Veteran Health Study

(CSP #569)

Sponsored by

VA Cooperative Studies Program

This booklet contains a range of questions about your general health, medical conditions, health habits, and emotional well-being.

Please read the instructions, as time frames and response options will vary.

Please do this:

Correct Mark	Incorrect Marks
○ ○ ● ○ ○	⊗ ✓ ● ⊙ ✗

Fill in one circle on each line. If you are unsure about how to answer a question, please give the best answer you can.

- Please answer each question unless you are asked to skip to another question.
- Fill in only one answer circle for each question unless it tells you to "Fill in all that apply".
- It is best to use a soft lead pencil in case you want to change an answer.
- Do not make any stray marks on the questionnaire.
- When you are finished, please place the questionnaire in the enclosed postage-paid envelope and put it in the mail.

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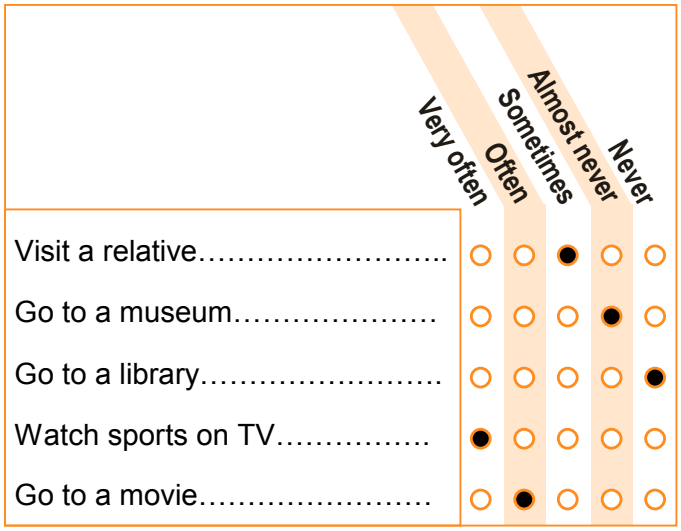
EXAMPLE

This is an example of how to fill out a series of questions that ask you to fill in only one choice per question.

How often do you do any of the following activities?

If you sometimes visit a relative, almost never go to a museum, never go to a library, very often watch sports on TV, and often go to a movie, you would mark the bubbles as shown.



● ○ ○

These questions ask for your views about your health.

Please answer every question by filling in one circle. If you are unsure about how to answer a question, please give the best answer you can.

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

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

2. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
<u>Vigorous</u> activities, such as running, lifting heavy objects, participating in strenuous sports?	○	○	○
<u>Moderate</u> activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	○	○	○
<u>Lifting</u> or carrying groceries?	○	○	○
Climbing <u>several</u> flights of stairs?	○	○	○
Climbing <u>one</u> flight of stairs?	○	○	○
Bending, kneeling, or stooping?	○	○	○
Walking more than a <u>mile</u>?	○	○	○
Walking <u>several</u> blocks?	○	○	○
Walking <u>one</u> block?	○	○	○
Bathing or dressing yourself?	○	○	○

3. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

	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
Cut down the <u>amount of time</u> you spent on work or other activities	○	○	○	○	○
<u>Accomplished less</u> than you would like	○	○	○	○	○
Were limited in the <u>kind</u> of work or other activities	○	○	○	○	○
Had difficulty performing the work or other activities (for example, it took extra effort)	○	○	○	○	○

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

	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
Cut down the <u>amount of time</u> you spent on work or other activities	○	○	○	○	○
<u>Accomplished less</u> than you would like	○	○	○	○	○
Didn't do work or other activities as <u>carefully</u> as usual	○	○	○	○	○

5. During the <u>past 4 weeks</u>, to what extent has <u>your physical health or emotional problems</u> interfered with your normal social activities with family, friends, neighbors, or groups?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite a bit
- ○ Extremely

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6. **How much bodily pain have you had during the past 4 weeks?**

- ○ None
- ○ Very mild
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Very severe

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

- ○ Not at all
- ○ A little bit
- ○ Moderately
- ○ Quite a bit
- ○ Extremely

8. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please fill in 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
Did you feel full of pep?	○	○	○	○	○	○
Have you been a very nervous person?	○	○	○	○	○	○
Have you felt so down in the dumps that nothing could cheer you up?	○	○	○	○	○	○
Have you felt calm and peaceful?	○	○	○	○	○	○
Did you have a lot of energy?	○	○	○	○	○	○
Have you felt down-hearted and blue?	○	○	○	○	○	○
Did you feel worn out?	○	○	○	○	○	○
Have you been a happy person?	○	○	○	○	○	○
Did you feel tired?	○	○	○	○	○	○

