

# **Attachment 5: In-home Survey**

OMB No.: 0925-0610 Expiration Date: April 30, 2016



# **Generation Health Study Survey**

Next Plus Participant In-Home Questionnaire

Public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0610). Do not return the completed form to this address.

PRA (0925-0610). Do not return the completed form to this address.					
INSTRUC	INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE				
□ Read €	☐ Read each question carefully.				
☐ Please	☐ Please write or mark your answer clearly.				
☐ Mark tl	☐ 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				
I. 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)				

### **Medication Use**

Please think about the medicines you are using now.

In the past 24 hours, have you taken:				
Medication		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.

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