



Draft



Your Health And Health Choices

START HERE:

1. Are you male or female?

Male

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

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 now 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

"VR-12: How to create VR-12 scales and PCS/MCS summaries" © 2014 by Trustees of Boston University. All Rights Reserved.

(Questions concerning the VR-12 can be directed to Professor Lewis E. Kazis, Boston University e-mail: lek@bu.edu)



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



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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?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. hopeless?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. restless or fidgety?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. so sad that nothing could cheer you up?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. that everything was an effort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. worthless?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.....	<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"/>



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Your Choices about Your Health



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

12. 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
13. 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
14. In the past 12 months, has a doctor, nurse, or other health care professional weighed you?
- Yes
 - No
15. About how much do you weigh without shoes?
- Weight (pounds)
16. About how tall are you without shoes?
- Feet Inches



17. 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

18. 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

19. In the last 12 months, have you had 5 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

20. 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

21. 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



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22. 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 26**
23. 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
24. 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
25. 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
26. 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



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

Yes

No

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

Yes

No



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

29. 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

30. 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

31. 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 33**

No

32. 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



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

Yes → **If Yes, go to 37**

No



34. **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

35. **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

36. **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

37. Have you had prostate cancer?

Yes → **If Yes, go to the "Date Completed" box on the next page**

No



38. About how old were you the last time you had a PSA test? A "P-S-A" is a blood test to detect prostate cancer. It is also called a prostate specific antigen test.

Never had a PSA test

Under age 50

Between 51 and 64

Between 65 and 74

75 or older



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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