9. **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

10. **Please choose the answer that best describes how TRUE or FALSE each of the following statements is for you.**

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
I seem to get sick a lot easier than other people	○	○	○	○	○
I am as healthy as anybody I know	○	○	○	○	○
I expect my health to get worse	○	○	○	○	○
My health is excellent	○	○	○	○	○

11. Have you ever been told by a doctor or other health professional that you had any of the following health conditions:	No	Yes	If Yes, age of diagnosis?	If Yes, in the past year, have you received medical treatment? No	If Yes, in the past year, have you received medical treatment? Yes
EXAMPLE: *If you've been told by a doctor you had the health condition listed, but you haven't received treatment in the last year, you would fill in like this:*	○	● →	2 2 →	●	○
Arthritis or rheumatism	○	○ →	→	○	○
Asthma	○	○ →	→	○	○
Emphysema	○	○ →	→	○	○
Other lung trouble	○	○ →	→	○	○
Stomach ulcers	○	○ →	→	○	○
Stomach or digestive disorder	○	○ →	→	○	○
Kidney stones	○	○ →	→	○	○
Other kidney problems	○	○ →	→	○	○
Bladder problems	○	○ →	→	○	○
Hepatitis C	○	○ →	→	○	○
Liver conditions	○	○ →	→	○	○
Vision conditions	○	○ →	→	○	○
Hearing condition that requires a hearing aid	○	○ →	→	○	○
Any other ear, nose, or throat condition	○	○ →	→	○	○
Sleep apnea	○	○ →	→	○	○
Osteoporosis (bone loss)	○	○ →	→	○	○
Seizure or convulsion	○	○ →	→	○	○
Prostate cancer	○	○ →	→	○	○
Brain cancer	○	○ →	→	○	○
Other cancers	○	○ →	→	○	○
Thyroid disease	○	○ →	→	○	○
Parkinson's disease	○	○ →	→	○	○
Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)	○	○ →	→	○	○
Multiple sclerosis	○	○ →	→	○	○
Tension headaches	○	○ →	→	○	○
Migraine headaches	○	○ →	→	○	○
An immune deficiency disease like HIV/AIDS	○	○ →	→	○	○
High cholesterol	○	○ →	→	○	○
Fibromyalgia	○	○ →	→	○	○
Chronic fatigue syndrome	○	○ →	→	○	○
Irritable bowel syndrome	○	○ →	→	○	○
Temporomandibular joint and muscle disorder (TMJ)	○	○ →	→	○	○
Acute prostatitis	○	○ →	→	○	○
Chronic prostatitis	○	○ →	→	○	○
Enlarged prostate	○	○ →	→	○	○
Benign prostatic hypertrophy (BPH)	○	○ →	→	○	○

12. Have you ever had any of the following health problems?	No	Yes	If Yes, age of onset?	If Yes, in the past year, have you received medical treatment? No	If Yes, in the past year, have you received medical treatment? Yes
Severe chronic pain	○	○ →	☐☐ →	○	○
Drug abuse or alcoholism	○	○ →	☐☐ →	○	○
Mental or emotional problems	○	○ →	☐☐ →	○	○
A serious accident-related injury	○	○ →	☐☐ →	○	○
Chronic back pain	○	○ →	☐☐ →	○	○
Chronic joint pain	○	○ →	☐☐ →	○	○
Chronic heartburn	○	○ →	☐☐ →	○	○
Chronic headaches	○	○ →	☐☐ →	○	○

The following questions ask about diabetes.

13. Have you ever been told by a medical doctor that you have diabetes?

- ○ No → **PLEASE SKIP TO 15 ON PAGE 6**
- ○ Yes

a. At what age was your diabetes first diagnosed?

☐☐ years old

b. Is your diabetes currently controlled by diet alone?

- ○ No
- ○ Yes

c. Is your diabetes currently treated with non-insulin medication (pill, etc…)?

- ○ No
- ○ Yes

d. Is your diabetes currently treated with insulin?

- ○ No
- ○ Yes

e. Has your doctor ever diagnosed diabetic ketoacidosis?

- ○ No
- ○ Yes

f. Have you ever been in a diabetic coma?

