Millennium Cohort Baseline 2017 Survey

The text in red on the following survey document indicates the source of the survey question.

Consent Form

What is the study about?

You are being asked to be a volunteer in a research study called "The Millennium Cohort Study" conducted by the US Department of Defense (DoD). This study will follow the long-term health of military personnel during and after their military service. The purpose is to assess the health outcomes of military deployment, military occupations, and general military service. You have been scientifically selected to represent your service branch, gender, service type, military occupation, and age group from among the over two million military personnel serving as of XXXXX in the regular Active Duty, Reserve, and National Guard forces. ***Your participation will help determine the long-term health effects of military service, define healthcare policy for future generations of service members, and guide prevention and treatment programs for years to come.***

What will participation involve?

You are being asked to do the following:

Complete the attached survey today. You are also being asked to complete X follow-up surveys over XX years, with one survey to complete every three years. Filling out the survey will take about 45 minutes each time you complete it. The surveys contain questions on a broad range of health topics, including medical conditions, health behaviors, and exposures that may affect your health. We will connect your survey data with other data, medical records, or biomarkers collected and maintained by the Department of Defense, Department of Veterans Affairs health care, disability, and other databases, or federal and state agencies. Additionally, you may be asked to participate in other sub-studies and if you so choose may involve a variety of tests including neurocognitive testing and blood samples. You will be contacted semi-annually to verify your contact information. In addition, there is a 3% random chance that you will be contacted by telephone for focus group testing. You are one of approximately XXXXXX volunteers who are being asked to participate in this very important study.

What risks are involved in the study?

The data collection procedures are not expected to involve any risk or discomfort to you. The main risks to you are those associated with the inappropriate disclosure of data that we collect from or about you. While inappropriate disclosure has the potential to impact your reputation, insurability, or employability, it is important for you to understand that this research group has collected similar information from numerous studies over many years without any cases of inappropriate disclosure. There is also the risk of possible discomfort from answering some sensitive questions, but you may skip any question(s) that make you uncomfortable. If you feel that you might need medical care or counseling you should make contact with the appropriate health care personnel.

How will your data be protected against those risks?

All questionnaires will be kept in locked files. When your data are entered into computer files for analysis, your answers will be identified only by a special study identification number known to you and research team members. This number is located on the barcode of your study envelope and survey. Your social security number and any other personal identification information will be removed from your questionnaire and data file upon return to the researchers. Even if someone outside the research team broke into the files, it would be impossible for them to identify your data. To minimize the risk of anyone breaking into the data files, those files will be maintained on DoD computers protected by all the measures required by DoD computer security regulations. All members of the research team with access to data files will be trained in DoD computer security procedures specifically designed to protect sensitive data. Reports of the study findings will contain only group data, so that no individual study participant can be identified. Similar procedures have been used to protect data in previous studies conducted within this research center.

According to the DoD Policy "Interim Regulations to Improve Privacy Protections for DoD Medical Records" dated October 31, 2000, the information you provide is for research purposes only and may not be disclosed except for specifically authorized purposes or with the consent of the individual about whom the information pertains. Uses and disclosures of this information shall comply with provisions of the Privacy Act and implementing regulations.

continued on page 2...

continued from page 1...

How is your information protected if you complete the questionnaire using the Internet web site option?

All information collected through the Internet questionnaire option is done by using Secure Sockets Layer (SSL) data transmission lines. SSL encrypts, or scrambles, all questionnaire data sent over the Internet. Information will only be understandable when it reaches the investigator database. The same methods of protection listed above will then be followed to further protect your information.

What are the benefits of participating in the study?

While your participation in this study will not directly benefit you, **your participation will help define health care policyfor future generations of military personnel and guide prevention and treatment programs for years to come.**

Do you have to participate?

No, you do not! Your participation must be completely voluntary. If you decide to participate, you can stop at any time you wish or skip any question you choose. If you choose not to participate or to discontinue your participation, you will not lose any benefit to which you are otherwise entitled. You may change your mind and revoke your permission to further collect or use your health information at any time. If you revoke your permission, no new health information about you will be gathered after that date. However, unless specified otherwise, information that has already been gathered may still be used for analyses. Collected data will be maintained until all research questions are answered. To end participation, contact the principal investigator at milcohortinfo@med.navy.mil, or (888) 942-5222.

Your participation may also be ended by the investigators. While this is not anticipated, available funding or other logistical considerations could conceivably result in the early termination of this study.

Who can provide additional information if you need it?

Questions about the research (science) aspects of this study should be directed to the principal investigator of the Millennium Cohort Study at milcohortinfo@med.navy.mil or (888) 942-5222. You may also refer to the web site at www.MillenniumCohort.org for more information. Questions about the ethical aspects of this study, your rights as a volunteer, or any problem related to the protection of research volunteers should be directed to Christopher G. Blood, JD, MA, Chairperson, Institutional Review Board, Naval Health Research Center, at telephone (619) 553-8386 or by email at NHRC-IRB@med.navy.mil.
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Where can you find your records if you wish to review them?

The principal investigator will be responsible for storing the consent form and other research records related to this study. The records will be stored at the Deployment Health Research Department, Naval Health Research Center, 140 Sylvester Road, San Diego, CA 92106. You can review your surveys until the study ends by contacting the principal investigator at milcohortinfo@med.navy.mil, or (888) 942-5222

Voluntary Consent

I consent to participate in the study described above. My consent is completely voluntary and is based solely on the information provided in this consent form.

Volunteer's signature

Date (mm/dd/yy)

Volunteer's printed name (first, middle initial, last)

Privacy Act Statement

You have rights under the Privacy Act.
The following statement describes how that ACT applies to this study:

The Privacy Act System of Records Notice (SORN) for this study is N6500-1. The SORN was published on the Defense Privacy and Civil Liberties Division (DPCLD) website on [insert date here]and can be found by visiting: <Link to active SORN>

Authority: Authority to request this information is granted under: 10 USC 136, Under Secretary of Defense for Personnel and Readiness, 10 USC 1782, Surveys of Military Families, 10 USC 2358, Research and Development Projects, Under Secretary of Defense Memorandum #: 99-028, 30 SEP 99 "Establishment of DoD Centers for Deployment Health" and Executive Order 9396, Numbering System for Federal Accounts Relating to Individual Persons.

Purpose: To create a probability-based database of service members and veterans who have, or have not, deployed overseas so that various longitudinal health and research studies may be conducted over a 67-year period. The database will be used: (a.) To systematically collect population-based demographic and health data to evaluate the health of Armed Forces personnel throughout their careers and after leaving the service. (b.) To evaluate the impact of operational deployments on various measures of health over time including medically unexplained symptoms and chronic diseases to include cancer, heart disease and diabetes. (c.) To serve as a foundation upon which other routinely captured medical and deployment data may be added to answer future questions regarding the health risks of operational deployment, occupations, and general service in the Armed Forces. (d.) To examine characteristics of service in the Armed Forces associated with common clinician-diagnosed diseases and with scores on several standardized self-reported health inventories for physical and psychological functional status. (e.) To provide a data repository and available representative Armed Forces cohort that future investigators and policy makers might use to study important aspects of service in the Armed Forces including disease outcomes among an Armed Forces cohort.

