

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

**HOS 2.5 2013**

**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:

58. What is your sex?

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 36 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.

OMB 0938-0701

## Medicare Health Outcomes Survey

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

**Excellent**

**Very good**

**Good**

**Fair**

**Poor**

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**

	<b>Yes, limited a lot</b>	<b>Yes, limited a little</b>	<b>No, not limited at all</b>
a. <b>Moderate activities</b> , 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 <b>several</b> 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?**

	<b>No, none of the time</b>	<b>Yes, a little of the time</b>	<b>Yes, some of the time</b>	<b>Yes, most of the time</b>	<b>Yes, all of the time</b>
a. <b>Accomplished less</b> 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 <b>kind</b> 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)?

	<b>No, none of the time</b>	<b>Yes, a little of the time</b>	<b>Yes, some of the time</b>	<b>Yes, most of the time</b>	<b>Yes, all of the time</b>
a. <b>Accomplished less</b> 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 <b>carefully</b> 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**

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**:

	<b>All of the time</b>	<b>Most of the time</b>	<b>A good bit of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
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.)?

<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
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**?

<b>Much better</b>	<b>Slightly better</b>	<b>About the same</b>	<b>Slightly worse</b>	<b>Much worse</b>
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**?

<b>Much better</b>	<b>Slightly better</b>	<b>About the same</b>	<b>Slightly worse</b>	<b>Much worse</b>
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"/>

11. Because of a health or physical problem, do you have any difficulty doing the following activities?

	No	Yes	I don't do this activity
a. Preparing meals .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Managing money.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Taking medication as prescribed .....	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.

12. 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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13. 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
--	--	------

14. 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
--	--	------

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

- |   | Yes                                   | No                                    |  |                            |
|---|---------------------------------------|---------------------------------------|--|----------------------------|
| 15. Are you blind or do you have serious difficulty seeing, even when wearing glasses?.....   | 1 <input type="checkbox"/>            | 2 <input type="checkbox"/>            |  |                            |
| 16. Are you deaf or do you have serious difficulty hearing?.....  | 1 <input type="checkbox"/>            | 2 <input type="checkbox"/>            |  |                            |
| 17. Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?.....             | 1 <input type="checkbox"/>            | 2 <input type="checkbox"/>            |  |                            |
| 18. Do you have serious difficulty walking or climbing stairs?.....   | 1 <input type="checkbox"/>            | 2 <input type="checkbox"/>            |  |                            |
| 19. Do you have difficulty dressing or bathing?.....  | 1 <input type="checkbox"/>            | 2 <input type="checkbox"/>            |  |                            |
| 20. Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?..... | 1 <input type="checkbox"/>            | 2 <input type="checkbox"/>            |  |                            |
| 21. In the last month, how often did memory problems interfere with your daily activities?  |                                       |                                       |  |                            |
| <b>Every day</b><br>(7 days a week)   | <b>Most days</b><br>(5-6 days a week) | <b>Some days</b><br>(2-4 days a week) | <b>Rarely</b><br>(once a week or less) | <b>Never</b>               |
| 1 <input type="checkbox"/>  | 2 <input type="checkbox"/>            | 3 <input type="checkbox"/>            | 4 <input type="checkbox"/>             | 5 <input type="checkbox"/> |

- | <b>Has a doctor ever told you that you had:</b>   | Yes                        | No                         |
|---|----------------------------|----------------------------|
| 22. Hypertension or high blood pressure.....  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 23. Angina pectoris or coronary artery disease.....   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 24. Congestive heart failure.....   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 25. A myocardial infarction or heart attack.....  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 26. Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat..... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 27. A stroke.....   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 28. Emphysema, or asthma, or COPD (chronic obstructive pulmonary disease).....                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

**Has a doctor ever told you that you had:**

- |  | <b>Yes</b>                 | <b>No</b>                  |
|--|----------------------------|----------------------------|
| 29. Crohn's disease, ulcerative colitis, or inflammatory bowel disease.....        | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 30. Arthritis of the hip or knee.....  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 31. Arthritis of the hand or wrist.....  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 32. Osteoporosis, sometimes called thin or brittle bones.....                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 33. Sciatica (pain or numbness that travels down your leg to below your knee)..... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 34. Diabetes, high blood sugar, or sugar in the urine.....                         | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 35. Depression.....  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 36. Any cancer (other than skin cancer).....                                       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