- ○ No
- ○ Yes

14. If you are currently being treated for diabetes, please fill in the circle next to the medications you have taken in the last 2 weeks to treat your diabetes. If you are taking a combination of medications, please fill in ALL that apply.

Non-Insulin Medications

- ○ Acarbose
- ○ ActoPlus Met
- ○ Actos
- ○ Amaryl
- ○ Avandamet
- ○ Avandaryl
- ○ Avandia
- ○ Byetta
- ○ Chlorpropamide
- ○ DiaBeta
- ○ Diabinese
- ○ Duetact
- ○ Exenatide
- ○ Fortamet
- ○ Glimepiride *(alone or in combination)*
- ○ Glipizide *(alone or in combination, XR)*
- ○ Glucophage *(regular, XR)*
- ○ Glucotrol *(regular, XL)*
- ○ Glucovance
- ○ Glumetza
- ○ Glyburide *(alone or in combination)*
- ○ Glynase Press Tab
- ○ Glyset
- ○ Janumet
- ○ Januvia
- ○ Metaglip
- ○ Metformin *(alone or in combination)*
- ○ Micronase
- ○ Miglitol
- ○ Nateglinide
- ○ Orinase
- ○ Pioglitazone *(alone or in combination)*
- ○ Pramlintide acetate
- ○ PrandiMet
- ○ Prandin
- ○ Precose
- ○ Repaglinide *(alone or in combination)*
- ○ Riomet
- ○ Rosiglitazone *(alone or in combination)*
- ○ Sitagliptin *(alone or in combination)*
- ○ Starlix
- ○ Symlin
- ○ Tolazamide
- ○ Tolbutamide
- ○ Tolinase
- ○ Other non-insulins, please specify:

_____

Insulins

- ○ Apidra
- ○ Exubera
- ○ Humalog *(alone or in combination)*
- ○ Humulin *(L, N, R, U, concentrated, or in combination)*
- ○ Iletin II *(lente or regular)*
- ○ Insulin *(aspart, concentrate, detemir, glargine, glulisine, isophane, lispro, regular, zinc)*
- ○ Lantus
- ○ Levemir
- ○ Novolin *(Lente, R, N, Ultralente, or in combination)*
- ○ NovoLog *(regular or in combination)*
- ○ Other insulins, please specify:

_____

_____

The following questions ask about cardiovascular disease.

15. Has a doctor ever told you that you have:	No	Yes	If Yes, age of diagnosis?	In the past year, have you received medical treatment? No	In the past year, have you received medical treatment? Yes
Angina pectoris	○	○ →	☐☐ →	○	○
Congestive heart failure	○	○ →	☐☐ →	○	○
Coronary heart disease	○	○ →	☐☐ →	○	○
Heart attack or myocardial infarction	○	○ →	☐☐ →	○	○
Stroke or cerebrovascular accident	○	○ →	☐☐ →	○	○

16. Do you get short of breath walking with other people at an ordinary pace on level ground?

- ○ No → **PLEASE SKIP TO 17**
- ○ Yes

↓

a. Do you get short of breath walking at your own pace?

- ○ No
- ○ Yes

17. Have you ever had any pain or discomfort in your chest?

- ○ No → **PLEASE SKIP TO 22**
- ○ Yes

18. When do you feel this pain or discomfort?

	No	Yes
When you are emotionally upset or excited?	○	○
When you walk fast or walk uphill?	○	○
When you walk at normal speed on level ground?	○	○
Under other conditions?	○	○

19. What do you do when you feel this pain or discomfort while you are walking?

- ○ Stop walking or walk more slowly.
- ○ Take medicine and continue walking at the same speed.
- ○ Continue walking at the same speed without taking medication.

20. If you stop walking, regardless of whether you take medicine or not, how is the pain or discomfort then?

- ○ The pain usually passes within ten minutes.
- ○ The pain usually continues for more than ten minutes.
- ○ Never stop walking.

21. Where are the pains or the discomfort located?

	No	Yes
In the middle of the chest?	○	○
In the left side of the chest?	○	○
In the left arm?	○	○
In some other place?	○	○

22. Have you ever had a severe pain across the front of your chest lasting for a half hour or more?

- ○ No
- ○ Yes

23. Have you ever been told by a doctor that you had hypertension or high blood pressure?

- ○ No → **PLEASE SKIP TO 24**
- ○ Yes

a. Age that you first had high blood pressure:

☐☐ years old

b. Has a doctor ever prescribed medication for you for hypertension or high blood pressure?