In addition to revealing changes in Service member and veteran' health status over time, the Millennium Cohort Study will serve as a data repository, providing a solid foundation upon which additional epidemiological studies may be constructed.

Routine Uses: The information provided in this questionnaire will be maintained in data files at the Deployment Health Research Department at the Naval Health Research Center and used only for medical research purposes. Use of these data may be granted to other federal and non-federal medical research agencies as approved by the Naval Health Research Center's Institutional Review Board. In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 522a(b)(3).

To the Department of Veterans Affairs (DVA) for (1) considering individual claims for benefits for which that DVA is responsible; and (2) for use in scientific, medical and other analysis regarding health outcomes research associated with military service. To the Department of Health and Human Services, Centers for Disease Control and Prevention for use in scientific, medical and other analysis regarding health outcome research associated with military service.

NOTE: All disclosures to the DVA and HHS must have prior approval of the Naval Health Research Center Institutional Review Board and a Memorandum of Understanding must be entered into to ensure the right and obligations of the signatories are clear. Access to data 1) is provided on need-to-know basis only; 2) must adhere to the rule of minimization in that only information necessary to accomplish the purpose for which the disclosure is being made is releasable; and 3) must follow strict guidelines established in the data sharing agreement. To the Social Security Administration (SSA) for considering individual claims for benefits for which that SSA is responsible. The DoD 'Blanket Routine Uses' that appear at the beginning of the Navy's compilation of systems of records notices apply to this system.

NOTE: This system of records contains individually identifiable health information. The DoD Health Information Privacy Regulation (DoD 6025.18-R) issued pursuant to the Health Insurance Portability and Accountability Act of 1996, applies to most such health information. DoD 6025.18-R may place additional procedural requirements on the uses and disclosures of such information beyond those found in the Privacy Act of 1974 or mentioned in this system of records notice.

Voluntary Disclosure: Completion of the questionnaire is voluntary. Failure to respond to any of the questions will NOT result in any disadvantages or penalties except possible lack of representation of your views in the final results and outcomes.

Agency Disclosure Notice

The public reporting burden for this collection of information, OMB Control Number 0703-0064, is estimated to average 45minutes 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. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

MARKING INSTRUCTIONS

- Use blue or black ink.
- Shade circles like this. ●
- Include additional comments in the open text field on the last page.

1. In general, would you say your health is: (Please select only one) **SF36V**

Excellent Very Good Good Fair Poor

2. The following questions are about activities you might do during a **typical day**. Does **your health now limit you** in these activities? If so, how much? SF36V

	No, not at all	Yes, limited a little	Yes, limited a lot
a. **Vigorous activities**, such as running, lifting heavy objects, or participating in strenuous sports			
b. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
c. **Lifting** or carrying groceries			
d. Climbing **several** flights of stairs			
e. Climbing **one** flight of stairs			
f. Bending, kneeling, or stooping			
g. Walking more than a **mile**			
h. Walking **several** blocks			
i. Walking **one** block			
j. Bathing or dressing yourself			

3. 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**? SF36V

	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
a. Cut down the **amount of time** you spent on work or other activities					
b. **Accomplished less** than you would like					
c. Were limited in the **kind** of work or other activities					
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)					

4. 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)? SF36V

	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
a. Cut down the **amount of time** you spent on work or other activities					
b. **Accomplished less** than you would like					
c. Didn't do work or other activities as **carefully** as usual					

5. During the **past 4 weeks**, **to what extent** has your **physical health** or **emotional problems** interfered with your normal social activities with family, friends, neighbors, or groups? SF36V

Not at all Slightly Moderately Quite a bit Extremely

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6. During the **past 4 weeks**, how much bodily pain have you had? SF36V

None Very mild Mild Moderate Severe Very Severe

7. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)? SF36V

Not at all A little bit Moderately Quite a bit Extremely

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8. During the **past 4 weeks**, how much of the time: (Select the **single best** answer for each question) SF36V

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
a. Did you feel **full of pep**?						
b. Have you been a **very nervous person**?						
c. Have you felt so down in the dumps that **nothing could cheer you up**?						
d. Have you felt **calm and peaceful**?						
e. Did you have a **lot of energy**?						
f. Have you felt **downhearted and blue**?						
g. Did you feel **worn out**?						
h. Have you been **a happy person**?						
i. Did you feel **tired**?						

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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 friends, relatives)? SF36V

None of the time A little of the time Some of the time Most of the time All of the time

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10. Please choose the answer that best describes **how true** or **false each** of the following statements is for you. SF36V

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
a. I seem to get sick a little easier than other people					
b. I am as healthy as anybody I know					
c. I expect my health to get worse					
d. My health is excellent					

11. **Compared to 3 years ago,** how would you describe your **physical health** in general now? SF36V

Much better Somewhat better About the same Somewhat worse Much worse

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12. **Compared to 3 years ago,** how would you describe your **emotional health** or **well being** (such as feeling anxious, depressed or irritable) now? SF36V

Much better Somewhat better About the same Somewhat worse Much worse

13. What is your **current** relationship status? Choose the single best answer.
Single, never married Now married Separated Divorced Widowed

14. If **NOT** married, please choose one of the following to describe your current relationship status:
In a committed relationship Dating casually Not seeing anyone

15. If **CURRENTLY** in a committed relationship or married, taking things all together, how would you describe your relationship with your significant other?

Very unhappy 1 2 3 4 5 6 7 Very happy

NSFH

16. I feel that I can trust my partner completely.

Dyadic Trust Scale

Strongly disagree
Disagree
Moderately disagree
Neither agree nor disagree
Moderately agree
Agree
Strongly agree

Comment [JLW1]: Web only. Only those that indicate married or in a committed relationship.

NSFH

17. How happy are you with the following aspects of your relationship?

	N/A	Very Unhappy	Unhappy	Somewhat unhappy	Neither happy or unhappy	Somewhat happy	Happy	Very Happy
The understanding you receive from your partner								
The love and affection you get from your partner								
The amount of time you spend with your partner								
Your partner as a parent								

Comment [JLW2]: Web only. Will be only for those that indicate that they are in a committed relationship or married.

18. In the last year, have you or your current spouse seriously suggested the idea of divorce or permanent separation?
No Yes

Comment [JLW3]: Web only. Only those that indicate married.

19. Including yourself, how many people currently reside in your household? (Please do not include anyone that does not live and sleep in your household the majority of the time, such as visiting relatives)

___ ___ adults (18 and older)

___ ___ children (17 and younger. Please include any biological, adopted, or foster children)

20. In general, how well do you feel you are coping with the day-to-day demands of parenthood/raising children?
Very well Somewhat well Fair Poorly Very poorly

NSCH

Comment [JLW4]: Web only. Only those that indicate children would see this.

