

**Medicare Health Outcomes Survey
Questionnaire (English)**

2011

Insert Cover Art (English)

Medicare Health Outcomes Survey Instructions

This survey asks about you and your health. Answer each question thinking about yourself. Please take the time to complete this survey. Your answers are very important to us. If you are unable to complete this survey, a family member or “proxy” can fill out the survey about you.

Please return the survey with your answers in the enclosed postage-paid envelope.

Sample Questions:

- Answer the questions by putting an ‘X’ in the box next to the appropriate answer category like this:

56. Are you male or female?

1 Male

2 Female

- Be sure to read all the answer choices given, before marking a box with an ‘X.’
- You are sometimes told to answer some questions in this survey only when you have answered a previous question. When this happens, you will see an *italicized* instruction like the one below:

If you answered "yes" to question 33 above (that you have had cancer),

All information that would permit identification of any person who completes this survey is protected by the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). This information will be used only for purposes permitted by law and will not be disclosed or released for any other reason. If you have any questions or want to know more about the study, please call [vendor name] at [toll-free number].

OMB 0938-0701 Version 02-1

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Items 1–9: The VR-12 Health Survey item content was developed and modified from a 36-item health survey.

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Medicare Health Outcomes Survey

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

Excellent	Very good	Good	Fair	Poor
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

2. 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?

ACTIVITIES	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.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Climbing several flights of stairs.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

3. 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 your physical health?**

	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
a. Accomplished less than you would like.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Were limited in the kind of work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

4. 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)?

	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
a. Accomplished less than you would like.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Didn't do work or other activities as carefully as usual.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

5. 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
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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.

6. 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
a. Have you felt calm and peaceful?.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
b. Did you have a lot of energy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
c. Have you felt downhearted and blue?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

7. 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
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

Now, we'd like to ask you some questions about how your health may have changed.

8. **Compared to one year ago**, how would you rate your **physical health** in general **now**?

Much better	Slightly better	About the same	Slightly worse	Much worse
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

9. **Compared to one year ago**, how would you rate your **emotional problems** (such as feeling anxious, depressed or irritable) in general **now**?

Much better	Slightly better	About the same	Slightly worse	Much worse
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

Earlier in the survey you were asked to indicate whether you have any limitations in your activities. We are now going to ask a few additional questions in this area.

10. Because of a health or physical problem, do you have any difficulty doing the following activities **without special equipment or help from another person**?

	No, I do not have difficulty	Yes, I have difficulty	I am unable to do this activity
a. Bathing.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Dressing.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Eating.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Getting in or out of chairs.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Walking.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Using the toilet.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

These next questions ask about your physical and mental health during the past 30 days.

11. Now, thinking about your physical health, which includes physical illness and injury, for how many days during the **past 30 days** was your physical health **not** good?

Please enter a number between "0" and "30" days. If no days, please enter "0" days.

		days
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12. Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the **past 30 days** was your mental health **not** good?

Please enter a number between "0" and "30" days. If no days, please enter "0" days.

		days
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13. During the **past 30 days**, for about how many days did **poor** physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Please enter a number between "0" and "30" days. If no days, please enter "0" days.

		days
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Now we are going to ask some questions about specific medical conditions.

14. During the **past 4 weeks**, how often have you had any of the following problems?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Chest pain or pressure when you exercise	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Chest pain or pressure when resting.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

15. During the **past 4 weeks**, how often have you felt short of breath under the following conditions?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. When lying down flat.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. When sitting or resting	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. When walking less than one block.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. When climbing one flight of stairs.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

16. During the **past 4 weeks**, how much of the time have you had any of the following problems with your legs and feet?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Numbness or loss of feeling in your feet	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Tingling or burning sensation in your feet especially at night.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Decreased ability to feel hot or cold with your feet.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. Sores or wounds on your feet that did not heal.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

17. During the **past 4 weeks**, how would you describe any arthritis pain you usually had?

None	Very Mild	Mild	Moderate	Severe
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

- | | Yes | No |
|---|----------------------------|----------------------------|
| 18. Can you see well enough to read newspaper print (with your glasses or contacts if that's how you see best)? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 19. Can you hear most of the things people say (with a hearing aid if that's how you hear best)? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

Has a doctor ever told you that you had:

- | | Yes | No |
|--|----------------------------|----------------------------|
| 20. Hypertension or high blood pressure..... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 21. Angina pectoris or coronary artery disease | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 22. Congestive heart failure..... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 23. A myocardial infarction or heart attack | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 24. Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 25. A stroke..... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 26. Emphysema, or asthma, or COPD (chronic obstructive pulmonary disease) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 27. Crohn's disease, ulcerative colitis, or inflammatory bowel disease | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 28. Arthritis of the hip or knee..... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 29. Arthritis of the hand or wrist..... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 30. Osteoporosis, sometimes called thin or brittle bones | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 31. Sciatica (pain or numbness that travels down your leg to below your knee)..... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

Has a doctor ever told you that you had:

Yes No

32. Diabetes, high blood sugar, or sugar in the urine.....

1

2

33. Any cancer (other than skin cancer).....

1

2

If you answered "yes" to question 33 above (that you have had cancer),

34. Are you currently under treatment for:

Yes No

a. Colon or rectal cancer.....

1

2

b. Lung cancer.....

1

2

c. Breast cancer.....