- ○ No
- ○ Yes

c. Are you now taking medication for this condition?

- ○ No
- ○ Yes

24. Have you ever had a cardiac catheterization?

- ○ No → **PLEASE SKIP TO 25**
- ○ Yes

a. At what age:

☐☐ years old

25. Have you ever had heart surgery?

- ○ No → **PLEASE SKIP TO 27**
- ○ Yes

26. Did you have:	No	Yes	If Yes, at what age?
Balloon angioplasty?	○	○ →	☐☐
Coronary artery bypass surgery?	○	○ →	☐☐
Valve repair?	○	○ →	☐☐
Valve replacement?	○	○ →	☐☐
Other heart surgery?	○	○ →	☐☐

Please specify: _____

_____

27. Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, fill in the circle that indicates how much you have been bothered by that problem in the past 4 weeks.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Repeated, disturbing memories, thoughts or images of a stressful experience from the past?	○	○	○	○	○
Repeated, disturbing dreams of a stressful experience from the past?	○	○	○	○	○
Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	○	○	○	○	○
Feeling very upset when something reminded you of a stressful experience from the past?	○	○	○	○	○
Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	○	○	○	○	○
Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	○	○	○	○	○
Avoid activities or situations because they remind you of a stressful experience from the past?	○	○	○	○	○
Trouble remembering important parts of a stressful experience from the past?	○	○	○	○	○
Loss of interest in things that you used to enjoy?	○	○	○	○	○
Feeling distant or cut off from other people?	○	○	○	○	○
Feeling emotionally numb or being unable to have loving feelings for those close to you?	○	○	○	○	○
Feeling as if your future will somehow be cut short?	○	○	○	○	○
Trouble falling or staying asleep?	○	○	○	○	○
Feeling irritable or having angry outbursts?	○	○	○	○	○
Having difficulty concentrating?	○	○	○	○	○
Being "super-alert" or watchful or on guard?	○	○	○	○	○
Feeling jumpy or easily startled?	○	○	○	○	○

28. These questions ask about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the last 4 weeks and answer these questions thinking about how much difficulty you had doing the following activities.

In the last 4 weeks how much difficulty did you have in:	None	Mild	Moderate	Severe	Extreme/Cannot Do
Understanding and communicating					
Concentrating on doing something for ten minutes?	○	○	○	○	○
Remembering to do important things?	○	○	○	○	○
Analyzing and finding solutions to problems in day to day life?	○	○	○	○	○
Learning a new task, for example, learning how to get to a new place?	○	○	○	○	○
Generally understanding what people say?	○	○	○	○	○
Starting and maintaining a conversation?	○	○	○	○	○
Getting around					
Standing for long periods such as 30 minutes?	○	○	○	○	○
Standing up from sitting down?	○	○	○	○	○
Moving around inside your home?	○	○	○	○	○
Getting out of your home?	○	○	○	○	○
Walking a long distance such as a half mile (or equivalent)?	○	○	○	○	○
Self care					
Washing your whole body?	○	○	○	○	○
Getting dressed?	○	○	○	○	○
Eating?	○	○	○	○	○
Staying by yourself for a few days?	○	○	○	○	○
Getting along with people					
Dealing with people you do not know?	○	○	○	○	○
Maintaining a friendship?	○	○	○	○	○
Getting along with people who are close to you?	○	○	○	○	○
Making new friends?	○	○	○	○	○
Sexual activities?	○	○	○	○	○
Life activities					
Taking care of your household responsibilities?	○	○	○	○	○
Doing most important household tasks well?	○	○	○	○	○
Getting all the household work done that you needed to do?	○	○	○	○	○
Getting your household work done as quickly as needed?	○	○	○	○	○

29. Do you work (paid, non-paid, self-employed) or go to school?

- ○ No → **PLEASE SKIP TO 31**
- ○ Yes

	None	Mild	Moderate	Severe	Extreme/Cannot Do
30. In the last 4 weeks, how much difficulty did you have in:					
Your day to day work/school?	○	○	○	○	○
Doing your most important work/school tasks well?	○	○	○	○	○
Getting all the work done that you need to do?	○	○	○	○	○
Getting your work done as quickly as needed?	○	○	○	○	○
Participation in society					
31. In the last 4 weeks:					
How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	○	○	○	○	○
How much of a problem did you have because of barriers or hindrances in the world around you?	○	○	○	○	○
How much of a problem did you have living with dignity because of the attitudes and actions of others?	○	○	○	○	○
How much time did you spend on your health condition, or its consequences?	○	○	○	○	○
How much have you been emotionally affected by your health condition?	○	○	○	○	○
How much has your health been a drain on the financial resources of you or your family?	○	○	○	○	○
How much of a problem did your family have because of your health problems?	○	○	○	○	○
How much of a problem did you have in doing things by yourself for relaxation or pleasure?	○	○	○	○	○

32. In the past 4 weeks, for how many days were you totally unable to carry out your usual activities or work because of any health condition?