21. What is the **highest level** of education that you have **completed**? Choose the single best answer.

Less than high school completion/diploma
High school degree/GED/or equivalent
Some college, no degree
Associate's degree
Bachelor's degree
Master's, doctorate, or professional degree

22. Which of the following **best** describes your employment status? Choose the single best answer.

Full-time (greater than or equal to 30 hours per week)	Not employed, retired
Part-time (less than 30 hours per week)	Not employed, disabled
Not employed, looking for work	Homemaker
Not employed, not looking for work	Other (please specify) _____

23. How tall are you? For example, a person who is 5'8" should write 5 feet 8 inches…… ___ feet ___ ___ inches

24. What is your **current** weight? …….. ___ ___ ___ pounds

25. Has your doctor or other health professional **ever** told you that you have any of the following conditions?			If **YES**, in what year were you **first** diagnosed?	Mark here if you were **ever** hospitalized for the condition
Hypertension (high blood pressure)	No	Yes	__ __ __ __	
High cholesterol requiring medication	No	Yes	__ __ __ __	
Coronary heart disease	No	Yes	__ __ __ __	
Heart attack	No	Yes	__ __ __ __	
Angina (chest pain)	No	Yes	__ __ __ __	
Chronic bronchitis	No	Yes	__ __ __ __	
Emphysema	No	Yes	__ __ __ __	
Asthma	No	Yes	__ __ __ __	
Kidney failure requiring dialysis	No	Yes	__ __ __ __	
Pancreatitis	No	Yes	__ __ __ __	
Gestational diabetes (diabetes during pregnancy)	No	Yes	__ __ __ __	
Diabetes or sugar diabetes	No	Yes	__ __ __ __	
Gallstones	No	Yes	__ __ __ __	
Kidney stones	No	Yes	__ __ __ __	
Hepatitis B	No	Yes	__ __ __ __	
Hepatitis C	No	Yes	__ __ __ __	
Cirrhosis	No	Yes	__ __ __ __	
Depression	No	Yes	__ __ __ __	
Schizophrenia or psychosis	No	Yes	__ __ __ __	
Manic depressive/bipolar disorder	No	Yes	__ __ __ __	
Posttraumatic stress disorder	No	Yes	__ __ __ __	
Thyroid condition other than cancer	No	Yes	__ __ __ __	
Cancer Please Specify _____	No	Yes	__ __ __ __	

Comment [JLW5]: Web will include 2 drop down list with a list of the most common cancers and an 'other' option and an open text field.

Q 25 continued……

			If **YES**, in what year were you **first** diagnosed?	Mark here if you were **ever** hospitalized for the condition
Stomach, duodenal, or peptic ulcer	No	Yes	__ __ __ __	
Ulcerative colitis or proctitis	No	Yes	__ __ __ __	
Acid reflux/gastroesophageal reflux disease requiring medication	No	Yes	__ __ __ __	
Significant hearing loss	No	Yes	__ __ __ __	
Significant vision loss even with glasses or contact lenses	No	Yes	__ __ __ __	
Tinnitus/ringing of the ears	No	Yes	__ __ __ __	
Memory loss or memory impairment	No	Yes	__ __ __ __	
Migraine headaches	No	Yes	__ __ __ __	
Stroke	No	Yes	__ __ __ __	
Traumatic brain injury (Do not include injuries that resulted in only a concussion)	No	Yes	__ __ __ __	
Neuropathy caused reduced sensation in the hands or feet	No	Yes	__ __ __ __	
Seizures	No	Yes	__ __ __ __	
Fibromyalgia	No	Yes	__ __ __ __	
Rheumatoid arthritis	No	Yes	__ __ __ __	
Degenerative joint disease/osteoarthritis	No	Yes	__ __ __ __	
Lupus	No	Yes	__ __ __ __	
Multiple sclerosis	No	Yes	__ __ __ __	
Chronic fatigue syndrome	No	Yes	__ __ __ __	
Crohn’s disease	No	Yes	__ __ __ __	
Sleep apnea	No	Yes	__ __ __ __	
Anemia	No	Yes	__ __ __ __	
Infertility	No	Yes	__ __ __ __	
Parkinson’s disease	No	Yes	__ __ __ __	
Alzheimer’s disease	No	Yes	__ __ __ __	
Sexual dysfunction	No	Yes	__ __ __ __	
Other (please specify)	No	Yes	__ __ __ __	

26. During the last **12 months**, have you had persistent or recurring problems with any of the following? Sea Bee

Rash or skin ulcer	No	Yes	Night sweats	No	Yes
Sore throat	No	Yes	Unusual muscle pain	No	Yes
Frequent bladder infections	No	Yes	Unusual fatigue	No	Yes
Cough	No	Yes	Forgetfulness	No	Yes
Fever	No	Yes	Confusion	No	Yes
Sudden Unexplained hair loss	No	Yes	Trouble Sleeping	No	Yes

27. Please describe your prior history and or current symptoms of low back pain (choose one option). I
    have never had low back pain → Skip to question xx
    I have had low back pain, but not in the past 6 months → Skip to question xx
    In the past 6 months, I have had low back pain on less than half the days
    In the past 6 months, I have had low back pain on at least half the days
    In the past 6 months, I have has low back pain every day or nearly every day

28. **If you have had low back pain in the past 6 months,** how long have your most recent symptoms of low back pain been a problem for you?
    I have not had low back pain in the past 6 months
    Less than 1 month
    1 to 3 months
    4 to 6 months
    7 months to less than 1 year
    1 to 3 years
    4 or more years

29. Have you had pain, aching or stiffness in or around your knee(s), on at least half the days in the past month?
    No, I have not had symptoms in either knee
    Yes, in my left knee
    Yes, in my right knee
    Yes, in both knees

30. Over the **past 12 months**, approximately how many days were you hospitalized because of illness or injury? (Excluding lost time for pregnancy and childbirth) __ __ __ __ days

31. Over the **past 12 months**, approximately how many days were you unable to perform your usual activities because of illness or injury? (Excluding lost time for pregnancy and childbirth) __ __ __ __ days

32. During the **last 4 weeks**, how much have you been bothered by any of the following problems? PHQ

	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain			
b. Back pain			
c. Pain in your arms, legs, or joints (knees, hips, etc.)			
d. Pain or problems during sexual intercourse			
e. Headaches			
f. Chest pain			
g. Dizziness			
h. Fainting spells			
i. Feeling your heart pound or race			
j. Shortness of breath			
k. Constipation, loose bowels, or diarrhea			
l. Nausea, gas or indigestion			
m. Ringing in the ears			
n. Difficulty with balance			
o. Little to no sexual desire			
o. **Women only**: menstrual cramps or other problems with your periods			

33. Over the l**ast 2 weeks**, how often have you been bothered by any of the following problems? PHQ

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling or staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				

i. If you answered "several days" or more to **any** item a-h above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult

34. a. In the **last 4 weeks**, have you had an anxiety attack – suddenly feeling fear or panic? PHQ No Yes

If you marked NO, please skip to question XX

b. Has this every happened to you before? No Yes
c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable? No Yes
d. Do these attacks bother you a lot, or are you worried about having another attack? No Yes

