

National Institutes of Health
U.S. Department of Health and Human Services

OMB# 0925-0538

Expiration Date: October 31, 2014



Health Information National Trends Survey



START HERE:

1. Is there more than one person age 18 or older living in this household?

Yes

No → GO TO A1 on the next page

2. Including yourself, how many people age 18 or older live in this household?

3. **The adult with the next birthday should complete this questionnaire.** This way, across all households, HINTS will include responses from adults of all ages.

4. Please write the first name, nickname or initials of the adult with the next birthday. This is the person who should complete the questionnaire.

Si prefiere recibir la encuesta en español, por favor llame 1-888-738-6812

STATEMENT OF PRIVACY: Collection of this information is authorized by The Public Health Service Act, Sections 411 (42 USC 285 a) and 412 (42 USC 285a-1.a and 285a1.3). The purpose of this data collection is to evaluate whether the survey questions are easy to understand. The results of the data collection will be used to improve the survey instrument. Rights of study participants are protected by The Privacy Act of 1974. Participation is voluntary, and there are no penalties for not participating or withdrawing from the study at any time. Refusal to participate will not affect your benefits in any way. The information collected in this study will be kept private under the Privacy Act and will only be seen by people authorized to work on this project. The report summarizing the findings will not contain any names or identifying information. Identifying information will be destroyed when the project ends.

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A: Looking For Health Information

A1. Have you ever looked for information about health or medical topics from any source?

- Yes
 No → **GO TO A6 in the next column**

A2. The most recent time you looked for information about health or medical topics, where did you go first?

Mark **only one.**

- Books
 Brochures, pamphlets, etc.
 Cancer organization
 Family
 Friend/Co-worker
 Doctor or health care provider
 Internet
 Library
 Magazines
 Newspapers
 Telephone information number
 Complementary, alternative, or unconventional practitioner

A3. The most recent time you looked for information about health or medical topics, who was it for?

- Myself
 Someone else
 Both myself and someone else

A4. Have you ever looked for information about cancer from any source?

- Yes
 No → **GO TO A6 in the next column**

A5. Based on the results of your most recent search for information about cancer, how much do you agree or disagree with each of the following statements?

Strongly agree Somewhat agree Somewhat disagree Strongly disagree

- a. It took a lot of effort to get the information you needed....................
- b. You felt frustrated during your search for the information....................
- c. You were concerned about the quality of the information....................
- d. The information you found was hard to understand....................

A6. Overall, how confident are you that you could get advice or information about cancer if you needed it?

- Completely confident
 Very confident
 Somewhat confident
 A little confident
 Not confident at all

A7. In general, how much would you trust information about cancer from each of the following?

Not at all A little Some A lot

- a....................
- b.....Family or friends....................
- c.....Newspapers or magazines....................
- d....................
- e....................
- f.....Television....................
- g.....Government health agencies....................
- h.....Charitable organizations....................
- i.....Religious organizations and leaders....................

B: Using the Internet to Find Information

B1. Do you ever go on-line to access the Internet or World Wide Web, or to send and receive e-mail?

- Yes
- No → **GO TO B4 in the next column**

B2. When you use the Internet, do you access it through...

GO TO B10 in the next column

Yes No

- a.....A regular dial-up telephone line
- b.....Broadband such as DSL, cable or FiOS.....
- c...A cellular network (i.e., phone, 3G/4G)
- d.....A wireless network (Wi-Fi)

B3. In the past 12 months, have you used the Internet to look for information about cancer for yourself?

- Yes
- No

B4. Please indicate if you have each of the following.

Mark **all that apply.**

- Tablet computer like an iPad, Samsung Galaxy, Motorola Xoom, or Kindle Fire
- Smartphone, such as an iPhone, Android, Blackberry, or Windows phone
- Basic cell phone only
- I do not have any of the above

B5. On your tablet or smartphone, do you have any software applications or “apps” related to health?

- Yes
- No → **GO TO B7 on the next page**
- Don't know → **GO TO B7 on the next page**

B6. Have the apps on your smartphone or tablet related to health done any of the following?

Yes No

- a.....Helped you achieve a health-related goal such as quitting smoking, losing weight, or increasing physical activity.....
- b.....Helped you make a decision about how to treat an illness or condition.....
- d.....Led you to ask a doctor new questions, or to get a second opinion from another doctor.....

