



The Continuity of Medication Management (COMM) Patient Survey

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2 OMB 2900-0770
Estimated Burden: 30 min.

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7 **The Paperwork Reduction Act of 1995:** This information is collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this survey will average 30 minutes. This includes the time it will take to follow instructions, gather the necessary facts and respond to questions asked. Customer satisfaction is used to gauge customer perceptions of VA services as well as customer expectations and desires. The results of this telephone/mail survey will lead to improvements in the quality of service delivery by helping to achieve continuity of prescription medical management services. Participation in this survey is voluntary and failure to respond will have no impact on benefits to which you may be entitled.

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A. The following questions are about your current health insurance coverage.

1. Do you currently obtain health care service from VA?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

2. Is any hospital care service you receive outside VA currently covered by Medicare?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

3. Are any doctor's office visits you have outside VA currently covered by Medicare?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

4. Do you have Medicare prescription service drug coverage, "Part D"?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

5. Is any care service you receive outside VA currently covered by Medicaid?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

6. Is any care you receive outside VA currently covered by the Department of Defense's TRICARE service or TRICARE for Life health care programs?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

7. Is any care you receive currently covered by any other individual or group health plan that either you, or an employer, or someone else, such as a family member obtains for you?

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- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

8. Does this coverage include prescription drug coverage?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

B. The following questions are about where you go to obtain health care service.

1. Is there a particular doctor's office, clinic, health center, or other place that you usually go if you are sick or need advice about your health?

- 01 Yes
- 02 No
- 03 I usually go to more than one location or doctor for medical care or advice

2. Over the past six months, how many different places have you gone to obtain medical care service or medical advice outside VA?

- 01 0
- 02 1
- 03 2
- 04 3 or more

3. Which of the following best represents the location you usually go to receive medical care service or advice?

- 01 VA Medical Center
- 02 VA community based outpatient clinic or satellite clinic
- 03 Non-VA Clinic or health center
- 04 Non-VA Doctor's office or HMO
- 05 Non-VA Hospital Emergency Room
- 06 Non-VA Hospital Outpatient Department
- 07 Other (please specify) _____

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4. From October through December 2011, did you use any medical or mental health care services that were not provided by or paid for by VA? Please include ANY service at all, such as a flu shot, a single prescription, a test of some sort, etc.

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

5. From October through December 2011, how many overnight stays, if any, did you have that were not provided by or paid for by the VA? A "stay" is a single trip into and out or admission into and discharge out of the hospital. Your best guess is fine.

- 01 ENTER NUMBER _____
- 98 Don't know
- 99 Prefer not to answer

6. From October through December 2011, how many outpatient visits or trips, did you have that were not provided by or paid for by the VA? Please do not count dental, mental health, substance abuse visits or any visits paid for by VA. Your best guess is fine.

- 01 ENTER NUMBER _____
- 98 Don't know
- 99 Prefer not to answer

C. The following questions are about where you get prescriptions filled.

1. Is there one particular pharmacy that you usually go to if you need to fill a prescription?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

2. How many different pharmacies do you usually go to when picking up prescriptions?

0	1	2	3	More than 3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. How likely are you to fill prescriptions at a VA pharmacy?

Very Unlikely	Unlikely	Neutral	Likely	Very Likely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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4. How likely are you to fill VA prescriptions at a mail-order pharmacy service?

Very Unlikely	Unlikely	Neutral	Likely	Very Likely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. The following items are about your military service.

1. How many terms of active duty military service have you served? [A one-time discharge from the military after continuous service is one term of service. Each enlistment after discharge is a new term of service]. Please do not include Reserve or National Guard training or drill periods unless “activated” at the time.

ENTER NUMBER _____

- 98 Don't know
- 99 Prefer not to answer

3. What year did each term of active duty military service start?

- 01 ENTER YEAR 1st _____ 2nd _____ 3rd _____ 4th _____
- 98 Don't know
- 99 Prefer not to answer

4. What year did each term of active duty military service end?

- 01 ENTER YEAR 1st _____ 2nd _____ 3rd _____ 4th _____
- 98 Don't know
- 99 Prefer not to answer

5. During this term of military service were you ever in or exposed to combat?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

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E. The following items are about your health.

1. Would you say in general your health is Excellent, Very Good, Good, Fair or Poor?

Excellent	Very Good	Good	Fair	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How tall are you without shoes?

