**Attachment 1: Proposed Web Questionnaire Introduction Screen and RANDS Questionnaire**

Form Approved

OMB No. 0920-0222

Exp. Date: 08/31/2021

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**Proposed Web Questionnaire Introduction Screen**

**** The National Center for Health Statistics, part of the Centers for Disease Control and Prevention, is conducting a study and we need your help. We are interested in your health and wellness, and will be asking you a series of questions about your health history, behaviors, and opinions. This should take about 20 minutes or less to complete. Participation in this survey is completely voluntary, and you may skip any question(s) you do not want to answer and may quit the survey at any time. You will not receive any monetary reward or incentive for participating in this survey. The information being collected is for research purposes only, and will assist NCHS and CDC in their ongoing efforts to track the health of the American public. Your data will be held confidential, will be used for statistical purposes only, and will not be disclosed or released to other persons without your consent in accordance with Section 308(d) of the Public Health Service Act [42 U.S.C. 242m(d)] and the Confidential Information and Statistical Efficiency Act (Title V of PL 107-347).

If you have any questions about this study, please call the office of the Ethics Review Board at the National Center for Health Statistics, toll-free at 1-800-223-8118. Please leave a brief message with your name and phone number. Say that you are calling about Protocol #2016-16-XX [**Note: The amendment number will be inserted into the form once NCHS ERB approval has been received**]. Your call will be returned as soon as possible.

Click the “Next” button below to begin.

**RANDS Questionnaire**

[Please note: questions that begin with either A\_ or B\_ will only be administered to one half of a split sample. Questions that are greyed out are for programming purposes only, and will not be administered separately to respondents]

**FORM “A”**

|  |  |
| --- | --- |
| **A\_PHSTATA** | Would you say your health in general is excellent, very good, good, fair, or poor? |
|  | 1 | Excellent |
|  | 2 | Very good |
|  | 3 | Good |
|  | 4 | Fair |
|  | 5 | Poor |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE1** | When you answered the previous question about your health, what did you think of? *(Please select all that apply.)* |
|  | 1 | Your diet and nutrition |
|  | 2 | Your exercise habits |
|  | 3 | Your smoking or drinking habits |
|  | 4 | Your health problems or conditions |
|  | 5 | The amount of times you seek health care |
|  | 6 | The amount of pain that you have |
|  | 7 | Your ability to do daily activities without assistance |
|  | 8 | The amount of sleep you get |
|  | 9 | Something else\_\_\_\_ |

|  |  |
| --- | --- |
| **A\_PROBE2\_1** | How would you rate your diet and nutrition? |
|  | 1 | Excellent | 2 | Very Good | 3 | Good | 4 | Fair | 5 | Poor |
|  |  |  |  |  |  |  |  |  |  |  |
| **A\_PROBE2\_2** | How would you rate your exercise habits? |
|  | 1 | Excellent | 2 | Very Good | 3 | Good | 4 | Fair | 5 | Poor |
|  |  |  |  |  |  |  |  |  |  |  |
| **A\_PROBE2\_3** | How would you rate your smoking or drinking habits? |
|  | 1 | Excellent | 2 | Very Good | 3 | Good | 4 | Fair | 5 | Poor |
|  |  |  |  |  |  |  |  |  |  |  |
| **A\_PROBE2\_4** | How would you rate yourself in terms of your health problems or conditions? |
|  | 1 | Excellent | 2 | Very Good | 3 | Good | 4 | Fair | 5 | Poor |
|  |  |  |  |  |  |  |  |  |  |  |
| **A\_PROBE2\_5** | How would you rate yourself in terms of the amount of healthcare you seek? |
|  | 1 | Excellent | 2 | Very Good | 3 | Good | 4 | Fair | 5 | Poor |
|  |  |  |  |  |  |  |  |  |  |  |
| **A\_PROBE2\_6** | How would you rate yourself in terms of pain? |
|  | 1 | Excellent | 2 | Very Good | 3 | Good | 4 | Fair | 5 | Poor |
|  |  |  |  |  |  |  |  |  |  |  |
| **A\_PROBE2\_7** | How would you rate your ability to do daily activities without assistance? |
|  | 1 | Excellent | 2 | Very Good | 3 | Good | 4 | Fair | 5 | Poor |
|  |  |  |  |  |  |  |  |  |  |  |
| **A\_PROBE2\_8** | How would you rate the amount of sleep you get? |
|  | 1 | Excellent | 2 | Very Good | 3 | Good | 4 | Fair | 5 | Poor |
|  |  |  |  |  |  |  |  |  |  |  |
| **A\_PROBE2\_9** | How would you rate yourself in terms of how frequently you get sick? |
|  | 1 | Excellent | 2 | Very Good | 3 | Good | 4 | Fair | 5 | Poor |
|  |  |  |  |  |  |  |  |  |  |  |

The next few questions are about health insurance, including health insurance obtained through employment or purchased directly, as well as government programs like Medicare and Medicaid that provide Medical care or help pay medical bills.

|  |  |
| --- | --- |
| **FHICOV** | Are you covered by any kind of health insurance or some other kind of health care plan? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If FHICOV=2, Skip to MCAIDPRB; Otherwise, continue)*

|  |  |
| --- | --- |
| **HIKIND** | Do you have any of the following kinds of health insurance or health care coverage? Include those plans that pay for only one type of service, such as nursing home care, accidents, or dental care. Exclude private plans that only provide extra cash while hospitalized. *(Select all that apply)* |
|  | 1 | Private Health Insurance |
|  | 2 | Medicare |
|  | 3 | Medi-Gap |
|  | 4 | Medicaid |
|  | 5 | SCHIP (CHIP/Children's Health Insurance Program) |
|  | 6 | Military health care (TRICARE/VA/CHAMP-VA) |
|  | 7 | Indian Health Service |
|  | 8 | State-sponsored health plan |
|  | 9 | Other government program |
|  | 10 | Single service plan (e.g., dental, vision, prescriptions) |
|  | 11 | No coverage of any type |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **PROBE3** | Which of the following describes how you got your health insurance? *(Please select all that apply.)* |
|  | 1 | Through a current or former employer, union, or professional association |
|  | 2 | Through one of my parent’s, spouse’s or other relative’s current or former employers |
|  | 3 | Through military service (by self, parent, or spouse) |
|  | 4 | It’s given to all people older than 65 and people under 65 with disabilities |
|  | 5 | It’s provided by the government to people who have difficulty affording health insurance |
|  | 6 | Purchased directly (by self, parent, or spouse) |
|  | 7 | Through [healthcare.gov](http://healthcare.gov) or one of the state health insurance marketplaces |
|  | 9 | Somewhere else\_\_\_\_ |

 *Skip: (If Respondent AGE≥65, AND HIKIND≠3, ADMINISTER MCAREPRB;*

 *If HIKIND==1, Skip to HDHP;*

*Otherwise, Skip to PROBE5)*

|  |  |
| --- | --- |
| **PROBE4** | Are you now covered by any other state or government assistance program that helps pay for healthcare? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | Don’t Know |
|  | 9 | [Refuse] |

 *Skip: (All in PROBE4, skip to PROBE5)*

|  |  |
| --- | --- |
| **HDHP** | Is the annual deductible for medical care for this plan less than $1,300 or $1,300 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here. |
|  | 1 | Less than $1,300 |
|  | 2 | $1,300 or more |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE5** | Which of the following best describes a deductible? |
|  | 1 | The amount you or a family member pay each month for coverage |
|  | 2 | The amount you have to pay before your insurance will start paying your bills |
|  | 3 | A fixed payment you make for each covered service or visit |
|  | 4 | The maximum amount you have to pay out-of-pocket per year for covered services |
|  | 7 | Don’t Know |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE6** | Which of the following best describes a premium? |
|  | 1 | The amount you or a family member pay each month for coverage |
|  | 2 | The amount you have to pay before your insurance will start paying your bills |
|  | 3 | A fixed payment you make for each covered service or visit |
|  | 4 | The maximum amount you have to pay out-of-pocket per year for covered services |
|  | 7 | Don’t Know |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE7** | Do you have to pay a certain amount for health care before your health insurance will start paying your medical bills? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | Don’t Know |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE8** | Do you or a family member have to pay a certain amount each month for health care coverage? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | Don’t Know |
|  | 9 | [Refused] |

