Medicare Health Outcomes Survey (HOS)

Questionnaire (English)

HOS 3.0 2015

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 like this:

  57. Are you male or female?

  1 ☒ Male

  2 ☐ Female

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

If you answered "yes" to question 34 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].

"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, C1-25-05, Baltimore, Maryland 21244-1850."

OMB 0938-0701 Version 02-1

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

Medicare Health Outcomes Survey

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

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

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

ACTIVITIES	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.....	1☐	2☐	3☐
b. Climbing **several** flights of stairs.....	1☐	2☐	3☐

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

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
a. **Accomplished less** than you would like	1☐	2☐	3☐	4☐	5☐
b. Were limited in the **kind** of work or other activities.....	1☐	2☐	3☐	4☐	5☐

4. During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
a. **Accomplished less** than you would like	1☐	2☐	3☐	4☐	5☐
b. Didn't do work or other activities as **carefully** as usual.....	1☐	2☐	3☐	4☐	5☐

5. During the **past 4 weeks,** how much did **pain** interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
1☐	2☐	3☐	4☐	5☐

These questions are about how you feel and how things have been with you during the **past 4 weeks.** For each question, please give the one answer that comes closest to the way you have been feeling.

6. How much of the time during the **past 4 weeks:**

	All of the time	**Most of the time**	**A good bit of the time**	**Some of the time**	**A little of the time**	**None of the time**
a. Have you felt calm and peaceful?	1☐	2☐	3☐	4☐	5☐	6☐
b. Did you have a lot of energy?	1☐	2☐	3☐	4☐	5☐	6☐
c. Have you felt downhearted and blue?	1☐	2☐	3☐	4☐	5☐	6☐

7. During the **past 4 weeks,** how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
1☐	2☐	3☐	4☐	5☐

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

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

Much better	**Slightly better**	**About the same**	**Slightly worse**	**Much worse**
1☐	2☐	3☐	4☐	5☐

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

Much better	**Slightly better**	**About the same**	**Slightly worse**	**Much worse**
1☐	2☐	3☐	4☐	5☐

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☐	2☐	3☐
b. Dressing.....	1☐	2☐	3☐
c. Eating.....	1☐	2☐	3☐
d. Getting in or out of chairs	1☐	2☐	3☐
e. Walking	1☐	2☐	3☐
f. Using the toilet	1☐	2☐	3☐

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

	No, I do not have difficulty	**Yes, I have difficulty**	**I don't do this activity**
a. Preparing meals.....	1☐	2☐	3☐
b. Managing money.....	1☐	2☐	3☐
c. Taking medication as prescribed.....	1☐	2☐	3☐

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. Your best estimate is fine.

    ☐☐ **days**

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. Your best estimate is fine.

☐☐ **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. Your best estimate is fine.

    ☐☐ **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☐	2☐
16. Are you deaf or do you have serious difficulty hearing, even with a hearing aid?	1☐	2☐
17. **Because of a physical, mental, or emotional condition**, do you have **serious** difficulty concentrating, remembering or making decisions?	1☐	2☐
18. **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☐	2☐

19. In the past month, how often did memory problems interfere with your daily activities?

Every day (7 days a week)	**Most days (5-6 days a week)**	**Some days (2-4 days a week)**	**Rarely (once a week or less)**	**Never**
1☐	2☐	3☐	4☐	5☐

Has a doctor ever told you that you had:	**Yes**	**No**
20. Hypertension or high blood pressure	1☐	2☐
21. Angina pectoris or coronary artery disease	1☐	2☐
22. Congestive heart failure	1☐	2☐
23. A myocardial infarction or heart attack	1☐	2☐

Has a doctor ever told you that you had:	**Yes**	**No**
24. Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat	1☐	2☐
25. A stroke	1☐	2☐
26. Emphysema, or asthma, or COPD (chronic obstructive pulmonary disease)	1☐	2☐
27. Crohn's disease, ulcerative colitis, or inflammatory bowel disease	1☐	2☐
28. Arthritis of the hip or knee	1☐	2☐
29. Arthritis of the hand or wrist	1☐	2☐
30. Osteoporosis, sometimes called thin or brittle bones	1☐	2☐
31. Sciatica (pain or numbness that travels down your leg to below your knee)	1☐	2☐
32. Diabetes, high blood sugar, or sugar in the urine	1☐	2☐
33. Depression	1☐	2☐
34. Any cancer (other than skin cancer)	1☐	2☐