35. Think about your last bad anxiety attack? PHQ

a. Were you short of breath?	No	Yes
b. Did your heart race, pound, or skip	No	Yes
c. Did you have chest pain or pressure?	No	Yes
d. Did you smoke?	No	Yes
e. Did you feel as if you were choking?	No	Yes
f. Did you have hot flashes or chills?	No	Yes
g. Did you have nausea, an upset stomach, or the feeling that you were going to have diarrhea?	No	Yes
h. Did you feel dizzy, unsteady, or faint?	No	Yes
i. Did you have tingling or numbness in parts of your body?	No	Yes
j. Did you tremble or snake?	No	Yes
k. Were you afraid you were dying?	No	Yes

36. Over the last 4 weeks, how often have you been bothered by any of the following problems? PHQ

	Not at all	Several days	More than half the days	Nearly every day
a. Feeling nervous, anxious or on edge, or worrying about a lot of different things	O	O	O	O
b. Feeling restless so that it is hard to sit still	O	O	O	O
c. Getting tired very easily	O	O	O	O
d. Muscle tension, aches, or soreness	O	O	O	O
e. Trouble falling asleep or staying asleep	O	O	O	O
f. Trouble concentrating on things, such as reading a book or watching TV	O	O	O	O
g. Becoming easily annoyed or irritable	O	O	O	O

37. Over the last 2 weeks, how often have you been bothered by the following problems? GAD 7

	Not at all	Several days	More than half the days	Nearly every day
a. Feeling nervous, anxious or on edge	O	O	O	O
b. Not being able to stop or control worrying	O	O	O	O
c. Worrying too much about different things	O	O	O	O
d. Trouble relaxing	O	O	O	O
e. Being so restless that it is hard to sit still	O	O	O	O
f. Becoming easily annoyed or irritable	O	O	O	O
g. Feeling afraid as if something awful might happen	O	O	O	O

38. On an average day, how many 8-12 oz beverages containing caffeine do you drink? RAP
None 1-2 per day 3-5 per day 6-10 per day 11 or more per day

39. Do you often feel that you can't control **what** or **how much** you eat? **PHQ** No Yes

b. Do you often eat, **within any 2 hour period**, what most people would regard as an unusually **large** amount of food? No Yes

c. If you marked **YES** to either of the above, has this been as often, on average, as **once a week** for the **LAST 3 MONTHS**? No Yes

40. **FOR WOMEN ONLY:**

Comment [JLW6]: Web only questions for women only.

a. How old were you when your menstrual periods began?
o 9 or less o 10 o 11 o 12 o 13 o 14 o 15 o 16 o 17 or more

b. Have you ever been pregnant? o No - skip to question 42h o Yes → How many times? __

c. Are you currently pregnant? o No o Yes

d. How many births (live born children or stillbirths) have you had? __ (If 0, skip to question X)

e. Have you given birth within the last 3 years? o No o Yes

f. How old were you when you first gave birth? __ years old

g. How many months in total did you breastfeed (total for all children)?
o Less than 3 months o 3-5 months o 6-11 months o 12-17 months o 18 or more months

h. Have you ever used oral contraceptives (birth control pills)? (If no, skip to question 37)
o No o Yes → Age when first used __ years old Age when last used __ years old

i. How many years in total have you used birth control pills (exclude time periods when you temporarily stopped)?
o Less than 1 year o 1-2 o 3-4 o 5-9 o 10-19 o 20 or more

41. Indicate the degree to which each statement describes your feelings or behavior:

DAR5

	None or almost none of the time	A little of the time	Some of the time	Most of the time	All or almost all of the time
a. I often find myself getting angry at people or situations					
e. My anger prevents me from getting along with people as well as I'd like to					

42. How often in the past month did you get angry with someone and kick/smash something, get into a fight, hit someone or threaten someone with physical violence?
Never 1 time 2 times 3-4 times 5 or more times

43. In the past 12 months, did you take any of the following medications regularly (at least once per week)?

		Yes, please indicate total tablets per week.			
	No, or less than once per week	1-2	3-5	6-14	15+
Multivitamins					
"Baby" or low dose aspirin (less than 100 mg)					
Aspirin or aspirin-containing products (e.g. Bayer, Excedrin)					
Ibuprofen (e.g. Advil, Motrin)					
Other over-the-counter pain relievers (e.g. Aleve, Tylenol)					
Prescription non-narcotic pain relievers (e.g. Celebrex)					
Prescription narcotic pain relievers (e.g. Codeine, OxyContin, Percocet, Vicodin)					

44. In the **last 12 months**, how long did you take prescription narcotics for pain relief, such as Codeine, OxyContin, Percocet, Vicodin?
Never Less than 1 week 1-2 weeks 3-4 weeks More than 4 weeks

45. Over the **past month**, how many hours of sleep did you get in an average 24-hour period? Persian Gulf War Survey
__ __ hours

46. Pease rate your sleep pattern for the **past 2 weeks**. Insomnia Severity Index

	None	Mild	Moderate	Severe	Very Severe
a. Difficulty falling asleep					
b. Difficulty staying asleep					
c. Problem waking up too early					

47. How **SATISFIED**/dissatisfied are you with your current sleep pattern? Insomnia Severity Index
Very satisfied Very dissatisfied
0 1 2 3 4

48. To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)? Insomnia Severity Index
Not at all interfering A little Somewhat Much Very much interfering

49. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life? Insomnia Severity Index
Not at all noticeable Barely Somewhat Much Very much noticeable

50. How **WORRIED**/distressed are you about your current sleep problem? Insomnia Severity Index
Not at all A little Somewhat Much Very much

51. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?
Pittsburgh Sleep Quality
- Not at all during past month
- Less than once a week
- Once or twice a week
- Three or more times a week

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52. Do you consider yourself to be:
Best Practices
- Heterosexual or straight
- Gay or lesbian
- Bisexual
- Prefer not to answer

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53. People are different in their sexual attraction to other people. Which best describes your feelings? Are you:
- Only attracted to females
- Mostly attracted to females
- Equally attracted to females and males
- Mostly attracted to males
- Only attracted to males
- Not sure
- Prefer not to answer

Best Practices

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54. In the past 3 years, who have you had sex with?
Best Practices
- Men only
- Women only
- Both men and women
- I have not had sex
- Prefer not to answer

---

55. In a **typical week**, how much time do you spend participating in…
(Please mark both your typical "days per week" and "minutes per day" doing these activities.) NHIS & HEAR

	# of days per week you exercise		On those days, how many **minutes per day** on average do you exercise		- None - Cannot physically do
a. **STRENGTH TRAINING** or work that strengthens your muscles? (such as lifting/pushing/pulling weights)	__ **days**	AND	__ __ __ **minutes**	OR	
b. **VIGOROUS** exercise or work that causes heavy sweating or large increases in breathing or heart rate? (such as running, active sports, marching biking)	__ **days**	AND	__ __ __ **minutes**	OR	
c. **MODERATE** or **LIGHT** exercise or work that causes light sweating or slight increases in breathing or heart rate? (such as walking, cleaning, slow jogging)	__ **days**	AND	__ __ __ **minutes**	OR	

