



### Vietnam-Era Veterans Follow-Up Study

This booklet contains questions about your current health and well-being. The purpose of this follow-up study is to better understand changes in Veterans' health status over time. With the information we obtain from this study, we can better understand factors that influence changes in health and well-being over time.

**Paperwork Reduction Act Statement:** This information is being collected in accordance with section 3507 of the Paperwork Reduction Act of 1995. Accordingly, we may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended to complete this survey will average 45 minutes. This includes the time needed to follow instructions, gather the necessary facts, and respond to the questions. This information is being collected to better understand civilian and military factors that can affect health and well-being over time. The results of this survey will help inform general knowledge about changes in Veterans' health status and treatment. Participation in this survey is voluntary, and failure to respond will not have any impact on your entitlement to benefits.

**Privacy Act Statement:** Information gathered will be kept private to the extent provided by law. Data collected will be aggregated, and no information will be attributable to you as an individual. Disclosure of information will involve release of statistical data and other non-identifying data for improving the quality of service delivery by providing additional background information about the participants to better serve them. Participation in this survey is voluntary, and failure to respond will not have any impact on your entitlement to benefits.

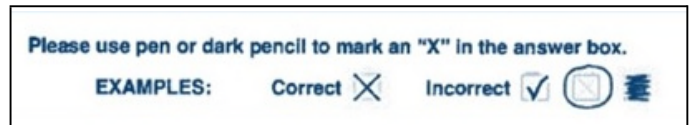
Thank you in advance for completing this survey. If you have any questions or suggestions to decrease the burden, you may contact our helpdesk at 877-776-5187.

#### Questionnaire Instructions

Please answer all the questions on the following pages as completely as possible. We are interested in your opinions. Please remember that you are free to skip any question that makes you feel uncomfortable without any penalty or prejudice.

Information you provide in this questionnaire will be considered privileged and held in confidence; you will not be identified in any presentation of the results. Only your unique study identification number will appear on these questionnaire pages.

- Fill in only one box for each question unless it tells you to "Mark all that apply."
- Please mark an "X" in the box as shown in the box to the right:



**Return your survey in the postage-paid envelope to receive \$20 cash.**

If you do not have the envelope, please send to:  
VIETNAM VET STUDY  
C/O ALTARUM  
3520 GREEN CT. STE 300  
ANN ARBOR, MI 48105

## Activity

A1 Which one of the following best describes your usual daily activities related to moving around? Do not include exercise, sports, or physically active hobbies done in your leisure time.

- Sit during most of the day  
 Stand during most of the day  
 Walk around most of the day

A2 During the past seven days, did you walk for at least 10 minutes at a time for fun, relaxation, exercise or to get somewhere?

- Yes  No

A3 During the past 12 months, have you increased your physical activity or exercise?

- Yes  No

A4 In a usual week, do you do vigorous activities for at least 10 minutes at a time that cause heavy sweating or large increases in breathing or heart rate (such as running, aerobics, heavy yard work, etc.)?

- Yes  No → Go to A7

A5 How many days per week do you do these vigorous activities for at least 10 minutes at a time?

- Number of days

A6 On days when you do vigorous activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

Hours per day:

OR Minutes per day:

A7 In a usual week, do you do light or moderate activities for at least 10 minutes at a time that cause only light sweating or a slight to moderate increase in breathing or heart rate (such as brisk walking, bicycling, vacuuming, gardening, etc.)?

- Yes  No → Go To A10

A8 How many days per week do you do these light to moderate activities for at least 10 minutes?

Number of days:

A9 On days when you do light to moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

Hours per day:

OR Minutes per day:

## The following questions are about your use of tobacco and alcohol.

A10 In your lifetime, have you smoked a total of at least 100 cigarettes, cigars, or pipes?

- Yes  No → Go To A14

A11 Have you ever smoked daily or almost every day for at least 1 year?

- Yes  No

A12 Do you smoke now?

- Yes, daily  
 Yes, occasionally  
 Not at all

A13 What tobacco products do you use?

- Cigarette  Pipe  
 Cigar  Smokeless  
(e.g., dip, snuff)

**For the following questions, a drink is a 12 oz beer, a 5 oz glass of wine, or 1.5 oz of liquor**

A14 During your entire life, have you had at least 12 drinks of any type of alcoholic beverage?

- Yes  No → Go To A18

A15 In the past 6 months, how often did you have a drink containing alcohol?

- Never  
 Monthly  
 2-4 times per month  
 2-4 times or less a week  
 4 or more times a week

A16 In the past 6 months, how many drinks of alcohol did you have on a typical day when you were drinking?

- 1 or 2  
 3 or 4  
 5 or 6  
 7, 8, or 9  
 10 or more  
 Not applicable

A17 How often do you have six or more drinks if you are a man, or five or more drinks if you are a woman, on one occasion?

- Never  
 Less than monthly  
 Monthly  
 Weekly  
 Daily or almost daily

A18 Please select the statement below which best describes you at present.

