7028

Form Approved
OMB# 0935-0118
Exp. Date 3/31/2027

2024

# Your Health and Health Opinions

## Your opinion matters!

MEPS
Medical Expenditure Panel Survey

There are a lot of clinical preventive care services available, such as screening tests for different types of cancer or heart disease. Not everyone makes the same choices about which tests to have, when to have a particular test or how often. By answering this questionnaire, you will help MEPS learn about the different choices different people make about preventive care as well as how people feel about their general health and health care.

## Survey Instructions

- Please answer every question by marking one box "☒." If you are unsure about how to answer a question, please give the best answer you can.
- You are sometimes told to skip over some questions in this survey. When this happens you will see arrows that tell you what questions to answer next, like this:

  ☐ Yes
  ☐ No ➔ **If No, go to question 3**

  **Next Question**

- Your participation is voluntary and your answers will be kept confidential as required by law. If you have any questions about this booklet, please call Alex Scott at 1-800-945-MEPS (6377).

**This Booklet Should Be Completed By ➔**

**REGION:** ☐ **RUID:** ☐☐☐☐☐☐☐☐☐ **PID:** ☐☐☐

**NAME:** _____

_____

**DOB:** ☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

This survey is authorized under 42 U.S.C. 299a. This information collection is voluntary and 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. Public reporting burden for this collection of information is estimated to average 7 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. The data you provide will help AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. 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 (OMB control number 0935-0118) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857 or by email at REPORTSCLEARANCEOFFICER@ahrq.hhs.gov.

The Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services

7028

# Your Health And Health Choices

**START HERE:**

**1.** In general, would you say your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

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

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

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

b. Climbing **several** flights of stairs?

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

**3.** During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of your physical health:**

a. **Accomplished less** than you would like **as a result of your physical health?**

- ☐ No, none of the time
- ☐ Yes, a little of the time
- ☐ Yes, some of the time
- ☐ Yes, most of the time
- ☐ Yes, all of the time

b. Were limited in the **kind** of work or other activities **as a result of your physical health?**

- ☐ No, none of the time
- ☐ Yes, a little of the time
- ☐ Yes, some of the time
- ☐ Yes, most of the time
- ☐ Yes, all of the time

**4.** During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious):

a. **Accomplished less** than you would like **as a result of any emotional problems?**

- ☐ No, none of the time
- ☐ Yes, a little of the time
- ☐ Yes, some of the time
- ☐ Yes, most of the time
- ☐ Yes, all of the time

b. Didn't do work or other activities as **carefully** as usual **as a result of any emotional problems?**

- ☐ No, none of the time
- ☐ Yes, a little of the time
- ☐ Yes, some of the time
- ☐ Yes, most of the time
- ☐ Yes, all of the time

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

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

These questions are about how you feel and how things have been with you during the **past 4 weeks.** For each question, please give the one answer that comes closest to the way you have been feeling.

**6.** How much of the time during the **past 4 weeks:**

a. Have you felt calm and peaceful?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

b. Did you have a lot of energy?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

c. Have you felt downhearted and blue?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

**7.** During the **past 4 weeks,** how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

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

**8.** The next questions are about how you feel about different aspects of your life. For each one, mark how often you feel that way.

a. First, how often do you feel that you lack companionship?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often

b. How often do you feel left out?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often

c. How often do you feel isolated from others?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often

**9.** The following questions ask about how you have been feeling during **the past 30 days.** For each question, please mark the box that best describes how often you had this feeling.

| During the past 30 days, about how often did you feel... | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|---|
| a. nervous?..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. hopeless?..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. restless or fidgety?..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. so sad that nothing could cheer you up?..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. that everything was an effort?..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. worthless?..... | ☐ | ☐ | ☐ | ☐ | ☐ |

**10.** The following two questions ask about how you have been feeling in the **past 2 weeks.**

| Over the last 2 weeks, how often have you been bothered by any of the following problems? | Nearly every day | More than half the days | Several days | Not at all |
|---|---|---|---|---|
| a. Little interest or pleasure in doing things..... | ☐ | ☐ | ☐ | ☐ |
| b. Feeling down, depressed, or hopeless..... | ☐ | ☐ | ☐ | ☐ |

**11.** During the **past 30 days**, how often have you experienced trouble getting to sleep or staying asleep?

- ☐ Not at all
- ☐ Once a month
- ☐ Several times a month
- ☐ Once a week
- ☐ Several times a week
- ☐ Almost every day

**12.** In the **past 30 days**, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7

**13.** On average, how many minutes did you usually spend exercising at this level on one of those days?

- ☐ 0
- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60 or greater

## Alcohol Use

**14.** Think about your drinking in the past 12 months. How often do you have a drink containing alcohol?

- ☐ Never ➔ **If Never, go to question 18, page 8**
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ 2-3 times a week
- ☐ 4-6 times a week
- ☐ Daily

*For questions on this page:*

**One drink** means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

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

- ☐ 1 drink
- ☐ 2 drinks
- ☐ 3 drinks
- ☐ 4 drinks
- ☐ 5-6 drinks
- ☐ 7-9 drinks
- ☐ 10 or more drinks

**16.** How often do you have **4 or more** drinks on one occasion?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ 2-3 times a week
- ☐ 4-6 times a week
- ☐ Daily

**17.** How often do you have **5 or more** drinks on one occasion?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ 2-3 times a week
- ☐ 4-6 times a week
- ☐ Daily

**18.** In the past 12 months, has a doctor, nurse, or other health care professional asked you how much and how often you drink alcohol? You may have answered in person, on paper, or on a computer.