B7. In the past 12 months, have you used any of the following to exchange medical information with a health care professional?

Mark ~~all that apply.~~

- E-mail
- Text message
- App on a smart phone or mobile device
- Video conference (e.g., Skype, Facetime, etc.)
- Social media (e.g., Facebook, Google+, CaringBridge, etc.)
- Fax
- None

B8. How interested are you in exchanging the following types of medical information with a health care provider electronically?

	<i>Not at all</i>	<i>A little</i>	<i>Somewhat</i>	<i>Very</i>
a. Appointment reminders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. General health tips.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medication reminders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Lab/test results.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Diagnostic information (e.g., medical illnesses or diseases).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Vital signs (e.g., heart rate, blood pressure, glucose levels, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Lifestyle behaviors (e.g., physical activity, food intake, sleep patterns, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Symptoms (e.g., nausea, pain, dizziness, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Digital images/video (e.g., photos of skin lesions).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C: Your Health Care

C1. Not including psychiatrists and other mental health professionals, is there a particular doctor, nurse, or other health professional that you see most often?

- Yes
- No

C2. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs or government plans such as Medicare?

- Yes
- No

C3. Since October of 2013, have you tried to get health insurance for yourself through the new federal health care law (for example, from healthcare.gov or a state Web site)?

- Yes
- No
- I don't know

C4. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

- Within past year (anytime less than 12 months ago)
- Within past 2 years (1 year but less than 2 years ago)
- Within past 5 years (2 years but less than 5 years ago)
- 5 or more years ago
- Don't know
- Never

C5. In the past 12 months, not counting times you went to an emergency room, how many times did you go to a doctor, nurse, or other health professional to get care for yourself?

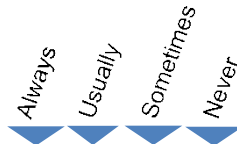
- None → **GO TO D1 on the next page**
- 1 time
- 2 times
- 3 times
- 4 times
- 5-9 times
- 10 or more times

C8. Overall, how would you rate the quality of health care you received in the past 12 months?

- Excellent
- Very good
- Good
- Fair
- Poor

C6. The following questions are about your communication with all doctors, nurses, or other health professionals you saw during the past 12 months.

How often did they do each of the following?



- | | | | |
|---|---|--------------------------|--------------------------|
| a.....Give you the chance to ask all the health-related questions you had..... | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b.....Give the attention you needed to your feelings and emotions..... | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c.....Involve you in decisions about your health care as much as you wanted..... | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d.....Make sure you understood the things you needed to do to take care of your health..... | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Explain things in a way you could understand..... | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f.....Spend enough time <u>with you</u> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g.....Help you deal with feelings of uncertainty about your health or health care..... | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

C7. In the past 12 months, how often did you feel you could rely on your doctors, nurses, or other health care professionals to take care of your health care needs?

- Always
- Usually
- Sometimes
- Never

D: Medical Records

D1. As far as you know, do any of your doctors or other health care providers maintain your medical information in a computerized system?

- Yes
 No

D2. Please indicate how important each of the following statements is to you.

Very important
Somewhat important
Not at all important

a.....Doctors and other health care providers should be able to share your medical information with each other electronically.....

b. You should be able to get to your own medical information electronically.....

D3. How confident are you that safeguards (including the use of technology) are in place to protect your medical records from being seen by people who aren't permitted to see them?

Having safeguards (including the use of technology) in place has to do with the security of your medical records.

- Very confident
 Somewhat confident
 Not confident

D4. How confident are you that you have some say in who is allowed to collect, use, and share your medical information?

Having a say in who can collect, use, and share your medical information has to do with the privacy of your records

- Very confident
- Somewhat confident
- Not confident

D5. Have you ever kept information from your health care provider because you were concerned about the privacy or security of your medical record?

- Yes
- No

D6. If your medical information is sent by fax from one health care provider to another, how concerned are you that an unauthorized person would see it?

- Very concerned
- Somewhat concerned
- Not concerned

D7. If your medical information is sent electronically from one health care provider to another, how concerned are you that an unauthorized person would see it?

Electronically means from computer to computer, instead of by telephone, mail, or fax machine.

- Very concerned
- Somewhat concerned
- Not concerned

D8. Have you ever been offered access to your own personal health information online through a secure website or app by your...

