



Million Veteran Program (MVP) COVID-19 Survey

OMB No. 2900-_____

Estimated Burden: 25 minutes

Expiration Date: _____

The Paperwork Reduction Act of 1995: This information is 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 by all individuals who complete this survey will average 25 minutes. This includes the time it will take to follow instructions, gather the necessary facts, and respond to questions asked. Customer satisfaction is used to gauge customer perceptions of VA services, as well as customer expectations and desires. This survey data will be analyzed in conjunction with biospecimens collected as part of the MVP and will assist with identification of potential biomarkers and allow researchers to analyze the incidence and outcomes of COVID-19 using genomic data. Participation in this survey is voluntary, and failure to respond will have no impact on benefits to which you may be entitled.

Privacy Act Statement: Information on this form is collected in accordance with Information on this form is collected in accordance with the Privacy Act of 1974 (5 U.S.C. § 552a), Code of Federal Regulations Title 38, Part 16, and the MVP research protocol approved by the VA Central Institutional Review Board. Information gathered will be kept private to the extent provided by law. The data we collect will be aggregated, and disclosure of information will involve the release of statistical data and other non-identifying data for improving the quality of service delivery. No information will be attributable to you as an individual.

Section A: Demographics

1. What is today's date?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
mm	dd	yyyy	

2. What is your date of birth?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
mm	dd	yyyy	

3. What is your gender?

7. What is your current marital status?

- Married
- Civil commitment
- Cohabiting
- Divorced
- Widowed
- Never married
- Separated

8. Including yourself, how many people currently live in your household?

1 2 3 4 5 6 7 8 9+

Male Prefer not to answer
 Female

4. Are you Spanish, Hispanic, or Latino?

- No, not Spanish, Hispanic, Latino
- Yes, Mexican, Mexican American, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, other Spanish, Hispanic, Latino

5. What is your race? (Mark all that apply)

- White Japanese
- Black / African - American Asian Indian
- American Indian / Alaska Native Other Asian
- Chinese Filipino
- Other Pacific Islander

6. What is your highest degree or level of school you have completed?

- Less than high school
- High school diploma / GED
- Some college credit, but no degree
- Associate's degree (e.g., AA, AS)
- Bachelor's degree (e.g., BA, BS)
- Master's degree (e.g., MA, MS, MBA)
- Professional or Doctorate degree

11. What is your weight:

pounds

9. Which income category represents the total income of your household from all sources (before taxes and deductions) during the last 12 months?

- Less than \$10,000
- \$10,000 - \$19,999
- \$20,000 - \$29,999
- \$30,000 - \$39,999
- \$40,000 - \$49,999
- \$50,000 - \$59,999
- \$60,000 - \$74,999
- \$75,000 - \$99,999
- \$100,000 - \$149,999
- \$150,000 or more
- Prefer not to answer

10. What is your height:

 feet inches

12. In which branch of the service did you serve? (Mark all that apply)

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Army | <input type="checkbox"/> National Guard |
| <input type="checkbox"/> Navy | <input type="checkbox"/> Merchant Marines |
| <input type="checkbox"/> Air Force | <input type="checkbox"/> NOAA |
| <input type="checkbox"/> Coast Guard | <input type="checkbox"/> Public Health Service |
| <input type="checkbox"/> Marine Corps | <input checked="" type="checkbox"/> None (Skip to Qu. 15) |

13. Please indicate whether your service was:

- Active Duty
 Reserves Only
 Not Applicable (Not in the military)

14. When did you serve? (Mark all that apply)

- September 2001 or later
 August 1990 to August 2001 (includes Gulf War)
 May 1975 to July 1990
 August 1964 to April 1975 (Vietnam era)
 February 1955 to July 1964
 July 1950 to January 1955 (Korean War)
 January 1947 to June 1950
 December 1941 to December 1946 (WWII)
 November 1941 or earlier

15. How often do you have a drink containing alcohol

- | | |
|--|--|
| <input checked="" type="checkbox"/> Never (Skip to Qu. 18) | <input type="checkbox"/> 2 – 3 days per week |
| <input type="checkbox"/> 1 – 3 days per month | <input type="checkbox"/> 4 – 5 days per week |
| <input type="checkbox"/> 1 day per week | <input type="checkbox"/> 6 or more days per week |

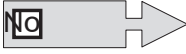
16. How many drinks containing alcohol do you have on a typical day when you are drinking?

- | | | |
|---------------------------------|---------------------------------|-------------------------------------|
| <input type="checkbox"/> 1 or 2 | <input type="checkbox"/> 5 or 6 | <input type="checkbox"/> 10 or more |
| <input type="checkbox"/> 3 or 4 | <input type="checkbox"/> 7 to 9 | |

17. How often do you have six or more drinks on one occasion?

- Never
 Less than monthly
 Monthly
 2 – 3 times per week
 4 or more times per week

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

- Yes No  (Skip to Qu. 21)

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

- Yes No

20. Do you smoke now?

- Yes, daily
 Yes, occasionally
 Not at all

The following questions concern electronic vaping products for nicotine use. Do not include marijuana use.