The next series of questions will ask you about certain medical conditions.

|  |  |
| --- | --- |
| **HYPEV** | Have you ever been told by a doctor or other health professional that you had hypertension, also called high blood pressure? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE9** | How did you define hypertension? |
|  | 1 | A feeling when you are stressed or overwhelmed |
|  | 2 | A medical condition when a medical professional tells you that you have chronic high blood pressure |
|  | 3 | A medical condition when a medical professional tells you that you have had one or two high blood pressure readings |
|  | 9 | Something else\_\_\_\_ |

|  |  |
| --- | --- |
| **PROBE10** | How did you find out about your blood pressure status? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | From a home blood pressure cuff |
|  | 5 | From a machine at a grocery store, pharmacy, or some other type of store |
|  | 6 | You have never had my blood pressure measured |
|  | 9 | Somewhere else\_\_\_\_ |

 *Skip: (If code 1 in HYPEV, Continue; Otherwise, Skip to CHLEV)*

|  |  |
| --- | --- |
| **HYPYR** | During the past 12 months, have you had hypertension, also called high blood pressure? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |
| **HYPMDEV2** | Was any medicine ever prescribed by a doctor for your high blood pressure? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If code 1 in HYPMDEV2, Continue; Otherwise, Skip to CHLEV)*

|  |  |
| --- | --- |
| **HYPMED2** | Are you now taking any medicine prescribed by a doctor for your high blood pressure? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **CHLEV** | Have you ever been told by a doctor or other health professional that you had high cholesterol? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE11** | How did you find out about your cholesterol status? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | From a home blood test kit |
|  | 5 | From a test when you donated blood |
|  | 6 | You have never had your cholesterol levels tested |
|  | 9 | Somewhere else\_\_\_\_ |

 *Skip: (If code 1 in CHLEV, Continue; Otherwise, Skip to A\_EPHEV)*

|  |  |
| --- | --- |
| **CHLYR** | During the past 12 months, have you had high cholesterol? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **CHLMDEV2** | Was any medication ever prescribed by a doctor to help lower your cholesterol? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip: (If code 1 in CHLMDEV2, Continue; Otherwise, Skip to A\_EPHEV)*

|  |  |
| --- | --- |
| **CHLMDNW2** | Are you now taking any medicine prescribed by a doctor to help lower your cholesterol? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_EPHEV** | Have you ever been told by a doctor or other health professional that you had emphysema? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_** **COPDEV** | Have you ever been told by a doctor or other health professional that you had chronic obstructive pulmonary disease, also called COPD? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_** **CBRCHYR** | Have you ever been told by a doctor or other health professional that you had chronic bronchitis? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE12** | How did you find out about your lung heath? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | You have never been tested or told about your lung health  |
|  | 9 | Somewhere else\_\_\_\_ |

 *Skip: (If code 1 in A\_EPHEV or A\_COPDEV or A\_CBRCHYR, Continue; Otherwise, Skip to AASMEV)*

|  |  |
| --- | --- |
| **PROBE13** | Which condition were you told you had? *(Please select all that apply.)* |
|  | 1 | COPD |
|  | 2 | Emphysema |
|  | 3 | Chronic Bronchitis |
|  | 4 | Bronchitis |
|  | 5 | Something else |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE14** | Thinking about the most recent time you had symptoms of Chronic Obstructive Pulmonary Disease or COPD, emphysema, or chronic bronchitis, how long did the symptoms last? |
|  | 1 | Less than one week |
|  | 2 | One week to less than one month |
|  | 3 | One month to less than three months |
|  | 4 | Three or more months |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **AASMEV** | Have you ever been told by a doctor or other health professional that you had asthma? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE15** | How did you find out about your asthma status? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | From a sports coach or a fitness professional |
|  | 6 | You have never been tested or told about your asthma status |
|  | 9 | Somewhere else\_\_\_\_ |

*Skip: (If code 1 AASMEV, Continue; Otherwise, Skip to PREDIB\_A)*

|  |  |
| --- | --- |
| **AASSTILL** | Do you still have asthma? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **AASMYR** | During the past 12 months have you had an episode of asthma, or an asthma attack? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **AASMERYR** | During the past 12 months have you had to visit an emergency room or urgent care center because of asthma? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PREDIB\_A** | Has a doctor or other health professional ever told you that you had prediabetes or borderline diabetes? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip: (If FEMALE, Continue; Otherwise, Skip to DIBEV\_A)*

|  |  |
| --- | --- |
| **GESDIB\_A** | Has a doctor or other health professional EVER told you that you had gestational diabetes, a type of diabetes that occurs ONLY during pregnancy?\*Read if necessary: Gestational diabetes is diabetes that you did not have prior to being pregnant and goes away after you are pregnant. Pregnant women are usually screened for gestational diabetes during the 24th to 28th week of pregnancy. |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **DIBEV\_A** | (If Respondent is FEMALE): Not including prediabetes or gestational diabetes, has a doctor or other health professional ever told you that you had diabetes?(If Respondent is MALE): Not including prediabetes, has a doctor or other health professional ever told you that you had diabetes? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE16** | How did you find out about your blood sugar status? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | From a home blood test kit |
|  | 5 | From a test at when you donated blood |
|  | 6 | You have never had your blood sugar tested |
|  | 9 | Somewhere else\_\_\_\_ |

*Skip: (If DIBEV\_A=1, continue; otherwise, skip to B\_PAIN\_2)*

|  |  |
| --- | --- |
| **DIBAGE\_A** | (If Respondent is FEMALE): How old were you when a doctor or other health professional first told you that you had diabetes, not including prediabetes or gestational diabetes)?(If Respondent is MALE): How old were you when a doctor or other health professional first told you that you had diabetes, not including prediabetes diabetes? |
|  | \_\_\_\_\_ | Age at which diagnosed |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| **DIBPILL\_A** | Are you now taking diabetic pills to lower your blood sugar? These are sometimes called oral agents or oral hypoglycemic agents. |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **DIBINS\_A** | Insulin can be taken by shot or pump. Are you now taking insulin? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_CHPAIN6M** | In the past six months, how often did you have pain?  |
|  | 1 | Never |
|  | 2 | Some days |
|  | 3 | Most days |
|  | 4 | Every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If A\_CHPAIN6M=2-4, continue; otherwise, skip to RX12M)*

|  |  |
| --- | --- |
| **A\_PAINLMT6** | Over the past six months, how often did pain limit your life or work activities?  |
|  | 1 | Never |
|  | 2 | Some days |
|  | 3 | Most days |
|  | 4 | Every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PAIN\_4** | Thinking about the last time you had pain, how much pain did you have?  |
|  | 1 | A little |
|  | 2 | A lot |
|  | 3 | Somewhere in between a little and a lot |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE17** | Which of the following statements, if any, describe your pain? *(Please select all that apply.)* |
|  | 1 | It is constantly present |
|  | 2 | Sometimes I’m in a lot of pain and sometimes it’s not so bad |
|  | 3 | Sometimes it is unbearable and excruciating |
|  | 4 | When I get my mind on other things, I’m not aware of the pain |
|  | 5 | Medication can take my pain away completely |
|  | 6 | My pain is because of my work |
|  | 7 | My pain is because of exercise |
|  | 8 | My pain is minor and infrequent |
|  | 9 | Somewhere else\_\_\_\_ |

|  |  |
| --- | --- |
| **RX12M** | During the past 12 months, were you prescribed medication by a doctor or other health professional? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **OPIOID1** | These next questions are about the use of prescription pain relievers called opioids. When answering these questions, please do not include over-the-counter pain relievers such as aspirin, Tylenol, Advil, or Aleve.During the past 12 months, have you taken any opioid pain relievers prescribed by a doctor or dentist? Examples include hydrocodone, Vicodin, Norco, Lortab, oxycodone, OxyContin, Percocet and Percodan.  |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If OPIOID1=1, continue; otherwise skip to PROBE18)*

|  |  |
| --- | --- |
| **OPIOID2** | During the past 3 months, have you taken any opioid pain relievers prescribed by a doctor or dentist? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If OPIOID2=1, continue; otherwise skip to PROBE18)*

|  |  |
| --- | --- |
| **OPIOID3** | During the past 3 months, how often did you take a prescription opioid?  |
|  | 1 | Some days |
|  | 2 | Most days |
|  | 3 | Every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE18** | Which of the following pain relievers have you used in the past year? (*Select all that apply)* |
|  | 1 | Hydrocodone |
|  | 2 | Vicodin |
|  | 3 | Norco |
|  | 4 | Lortab |
|  | 5 | Oxycodone |
|  | 6 | OxyContin |
|  | 7 | Percocet |
|  | 8 | Percodan |
|  | 9 | Aspin |
|  | 10 | Tylenol or Acetaminophen |
|  | 11 | Advil or Ibuprofen |
|  | 12 | Alieve or Naproxen |
|  | 13 | Something else\_\_\_\_ |