☐☐ days

33. In the past 4 weeks, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?

☐☐ days

The following items ask about pain you may have.

34. Please describe your pain during the last week.

	None	Mild	Moderate	Severe
Throbbing	○	○	○	○
Shooting	○	○	○	○
Stabbing	○	○	○	○
Sharp	○	○	○	○
Cramping	○	○	○	○
Gnawing	○	○	○	○
Hot-burning	○	○	○	○
Aching	○	○	○	○
Heavy (like a weight)	○	○	○	○
Tender	○	○	○	○
Splitting	○	○	○	○
Tiring-Exhausting	○	○	○	○
Sickening	○	○	○	○
Fear-causing	○	○	○	○
Punishing-Cruel	○	○	○	○

35. Please fill in the number that best represents how intense your pain has been during the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Possible

36. Please rate your overall pain intensity during the last week.

- ○ No pain
- ○ Mild
- ○ Discomforting
- ○ Distressing
- ○ Horrible
- ○ Excruciating

37. Please indicate how much you agree with the following statements as they apply to you over the past 4 weeks. If a particular situation has not occurred recently, answer according to how you think you would have felt.

	Not at all true	Rarely true	Sometimes true	Often true	True nearly all of the time
I am able to adapt when changes occur	○	○	○	○	○
I can deal with whatever comes my way	○	○	○	○	○
I try to see the humorous side of things when I am faced with problems	○	○	○	○	○
Having to cope with stress can make me stronger	○	○	○	○	○
I tend to bounce back after illness, injury or other hardships	○	○	○	○	○
I believe I can achieve my goals, even if there are obstacles	○	○	○	○	○
Under pressure, I stay focused and think clearly	○	○	○	○	○
I am not easily discouraged by failure	○	○	○	○	○
I think of myself as a strong person when dealing with life's challenges and difficulties	○	○	○	○	○
I am able to handle unpleasant or painful feelings like sadness, fear and anger	○	○	○	○	○

38. Have you ever had a severe head injury that was associated with loss of consciousness or confusion?

- ○ No → **PLEASE SKIP TO 40**
- ○ Yes

39. Did the head injury (or any head injuries) result in your staying overnight in a hospital?

- ○ No
- ○ Yes

40. Have you ever been told by a doctor that you had a concussion?

- ○ No
- ○ Yes

a. If yes: How many times? ☐☐☐

41. Altogether how many different head injuries or concussions have you had?

- ○ None → **PLEASE SKIP TO 45**
- ○ One
- ○ More than one → **PLEASE SKIP TO 43**

42. If you only had <u>one</u> concussion, how old were you when it happened?

☐☐ → **PLEASE SKIP TO 44**

43. If you had <u>more than one</u> concussion:

a. How old were you when you had the <u>first</u> one?

☐☐

b. How old were you when you had the <u>last</u> one?

☐☐

44. Did any of these head injuries or concussions occur while you were on active military duty?

- ○ No
- ○ Yes

Below is a list of problems and complaints that sometimes bother people.

45. Over the <u>last 2 weeks</u> 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
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed or hopeless	○	○	○	○
Trouble falling or staying asleep	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
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	○	○	○	○
Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

46. If you filled in <u>any</u> problems listed in Question 45 above, how <u>difficult</u> 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

Below is a list of problems and complaints that people sometimes experience.