21. Have you ever used an e-cigarette or other electronic vaping product, even just one time, in your entire life?

- Yes
 No (Skip to Qu. 23)
 Prefer not to answer (Skip to Qu. 23)

Don't know (Skip to Qu. 23)

22. Do you NOW use e-cigarettes or other electronic vaping products every day, some days, or not at all?

- Every day
 Some days
 Not at all
 Prefer not to answer
 Don't know

Section B: COVID-19 Exposure/Household Contact

23. Have you been in close contact with anyone with COVID-19 like symptoms?

- Yes, I was in contact with a person with COVID-19 who was confirmed positive by a test
- Yes, I was in contact with a person with COVID-19 symptoms, but was not confirmed by a test
- No, not to my knowledge

24. Has anyone in your household had COVID-19? Please do not include yourself.

Yes 

No

Please indicate the number of people.

People

25. Are you a healthcare worker helping to manage patients with COVID-19?

Yes

Don't know

No

Prefer not to answer

Section C: COVID-19 Symptoms/Diagnosis

26. Have you experienced any of the following symptoms more than normal since January 2020? Please check "Yes" or "No" next to each symptom and provide the date the symptoms began.

<i>If yes, please indicate the date and number of days you experienced any of these symptoms.</i>	No	Yes	Date Symptoms Began [MM/DD/YYYY]	Number of Days You Experienced Symptom
a. Coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours				
b. Shortness of breath				
c. Unusual chest pain or tightness in your chest				
d. Fatigue (struggling to get out of bed)				
e. Feeling of heaviness in arms or legs				
f. Headache				
g. Loss of sense of smell or taste				
h. Sore throat				
i. Diarrhea, nausea and/or vomiting				
j. Fever/chills (temp>100.4 Fahrenheit)				

27. Did you seek medical attention for these symptoms? If yes, please include the date that you received medical care.



No (Skip to Qu. 41)

a. If yes, please indicate where you received care and the date care was received:

VA facility (Date) [MM/DD/YYYY]

Non-VA facility (Date) [MM/DD/YYYY]

b. If yes, how long after your symptoms started did you seek care?

Less than 2 days

2 – 7 days

Greater than 1 week

28. Did doctors use a laboratory test to check that you didn't have influenza (Flu)?

Yes

No

Don't know

29. Have you been diagnosed with COVID-19? Please indicate if you were diagnosed at a VA-facility or Non-VA facility.

Yes, confirmed by a positive laboratory test _____VA-Facility _____Non-VA Facility

Yes, suspected by a doctor but not confirmed by a test (Skip to Qu. 41)

No (Skip to Qu. 41)

30. Please indicate the type of laboratory test you received to diagnose COVID-19 and date of test.

Yes, by nasal swab (PCR)
Date _____ [MM/DD/YYYY]

Yes, by blood test (antibody)
Date _____ [MM/DD/YYYY]

Yes, by self-administered at-home testing Date _____

Yes, by another test
Date _____ [MM/DD/YYYY]

Don't know the type of test
Date _____ [MM/DD/YYYY]

31. Is there a suspected source of your COVID-19?

Travel related

Spouse

Child

Extended family member

Coworker or other work contact

Friend or other social contact

Don't know

Prefer not to answer

Section D: COVID-19 Medical Treatment and Hospitalization

32. Did you receive medical treatment for COVID-19?

Yes

____ VA Facility ____ Non-VA Facility

No

33. Were you hospitalized for COVID-19?

Yes

____ VA Facility ____ Non-VA Facility

No (*Skip to Qu. 38*)

34. When were you admitted to the hospital for treatment of COVID-19?

mm / dd / yyyy

35. What date were you discharged from the hospital after treatment of COVID-19?

mm / dd / yyyy

36. Did you require a breathing tube through the mouth for respiratory support while in the hospital (intubation / mechanical ventilation / respirator)?

Yes

No

37. Were you hospitalized in an Intensive Care Unit (ICU) for treatment of COVID-19?

Yes

No

38. Do you know if doctors used any of the following medications to treat your illness while you were sick with COVID-19? (Mark all that apply)

Medication	Did doctors use this medication?	If yes, indicate date
Tamiflu (oseltamivir) or Xofluza (baloxavir marboxil)	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YYYY
Chloroquine or Hydroxychloroquine	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YYYY
Azithromycin	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YYYY
Remdesivir	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YYYY
Dexamethasone	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YYYY
Convalescent Plasma	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YYYY
Experimental medications/treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YYYY
Other treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YYYY
Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YYYY

39. Did you receive respiratory support at home to treat your COVID-19, such as oxygen therapy by nasal prong or facemask or CPAP machine?