If you answered "yes" to question 34 above (that you have had cancer),

35. Are you currently under treatment for:	**Yes**	**No**
a. Colon or rectal cancer	1☐	2☐
b. Lung cancer	1☐	2☐
c. Breast cancer	1☐	2☐
d. Prostate cancer	1☐	2☐
e. Other cancer (other than skin cancer)	1☐	2☐

36. In the past 7 days, how much did pain interfere with your day to day activities?

Not at all	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
1☐	2☐	3☐	4☐	5☐

37. In the past 7 days, how often did pain keep you from socializing with others?

Never	**Rarely**	**Sometimes**	**Often**	**Always**

1☐ 2☐ 3☐ 4☐ 5☐

38. In the past 7 days, how would you rate your pain **on average**?

No pain									**Worst imaginable pain**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
01☐	02☐	03☐	04☐	05☐	06☐	07☐	08☐	09☐	10☐

39. Over the past 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	1☐	2☐	3☐	4☐
b. Feeling down, depressed or hopeless	1☐	2☐	3☐	4☐

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

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

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

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

42. Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?

1☐ Yes ➔***Go to Question 43***
2☐ No ➔***Go to Question 46***

43. During the past six months, how much did leaking of urine make you change your daily activities or interfere with your sleep?

1☐ A lot
2☐ Somewhat

3 ☐ Not at all

44. Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine?

1 ☐ Yes

2 ☐ No

45. There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches?

1 ☐ Yes
2 ☐ No

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

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

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

1 ☐ Yes
2 ☐ No

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

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

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

1 ☐ Yes
2 ☐ No

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

1 ☐ Yes
2 ☐ No

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

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

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

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

1 ☐ Yes
2 ☐ No

53. During the past month, on average, how many hours of actual sleep did you get at night? (This may be different from the number of hours you spent in bed.)

1 ☐ Less than 5 hours
2 ☐ 5 – 6 hours
3 ☐ 7 – 8 hours
4 ☐ 9 or more hours

54. During the past month, how would you rate your overall sleep quality?

1 ☐ Very Good
2 ☐ Fairly Good
3 ☐ Fairly Bad
4 ☐ Very Bad

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

lbs.

56. How tall are you without shoes on in feet (ft.) and inches (in.)? Please remember to fill in both feet and inches (for example, 5 ft. 00 in.) If 1/2 in., please round up.

☐ ft. ☐☐ in.

57. Are you male or female?

1 ☐ Male
2 ☐ Female

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

1 ☐ No, not of Hispanic, Latino/a or Spanish origin
2 ☐ Yes, Mexican, Mexican American, Chicano/a
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, Another Hispanic, Latino/a or Spanish origin

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

01 ☐ White
02 ☐ Black or African American
03 ☐ American Indian or Alaska Native
04 ☐ Asian Indian
05 ☐ Chinese
06 ☐ Filipino
07 ☐ Japanese
08 ☐ Korean
09 ☐ Vietnamese
10 ☐ Other Asian
11 ☐ Native Hawaiian
12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander

60. How well do you speak English?

1 ☐ Very well
2 ☐ Well
3 ☐ Not well
4 ☐ Not at all

61. What is your current marital status?

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

62. 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

63. Do you live alone or with others? (One or more categories may be selected)

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

64. Where do you live?

1 ☐ House, apartment, condominium or mobile home ➔***Go to Question 65***
2 ☐ Assisted living or board and care home ➔***Go to Question 65***
3 ☐ Nursing home ➔***Go to Question 66***
4 ☐ Other ➔***Go to Question 66***

65. 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

66. Who completed this survey form?

1 ☐ Person to whom survey was addressed ➔ ***Go to Question 68***

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

67. If you completed the survey for someone else, please fill in your name. **DO NOT** complete this question if you completed the survey for yourself. Please **print** clearly.

First Name

Last Name

68. 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.

Insert Vendor Contact Information Here