56. In the **past month** have you experienced…? PCL-C

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Repeated, disturbing **memories** of stressful experiences from the past					
b. Repeated, disturbing **dreams** of stressful experiences from the past					
c. Suddenly acting or feeling as if stressful experiences were happening again					
d. Feeling very upset when something happened that reminds you of stressful experiences					
e. Trouble remembering important parts of stressful experiences from the past					
f. Loss of interest in activities that you used to enjoy					
g. Feeling distant or cut off from other people					
h. Feeling emotionally numb, or being unable to have loving feelings for those close to you					
i. Feeling as if your future will somehow be cut short					
j. Trouble falling asleep or staying asleep					
k. Feeling irritable or having angry outbursts					
l. Difficulty concentrating					
m. Feeling "super-alert" or watchful or on guard					
n. Feeling jumpy or easily startled					
o. Physical reactions when something reminds you of stressful experiences from the past					
p. Efforts to avoid thinking about your stressful experiences from the past or avoid having feelings about them					
q. Efforts to avoid activities or situations because they remind you of stressful experiences from the past					

57. On a typical day, how much time do you spend sitting and watching TV or videos or using a computer? NHANES

__ __ hours per day

58. Have you used any of the following practices in the last 12 months? If **YES**, please indicate whether the following were reasons you most recently received this treatment (mark all that apply)

	No	Yes	For a condition that lasted **less than one month**	For a condition that lasted **more than one month**	To improve well-being	Pain management	Please Specify
a. Acupuncture	O	O →	O	O	O	O	_____
b. Chiropractic care	O	O →	O	O	O	O	_____
c. Spiritual healing	O	O →	O	O	O	O	_____
d. Meditation	O	O →	O	O	O	O	_____

59. If you answered **YES** to any item in question xx above, has your level of satisfaction with conventional medicine led you to seek alternative health practices?

No Yes

60. Have you taken any of the following supplements in the **last 12 months**?

	No	Yes
a. Hormones for muscular strength, enhancement, or performance (e.g. anabolic steroids)		
b. Body building supplements (e.g. amino acids, weight gain products, creatine, etc.)		
c. Energy drinks (e.g. Red Bull, Monster, Rock Star, etc.)		
d. Energy supplements (e.g. energy pills or energy enhancing herbs)		
e. Weight loss supplements (e.g. examples)		

61. Please indicate how you feel about each statement.

MSPSS	Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
a. There is a special person with whom I can share my joys and sorrows.							
b. My family really tries to help me.							
c. I have a special person who is a real source of comfort to me							
d. My friends really try to help me							
e. I can talk about my problems with my family							
f. I have friends with whom I can share my joys and sorrows							

62. Indicate the degree to which the following statements are true in your life: PTGI

	Not at all	To a very small degree	To a small degree	To a moderate degree	To a great degree	To a very great degree
a. I prioritize what is important in life						
b. I have an appreciation for the value of my own life						
c. I am able to do good things with my life						
d. I have an understanding of spiritual matters						
e. I have a sense of closeness with others						
f. I have established a path for my life						
g. I know that I can handle difficulties						
h. I have religious faith						
i. I'm stronger than I thought I was						
j. I have learned a great deal about how wonderful people are						
k. I have compassion for others						

63. Please indicate your level of agreement with these statements: Pearlin & Schooler

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I have little control over the things that happen to me					
b. There is really no way I can solve some of the problems I have					
c. There is little I can do to change many of the important things in my life.					
d. I often feel helpless in dealing with the problems of life.					
e. Sometimes I feel that I am being pushed around in life.					
f. What happens to me in the future mostly depends on me					
g. I can do just about anything I really set my mind to do					

64. In the **last 12 months**, did you seek care for any of the following?

	No	Yes	Number of therapy* sessions attended. If None, write 0	Are you or did you take medication for this?
a. Posttraumatic stress disorder (PTSD) or posttraumatic stress (PTS) symptoms			__ __ __	o
b. Anxiety			__ __ __	o
c. Depression			__ __ __	o
d. Stress			__ __ __	o
e. Anger			__ __ __	o
f. Substance use			__ __ __	o
g. Relationship/family issues			__ __ __	o

*Therapy sessions are individual or group meetings to treat symptoms without or in addition to medication.

These next few questions are about drinking alcoholic beverages. Alcoholic beverages include beer, wine, and liquor (such as whiskey, gin, etc.). For the purpose of this questionnaire:

One drink = one 12-ounce beer, one 4-ounce glass of wine, or one 1.5-ounce shot of liquor

65. In the **past year**, did you drink any type of alcoholic beverage?
No Yes

If you marked NO, skip to question xx

66. In the **past year**, on those days that you drank alcoholic beverages, on average, how many drinks did you have? NHIS
__ __ drinks

67. **Last week**, how many drinks of alcoholic beverages did you have? (If NONE, please enter 0) NHIS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
__ __	__ __	__ __	__ __	__ __	__ __	__ __

68. In the **past year**, on how many **days** did you have 5 or more drinks of any alcoholic beverage? NHIS
(If NONE, please enter 0) __ __ __ days

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69. **FOR MEN ONLY**:
In the **past year**, how often did you typically have **5** or more drinks of alcoholic beverages within a **2-hour period**?
NIAAA Taskforce

Never Monthly or less 2-4 times a month >4 times a month

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70. **FOR WOMEN ONLY**:
In the **past year**, how often did you typically have **4** or more drinks of alcoholic beverages within a **2-hour period**?
NIAAA Taskforce

Never Monthly or less 2-4 times a month >4 times a month

---

71. In the **last 12 months**, have any of the following happened to you **more than once**? PHQ

	No	Yes
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health		
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities		
c. You missed or were late for work, school, or other activities because you were drinking or hung over		
d. You had a problem getting along with people while you were drinking		
e. You drove a car after having several drinks or after drinking too much		

72. Have you **ever** felt any of the following? CAGE

	No	Yes
a. Felt that you needed to cut back on your drinking		
b. Felt annoyed at anyone who suggested you cut back on your drinking		
c. Felt you needed an “eye-opener” or early morning drink		
d. Felt guilty about your drinking		

73. In the **past year**, have you used any of the following tobacco products? Persian Gulf War Survey

	No	Yes
a. Cigarettes (smoke)		
b. Electronic cigarettes or vape products		
c. Cigars		
d. Pipes		
e. Smokeless tobacco (chew, dip, snuff)		

74. **In your lifetime**, have you smoked at least 100 cigarettes (5 packs)? Sea Bee No Yes

If you marked NO, skip to question XX

Questions xx-xx refer to smoking CIGARETTES and not electronic cigarettes or vaping

75. At what age did you start smoking? Persian Gulf War Survey __ __ years old

76. How many years have or did you smoke an average of at least 3 cigarettes per day (or one pack per week)?

__ __ years

77. Do you CURRENTLY smoke cigarettes?
No, not at all Yes, every day Yes, some days

78. When smoking, how many packs per day did you or do you smoke? RAP
Less than half a pack a day Half to 1 pack per day 1 to 2 packs per day More than 2 packs per day