- Former drinker  
 Occasional drinker  
 Light drinker  
 Moderate drinker  
 Heavy drinker  
 Teetotaler (I never drank)  
 Other (please specify)

**The following question is about your sleep habits.**

A19 On average, how many hours do you sleep per night?

- Less than 2 hours  
 2 or more hours but less than 4 hours  
 4 or more hours but less than 6 hours  
 6 or more hours but less than 8 hours  
 8 or more hours but less than 10 hours  
 10 hours or more

**The following questions are about your ability to perform various activities involved in daily living.**

B1 In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

B2 In the past week, how much assistance did you require in the following activities due to a health condition?

	I can do without any assistance	I can do with some assistance	I am completely dependent on assistance	I do not do this activity
a. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Transferring from bed or a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Walking around your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Managing your money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Doing household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Taking medications properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B3 The following questions ask you to compare your health one year ago to your health now.

Some About Some  
Much -what the -what Much  
better better same worse worse

a. Compared to **one** year ago, how would you rate your physical health in general **now**

b. Compared to **one** year ago, how would you rate your emotional health in general **now**

B4 The following items are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much?

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

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

b. Climbing **several** flights of stairs

B5 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?

Yes, a little bit of the time    Yes, some of the time    Yes, most of the time    Yes, all of the time

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

b. Didn't do work or other activities as **carefully** as usual

B6 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)?

Yes, a little bit of the time    Yes, some of the time    Yes, most of the time    Yes, all of the time

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

b. Didn't do work or other activities as **carefully** as usual

B7 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

B8 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 best answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt <b>calm</b> and <b>peaceful</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Did you have a lot of <b>energy</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt <b>downhearted</b> and <b>blue</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. How much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B9 In the past 30 days, how much difficulty did you have in ....

	None	Mild	Moderate	Severe	Extreme/ cannot do
a. Standing for long periods, such as 30 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Taking care of your household responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Learning a new task, for example, learning how to get to a new place?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Joining community activities (for example, festivities, religious or other activities) in the same way as anyone can?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. How much have you been emotionally affected by your health problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Concentrating on doing something for ten minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking a long distance such as a kilometer (or equivalent)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Washing your whole body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Getting dressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Dealing with people you do not know?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Maintaining a friendship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Your day-to-day work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The following questions are about specific health conditions and your history with these conditions.**

**C1** Have you ever been told by a doctor or other health professional that you had any of the following **Circulatory System** conditions? *Select all that apply.*

	Yes	I currently take medication and/or receive treatment for this condition
a. High blood pressure (hypertension)	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
c. Transient ischemic attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
e. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
f. Coronary artery/ coronary heart disease (includes angina)	<input type="checkbox"/>	<input type="checkbox"/>
g. Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
h. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
i. Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>
j. Anemia	<input type="checkbox"/>	<input type="checkbox"/>

**C1.1** If applicable, please tell us the year that you were diagnosed with the following conditions.

a. Stroke	Year Diagnosed:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> </tr> </table>				
b. Transient ischemic attack (TIA)	Year Diagnosed:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> </tr> </table>				
c. Heart attack	Year Diagnosed:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> </tr> </table>				

**C2** Have you ever been told by a doctor or other health professional that you had any of the following **Mental Health** conditions? *Select all that apply.*

	Yes	I currently take medication and/or receive treatment for this condition
a. Panic disorder	<input type="checkbox"/>	<input type="checkbox"/>
b. Generalized anxiety disorder (GAD)	<input type="checkbox"/>	<input type="checkbox"/>
c. Social Phobia	<input type="checkbox"/>	<input type="checkbox"/>
d. Other anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>
e. Attention deficit hyperactivity disorder	<input type="checkbox"/>	<input type="checkbox"/>
f. Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>
g. Depressive disorder	<input type="checkbox"/>	<input type="checkbox"/>
h. Posttraumatic stress disorder (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>
i. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
j. Personality disorder	<input type="checkbox"/>	<input type="checkbox"/>
k. Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>

C3 Have you ever been told by a doctor or other health professional that you had any of the following **types of Cancer**? *Select all that apply.*

	Yes	I currently take medication and/or receive treatment for this condition
a. Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>
b. Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>
c. Testicular cancer	<input type="checkbox"/>	<input type="checkbox"/>
d. Colon cancer/ Rectal cancer	<input type="checkbox"/>	<input type="checkbox"/>
e. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
f. Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
g. Brain cancer	<input type="checkbox"/>	<input type="checkbox"/>
h. Liver cancer	<input type="checkbox"/>	<input type="checkbox"/>
i. Pancreatic cancer	<input type="checkbox"/>	<input type="checkbox"/>
j. Respiratory cancers (e.g., lung, larynx, throat, tonsil)	<input type="checkbox"/>	<input type="checkbox"/>
k. Urinary bladder cancer	<input type="checkbox"/>	<input type="checkbox"/>
l. Soft tissue sarcoma	<input type="checkbox"/>	<input type="checkbox"/>
m. Thyroid cancer	<input type="checkbox"/>	<input type="checkbox"/>
n. Other cancer:	<input type="checkbox"/>	<input type="checkbox"/>
<input style="width: 350px; height: 20px;" type="text"/>		