Yes No

- a.....health care provider?
- b.....health insurer?

D9. How many times did you access your personal health information online through a secure website or app in the last 12 months?

- None
- 1 to 2 times
- 3 to 5 times
- 6 to 9 times
- 10 or more times

D10. How many times did you access a family member's personal health information online through the secure website or app over the last 12 months?

- None
- 1 to 2 times
- 3-5 times
- 6 to 9 times
- 10 or more times

E: Medical Research

E1. Have you ever been in a medical research study where you got one of two treatments, such as medicines or surgery procedures?

- Yes
No

E2. Genetic tests that analyze your DNA, diet and lifestyle for potential health risks are currently being marketed by companies directly to consumers. Have you heard or read about these genetic tests?

- Yes
No

E3. How much do you think health behaviors like diet, exercise and smoking determine whether or not a person will develop each of the following conditions?

Table with 5 rows (a-e) and 4 columns (Not at all, A little, Somewhat, A lot) for conditions: Diabetes/High blood sugar, Heart disease, High Blood Pressure/Hypertension.

E4. How much do you think genetics, that is characteristics passed from one generation to the next, determine whether or not a person will develop each of the following conditions?

	Not at all	A little	Somewhat	A lot
a.....Diabetes/High blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.....Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.....High Blood Pressure/Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E5. More and more, people are getting involved in research in new ways beyond being a research subject. They are partnering with medical researchers to help decide what research is done and how it is done. For example, people can suggest important topics to study or how to report results to the public. This is sometimes called “patient engagement” in research.

	Yes	No	Not sure
a. Have you ever heard about “patient engagement” in medical research?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever engaged in medical research in this way?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Would you ever be interested in engaging in research in this way?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F: Your Overall Health

F1. In general, would you say your health is...

- Excellent,
- Very good,
- Good,
- Fair, or
- Poor?

F2. Overall, how confident are you about your ability to take good care of your health?

- Completely confident
- Very confident
- Somewhat confident
- A little confident
- Not confident at all

F3. Has a doctor or other health professional ever told you that you had any of the following medical conditions:

- | | Yes | No |
|---|--------------------------|--------------------------|
| a.....Diabetes or high blood sugar? | <input type="checkbox"/> | <input type="checkbox"/> |
| b....High blood pressure or hypertension? | <input type="checkbox"/> | <input type="checkbox"/> |
| c...A heart condition such as heart attack, angina, or congestive heart failure?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d.....Chronic lung disease, asthma, emphysema, or chronic bronchitis?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e.....Arthritis or rheumatism? | <input type="checkbox"/> | <input type="checkbox"/> |
| f.....Depression or anxiety disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

F4. About how tall are you without shoes?

Feet **and** Inches

F5. About how much do you weigh, in pounds, without shoes?

Pounds

F6. Over the past 2 weeks, how often have you been bothered by any of the following problems?

Nearly every day
More than half the days
Several days
Not at all

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 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.....Feeling nervous, anxious, or on edge..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d.....Not being able to stop or control worrying..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

F7. Is there anyone you can count on to provide you with emotional support when you need it – such as talking over problems or helping you make difficult decisions?

- Yes
- No

F8. Do you have friends or family members that you talk to about your health?

- Yes
- No

F9. If you needed help with your daily chores, is there someone who can help you?

- Yes
- No

G: Health and Nutrition

G1. When available, how often do you use menu information on calories in deciding what to order?

- Always
- Often
- Sometimes
- Rarely
- Never

G2. About how many cups of fruit (including 100% pure fruit juice) do you eat or drink each day?

- None
- ½ cup or less
- ½ cup to 1 cup
- 1 to 2 cups
- 2 to 3 cups
- 3 to 4 cups
- 4 or more cups

1 cup of fruit could be:

- 1 small apple
- 1 large banana
- 1 large orange
- 8 large strawberries
- 1 medium pear
- 2 large plums
- 32 seedless grapes
- 1 cup (8 oz.) fruit juice
- ½ cup dried fruit
- 1 inch-thick wedge of

G3. At any time in the past year, have you intentionally tried to...

- INCREASE the amount of fruit or 100% fruit juice you eat or drink,
- MAINTAIN the same amount of fruit or 100% fruit juice you eat or drink, or
- You haven't really paid attention to the amount of fruit or 100% fruit juice you eat or drink each day?