- Yes
 No (Skip to Qu. 41)

40. If yes, for how long did you need respiratory support at home? Please enter the duration of your respiratory support in days

Section E: COVID-19 Impact Behavior/Well-Being

The next questions ask about your behaviors and well-being since the COVID-19 pandemic and the impact it has had on you. For each of the statements below, please select the best choice that describes your response. (Select only one response for each question or statement).

41. Which of the following have you done since the COVID-19 pandemic?

	Never	Sometimes	Most of the Time	Always
Used a face mask or other face covering while in public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used gloves while in public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washed your hands with soap or used hand sanitizer several times a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaned high touch surfaces like door handles, counters, faucets, and remote controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practiced social distancing (avoiding contact with anyone outside of the home)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoided contact with people who could be high-risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoided eating at restaurants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoided public spaces, gatherings, or crowds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoided gatherings of more than 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. Since the COVID-19 pandemic started, have any of the following aspects of your life changed?

		Decreased	Stayed the Same	Increased	Not Applicable
a.	Amount you sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Amount of physical activity you do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Amount you smoke/vape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Amount of alcohol you drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Number of hours you work in usual workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Number of hours you work at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Time spent talking to family/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Time spent talking to work colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	Practicing relaxation / mindfulness / meditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j.	Time watching TV/streaming services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k.	Time spent reading or listening to the news	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l.	Time spent on social media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m.	Time spent playing video games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n.	Time spent doing hobbies/things you enjoy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o.	Amount you eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p.	Amount of money you've spent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

43. Over the past 2 weeks, have you been bothered by any of these problems?

		Not at all	Several days	More days than not	Nearly every day
a.	Feeling nervous, anxious, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

44. Since the COVID-19 pandemic, for each of the statements below please select the best choice that describes how you feel. Select only one response for each question or statement.

		Never	Rarely	Sometimes	Usually	Always	Don't know or N/A
Social Isolation							
a.	I feel left out...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I feel that people barely know me...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	I feel isolated from others...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I feel that people are around me, but not with me...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

45. Since the COVID-19 pandemic, for each of the statements below please select the best choice that describes how you feel. Select only one response for each question or statement.

		Never	Rarely	Sometimes	Usually	Always	Don't know or N/A
Emotional Support							
a.	I have someone who will listen to me when I need to talk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I have someone to confide in or talk to about myself or my problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	I have someone who makes me feel appreciated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I have someone to talk with when I have a bad day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

46. Since the COVID-19 pandemic, for each of the items below please select the best choice describing the degree of impact. *Select only one response for each question or statement.*

		No Loss	Minimal Loss	Noticeable Loss	Extreme Loss	Don't Know or N/A
a.	Adequate food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Your residence / home you live in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Things you need for your children or members of your household	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Money for extras	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Savings or emergency money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Adequate income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Financial credit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Your retirement security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	Free time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j.	Time for enough sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k.	Feeling valuable to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l.	A feeling of intimacy with one or more family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m.	The feeling that you're accomplishing the goals in your life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n.	Time with your loved ones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o.	The sense of a daily routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p.	Health of a family member / friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q.	Stable employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r.	Ability to organize tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s.	Time needed to do your work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t.	Understanding from your boss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u.	Support from your co-workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v.	The chance to get more training or education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<i>Continued</i>	No Loss	Minimal Loss	Noticeable Loss	Extreme Loss	Don't Know or N/A
w.	Feeling of being independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x.	Companionship with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y.	Feeling that your life has meaning or purpose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z.	Involvement with your church	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
aa.	Help with tasks at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bb.	Loyalty of friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cc.	Help with childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dd.	Involvement in organizations or clubs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section F: Medical Conditions/Comorbidity

47. We'd like to ask about your general health. Please tell us if you have ever been diagnosed with the following conditions. Check the appropriate box and indicate the year of diagnosis and whether you currently take any medication(s) ("TAKE MEDS") for that condition. (Mark all that apply)

48.	Circulatory System Problems			Mental Health Disorders		
	YES	YEAR DIAGNOSED	TAKE MEDS	YES	YEAR DIAGNOSED	TAKE MEDS
High blood pressure (Hypertension)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Anxiety reaction / Panic disorder	<input type="checkbox"/>	<input type="text"/>
Stroke	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Attention deficit hyper-activity disorder (ADHD)	<input type="checkbox"/>	<input type="text"/>
Transient ischemic attack (TIA)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Bipolar disorder	<input type="checkbox"/>	<input type="text"/>
Heart attack	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Post traumatic stress disorder (PTSD)	<input type="checkbox"/>	<input type="text"/>
Coronary artery / Coronary heart disease (includes angina)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="text"/>
Peripheral vascular disease	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="text"/>
High cholesterol	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Personality disorder	<input type="checkbox"/>	<input type="text"/>
Pulmonary embolism or deep vein thrombosis (DVT)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="text"/>
Congestive heart failure	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Social phobia	<input type="checkbox"/>	<input type="text"/>
Other circulatory system problem	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Other mental health disorder	<input type="checkbox"/>	<input type="text"/>