79. Have you ever tried to quit smoking? RAP
Yes, and succeeded Yes, but not successfully No

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80. Do you CURRENTLY use electronic cigarettes or vape products?
No, not at all Yes, every day Yes, some days

Comment [JLW7]: Web only

81. Have you used electronic cigarettes or vape products in the past? (More than a year ago)
No, not at all Yes, every day Yes, some days

Comment [JLW8]: Web only

PCL-5

82. In the past month have you experienced…?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)					
b. Blaming yourself or someone else for a stressful experience or what happened after it					
c. Having strong negative feelings such as fear, horror, anger, guilt, or shame					
d. Taking too many risks or doing things that could cause you harm					
e. Trouble experiencing positive feelings (for example, being unable to feel happiness or having loving feelings for people close to you)					

83. Have you **ever** had any of the following life events happened to you? Persian Gulf War Survey

	No	Yes	If **YES**, list most recent year
a. You moved or changed residence more than once			__
b. You changed jobs, assignment, or career path involuntarily (for example, you lost a job, or you had to take a job you did not like)			__
c. You or your partner had an unplanned pregnancy			__
d. You were divorced or separated			__
e. Suffered major financial problems (such as bankruptcy)			__
f. Suffered forced sexual relations or sexual assault*			__
g. Experienced sexual harassment*			__
h. Hazing/initiation rituals			
i. Experienced harassment (other than sexual harassment)			__
j. Experienced discrimination			__
k. Suffered a violent assault			__
l. Had a family member or loved one who became severely ill			__
m. Had a family member or loved one who died			__
n. Suffered a disabling illness or injury			__
o. Experienced infidelity or unfaithfulness in a committed relationship			__

Comment [JLW9]: Web only will see additional questions

Comment [JLW10]: Web only will see additional questions

84. a. While serving in the military, how often have you had unwanted experiences where a person(s) sexually touched you (e.g., intentional touching of genitalia, breasts, or buttocks), made you sexually touch them, attempted to or actually made you have sexual intercourse/oral or anal sex (or sexual penetration with finger/object) without your consent?"

Never Once Twice A few times Many times

b. Most recent experience - YYYY

85. During this experience, did the offender(s): (Response for each item is yes/no)
Take advantage of you when you couldn't defend yourself (e.g., too drunk/high or asleep)?
Use physical force/violence, or threaten you/someone close to you with physical harm?

***You indicated that you suffered a forced sexual relation or sexual assault. This section asks additional questions about these experiences. We are aware that many of these questions are quite personal. Your answers are strictly confidential and will not be used to identify any persons.**

Comment [JLW11]: Web only sexual assault questions

Have you suffered a forced sexual relation or sexual assault?		
Once with one person	No	Yes
Once with multiple people	No	Yes
More than once with the same person	No	Yes
More than once with multiple people	No	Yes
Not sure	No	Yes

***For the following questions, we'd like you to think about the sexual assault, or, if you experienced more than one sexual assault in the past three years, the one sexual assault incident that had the biggest effect on you:**

Where did the incident occur?		
At a military installation?	No	Yes
At a civilian location?	No	Yes
During your work day/duty hours?	No	Yes
While you were on TDY/TAD, at sea, during field exercises/alerts, or any type of military combat training?	No	Yes
While you were deployed to a combat zone or to an area where you drew imminent danger pay or hostile fire pay?	No	Yes
During military schooling*?	No	Yes

*(e.g., Officer Candidate School, Basic or Advanced Officer Course, basic military training, occupational specialty school / technical training, or advanced individual training/ professional military education)

At the time that the incident occurred, was the offender(s)...		
Someone in your chain of command?	No	Yes
Other military person(s) of higher rank/grade who was/were not in your chain of command?	No	Yes
Your military coworker(s)?	No	Yes
Other military person(s)?	No	Yes
DoD/Service civilian employee(s) or contractor(s)?	No	Yes
Your spouse/significant other?	No	Yes
Other civilian person(s) (e.g. friend(s), relative(s), acquaintance(s))	No	Yes
Unknown person(s)/don't know?	No	Yes

What was the gender(s) of the offender(s)?

- Male only
- Female only
- Both male and female
- Not sure

You indicated that you suffered sexual harassment. This section asks additional questions about these experiences. We are aware that many of these questions are quite personal. Your answers are strictly confidential and will not be used to identify any persons.

Comment [JLW12]: Web only sexual harassment questions

Have you suffered sexual harassment?

Once with one person	No	Yes
Once with multiple people	No	Yes
More than once with the same person	No	Yes
More than once with multiple people	No	Yes
Not sure	No	Yes

For the following questions, we'd like you to think about the sexual harassment situation, or, if you experienced more than one sexual harassment incident, the one sexual harassment incident that had the biggest effect on you:

Where did the incident occur?

At a military installation?	No	Yes
At a civilian location?	No	Yes
During your work day/duty hours?	No	Yes
While you were on TDY/TAD, at sea, during field exercises/alerts, or any type of military combat training?	No	Yes
While you were deployed to a combat zone or to an area where you drew imminent danger pay or hostile fire pay?	No	Yes
During military schooling*?	No	Yes

*(e.g., Officer Candidate School, Basic or Advanced Officer Course, basic military training, occupational specialty school / technical training, or advanced individual training/ professional military education)

At the time that the incident occurred, was the offender(s)...

Someone in your chain of command?	No	Yes
Other military person(s) of higher rank/grade who was/were not in your chain of command?	No	Yes
Your military coworker(s)?	No	Yes
Other military person(s)?	No	Yes
DoD/Service civilian employee(s) or contractor(s)?	No	Yes
Your spouse/significant other?	No	Yes
Other civilian person(s) (e.g. friend(s), relative(s), acquaintance(s))	No	Yes
Unknown person(s)/don't know?	No	Yes

What was the gender(s) of the offender(s)?

- Male only
- Female only
- Both male and female
- Not sure

86. Have you **ever** been PERSONALLY exposed to any of the following?
(Do not include TV, video, movies, computers, or theater) Persian Gulf War Survey

	No	Yes, 1 time	Yes, more than 1 time	If **YES**, list most recent year of exposure
a. Witnessing a person's death due to war, disaster, or tragic event	O	O	O	➔ __
b. Witnessing instances of physical abuse (torture, beating, rape)	O	O	O	➔ __
c. Dead and/or decomposing bodies	O	O	O	➔ __
d. Maimed soldiers or civilians	O	O	O	➔ __
e. Prisoners of war or refugees	O	O	O	➔ __

It would be helpful for this study to know about the background experiences that may have happened to some people. JVQ

87. a. Not including spanking on your bottom, before the age of 18, how often did a grown-up in your life hit, beat, kick, or physically hurt you in any way?

O Never O Once O More than once O Prefer not to answer

b. Not including spanking on your bottom, before the age of 18, how often did a grown-up ever touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?