These next questions are about cigarette smoking.

|  |  |
| --- | --- |
| **SMKEV** | Have you smoked at least 100 cigarettes in your entire life? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If code 1 in SMKEV, Continue; Otherwise, Skip to A\_ECIGEV\_A)*

|  |  |
| --- | --- |
| **SMKNOW** | Do you now smoke cigarettes every day, some days, or not at all? |
|  | 1 | Every day |
|  | 2 | Some days |
|  | 3 | Not at all |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip: (If code 3 in SMKNOW, Continue; If code 1 or 2 in SMKNOW, Skip to CIGQTYR; Otherwise, Skip to A\_ECIGEV\_A)*

|  |  |
| --- | --- |
| **SMKQTNO** | How long has it been since you quit smoking cigarettes? |
|  | 1 | (OPEN: 1-120) (enter time period in SMKQTTP below) |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| ***SMKQTTP*** | *\* Enter time period for time since quit smoking.* |
|  | *1* | *Day(s)* |
|  | *2* | *Week(s)* |
|  | *3* | *Month(s)* |
|  | *4* | *Year(s)* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

 *Skip: (All in SMKQTTP, Skip to A\_ECIGEV\_A)*

|  |  |
| --- | --- |
| **CIGQTYR** | During the past 12 months, have you stopped smoking for more than one day because you were trying to quit smoking? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_ECIGEV\_A** | The next question is about electronic cigarettes or e-cigarettes. You may also know them as vape-pens, hookah-pens, e-hookahs, or e-vaporizers. Some look like cigarettes, and others look like pens or small pipes. These are battery-powered, usually contain liquid nicotine, and produce vapor instead of smoke. Have you ever used an e-cigarette even one time? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE19** | What counts as an e-cigarette? (*select all that apply*) |
|  | 1 | A vape with cannabis, THC, or CBD oil |
|  | 2 | A vape with nicotine or other flavored oil |
|  | 3 | A hookah-pen or e-hookah |
|  | 4 | An e-vaporizer |
|  | 5 | A tobacco cigarette or cigar |
|  | 7 | A marijuana cigarette |
|  | 8 | Other\_\_\_ |

The next questions are about physical activities (exercise, sports, physically active hobbies…) that you may do in your leisure time.

|  |  |
| --- | --- |
| **MODNO** | How often do you do light or moderate leisure time physical activities for at least 10 minutes that cause only light sweating or a slight to moderate increase in breathing or heart rate?\*If necessary, prompt with: How many times per day, per week, per month, or per year do you do these activities? |
|  | \_\_\_\_ | Number of times (enter time period in MODTP below) |
|  | 996 | [Unable to do this type of activity] |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***MODTP*** | *\* Enter time period for light or moderate leisure-time physical activities* |
|  | *0* | *Never* |
|  | *1* | *Per day* |
|  | *2* | *Per week* |
|  | *3* | *Per month* |
|  | *4* | *Per year* |
|  | *6* | *[Unable to do this activity]* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

 *Skip: (If code 1 - 4 in MODTP, Continue; Otherwise, Skip to VIGNO)*

|  |  |
| --- | --- |
| **MODLNGNO** | About how long do you do these light or moderate leisure-time physical activities each time? |
|  | \_\_\_\_ | Number of minutes/hours (enter time period in MODLNGTP below) |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***MODLNGTP*** | *\* Enter time period for length of light or moderate leisure-time physical activities.* |
|  | *1* | *Minutes* |
|  | *2* | *Hours* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

|  |  |
| --- | --- |
| **PROBE20** | Which of the following types of physical activity, if any, did you include when you answered the previous question? *(Please select all that apply.)* |
|  | 1 | Running |
|  | 2 | Jogging |
|  | 3 | Walking or hiking for exercise |
|  | 4 | Walking to or from an activity |
|  | 5 | Walking at work |
|  | 6 | Working out with exercise equipment |
|  | 7 | Cycling, swimming, or other aerobic exercises |
|  | 8 | Yoga or stretching |
|  | 9 | Playing sports |
|  | 11 | Other\_\_ |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **VIGNO** | How often do you do vigorous leisure-time physical activities for at least 10 minutes that cause heavy sweating or large increases in breathing or heart rate?\*Read if necessary: How many times per day, per week, per month, or per year do you do these activities? |
|  | \_\_\_\_ | Number of times (enter time period in VIGTP below) |
|  | 996 | [Unable to do this type of activity] |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***VIGTP*** | *\* Enter time period for vigorous leisure-time physical activities* |
|  | *0* | *Never* |
|  | *1* | *Per day* |
|  | *2* | *Per week* |
|  | *3* | *Per month* |
|  | *4* | *Per year* |
|  | *6* | *[Unable to do this activity]* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

 *Skip: (If code 1 - 4 in VIGTP, Continue; Otherwise, Skip to STRNGNO)*

|  |  |
| --- | --- |
| **VIGLNGNO** | About how long do you do these vigorous leisure-time physical activities each time? |
|  | \_\_\_\_ | Number of minutes/hours (enter time period in VIGLNGTP below) |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***VIGLNGTP*** | *\* Enter time period for length of vigorous leisure-time physical activities.* |
|  | *1* | *Minutes* |
|  | *2* | *Hours* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

|  |  |
| --- | --- |
| **PROBE21** | Which of the following types of physical activity, if any, did you include when you answered the previous question? *(Please select all that apply.)* |
|  | 1 | Running |
|  | 2 | Jogging |
|  | 3 | Walking or hiking for exercise |
|  | 4 | Walking to or from an activity |
|  | 5 | Walking at work |
|  | 6 | Working out with exercise equipment |
|  | 7 | Cycling, swimming, or other aerobic exercises |
|  | 8 | Yoga or stretching |
|  | 9 | Playing sports |
|  | 11 | Other\_\_ |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **STRNGNO** | How often do you do leisure time physical activities specifically designed to strengthen your muscles such as lifting weights or doing calisthenics? (Include all such activities even if you have mentioned them before.)\*Read if necessary: How many times per day, per week, per month, or per year do you do these activities? |
|  | \_\_\_\_\_ | Number of times (enter time period in STRNGTP below) |
|  | 996 | [Unable to do this type of activity] |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***STRNGTP*** | *\* Enter time period for strengthening activities* |
|  | *0* | *Never* |
|  | *1* | *Per day* |
|  | *2* | *Per week* |
|  | *3* | *Per month* |
|  | *4* | *Per year* |
|  | *6* | *[Unable to do this activity]* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

|  |  |
| --- | --- |
| **PROBE22** | In the last week, did you do any of the following things for 20 or more minutes at once? *(Please select all that apply.)* |
|  | 1 | Running |
|  | 2 | Jogging |
|  | 3 | Walking outside of work |
|  | 4 | Lifting or carrying heavy objects outside of work |
|  | 6 | Working out with exercise equipment |
|  | 7 | Cycling, swimming, or other aerobic exercises |
|  | 8 | Yoga or stretching |
|  | 9 | Playing sports |
|  | 10 | Yardwork or cleaning your home |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

These next questions are about drinking alcoholic beverages. Included are liquor such as whiskey or gin, beer, wine, wine coolers, and any other type of alcoholic beverage.

