

Lifetime of Good Health – Feedback Survey

Thank you for taking the time to complete this Participant Feedback Survey for the **Lifetime of Good Health: Your Guide to Staying Healthy (The Guide)**. Please keep in mind that all survey responses are anonymous. Your honest responses will help the Office on Women’s Health improve their current materials and create new materials for women.

Please answer the following questions about the <i>Lifetime of Good Health Guide</i>:			
1. How did you receive a copy of the Guide?	<input type="checkbox"/> Community health fair	<input type="checkbox"/> Internet	<input type="checkbox"/> Doctor
	<input type="checkbox"/> Professional conference or event	<input type="checkbox"/> Class/Workshop	<input type="checkbox"/> Nurse
	<input type="checkbox"/> Peer Counselor	<input type="checkbox"/> Lactation Consultant	
	<input type="checkbox"/> National Women’s Health Information Center		
	<input type="checkbox"/> Other (please specify): _____		
2. How much of the Guide did you read?	<input type="checkbox"/> Little or none	<input type="checkbox"/> Less than half	<input type="checkbox"/> More than half
	<input type="checkbox"/> Almost all or all		
3. Did you like the Guide?	<input type="checkbox"/> No, not at all	<input type="checkbox"/> No, not very much	<input type="checkbox"/> Yes, somewhat
	<input type="checkbox"/> Yes, very much		
4. How attractive was the format or design of the Guide (<i>i.e. color, pictures, font</i>)?	<input type="checkbox"/> Not at all attractive	<input type="checkbox"/> Not very attractive	<input type="checkbox"/> Somewhat attractive
	<input type="checkbox"/> Very attractive		
5. How useful was the Guide?	<input type="checkbox"/> Not at all useful	<input type="checkbox"/> Not very useful	<input type="checkbox"/> Somewhat useful
	<input type="checkbox"/> Very useful		
6. How does the Guide compare to other health information materials you have read?	<input type="checkbox"/> Not as good	<input type="checkbox"/> Better than most	<input type="checkbox"/> About the same
	<input type="checkbox"/> I have not received any other general health information		
7. Would you recommend the Guide to a friend or family member?	<input type="checkbox"/> No, definitely not	<input type="checkbox"/> No, probably not	<input type="checkbox"/> Yes, probably
	<input type="checkbox"/> Yes, definitely		
8. I chose to read the Guide because (<i>check all that apply</i>):	<input type="checkbox"/> I had specific health questions		
	<input type="checkbox"/> I wanted to learn more about my health in general		
	<input type="checkbox"/> A health care provider recommended it		
	<input type="checkbox"/> A friend or family member recommended it		
	<input type="checkbox"/> Other: _____		

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0990**. The time required to complete this information collection is estimated to average (hours) (minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/ocio/PRA, 200 Independence Ave., S.W., Suite 531-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer. Alice Bettencourt

Please circle the answer to the questions below that best matches how much you agree or disagree with the following statements? When responding to each item, use a scale from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*).

AS A RESULT OF reading the <i>Lifetime of Good Health Guide</i>...	Strongly Disagree	Disagree	Agree	Strongly Agree
9. I have thought more about my health in general.	1	2	3	4
10. I have a greater understanding of the importance of my health.	1	2	3	4
11. I plan to learn more about my health.	1	2	3	4
12. I feel more confident in my ability to lead a healthy life.	1	2	3	4
13. I have a better understanding of where I can get health information.	1	2	3	4

Please answer the questions below thinking about what you knew or felt AS A RESULT OF reading the Guide. When responding to each item, use a scale from 1 (*No, not at all*) to 4 (*Yes, definitely*).

AS A RESULT OF Reading the Guide?	No, Not At All			Yes, Definitely
	1	2	3	4
14. I felt motivated to take new steps to improve my health.	1	2	3	4
15. I felt motivated to talk to my doctor.	1	2	3	4
16. I felt motivated to get regular screening tests and immunizations.	1	2	3	4
17. I got regular screening tests and immunizations.	1	2	3	4
18. I knew my family health history.	1	2	3	4

Circle your response to the following questions.

AS A RESULT OF reading the Guide...	No	Yes
19. Do you plan to make an appointment to see a health care provider?	No	Yes
20. Do you plan to get any screening tests or immunizations?	No	Yes
21. Do you plan to contact Medicare directly by phone?	No	Yes
22. Do you plan to review the Medicare website?	No	Yes

On a scale of 1 (*No, not at all*) to 6 (*Yes, Definitely*), how much do you agree or disagree with the following statements?

	No, Not at all		Yes, Definitely	
	1	2	3	4
23. The steps provided in the Guide were easy to follow.	1	2	3	4
24. I was able to find information quickly.	1	2	3	4
25. I used the Guide to make healthy choices for myself.	1	2	3	4

Please answer the following questions about the specific sections in the *Lifetime of Good Health* Guide. If you place a check (✓) in Column A, please answer the questions in Columns B and C. If you do NOT place a check (✓) in Column A, please move on to the next Section.

