# Attachment 5: In-home Survey

OMB No.: 0925-0610
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# Generation Health Study Survey

## Next Plus Participant In-Home Questionnaire



INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

- Read each question carefully.
- Please write or mark your answer clearly.
- Mark the answer that best fits your situation.

# Next Plus

# Chronic Illness and Medication Use

**Medical History**

| Has a doctor, nurse of other health provider told you that you have any of the following conditions | | |
|---|---|---|
| **Condition** | **Yes** | **No** |
| a. Cancer or lymphoma or leukemia. Don't include skin cancer, except melanoma | ☐ | ☐ |
| b. High blood cholesterol or triglycerides or lipids | ☐ | ☐ |
| c. High blood pressure or hypertension (when not pregnant) | ☐ | ☐ |
| d. High blood pressure or hypertension (when not pregnant) | ☐ | ☐ |
| e. High blood sugar or diabetes (when not pregnant) | ☐ | ☐ |
| f. High blood sugar or diabetes (when pregnant only) | ☐ | ☐ |
| g. Heart disease | ☐ | ☐ |
| h. Asthma, chronic bronchitis or emphysema | ☐ | ☐ |
| i. Migraine headaches | ☐ | ☐ |
| j. Depression | ☐ | ☐ |
| k. Post-traumatic stress disorder or PTSD | ☐ | ☐ |
| l. Anxiety or panic disorder | ☐ | ☐ |
| m. Epilepsy or another seizure disorder | ☐ | ☐ |
| n. Attention problem or SDD or ADHD | ☐ | ☐ |
| o. HIV/AIDS | ☐ | ☐ |
| p. Hepatitis C | ☐ | ☐ |
| q. Allergies | ☐ | ☐ |
| r. Celiac disease | ☐ | ☐ |
| s. Other (specify)<br><br>_____ | ☐ | ☐ |

**Medication Use**

Please think about the medicines you are using now.

| In the past 24 hours, have you taken: | | |
|---|---|---|
| **Medication** | **Yes** | **No** |
| a. Aspirin containing mediations including cold and allergy medication or headache powders. Some examples of those include Anacin, Excedrin, Bayer, Goody's Pain Relief. | ☐ | ☐ |
| b. Other non-aspirin anti-inflammatory medications? Some examples include Advil, Ibuprofen, Motrin, 166, Aleve, Naproxen, Nuprin. | ☐ | ☐ |
| c. Any prescription medication whether or not they were prescribed for you? | ☐ | ☐ |
| d. How many different prescription medication have you used in the past 24 hours? | _____ | |

Please list all medications you have taken in the last 24 hours.

| **Name of the Medication** | **Time you took this medication** | | |
|---|---|---|---|
| | Hour: Minute (example 7:30) | AM | PM |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |