

# National Health Study for a New Generation of U.S. Veterans Questionnaire

Sponsored by  
**U.S. Department of Veterans Affairs**



6 DIGIT BARCODE

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The information requested on this questionnaire 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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PLEASE DO NOT WRITE IN THIS AREA



SERIAL #



**PLEASE START HERE**

**1** In what component(s) have you served? (Mark all that apply)

- Active Duty                       Reserve                       National Guard

**2** What branch(es) did you serve with? (Mark all that apply)

- Air Force                       Army                       Coast Guard                       Marine Corps                       Navy

**3a** During military service, what was your last principal duty? \_\_\_\_\_

**3b** During military service, what was your last occupation code (MOS, NEC or AFSC)?                   

**4a** Have you been deployed to Operation Enduring Freedom (OEF) and/or Operation Iraqi Freedom (OIF)?

- No                       Yes → **4b** IF YES, what was your period of last deployment:

From m m / d d / y y y y To m m / d d / y y y y

**5** Since 2001, please mark all locations of operations you served in:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Afghanistan                  | <input type="checkbox"/> Qatar         | <input type="checkbox"/> Europe        | <input type="checkbox"/> Central America |
| <input type="checkbox"/> Iraq                         | <input type="checkbox"/> Turkey        | <input type="checkbox"/> Africa        | <input type="checkbox"/> South America   |
| <input type="checkbox"/> Kuwait                       | <input type="checkbox"/> Bosnia/Kosovo | <input type="checkbox"/> North America | <input type="checkbox"/> On a ship       |
| <input type="checkbox"/> Other (Please specify) _____ |  |  |  |

**6** Since 2001, how many times were you deployed to the following operations?

Total Deployments						
	0	1	2	3	4	5+
OEF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OIF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7a** Have you used VA health care services since you were separated from active duty?

- No (Skip to question 7d)                       Yes

**7b** What are the main reasons you enrolled in VA health care services? (Mark all that apply)

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

**7c** All things considered, how satisfied are you with your health care in the VA?

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

} Skip to question 8

PLEASE DO NOT WRITE IN THIS AREA



SERIAL #

**7d** If you have never used VA services, why not? (Mark all that apply)

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

**8** What health care coverage do you have? (Mark all that apply)

- Private or self-purchased insurance       Department of Defense's TRICARE       Medicare       Other  
 Employer-based insurance       Veterans Affairs       Medicaid       None

**9** Since separation from active duty, have you received a letter from the VA Secretary informing you of programs and benefits that you may be entitled to through the VA?

- No       Yes       Don't remember

**10** Do you belong to a Veterans group(s) such as Veterans of Foreign Wars of the United States (VFW) or American Legion?

- No       Yes (Please specify all) \_\_\_\_\_

**11** Has a doctor ever told you that you have any of the following conditions? (Please mark after each condition)

Condition	No	Yes	Year First Told	Condition	No	Yes	Year First Told
a. Arthritis of any kind	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	m. Stroke	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
b. Skin cancer	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	n. Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
c. Any other cancer (Please specify) _____	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	o. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
d. Cirrhosis of the liver	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	p. Asthma	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
e. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	q. Frequent bladder infections	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
f. Any other liver trouble	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	r. Significant hearing loss	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
g. Irritable bowel syndrome or colitis (irritation of the colon)	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	s. Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
h. Diabetes	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	t. Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
i. Repeated seizures, convulsions, or blackouts	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	u. Posttraumatic stress disorder	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
j. Migraines	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	v. Depression	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
k. Coronary heart disease or artery disease	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	w. Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
l. Hypertension	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	x. Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



19

- |  | No                          | Yes                      |
|--|-----------------------------|--------------------------|
| a. Has a doctor or other health professional ever told you that you had a head injury?       | <input type="checkbox"/>    | <input type="checkbox"/> |
|  | If NO, skip to question 20. |                          |
| b. Have you received treatment from a doctor or other health professional for a head injury? | <input type="checkbox"/>    | <input type="checkbox"/> |
|  | If NO, skip to question 20. |                          |
| c. Was this treatment helpful?   | <input type="checkbox"/>    | <input type="checkbox"/> |
| d. Were you prescribed medication(s)?  | <input type="checkbox"/>    | <input type="checkbox"/> |