C3.1 If applicable, please tell us the year that you were diagnosed with the following conditions.

a. Breast cancer	Year Diagnosed:	<input type="text"/>
b. Prostate cancer	Year Diagnosed:	<input type="text"/>
c. Colon/rectal cancer	Year Diagnosed:	<input type="text"/>
d. Lung cancer	Year Diagnosed:	<input type="text"/>
e. Brain cancer	Year Diagnosed:	<input type="text"/>
f. Liver cancer	Year Diagnosed:	<input type="text"/>
g. Pancreatic cancer	Year Diagnosed:	<input type="text"/>
h. Respiratory cancers	Year Diagnosed:	<input type="text"/>

C4 Have you ever been told by a doctor or other health professional that you had any of the following types of **Nervous System** conditions? *Select all that apply.*

	Yes	I currently take medication and/or receive treatment for this condition
a. Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
b. Memory loss or impairment	<input type="checkbox"/>	<input type="checkbox"/>
c. Dementia (includes Alzheimer's, vascular, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
d. Concussion or loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
e. Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>
f. Spinal cord injury or impairment	<input type="checkbox"/>	<input type="checkbox"/>
g. Epilepsy/seizure	<input type="checkbox"/>	<input type="checkbox"/>
h. Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
i. Amyotrophic lateral sclerosis ALS or Lou Gehrig's disease	<input type="checkbox"/>	<input type="checkbox"/>
j. Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>

C4.1 If applicable, please tell us the year that you were diagnosed with the following conditions.

a. Dementia	Year Diagnosed:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. Parkinson's disease	Year Diagnosed:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. Amyotrophic lateral sclerosis	Year Diagnosed:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d. Multiple sclerosis	Year Diagnosed:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



C5 Have you ever been told by a doctor or other health professional that you had any of the following **Health** conditions? *Select all that apply.*

	Yes	I currently take medication and/or receive treatment for this condition
a. Enlarged prostate (benign prostatic hyperplasia)	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic lung disease (COPD, emphysema, or bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>
d. Diabetes/"sugar"	<input type="checkbox"/>	<input type="checkbox"/>
e. Liver condition (e.g., cirrhosis)	<input type="checkbox"/>	<input type="checkbox"/>
f. Skin condition (e.g., eczema, psoriasis)	<input type="checkbox"/>	<input type="checkbox"/>
g. Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
h. Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
i. Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
j. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
k. Lupus	<input type="checkbox"/>	<input type="checkbox"/>
l. Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>
m. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
n. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
o. Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
p. Blindness, all causes	<input type="checkbox"/>	<input type="checkbox"/>
q. Tinnitus or ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>
r. Severe hearing loss or partial deafness in one or both ears	<input type="checkbox"/>	<input type="checkbox"/>
s. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
t. Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
u. HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
v. Kidney disease without dialysis	<input type="checkbox"/>	<input type="checkbox"/>
w. Kidney disease with dialysis	<input type="checkbox"/>	<input type="checkbox"/>
x. Acute kidney disease with no current dialysis	<input type="checkbox"/>	<input type="checkbox"/>
y. Irritable bowel syndrome (IBS)	<input type="checkbox"/>	<input type="checkbox"/>
z. Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>
aa. Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>
bb. Celiac disease / Sprue	<input type="checkbox"/>	<input type="checkbox"/>
cc. Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
dd. Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
ee. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>

C5.1 If applicable, please tell us the year that you were diagnosed with the following conditions.

a. Chronic lung disease	Year Diagnosis:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. Diabetes/"sugar"	Year Diagnosis:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**The following questions are for women only. *Select all that apply.***

**C6 Women's Health Conditions**

	No	Yes	Not Sure
a. Have you had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you had both of your ovaries removed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you ever taken female hormones (other than birth control pills or fertility drugs) for any reason? (Female hormones include estrogens or progestins, hormone patches or creams, hormone injections, or postmenopausal hormones).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. During and after menopause, women are sometimes prescribed <u>estrogen</u> (Examples include "Estrogen", "Conjugated Estrogen", "Premarin", "Estrogen Patch", "Combined Estrogen/Progestin"). Have you ever taken menopausal estrogens?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. During and after menopause, women are sometimes prescribed <u>progestin</u> (Examples include "Provera, Medroxyprogesterone", etc.) Have you ever taken menopausal progestins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**These next few questions ask about your experience with benefits provided by the Department of Veterans Affairs. *This does not include tuition assistance (TA) you may have received while on active duty.***

**D1** Have you used any VA education or training benefits, excluding VA vocational rehabilitation?

- Yes                       No

**D2** Have you ever been enrolled in VA health care?

- Yes  
 No  
 Don't know

**D3** Have you ever used any VA health care services?

- Yes  
 No                      → Go to D5  
 Don't know            → Go to D5

**D4** In the last 6 months, did you use any VA health care services, or did you have any of your health care paid for by VA?