|  |  |
| --- | --- |
| **ALC1YR** | In any one year, have you had at least 12 drinks of any type of alcoholic beverage? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If code 1 in ALC1YR, Continue; Otherwise, skip to PROBE23)*

|  |  |
| --- | --- |
| **ALC5UPNO** | *(If gender is FEMALE):* In the past year, on how many days did you have 4 or more drinks of any alcoholic beverage?*(If gender is MALE):* In the past year, on how many days did you have 5 or more drinks of any alcoholic beverage?\* Read if necessary: How many days per week, per month or per year did you have [4 or more/ 5 or more] drinks in a single day? |
|  | \_\_\_\_\_ | Number of days (enter time period in ALC5UPTP below) |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| ***ALC5UPTP*** | *\* Enter time period for days per week, per month or per year.* |
|  | *0* | *Never / None* |
|  | *1* | *Per week* |
|  | *2* | *Per month* |
|  | *3* | *Per year* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

 *Skip: (If code 0 in ALC5UPTP, Skip to PROBE23; Otherwise, Continue)*

|  |  |
| --- | --- |
| **BINGE1** | *(If gender is FEMALE):* Considering all types of alcoholic beverages, during the past 30 days, how many times did you have 4 or more drinks on an occasion?*(If gender is MALE):* Considering all types of alcoholic beverages, during the past 30 days, how many times did you have 5 or more drinks on an occasion? |
|  | \_\_\_\_\_ | Number of times |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **PROBE23** | In the last 30 days, what is the largest number of drinks you have consumed in a single day? |
|  | 1 | [OPEN] |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE24** | When answering the previous questions, what did you count as a drink? *(Please select all that apply.)* |
|  | 1 | A can or bottle of beer or malt liquor |
|  | 2 | A glass of wine or shot of liquor |
|  | 3 | A bottle of wine or liquor |
|  | 4 | A drink you purchased from a restaurant or bar |
|  | 5 | A drink you made or poured for yourself |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **ACISLEEP** | On average, how many hours of sleep do you get in a 24-hour period? |
|  | \_\_\_\_\_ | Number of hours |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **ACISLPFL** | In the past week, how many times did you have trouble falling asleep? |
|  | 0 | Did not have trouble falling asleep in the past week |
|  | 1 | 1 time |
|  | 2 | 2 times |
|  | 3 | 3 times |
|  | 4 | 4 times |
|  | 5 | 5 times |
|  | 6 | 6 times |
|  | 7 | 7 or more times |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **ACISLPST** | In the past week, how many times did you have trouble staying asleep? |
|  | 0 | Did not have trouble staying asleep in the past week |
|  | 1 | 1 time |
|  | 2 | 2 times |
|  | 3 | 3 times |
|  | 4 | 4 times |
|  | 5 | 5 times |
|  | 6 | 6 times |
|  | 7 | 7 or more times |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **ACISLPMD** | In the past week, how many times did you take medication to help you fall asleep or stay asleep? |
|  | 0 | Did not take medication to help sleep in the past week |
|  | 1 | 1 time |
|  | 2 | 2 times |
|  | 3 | 3 times |
|  | 4 | 4 times |
|  | 5 | 5 times |
|  | 6 | 6 times |
|  | 7 | 7 or more times |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **ACIREST** | In the past week, on how many days did you wake up feeling well rested? |
|  | 0 | Never felt rested in the past week |
|  | 1 | 1 day |
|  | 2 | 2 days |
|  | 3 | 3 days |
|  | 4 | 4 days |
|  | 5 | 5 days |
|  | 6 | 6 days |
|  | 7 | 7 days |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **PROBE25** | In the past week, what time did you typically go to sleep? |
|  | 1 | [OPEN (hh:mm AM/PM)] |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE26** | In the past week, what time did you typically wake up? |
|  | 1 | [OPEN (hh:mm AM/PM)] |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE27** | In the past week, did you take any naps? |
|  | 1 | Yes |
|  | 2 | No |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

 *Skip*: (If PROBE27==1, continue; otherwise skip to ACISAD)

|  |  |
| --- | --- |
| **PROBE28** | In the past week, how long was your typical nap? |
|  | 1 | [OPEN (hours\_\_\_ minutes\_\_\_)] |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

During the past 30 days, how often did you feel…

|  |  |
| --- | --- |
| **ACISAD** | So sad that nothing could cheer you up? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip*: (If ACISAD=1:4, continue; otherwise skip to ACINERV)

|  |  |
| --- | --- |
| **PROBE29** | Which of the following statements, if any describe your feelings of being so sad that nothing could cheer you up? *(Please select all that apply.)* |
|  | 1 | Sometimes the feelings can be so intense that I cannot get out of bed. |
|  | 2 | The feelings sometimes interfere with my life, and I wish that I did not have them. |
|  | 3 | I get over the feelings quickly |
|  | 5 | Feeling that way is normal, and everyone feels that way sometimes |
|  | 6 | I have been told by a medical professional that I have depression |
|  | 9 | Somewhere else\_\_\_\_ |

|  |  |
| --- | --- |
| **ACINERV** | Nervous? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip*: (If ACINERV=1:4, continue; otherwise skip to ACIRSTLS)

|  |  |
| --- | --- |
| **PROBE30** | Which of the following statements, if any describe your feelings of being nervous or anxious? *(Please select all that apply.)* |
|  | 1 | Sometimes the feelings can be so intense that my chest hurts and I have trouble breathing. |
|  | 2 | These are positive feelings that help me to accomplish goals and be productive. |
|  | 3 | The feelings sometimes interfere with my life, and I wish that I did not have them. |
|  | 4 | Feeling that way is normal, and everyone feels that way sometimes |
|  | 5 | I have been told by a medical professional that I have anxiety. |
|  | 6 | Something else\_\_\_\_ |

|  |  |
| --- | --- |
| **ACIRSTLS** | Restless or fidgety? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **ACIHOPLS** | Hopeless? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **ACIEFFRT** | That everything was an effort? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE31** | Would you consider everything being an effort a good thing or a bad thing? |
|  | 1 | Good thing |
|  | 2 | Bad thing |
|  | 3 | Neither good nor bad |
|  | 6 | Something else\_\_\_\_ |

 *Skip*: (If ACIEFFRT=1:4, continue; otherwise skip to ACIWTHLS)

|  |  |
| --- | --- |
| **PROBE32** | How concerned are you about feeling as if everything is an effort? |
|  | 1 | Very concerned |
|  | 2 | Somewhat concerned |
|  | 3 | A little concerned |
|  | 4 | Not at all concerned |

|  |  |
| --- | --- |
| **ACIWTHLS** | Worthless? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **TIRED\_1** | In the past 3 months, how often did you feel very tired or exhausted?  |
|  | 1 | Never |
|  | 2 | Some Days |
|  | 3 | Most Days |
|  | 4 | Every Day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip (If TIRED\_1=1, skip to A\_PHQ1; otherwise continue)*

|  |  |
| --- | --- |
| **TIRED\_2** | Thinking about the last time you felt very tired or exhausted, how long did it last?  |
|  | 1 | Some of the day |
|  | 2 | Most of the day |
|  | 3 | All of the day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **TIRED\_3** | Thinking about the last time you felt this way, how would you describe the level of tiredness?  |
|  | 1 | A little |
|  | 2 | A lot |
|  | 3 | Somewhere in between a little and a lot |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_PHQ1** | Little interest or pleasure in doing things |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_PHQ2** | Feeling down, depressed, or hopeless |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_PHQ3** | Trouble falling or staying asleep, or sleeping too much |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_PHQ4** | Feeling tired or having little energy |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_PHQ5** | Poor appetite or overeating |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_PHQ6** | Feeling bad about yourself — or that you are a failure or have let yourself or your family down |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_PHQ7** | Trouble concentrating on things, such as reading thenewspaper or watching television |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_PHQ8** | Moving or speaking so slowly that other people could havenoticed? Or the opposite — being so fidgety or restlessthat you have been moving around a lot more than usual |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip: (If any of A\_PHQ1 – A\_PHQ8 = 2,3,4, continue; otherwise END SURVEY)*

|  |  |
| --- | --- |
| **A\_PHQImp** | We just talked about problems you have been bothered by over the past 2 weeks. Altogether, 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? |
|  | 1 | Not at all difficult |
|  | 2 | Somewhat difficult |
|  | 3 | Very difficult |
|  | 4 | Extremely difficult |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **A\_PROBE33** | Which of the following statements, if any describe your feelings of being sad or depressed? |
|  | 1 | Sometimes the feelings can be so intense that I cannot get out of bed. |
|  | 2 | The feelings sometimes interfere with my life, and I wish that I did not have them. |
|  | 3 | I get over the feelings quickly |
|  | 5 | Feeling that way is normal, and everyone feels that way sometimes |
|  | 6 | I have been told by a medical professional that I have depression |
|  | 9 | Somewhere else\_\_\_\_ |

