OMB Number 2900-XXXX
Estimated burden: 30-45 minutes

HEALTH SURVEILLANCE FOR A NEW GENERATION OF U.S. VETERANS

QUESTIONNAIRE

Sponsored by
U.S. Department of Veterans Affairs

PRIVACY ACT STATEMENT

The information requested on this survey is solicited under authority of 38 U.S.C. Section 7303. It is being collected to assist VA in learning more about the health of recent veterans and will help VA to provide better medical care. The information you supply will be confidential and protected by the provisions of the Privacy Act of 1974 (5 U.S.C. 552a) and specifically the VA system of records entitled 34VA12, "Veteran, Patient, Employee and Volunteer Research and Development Project Records – VA." Releases of the information may only be made with your consent or as identified in a "routine use" of the system of records. Routine uses include releases of statistical data and non-identifying data for research and associated administrative purposes. Disclosure is voluntary; failure to furnish the requested information will have no adverse effect on any VA benefit to which you may be entitled.

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HEALTH SURVEILLANCE FOR A NEW GENERATION OF U.S. VETERANS

1. Please check all locations in which you served in the past 5 years prior to separation from active duty:

O Afghanistan	**O SW Asia - Other**	**O North America**
O Iraq	**O Bosnia/Kosovo**	**O Central America**
O Kuwait	**O Europe**	**O South America**
O Qatar	**O Africa**	**O On a ship**
O Turkey		**O Other _____**

2. Please check your total number of deployments in the past 5 years prior to separation from active duty:

Operation Iraqi Freedom	**Operation Enduring Freedom**	**Other _____**
O 1	**O 1**	**O 1 Name of operation of your most recent deployment**
O 2	**O 2**	**O 2**
O 3	**O 3**	**O 3**
O 4	**O 4**	**O 4**
O 5 or more	**O 5 or more**	**O 5 or more**

3. In what component(s) have you served? (*Check all that apply*.)

- **O Active Duty**
- **O Reserve**
- **O National Guard**

4. What branch(es) did you serve with? (*Check all that apply*.)

- **O Air Force**
- **O Army**
- **O Coast Guard**
- **O Marine Corps**
- **O Navy**

5. What was your most recent job in the military?_____

6a. Did you serve in Afghanistan or neighboring countries in support of Operation Enduring Freedom or in Iraq or elsewhere in the Persian Gulf in support of Operation Iraqi Freedom?

O No IF NO, continue to question #7.
O Yes

6b. IF YES, what was your period of last deployment:

From ____/____/____ to ____/____/____
Month Day Year Month Day Year

7. What were you doing most of the <u>past 12 months</u>?

- **O Working outside the home**
- **O Looking for work and unemployed**
- **O On active duty**
- **O Student**
- **O Homemaker/Caring for family**
- **O Retired**
- **O On disability/Unable to work**
- **O Own small business**
- **O Other*(Please specify:_____)***

8. Have you received a letter from the VA secretary or other VA office informing you of programs and benefits that you may be entitled to through VA?

O No O Yes O Don't remember

9. Do you belong to a Veterans Group(s) such as Veterans of Foreign Wars of the Untied States (VFW) or The American Legion?

O No O Yes

IF YES, which one(s)?

_____

10a. During the <u>past 12 months</u> how many clinic or doctor visits have you made because you had a health problem? (exclude routine visits for vaccinations, physical examinations, etc.)

O None No. of visits _____

10b. Please explain reasons for visit or diagnoses.

1._____
2._____
3._____
4._____

11a. During the <u>past 12 months</u> how many times have you been hospitalized overnight or longer?

O None No. of hospitalizations _____

11b. Please explain reasons for hospitalization or diagnoses.

1._____
2._____
3._____
4._____

12. What health care coverage do you have (*check all that apply*):

- **O Department of Defense's TRICARE**
- **O Private insurance**
- **O Medicaid**
- **O Other individual or group plan**
- **O VA**
- **O Medicare**
- **O None**

13a. Have you used VA health care services since you were separated from active duty?