47. In the <u>past 6 months</u>, how frequently have you experienced the following problems?

	Very often	Often	Sometimes	Almost never	Never
Had trouble falling asleep, staying asleep, or sleeping too much	○	○	○	○	○
Had repeated dreams or nightmares about things that happened to you while in the military	○	○	○	○	○
Had painful memories of things that happened to you while in the military	○	○	○	○	○
Avoided activities that might remind you of things that happened to you while in the military	○	○	○	○	○
Found yourself in a situation where you started to feel and act as though a disturbing event you experienced in the military was happening all over again	○	○	○	○	○
Had times when feelings or actions became stronger when you were in situations that reminded you of times in the military	○	○	○	○	○
Felt ashamed or guilty about the kind of things you did to survive while in the military	○	○	○	○	○
Had trouble concentrating	○	○	○	○	○
Had trouble with your memory	○	○	○	○	○
Have been irritable and short-tempered	○	○	○	○	○
Had explosions of angry or aggressive behavior	○	○	○	○	○
Lost interest in your usual daily activities	○	○	○	○	○
Felt distant from everyone, even those people you care about	○	○	○	○	○
Felt that life is not meaningful	○	○	○	○	○
Felt jumpy and easily startled or felt that you had to stay on guard all of the time	○	○	○	○	○

48. People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Someone you can count on to listen to you when you need to talk	○	○	○	○	○
Someone to give you information to help you understand a situation	○	○	○	○	○
Someone to give you good advice about a crisis	○	○	○	○	○
Someone to confide in or talk to about yourself or your problems	○	○	○	○	○
Someone whose advice you really want	○	○	○	○	○
Someone to share your most private worries and fears with	○	○	○	○	○
Someone to turn to for suggestions about how to deal with a personal problem	○	○	○	○	○
Someone who understands your problems	○	○	○	○	○
Someone to help you if you were confined to bed	○	○	○	○	○
Someone to take you to the doctor if you needed it	○	○	○	○	○
Someone to prepare your meals if you were unable to do it yourself	○	○	○	○	○
Someone to help with daily chores if you were sick	○	○	○	○	○
Someone who shows you love and affection	○	○	○	○	○
Someone to love and make you feel wanted	○	○	○	○	○
Someone who hugs you	○	○	○	○	○
Someone to have a good time with	○	○	○	○	○
Someone to get together with for relaxation	○	○	○	○	○
Someone to do something enjoyable with	○	○	○	○	○
Someone to do things with to help you get your mind off things	○	○	○	○	○

The following questions ask about your health and lifestyle.

49. When you are at work, which of the following best describes what you do? Would you say that you are…

- ○ Mostly sitting or standing
- ○ Mostly walking
- ○ Mostly heavy labor or physically demanding work
- ○ I do not work

We are interested in two types of physical activity - vigorous and moderate. Vigorous activities cause large increases in breathing or heart rate while moderate activities cause small increases in breathing or heart rate.

50. Now, thinking about the moderate activities you do in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate?

- ○ No → **PLEASE SKIP TO 53**
- ○ Yes

51. How many days per week do you do these moderate activities for at least 10 minutes? (Please fill in ONLY one)

⓪ ① ② ③ ④ ⑤ ⑥ ⑦

52. On days when you do moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

☐☐ : ☐☐ Hours and minutes per day
(30 minutes would be 00:30)

53. Now, thinking about the vigorous activities you do in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate?

- ○ No → **PLEASE SKIP TO 56**
- ○ Yes

54. How many days per week do you do these vigorous activities for at least 10 minutes at a time? (Please fill in ONLY one)

⓪ ① ② ③ ④ ⑤ ⑥ ⑦

55. On days when you do vigorous activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

☐☐ : ☐☐ Hours and minutes per day
(30 minutes would be 00:30)

In order to get an accurate picture of each twin's general health, everyone is asked to answer the next few questions about smoking and alcoholic beverages.

56. Have you smoked at least 100 cigarettes in your life?

- ○ No → **PLEASE SKIP TO 61**
- ○ Yes

57. Do you smoke cigarettes now?

- ○ No
- ○ Yes → **PLEASE SKIP TO 59**

58. About how long has it been since you last smoked cigarettes regularly?
(If less than 1 year, write in "0")

☐☐ years
OR
- ○ Never smoked regularly → **PLEASE SKIP TO 61**

59. On average, about how many cigarettes a day (do/did) you smoke?

☐☐☐ cigarettes

60. About how old were you when you first started smoking cigarettes regularly?

☐☐ years old

4 0 0 0 0 5

61. Have you had more than 20 alcoholic drinks in your entire life?

- ○ No → **PLEASE SKIP TO 66**
- ○ Yes

62. How old were you when you started drinking alcoholic beverages regularly?

☐☐ years

OR

- ○ Never drank regularly

63. Do you drink alcoholic beverages now?

- ○ No
- ○ Yes → **PLEASE SKIP TO 64**

a. How old were you when you stopped drinking alcoholic beverages?