- Yes, I received services at VA, or they were paid for by VA (including the Mission Act)  
 No, I received services, but not from VA and were not paid for by VA  
 No, I did not receive any health care services  
 Don't know/don't remember

**D5** Where do you go to get health care? *Select all that apply.*

- VA hospital or clinic that is part of VA  
 Hospital that is not part of VA (emergency room)  
 Urgent care facility  
 Community health center  
 Do not get health care

**D6** Do you have a VA service-connected disability rating?

- Yes                       No                      → Go to D10

D7 What is your current VA service-connected disability rating?

			%
--	--	--	---

D8 When did you get this rating?

- In the past year
- 2 – 5 years ago
- 6 - 10 years ago
- More than 10 years ago

D9 For what conditions?

- Physical/medical conditions
- Mental health conditions
- Both physical and mental health conditions

D10 Do you receive a non-service-connected disability pension from the VA?

- Yes
- No

D11 During the past year, how important was the disability payment benefit you received from VA in helping you meet your financial needs?

- Extremely important
- Very important
- Moderately important
- Slightly important
- Not at all important
- Don't know

D12 Indicate whether you have used any of the following types of health care services in the **past 6 months**. If so, please indicate if you received this care at a VA facility.

	Received this care (past 6 months)?	Did you receive this care at a VA facility?
a. Overnight stay in a hospital for medical or surgical care	<input type="checkbox"/>	<input type="checkbox"/>
b. Outpatient care for doctor visits, urgent care, routine exams, medical tests, or shots	<input type="checkbox"/>	<input type="checkbox"/>
c. Overnight stay in a hospital for mental health or substance abuse treatment	<input type="checkbox"/>	<input type="checkbox"/>
d. Prescription medications	<input type="checkbox"/>	<input type="checkbox"/>
e. Over the counter medications	<input type="checkbox"/>	<input type="checkbox"/>
f. In-home health care for yourself	<input type="checkbox"/>	<input type="checkbox"/>
g. Care for any prosthetics or medical equipment, including home oxygen	<input type="checkbox"/>	<input type="checkbox"/>
h. Care for hearing aids or eye glasses	<input type="checkbox"/>	<input type="checkbox"/>
i. Overnight stay in a rehabilitation hospital or nursing care facility	<input type="checkbox"/>	<input type="checkbox"/>
j. Dental care	<input type="checkbox"/>	<input type="checkbox"/>
k. Emergency room	<input type="checkbox"/>	<input type="checkbox"/>
l. Other types of medical treatments	<input type="checkbox"/>	<input type="checkbox"/>

D13 How much do you agree or disagree with the following statements?

	Completely agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Completely disagree	N/A
a. If the cost of health care to me increases, I will use VA more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I would only use VA if I did not have access to any other sources of health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I have a doctor outside VA who I really like and trust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Veterans who can afford to use other sources of health care should leave the VA to those who really need it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Veterans like me who use VA are satisfied with the health care they receive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. VA health care providers explain treatment/diagnoses in a way that patients can understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. There is a VA provider in my area that offers all of the health care services that Veterans like me need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I have one particular health care provider who is in charge of my care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D14 If you needed long-term Nursing Home Care, would you ...

- Definitely go to the VA?
- Maybe go to the VA?
- Definitely go somewhere else?

D15 What are the ways you plan to use VA health care in the future? *Select all that apply.*

- As a primary source of health care
- Backup to non-VA care for specialized services
- A "safety net" to use only if needed
- For prescriptions
- For specialized care
- Some other way
- No plans to use VA for health care

D16 Are you currently covered by any of the following types of health insurance or health coverage plans? *Select all that apply.*

- Not covered by any health insurance or health plan
- Insurance through a current or former employer or union (of yours or another family member)
- Insurance purchased directly from an insurance company (by you or another family member)
- Medicare, for people 65 and older, or people with certain disabilities
- Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability
- VA
- TRICARE, TRICARE For Life, CHAMPVA, CHAMPUS or other military health care
- Indian Health Services
- Any other type of health insurance or health coverage plan (please specify)

**In this section we are going to make a series of statements about the VA. For each question, select the one answer that best reflects how true or correct the statement is for you.**

D17 How long does it take to travel from your home to the VA facility nearest your home?

- Less than 1 hour
- Between 1 and 2 hours
- Between 2 and 4 hours
- More than 4 hours

D18 Have you ever sought treatment at a VA Hospital or Outpatient Facility?

- Yes
- No → Go to D23

D19 When was the last time you used the VA Outpatient Facility?

- Past 3 months
- Past 6 months
- Past 1 year
- Past 3 years
- Past 5 years

D20 Do you use the VA Outpatient Facility as your primary source for medical care?

- Yes
- No

D21 About how many times have you used the VA Hospital or Outpatient Facility in the past 3 years?

- 1 - 2 times
- 3 - 5 times
- 6 - 10 times
- 11 or more

D22 If you have been treated at a VA facility, how correct or true are the following statements about your actual experiences with the VA healthcare system the last time you used it?