20

- |  | No                          | Yes                      |
|--|-----------------------------|--------------------------|
| a. Has a doctor or other health professional ever told you that you have posttraumatic stress disorder (PTSD)? | <input type="checkbox"/>    | <input type="checkbox"/> |
|  | If NO, skip to question 21. |                          |
| b. Have you received treatment from a doctor or other health professional for PTSD?                            | <input type="checkbox"/>    | <input type="checkbox"/> |
|  | If NO, skip to question 21. |                          |
| c. Was this treatment helpful?   | <input type="checkbox"/>    | <input type="checkbox"/> |
| d. Were you prescribed medication(s)?  | <input type="checkbox"/>    | <input type="checkbox"/> |

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

22 The following questions are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

- |  | Yes, limited a lot       | Yes, limited a little    | No, not limited at all   |
|--|--------------------------|--------------------------|--------------------------|
| a. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Climbing <u>several</u> flights of stairs   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

23 During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

- |  | All of the time          | Most of the time         | Some of the time         | A little of the time     | None of the time         |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. <u>Accomplished less</u> than you would like                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Were limited in the <u>kind</u> of work or other activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

24 During the **past 4 weeks**, how much of the time 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)?

- |  | All of the time          | Most of the time         | Some of the time         | A little of the time     | None of the time         |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. <u>Accomplished less</u> than you would like                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Did work or other activities <u>less carefully than usual</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

25 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

**26** 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Did you have a lot of energy?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
c. Have you felt downhearted and depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**27** 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.)?

All of the time     Most of the time     Some of the time     A little of the time     None of the time

**28** 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 **during the past 4 weeks**. **If it did not occur during the past 4 weeks, please mark the 'Not at all' column.**

In the past 4 weeks, have you had...?	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Repeated, disturbing memories of stressful experiences from the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Repeated, disturbing dreams of stressful experiences from the past	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
c. Suddenly acting or feeling as if stressful experiences were happening again	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling very upset when something happened that reminds you of stressful experiences from the past	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
e. Trouble remembering important parts of stressful experiences from the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Loss of interest in activities that you used to enjoy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
g. Feeling distant or cut off from other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Feeling emotionally numb, or being unable to have loving feelings for those close to you	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
i. Feeling as if your future will somehow be cut short	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Trouble falling asleep or staying asleep	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
k. Feeling irritable or having angry outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Having difficulty concentrating	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
m. Being "super-alert," or watchful or on guard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Feeling jumpy or easily startled	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
o. Having physical reactions when something reminds you of stressful experiences from the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Avoid thinking about your stressful experiences from the past, or avoid having feelings about them	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
q. Avoid activities or situations because they remind you of stressful experiences from the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE DO NOT WRITE IN THIS AREA



SERIAL #

**29** If you experienced any of the symptoms described in **question 28**, were these stressful experiences related to:

- Military service only                       Both military and other life events  
 Other traumatic life events only         Don't know/not applicable

**30** Over the last **2 weeks**, 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
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ **If you are experiencing emotional distress and need to talk to a trained VA professional, you may call 1-800-273-TALK (8255), 24 hours a day, 7 days a week.**

**31** Over the last **4 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days
a. Feeling nervous, anxious, on edge, or worrying a lot about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling restless so that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Getting tired very easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Muscle tension, aches, or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble falling asleep or staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Trouble concentrating on things, such as reading a book or watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**32a** During military service, did you experience any of the following events? (Mark all that apply)

	No	Yes	Estimated Number of Times
a. Blast or explosion (IED, RPG, land mine, grenade, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> <input type="text"/> <input type="text"/>
b. Motor vehicle, aircraft, or water transportation accident	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> <input type="text"/>
c. Fragment wound or bullet wound above the shoulders	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> <input type="text"/>
d. Falls	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> <input type="text"/>
e. Injury from sports/physical training	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> <input type="text"/>
f. Other injury (Please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> <input type="text"/>

If you marked NO for all events, skip to question 34.