☐☐ years old → **PLEASE SKIP TO 66**

64. On average, how many days in a week do you drink at least one alcoholic beverage? (If you average less than 1 day a week mark "0". Please fill in ONLY one)

⓪ ① ② ③ ④ ⑤ ⑥ ⑦

In this study, a drink is one can or bottle of beer, or one glass of wine, or one mixed drink, or one shot of hard liquor.

65. On those days when you have an alcoholic beverage, how many drinks do you have, on average?

☐☐ drinks on average day

The following questions ask about sleep habits.

66. On average, how many hours do you sleep per night?

- ○ Less than 3 hours
- ○ Less than 4 hours
- ○ Less than 5 hours
- ○ Less than 6 hours
- ○ Less than 7 hours
- ○ Less than 8 hours
- ○ Less than 9 hours
- ○ Less than 10 hours
- ○ 10 hours or more

67. The following refer to your behavior while sleeping, trying to sleep, or while feeling sleepy. In the past 4 weeks have you had, or have you been told about the following?

	Never	Less than once per week	1-2 times per week	3-4 times per week	5-7 times per week
Loud snoring.....	○	○	○	○	○
Snorting or gasping.....	○	○	○	○	○
Your breathing stops or you struggle for breath.....	○	○	○	○	○

The following questions ask about aspirin use.

68. How often do you take aspirin? (Do not include non-aspirin products such as Tylenol, Motrin, Ibuprofen, etc.)

- ○ Daily
- ○ 3-6 times a week
- ○ 1-2 times a week
- ○ 1-3 times a month
- ○ Less than once a month
- ○ Never

69. What dose of aspirin do you usually take?

- ○ 81 mg (baby aspirin)
- ○ 325 mg
- ○ 500 mg
- ○ 650 mg
- ○ More than 650 mg
- ○ Do not take aspirin
- ○ Don't know

The next questions are about health insurance plans or programs that you currently have, or are covered by.

70. Are you currently covered by any of the following types of health insurance or health coverage plans? (Please fill in ALL that apply)

- ○ Insurance through a current or former employer or union (of yours or another family member)
- ○ Insurance purchased directly from an insurance company (by you or another family member)
- ○ Medicare, for people 65 and older, or people with certain disabilities
- ○ Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability
- ○ VA (including those who have ever used or enrolled for VA health care)
- ○ TRICARE, TRICARE for Life or other military health care
- ○ Indian Health Service
- ○ Any other type of health insurance or health coverage plan → Please specify: _____
- ○ No insurance → **PLEASE SKIP TO 71**

a. Who provides this coverage? (Please fill in ALL that apply)

- ○ Current employer, including COBRA coverage
- ○ Former employer
- ○ Individually purchased coverage
- ○ Federal, State, County, or local community health services program
- ○ Family member, such as a spouse, parent, etc.
- ○ Or from somewhere else? → Please specify: _____

71. Below is a list of health services that you may have used during the <u>past 6 months</u>. Please tell us if you used each service and how you paid for this service.

(Fill in ALL the sources of payment for each service that you used)

Service:	No	Yes	Dept. of Veterans Affairs (VA)	Dept. of Defense	Medicare	Medigap	Medicaid	Other government program	Private insurance	Out of pocket
Example: *If you were overnight in the hospital in the past 6 months, and your care was paid for by private insurance and out of pocket, you would fill in like this:*	○	● →	○	○	○	○	○	○	●	●
Overnight stay in a hospital or medical or surgical care.....	○	○ →	○	○	○	○	○	○	○	○
Outpatient care for doctor visits, urgent care, routine exams, medical tests, or shots.....	○	○ →	○	○	○	○	○	○	○	○
Overnight stay in a hospital for mental health or substance abuse treatment.....	○	○ →	○	○	○	○	○	○	○	○
Outpatient visits for psychological counseling, therapy or mental health, or substance abuse treatment.....	○	○ →	○	○	○	○	○	○	○	○
Prescription medications.....	○	○ →	○	○	○	○	○	○	○	○
Over the counter medications.....	○	○ →	○	○	○	○	○	○	○	○
In-home health care for yourself.....	○	○ →	○	○	○	○	○	○	○	○
Care for any prosthetics or medical equipment, including home oxygen.....	○	○ →	○	○	○	○	○	○	○	○
Care for hearing aids or eye glasses.....	○	○ →	○	○	○	○	○	○	○	○
Overnight stay in a rehabilitation hospital or nursing care facility.....	○	○ →	○	○	○	○	○	○	○	○
Dental care.....	○	○ →	○	○	○	○	○	○	○	○
Emergency Room.....	○	○ →	○	○	○	○	○	○	○	○
Other types of medical treatment.....	○	○ →	○	○	○	○	○	○	○	○
Please specify: _____										

72. Have you ever applied for VA disability compensation benefits?

- ○ No → **PLEASE SKIP TO 74**
- ○ Yes

73. Do you have a VA service-connected disability rating?

- ○ No → **PLEASE SKIP TO 74**
- ○ Yes

a. What is your current service connected disability rating?