O Never O Once O More than once O Prefer not to answer

c. Before the age of 18, how often did did you get scared or feel really bad because a grown-up in your life called you names, said mean things to you, or said that they didn't want you?

O Never O Once O More than once O Prefer not to answer

d. When someone is neglected, it means that the grown-ups in their life didn't take care of them the way that they should. They might not get enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. Not including spanking on your bottom, before the age of 18, were you neglected?

O Never O Once O More than once O Prefer not to answer

88. During any military deployment, were you EVER exposed to any of the following?

	No	Yes	If **YES,** please indicate how often and how long you were exposed: Daily	Weekly	Monthly	Less than once per month	For how many **months** were you exposed
a. Exhaust fumes (from engine or jet fuels)	O	O →	O	O	O	O	__ __
b. Sand or dust storms	O	O →	O	O	O	O	__ __
c. Ionizing radiation (requiring a personal monitoring device)	O	O →	O	O	O	O	__ __
d. Munitions disposal	O	O →	O	O	O	O	__ __
e. Chemical or biological warfare agents	O	O →	O	O	O	O	__ __
f. Medical countermeasures for chemical or biological warfare agent exposure	O	O →	O	O	O	O	__ __
g. Alarms necessitating wearing of chemical or biological warfare protective gear	O	O →	O	O	O	O	__ __
h. Smoke from burning trash and/or feces	O	O →	O	O	O	O	__ __

89. Are you currently serving in the US military?
O Yes, Active duty O Yes, Reserve or National Guard O No

90. a. Since 2010 did you retire, separate or leave the service for any reason?
O Yes O No➔ skip to question xx

b. What was your date of separation or retirement from the military? M M/ Y Y

c. What was the reason for your separation/retirement from the military?
O Planned separation (end of service term/retirement)
O Medical separation
O Disciplinary separation
O Unplanned administrative separation (e.g. military downsizing, failure to promote, failure to meet service standards)
O Other (e.g. pregnancy, parenthood, educational pursuits)

91. How much did each of the following reasons affect your decision to leave the military?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Desire to continue your education, start a new career, or change in personal goals	O	O	O	O	O
b. Disability or other medical reasons	O	O	O	O	O
c. Difficulty meeting weight standards and/or fitness standards	O	O	O	O	O
d. Incompatibility with the military	O	O	O	O	O
e. Legal problems or problems meeting a military obligation	O	O	O	O	O

92. a. Has the VA determined that you have one or more service connected disabilities?
O No O Yes O Pending determination O N/A

1. If **YES,** indicate the total percent of you VA service-connected disabilities…….. ___ ___ ___ % disability

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93. In the last 3 years, how much of your medical care, if any, have you received from the Department of Veterans Affairs/Veterans Health Administration facilities?
O None O Very little O Some O Most O All of my care

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94. What kind of health coverage or insurance do you currently have? (Check all that apply)
O No insurance
O VA health care
O Tricare or military health insurance
O Medicaid
O Medicare
O Other insurance (from employer or school)

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95. Have you deployed or been on a deployment at any time* in the past 3 years? (WEB: ….since "anchor date")
O No ➔ Go to Question xx O Yes

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96. **Since 2001**, how often have you experienced the following during deployment?

	Never	1 time	More than 1 time	List most recent year of exposure
a. Feeling that you were in great danger of being killed	O	O	O	➔ 2 0___
b. Being attacked or ambushed	O	O	O	➔ 2 0___
c. Receiving small arms fire	O	O	O	➔ 2 0___
d. Cleaning/searching homes or buildings	O	O	O	➔ 2 0___
e. Having an improvised explosive device (IED) or booty trap explode near you	O	O	O	➔ 2 0___
f. Being wounded or injured	O	O	O	➔ 2 0___
g. Seeing dead bodies or human remains	O	O	O	➔ 2 0___
h. Handing or uncovering human remains	O	O	O	➔ 2 0___
i. Knowing someone seriously injured or killed	O	O	O	➔ 2 0___
j. Seeing Americans who were seriously injured or killed	O	O	O	➔ 2 0___
k. Having a member of your unit be seriously injured or killed	O	O	O	➔ 2 0___
l. Being directly responsible for the death of an enemy combatant	O	O	O	➔ 2 0___
m. Being directly responsible for the death of a non-combatant	O	O	O	➔ 2 0___

97. Based on your most recent duty assignment, please indicate how much you agree or disagree for each item.

DRRI	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
a. I felt a sense of camaraderie between myself and others in my unit	O	O	O	O	O
b. I was impressed by the quality of leadership in my unit	O	O	O	O	O
c. I was supported by the military	O	O	O	O	O

Comment [JLW13]: Web only. Everyone **except** those that separated MORE than 3 years ago would answer.

98. a. How often did you communicate with your spouse during your last completed deployment?
Almost daily At least once a week Every other week Once a month Less than once a month

b. Overall, when you communicated with your spouse during your last completed deployment how satisfied were you with your ability to support each other (connect emotionally and/or spiritually)?
Very satisfied 1 2 3 4 5 Very dissatisfied

Comment [JLW14]: Web only. Only those that indicate that they are currently married would see this question.

Comment [JLW15]: Web only. Only those that indicate that they are currently married would see this question.

99. How satisfied are/were you with each of the following aspects of your military service?

	N/A	Very satisfied	Satisfied	Neither satisfied or dissatisfied	Dissatisfied	Very dissatisfied
a. Pay and housing allowance	O	O	O	O	O	O
b. Medical/health care for you and your family	O	O	O	O	O	O
c. Pace of promotions/chance for advancement	O	O	O	O	O	O
d. Frequencies of deployments/unaccompanied tours	O	O	O	O	O	O
e. Time with family	O	O	O	O	O	O
f. Impact on spouse's employment and career opportunities	O	O	O	O	O	O

The questions below are about your past and most recent head injuries.

100. Have you **ever** had an injury, such as from a fall, blow to the head, blast exposure, motor vehicle crash, sports, or any other cause that resulted in any of the following?

	No	Yes	Don't know
a. Being dazed right after the injury?	O	O	O
b. Being confused or not thinking clearly right after the injury?	O	O	O
c. Not remembering the actual injury right after it happened?	O	O	O
d. Not remembering things that happened right after the injury?	O	O	O
e. Losing consciousness or being knocked out?	O	O	O

101. If **YES** to any item in question xx above, how many total lifetime injuries have occurred?
Prior to joining the service ___ ___ injuries
During the service ___ ___ injuries
After leaving the service ___ ___ injuries

If you answered **YES** to any item in question xx above, please describe the injury events starting with the most recent one and then the second most recent one.

102. For the **most recent injury** that resulted in being dazed, confused, not remembering, etc.:
a. Was this your most serious injury that resulted in being dazed, confused, not remembering, etc.?
O No O Yes

b. When did it happen? (mm/yy) __ __ / __ __

c. Were you deployed when the injury happened?