**FORM “B”**

|  |  |
| --- | --- |
| **B\_ PHSTATB** | Would you say your health in general is very good, good, fair, bad, or very bad? |
|  | 1 | Very good |
|  | 2 | Good |
|  | 3 | Fair |
|  | 4 | Bad |
|  | 5 | Very bad |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE1** | When you answered the previous question about your health, what did you think of? *(Please select all that apply.)* |
|  | 1 | Your diet and nutrition |
|  | 2 | Your exercise habits |
|  | 3 | Your smoking or drinking habits |
|  | 4 | Your health problems or conditions |
|  | 5 | The amount of times you seek health care |
|  | 6 | The amount of pain that you have |
|  | 7 | Your ability to do daily activities without assistance |
|  | 8 | The amount of sleep you get |
|  | 9 | Something else\_\_\_\_ |

|  |  |
| --- | --- |
| **B\_PROBE2\_1** | Please rate your agreement with the following statements: I have a healthy diet |
|  | 1 | Strongly Agree |
|  | 2 | Somewhat Agree |
|  | 3 | Somewhat Disagree |
|  | 4 | Strongly Disagree |

|  |  |
| --- | --- |
| **B\_PROBE2\_2** | Please rate your agreement with the following statements: I get enough exercise |
|  | 1 | Strongly Agree |
|  | 2 | Somewhat Agree |
|  | 3 | Somewhat Disagree |
|  | 4 | Strongly Disagree |

|  |  |
| --- | --- |
| **B\_PROBE2\_3** | Please rate your agreement with the following statements: I drink more than I should |
|  | 1 | Strongly Agree |
|  | 2 | Somewhat Agree |
|  | 3 | Somewhat Disagree |
|  | 4 | Strongly Disagree |

|  |  |
| --- | --- |
| **B\_PROBE2\_4** | Please rate your agreement with the following statements: I smoke more than I should |
|  | 1 | Strongly Agree |
|  | 2 | Somewhat Agree |
|  | 3 | Somewhat Disagree |
|  | 4 | Strongly Disagree |

|  |  |
| --- | --- |
| **B\_PROBE2\_5** | Please rate your agreement with the following statements: I’m satisfied with my sleep |
|  | 1 | Strongly Agree |
|  | 2 | Somewhat Agree |
|  | 3 | Somewhat Disagree |
|  | 4 | Strongly Disagree |

|  |  |
| --- | --- |
| **B\_PROBE2\_6** | Please rate your agreement with the following statements: I don’t have any major health problems or medical conditions |
|  | 1 | Strongly Agree |
|  | 2 | Somewhat Agree |
|  | 3 | Somewhat Disagree |
|  | 4 | Strongly Disagree |

|  |  |
| --- | --- |
| **B\_PROBE2\_7** | Please rate your agreement with the following statements: I frequently experience pain |
|  | 1 | Strongly Agree |
|  | 2 | Somewhat Agree |
|  | 3 | Somewhat Disagree |
|  | 4 | Strongly Disagree |

|  |  |
| --- | --- |
| **B\_PROBE2\_8** | Please rate your agreement with the following statements: I’m able to perform my daily activities independently |
|  | 1 | Strongly Agree |
|  | 2 | Somewhat Agree |
|  | 3 | Somewhat Disagree |
|  | 4 | Strongly Disagree |

|  |  |
| --- | --- |
| **B\_PROBE2\_9** | Please rate your agreement with the following statements: I get sick more often than other people |
|  | 1 | Strongly Agree |
|  | 2 | Somewhat Agree |
|  | 3 | Somewhat Disagree |
|  | 4 | Strongly Disagree |

The next few questions are about health insurance, including health insurance obtained through employment or purchased directly, as well as government programs like Medicare and Medicaid that provide Medical care or help pay medical bills.

|  |  |
| --- | --- |
| **FHICOV** | Are you covered by any kind of health insurance or some other kind of health care plan? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If FHICOV=2, Skip to MCAIDPRB; Otherwise, continue)*

|  |  |
| --- | --- |
| **HIKIND** | Do you have any of the following kinds of health insurance or health care coverage? Include those plans that pay for only one type of service, such as nursing home care, accidents, or dental care. Exclude private plans that only provide extra cash while hospitalized. *(Select all that apply)* |
|  | 1 | Private Health Insurance |
|  | 2 | Medicare |
|  | 3 | Medi-Gap |
|  | 4 | Medicaid |
|  | 5 | SCHIP (CHIP/Children's Health Insurance Program) |
|  | 6 | Military health care (TRICARE/VA/CHAMP-VA) |
|  | 7 | Indian Health Service |
|  | 8 | State-sponsored health plan |
|  | 9 | Other government program |
|  | 10 | Single service plan (e.g., dental, vision, prescriptions) |
|  | 11 | No coverage of any type |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **PROBE3** | Which of the following describes how you got your health insurance? *(Please select all that apply.)* |
|  | 1 | Through a current or former employer, union, or professional association |
|  | 2 | Through one of my parent’s, spouse’s or other relative’s current or former employers |
|  | 3 | Through military service (by self, parent, or spouse) |
|  | 4 | It’s given to all people older than 65 and people under 65 with disabilities |
|  | 5 | It’s provided by the government to people who have difficulty affording health insurance |
|  | 6 | Purchased directly (by self, parent, or spouse) |
|  | 7 | Through [healthcare.gov](http://healthcare.gov) or one of the state health insurance marketplaces |
|  | 9 | Somewhere else\_\_\_\_ |

 *Skip: (If Respondent AGE≥65, AND HIKIND≠3, ADMINISTER MCAREPRB;*

 *If HIKIND==1, Skip to HDHP;*

*Otherwise, Skip to PROBE5)*

|  |  |
| --- | --- |
| **PROBE4** | Are you now covered by any other state or government assistance program that helps pay for healthcare? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | Don’t Know |
|  | 9 | [Refuse] |

 *Skip: (All in PROBE4, skip to PROBE5)*

|  |  |
| --- | --- |
| **HDHP** | Is the annual deductible for medical care for this plan less than $1,300 or $1,300 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here. |
|  | 1 | Less than $1,300 |
|  | 2 | $1,300 or more |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE5** | Which of the following best describes a deductible? |
|  | 1 | The amount you or a family member pay each month for coverage |
|  | 2 | The amount you have to pay before your insurance will start paying your bills |
|  | 3 | A fixed payment you make for each covered service or visit |
|  | 4 | The maximum amount you have to pay out-of-pocket per year for covered services |
|  | 7 | Don’t Know |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE6** | Which of the following best describes a premium? |
|  | 1 | The amount you or a family member pay each month for coverage |
|  | 2 | The amount you have to pay before your insurance will start paying your bills |
|  | 3 | A fixed payment you make for each covered service or visit |
|  | 4 | The maximum amount you have to pay out-of-pocket per year for covered services |
|  | 7 | Don’t Know |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE7** | Do you have to pay a certain amount for health care before your health insurance will start paying your medical bills? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | Don’t Know |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE8** | Do you or a family member have to pay a certain amount each month for health care coverage? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | Don’t Know |
|  | 9 | [Refused] |

The next series of questions will ask you about certain medical conditions.

|  |  |
| --- | --- |
| **HYPEV** | Have you ever been told by a doctor or other health professional that you had hypertension, also called high blood pressure? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE9** | How did you define hypertension? |
|  | 1 | A feeling when you are stressed or overwhelmed |
|  | 2 | A medical condition when a medical professional tells you that you have chronic high blood pressure |
|  | 3 | A medical condition when a medical professional tells you that you have had one or two high blood pressure readings |
|  | 9 | Something else\_\_\_\_ |

|  |  |
| --- | --- |
| **PROBE10** | How did you find out about your blood pressure status? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | From a home blood pressure cuff |
|  | 5 | From a machine at a grocery store, pharmacy, or some other type of store |
|  | 6 | You have never had your blood pressure measured |
|  | 9 | Somewhere else\_\_\_\_ |