***If you answered "yes" to question 36 above (that you have had cancer),***

37. Are you currently under treatment for:
- |                                | <b>Yes</b>                 | <b>No</b>                  |
|--------------------------------|----------------------------|----------------------------|
| a. Colon or rectal cancer..... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b. Lung cancer.....            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| c. Breast cancer.....          | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| d. Prostate cancer.....        | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

38. In the past 7 days, how much did pain interfere with your day to day activities?
- | <b>Not at all</b>          | <b>A little bit</b>        | <b>Somewhat</b>            | <b>Quite a bit</b>         | <b>Very much</b>           |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

39. In the past 7 days, how often did pain keep you from socializing with others?
- | <b>Never</b>               | <b>Rarely</b>              | <b>Sometimes</b>           | <b>Often</b>               | <b>Always</b>              |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

40. In the past 7 days, how would you rate your pain on average?
- | <b>No pain</b>              |                             |                             |                             |                             |                             |                             |                             |                             | <b>Worst imaginable pain</b> |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|------------------------------|
| 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> | 05 <input type="checkbox"/> | 06 <input type="checkbox"/> | 07 <input type="checkbox"/> | 08 <input type="checkbox"/> | 09 <input type="checkbox"/> | 10 <input type="checkbox"/>  |

41. Over the past 2 weeks, how often have you been bothered by any of the following problems?
- | <b>Not at all</b> | <b>Several days</b> | <b>More than half the</b> | <b>Nearly every day</b> |
|-------------------|---------------------|---------------------------|-------------------------|
|-------------------|---------------------|---------------------------|-------------------------|

**days**

- a. Little interest or pleasure in doing things ..... 1  2  3  4
- b. Feeling down, depressed or hopeless ..... 1  2  3  4

42. 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

43. 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

44. 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 45**  
2  No → **Go to Question 48**

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

- 1  A big problem → **Go to Question 46**  
2  A small problem → **Go to Question 46**  
3  Not a problem → **Go to Question 48**

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

- 1  Yes  
2  No

47. 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



48. 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.

Yes

→ Go to Question 49

No

→ Go to Question 49

I had no visits in the past 12 months

→ Go to Question 50

49. 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.

Yes

No

50. 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?

Yes

No

I had no visits in the past 12 months

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

Yes

No

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

Yes

No

53. 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.

Yes

No

I had no visits in the past 12 months

54. 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

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

			lbs.
--	--	--	------

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

	ft.			in.
--	-----	--	--	-----

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

1	9		
---	---	--	--

58. What is your sex?

- Male  
 Female

59. Are you Hispanic, Latino/a or Spanish Origin? (One or more categories may be selected)

- No, not of Hispanic, Latino/a or Spanish origin  
 Yes, Mexican, Mexican American, Chicano/a  
 Yes, Puerto Rican  
 Yes, Cuban  
 Yes, Another Hispanic, Latino/a or Spanish origin

60. What is your race? (One or more categories may be selected)

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Korean                 |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Guamanian or Chamorro  |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Other Pacific Islander |

61. How well do you speak English?

- Very well  
 Well

- 3  Not well
- 4  Not at all

62. What is your current marital status?

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

63. 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

64. Do you live alone or with others?

- 1  Alone
- 2  With spouse/significant other
- 3  With children/other relatives
- 4  With non-relatives
- 5  With paid caregiver

65. Where do you live?

- 1  Independent house, apartment, condominium or mobile home → **Go to Question 66**
- 2  Assisted living apartment or board and care home → **Go to Question 66**
- 3  Nursing home → **Go to Question 69**
- 4  Other → **Go to Question 69**

66. 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

67. Do you currently provide care for someone else in your home?

- 1  Yes
- 2  No

**If you answered "yes" to question 67 above (that you currently provide care for someone else in your home),**

68. How often do you provide care? **Please provide both Hours per day and Days per week.**

Hours per day       Days per week

69. Do you have difficulty driving or getting a ride to places you need to go?

- 1  Always or almost always
- 2  Sometimes
- 3  Almost never or never

70. Who completed this survey form?

- 1  Person to whom survey was addressed      **→ Go to Question 72**
- 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

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

First Name

Last Name

72. 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.**

“According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information that does not display a valid OMB control number. The valid OMB control number for this information collection is 0938-0701. The time required to complete this information collection is estimated to average 20 minutes including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, C3-24-07, Baltimore, Maryland 21244-1850.”

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