**32b** Did you have any of the following *IMMEDIATELY* after any of the events in question 32a? (Mark all that apply)

- Losing consciousness/"knocked out" → IF MARKED, about how long were you unconscious? →    minutes
- Being dazed, confused, or "seeing stars"
- Not remembering the event
- Concussion
- Head injury
- No, none of the above (Skip to question 34)

**32c** Did any of the following problems begin or get worse after any of the events in question 32a? (Mark all that apply)

- Memory problems or lapses
- Balance problems or dizziness
- Sensitivity to bright light
- Irritability
- Headaches
- Sleep problems
- Trouble concentrating
- Hearing problems
- Other problems (Please specify) \_\_\_\_\_
- No, none of the above (Skip to question 34)

**33** In the past week, have you had any of the following? (Mark all that apply)

- Memory problems or lapses
- Balance problems or dizziness
- Sensitivity to bright light
- Irritability
- Headaches
- Sleep problems
- Trouble concentrating
- Hearing problems
- No, none of the above



**34** During military service, were you exposed to or did you experience any of the following?

	No	Yes		No	Yes
a. Dust and sand	<input type="checkbox"/>	<input type="checkbox"/>	i. Pesticide-treated uniforms	<input type="checkbox"/>	<input type="checkbox"/>
b. Burning trash/feces	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	j. Depleted uranium (DU) (e.g., handling DU munitions)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
c. Diesel, kerosene and/or other petrochemical fumes	<input type="checkbox"/>	<input type="checkbox"/>	k. Ate local food other than provided by Armed Forces	<input type="checkbox"/>	<input type="checkbox"/>
d. Skin exposure to JP8, diesel, or other petrochemical fuel	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	l. Contact with Prisoners of War (POWs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
e. Smoke from oil fires	<input type="checkbox"/>	<input type="checkbox"/>	m. Exposure to loud noises	<input type="checkbox"/>	<input type="checkbox"/>
f. Solvents or degreasers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	n. Radiation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
g. Paint operations (vehicles or equipment)	<input type="checkbox"/>	<input type="checkbox"/>	o. Industrial pollution	<input type="checkbox"/>	<input type="checkbox"/>
h. Insect repellent (spray, lotion, or cream applied to your skin)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	p. Other exposure you consider harmful (Please specify) _____	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**35** During military service, did you receive any of the following vaccinations?

- |  |  |   |
|--|--|---|
| a. Smallpox (leaves a scar on the arm) | <input checked="" type="checkbox"/> No | <input checked="" type="checkbox"/> Yes |
| b. Anthrax                             | <input checked="" type="checkbox"/> No | <input checked="" type="checkbox"/> Yes |
| c. Rabies                              | <input checked="" type="checkbox"/> No | <input checked="" type="checkbox"/> Yes |

**36a** During military service, did you ever take medications to prevent malaria?

No     Yes    → **36b** IF YES, please indicate which medicines you took. (Mark all that apply)

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Chloroquine (Aralen®) | <input checked="" type="checkbox"/> Doxycycline (Vibramycin®)    |
| <input checked="" type="checkbox"/> Mefloquine (Lariam®)  | <input checked="" type="checkbox"/> Primaquine                   |
| <input checked="" type="checkbox"/> Don't know            | <input checked="" type="checkbox"/> Other (Please specify) _____ |

**37** When you were in the military...

	No	Yes
a. Did you ever receive uninvited or unwanted sexual attention (e.g., touching, cornering, pressure for sexual favors, inappropriate verbal remarks)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Did anyone ever use force or the threat of force to have sex with you against your will?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<b>If NO, skip to question 38.</b>		
c. If yes, did you ever contract a sexually transmitted disease as a result?	<input type="checkbox"/>	<input type="checkbox"/>

**During any of your deployments: (If no deployment, skip to question 43a)**

	No	Yes		No	Yes
<b>38</b> Were you wounded or injured by hostile actions?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			

**39** Did you ever feel that you were in great danger of being killed?     No     Yes

**40** Did you see anyone wounded, killed, or dead? (Mark all that apply)

- No     Yes, coalition     Yes, enemy     Yes, civilian

**41** Were you engaged in direct combat where you discharged your weapon? (Mark all that apply)

- No     Yes, land     Yes, sea     Yes, air

PLEASE DO NOT WRITE IN THIS AREA



SERIAL #

**42** Since returning from your deployment, have you had serious conflicts with your spouse, family members, or close friends that continue to cause you worry or concern?