G4. About how many cups of vegetables (including 100% pure vegetable juice) do you eat or drink each day?

- None
- ½ cup or less
- ½ cup to 1 cup
- 1 to 2 cups
- 2 to 3 cups
- 3 to 4 cups
- 4 or more cups

1 cup of vegetables
could be:

- 3 broccoli spears
- 1 cup cooked leafy greens
- 2 cups lettuce or raw greens
- 12 baby carrots
- 1 medium potato
- 1 large sweet potato
- 1 large ear of corn
- 1 large raw tomato
- 2 large celery sticks

G7. At any time in the past year, have you intentionally tried to...

- Lose weight,
- Maintain your weight,
- Gain weight, or
- You haven't really paid attention to your weight?

G8. How much do you agree or disagree with this statement: "Body weight is something basic about a person that they can't change very much."

- Strongly agree
- Somewhat agree
- Somewhat disagree
- Strongly disagree

G5. At any time in the past year, have you intentionally tried to . . .

- INCREASE the amount of vegetables or 100% vegetable juice you eat or drink,
- MAINTAIN the same amount of vegetables or 100% vegetable juice you eat or drink, or
- You haven't really paid attention to the amount of vegetables or 100% vegetable juice you eat or drink each day?

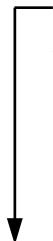
G6. At any time in the past year have you intentionally tried to . . .

- DECREASE the amount of regular soda or pop you usually drink a week,
- MAINTAIN the same amount of regular soda or pop you usually drink a week, or
- You haven't really paid attention to amount of regular soda or pop you usually drink a week?

H: Physical Activity and Exercise

H1. In a typical week, how many days do you do any physical activity or exercise of at least moderate intensity, such as brisk walking, bicycling at a regular pace, and swimming at a regular pace?

- None → **GO TO H3 below**
- 1 day per week
- 2 days per week
- 3 days per week
- 4 days per week
- 5 days per week
- 6 days per week
- 7 days per week



H2. On the days that you do any physical activity or exercise of at least moderate intensity, how long do you typically do these activities?

Write a number in one box below.

<input type="text"/>	<input type="text"/>	Minutes	<input type="text"/>	<input type="text"/>	Hours
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H3. At any time in the past year, have you intentionally tried to . . .

- INCREASE the amount of exercise you get in a typical week,
- MAINTAIN the amount of exercise you get in a typical week, or
- You haven't really paid much attention to the amount of exercise you get?

J: Tobacco Products

H4. People start or continue exercising regularly for lots of reasons. How much do each of the following reflect why you would start or continue exercising regularly?

	<i>Not at all</i>	<i>A little</i>	<i>Some</i>	<i>A lot</i>
a. Pressure from others.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Concern over the way you look.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Feeling guilty when you skip exercising.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Getting enjoyment from exercise.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H5. Over the past 30 days, in your leisure time, how many hours per day, on average, did you sit and watch TV or movies, surf the web, or play computer games? Do not include “active gaming” such as Wii.

		Hours per day
--	--	---------------

H6. How many times in the past 12 months have you used a tanning bed or booth?

- 0 times
- 1 to 2 times
- 3 to 10 times
- 11 to 24 times
- 25 or more times

H7. When you are outside for more than one hour on a warm, sunny day, how often do you wear sunscreen?

- Always
- Often
- Sometimes
- Rarely
- Never
- Don't go out on sunny days

J1. Have you smoked at least 100 cigarettes in your entire life?

Yes
 No → **GO TO J7 below**

J2. How often do you now smoke cigarettes?

- Everyday
- Some days
- Not at all

J3. At any time in the past year, have you stopped smoking for one day or longer because you were trying to quit?

- Yes
- No

J4. Are you seriously considering quitting smoking in the next six months?

- Yes
- No

J5. Have you heard of any tests to find lung cancer before the cancer creates noticeable problems?

- Yes
- No

J6. At any time in the past year, have you talked with your doctor or other health professional about having a test to check for lung cancer?

- Yes
- No
- Don't know

J7. How much do you agree or disagree with this statement: "Smoking behavior is something basic about a person that they can't change very much."

- Strongly agree
- Somewhat agree
- Somewhat disagree
- Strongly disagree

J8. In your opinion, do you think that some smokeless tobacco products, such as chewing tobacco, snus and snuff are less harmful to a person's health than cigarettes?