	Not true	Slightly true	Moderately true	Very true
a. I was given an appointment within a reasonable time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The medical staff of the VA has a positive attitude toward Vietnam veterans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Vietnam veterans are treated the same as veterans of other wars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. The medical staff is competent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. The staff of the VA is well aware of special Vietnam veteran needs like Agent Orange	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I was asked about the possibility of exposure to Agent Orange	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. There is an adequate staff at the VA to meet patient needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. When I tell the doctor something, I am confident it was completely understood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. The doctor is able to communicate effectively and clearly to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. The VA service is well organized and smoothly running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. There is a lot of paperwork and "red tape" involved in using the VA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. The staff at the VA is courteous to patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. The staff at the VA is helpful to me in filling out the required paperwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. The facilities available for doing the paperwork are private	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. I have always been fully informed about the examinations and tests I have undergone at the VA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Taken all in all, the service at the VA is as good as most other health care facilities I have dealt with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. I am confident the VA will always "be there" for me in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D23 Have you ever seen anyone for advice and help with emotional, nervous or mental problems?

Yes

No → Go to next page

D24 When did you first seek this help? (enter year)

--	--	--	--

D25 Have you seen anyone during the **past six months** for an emotional, nervous or mental problem?

Yes

No

D26 Did you ever go to a VA facility for help with an emotional, nervous or mental problem?

Yes

No → Go to E1

D27 When did you first go? (enter year)

--	--	--	--

D28 During your examination at the VA, were you asked...

	Yes	No
a. Whether you were ever in a life-threatening situation?	<input type="checkbox"/>	<input type="checkbox"/>
b. Whether you were ever in combat?	<input type="checkbox"/>	<input type="checkbox"/>
c. Whether bad memories from the service come back to you?	<input type="checkbox"/>	<input type="checkbox"/>
d. Whether you have nightmares about the service?	<input type="checkbox"/>	<input type="checkbox"/>
e. Whether you avoid situations that remind you of the service?	<input type="checkbox"/>	<input type="checkbox"/>
f. Whether you ever experienced military sexual trauma?	<input type="checkbox"/>	<input type="checkbox"/>

**SOUTHEAST ASIA MILITARY SERVICE**

In this section we are going to ask a series of questions about your service experiences in Southeast Asia. If you did not serve in that area of the world, check the box below and go to question E4.

I did not serve in Southeast Asia →Go to E4

We are interested in finding out what you remember about whether you were exposed to defoliating herbicides, such as Agent Orange, which were used to kill jungle cover in Southeast Asia. If you believe you were exposed to such a chemical agent, either directly loading it, spraying it, or entering a freshly sprayed area, we would like you to describe how you were exposed, for how long and whether you felt any immediate effects. If you don't remember being directly exposed to herbicides check the box below and go to question E4.

I don't remember being directly exposed to herbicides →Go to E4

**E1 Exposure situations.** Listed below are some ways in which servicemen may have been exposed to herbicides. Check all the ways in which these situations apply to you.

	Did you hold this job?		Did you experience immediate effects?		What were these effects?			
	No	Yes	No	Yes	Coughing	Skin irritation	Nausea	Other
a. Sprayer on airplane (C-123)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Sprayer on helicopter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Sprayer on boat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Loader/handler of spray for a plane, helicopter or boat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Job involving clearing vegetation and/or patrolling around camp, roads or clearing fire free zones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Slept in/walked through sprayed areas. Exposed to herbicides used near camp or on roads you traveled on	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other jobs or situations involving exposure (please specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>								

**E2** Estimate the total number of weeks you were exposed to herbicides.

Weeks

**E3** Did you participate in Operation Ranch Hand?

Yes  No



**For the next two questions, think back to your service during the Vietnam War era (1961-1975).**

E4 Did you have any injury(ies) from any of the following? Please only include injuries from your military service during the Vietnam War era (1961-1975). *Select all that apply.*

- Fragment or shrapnel
- Bullet
- Vehicular (any type of vehicle, including airplane)
- Fall
- Blast (Booby trap, RPG, Land mine, Grenade, etc.)
- Other (please specify)

E5 Did you have a concussion or head injury during your service?

- Yes  No → **Go to E8**

E6 Approximately how many times did this occur?

--	--

E7 Did you experience any of the following symptoms? *Select all that apply.*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> No problems at the time of the injury                       | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Memory problems  |
| <input type="checkbox"/> Did not remember what happened immediately before the event | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Sleep problems   |
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Balance problems |
|  | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Confusion        |
|  | <input type="checkbox"/> Double-vision       |   |

**For the next question, please include any injury, whether or not it was related to your military service. Do not include any injuries you reported in questions E4 and E5.**

E8 Have you ever had concussions or brain injuries from any of the following? *Select all that apply.*

- |  |   |
|--|---|
| <input type="checkbox"/> Military training | <input type="checkbox"/> Accidents (vehicular, falls, etc.) |
| <input type="checkbox"/> Playing sports    | <input type="checkbox"/> Violence (non-military)            |