Sections	A. Check (✓) the box if you read this section in the Guide	B. How much <u>new</u> information did you learn from reading this section?				C. After you read this section, did you <u>start</u> taking any of the recommended “Steps You Can Take”?	
		Nothing At All		A lot		No	Yes
		1	2	3	4		
26. Healthy Heart & Stroke Prevention	<input type="checkbox"/>	1	2	3	4	No	Yes
27. Healthy Bones	<input type="checkbox"/>	1	2	3	4	No	Yes
28. Breast Cancer Early Detection	<input type="checkbox"/>	1	2	3	4	No	Yes
29. Healthy Pregnancy	<input type="checkbox"/>	1	2	3	4	No	Yes
30. Breastfeeding	<input type="checkbox"/>	1	2	3	4	No	Yes
31. Stress	<input type="checkbox"/>	1	2	3	4	No	Yes
32. Menopause	<input type="checkbox"/>	1	2	3	4	No	Yes
33. Reproductive Health	<input type="checkbox"/>	1	2	3	4	No	Yes
34. Cervical Health	<input type="checkbox"/>	1	2	3	4	No	Yes
35. Healthy Eyes and Ears	<input type="checkbox"/>	1	2	3	4	No	Yes
36. Colorectal Health	<input type="checkbox"/>	1	2	3	4	No	Yes
37. Healthy Lungs	<input type="checkbox"/>	1	2	3	4	No	Yes
38. Healthy Smile	<input type="checkbox"/>	1	2	3	4	No	Yes
39. Healthy Skin	<input type="checkbox"/>	1	2	3	4	No	Yes
40. Urinary Tract Health	<input type="checkbox"/>	1	2	3	4	No	Yes
41. Violence in Your Life	<input type="checkbox"/>	1	2	3	4	No	Yes
42. Healthy Weight	<input type="checkbox"/>	1	2	3	4	No	Yes
43. Diabetes	<input type="checkbox"/>	1	2	3	4	No	Yes

Additional Comments
44. Please provide additional comments about the Lifetime of Good Health Guide below.

Please answer the following questions about yourself.	
A. How often do you get a physical examination from a health care provider?	
<input type="checkbox"/> More than once each year	<input type="checkbox"/> Every 4-5 years
<input type="checkbox"/> Once a year	<input type="checkbox"/> I do not regularly visit a doctor
<input type="checkbox"/> Every 2-3 years	
B. How often do you get a pap smear? [A pap smear is a test given by a gynecologist or obstetrician to screen for cervical cancer]	
<input type="checkbox"/> Once a year	<input type="checkbox"/> Every 4-5 years
<input type="checkbox"/> Every 2-3 years	<input type="checkbox"/> I do not regularly get a pap smear
C. How often do you perform a breast self-examination?	
<input type="checkbox"/> Once a month or more	<input type="checkbox"/> Once a year or less
<input type="checkbox"/> A few times a year	<input type="checkbox"/> I do not perform breast self-examinations
D. Please describe your marital status (check ALL that apply):	
<input type="checkbox"/> Single	<input type="checkbox"/> Separated or divorced
<input type="checkbox"/> In a relationship	<input type="checkbox"/> Widowed
<input type="checkbox"/> Married	<input type="checkbox"/> Other (please specify): _____
E. Please check ALL of the following that apply:	
<input type="checkbox"/> I have never been pregnant	<input type="checkbox"/> I am the mother of a baby <i>younger</i> than 1 yr. old
<input type="checkbox"/> I plan to get pregnant within the next six months	<input type="checkbox"/> I am the mother of a child <i>older</i> than 1 yr. old
<input type="checkbox"/> I am currently pregnant	<input type="checkbox"/> None of the above
F. How many children do you have?	
<input type="checkbox"/> 0	<input type="checkbox"/> 2
<input type="checkbox"/> 1	<input type="checkbox"/> 3
	<input type="checkbox"/> 4
	<input type="checkbox"/> 5 or more
G. How old are you?	
<input type="checkbox"/> Under 18 yrs	<input type="checkbox"/> 25-29 yrs
<input type="checkbox"/> 18-24 yrs	<input type="checkbox"/> 30-39 yrs
	<input type="checkbox"/> 40-49 yrs
	<input type="checkbox"/> 50-59 yrs
	<input type="checkbox"/> 60-69 yrs
	<input type="checkbox"/> 70+ yrs
I. What is your race? (Check ALL that apply.)	J. What is the highest level of education that you have completed?
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Part of high school
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> High school graduate / GED
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Part of college / university
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> College / university graduate
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Graduate school
<input type="checkbox"/> Asian	

K. For how much of this past year have you had health insurance? <input type="checkbox"/> I have had health insurance for <i>the entire year</i> . <input type="checkbox"/> I have had health insurance for <i>part of the year</i> . <input type="checkbox"/> I did <i>NOT</i> have any health insurance <i>during the past year</i> .		
M. In what city and state do you live?		
_____	_____	
City	State	
N. Are you?		
Female	Male	
O. Are you a health care provider or health educator?		
No	Yes	

Thank you for taking the time to complete this survey.