- Yes
- No
- Don't know

J9. New types of cigarettes are now available called electronic cigarettes (also known as e-cigarettes or personal vaporizers). These products deliver nicotine through a vapor. Compared to smoking cigarettes, would you say that electronic cigarettes are ...

- Much less harmful,
- Less harmful,
- Just as harmful,
- More harmful,
- Much more harmful, or
- I've never heard of electronic cigarettes

J10. A hookah pipe (or shisha) is a large water pipe. People smoke tobacco using hookah pipes in groups at cafes or bars. Compared to smoking cigarettes, would you say that smoking tobacco using a hookah is...

- Much less harmful,
- Less harmful,
- Just as harmful,
- More harmful,
- Much more harmful, or
- I've never heard of Hookah.

J11. How much do you think quitting cigarette smoking can help reduce the harmful effects of smoking?

- Not at all
- A little
- Some
- A lot

J12. How much do you think each of the following help a current smoker reduce the harmful effects of smoking if the person continues to smoke?

	<i>Not at all</i>	<i>A little</i>	<i>Somewhat</i>	<i>A lot</i>
a. Exercising.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Eating fruits and vegetables.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Taking vitamins.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sleeping at least 8 hours per night.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

K: Women and Cancer

K1. Are you male or female?

Male → **GO TO L1 on the next page**

Female



K2. Has a doctor ever told you that you could choose whether or not to have the Pap test?

Yes

No

K3. How long ago did you have your most recent Pap test to check for cervical cancer?

A year ago or less

More than 1, up to 2 years ago

More than 2, up to 3 years ago

More than 3, up to 5 years ago

More than 5 years ago

I have never had a Pap test

K4. A mammogram is an x-ray of each breast to look for cancer.

Has a doctor ever told you that you could choose whether or not to have a mammogram?

Yes

No

K5. When did you have your most recent mammogram to check for breast cancer, if ever?

A year ago or less

More than 1, up to 2 years ago

More than 2, up to 3 years ago

More than 3, up to 5 years ago

More than 5 years ago

I have never had a mammogram

L: Screening for Cancer

L1. Have you ever heard of HPV? HPV stands for Human Papillomavirus. It is not HIV, HSV, or herpes.

- Yes
- No → **GO TO L5 below**



L2. Do you think HPV can cause...

	Yes	No
a.....Cervical Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
b.....Penile Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
c.....Anal Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
d.....Oral Cancer?	<input type="checkbox"/>	<input type="checkbox"/>

L3. Do you think that HPV is a sexually transmitted disease (STD)?

- Yes
- No
- Not sure

L4. Do you think HPV requires medical treatment or will it usually go away on its own without treatment?

- Requires medical treatment
- Will usually go away on its own

L5. A vaccine to prevent HPV infection is available and is called the HPV shot, cervical cancer vaccine, GARDASIL®, or Cervarix®.

Before today, have you ever heard of the cervical cancer vaccine or HPV shot?

- Yes
- No

L6. In your opinion, how successful is the HPV vaccine at preventing cervical cancer?

- Not at all successful
- A little successful
- Pretty successful
- Very successful
- Don't know

L7. Including yourself, is anyone in your immediate family between the ages of 9 and 27 years old?

- Yes
- No → **GO TO L10 below**

L8. In the last 12 months, has a doctor or health care professional ever talked with you or an immediate family member about the HPV shot or vaccine?

- Yes
- No
- Don't know

L9. In the last 12 months, has a doctor or health care professional recommended that you or someone in your immediate family get an HPV shot or vaccine?

- Yes
- No
- Don't know

L10. Has a doctor ever discussed with you the pros and cons of different tests to detect colorectal cancer such as colonoscopy, sigmoidoscopy, or blood stool tests?

- Yes
- No
- I have never discussed these tests with a doctor

Males, continue to L11 in the next column.

Females, GO TO L13 in the next column.

L11. The following questions are about discussions doctors or other health care professionals may have with their patients about the PSA test that is used to look for prostate cancer.

Have you ever had a PSA test?

- Yes
- No

L12. Has a doctor ever discussed with you whether or not you should have the PSA test?

- Yes
- No

L13. How much do you agree or disagree with the statement?

"If experts had conflicting opinions about a medical test or treatment, I would still be willing to try it."