- ○ 10%
- ○ 20%
- ○ 30%
- ○ 40%
- ○ 50%
- ○ 60%
- ○ 70%
- ○ 80%
- ○ 90%
- ○ 100%

74. About how tall are you without shoes?

FEET	INCHES	
4	0	6
5	1	7
6	2	8
7	3	9
	4	10
	5	11

75. About how much do you weigh without clothes or shoes?

[ ][ ][ ] pounds

Demographics

76. Are you… ?

- ○ Currently married or living with your partner
- ○ Currently divorced or separated
- ○ Currently widowed
- ○ Never married

77. How many times have you been married?

0 1 2 3 4+

4 or more times

78. What is your ethnic background?

- ○ Spanish, Hispanic or Latino
- ○ Not Spanish, Hispanic or Latino

79. What is your race? (Fill in ALL that apply)

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White

80. What is the highest grade or year of school you have completed and gotten credit for?
(Please fill in ONE HIGHEST Grade or Year)

- ○ Kindergarten
- ○ 1st Grade
- ○ 2nd Grade
- ○ 3rd Grade
- ○ 4th Grade
- ○ 5th Grade
- ○ 6th Grade
- ○ 7th Grade
- ○ 8th Grade
- ○ 9th Grade
- ○ 10th Grade
- ○ 11th Grade
- ○ 12th Grade
- ○ Vocational or technical school after High School
- ○ Some college but no degree
- ○ Two-year college degree (Associates)
- ○ Four-year college degree
- ○ Some graduate school
- ○ Graduate degree or professional degree

81. Are you currently employed?
(Please fill in ALL that apply)

- ○ Working full time
- ○ Working part time
- ○ Retired
- ○ Disabled
- ○ Not working at all

82. During the last week were you…

- ○ Working,(including on vacation or sick leave from work)
- ○ Not working, but looking for work, or
- ○ Not working and not looking for work

83. Do you work at least 35 hours per week for pay?

- ○ No
- ○ Yes

84. How many different employers have you worked for in the last 5 years?

⓪ ① ② ③ ④ ⑤ ⑥ 7+

85. In the last 12 months, did you yourself receive income from:
(Please fill in ALL that apply)

- ○ Wages, salaries, or other employment income, like commissions, bonuses, or tips
- ○ Your own business
- ○ Social Security, including Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)
- ○ VA disability payment
- ○ Any retirement or pension plan
- ○ Unemployment insurance
- ○ Interest and dividends
- ○ Worker's Compensation or Black Lung benefit
- ○ Welfare, or general assistance payments
- ○ No income
- ○ Any other source

86. Which group best describes an estimate of your total combined family income in the last 12 months before taxes and deductions?

- ○ Less than $15,000
- ○ $15,000-$29,999
- ○ $30,000-$49,999
- ○ $50,000-$74,999
- ○ $75,000-$99,999
- ○ $100,000-$149,999
- ○ $150,000 or more

Thank you for taking the time to complete this survey. You will be mailed a $75 check once the survey is received. Please remember that all of the information you provided is confidential.

Please return the completed survey in the enclosed postage-paid envelope to:

Abt SRBI Inc.
55 Wheeler St.
Cambridge, MA 02138

Reminder: Someone from Abt SRBI will be contacting you in a few weeks to invite you to participate in the telephone interview part of the study. You will receive an additional check for **$75** after completing the telephone interview.

Please update your contact information:

FIRST NAME:

LAST NAME:

ADDRESS: APT:

CITY: STATE: ZIP: -

EMAIL ADDRESS:

☐ Cell Phone
☐ Home
☐ Work
( ) -

☐ Cell Phone
☐ Home
☐ Work
( ) -

Please use the table below to write in some convenient times to reach you.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	:	:	:	:	:	:	:
Afternoon	:	:	:	:	:	:	:
Evening	:	:	:	:	:	:	:

Is there anything else you would like to tell us about your health?

Thank you again for your time and participation in this important study.