**Life experiences often have some mixture of the desirable and undesirable. The following are experiences that some individuals feel resulted from their military service. From the two lists of desirable and undesirable experiences, please indicate to what extent you experienced each one by selecting the appropriate box to the right of each statement.**

**F1 Desirable Experiences**

	Not at all	A little	Somewhat	A lot
a. Lifelong friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. A broader perspective on things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Learned to cope with adversity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Greater self-discipline, dependability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Became more independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Improved life chances through education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Value life more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Positive feelings about self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Became proud to be an American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Clearer direction and purpose in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Better job skills and options	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Rewarding memories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Learned cooperation, teamwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Appreciate peace more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**F2 Undesirable Experiences**

	Not at all	A little	Somewhat	A lot
a. Economic problems for me or my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Disrupted my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lonely for my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Delayed career, put me behind age mates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Combat anxieties, apprehensions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Hurt my marriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Waste of time, boredom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Misery, discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Loss of friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Lost my good health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Separation from loved ones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Drinking problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Bad memories or nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Death and destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F3 Please think about your military experience, and what was the most distressing or disturbing event that occurred during that time. Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then mark one of the boxes to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Repeated, disturbing, and unwanted memories of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Repeated, disturbing dreams of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling very upset when something reminded you of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Avoiding memories, thoughts, or feelings related to the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Trouble remembering important parts of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Blaming yourself or someone else for the stressful experience or what happened after it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Loss of interest in activities that you used to enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Feeling distant or cut off from other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Irritable behavior, angry outbursts, or acting aggressively?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Taking too many risks or doing things that could cause you harm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Being "superalert" or watchful or on guard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Feeling jumpy or easily startled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Having difficulty concentrating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Trouble falling or staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F4 The following statements ask about your attitudes, experiences, and thoughts about your military service, and how these may have changed compared to when you were younger. Please read each item carefully and mark the choice that best applies. When responding to these statements, think about the war(s) in which you served.

	Strongly disagree	Disagree	Neither disagree or agree	Agree	Strongly agree
a. I think about the war more than I used to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Everyday things have started reminding me of the war	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. As I get older, I get more upset when talking about the war than I used to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My family and friends tell me that I have recently been speaking more emotionally about the war	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I dream about the war more now than when I was younger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. These days, I become more emotional around certain days or anniversaries that remind me of the war	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Lately, my thoughts about the war bother me more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I need to talk about the war more now than when I was younger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. These days, I think more about my role in the war	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. When I am faced with stressful events, I find myself thinking about the war	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Lately, I think more about friends I lost during the war	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**It is possible for the same experience to be both positive and negative.**

F5

	Worst 1	2	3	4	5	6	7	8	9	Best 10
Considering the <b>very best</b> periods of your life, where would you place military service, on a scale from 1-10, with 1 being the worst and 10 being the best?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F6

	Worst 1	2	3	4	5	6	7	8	9	Best 10
Considering the <b>very worst</b> periods of your life, where would you place military service, on a scale from 1-10, with 1 being the worst and 10 being the best?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F7

	Definite dis- advantage 1	2	3	4	5	6	7	8	9	Definite advantage 10
Overall, would you say that the experience of military service has turned out to be more of a disadvantage or advantage in life, on a scale from 1-10, with 1 being a <i>definite disadvantage</i> and 10 being a <i>definite advantage</i> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F8

Least influential 1 2 3 4 5 6 7 8 9 10 Most influential

Considering the most influential events in your life, where would you place military service as an influence on the person you are now, on a scale from 1-10, with 1 being *least influential* and 10 being *most influential*?

G1 Below are several statements with which you may agree or disagree. Indicate your agreement with each item by selecting the appropriate response.

Strongly Disagree    Disagree    Slightly Disagree    Neither agree nor disagree    Slightly agree    Agree    Strongly agree

a. In most ways my life is close to ideal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The conditions of my life are excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I am satisfied with my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. So far I have gotten the important things I want in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. If I could live my life over, I would change almost nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G2 When you were a child, younger than 18, did you experience the following? *Select all that apply.*

No                      Yes

a. Death of mother	<input type="checkbox"/>	<input type="checkbox"/>
b. Death of father	<input type="checkbox"/>	<input type="checkbox"/>
c. Permanent separation from mother	<input type="checkbox"/>	<input type="checkbox"/>
d. Permanent separation from father	<input type="checkbox"/>	<input type="checkbox"/>
e. Have a parent that had problems with drugs or alcohol and/or emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
f. Sexual abuse by someone in charge of your care	<input type="checkbox"/>	<input type="checkbox"/>
g. Physical abuse by someone in charge of your care	<input type="checkbox"/>	<input type="checkbox"/>

G3 Since you were an adult, 18 or older, did you experience the following ever or while in the military? *Select all that apply.*

Yes, ever                      Yes, in the military?