O No O Yes

d. What caused the injury? (Please choose the single best answer)

O Blast/explosion
O Bullet/fragment
O Motor vehicle crash
O Military training
O Playing sports/recreation activity/PT
O Fall
O Fighting with someone
O Other
O Don't know

e. Right after the injury, were you dazed?

O No O Yes O Don't know

e1. If **YES**, how long did it last?

O Less than 1 minute
O 1 minute but less than 10 minutes
O 10 minutes but less than 30 minutes
O 30 minutes but less than 24 hours
O 24 hours or more
O Don't know

f. Right after the injury, were you confused or not thinking clearly?

O No O Yes O Don't know

f1. If **YES**, how long did it last?

O Less than 1 minute
O 1 minute but less than 10 minutes
O 10 minutes but less than 30 minutes
O 30 minutes but less than 24 hours
O 24 hours or more
O Don't know

	No	Yes	Don't know
g. Did you lose memory about things that happened right before the injury?	O	O	O
h. Were you unable to remember the actual injury itself?	O	O	O
i. Were you unable to remember things that happened right after the injury?	O	O	O

j. If you had memory gaps or could not remember the injury, how long was it after the injury before you started remembering **NEW** things again?

O Less than 1 hour
O 1 hour to 24 hours
O More than 24 hours but less than 7 days
O 7 days or more
O Don't know

k. Did anyone tell you that you seemed dazed or confused, talked or acted oddly, and/or did not make sense after the injury?

O No O Yes O Don't know

l. Were you unconscious or knocked out?

O No O Yes O Don't know

l1. If **YES**, how long were you unconscious or knocked out?

O Less than 1 minute
O 1 minute but less than 10 minutes
O 10 minutes but less than 30 minutes
O 30 minutes but less than 24 hours
O 24 hours or more
O Don't know

m. After the injury, did anyone tell you that you were lying unresponsive, not opening your eyes, or not responding in any way?
O No O Yes O Don't know

n. When this injury happened, were any parts of your body injured OTHER THAN your head?
O No O Yes O Don't know

o. Did this injury disrupt your personal and/or work activities for more than 1 day?
O No O Yes O Don't know

p. Did you get a medical evaluation/treatment for this injury?
O No O Yes O Don't know

p1. If **YES** where did you get evaluated/treated? (Check all that apply)
- O In the field by a medic
- O Outpatient clinic/doctor's office
- O Emergency room/urgent care center
- O Admitted to the hospital as an INPATIENT → how many nights __ __ __
- O Don't know

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103. For the **second most recent injury** that resulted in being dazed, confused, not remembering, etc.:
a. Was this your most serious injury that resulted in being dazed, confused, not remembering, etc.?
O No O Yes

b. When did it happen? (Mm/my) __ __ / __ __

c. Were you deployed when the injury happened?
O No O Yes

d. What causes the injury? (Please choose the single best answer)

O Blast/explosion	O Military training	O Fighting with someone
O Bullet/fragment	O Playing sports/recreation activity/PT	O Other
O Motor vehicle crash	O Fall	O Don't know

e. Right after the injury, were you dazed?
O No O Yes O Don't know

e1. If **YES**, how long did it last?

O Less than 1 minute	O 30 minutes but less than 24 hours
O 1 minute but less than 10 minutes	O 24 hours or more
O 10 minutes but less than 30 minutes	O Don't know

f. Right after the injury, were you confused or not thinking clearly?
O No O Yes O Don't know

f1. If **YES**, how long did it last?

O Less than 1 minute	O 30 minutes but less than 24 hours
O 1 minute but less than 10 minutes	O 24 hours or more
O 10 minutes but less than 30 minutes	O Don't know

	No	Yes	Don't know
g. Did you lose memory about things that happened right before the injury?	O	O	O
h. Were you unable to remember the actual injury itself?	O	O	O
i. Were you unable to remember things that happened right after the injury?	O	O	O

j. If you had memory gaps or could not remember the injury, how long was it after the injury before you started remembering **NEW** things again?

- O Less than 1 hour
- O 1 hour to 24 hours
- O More than 24 hours but less than 7 days
- O 7 days or more
- O Don't know

k. Did anyone tell you that you seemed dazed or confused, talked or acted oddly, and/or did not make sense after the injury?

O No O Yes O Don't know

l. Were you unconscious or knocked out?

O No O Yes O Don't know

l1. If **YES**, how long were you unconscious or knocked out?

- O Less than 1 minute
- O 1 minute but less than 10 minutes
- O 10 minutes but less than 30 minutes
- O 30 minutes but less than 24 hours
- O 24 hours or more
- O Don't know

m. After the injury, did anyone tell you that you were lying unresponsive, not opening your eyes, or not responding in any way?

O No O Yes O Don't know

n. When this injury happened, were any parts of your body OTHER THAN your head?

O No O Yes O Don't know

o. Did this injury disrupt your personal and/or work activities for more than 1 day?

O No O Yes O Don't know

p. Did you get a medical evaluation/treatment for this injury?

O No O Yes O Don't know

p1. If **YES** where did you get evaluated/treated? (Check all that apply)

- O In the field by a medic
- O Outpatient clinic/doctor's office
- O Emergency room/urgent care center
- O Admitted to the hospital as an INPATIENT ➔ how many nights __ __ __
- O Don't know

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104. How many motor vehicle accident(s)/crash (es) have you **ever** been in while NOT deployed? ___ ___ accidents/crashes

Comment [JLW16]: Web only.

If NONE, skip to question XXX

b. List the date of your most recent motor vehicle accident/crash (mm/yy) __ __ / __ __

c. What is the total number of work days lost as a result of this motor vehicle accident/crash: ___ ___ ___ ___ days

d. What treatment did you seek for your injuries from this motor vehicle accident/crash?

O No treatment sought O Clinic or office visit only O Hospitalized: number of days…___ ___ ___ ___

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105. What is your annual **household** income? Please choose only one.

- O Less than $25,000
- O $25,000 – $49,999
- O $50,000 – $74,999
- O $75,000 – $99,999
- O $100,000 – $124,999
- O $125,000 – $149,999
- O $150,000 or more

106. Which best describes the financial condition of you and your family? Please choose only one.

Very comfortable and secure
Able to make ends meet without much difficulty
Occasionally have some difficulty making ends meet
Tough to make ends meet but keeping our heads above water
In over our heads

107. Has someone assisted you with filling out this survey?

No Yes

Address: _____ Apt/Suite: _____

City (of FPO/APO): _____ State/Province Region (or AA/AE/SP): _____

Zip/Postal Code: _____ Country: _____

108. Please provide your phone number(s): (Separate multiple phone numbers with a space)

109. Please provide your email address(es): (Separate multiple email addresses with a space)

110. What year were you born? ___ ___ ___ ___

111. What are the last four digits of your Social Security Number? ___ ___ ___ ___

112. What is today's date (mm/dd/yyyy) ___ ___ / ___ ___ / ___ ___ ___ ___

113. Do you have any concerns about your health that are not covered in this questionnaire that you would like to share? (Continue on a separate sheet if necessary.) Do not include any Personally Identifiable Information (PII)