Enter height in feet and inches

|__| enter number of feet

and

|__|__| enter number of inches

98 Don't know

99 Prefer not to answer

3. How much weigh without clothes or shoes

|__|__|__| pounds

98 Don't know

99 Prefer not to answer

4. How often did you have a drink containing alcohol in the past year?

01 Never (0 points)*

02 Monthly or less (1 point)

03 Two to four times a month (2 points)

04 Two to three times per week (3 points)

05 Four or more times a week (4 points)

5. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

01 0 drinks (0 points)*

02 1 or 2 (0 points)

03 3 or 4 (1 point)

04 5 or 6 (2 points)

05 7 to 9 (3 points)

06 10 or more (4 points)

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6. How often did you have six or more drinks on one occasion in the past year?

- 01 Never (0 points)
- 02 Less than monthly (1 point)
- 03 Monthly (2 points)
- 04 Weekly (3 points)
- 05 Daily or almost daily (4 points)

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

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

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

- 01 Every day
- 02 Some days
- 03 Not at all
- 98 Don't know
- 99 Prefer not to answer

9. During the past 12 months, have you stopped smoking for more than one day because you were trying to quit smoking?

- 01 Yes
- 02 No
- 98 Don't know
- 99 Prefer not to answer

Please answer the following questions about your mood over the past month.

10. During the past month, how much of the time were you a happy person?					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>None of the time</i>	<i>A little of the time</i>	<i>Some of the time</i>	<i>A good bit of the time</i>	<i>Most of the time</i>	<i>All of the time</i>
11. How much of the time, during the past month, have you felt calm and peaceful?					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>None of the time</i>	<i>A little of the time</i>	<i>Some of the time</i>	<i>A good bit of the time</i>	<i>Most of the time</i>	<i>All of the time</i>
12. How much of the time, during the past month, have you been a very nervous person?					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>None of the time</i>	<i>A little of the time</i>	<i>Some of the time</i>	<i>A good bit of the time</i>	<i>Most of the time</i>	<i>All of the time</i>
13. How much of the time, during the past month, have you felt downhearted and blue?					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>None of the time</i>	<i>A little of the time</i>	<i>Some of the time</i>	<i>A good bit of the time</i>	<i>Most of the time</i>	<i>All of the time</i>
14. How much of the time, during the past month, did you feel so down in the dumps that nothing could cheer you up?					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>None of the time</i>	<i>A little of the time</i>	<i>Some of the time</i>	<i>A good bit of the time</i>	<i>Most of the time</i>	<i>All of the time</i>

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F. The following questions are about medications that you take.

F1. Do you have a current prescription for blood pressure medications?

Yes: Continue to F1 below.

No: Go to F2.

F1. In order for blood pressure medication to work best, people should take it according to the doctor's instructions. For one reason or another, people can't or don't always take all of their pills as prescribed. We want to know *how often* you have missed your blood pressure medication. When answering these questions, please think about all of your blood pressure medications. Please rate your agreement with the following statements.

Over the past 7 days...

	Never	Rarely	Sometimes	Often	Always
1. I took all doses of my blood pressure medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I missed or skipped at least one dose of my blood pressure medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I was not able to take all of my blood pressure medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Situations come up that make it difficult for people to take their blood pressure medications as prescribed by their doctors. Below is a list of those situations. We want to know how much these situations contributed to you missing a dose of your blood pressure medication. Only one of these situations may apply to you, or many may apply to you.

In the past 7 days, how much did each situation contribute to you missing a dose of your blood pressure medication?

	Not at All				Very Much
1. I was busy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I forgot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The medication caused some side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I worried about taking them for the rest of my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. They cost a lot of money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I came home late	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I did not have any symptoms of high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I was with friends or family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was in a public place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I was afraid of becoming dependent on them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I was afraid they may affect my sexual performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. The time to take them was between my meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I felt I did not need them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Not at all				Very Much

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14. I was traveling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I was supposed to take them too many times a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I had other medications to take	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. They make me need to urinate too often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I ran out of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I was afraid the medication would interact with other medication I take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. My blood pressure was too low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I was feeling too ill to take them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Of the situations that contributed to you missing at least one dose of your blood pressure medication, we would like to know which are the most important or influential. Please rank the top three most important or influential reasons below. You may write the number that corresponds to the reason listed above (e.g., if running out of medication was the most important reason, then write "18" on the top line).

Most important or influential situation: _____

2nd Most important or influential situation: _____

3rd Most important or influential situation: _____

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F2. Do you have a current prescription for cholesterol medications?

Yes: Continue F2 below.

No: Go to F3.