O No O Yes IF YES, continue to question #14.

13b. IF NO, why? (Answer and then skip to question #16.)

- **O I prefer to use other health care coverage**
- **O I do not wish to use VA health care services because of concerns about quality of care**
- **O I do not know if I am eligible**
- **O VA health care services are not in a convenient location for me**
- **O Other (*Please specify*: _____)**

14. What are the main reasons you enrolled? (*Check all that apply*.)

- O **To obtain regular or routine health care;**
- O **To obtain specialist healthcare;**
- O **To obtain dental care;**
- O **To obtain prescription medications, eye glasses, hearing aids, or other devices;**
- O **To obtain mental health care;**
- O **To obtain special emphasis care such as for a spinal cord injury, traumatic brain injury, blind rehabilitation, prosthetics, etc.;**
- O **To receive nursing home care;**
- O **To obtain home health care**

15. All things considered, how satisfied are you with your health care in VA?

- O **Completely satisfied**
- O **Very satisfied**
- O **Somewhat satisfied**
- O **Neither satisfied nor dissatisfied**
- O **Somewhat dissatisfied**
- O **Very dissatisfied**
- O **Completely dissatisfied**

16. About how tall are you without shoes? _____(feet) _____(inches)

17. About how much do you weigh without shoes? _____ (pounds)
***If currently pregnant, please give your usual weight before becoming pregnant**

18. In general, would you say your health is:
O Excellent O Very good O Good O Fair O Poor

19a. Has your doctor <u>ever</u> told you that you have any of the following conditions?	**NO**	**YES**	**19b. If yes, in what year were you first diagnosed?** **YEAR**
1. Arthritis of any kind	☐	☐	_____
2. Skin cancer	☐	☐	_____
3. Any other cancer (specify type:_____)	☐	☐	_____
4. Cirrhosis of the liver	☐	☐	_____
5. Hepatitis	☐	☐	_____
6. Any other liver trouble	☐	☐	_____
7. Irritable bowel syndrome or colitis (irritation of the colon)	☐	☐	_____
8. Diabetes	☐	☐	_____
9. Repeated seizures, convulsions, or blackouts	☐	☐	_____

19a. Has your doctor <u>ever</u> told you that you have any of the following conditions?	NO	YES	19b. If yes, in what year were you first diagnosed? Year
10. Migraines	☐	☐	_____
11. Coronary heart disease or artery disease	☐	☐	_____
12. Hypertension	☐	☐	_____
13. Stroke	☐	☐	_____
14. Sinusitis	☐	☐	_____
15. Bronchitis	☐	☐	_____
16. Asthma	☐	☐	_____
17. Frequent bladder infections	☐	☐	_____
18. Significant hearing loss	☐	☐	_____
19. Multiple sclerosis	☐	☐	_____
20. Chronic Fatigue Syndrome	☐	☐	_____
21. Posttraumatic Stress Disorder	☐	☐	_____
22. Depression	☐	☐	_____
23. Sleep apnea	☐	☐	_____
24. Traumatic Brain Injury	☐	☐	_____

20a. Did you experience any of the following events while serving in the military? (*Check all that apply*.) **20b. <u>Number of times</u>**

- o **Blast or Explosion (IEF, RPG, Land Mine, Grenade, etc.)** ____
- o **Motor vehicle, aircraft, or water transportation accident** ____
- o **Fragment wound or bullet wound above the shoulders** ____
- o **Fall** ____
- o **Injury from sports/physical training** ____
- o **Other injury (*Please specify:* _____)** ____
- o **No, none of the above (Skip to question #24)**

21. Did you have any of these IMMEDIATELY afterwards?
(*Check all that apply.*)
O Losing consciousness/ "knocked out" IF YES: About how long were you unconscious? ___ min.
O Being dazed, confused, or "seeing stars"
O Not remembering the event
O Concussion
O Head injury
O No, none of the above (Skip to question #24)

