



Attachment 5: In-home Survey



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.

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 or 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	<input type="checkbox"/>	<input type="checkbox"/>
b. High blood cholesterol or triglycerides or lipids	<input type="checkbox"/>	<input type="checkbox"/>
c. High blood pressure or hypertension (when not pregnant)	<input type="checkbox"/>	<input type="checkbox"/>
d. High blood pressure or hypertension (when not pregnant)	<input type="checkbox"/>	<input type="checkbox"/>
e. High blood sugar or diabetes (when not pregnant)	<input type="checkbox"/>	<input type="checkbox"/>
f. High blood sugar or diabetes (when pregnant only)	<input type="checkbox"/>	<input type="checkbox"/>
g. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
h. Asthma, chronic bronchitis or emphysema	<input type="checkbox"/>	<input type="checkbox"/>
i. Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
j. Depression	<input type="checkbox"/>	<input type="checkbox"/>
k. Post-traumatic stress disorder or PTSD	<input type="checkbox"/>	<input type="checkbox"/>
l. Anxiety or panic disorder	<input type="checkbox"/>	<input type="checkbox"/>
m. Epilepsy or another seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
n. Attention problem or SDD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>
o. HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
p. Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
q. Allergies	<input type="checkbox"/>	<input type="checkbox"/>
r. Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>
s. Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