F2. In order for cholesterol medication to work best, people should take it according to the doctor's instructions. For one reason or another, people can't or don't always take all of their pills as prescribed. We want to know *how often* you have missed your cholesterol medication. When answering these questions, please think about all of your cholesterol medications. Please rate your agreement with the following statements.

Over the past 7 days...

	Never	Rarely	Sometimes	Often	Always
1. I took all doses of my cholesterol medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I missed or skipped at least one dose of my cholesterol medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I was not able to take all of my cholesterol medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Situations come up that make it difficult for people to take their cholesterol medications as prescribed by their doctors. Below is a list of those situations. We want to know how much these situations contributed to you missing a dose of your cholesterol medication. Only one of these situations may apply to you, or many may apply to you.

In the past 7 days, how much did each situation contribute to you missing a dose of your cholesterol medication?

	Not at All				Very Much
1. I was busy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I forgot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The medication caused some side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I worried about taking them for the rest of my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. They cost a lot of money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I came home late	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I did not have any symptoms of high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I was with friends or family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was in a public place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I was afraid of becoming dependent on them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I was afraid they may affect my sexual performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. The time to take them was between my meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I felt I did not need them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Not at all				Very Much
14. I was traveling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I was supposed to take them too many times a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I had other medications to take	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. They make me need to urinate too often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I ran out of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I was afraid the medication would interact with other medication I take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. My cholesterol was low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I was feeling too ill to take them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Of the situations that contributed to you missing at least one dose of your cholesterol medication, we would like to know which are the most important or influential. Please rank the top three most important or influential reasons below. You may write the number that corresponds to the reason listed above (e.g., if running out of medication was the most important reason, then write "18" on the top line).

Most important or influential situation: _____

2nd Most important or influential situation: _____

3rd Most important or influential situation: _____

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F3. Do you have a current prescription for diabetes medications?

Yes: Continue F3 below.

No: Go to F4.

F3. In order for diabetes medication to work best, people should take it according to the doctor's instructions. For one reason or another, people can't or don't always take all of their pills as prescribed. We want to know *how often* you have missed your diabetes medication. When answering these questions, please think about all of your diabetes medications. Please rate your agreement with the following statements.

Over the past 7 days...

	Never	Rarely	Sometimes	Often	Always
1. I took all doses of my diabetes medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I missed or skipped at least one dose of my diabetes medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I was not able to take all of my diabetes medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Situations come up that make it difficult for people to take their diabetes medications as prescribed by their doctors. Below is a list of those situations. We want to know how much these situations contributed to you missing a dose of your diabetes medication. Only one of these situations may apply to you, or many may apply to you.

In the past 7 days, how much did each situation contribute to you missing a dose of your diabetes medication?

	Not at All				Very Much
1. I was busy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I forgot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The medication caused some side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I worried about taking them for the rest of my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. They cost a lot of money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I came home late	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I did not have any symptoms of high blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I was with friends or family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was in a public place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I was afraid of becoming dependent on them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I was afraid they may affect my sexual performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. The time to take them was between my meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I felt I did not need them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Not at all				Very Much
14. I was traveling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I was supposed to take them too many times a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I had other medications to take	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. They make me need to urinate too often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I ran out of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I was afraid the medication would interact with other medication I take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. My blood sugar was too low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I was feeling too ill to take them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Of the situations that contributed to you missing at least one dose of your diabetes medication, we would like to know which are the most important or influential. Please rank the top three most important or influential reasons below. You may write the number that corresponds to the reason listed above (e.g., if running out of medication was the most important reason, then write "18" on the top line).

Most important or influential situation: _____

2nd Most important or influential situation: _____

3rd Most important or influential situation: _____

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F4. Do you have a current prescription for medications for chronic obstructive pulmonary disease (COPD)?

Yes: Continue F4 below.

No: Go to F5.

F4. In order for COPD medication to work best, people should take it according to the doctor's instructions. For one reason or another, people can't or don't always take all of their pills as prescribed. We want to know *how often* you have missed your COPD medication. When answering these questions, please think about all of your COPD medications. Please rate your agreement with the following statements.

Over the past 7 days...

	Never	Rarely	Sometimes	Often	Always
1. I took all doses of my COPD medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I missed or skipped at least one dose of my COPD medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I was not able to take all of my COPD medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Situations come up that make it difficult for people to take their COPD medications as prescribed by their doctors. Below is a list of those situations. We want to know how much these situations contributed to you missing a dose of your COPD medication. Only one of these situations may apply to you, or many may apply to you.