 *Skip: (If code 1 in HYPEV, Continue; Otherwise, Skip to CHLEV)*

|  |  |
| --- | --- |
| **HYPYR** | During the past 12 months, have you had hypertension, also called high blood pressure? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |
| **HYPMDEV2** | Was any medicine ever prescribed by a doctor for your high blood pressure? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If code 1 in HYPMDEV2, Continue; Otherwise, Skip to CHLEV)*

|  |  |
| --- | --- |
| **HYPMED2** | Are you now taking any medicine prescribed by a doctor for your high blood pressure? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **CHLEV** | Have you ever been told by a doctor or other health professional that you had high cholesterol? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE11** | How did you find out about your cholesterol status? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | From a home blood test kit |
|  | 5 | From a test at when you donated blood |
|  | 6 | You have never had your cholesterol levels tested |
|  | 9 | Somewhere else\_\_\_\_ |

 *Skip: (If code 1 in CHLEV, Continue; Otherwise, Skip to NEWLUNG)*

|  |  |
| --- | --- |
| **CHLYR** | During the past 12 months, have you had high cholesterol? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **CHLMDEV2** | Was any medication ever prescribed by a doctor to help lower your cholesterol? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip: (If code 1 in CHLMDEV2, Continue; Otherwise, Skip to NEWLUNG)*

|  |  |
| --- | --- |
| **CHLMDNW2** | Are you now taking any medicine prescribed by a doctor to help lower your cholesterol? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **NEWLUNG** | Have you ever been told by a doctor or other medical professional that you have Chronic Obstructive Pulmonary Disease or COPD, emphysema, or chronic bronchitis? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE12** | How did you find out about your lung heath? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | You have never been tested or told about your lung health  |
|  | 9 | Somewhere else\_\_\_\_ |

 *Skip: (If code 1 in NEWLUNG, Continue; Otherwise, Skip to AASMEV)*

|  |  |
| --- | --- |
| **PROBE13** | Which condition were you told you had? *(Please select all that apply.)* |
|  | 1 | COPD |
|  | 2 | Emphysema |
|  | 3 | Chronic Bronchitis |
|  | 4 | Bronchitis |
|  | 5 | Something else |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE14** | Thinking about the most recent time you had symptoms of Chronic Obstructive Pulmonary Disease or COPD, emphysema, or chronic bronchitis, how long did the symptoms last? |
|  | 1 | Less than one week |
|  | 2 | One week to less than one month |
|  | 3 | One month to less than three months |
|  | 4 | Three or more months |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **AASMEV** | Have you ever been told by a doctor or other health professional that you had asthma? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE15** | How did you find out about your asthma status? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | From a sports coach or a fitness professional |
|  | 6 | You have never been tested or told about your asthma status |
|  | 9 | Somewhere else\_\_\_\_ |

*Skip: (If code 1 AASMEV, Continue; Otherwise, Skip to PREDIB\_A)*

|  |  |
| --- | --- |
| **AASSTILL** | Do you still have asthma? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **AASMYR** | During the past 12 months have you had an episode of asthma, or an asthma attack? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **AASMERYR** | During the past 12 months have you had to visit an emergency room or urgent care center because of asthma? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PREDIB\_A** | Has a doctor or other health professional ever told you that you had prediabetes or borderline diabetes? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip: (If FEMALE, Continue; Otherwise, Skip to DIBEV\_A)*

|  |  |
| --- | --- |
| **GESDIB\_A** | Has a doctor or other health professional EVER told you that you had gestational diabetes, a type of diabetes that occurs ONLY during pregnancy?\*Read if necessary: Gestational diabetes is diabetes that you did not have prior to being pregnant and goes away after you are pregnant. Pregnant women are usually screened for gestational diabetes during the 24th to 28th week of pregnancy. |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **DIBEV\_A** | (If Respondent is FEMALE): Not including prediabetes or gestational diabetes, has a doctor or other health professional ever told you that you had diabetes?(If Respondent is MALE): Not including prediabetes, has a doctor or other health professional ever told you that you had diabetes? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE16** | How did you find out about your blood sugar status? |
|  | 1 | From a doctor or medical professional during an appointment |
|  | 2 | From a medical professional at an emergency room |
|  | 3 | From a test at a free clinic or health screening event |
|  | 4 | From a home blood test kit |
|  | 5 | From a test at when you donated blood |
|  | 6 | You have never had your blood sugar tested |
|  | 9 | Somewhere else\_\_\_\_ |

*Skip: (If DIBEV\_A=1, continue; otherwise, skip to B\_PAIN\_2)*

|  |  |
| --- | --- |
| **DIBAGE\_A** | (If Respondent is FEMALE): How old were you when a doctor or other health professional first told you that you had diabetes, not including prediabetes or gestational diabetes)?(If Respondent is MALE): How old were you when a doctor or other health professional first told you that you had diabetes, not including prediabetes diabetes? |
|  | \_\_\_\_\_ | Age at which diagnosed |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| **DIBPILL\_A** | Are you now taking diabetic pills to lower your blood sugar? These are sometimes called oral agents or oral hypoglycemic agents. |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **DIBINS\_A** | Insulin can be taken by shot or pump. Are you now taking insulin? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **B\_PAIN\_2** | In the past 3 months, how often did you have pain?  |
|  | 1 | Never |
|  | 2 | Some Days |
|  | 3 | Most Days |
|  | 4 | Every Day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If B\_PAIN\_2=2-4, continue; otherwise, skip to RX12M)*

|  |  |
| --- | --- |
| **B\_PAINLMT3** | Over the past three months, how often did pain limit your life or work activities?  |
|  | 1 | Never |
|  | 2 | Some days |
|  | 3 | Most days |
|  | 4 | Every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PAIN\_4** | Thinking about the last time you had pain, how much pain did you have?  |
|  | 1 | A little |
|  | 2 | A lot |
|  | 3 | Somewhere in between a little and a lot |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE17** | Which of the following statements, if any, describe your pain? *(Please select all that apply.)* |
|  | 1 | It is constantly present |
|  | 2 | Sometimes I’m in a lot of pain and sometimes it’s not so bad |
|  | 3 | Sometimes it is unbearable and excruciating |
|  | 4 | When I get my mind on other things, I’m not aware of the pain |
|  | 5 | Medication can take my pain away completely |
|  | 6 | My pain is because of my work |
|  | 7 | My pain is because of exercise |
|  | 8 | My pain is minor and infrequent |
|  | 9 | Somewhere else\_\_\_\_ |

|  |  |
| --- | --- |
| **RX12M** | During the past 12 months, were you prescribed medication by a doctor or other health professional? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **OPIOID1** | These next questions are about the use of prescription pain relievers called opioids. When answering these questions, please do not include over-the-counter pain relievers such as aspirin, Tylenol, Advil, or Aleve.During the past 12 months, have you taken any opioid pain relievers prescribed by a doctor or dentist? Examples include hydrocodone, Vicodin, Norco, Lortab, oxycodone, OxyContin, Percocet and Percodan.  |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If OPIOID1=1, continue; otherwise skip to PROBE18)*

|  |  |
| --- | --- |
| **OPIOID2** | During the past 3 months, have you taken any opioid pain relievers prescribed by a doctor or dentist? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If OPIOID2=1, continue; otherwise skip to PROBE18)*

|  |  |
| --- | --- |
| **OPIOID3** | During the past 3 months, how often did you take a prescription opioid?  |
|  | 1 | Some days |
|  | 2 | Most days |
|  | 3 | Every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE18** | Which of the following pain relievers have you used in the past year? (*Select all that apply)* |
|  | 1 | Hydrocodone |
|  | 2 | Vicodin |
|  | 3 | Norco |
|  | 4 | Lortab |
|  | 5 | Oxycodone |
|  | 6 | OxyContin |
|  | 7 | Percocet |
|  | 8 | Percodan |
|  | 9 | Aspin |
|  | 10 | Tylenol or Acetaminophen |
|  | 11 | Advil or Ibuprofen |
|  | 12 | Alieve or Naproxen |
|  | 13 | Something else\_\_\_\_ |

These next questions are about cigarette smoking.