- ☐ Yes
- ☐ No

**19.** In the past 12 months, has a doctor, nurse, or other health care professional advised you to cut back or stop drinking alcohol?

- ☐ Yes
- ☐ No

## Counseling and Treatment

**20.** People can get counseling, treatment or medicine for many different reasons, such as:

- For feeling depressed, anxious, or “stressed out”
- Personal problems (like when a loved one dies or when there are problems at work)
- Family problems (like marriage problems or when parents and children have trouble getting along)
- Needing help with drug or alcohol use
- For mental or emotional illness

In the last 12 months, did you get counseling, treatment or medicine for any of these reasons?

- ☐ Yes
- ☐ No

**21.** During the past 12 months, was there any time when you felt you **needed** counseling or treatment for yourself but **didn't get it?**

- ☐ Yes
- ☐ No

**22.** In the last 12 months, how much of a problem, if any, was it to get any counseling or treatment you thought you needed?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem
- ☐ Did not seek counseling in the last 12 months

**23.** Have you ever worried about your family's financial stability because of your mental health, its treatment, or lasting effects of that treatment?

- ☐ Yes
- ☐ No

## Your Choices about Your Health

**24.** When was the last time you visited a doctor or nurse for a check-up, follow-up care for an ongoing problem, or a concern that you have about your health? Do not include times you were hospitalized overnight or visits to the hospital emergency room.

- ☐ Within the past 12 months
- ☐ Within the past one to two years
- ☐ Within the past two to five years
- ☐ More than five years ago
- ☐ Never

**25.** During the past 12 months, have you had either a flu shot (directly in the arm or into the skin) or a flu vaccine that was sprayed in your nose?

- ☐ Yes
- ☐ No

**26.** In the past 12 months, has a doctor, nurse, or other health care professional weighed you?

- ☐ Yes
- ☐ No

**27.** About how much do you weigh without shoes?

☐☐☐ **Weight (pounds)**

**28.** About how tall are you without shoes?

☐ **Feet** ☐☐ **Inches**

**29.** In the past 12 months, has a doctor, nurse, or other health care professional given you advice about how to manage your weight, discussed weight loss goals with you, or referred you to a weight loss program to help with your diet and exercise?

- ☐ Yes
- ☐ No

**30.** Has a doctor, nurse, or other health care professional ever asked you if you smoke or use tobacco? You may have answered in person, on paper, or on a computer.

- ☐ Yes
- ☐ No

**31.** In the last 12 months, on average, would you say you smoked cigarettes or used tobacco every day, some days, or not at all?

- ☐ Every day
- ☐ Some days
- ☐ Not at all ➔ **If Not at all, go to question 35**

**32.** In the past 12 months, were you advised by a doctor, nurse, or other health care professional to quit smoking or quit using tobacco?

- ☐ Yes
- ☐ No

**33.** In the past 12 months, were you advised by a doctor, nurse, or other health care professional to take a medication to assist you with quitting smoking or using tobacco? Some medications that can be used are: nicotine gum, patch, nasal spray, inhaler, or prescription medicine.

- ☐ Yes
- ☐ No

**34.** In the past 12 months, has a doctor, nurse, or other health care professional discussed or provided methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or program to help stop smoking.

- ☐ Yes
- ☐ No

**35.** In the past 12 months, has your doctor, nurse, or other health care professional asked you about your mood, such as whether you are anxious or depressed? You may have answered in person, on paper, or on a computer.

- ☐ Yes
- ☐ No

**36.** **During the past 24 months**, have you had your blood pressure checked by a doctor, nurse, or other health care professional?

- ☐ Yes
- ☐ No

**37.** **Within the past 5 years**, have you had your blood cholesterol checked by a doctor, nurse, or other health care professional?

- ☐ Yes
- ☐ No

**If you are female, continue with the questions on this page.**
**If you are male, go to the next page.**

## If Female:

**38.** In the past 12 months, have you received counseling or information about birth control from a doctor or other medical care provider?

- ☐ Yes
- ☐ No

**39.** Have you had a hysterectomy or have you ever had cervical cancer?

- ☐ Yes ➔ **If Yes, go to next page**
- ☐ No

**40. Within the past 5 years**, have you had a Pap or human papillomavirus (HPV) test? A Pap or HPV test is a routine test in which the doctor takes a cell sample from the cervix with a small stick or brush, and sends it to the lab.