In the past 7 days, how much did each situation contribute to you missing a dose of your COPD medication?

	Not at All				Very Much
1. I was busy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I forgot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The medication caused some side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I worried about taking them for the rest of my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. They cost a lot of money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I came home late	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I did not have any symptoms of COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I was with friends or family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I was in a public place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I was afraid of becoming dependent on them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I was afraid they may affect my sexual performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. The time to take them was between my meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I felt I did not need them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Not at all				Very Much
14. I was traveling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I was supposed to take them too many times a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I had other medications to take	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. They make me need to urinate too often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I ran out of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I was afraid the medication would interact with other medication I take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I was feeling too ill to take them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Of the situations that contributed to you missing at least one dose of your COPD medication, we would like to know which are the most important or influential. Please rank the top three most important or influential reasons below. You may write the number that corresponds to the reason listed above (e.g., if running out of medication was the most important reason, then write "18" on the top line).

Most important or influential situation: _____

2nd Most important or influential situation: _____

3rd Most important or influential situation: _____

F5. We would like to ask you about your personal views about your medicine(s). These are statements other people have made about their medicines. Please indicate the extent to which you agree or disagree with them. There are no right or wrong answers. We are interested in your personal views about your medicine(s). When answering these, please think about all of your medicine(s).

	Strongly Agree	Disagree	Neutral	Agree	Strongly Agree
1. Having to take medicines worries me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I sometimes worry about becoming too dependent on medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I sometimes worry about long-term effects of my medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. My medicines disrupt my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My life will be impossible without my medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My health, at present, depends on my medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Without my medicines, I would be very ill.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. My health in the future will depend on my medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. My medicines protect me from becoming worse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. If doctors had more time with patients, they would prescribe fewer medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Doctors place too much trust in medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Doctors use too many medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Natural remedies are safer than medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Most medicines are addictive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Medicines do more harm than good.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. All medicines are poison.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. My medicines are a mystery to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. People who take medicines should stop their treatment for a while every now and again.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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G. The following questions are about your primary care doctor. Please rate how much you agree with the following statements about your ***primary care doctor***.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. My doctor will do whatever it takes to get me all the care I need.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Sometimes my doctor cares more about what is convenient for (him/her) than about my medical needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. My doctor's medical skills are not as good as they should be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. My doctor is extremely thorough and careful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I completely trust my doctor's decisions about which medical treatments are best for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My doctor is totally honest in telling me about all of the different treatment options available for my condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. My doctor only thinks about what is best for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sometimes my doctor does not pay full attention to what I am trying to tell (him/her).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I have no worries about putting my life in my doctor's hands.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. All in all, I have complete trust in my doctor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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H. Finally, we have a few questions to help us describe the people who completed this survey.

1. Are you of Hispanic and Latino origin?

NO

YES

2. Looking at the options below, which best describes your race? Please select only one option.

American Indian
or Alaska

Black or African
American

White

Asian

Native Hawaiian or
other Pacific Islander

Another Race

3. What is highest degree or level of school completed? Please select only one option.

No Schooling completed

Nursery school to 8th grade

9th-12th Grade, no Diploma

High School Graduate (High School Diploma or the Equivalent)

Vocational/Technical/Business/Trade School Certificate or Diploma (Beyond the High School Level)

Some College, but no Degree

Associate Degree

Bachelor's Degree

Master's, Professional or Doctorate Degree

4. How would you best characterize your current employment status?

01 Employed Fulltime

02 Self-employed fulltime

03 Employed part-time

04 Self employed part-time

05 Unemployed, looking for work, or laid off

06 Currently not employed – either retired, a homemaker, student, etc.

98 Don't Know

99 Prefer not to answer

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5. Please be assured that your response to this question is private, and your answer will not affect your benefits. Your best guess or estimate is fine. Could you please indicate which of the following best describes your 2011 total annual household income from all sources.

- 01 UNDER \$11,00
- 02 \$11,000-\$15,999
- 03 \$16,000-\$20,999
- 04 \$21,000-\$25,999
- 05 \$26,000-\$30,999
- 06 \$31,000-\$35,999
- 07 \$36,000-\$40,999
- 08 \$41,000-\$45,999
- 09 \$46,000-\$50,999
- 10 \$51,000-\$55,999
- 11 \$56,000 or over
- 13 Don't know
- 14 Prefer not to answer

THANK YOU FOR TAKING TIME TO COMPLETE THIS SURVEY