Form Approved

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**SASH Participant**

**Survey**

**Sponsored by**

**The U.S. Department of Health and Human Services**

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| **Survey Instructions**Answer each question by marking the box to the left of your answer. Yes No**Your Health****1.** Please think about the health care provider you see most often. In the last 12 months, how many times did you visit this provider to get care for yourself?1 None2 1 time3 24 35 46 5 to 97 10 or more times**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?**2a.** Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?1 Yes, limited a lot2 Yes, limited a little3 No, not limited at all**2b.** Climbing several flights of stairs?1 Yes, limited a lot2 Yes, limited a little3 No, not limited at all**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?**3a.** Accomplished less than you would like?1 Yes2 No | **3b.** Were limited in the kind of work or other activities?1 Yes2 No**3c.** During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?1 Not at all2 A little bit3 Moderately4 Quite a bit5 Extremely**4.** Please indicate which statement best describes your own health state today?**4a.** **Mobility** 1 I have no problems in walking about2 I have some problems in walking about3 I am confined to bed**4b.** **Self-Care**1 I have no problems with self-care2 I have some problems washing or dressing myself3 I am unable to wash or dress myself**4c.** **Usual activities** (e.g. work, study, housework, family or leisure activities)1 I have no problems with performing my usual activities2 I have some problems performing my usual activities3 I am unable to perform my usual activities**4d.** **Pain/Discomfort**1 I have no pain or discomfort2 I have moderate pain or discomfort3 I have extreme pain or discomfort**4e.** **Anxiety/Depression**1 I am not anxious or depressed2 I am moderately anxious or depressed3 I am extremely anxious or depressed |
| **5.** Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person?**5a.** Bathing1 No, I do not have difficulty2 Yes, I have difficulty3 I am unable to do this activity**5b.** Dressing1 No, I do not have difficulty2 Yes, I have difficulty3 I am unable to do this activity**5c.** Eating1 No, I do not have difficulty2 Yes, I have difficulty3 I am unable to do this activity**5d.** Getting in or out of chairs1 No, I do not have difficulty2 Yes, I have difficulty3 I am unable to do this activity**5e.** Walking1 No, I do not have difficulty2 Yes, I have difficulty3 I am unable to do this activity**5e.** Using the toilet1 No, I do not have difficulty2 Yes, I have difficulty3 I am unable to do this activity**Your Medications****6.** Below is a list of problems that people sometimes have with their medicines. Please check how hard it is for you to do each of the following:**6a.** Open or close the medication bottle1 very hard2 somewhat hard3 not hard at all | **6b.** Read the print on the bottle1 very hard2 somewhat hard3 not hard at all**6c.** Remember to take all the pills1 very hard2 somewhat hard3 not hard at all**6d.** Get your refills in time1 very hard2 somewhat hard3 not hard at all**6e.** Take so many pills at the same time1 very hard2 somewhat hard3 not hard at all**Your Diet****7.** The next questions are about your recent diet.**7a.** Has your food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?1 severe loss of appetite2 moderate loss of appetite3 no loss of appetite**7b.** How many full meals do you eat each day?1 1 meal2 2 meals3 3 meals**7c.** Do you eat at least one serving of dairy products (milk, cheese, yogurt) each day?1 Yes2 No**7d.** Do you eat at two or more servings of peas, beans or eggs each week? 1 Yes2 No |

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| **7e.** Do you eat meat, fish, or poultry every day?1 Yes2 No**7f.** Do you eat two or more servings of fruits or vegetables per day?1 Yes2 No**7g.** How much fluid (water, juice, coffee, tea, milk) do you consume per day?1 less than 3 cups2 3 to 5 cups3 more than 5 cups**7h.** Which of the following best describe how you are fed?1 I’m unable to eat without assistance2 I’m able to fee myself with some difficulty3 I can feed myself without any problems**7i.** How would you describe your nutritional status?1 I think I’m malnourished2 I’m uncertain about my nutritional state3 I don’t think I have any nutritional problems**About You****8.** In general, how would you rate your overall health?1 Excellent2 Very good3 Good4 Fair5 Poor**9.** What is your age?1 18 to 242 25 to 343 35 to 444 45 to 545 55 to 646 65 to 747 75 to 848 85 or older | **10.** Are you male or female?1 Male2 Female**11.** What is the highest grade or level of school that you have completed?1 8th grade or less2 Some high school, but did not graduate3 High school graduate or GED4 Some college or 2-year degree5 4-year college graduate6 More than 4-year college degree**12.** Are you of Hispanic or Latino origin or descent?1 Yes, Hispanic or Latino2 No, not Hispanic or Latino**13.** What is your race? Mark one or more.1 White2 Black or African American3 Asian4 Native Hawaiian or Other PacificIslander5 American Indian or Alaskan Native6 Other**14.** Did someone help you complete this survey? 1 Yes2 No → **Thank you.****Please return the completed survey in the postage-paid envelope.****15.** How did that person help you? Mark one or more.1 Read the questions to me2 Wrote down the answers I gave3 Answered the questions for me4 Translated the questions into my language5 Helped in some other way |

**Thank you**

**Please return the completed survey in the postage-paid envelope.**