- No  Yes

**43a** During the **past 12 months**, have you smoked cigarettes?

- No  Yes



**43b** IF YES, how many cigarettes do you smoke per day?   number of cigarettes per day

**43c** How old were you when you first started smoking?   age (Skip to question 44)

**43d** IF NO, have you ever smoked cigarettes even occasionally?

- No  Yes → **43e** IF YES, in what year did you last stop?     year

**44** How often do you have a drink containing alcohol?

- Never (Skip to question 48)  Once a month or less  2 to 4 times a month  2 to 3 times a week  4 or more times a week

**45** How many drinks containing alcohol do you have on a typical day **when you are drinking**?

- 1 - 2  3  4  5 - 6  7 - 9  10 or greater

**46** How often do you have 5 or more drinks on one occasion?

- Never  Less than monthly  Once a month  Weekly  Daily or almost daily

**47** Have any of the following happened to you **more than once in the last 6 months**?

	No	Yes
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health	<input type="checkbox"/>	<input type="checkbox"/>
b. 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	<input type="checkbox"/>	<input type="checkbox"/>
c. You missed or were late for work, school, or other activities because you were drinking or hung over	<input type="checkbox"/>	<input type="checkbox"/>
d. You had a problem getting along with other people while you were drinking	<input type="checkbox"/>	<input type="checkbox"/>
e. You drove a car after having several drinks or after drinking too much	<input type="checkbox"/>	<input type="checkbox"/>

**48** How often do you use seat belts when you drive or ride in a car?

- Always  Nearly always  Sometimes  Seldom  Never  Never drive or ride in a car (Skip to question 50)

**49** During the **past 4 weeks**, how many times did you ride with a driver who had perhaps too much to drink?

- number of times  None  Don't know

**50** Do you ride a motorcycle?  No  Yes, usually with a helmet  Yes, usually without a helmet

**51** Do you usually drive... (Mark only one)

- 20 miles per hour or more over the speed limit  about 5 miles per hour over the speed limit  
 about 15 miles per hour over the speed limit  at or below the speed limit  
 about 10 miles per hour over the speed limit  never drive

**52** During the **past 3 years**, have you:

No Yes

- a. Gotten a ticket for speeding?  No  Yes
- b. Gotten a warning for speeding?  No  Yes
- c. Gotten a ticket for any other moving violation (such as running a red light or stop sign)?  No  Yes
- d. Been convicted of DWI or DUI?  No  Yes
- e. Had your car insurance canceled or premiums increased as a result of claims or points?  No  Yes

**53a** Since 2001, have you been in a vehicle crash while in the United States?

- No (Skip to question 54)
- Yes



**53b** If so, were you: (Mark all that apply)

Yes Number of crashes

- a. On a motorcycle wearing a helmet?  Yes →
- b. On a motorcycle not wearing a helmet?  Yes →
- c. In a vehicle as a driver?  Yes →
- d. In a vehicle as a passenger?  Yes →
- e. Speeding over the limit?  Yes →
- f. Driving while intoxicated or under the influence?  Yes →
- g. Wearing a seatbelt?  Yes →

**53c** Did any of these crashes occur: (Mark all that apply)

Yes Number of crashes

- a. Before first deployment?  Yes →
- b. Between deployments?  Yes →
- c. Since last deployment?  Yes →
- d. Did not deploy  Yes →

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**54** During the **past 12 months**, how many people have you had sex with?

- 0
- 1
- 2
- 3
- 4
- 5+

**55a** During 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?

- No (**Skip to question 56a**)
- Yes

**55b** **IF YES**, thinking back to the last time you had sex with that person, was a condom used?

- No
- Yes

**56a** Have you or your partner ever tried, for a period of **12 months or longer**, to become pregnant?

- No (**Skip to question 57a**)
- Yes

**56b** **IF YES**, did you or your partner eventually get pregnant?

- Stopped trying
- Got pregnant
- Still trying

**56c** Did you or your partner seek any medical help while trying to get pregnant?

- No (**Skip to question 57a**)
- Yes

**56d** Did the medical provider find any of the following reasons to explain why you or your partner were having difficulty getting pregnant?

- Problems with ovulation
- Blocked tubes
- Endometriosis
- Semen or sperm problems
- No reason found
- Other (**Please specify**) \_\_\_\_\_

**57a** **If you are FEMALE:** Have you ever been pregnant, regardless of whether there was a live birth outcome from that pregnancy?

- No (**Skip to question 59**)
- Yes →  number of pregnancies (**Continue with question 58**)

**57b** **If you are MALE:** Have you ever been the biological father in any pregnancy, regardless of whether there was a live birth outcome from that pregnancy?