|  |  |
| --- | --- |
| **SMKEV** | Have you smoked at least 100 cigarettes in your entire life? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If code 1 in SMKEV, Continue; Otherwise, Skip to B\_ECIGEV\_A)*

|  |  |
| --- | --- |
| **SMKNOW** | Do you now smoke cigarettes every day, some days, or not at all? |
|  | 1 | Every day |
|  | 2 | Some days |
|  | 3 | Not at all |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip: (If code 3 in SMKNOW, Continue; If code 1 or 2 in SMKNOW, Skip to CIGQTYR; Otherwise, Skip to B\_ECIGEV\_A)*

|  |  |
| --- | --- |
| **SMKQTNO** | How long has it been since you quit smoking cigarettes? |
|  | 1 | (OPEN: 1-120) (enter time period in SMKQTTP below) |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| ***SMKQTTP*** | *\* Enter time period for time since quit smoking.* |
|  | *1* | *Day(s)* |
|  | *2* | *Week(s)* |
|  | *3* | *Month(s)* |
|  | *4* | *Year(s)* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

 *Skip: (All in SMKQTTP, Skip to B\_ECIGEV\_A)*

|  |  |
| --- | --- |
| **CIGQTYR** | During the past 12 months, have you stopped smoking for more than one day because you were trying to quit smoking? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **B\_ECIGEV\_A** | Have you ever used an e-cigarette even one time? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE19** | What counts as an e-cigarette? (*select all that apply*) |
|  | 1 | A vape with cannabis, THC, or CBD oil |
|  | 2 | A vape with nicotine or other flavored oil |
|  | 3 | A hookah-pen or e-hookah |
|  | 4 | An e-vaporizer |
|  | 5 | A tobacco cigarette or cigar |
|  | 7 | A marijuana cigarette |
|  | 8 | Other\_\_\_ |

The next questions are about physical activities (exercise, sports, physically active hobbies…) that you may do in your leisure time.

|  |  |
| --- | --- |
| **MODNO** | How often do you do light or moderate leisure time physical activities for at least 10 minutes that cause only light sweating or a slight to moderate increase in breathing or heart rate?\*If necessary, prompt with: How many times per day, per week, per month, or per year do you do these activities? |
|  | \_\_\_\_ | Number of times (enter time period in MODTP below) |
|  | 996 | [Unable to do this type of activity] |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***MODTP*** | *\* Enter time period for light or moderate leisure-time physical activities* |
|  | *0* | *Never* |
|  | *1* | *Per day* |
|  | *2* | *Per week* |
|  | *3* | *Per month* |
|  | *4* | *Per year* |
|  | *6* | *[Unable to do this activity]* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

 *Skip: (If code 1 - 4 in MODTP, Continue; Otherwise, Skip to VIGNO)*

|  |  |
| --- | --- |
| **MODLNGNO** | About how long do you do these light or moderate leisure-time physical activities each time? |
|  | \_\_\_\_ | Number of minutes/hours (enter time period in MODLNGTP below) |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***MODLNGTP*** | *\* Enter time period for length of light or moderate leisure-time physical activities.* |
|  | *1* | *Minutes* |
|  | *2* | *Hours* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

|  |  |
| --- | --- |
| **PROBE20** | Which of the following types of physical activity, if any, did you include when you answered the previous question? *(Please select all that apply.)* |
|  | 1 | Running |
|  | 2 | Jogging |
|  | 3 | Walking or hiking for exercise |
|  | 4 | Walking to or from an activity |
|  | 5 | Walking at work |
|  | 6 | Working out with exercise equipment |
|  | 7 | Cycling, swimming, or other aerobic exercises |
|  | 8 | Yoga or stretching |
|  | 9 | Playing sports |
|  | 11 | Other\_\_ |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **VIGNO** | How often do you do vigorous leisure-time physical activities for at least 10 minutes that cause heavy sweating or large increases in breathing or heart rate?\*Read if necessary: How many times per day, per week, per month, or per year do you do these activities? |
|  | \_\_\_\_ | Number of times (enter time period in VIGTP below) |
|  | 996 | [Unable to do this type of activity] |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***VIGTP*** | *\* Enter time period for vigorous leisure-time physical activities* |
|  | *0* | *Never* |
|  | *1* | *Per day* |
|  | *2* | *Per week* |
|  | *3* | *Per month* |
|  | *4* | *Per year* |
|  | *6* | *[Unable to do this activity]* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

 *Skip: (If code 1 - 4 in VIGTP, Continue; Otherwise, Skip to STRNGNO)*

|  |  |
| --- | --- |
| **VIGLNGNO** | About how long do you do these vigorous leisure-time physical activities each time? |
|  | \_\_\_\_ | Number of minutes/hours (enter time period in VIGLNGTP below) |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***VIGLNGTP*** | *\* Enter time period for length of vigorous leisure-time physical activities.* |
|  | *1* | *Minutes* |
|  | *2* | *Hours* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

|  |  |
| --- | --- |
| **PROBE21** | Which of the following types of physical activity, if any, did you include when you answered the previous question? *(Please select all that apply.)* |
|  | 1 | Running |
|  | 2 | Jogging |
|  | 3 | Walking or hiking for exercise |
|  | 4 | Walking to or from an activity |
|  | 5 | Walking at work |
|  | 6 | Working out with exercise equipment |
|  | 7 | Cycling, swimming, or other aerobic exercises |
|  | 8 | Yoga or stretching |
|  | 9 | Playing sports |
|  | 11 | Other\_\_ |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **STRNGNO** | How often do you do leisure time physical activities specifically designed to strengthen your muscles such as lifting weights or doing calisthenics? (Include all such activities even if you have mentioned them before.)\*Read if necessary: How many times per day, per week, per month, or per year do you do these activities? |
|  | \_\_\_\_\_ | Number of times (enter time period in STRNGTP below) |
|  | 996 | [Unable to do this type of activity] |
|  | 997 | [Don’t Know] |
|  | 999 | [Refused] |

|  |  |
| --- | --- |
| ***STRNGTP*** | *\* Enter time period for strengthening activities* |
|  | *0* | *Never* |
|  | *1* | *Per day* |
|  | *2* | *Per week* |
|  | *3* | *Per month* |
|  | *4* | *Per year* |
|  | *6* | *[Unable to do this activity]* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

|  |  |
| --- | --- |
| **PROBE22** | In the last week, did you do any of the following things for 20 or more minutes at once? *(Please select all that apply.)* |
|  | 1 | Running |
|  | 2 | Jogging |
|  | 3 | Walking outside of work |
|  | 4 | Lifting or carrying heavy objects outside of work |
|  | 6 | Working out with exercise equipment |
|  | 7 | Cycling, swimming, or other aerobic exercises |
|  | 8 | Yoga or stretching |
|  | 9 | Playing sports |
|  | 10 | Yardwork or cleaning your home |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

These next questions are about drinking alcoholic beverages. Included are liquor such as whiskey or gin, beer, wine, wine coolers, and any other type of alcoholic beverage.

|  |  |
| --- | --- |
| **ALC1YR** | In any one year, have you had at least 12 drinks of any type of alcoholic beverage? |
|  | 1 | Yes |
|  | 2 | No |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip: (If code 1 in ALC1YR, Continue; Otherwise, skip to PROBE23)*

|  |  |
| --- | --- |
| **ALC5UPNO** | *(If gender is FEMALE):* In the past year, on how many days did you have 4 or more drinks of any alcoholic beverage?*(If gender is MALE):* In the past year, on how many days did you have 5 or more drinks of any alcoholic beverage?\* Read if necessary: How many days per week, per month or per year did you have [4 or more/ 5 or more] drinks in a single day? |
|  | \_\_\_\_\_ | Number of days (enter time period in ALC5UPTP below) |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| ***ALC5UPTP*** | *\* Enter time period for days per week, per month or per year.* |
|  | *0* | *Never / None* |
|  | *1* | *Per week* |
|  | *2* | *Per month* |
|  | *3* | *Per year* |
|  | *7* | *[Don’t Know]* |
|  | *9* | *[Refused]* |

