Form Approved
OMB No. 0990-XXXX
Exp. 07-XX-2008

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 *Lifetime of Good Health* Guide:

1. How did you receive a copy of The Guide?
   - ☐ Community health fair ☐ Internet ☐ Doctor ☐ Nurse
   - ☐ Professional conference or event ☐ Class/Workshop ☐ Lactation Consultant
   - ☐ Peer Counselor ☐ National Women's Health Information Center
   - ☐ Other (please specify):______________________________

2. How much of The Guide did you read?
   - ☐ Little or none ☐ Less than half ☐ More than half ☐ Almost all or all

3. Did you like The Guide?
   - ☐ No, not at all ☐ No, not very much ☐ Yes, somewhat ☐ Yes, very much

4. How attractive was the format or design of The Guide *(i.e. color, pictures, font)*?
   - ☐ Not at all attractive ☐ Not very attractive ☐ Somewhat attractive ☐ Very attractive

5. How useful was The Guide?
   - ☐ Not at all useful ☐ Not very useful ☐ Somewhat useful ☐ Very useful

6. How does The Guide compare to other health information materials you have read?
   - ☐ Not as good ☐ Better than most ☐ About the same
   - ☐ I have not received any other general health information

7. Would you recommend The Guide to a friend or family member?
   - ☐ No, definitely not ☐ No, probably not ☐ Yes, probably ☐ Yes, definitely

8. I chose to read The Guide because *(check all that apply)*:
   - ☐ I had specific health questions
   - ☐ I wanted to learn more about my health in general
   - ☐ A health care provider recommended it
   - ☐ A friend or family member recommended it
   - ☐ 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

Prepared by Shattuck & Associates, Inc. 10/25/2007

Please circle the answer to the questions below that best matches your response. When responding to each item, use a scale from 1 *(No, Not At All)* to 4 *(Yes, Definitely)*.				
Did The Guide encourage you to…	**No, Not At All** **1**	**2**	**3**	**Yes, Definitely** **4**
9. Think more about your health in general.	1	2	3	4
10. Understand better the importance of your health.	1	2	3	4
11. Learn more about your health.	1	2	3	4
12. Feel more confident in your ability to lead a healthy life.	1	2	3	4
13. Have a better understanding of where you can get health information.	1	2	3	4
14. Take new steps to improve your health.	1	2	3	4
15. Talk to your doctor.	1	2	3	4
16. Get regular screening tests and immunizations.	1	2	3	4
17. Learn about your family health history.	1	2	3	4

Circle your response to the following questions.		
Did The Guide encourage you to …	**No**	**Yes**
18. Make an appointment to see a health care provider in the next three months?	No	Yes
19. Get any screening tests or immunizations in the next three months?	No	Yes
20. Contact Medicare by phone in the next three months?	No	Yes
21. Review the Medicare website in the next three months?	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**
22. The steps provided in The Guide were easy to follow.	1	2	3	4
23. I was able to find information quickly.	1	2	3	4
24. 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 new information did you learn from reading this section?**				**C. After you read this section, did you start taking any of the recommended *"Steps You Can Take"*?**	
		Nothing At All			**A lot**		
		1	**2**	**3**	**4**	**No**	**Yes**
25. Healthy Heart & Stroke Prevention	☐	1	2	3	4	No	Yes
26. Healthy Bones	☐	1	2	3	4	No	Yes
27. Breast Cancer Early Detection	☐	1	2	3	4	No	Yes
28. Healthy Pregnancy	☐	1	2	3	4	No	Yes
29. Breastfeeding	☐	1	2	3	4	No	Yes
30. Stress	☐	1	2	3	4	No	Yes
31. Menopause	☐	1	2	3	4	No	Yes
32. Reproductive Health	☐	1	2	3	4	No	Yes
33. Cervical Health	☐	1	2	3	4	No	Yes
34. Healthy Eyes and Ears	☐	1	2	3	4	No	Yes
35. Colorectal Health	☐	1	2	3	4	No	Yes
36. Healthy Lungs	☐	1	2	3	4	No	Yes
37. Healthy Smile	☐	1	2	3	4	No	Yes
38. Healthy Skin	☐	1	2	3	4	No	Yes
39. Urinary Tract Health	☐	1	2	3	4	No	Yes
40. Violence in Your Life	☐	1	2	3	4	No	Yes
41. Healthy Weight	☐	1	2	3	4	No	Yes
42. Diabetes	☐	1	2	3	4	No	Yes

Additional Comments

43. 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?

- ☐ More than once each year
- ☐ Once a year
- ☐ Every 2-3 years
- ☐ Every 4-5 years
- ☐ I do not regularly visit a doctor

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]*

- ☐ Once a year
- ☐ Every 2-3 years
- ☐ Every 4-5 years
- ☐ I do not regularly get a pap smear

C. How often do you perform a breast self-examination?

- ☐ Once a month or more
- ☐ A few times a year
- ☐ Once a year or less
- ☐ I do not perform breast self-examinations

D. Please describe your marital status *(check ALL that apply)*:

- ☐ Single
- ☐ In a relationship
- ☐ Married
- ☐ Separated or divorced
- ☐ Widowed
- ☐ Other (please specify):__________________________________

E. Please check ALL of the following that apply:

- ☐ I have never been pregnant
- ☐ I plan to get pregnant within the next six months
- ☐ I am currently pregnant
- ☐ I am the mother of a baby *younger* than 1 yr. old
- ☐ I am the mother of a child *older* than 1 yr. old
- ☐ None of the above

F. How many children do you have?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 or more

G. How old are you?

- ☐ Under 18 yrs
- ☐ 18–24 yrs
- ☐ 25-29 yrs
- ☐ 30-39 yrs
- ☐ 40-49 yrs
- ☐ 50-59 yrs
- ☐ 60-69 yrs
- ☐ 70+ yrs

H. Are you Hispanic or Latino?

- ❑ **Yes**
- ❑ **No**

I. What is your race? *(Check ALL that apply.)*

- ☐ Black/African American
- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Asian

J. What is the highest level of education that you have completed?

- ☐ Part of high school
- ☐ High school graduate / GED
- ☐ Part of college / university
- ☐ College / university graduate
- ☐ Graduate school

K. For how much of this past year have you had health insurance?

- ☐ I have had health insurance for ***the entire year.***
- ☐ I have had health insurance for ***part of the year.***
- ☐ I did *NOT* have any health insurance ***during the past year.***

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.