a. Sudden unexpected death (due to suicide, murder, or sudden illness) of someone you were very close to	<input type="checkbox"/>	<input type="checkbox"/>
b. Sexual activity against your will because of force or threat of force	<input type="checkbox"/>	<input type="checkbox"/>
c. Separation from your child due to loss of custody	<input type="checkbox"/>	<input type="checkbox"/>
d. Death of a child	<input type="checkbox"/>	<input type="checkbox"/>
e. Physical assault (e.g., beat up) by someone with whom you had a sustained relationship (e.g., boyfriend)	<input type="checkbox"/>	<input type="checkbox"/>
f. Witness someone else being physically assaulted	<input type="checkbox"/>	<input type="checkbox"/>
g. Serious natural or man-made disaster (e.g., hurricane, earthquake, fire)	<input type="checkbox"/>	<input type="checkbox"/>
h. Combat (e.g., incoming fire, physical threat)	<input type="checkbox"/>	<input type="checkbox"/>
i. During any of the above-mentioned events, in childhood or adulthood, did you expect that you would be killed?	<input type="checkbox"/>	<input type="checkbox"/>

**Thinking about the events reported above, indicate the degree to which the listed changes occurred in your life as a result of the event.**

G4 As a result of this event,

	Did <u>not</u> experience	Very small degree	Small degree	Moderate degree	Great degree	Very great degree
a. I changed my priorities about what is important in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I have a greater appreciation for the value of my own life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I developed new interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I have a greater feeling of self-reliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I have a better understanding of spiritual matters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I more clearly see that I can count on people in times of trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I established a new path for my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I have a greater sense of closeness with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. I am more willing to express my emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. I know better than I can handle difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. I am able to do better things with my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. I am better able to accept the way things work out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. I can better appreciate each day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. New opportunities are available which wouldn't have been otherwise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. I have more compassion for others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. I put more effort into my relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. I am more likely to try to change things which need changing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. I have a stronger religious faith	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. I discovered that I'm stronger than I thought I was	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. I learned a great deal about how wonderful people are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions are about your health and well-being.

**Your Well-Being**

H1 Thinking about only the past 7 days ...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
a. I have been able to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I have been able to bring to mind words that I wanted to use while talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I have been able to remember things, like where I left my keys or wallet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I have been able to remember to do things, like take medicine or buy something I needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I am able to pay attention and keep track of what I am doing without extra effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. My mind is as sharp as it has always been	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I am able to shift back and forth between two activities that require thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. My memory is as good as it has always been	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. I am able to keep track of what I am doing, even if I am interrupted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H2 In the past 7 days ...

	Never	Rarely	Sometimes	Often	Always
a. I felt worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I felt that I had nothing to look forward to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I felt helpless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I felt sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I felt like a failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I felt depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I felt unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I felt hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H3 In the past 7 days ...

	Never	Rarely	Sometimes	Often	Always
a. I felt fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I found it hard to focus on anything other than my anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My worries overwhelmed me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I felt uneasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I felt nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I felt like I needed help for my anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I felt anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. I felt tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H4 How much of the time during the past 4 weeks did you ...

	All of the time	Most of the time	Good bit of the time	Some of the time	A little of the time	None of the time
a. Have difficulty reasoning and solving problems? For example, making plans, making decisions, and/or learning new things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have difficulty doing activities involving concentration and thinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Become confused and start several actions at a time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Forget, for example, things that happened recently, where you put things, and/or appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Have trouble keeping your attention on any activity for very long?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. React slowly to things that were said or done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## Recent Life Issues

Please read each item below. Indicate if you experienced it during the past year or ever in your lifetime. Check both if apply.

I1 Have you experienced ...

	Yes, in past year	Yes, in my lifetime
a. Deterioration of memory?	<input type="checkbox"/>	<input type="checkbox"/>
b. Death of spouse?	<input type="checkbox"/>	<input type="checkbox"/>
c. Institutionalization of spouse?	<input type="checkbox"/>	<input type="checkbox"/>
d. Death of son or daughter?	<input type="checkbox"/>	<input type="checkbox"/>
e. Death of a parent?	<input type="checkbox"/>	<input type="checkbox"/>
f. Death of other close family member?	<input type="checkbox"/>	<input type="checkbox"/>
g. Major personal injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>
h. Retirement?	<input type="checkbox"/>	<input type="checkbox"/>
i. Divorce?	<input type="checkbox"/>	<input type="checkbox"/>
j. Major deterioration in financial state?	<input type="checkbox"/>	<input type="checkbox"/>
k. Marital separation?	<input type="checkbox"/>	<input type="checkbox"/>
l. Marriage?	<input type="checkbox"/>	<input type="checkbox"/>
m. Death of a friend?	<input type="checkbox"/>	<input type="checkbox"/>
n. Major deterioration in health or behavior of a family member?	<input type="checkbox"/>	<input type="checkbox"/>
o. Major decrease in activities that you really enjoyed?	<input type="checkbox"/>	<input type="checkbox"/>
p. Child's divorce or marital separation?	<input type="checkbox"/>	<input type="checkbox"/>
q. Decrease in responsibilities or hours at work or where you volunteer?	<input type="checkbox"/>	<input type="checkbox"/>
r. Increase in responsibilities or hours at work or where you volunteer?	<input type="checkbox"/>	<input type="checkbox"/>
s. Move to a less desirable residence?	<input type="checkbox"/>	<input type="checkbox"/>
t. Change to a less desirable line of work?	<input type="checkbox"/>	<input type="checkbox"/>
u. Spouse retired?	<input type="checkbox"/>	<input type="checkbox"/>
v. Deterioration in living conditions?	<input type="checkbox"/>	<input type="checkbox"/>
w. Troubles with the boss or coworkers?	<input type="checkbox"/>	<input type="checkbox"/>
x. Worsening relationship with a child?	<input type="checkbox"/>	<input type="checkbox"/>
y. Worsening relationship with your spouse or partner?	<input type="checkbox"/>	<input type="checkbox"/>
z. Assuming major responsibility for a parent?	<input type="checkbox"/>	<input type="checkbox"/>
aa. Institutionalization of parent?	<input type="checkbox"/>	<input type="checkbox"/>
bb. Loss of a very close friend due to a move or break in friendship?	<input type="checkbox"/>	<input type="checkbox"/>
cc. Being burglarized or robbed?	<input type="checkbox"/>	<input type="checkbox"/>
dd. Loss of prized possessions due to move?	<input type="checkbox"/>	<input type="checkbox"/>