- Strongly agree
- Somewhat agree
- Somewhat disagree
- Strongly disagree

L14. As far as you know, which of the following statements are true or false about medical tests or exams such as colonoscopies, mammograms, and pap tests that check for early signs of cancer?

	True	False	Don't know
a.....These tests can definitely tell that a person has cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.....When a test finds something abnormal, more tests are needed to know if it is cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.....When a test finds something abnormal, it is very likely to be cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.....The harms of these tests and exams sometimes outweigh the benefits.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

M: Your Cancer History

M1. Have you ever been diagnosed as having cancer?

- Yes
 No → **GO TO M13 on page 15**

M2. What type of cancer did you have?

Mark ~~X~~ **all that apply.**

- Bladder cancer
- Bone cancer
- Breast cancer
- Cervical cancer (cancer of the cervix)
- Colon cancer
- Endometrial cancer (cancer of the uterus)
- Head and neck cancer
- Hodgkin's lymphoma
- Leukemia/Blood cancer
- Liver cancer
- Lung cancer
- Melanoma
- Non-Hodgkin lymphoma
- Oral cancer
- Ovarian cancer
- Pancreatic cancer
- Pharyngeal (throat) cancer
- Prostate cancer
- Rectal cancer
- Renal (kidney) cancer
- Skin cancer, non-melanoma
- Stomach cancer
- Other-Specify →

M4. Did you ever receive any treatment for your cancer?

- Yes
 No → **GO TO M8 on the next page**

M5. Which of the following cancer treatments have you ever received?

	Yes	No
a.....Chemotherapy (IV or pill(s))	<input type="checkbox"/>	<input type="checkbox"/>
b.....Radiation	<input type="checkbox"/>	<input type="checkbox"/>
c.....Surgery	<input type="checkbox"/>	<input type="checkbox"/>
d.....Other	<input type="checkbox"/>	<input type="checkbox"/>

M6. About how long ago did you receive your last cancer treatment?

- Still receiving treatment → **GO TO M10 on the next page**
 Less than 1 year ago
 1 year ago to less than 5 years ago
 5 years ago to less than 10 years ago
 10 or more years ago

M7. Did you ever receive a summary document from your doctor or other health care professional that listed all of the treatments you received for your cancer?

- Yes
 No

M3. At what age were you first told that you had cancer?

--	--	--

Age

M8. Were you ever denied health insurance coverage because of your cancer?

- Yes
- No

M9. Looking back, since the time you were first diagnosed with cancer, how much, if at all, has cancer and its treatment hurt your financial situation?

- Not at all
- A little
- Some
- A lot

M10. Clinical trials are research studies that involve people. They are designed to test the safety and effectiveness of new treatments and to compare new treatments with the standard care that people currently get. Have you ever participated in a clinical trial for treatment of your cancer?

- Yes
- No → **GO TO M15 on the next page**
- Don't know

M11. Has a doctor or other member of your medical team discussed clinical trials as a treatment option for your cancer?

- Yes
- No

M12. At any time since you were first diagnosed with cancer, did any doctor or other healthcare provider ever discuss with you the impact of cancer or its treatment on your ability to work?

- Discussed it with me in detail
- Briefly discussed it with me
- Did not discuss it at all
- I don't remember
- I was not working at the time of my diagnosis.

M13. Suppose you have been diagnosed with cancer with a moderate chance of survival and several treatment options, what role would you prefer to take in deciding your cancer treatment?


Mark **only one.**

- I prefer to make the decision with little or no input from my doctor.
- I prefer to make the decision after seriously considering my doctor's opinion.
- I prefer that my doctor and I share responsibility for the decision together.
- I prefer my doctor to make the decision after seriously considering my opinion.
- I prefer to leave all decisions about my treatment to my doctor.

M14. Suppose you have been diagnosed with cancer with a low chance of survival and limited treatment options, what role would you prefer to take in deciding your cancer treatment?

Mark **only one.**

- I prefer to make the decision with little or no input from my doctor.
- I prefer to make the decision after seriously considering my doctor's opinion.
- I prefer that my doctor and I share responsibility for the decision together.
- I prefer my doctor to make the decision after seriously considering my opinion.
- I prefer to leave all decisions about my treatment to my doctor.

