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General Health

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 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?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. hopeless?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. restless or fidgety?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. so sad that nothing could cheer you up?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. that everything was an effort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. worthless?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. 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.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Opinions About Health

10. For the four statements below, please mark **one** of the boxes to indicate how strongly you **agree** or **disagree** for each statement. If you are uncertain, mark the box for uncertain.

	Disagree strongly	Disagree somewhat	Uncertain	Agree somewhat	Agree strongly
a. I'm healthy enough that I really don't need health insurance.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Health insurance is not worth the money it costs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I'm more likely to take risks than the average person.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I can overcome illness without help from a medically trained person.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Health Care in the Last 12 Months

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

- Yes
- No

12. About how much do you weigh without shoes?

			Weight (pounds)
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13. About how tall are you without shoes?

	Feet			Inches
--	------	--	--	--------



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These questions ask about your own health care from a clinic, emergency room, or doctor's office. This includes care you got in person, by phone, or by video. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

14. In the last 12 months, did you have an illness, injury, or condition **that needed care right away**?

- Yes
- No → **If No, go to question 16**

15. In the last 12 months, when you **needed care right away**, how often did you get care as soon as you thought you needed?

- Never
- Sometimes
- Usually
- Always

16. In the last 12 months, did you make any in-person, phone, or video appointments for a **check-up or routine care**?

- Yes
- No → **If No, go to question 18**

17. In the last 12 months, how often did you get an appointment for a **check-up or routine care** as soon as you needed?

- Never
- Sometimes
- Usually
- Always

18. In the last 12 months, **not** counting the times you went to an emergency room, how many times did you get health care for yourself in person, by phone, or by video?

- None → **If None, go to question 29, page 11**
- 1 time
- 2
- 3
- 4
- 5-9
- 10 or more times



19. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?

- 0 Worst health care possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best health care possible

20. In the last 12 months, did a doctor or other health provider give you instructions about what to do about a specific illness or health condition?

- Yes
- No → If No, go to question 23, page 10



21. In the last 12 months, how often were these instructions easy to understand?

- Never
- Sometimes
- Usually
- Always

22. In the last 12 months, how often did doctors or other health providers ask you to describe how you were going to follow these instructions?

- Never
- Sometimes
- Usually
- Always



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23. In the last 12 months, did you have to fill out or sign any forms at a doctor's or other health provider's office?

Yes

No → If No, go to question 25

24. In the last 12 months, how often were you offered help in filling out a form at the doctor's or other health provider's office?

Never

Sometimes

Usually

Always

25. In the last 12 months, how often did doctors or other health professionals explain things in a way that was easy to understand?

Never

Sometimes

Usually

Always

26. In the last 12 months, how often did doctors or other health professionals listen carefully to you?

Never

Sometimes

Usually

Always

27. In the last 12 months, how often did doctors or other health professionals show respect for what you had to say?

Never

Sometimes

Usually

Always

28. In the last 12 months, how often did doctors or other health professionals spend enough time with you?

Never

Sometimes

Usually

Always



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Getting Health Care from Specialists

When you answer the next questions, include the care you got in person, by phone, or by video. Do **not** include dental visits or care you got when you stayed overnight in a hospital.

29. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you make any appointments with a specialist?

Yes

No → If No, go to question 31

30. In the last 12 months, how often did you get an appointment with a specialist as soon as you needed?

Never

Sometimes

Usually

Always

E-cigarette and Electronic Vaping Use

For questions in this section:



Electronic cigarettes (e-cigarettes) and other electronic vaping products include JUULs, vape pens, e-cigars, and others. These products are battery-powered and usually contain nicotine and flavors such as fruit, mint, or candy.

These questions concern electronic vaping products for nicotine use. Do **not** include marijuana use.

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

Yes

No → If No, go to next page

32. 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



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▶ **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, wife, or spouse

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 provided and mail it back.

▶ If the envelope is missing, mail the survey to:

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