

Instructions

- ▶ Please use a black or blue pen to complete this form.
- ▶ Mark to indicate your answer.
- ▶ If you want to change your answer, mark on the wrong answer.

First we have some questions about you.

Q1. In general, compared to other people of your age, would you say that your health is excellent, very good, good, fair, or poor?

- Excellent
- Very Good
- Good
- Fair
- Poor

Q2. In general, would you say that your mental health is excellent, very good, good, fair, or poor?

- Excellent
- Very Good
- Good
- Fair
- Poor

Next we have some questions about everyone in your household including yourself.

Q3. Has anyone in the household ever been told by a doctor or other health professional that they had any of the following medical conditions?

	Yes	No
Hypertension (i.e. High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease (e.g., Coronary Heart Disease, Angina, or Heart Attack)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Lung Disease (e.g., Emphysema, Chronic Bronchitis, or Asthma)	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other Types of Cancer (e.g., Primary Tumor or Metastatic Tumor)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes or Sugar Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Renal Disease (e.g., Chronic Kidney Failure)	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Liver Disease (e.g., Cirrhosis or Chronic Hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

Q4. In general, compared to other people of their age, does anyone in the household have poor physical or mental health?

- Yes
- No

Q5. Does anyone in the household have difficulties walking, climbing stairs, grasping objects, reaching overhead, lifting, bending or stooping, or standing for long periods of time because of an impairment or a physical or mental health problem?

- Yes
- No

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Q6. During the past 12 months, has anyone in the household been admitted to the hospital for two or more nights?

- Yes
- No

Q7. During the past 12 months, has anyone in the household received care in person, by phone, or by video from any type of mental health professional such as psychiatrist, psychologist, a licensed clinical social worker or any other type of mental health therapist or counselor?

- Yes
- No

Q8. Is anyone in the household age 65 or older?

- Yes
- No

Q9. Is anyone in the household of Hispanic, Latino, or Spanish origin?

- Yes
- No

Q10. Please mark Yes if anyone in the household is of that race. If a person is of two or more races, mark Yes to each race that applies.

	Yes	No
White	<input type="checkbox"/>	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>	<input type="checkbox"/>
American Indian or Alaska Native	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian or Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>

Thank you!

Please return this questionnaire in the postage-paid envelope within X weeks.

If you have lost the envelope, mail the completed questionnaire to:

Health Study
 Westat
 1600 Research Boulevard
 Rockville, MD 20850

This survey is authorized under 42 U.S.C. 299a. The confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. Your participation is voluntary and all of your answers will be kept confidential to the extent permitted by law. Public reporting burden for this collection of information is estimated to average 30 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0124) AHRO, 540 Gaither Road, Room # 5036, Rockville, MD 20850.