 If you've been diagnosed with cancer at any time in your life, please **GO TO N4 on the next page.**

N: Beliefs About Cancer

► Think about cancer in general when answering the questions in this section.

N1. How likely are you to get cancer in your lifetime?

- Very unlikely
- Unlikely
- Neither unlikely nor likely
- Likely
- Very likely

N2. How much do you agree or disagree with each of the following statements?

Strongly agree Somewhat agree Somewhat disagree Strongly disagree

- a. It seems like everything causes cancer....................
- b. There's not much you can do to lower your chances of getting cancer
- c. There are so many different recommendations about preventing cancer, it's hard to know which ones to follow
- d. In adults, cancer is more common than heart disease

N3. How much do you agree or disagree with the statement: "I'd rather not know my chance of getting cancer."

- Strongly agree
- Somewhat agree
- Somewhat disagree
- Strongly disagree

N4. How worried are you about getting cancer?

- Not at all
- Slightly
- Somewhat
- Moderately
- Extremely

N5. Have any of your family members ever had cancer?

- Yes
- No
- Not sure

O: You and Your Household

O1. What is your age?

Years old

O2. What is your current occupational status?

Mark **only one.**

- Employed
- Unemployed
- Homemaker
- Student
- Retired
- Disabled
- Other-Specify →

O3. Have you ever served on active duty in the U.S. Armed Forces, military Reserves or National Guard? Active duty does not include training in the Reserves or National Guard, but DOES include activation, for example, for the Persian Gulf War.

- Yes, now on active duty
- Yes, on active duty in the last 12 months but not now
- Yes, on active duty in the past, but not in the last 12 months
- No, training for Reserves or National Guard only
- No, never served in the military

O4. In the past 12 months, have you received some or all of your health care from a VA hospital or clinic?

- Yes, all of my health care
- Yes, some of my health care
- No, no VA health care received

GO TO O5
on the next
page

O5. What is your marital status?

Mark **only one.**

- Married
- Living as married
- Divorced
- Widowed

- Separated
- Single, never been married

O6. What is the highest grade or level of schooling you completed?

- Less than 8 years
- 8 through 11 years
- 12 years or completed high school
- Post high school training other than college (vocational or technical)
- Some college
- College graduate
- Postgraduate

O7. Were you born in the United States?

- Yes → **GO TO O10 in the next column**
- No

O8. In what year did you come to live in the United States?

Year

O9. How well do you speak English?

- Very well
- Well
- Not well
- Not at all

O10. Are you of Hispanic, Latino/a, or Spanish origin? One or more categories may be selected.

Mark **one or more.**

- 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

O11. What is your race? One or more categories may be selected.

Mark **one or more.**

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander

O12. Including yourself, how many people live in your household?

Number of people

O13. Starting with yourself, please mark the sex, and write in the age and month of birth for each adult 18 years of age or older living at this address.

	Sex	Age	Month Born (01-12)
SELF	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="text"/>
Adult 2	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="text"/>
Adult 3	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="text"/>
Adult 4	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="text"/>
Adult 5	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="text"/>

O17. Is there at least one telephone inside your home that is currently working and is not a cell phone?

- Yes
 No

O14. How many children under the age of 18 live in your household?

Number of children under 18

O15. Do you currently rent or own your home?

- Own
 Rent
 Occupied without paying monetary rent

O16. Does anyone in your family have a working cell phone?

- Yes
 No

O18. Thinking about members of your family living in this household, what is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?

- \$0 to \$9,999
- \$10,000 to \$14,999
- \$15,000 to \$19,999
- \$20,000 to \$34,999
- \$35,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$199,999
- \$200,000 or more



O19. About how long did it take you to complete the survey?

Write a number in one box below.

<input type="text"/>	<input type="text"/>	Minutes	<input type="text"/>	<input type="text"/>	Hours
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O20. At which of the following types of addresses does your household currently receive residential mail?

Mark **All that apply.**

- A street address with a house or building number
- An address with a rural route number
- A U.S. post office box (P.O. Box)
- A commercial mail box establishment (such as Mailboxes R Us, and Mailboxes Etc.)

Thank you!



Please return this questionnaire in the postage-paid envelope within 2 weeks.



If you have lost the envelope, mail the completed questionnaire to:

HINTS Study, TC 1046F
Westat
1600 Research Boulevard
Rockville, MD 20850