## Your Social Support

**People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it?**

J1 How often is the following support available to you?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Someone to help you if you were confined to bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Someone you can count on to listen to you when you need to talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Someone to give you good advice about a crisis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Someone to take you to the doctor if you needed it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Someone who shows you love and affection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Someone to have a good time with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Someone to give you information to help you understand a situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Someone to confide in or talk to about yourself or your problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Someone who hugs you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Someone to get together with for relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Someone to prepare your meals if you were unable to do it yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Someone whose advice you really want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Someone to do things with to help get your mind off things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Someone to help with daily chores if you were sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Someone to share your most private worries and fears with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Someone to turn to for suggestions about how to deal with a personal problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Someone to do something enjoyable with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Someone who understands your problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Someone to love and make you feel wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## About You

K1 What is your current relationship status?

- Married
- Divorced
- Separated
- Widowed
- Single/never married
- In a romantic relationship and living as a couple
- In a romantic relationship but not living as a couple

K2 Is there someone for whom you are the primary caregiver?

- Yes                       No → Go to K4

K3 What is their relationship to you? *Select all that apply.*

- Spouse/partner
- Parent
- Child
- Sibling
- Grandparent
- Grandchild
- Other (please describe)

K4 What is your current employment situation? *Select all that apply.*

- Working for pay full-time (30 hours or more per week)
- Working for pay part-time (less than 30 hours per week)
- Working at more than one job
- Working as a volunteer (no pay)
- Not working but actively looking for work
- Not working and not looking for work
- Disabled
- Homemaker
- Retired
- Other (please describe)

K5 Which of these best describes your present situation?

- I really can't make ends meet with the income I now have
- I just about manage to get by with the income I now have
- I have enough to get by and even a little extra
- I can buy pretty much anything I want with the income I now have

K6 What was your family annual income (before taxes) last year?

- Under \$25,000
- \$25,000 - \$49,999
- \$50,000 - \$99,999
- \$100,000 or higher

K7 About how tall are you without shoes?

Feet  
 Inches

K8 About how much do you weigh without clothes or shoes?

lbs

K9 How do you describe your race/ethnicity? *Select all that apply.*

- Native American or Alaska Native
- Black or African American
- Asian
- Filipino
- West Asian/Middle Eastern/North African
- Hispanic/Latino
- Native Hawaiian
- Other Pacific Islander (please specify in first box below)
- White/European
- Other race /ethnicity (please specify in second box below)

Other Pacific Islander

Other race/ethnicity:

If you are feeling any distress after completing this survey, please call the anonymous VA Crisis Line at 1-800-273-TALK (8255). The Crisis Line can help you find out about additional help in your area, or you can just talk about any concerns. The people who answer the phone are professionals who are trained and experienced in talking with others about various problems and situations. You can call anytime, 24 hours a day, 7 days a week. This free service has no connection with this study.

**Thank you for taking the time to complete this survey. You will be mailed \$20 in cash once the survey is received. Please remember that all the information you have provided is confidential.**

**Someone may be contacting you in a few weeks to invite you to participate in a telephone interview that is a continuation of this study. You will receive an additional \$20 after completing the telephone interview.**

The best phone number(s) to reach you:

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

- Home
- Cell
- Work

			-				-				
--	--	--	---	--	--	--	---	--	--	--	--

- Home
- Cell
- Work

Please indicate the most convenient times to reach you. *Select all that apply.*

- Days
- Evenings
- Weekends

What time zone do you live in?

- Alaskan Standard Time (AKST)
- Atlantic Standard Time (AST)
- Central Standard Time (CST)
- Eastern Standard Time (EST)
- Hawaii-Aleutian Standard Time (HST)
- Mountain Standard Time (MST)
- Pacific Standard Time (PST)