Draft

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2018

Your Health and Health Opinions

Your opinion matters!

MEPS
Medical Expenditure Panel Survey

There are a lot of clinical preventive care services available, such as screening tests for different types of cancer or heart disease. Not everyone makes the same choices about which tests to have, when to have a particular test or how often. By answering this questionnaire, you will help MEPS learn about the different choices different people make about preventive care.

This Booklet Should Be Completed By →

REGION: ☐ **RUID:** ☐☐☐☐☐☐☐☐☐ **PID:** ☐☐☐

NAME: _____

_____

DOB: ☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

The Agency for Healthcare Research and Quality and
The Centers for Disease Control and Prevention of the
U.S. Department of Health and Human Services

MEPS
Medical Expenditure Panel Survey

Your Health And Health Choices

START HERE:

1. Are you male or female?

- ☐ Male → Please call Alex Scott, toll free at 1-800-945-6377 before completing.
- ☐ Female

2. What is your age?

- ☐ Under 18
- ☐ 18 to 34
- ☐ 35 to 49
- ☐ 50 or older

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

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

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

a. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

b. Climbing **several** flights of stairs

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

5. 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?**

a. **Accomplished less** than you would like **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

b. Were limited in the **kind** of work or other 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

6. 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)?

a. **Accomplished less** than you would like **as a result of any emotional problems**

- ☐ 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

b. Didn't do work or other activities as **carefully** as usual **as a result of any emotional problems**

- ☐ 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

7. 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

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.

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

a. Have you felt calm and peaceful?

- ☐ 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

b. Did you have a lot of energy?

- ☐ 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

c. Have you felt downhearted and blue?

- ☐ 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

9. 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

10. The following questions ask about how you have been feeling during **the past 30 days.** For each question, please mark the box that best describes how often you had this feeling.

During the past 30 days, about how often did you feel...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. nervous?	☐	☐	☐	☐	☐
b. hopeless?	☐	☐	☐	☐	☐
c. restless or fidgety?	☐	☐	☐	☐	☐
d. so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
e. that everything was an effort?	☐	☐	☐	☐	☐
f. worthless?	☐	☐	☐	☐	☐

11. The following two questions ask about how you have been feeling in the **past 2 weeks.**

Over the last 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	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐

Your Choices about Your Health

12. In the past 12 months, have you received counseling or information about birth control from a doctor or other medical care provider?

- ☐ Yes
- ☐ No

If you are 35 or older, please continue with the questions.
If you are under 35 years old, please turn to the back cover.

13. When was the last time you visited a doctor or nurse for a check-up, follow-up care for an ongoing problem, or a concern that you have about your health? Do not include times you were hospitalized overnight or visits to the hospital emergency room.

- ☐ Within the past 12 months
- ☐ Within the past one to two years
- ☐ Within the past two to five years
- ☐ More than five years ago
- ☐ Never

14. During the past 12 months, have you had either a flu shot (directly in the arm or into the skin) or a flu vaccine that was sprayed in your nose?

- ☐ Yes
- ☐ No

15. In the past 12 months, has a doctor, nurse, or other health care professional weighed you?

- ☐ Yes
- ☐ No

16. About how much do you weigh without shoes?

☐☐☐ **Weight (pounds)**

17. About how tall are you without shoes?

☐☐ **Feet** ☐☐ **Inches**

18. In the past 12 months, has a doctor, nurse, or other health care professional given you advice about how to manage your weight, discussed weight loss goals with you, or referred you to a weight loss program to help with your diet and exercise?

- ☐ Yes
- ☐ No

19. In the last 12 months, has a doctor, nurse, or other health professional asked you how much and how often you drink alcohol? You may have answered in person, on paper, or on a computer.

- ☐ Yes
- ☐ No

20. In the last 12 months, have you had 4 or more drinks in one day? (A drink refers to one 12 oz. beer, 5 oz. glass of wine, or 1.5 oz. shot of hard liquor.)

- ☐ Yes
- ☐ No

21. In the last 12 months, has a doctor, nurse, or other health care professional advised you to cut back or stop drinking alcohol?

- ☐ Yes
- ☐ No

22. Has a doctor, nurse, or other health care professional ever asked you if you smoke or use tobacco? You may have answered in person, on paper, or on a computer.

- ☐ Yes
- ☐ No

23. In the last 12 months, on average, would you say you smoked cigarettes or used tobacco every day, some days, or not at all?