22. Did any of the following problems begin or get worse afterwards?
(*Check all that apply*.)
O Memory problems or lapses
O Balance problems or dizziness
O Sensitivity to bright light
O Irritability
O Headaches
O Sleep problems
O Hearing problems
O Other problems (*Please specify:_____)*
O No, none of the above (Skip to question #24)

23. In the past week, have you had any of the following symptoms?
(*Check all that apply*.)
O Memory problems or lapses
O Balance problems or dizziness
O Sensitivity to bright light
O Irritability
O Headaches
O Sleep problems
O Trouble concentrating
O Hearing problems
O None of the above

24a. Has your doctor <u>ever</u> told you that you had a head injury?
O No O Yes (IF NO, continue to question #25)

24b. Have you received treatment from a doctor or other health professional for a head injury?
O No O Yes (IF NO, continue to question # 25)

24c. Has this treatment been helpful?
O No O Yes

24d. Were you prescribed medicine?
O No O Yes (*Please specify:_____*)

25. This question contains a list of comments made by people after stressful life events. Please read each item and mark how frequently these comments were true for you <u>DURING THE PAST 4 WEEKS.</u> If it did not occur during the past 4 weeks, please mark the "not at all" column.

25. In the past 4 weeks, have you had … ?	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Repeated, disturbing memories of stressful experiences from the past.	☐	☐	☐	☐	☐
2. Repeated, disturbing dreams of stressful experiences from the past.	☐	☐	☐	☐	☐
3. Suddenly acting or feeling as if stressful experiences were happening again.	☐	☐	☐	☐	☐
4. Feeling very upset when something happened that reminds you of stressful experiences from the past.	☐	☐	☐	☐	☐
5. Trouble remembering important parts of stressful experiences from the past.	☐	☐	☐	☐	☐
6. Loss of interest in activities that you used to enjoy.	☐	☐	☐	☐	☐
7. Feeling distant or cut off from other people.	☐	☐	☐	☐	☐
8. Feeling emotionally numb, or being unable to have loving feelings for those close to you.	☐	☐	☐	☐	☐
9. Feeling as if your future will somehow be cut short.	☐	☐	☐	☐	☐
10. Trouble falling asleep or staying asleep.	☐	☐	☐	☐	☐
11. Feeling irritable or having angry outbursts.	☐	☐	☐	☐	☐
12. Having difficulty concentrating.	☐	☐	☐	☐	☐
13. Being "super-alert," or watchful or on guard.	☐	☐	☐	☐	☐
14. Feeling jumpy or easily startled.	☐	☐	☐	☐	☐
15. Having physical reactions when something reminds you of stressful experiences from the past.	☐	☐	☐	☐	☐
16. Avoid thinking about your stressful experiences from the past, or avoid having feelings about them.	☐	☐	☐	☐	☐
17. Avoid activities or situations because they remind you of stressful experiences from the past.	☐	☐	☐	☐	☐

26. If you have any of the symptoms listed above, do you think they are related to your military experiences, other traumatic events in your life, or both?
O Military experiences only
O Other traumatic life events only
O Both
O Don't know

27. Over the <u>past 4 weeks</u>, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**
1. Feeling nervous, anxious, on edge, or worrying a lot about different things **If you checked "Not at all", go to question #28.**	☐	☐	☐
2. Feeling restless so that it is hard to sit still	☐	☐	☐
3. Getting tired very easily	☐	☐	☐
4. Muscle tension, aches, or soreness	☐	☐	☐
5. Trouble falling asleep or staying asleep	☐	☐	☐
6. Trouble concentrating on things, such as reading a book or watching TV	☐	☐	☐
7. Becoming easily annoyed or irritable	☐	☐	☐

28. Over the <u>past 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**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. 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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

29. Have you taken a prescribed medication for a physical or psychological/emotional condition in the past year?
O No O Yes

IF YES, specify name(s) of medication(s)

_____
_____
_____
_____

30. Since return from your deployment, have you had serious conflicts with your spouse, family members, or close friends that continue to cause you worry or concern?
O No O Yes O Unsure

31. How often do you get into arguments with others at work?
O Very Often O Often O Sometimes O Rarely O Never

32. 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
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
b. Climbing several flights of stairs			

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

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like					
b. Were limited in the kind of work or other activities					

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

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like					
b. Did work or other activities less carefully than usual					

35. 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	Some of the time	A little of the time	None of the time
a. have you felt calm and peaceful?					
b. did you have a lot of energy?					
c. have you felt downhearted and depressed?					

36. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?
O All of the time O Most of the time O Some of the time O A little of the time O None of the time

37. While you were deployed, do you believe you were exposed to or did you experience any of the following?

	No	Yes
1. Dust and sand	O	O
2. Burning trash/feces	O	O
3. Diesel, kerosene and/or other petrochemical fumes	O	O
4. Skin exposure to JP8, diesel, or other petrochemical fuel	O	O
5. Smoke from oil fires	O	O
6. Solvents or degreasers	O	O
7. Paint operations (vehicles or equipment)	O	O
8. Insect repellant (spray, lotion, or cream applied to your skin)	O	O
9. Pesticide-treated uniforms	O	O
10. Depleted uranium (DU) (handling DU munitions)	O	O
11. Ate local food other than provided by Armed Forces	O	O
12. Contact with Prisoners of War (POWs)	O	O
13. Exposure to Loud Noises	O	O
14. Radiation	O	O
15. Industrial pollution	O	O
16. Other exposure which you consider harmful (*Please describe.*) _____	O	O

38. During any of your deployments, were you wounded or injured by hostile actions?
O No O Yes

39. Did you see anyone wounded, killed or dead during any deployment? (*Check all that apply*.)
O No O Yes – coalition O Yes – enemy O Yes- civilian

40. Were you engaged in direct combat where you discharged your weapon?
O No O Yes (O land O sea O air)

41. During any of your deployments, did you ever feel that you were in great danger of being killed?
O No O Yes

42. When you were in the military, did you ever receive uninvited or unwanted sexual attention (i.e., touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc…)?
O No O Yes

43. When you were in the military, did anyone ever use force or the threat of force to have sex with you against your will?
O No O Yes

44. Did you ever contract a sexually transmitted disease as a result of military sexual trauma?
O No O Yes

45. Did you receive any of the following vaccinations just before or during deployment?

	No	Yes
1. Smallpox (leaves a scar on the arm)	**O**	**O**
2. Anthrax series	**O**	**O**
3. Rabies	**O**	**O**

46a. Did you take medications to prevent malaria?
O No O Yes

46b. If YES, please indicate which medicines you took and whether you took them as directed.
(*Mark all that apply)*

Anti-malarial medications	Took as Directed	
O Chloroquine (Aralen®)	**O No**	**O Yes**
O Doxycycline (Vibramycin®)	**O No**	**O Yes**
O Mefloquine (Larium®)	**O No**	**O Yes**
O Primaquine	**O No**	**O Yes**
O Other:_____	**O No**	**O Yes**

47a. Have you smoked cigarettes in the <u>past 12 months?</u>
O No O Yes →IF YES, 47b. How many cigarettes do you smoke per day? _____

47c. How old were you when you first started smoking?
_____
(AGE)

IF NO, 47d. Have you ever smoked cigarettes even occasionally?

O No O Yes → IF YES, 47e. When did you last stop? **_____**
(YEAR)

48. How often do you have a drink containing alcohol?
O Never O Monthly or less O 2 to 4 times a month O 2 to 3 times a week O 4 or more times a week

49. How many drinks containing alcohol do you have on a typical day when you are drinking?
O 1 or 2 O 3 or 4 O 5 or 6 O 7 to 9 O 10 or more

50. How often do you have 5 or more drinks on one occasion?
O Never O Less than monthly O Monthly O Weekly O Daily or almost daily

51. Have any of the following happened to you more than once in the past 6 months?	NO	YES
1. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health	☐	☐
2. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities	☐	☐
3. You missed or were late for work, school, or other activities because you were drinking or hung over	☐	☐
4. You had a problem getting along with other people while you were drinking	☐	☐
5. You drove a car after having several drinks or after drinking too much	☐	☐