 *Skip: (If code 0 in ALC5UPTP, Skip to PROBE23; Otherwise, Continue)*

|  |  |
| --- | --- |
| **BINGE1** | *(If gender is FEMALE):* Considering all types of alcoholic beverages, during the past 30 days, how many times did you have 4 or more drinks on an occasion?*(If gender is MALE):* Considering all types of alcoholic beverages, during the past 30 days, how many times did you have 5 or more drinks on an occasion? |
|  | \_\_\_\_\_ | Number of times |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **PROBE23** | In the last 30 days, what is the largest number of drinks you have consumed in a single day? |
|  | 1 | [OPEN] |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE24** | When answering the previous questions, what did you count as a drink? *(Please select all that apply.)* |
|  | 1 | A can or bottle of beer or malt liquor |
|  | 2 | A glass of wine or shot of liquor |
|  | 3 | A bottle of wine or liquor |
|  | 4 | A drink you purchased from a restaurant or bar |
|  | 5 | A drink you made or poured for yourself |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **ACISLEEP** | On average, how many hours of sleep do you get in a 24-hour period? |
|  | \_\_\_\_\_ | Number of hours |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **ACISLPFL** | In the past week, how many times did you have trouble falling asleep? |
|  | 0 | Did not have trouble falling asleep in the past week |
|  | 1 | 1 time |
|  | 2 | 2 times |
|  | 3 | 3 times |
|  | 4 | 4 times |
|  | 5 | 5 times |
|  | 6 | 6 times |
|  | 7 | 7 or more times |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **ACISLPST** | In the past week, how many times did you have trouble staying asleep? |
|  | 0 | Did not have trouble staying asleep in the past week |
|  | 1 | 1 time |
|  | 2 | 2 times |
|  | 3 | 3 times |
|  | 4 | 4 times |
|  | 5 | 5 times |
|  | 6 | 6 times |
|  | 7 | 7 or more times |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **ACISLPMD** | In the past week, how many times did you take medication to help you fall asleep or stay asleep? |
|  | 0 | Did not take medication to help sleep in the past week |
|  | 1 | 1 time |
|  | 2 | 2 times |
|  | 3 | 3 times |
|  | 4 | 4 times |
|  | 5 | 5 times |
|  | 6 | 6 times |
|  | 7 | 7 or more times |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **ACIREST** | In the past week, on how many days did you wake up feeling well rested? |
|  | 0 | Never felt rested in the past week |
|  | 1 | 1 day |
|  | 2 | 2 days |
|  | 3 | 3 days |
|  | 4 | 4 days |
|  | 5 | 5 days |
|  | 6 | 6 days |
|  | 7 | 7 days |
|  | 97 | [Don’t Know] |
|  | 99 | [Refused] |

|  |  |
| --- | --- |
| **PROBE25** | In the past week, what time did you typically go to sleep? |
|  | 1 | [OPEN (hh:mm AM/PM)] |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE26** | In the past week, what time did you typically wake up? |
|  | 1 | [OPEN (hh:mm AM/PM)] |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE27** | In the past week, did you take any naps? |
|  | 1 | Yes |
|  | 2 | No |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

 *Skip*: (If PROBE27==1, continue; otherwise skip to ACISAD)

|  |  |
| --- | --- |
| **PROBE28** | In the past week, how long was your typical nap? |
|  | 1 | [OPEN (hours\_\_\_ minutes\_\_\_)] |
|  | -7 | [Don’t Know] |
|  | -9 | [Refused] |

During the past 30 days, how often did you feel…

|  |  |
| --- | --- |
| **ACISAD** | So sad that nothing could cheer you up? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip*: (If ACISAD=1:4, continue; otherwise skip to ACINERV)

|  |  |
| --- | --- |
| **PROBE29** | Which of the following statements, if any describe your feelings of being so sad that nothing could cheer you up? *(Please select all that apply.)* |
|  | 1 | Sometimes the feelings can be so intense that I cannot get out of bed. |
|  | 2 | The feelings sometimes interfere with my life, and I wish that I did not have them. |
|  | 3 | I get over the feelings quickly |
|  | 5 | Feeling that way is normal, and everyone feels that way sometimes |
|  | 6 | I have been told by a medical professional that I have depression |
|  | 9 | Somewhere else\_\_\_\_ |

|  |  |
| --- | --- |
| **ACINERV** | Nervous? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

 *Skip*: (If ACINERV=1:4, continue; otherwise skip to ACIRSTLS)

|  |  |
| --- | --- |
| **PROBE30** | Which of the following statements, if any describe your feelings of being nervous or anxious? *(Please select all that apply.)* |
|  | 1 | Sometimes the feelings can be so intense that my chest hurts and I have trouble breathing. |
|  | 2 | These are positive feelings that help me to accomplish goals and be productive. |
|  | 3 | The feelings sometimes interfere with my life, and I wish that I did not have them. |
|  | 4 | Feeling that way is normal, and everyone feels that way sometimes |
|  | 5 | I have been told by a medical professional that I have anxiety. |
|  | 6 | Something else\_\_\_\_ |

|  |  |
| --- | --- |
| **ACIRSTLS** | Restless or fidgety? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **ACIHOPLS** | Hopeless? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **ACIEFFRT** | That everything was an effort? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **PROBE31** | Would you consider everything being an effort a good thing or a bad thing? |
|  | 1 | Good thing |
|  | 2 | Bad thing |
|  | 3 | Neither good nor bad |
|  | 6 | Something else\_\_\_\_ |

 *Skip*: (If ACIEFFRT=1:4, continue; otherwise skip to ACIWTHLS)

|  |  |
| --- | --- |
| **PROBE32** | How concerned are you about feeling as if everything is an effort? |
|  | 1 | Very concerned |
|  | 2 | Somewhat concerned |
|  | 3 | A little concerned |
|  | 4 | Not at all concerned |

|  |  |
| --- | --- |
| **ACIWTHLS** | Worthless? |
|  | 1 | All of the time |
|  | 2 | Most of the time |
|  | 3 | Some of the time |
|  | 4 | A little of the time |
|  | 5 | None of the time |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **TIRED\_1** | In the past 3 months, how often did you feel very tired or exhausted?  |
|  | 1 | Never |
|  | 2 | Some Days |
|  | 3 | Most Days |
|  | 4 | Every Day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip (If TIRED\_1=1, skip to B\_GAD1; otherwise continue)*

|  |  |
| --- | --- |
| **TIRED\_2** | Thinking about the last time you felt very tired or exhausted, how long did it last?  |
|  | 1 | Some of the day |
|  | 2 | Most of the day |
|  | 3 | All of the day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **TIRED\_3** | Thinking about the last time you felt this way, how would you describe the level of tiredness?  |
|  | 1 | A little |
|  | 2 | A lot |
|  | 3 | Somewhere in between a little and a lot |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

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

|  |  |
| --- | --- |
| **B\_GAD1** | Feeling nervous, anxious or on edge |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **B\_GAD2** | Not being able to stop or control worrying |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **B\_GAD3** | Worrying too much about different things |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **B\_GAD4** | Trouble relaxing |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **B\_GAD5** | Being so restless that it is hard to sit still |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **B\_GAD6** | Becoming easily annoyed or irritable |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **B\_GAD7** | Feeling afraid as if something awfulmight happen |
|  | 1 | Not at all |
|  | 2 | Several days |
|  | 3 | More than half the days |
|  | 4 | Nearly every day |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

*Skip: (If any of B\_GAD1 – B\_GAD7 = 2,3,4, continue; otherwise END SURVEY)*

|  |  |
| --- | --- |
| **B\_GADImp** | We just talked about problems you have been bothered by over the past 2 weeks. Altogether, 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? |
|  | 1 | Not difficult at all |
|  | 2 | Somewhat difficult |
|  | 3 | Very difficult |
|  | 4 | Extremely difficult |
|  | 7 | [Don’t Know] |
|  | 9 | [Refused] |

|  |  |
| --- | --- |
| **B\_PROBE34** | Which of the following statements, if any describe your feelings of being nervous or anxious? *(Please select all that apply.)* |
|  | 1 | Sometimes the feelings can be so intense that my chest hurts and I have trouble breathing. |
|  | 2 | These are positive feelings that help me to accomplish goals and be productive. |
|  | 3 | The feelings sometimes interfere with my life, and I wish that I did not have them. |
|  | 4 | Feeling that way is normal, and everyone feels that way sometimes |
|  | 5 | I have been told by a medical professional that I have anxiety. |
|  | 6 | Something else\_\_\_\_ |