- ☐ Yes
- ☐ No

**41.** About how old were you the last time you had a Pap or HPV test?

- ☐ Younger than 35
- ☐ 35 to 44 years old
- ☐ 45 to 54 years old
- ☐ 55 to 64 years old
- ☐ 65 to 74 years old
- ☐ 75 or older
- ☐ I have never had a Pap or HPV test

**If you are age 40 or older, continue with the questions on this page.**
**If you are younger than 40, go to question 56 on page 15.**

## If 40 or older:

**42.** Have you ever had a pneumonia shot? A pneumonia shot or pneumococcal vaccine is usually only given once or twice in a person's lifetime.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

**43.** Have you had the shingles vaccine? Two shingles vaccines are available: Zostavax® and Shingrix®. The chicken pox virus causes shingles. Zostavax® has been available since 2006 and Shingrix® since 2017.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

**44.** Is there any medical reason why you cannot take aspirin, such as an allergy, another medication you take, or other side effect?

- ☐ Yes ➔ **If Yes, go to question 46, page 13**
- ☐ No

**45.** Has a doctor, nurse, or other health care professional ever discussed with you the use of aspirin to prevent heart attack or stroke?

- ☐ Yes
- ☐ No

## If 40 or older:

**46.** Have you had colon cancer or your entire colon removed?

- ☐ Yes ➔ **If Yes, go to next page**
- ☐ No

**47. Within the past 10 years**, have you had a colonoscopy? A colonoscopy test examines the bowel by inserting a tube into the rectum. After a colonoscopy, you feel tired and usually need someone to drive you home.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

**48. Within the past 5 years**, have you had a sigmoidoscopy? A sigmoidoscopy test also examines the bowel by inserting a tube into the rectum. You are awake during this test and can drive yourself home.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

**49. Within the past 12 months**, have you had a blood stool test using a home kit? A doctor, nurse, or other health professional provides you a special kit or cards to use at home to determine whether the stool contains blood.

- ☐ Yes
- ☐ No, it was offered to me by a doctor, nurse, or other health care professional but I chose not to receive it
- ☐ No, for any other reason

**If you are 40 or older and female, complete the left side of this page.**
**If you are 40 or older and male, complete the right side of this page.**

## If Female & 40 or older

**50.** Have you ever been told by a doctor, nurse or other health care professional that you have osteoporosis? Osteoporosis is when the bones become fragile and break easily.

- ☐ Yes ➔ **If Yes, go to question 52**
- ☐ No

**51.** There are several tests to measure bone density and detect osteoporosis at an early stage, including a DEXA scan. Have you ever had your bone density measured?

- ☐ Yes
- ☐ No

**52.** Have you had both breasts removed or have you ever had breast cancer?

- ☐ Yes ➔ **If Yes, go to next page**
- ☐ No

**53.** **Within the past 2 years**, have you had a mammogram? A mammogram is an x-ray taken only of the breast by a machine that presses against the breast.

- ☐ Yes
- ☐ No

**GO TO NEXT PAGE.**

## If Male & 40 or older

**54.** Have you had prostate cancer?

- ☐ Yes ➔ **If Yes, go to next page**
- ☐ No

**55.** About how old were you the last time you had a PSA test? A "P-S-A" is a blood test to detect prostate cancer. It is also called a prostate specific antigen test.

- ☐ Never had a PSA test
- ☐ Under age 50
- ☐ Between 51 and 64
- ☐ Between 65 and 74
- ☐ 75 or older

**GO TO NEXT PAGE.**

## About You

**56.** What is your age?

- ☐ Under 18
- ☐ 18 to 39
- ☐ 40 to 49
- ☐ 50 or older

**57.** What is your current gender?

- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ I use a different term (specify) _____

**58.** What sex were you assigned at birth, for example on your original birth certificate?

- ☐ Female
- ☐ Male

**59.** Which of the following best represents how you think of yourself?

- ☐ Gay or lesbian
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term (specify) _____
- ☐ I don't know

**Date completed:** ☐☐ / ☐☐ / ☐☐☐☐
MONTH DAY YEAR

**Who completed this form?**

- ☐ Person named on front of this form
- ☐ Someone else

**If Someone Else,** what is person's relationship to the person named on the front of this form?

- ☐ Husband or wife
- ☐ Unmarried partner
- ☐ Mother, father, or guardian
- ☐ Son or daughter
- ☐ Other relative
- ☐ Not related

## THANK YOU FOR TAKING THE TIME TO COMPLETE THE QUESTIONNAIRE!

- Please give your completed survey to your MEPS interviewer or place it in the return envelope and mail it back.

- If the envelope is missing, mail this survey to:

  MEPS
  c/o Westat
  1600 Research Blvd, RC B16
  Rockville, MD 20850

24-233