1

2

d. Prostate cancer.....

1

2

35. In the **past 4 weeks**, how often has low back pain interfered with your usual daily activities (for example, work, school, or housework)?

All of the time

1

Most of the time

2

Some of the time

3

A little of the time

4

None of the time

5

Yes No

36. In the past **year**, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost interest or pleasure in things that you usually cared about or enjoyed?.....

1

2

37. In the past **year**, have you felt depressed or sad much of the time?.....

1

2

38. Have you ever had **2 years or more** in your life when you felt depressed or sad most days, even if you felt okay sometimes?.....

1

2

39. How much of the time in the past **week** did you feel depressed?

Rarely or none of the time

1

Some or a little of the time

2

Occasionally or a moderate amount of the time

3

Most or all of the time

4

40. In general, compared to other people your age, would you say that your health is:

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

41. Do you now smoke every day, some days, or not at all?

- 1 Every day
- 2 Some days
- 3 Not at all
- 4 Don't know

42. Many people experience problems with urinary incontinence, the leakage of urine. In the **past 6 months**, have you accidentally leaked urine?

- 1 Yes **→ Go to Question 43**
- 2 No **→ Go to Question 46**

43. How much of a problem, if any, was the urine leakage for you?

- 1 A big problem **→ Go to Question 44**
- 2 A small problem **→ Go to Question 44**
- 3 Not a problem **→ Go to Question 46**

44. Have you talked with your current doctor or other health provider about your urine leakage problem?

- 1 Yes
- 2 No

45. There are many ways to treat urinary incontinence including bladder training, exercises, medication and surgery. Have you received these or any other treatments for your current urine leakage problem?

- 1 Yes
- 2 No

46. In the **past 12 months**, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.

- 1 Yes → **Go to Question 47**
2 No → **Go to Question 47**
3 I had no visits in the past 12 months → **Go to Question 48**

47. In the **past 12 months**, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

- 1 Yes
2 No

48. A fall is when your body goes to the ground without being pushed. In the **past 12 months**, did you talk with your doctor or other health provider about falling or problems with balance or walking?

- 1 Yes
2 No
3 I had no visits in the past 12 months

49. Did you fall in the **past 12 months**?

- 1 Yes
2 No

50. In the **past 12 months**, have you had a problem with balance or walking?

- 1 Yes
2 No

51. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:

- Suggest that you use a cane or walker.
- Check your blood pressure lying or standing.
- Suggest that you do an exercise or physical therapy program.
- Suggest a vision or hearing testing.

- 1 Yes
2 No
3 I had no visits in the past 12 months

52. Have you ever had a **bone density test** to check for **osteoporosis**, sometimes thought of as “brittle bones”? This test may have been done to your back, hip, wrist, heel or finger.

Yes

No

53. How much do you weigh in pounds (lbs.)?

90 lbs. or less

151–160 lbs.

221–230 lbs.

291–300 lbs.

91–100 lbs.

161–170 lbs.

231–240 lbs.

301–310 lbs.

101–110 lbs.

171–180 lbs.

241–250 lbs.

311–320 lbs.

111–120 lbs.

181–190 lbs.

251–260 lbs.

321 lbs. or more

121–130 lbs.

191–200 lbs.

261–270 lbs.

131–140 lbs.

201–210 lbs.

271–280 lbs.

141–150 lbs.

211–220 lbs.

281–290 lbs.

54. How tall are you without shoes on in feet (ft.) and inches (in.)? (If 1/2 in., 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

55. In what **year** were you born? Please provide your **year of birth** only.

1	9		
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56. Are you male or female?

Male

Female

57. Are you of Hispanic or Latino origin or descent?

- 1 Yes, Hispanic or Latino
2 No, not Hispanic or Latino

58. How would you describe your race? Please mark one or more.

- a American Indian or Alaskan Native
b Asian
c Black or African American
d Native Hawaiian or Other Pacific Islander
e White

59. What is your current marital status?

- 1 Married
2 Divorced
3 Separated
4 Widowed
5 Never married

60. What is the highest grade or level of school that you have completed?

- 1 8th grade or less
2 Some high school, but did not graduate
3 High school graduate or GED
4 Some college or 2 year degree
5 4 year college graduate
6 More than a 4 year college degree

61. Is the house or apartment you currently live in:

- 1 Owned or being bought by you
2 Owned or being bought by someone in your family other than you
3 Rented for money
4 Not owned and one in which you live without payment of rent
5 None of the above

62. Who completed this survey form?

- 1 Person to whom survey was addressed **→ Go to Question 64**
- 2 Family member or relative of person to whom the survey was addressed
- 3 Friend of person to whom the survey was addressed
- 4 Professional caregiver of person to whom the survey was addressed

63. What is the name of the person who completed this survey form? Please **print** clearly.

First Name

Last Name

64. Which of the following categories best represents the **combined income for all family members in your household** for the past 12 months?

- 01 Less than \$5,000
- 02 \$5,000–\$9,999
- 03 \$10,000–\$19,999
- 04 \$20,000–\$29,999
- 05 \$30,000–\$39,999
- 06 \$40,000–\$49,999
- 07 \$50,000–\$79,999
- 08 \$80,000–\$99,999
- 09 \$100,000 or more
- 10 Don't know

YOU HAVE COMPLETED THE SURVEY. THANK YOU.

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