	YES	YEAR DIAGNOSED	TAKE MEDS		YES	YEAR DIAGNOSED	TAKE MEDS
Osteoarthritis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Other arthritis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Blindness, all causes	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Tinnitus or ringing in the ears	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Other skeletal / muscular problem	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Severe hearing loss or partial deafness in one or both ears	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

Infectious Diseases				Cancer			
	YES	YEAR DIAGNOSED	TAKE MEDS		YES	YEAR DIAGNOSED	TAKE MEDS
Tuberculosis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Breast cancer	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Colon cancer / Rectal cancer	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Lung cancer	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Other infectious disease	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Prostate cancer	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
				Skin cancer	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
				Other cancer	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Kidney disease without dialysis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>				
Kidney disease with dialysis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>				
Acute kidney disease with no current dialysis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
				Other headaches	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
				Memory loss or	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
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YES

DIAGNOSED

MEDS

impairment

Acid reflux / GERD

Dementia (includes Alzheimer's, vascular, etc.)

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Peptic ulcers

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Concussion or loss of consciousness

Bowel obstruction

Traumatic brain injury

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Colon polyps

Spinal cord injury or impairment

Irritable bowel syndrome (IBS)

Epilepsy / Seizure

--	--	--	--

Ulcerative colitis

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Parkinson's disease

Crohn's disease

Amyotrophic lateral sclerosis (Lou Gehrig's disease)

--	--	--	--

Celiac disease / Sprue

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Multiple sclerosis

Other digestive system disorder

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Other nervous system problem

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Other Conditions

YEARTAKE YESDIAGNOSEDMEDS

Asthma

Chronic lung disease (COPD, Emphysema or Bronchitis)

Diabetes / "sugar"

Enlarged prostate (Benign prostatic hyperplasia)

Liver condition (e.g., Cirrhosis)

Skin condition (e.g., Eczema, Psoriasis)

Sleep apnea

Thyroid problems

Gulf War Illness/ Syndrome

Skin condition (e.g.,
Eczema, Psoriasis)

Chronic Fatigue Syndrome Fibromyalgia

Other disease / disorder

48. Did you receive the following vaccines while in the military? If yes, please write in the year of the last vaccine dose.

Anthrax

Yes → Year Vaccinated:

- No
 Don't Know

Small Pox

Yes → Year Vaccinated:

- No
 Don't Know

Rabies

Yes → Year Vaccinated:

- No
 Don't Know

Yellow Fever

Yes → Year Vaccinated:

- No
 Don't Know

Typhoid

Yes → Year Vaccinated:

- No
 Don't Know

Japanese Encephalitis

Yes → No

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

- Excellent Fair
 Very Good Poor
 Good

50. In the PAST YEAR, have you received health care that was paid for by any of the following insurance types? (Mark all that apply)

- Private insurance Veterans Choice Program
 TRICARE
 Medicare VA health care
 Medicaid Indian Health

51. In the PAST YEAR, about how much of your health care did you get at a VA facility (e.g., doctor's visits, hospitalizations, urgent care visits, or counseling)?

- None 51 – 75%
 1 – 25% 76 – 99%
 26 – 50% 100%

52. In the PAST YEAR, how many times were you a patient in a hospital overnight or longer?

- VA Facility**
 None 4 - 6 10 or more
 1 - 3 7 - 9
- Non-VA Healthcare Facility**
 None 4 - 6 10 or more
 1 - 3 7 - 9

53. How many prescription medications do you currently receive from:

VA Pharmacy

- None 4 - 6 10 or more
 1 - 3 7 - 9

Non-VA Pharmacy

- None 4 - 6 10 or more
 1 - 3 7 - 9

54. How many non-prescription medications do you currently receive from:

VA Pharmacy

- None 4 - 6 10 or more
 1 - 3 7 - 9

Non-VA Pharmacy

- None 4 - 6 10 or more
 1 - 3 7 - 9

55. Did you receive the seasonal flu shot in the last six months?

- Yes
 ____ VA Facility ____ Non-VA Facility
- No
- Don't know

56. In the past, how likely were you to receive your annual flu shot?

- Always
- Most of the time
- Some of the time
- Never

Comments concerning the accuracy of the survey burden estimate and suggestions for reducing this burden should be sent to: MVP at AskMVP@va.gov