- ☐ Every day
- ☐ Some days
- ☐ Not at all → **If Not at all, go to 27**

24. In the past 12 months, were you advised by a doctor, nurse, or other health care professional to quit smoking or quit using tobacco?

- ☐ Yes
- ☐ No

25. In the past 12 months, were you advised by a doctor, nurse, or other health care professional to take a medication to assist you with quitting smoking or using tobacco? Some medications that can be used are: nicotine gum, patch, nasal spray, inhaler, or prescription medicine.

- ☐ Yes
- ☐ No

26. In the past 12 months, has a doctor, nurse, or other health care professional discussed or provided methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or program to help stop smoking.

- ☐ Yes
- ☐ No

27. In the past 12 months, has your doctor, nurse, or other health care professional asked you about your mood, such as whether you are anxious or depressed? You may have answered in person, on paper, or on a computer.

- ☐ Yes
- ☐ No

28. **During the past 24 months**, have you had your blood pressure checked by a doctor, nurse, or other health care professional?

- ☐ Yes
- ☐ No

29. **Within the past 5 years**, have you had your blood cholesterol checked by a doctor, nurse, or other health care professional?

- ☐ Yes
- ☐ No

30. Have you had a hysterectomy or have you ever had cervical cancer?

- ☐ Yes → **If Yes, go to the next page**
- ☐ No

31. **Within the past 5 years**, have you had a Pap or human papillomavirus (HPV) test? A Pap or HPV test is a routine test in which the doctor takes a cell sample from the cervix with a small stick or brush, and sends it to the lab.

- ☐ Yes
- ☐ No

32. About how old were you the last time you had a Pap or HPV test?

- ☐ Younger than 35
- ☐ 45 to 54 years old
- ☐ 55 to 64 years old
- ☐ 65 to 74 years old
- ☐ 75 or older
- ☐ I have never had a Pap or HPV test

If you are 50 or older, please continue with the questions.
If you are under 50 years old, please turn to the back cover.

33. Have you ever had a pneumonia shot? A pneumonia shot or pneumococcal vaccine is usually only given once or twice in a person's lifetime.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

34. Have you had the shingles vaccine? The vaccine is called Zostavax®, the zoster vaccine, or the shingles vaccine. The chicken pox virus causes shingles. The vaccine has been available since May 2006.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

35. Is there any medical reason why you cannot take aspirin, such as an allergy, another medication you take, or other side effect?

- ☐ Yes → **If Yes, go to 37**
- ☐ No

36. Has a doctor, nurse, or other health care professional ever discussed with you the use of aspirin to prevent heart attack or stroke?

- ☐ Yes
- ☐ No

37. Have you ever been told by a doctor, nurse or other health care professional that you have osteoporosis? Osteoporosis is when the bones become fragile and break easily?

- ☐ Yes → **If Yes, go to 39**
- ☐ No

38. There are several tests to measure bone density and detect osteoporosis at an early stage, including a DEXA scan. Have you ever had your bone density measured?

- ☐ Yes
- ☐ No

39. Have you had both breasts removed or have you ever had breast cancer?

- ☐ Yes → **If Yes, go to 40**
- ☐ No

40. **Within the past 2 years**, have you had a mammogram? A mammogram is an x-ray taken only of the breast by a machine that presses against the breast.

- ☐ Yes
- ☐ No

41. Have you had colon cancer or your entire colon removed?

- ☐ Yes → **If Yes, go to the "Date Completed" box on the next page**
- ☐ No

42. **Within the past 10 years**, have you had a colonoscopy? A colonoscopy test examines the bowel by inserting a tube into the rectum. After a colonoscopy, you feel tired and usually need someone to drive you home.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

43. **Within the past 5 years**, have you had a sigmoidoscopy? A sigmoidoscopy test also examines the bowel by inserting a tube into the rectum. You are awake during this test and can drive yourself home.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

44. **Within the past 12 months**, have you had a blood stool test using a home kit? A doctor, nurse, or other health professional provides you a special kit or cards to use at home to determine whether the stool contains blood.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

Date completed: ☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

THANK YOU FOR COMPLETING THE QUESTIONNAIRE!

- Please place this survey in the envelope provided to you and give it to the MEPS interviewer.
- If the interviewer is no longer available, place the survey in the return envelope provided to you by the interviewer. If the envelope is missing, mail this survey to:

MEPS
c/o Westat
1600 Research Blvd, Room GA51
Rockville, MD 20850