpatient care

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

86. Within the past 4 months, how many visits have you had with a **mental health professional** within the VA?

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

87. Within the past 4 months, how many visits have you had with a **mental health professional** outside the VA?

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15+

*The following questions ask for your views about your regular doctor.
Your doctor will not be able to link your name to your responses.*

88. Do you have one person you think of as your regular doctor?

- YES, VA
- YES, NON-VA
- NO

89. How many minutes does it usually take you to get to your regular doctor's office?

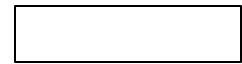
- 15 OR LESS
- 16 - 30
- 31 - 60
- 60 OR MORE

90. How would you rate the convenience of your regular doctor's office location?

- VERY POOR
- POOR
- FAIR
- GOOD
- VERY GOOD
- EXCELLENT

91. Thinking about talking with your regular doctor, how would you rate the following?

	<u>VERY POOR</u>	<u>POOR</u>	<u>FAIR</u>	<u>GOOD</u>	<u>VERY GOOD</u>	<u>EXCELLENT</u>
a. Thoroughness of your doctor's questions about your symptoms and how you are feeling	0	0	0	0	0	0
b. Attention your doctor gives to what you have to say	0	0	0	0	0	0
c. Doctor's explanation of your problems or treatment that you need	0	0	0	0	0	0



92. Thinking about how well your regular doctor knows you, how would you rate your doctor's knowledge of what worries you most about your health?

- VERY POOR
- POOR
- FAIR
- GOOD
- VERY GOOD
- EXCELLENT

93. All things considered, how much do you trust your regular doctor?

NOT AT ALL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	COMPLETELY
	1	2	3	4	5	6	7	8	9	10	

94. Do you know who to ask when you have questions about your care?

- YES, ALWAYS
- YES, SOMETIMES I DO
- NO
- DIDN'T HAVE ANY QUESTIONS

95. Do you know what the next step in your care will be?

- YES, ALWAYS
- YES, SOMETIMES
- NO

96. Have any of the following been a problem for you in arranging for your medical care in the last 12 months? If so, how much of a problem?

	<u>YES, A BIG PROBLEM</u>	<u>YES, A SMALL PROBLEM</u>	<u>NO, NOT A PROBLEM</u>
a. Difficulty receiving care you and your doctor believed necessary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Not being able to get a referral to a specialist that you wanted to see	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

97. Overall, how would you rate the quality of care you received the past two months?

- VERY POOR
- POOR
- FAIR
- GOOD
- VERY GOOD
- EXCELLENT

MEDICATIONS:

98. Do you take any prescription medicine to treat any medical problems you may have?

- YES (If YES, please answer #99)
- NO (if NO, skip to #100 at bottom of the page)

99. Over the past 4 days, on how many days did you miss taking any of your doses?

- NONE
- ONE DAY
- TWO DAYS
- THREE DAYS
- FOUR DAYS

SYMPTOMS

100. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Fevers, chills, or sweats?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Feeling dizzy or light headed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Pain, numbness, or tingling in the hands or feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Trouble remembering?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



	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
f. Nausea or vomiting?	0	0	0	0	0
g. Diarrhea or loose bowel movements?	0	0	0	0	0
h. Felt sad, down, or depressed?	0	0	0	0	0
i. Felt nervous or anxious?	0	0	0	0	0
j. Difficulty falling or staying asleep?	0	0	0	0	0
k. Skin problems, such as rash, dryness, or itching?	0	0	0	0	0
l. Cough or trouble catching your breath?	0	0	0	0	0
m. Headache?	0	0	0	0	0
n. Loss of appetite or change in the taste of food?	0	0	0	0	0
o. Bloating, pain, or gas in your stomach?	0	0	0	0	0
p. Muscle aches or joint pain?	0	0	0	0	0
q. Problems with having sex, such as loss of interest or lack of satisfaction?	0	0	0	0	0
r. Changes in the way your body looks, such as fat deposits or weight gain?	0	0	0	0	0
s. Problems with weight loss or wasting?	0	0	0	0	0
t. Hair loss or changes in the way your hair looks?	0	0	0	0	0
101. Do you think your symptoms are caused by drugs you take to treat other medical conditions?					
	0	0	0	0	0
	YES	UNSURE		NO	

QUALITY OF LIFE

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

	<u>NOT AT ALL</u>	<u>SEVERAL DAYS</u>	<u>MORE THAN HALF THE DAYS</u>	<u>NEARLY EVERY DAY</u>
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

103. 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?

- NOT DIFFICULT AT ALL
- SOMEWHAT DIFFICULT
- VERY DIFFICULT
- EXTREMELY DIFFICULT

**Questions 104a-g are from the Beck Depression Inventory®-II (BDI®-II).
The BDI®-II is protected by federal copyright law.**

105. These questions are about any physical limitations you might have.

For these activities, please indicate which response best describes you by darkening the circle under the appropriate response after each statement

	<u>YES, I CAN DO THIS</u>	<u>YES, BUT ONLY SLOWLY</u>	<u>NO, I CANNOT DO THIS</u>
a. Can you do heavy work at home, like scrubbing floors, lifting or moving heavy furniture?	0	0	0
b. Can you do moderate work at home like moving a chair or table, or pushing a vacuum cleaner?	0	0	0
c. Can you do light work around the house like dusting or washing dishes?	0	0	0
d. If you want to, can you participate in active sports such as swimming, tennis, basketball, volleyball or rowing a boat?	0	0	0
e. If you want to, can you run a short distance?	0	0	0
f. Can you walk uphill or upstairs?	0	0	0
g. Can you walk a block or more?	0	0	0
h. Can you walk around inside the house?	0	0	0
i. Can you walk to a table for meals?	0	0	0
j. Can you dress yourself?	0	0	0
k. Can you eat without help?	0	0	0
l. Can you use the bathroom without help?	0	0	0

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 give the best answer you can.

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

- EXCELLENT
- VERY GOOD
- GOOD
- FAIR
- 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 <u>A LOT</u>	YES, LIMITED <u>A LITTLE</u>	NO, NOT LIMITED <u>AT ALL</u>
107. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	0	0	0
108. Climbing several flights of stairs	0	0	0

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?

109. **Accomplished less** than you would like

YES

NO

110. Were limited in the **kind** of work or other activities

YES

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)?

111. **Accomplished less** than you would like

YES

NO

112. Didn't do work or other activities as **carefully** as usual

YES

NO

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

NOT AT ALL

A LITTLE BIT

MODERATELY

QUITE A BIT

EXTREMELY

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 <u>TIME</u>	MOST OF THE <u>TIME</u>	A GOOD BIT OF <u>THE TIME</u>	SOME OF THE <u>TIME</u>	A LITTLE OF THE <u>TIME</u>	NONE OF THE <u>TIME</u>
114. Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
115. Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
116. Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

DEMOGRAPHICS

118. What is your date of birth? / /

month day year

119. What is your sex?

- MALE
- FEMALE

120. What is the highest grade or year of school you completed?

- NEVER ATTENDED SCHOOL OR ONLY KINDERGARTEN
- GRADES 1 THROUGH 8 (ELEMENTARY)
- GRADES 9 THROUGH 11 (SOME HIGH SCHOOL)
- HIGH SCHOOL GRADUATE
- GED
- COLLEGE 1 YEAR TO 3 YEARS (SOME COLLEGE OR TECHNICAL SCHOOL)
- COLLEGE GRADUATE
- GRADUATE SCHOOL

121. What is your race (Mark one or more)?

- AMERICAN INDIAN OR ALASKA NATIVE
- ASIAN
- BLACK OR AFRICAN AMERICAN
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- WHITE

122. What is your ethnicity?

- HISPANIC OR LATINO
- NOT HISPANIC OR LATINO

123. What is your current marital status?

- MARRIED
- DIVORCED
- SEPARATED
- WIDOWED
- NEVER MARRIED
- LIVING WITH PARTNER

124. How many persons live in your household (including yourself)?

people

125. Are you currently...(mark all that apply)

- EMPLOYED FOR WAGES
- SELF-EMPLOYED
- LOOKING FOR WORK AND UNEMPLOYED FOR MORE THAN ONE YEAR
- LOOKING FOR WORK AND UNEMPLOYED FOR LESS THAN ONE YEAR
- HOMEMAKER
- STUDENT
- RETIRED
- UNABLE TO WORK

126. What is your annual household income?

- LESS THAN \$6,000
- \$6,000 TO \$11,999
- \$12,000 TO \$24,999
- \$25,000 TO \$49,999
- OVER \$50,000

Thank you for completing our questionnaire.

Please return this to the Survey Coordinator who gave it to you. page 29 of 29