- No (**Skip to question 65**)
- Yes →  number of pregnancies (**Continue with question 58**)



**58** Please provide information on ALL of your pregnancies or pregnancies of your partner in which you are the biological father. 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 or due date	Birth weight (if live birth)	Length of pregnancy	Birth defects	Did partner serve in:																							
1	<input type="checkbox"/> Live Birth <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Stillbirth <input type="checkbox"/> Miscarriage <input type="checkbox"/> Other: <hr/>	<table border="1"> <tr> <td>m</td><td>m</td><td>/</td><td>y</td><td>y</td> </tr> </table>	m	m	/	y	y	<table border="1"> <tr><td> </td><td> </td></tr> <tr><td>lbs.</td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>oz.</td><td> </td></tr> </table>			lbs.				oz.		<table border="1"> <tr><td> </td><td> </td></tr> <tr><td>Months</td><td> </td></tr> <tr><td>or</td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>Weeks</td><td> </td></tr> </table>			Months		or				Weeks		<input type="checkbox"/> No <input type="checkbox"/> Yes (please describe): <hr/>	<input type="checkbox"/> OEF/OIF <input type="checkbox"/> Military <input type="checkbox"/> None
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If you are FEMALE please continue to question 59. If you are MALE please skip to question 65.

**59** What forms of contraception have you used before, during, or after active duty? (Mark all that apply)

	Before active duty	On active duty not deployed	On active duty deployed	After separation from active duty
a. Birth control pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Birth control ring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Birth control patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Male condoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Female condoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Partner's vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Injectable, e.g., Depo-Provera®, Lunelle®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Calendar/rhythm method or natural family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Diaphragm or cervical cap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Intrauterine device (IUD), e.g., Mirena®, copper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Morning after pills/emergency contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Foam or jelly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Progestin implant, e.g., Norplant®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Not sexually active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Other: (Please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**60** Have you experienced any of the following?

	Before active duty	On active duty not deployed	On active duty deployed	After separation from active duty
a. Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Painful periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Abnormal Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Pelvic inflammatory disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Chronic pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Low sexual interest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

61 Are you currently using a hormonal method to stop or control your period?

No  Yes (Please specify) \_\_\_\_\_

Please answer questions 62-64 only if you were deployed. If not deployed, please skip to question 65.

62 While deployed, was it easy for you to get contraception?

No  Yes  Not desired

63a While deployed, did you use any hormonal methods to stop or control your period?

No  Yes (Please specify) \_\_\_\_\_ (Skip to question 64)

63b Were you offered a hormonal method to stop or control your period by a health care provider?

No  Yes (Skip to question 64)

63c Would you have preferred to have a hormonal method to stop or control your period?

No  Yes

64 While deployed, did you have access to sanitary supplies (e.g., pads, tampons)?

No  Yes  Not needed

65 During the past 12 months, what were you doing most of the time?

Employed for wages  Looking for work or unemployed  Student  
 Self-employed  On disability/unable to work  Retired  
 On active duty  Homemaker/caring for family  Other (Please specify) \_\_\_\_\_

66 Current marital status: →  Married or living with partner  Single, never married  Widowed  
 Married but separated from partner  Divorced

67 Current annual household income before taxes: →  Less than \$35,000  \$50,000–\$74,999  \$100,000–\$149,999  
 \$35,000–\$49,999  \$75,000–\$99,999  \$150,000 or more

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

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

69 What is your race/ethnicity? (Mark all that apply)

White  Hispanic or Latino  American Indian or Alaska Native  
 Black or African American  Asian  Native Hawaiian or Pacific Islander

70 About how tall are you without shoes? →  and  inches

71 About how much do you weigh without shoes? →  pounds  
*\*If currently pregnant, please give your usual weight before becoming pregnant.*

72 Gender:  Male  Female

Thank you very much for taking the time to complete this questionnaire. Your assistance in providing this information is very much appreciated. Please mail this completed questionnaire with the signed Consent Form in the postage-paid envelope as soon as possible. If you have any questions, you may call us at 1-877-VET-0088 or e-mail us at vetwellness@hmstech.com.

National Health Study for a New Generation of U.S. Veterans, c/o HMS TECHNOLOGIES, INC., P.O. Box 708, Martinsburg, WV 25402

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