52. How often do you use seat belts when you drive or ride in a car?
O Always O Nearly always O Sometimes O Seldom O Never
O Don't know / Not sure O Never drive or ride in a car

53. During the past 4 weeks, how many times did you ride with a driver who had perhaps too much to drink?
____ Number of times
O None
O Don't know / Not sure

54. Do you ride a motorcycle?
O No O Yes

55. Do you usually drive:
O 20 miles per hour or more over the speed limit
O about 15 miles per hour over the speed limit
O about 10 miles per hour over the speed limit
O about 5 miles per hour over the speed limit
O at or below the speed limit.

56. Have you been in a vehicle crash while in the United States during the past 3 years?
O No
O Yes
O Don't know

57. For Operation Iraqi Freedom/Operation Enduring Freedom veterans: If you answered yes to the previous question, did any of these crashes occur after you came back from deployment?
O No O Yes
How many?_____

58. Were you driving or was someone else driving during your most recent crash?
O I was driving
O Someone else

59. Within the past 3 years, have you:	NO	YES
1. Gotten a ticket for speeding	☐	☐
2. Gotten a warning for speeding	☐	☐
3. Gotten a ticket for any other moving violation (such as running a red light or stop sign)	☐	☐
4. Been convicted of DWI or DUI	☐	☐
5. Had your car insurance canceled or premiums increased as a result of claims or points	☐	☐

60. Not including blood donations, in what month and year was your last HIV test?
____(Month)_____(Year)
O Don't know or Not sure
O Never tested

61. During the past 12 months, how many people have you had sex with?
O None
O One
O More than one (give number_____)

62. Have you been treated for a sexually transmitted disease or venereal disease in the past 12 months (for example, gonorrhea, syphilis, herpes, chlamydia, etc.)?
O No
O Yes

63a. In the past 12 months, have you had sex with someone who is not your main partner or whom you do not consider to be your main partner?
O No
O Yes

63b. If "Yes," thinking back to the last time you had sex with that person, was a condom used?
O No
O Yes

64. Have you ever tried for a period of 12 months or longer for you or your partner to become pregnant?
O No (Skip to question #67)
O Yes (Continue with question #65)

65a. Did you or your partner eventually get pregnant or did you stop trying?
O Got pregnant O Stopped trying

65b. Did your partner with the pregnancy serve in Operation Iraqi Freedom or Operation Enduring Freedom?
O No O Yes

65c. Did you seek any medical help while trying?
O No (Skip to question #67)
O Yes (Continue with question #66)

66. Did the medical provider find any of the following reasons to explain why you or your partner were having difficulty getting pregnant?

O Problems with ovulation
O Blocked tubes
O Endometriosis
O Semen or sperm problems
O Other (*Please specify.*)_____
O No reason found

67a. FOR WOMEN: Have you ever been pregnant?

O No (Skip to question #69)
O Yes (Continue with question #68)

67b. FOR MEN: Have you ever been the biological father in any pregnancy, regardless of whether there was a live birth outcome from that pregnancy?

O No (Skip to question #69)
O Yes (Continue with question #68)

68) Please provide information on all of your or your partner's(s') pregnancies. For multiple birth outcomes, make a separate entry for each (e.g., 2 entries for twins). If you are uncertain about a detail, please provide your best estimate:

Pregnancy	Outcome	Date of Pregnancy Outcome	Birth Weight (If live birth)	Length of pregnancy	Birth Defects	Medical Conditions and Health Habits During Pregnancy	Did your partner serve in OIF or OEF?
1	O Single Live Birth O Multiple births (please fill out one row for each) O Miscarriage O Abortion O Stillbirth O Ectopic or tubal O Molar pregnancy O Other: _____	___/___/_____ MM DD Year	___lbs _____oz O Not applicable	Months _____ or Weeks_____	O No O Yes (please describe): _____ _____ _____ O Not applicable	O Diabetes O High blood pressure O Premature labor O Maternal smoking O Maternal drinking O Infection(s) O Prenatal care	O No O Yes
2	O Single Live Birth O Multiple births (please fill out one row for each) O Miscarriage O Abortion O Stillbirth O Ectopic or tubal O Molar pregnancy O Other: _____	___/___/_____ MM DD Year	___lbs _____oz O Not applicable	Months _____ or Weeks_____	O No O Yes (please describe): _____ _____ _____ O Not applicable	O Diabetes O High blood pressure O Premature labor O Maternal smoking O Maternal drinking O Infection(s) O Prenatal care	O No O Yes
3	O Single Live Birth O Multiple births (please fill out one row for each) O Miscarriage O Abortion O Stillbirth O Ectopic or tubal O Molar pregnancy O Other: _____	___/___/_____ MM DD Year	___lbs _____oz O Not applicable	Months _____ or Weeks_____	O No O Yes (please describe): _____ _____ _____ O Not applicable	O Diabetes O High blood pressure O Premature labor O Maternal smoking O Maternal drinking O Infection(s) O Prenatal care	O No O Yes

69. For women only: If any of these pregnancies were the result of military sexual trauma, please specify: _____

70.) For women only: What forms of contraception have you used before, during, and after your service in the military? Check all that apply:

	Before the military	On active duty	After separation from active duty
Birth control pills	☐	☐	☐
Birth control ring	☐	☐	☐
Birth control patch	☐	☐	☐
Condom	☐	☐	☐
Tubal ligation	☐	☐	☐
Partner's vasectomy	☐	☐	☐
Withdrawal	☐	☐	☐
Depo-Provera	☐	☐	☐
Calendar method	☐	☐	☐
Diaphragm or cervical cap	☐	☐	☐
IUD	☐	☐	☐
"Morning after" pills	☐	☐	☐
Foam/jelly	☐	☐	☐
Progestin implant	☐	☐	☐
None	☐	☐	☐
Not sexually active	☐	☐	☐
Other: (please specify) _____	☐	☐	☐

71. While on active duty, was it easy for you to get contraception if desired?

O No

O Yes

72a. While on active duty, did you use any hormonal methods to stop or control your period?
O No O Yes (*please specify*):_____(skip to question 72d.)

72b. Were you offered a hormonal method to stop or control your period by a health care provider?
O No O Yes (skip to question 72d.)

72c. Would you have preferred to have a hormonal method to stop or control your period?
O No O Yes

72d. Did you have access to sanitary supplies (i.e., pads, tampons) if needed?
O No O Yes

72e. Are you currently using a hormonal method to stop or control your period?
O No O Yes (*please specify*):_____

73. Have you experienced any of the following problems before, during, or after active duty? Check all that apply:

	Before the military	On active duty	After separation from active duty
Irregular periods	☐	☐	☐
Painful periods	☐	☐	☐
Abnormal PAP smear	☐	☐	☐
Pelvic inflammatory disease	☐	☐	☐
Chronic pelvic pain	☐	☐	☐
Low sexual interest	☐	☐	☐
Painful intercourse	☐	☐	☐
Urinary tract infection	☐	☐	☐

74. Name: _____ _____ _____ _____
Last Suffix First MI

75. Date of Birth: _____ / _____ / _____
Month Day Year

76. Last four digits of your social security number: ____ ____ ____ ____

77. Gender: O Male O Female

78. Current marital status

O Married or living with partner
O Married but separated from partner
O Single, never married
O Divorced
O Widowed

79. Current annual household income before tax:

O less than $35,000 **O $75,000-$99,999**
O $35,000-$49,999 **O $100,000 - $149,999**
O $50,000-$74,999 **O $150,000 or more**

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

O High School degree/GED/or equivalent
O Some college, no degree
O Associate's degree
O Bachelor's degree
O Master's, doctorate, or professional degree

81. Current contact information:

Home Phone: (_____) _____--_____
Cell Phone: (_____) _____--_____
E-mail address:_____
Mailing address: _____
_____

82. Point of contact who can always reach you:

Name:_____
Phone: (_____) _____--_____
E-mail address:_____
Mailing address: _____
_____