



# SJLIFE

## Health Habits Survey

Finding cures. Saving children.

The questions in this booklet relate to:

Name

Person completing this questionnaire is:

percomp text

Your relationship:

1  Self 2  Parent 3  Other: percode coded  
relation

Today's date:

/   /

datecomp

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STUDYNAME

Please! Do not mark below this line

MRN

Survey #308

4413165420

05/03/2022 01:48:52 PM

# SUN SENSITIVITY

**A1. How would you describe your natural skin color on parts of your body not exposed to the sun? *skinco***

- 1  Pale or milky white
- 2  Very light brown, sometimes freckles
- 3  Light tan, brown, or olive
- 4  Brown, dark brown, or black

**A2. What color are your eyes? *eyeco***

- 1  Blue
- 2  Blue-grey
- 3  Hazel
- 4  Green
- 5  Light brown
- 6  Dark brown/black
- 7  Mixed/other

**A3. What is your natural adult hair color? (*check only one*) *hairco***

- 1  Light blond
- 2  Blond
- 3  Light brown
- 4  Medium brown
- 5  Red-brown
- 6  Strawberry (reddish) blond
- 7  Red
- 8  Dark brown/black
- 9  Jet black

**Sunburn is a reddening of the skin that lasts at least 12 hours after you have been outdoors in the sun.**

**A4. Suppose that after several months of not being in the sun, you went out in the sun without a hat, sunscreen, or protective clothing for an hour. Would you . . . (*check only one*) *nohat***

- 1  Never tan, always burn
- 2  Sometimes tan, usually burn
- 3  Usually tan, sometimes burn
- 4  Always tan, rarely burn

**A5. Thinking back when you were a child/adolescent (less than 21 years old), how often have you had a severe, painful sunburn on each of these areas of the body? *brn***

	1 Never	2 1-2 times	3 3-5 times	4 6+ times
Back and shoulders . . . . . <i>brnbk</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower limbs . . . . . <i>brnleg</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face or arms . . . . . <i>brnfac</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All over . . . . . <i>brnall</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you are under 21: **→ Go to Question A7.**

**A6. As an adult (age 21 or older), how often have you had a severe, painful sunburn on each of these areas of the body? *adb***

Back and shoulders . . . . . <i>adbbk</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower limbs . . . . . <i>adblg</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face or arms . . . . . <i>adbfc</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All over . . . . . <i>adbll</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A7. Have you ever sunbathed or sat outside by the water? *eversn***

- 2  No **→ Go to Question A9.**
- 1  Yes **↓**

**A8. If yes, how many days in the last 12 months have you sunbathed or sat outside by the water? *daysun***

- 1  None
- 2  1-5 days
- 3  6-10 days
- 4  11 or more days

**A9. Have you ever used artificial tanning devices such as a sunlamp, or gone to a tanning booth? *fakesn***

- 2  No **→ Go to Question A11, next page.**
- 1  Yes

**A10. If yes, how many days in the last 12 months have you used any artificial tanning devices such as a sunlamp, or gone to a tanning booth?** *dyfsn*

- 1  None
- 2  1-5 days
- 3  6-10 days
- 4  11 or more days

**A11. When you were outside last summer for more than 15 minutes, how often did you protect yourself from the sun by . . .**

	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
Applying a sunscreen with a sun protection factor (SPF) of 15 or more on all sun exposed skin areas. . . . . <i>spf</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wearing protective clothing such as long-sleeved shirts and long pants. . . . . <i>protect</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wearing a hat. . . . . <i>hat</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limiting exposure to the sun during the mid-day hours. . . . . <i>limit</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying in the shade. . . . . <i>shade</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A12. Has a medical doctor or nurse ever examined all or most of your skin for signs of skin cancer, not just looked at a certain spot?** *exams*

- 2  No
- 1  Yes
- 3  Don't know

**A13. Have you ever had a health care professional remove a skin growth?** *rmgr*

- 2  No
- 1  Yes

**A14. Have you ever been told that you had skin cancer? This includes basal cell, squamous cell, and melanoma.** *evsca*

2  No → Go to Question B1, page 6.

1  Yes

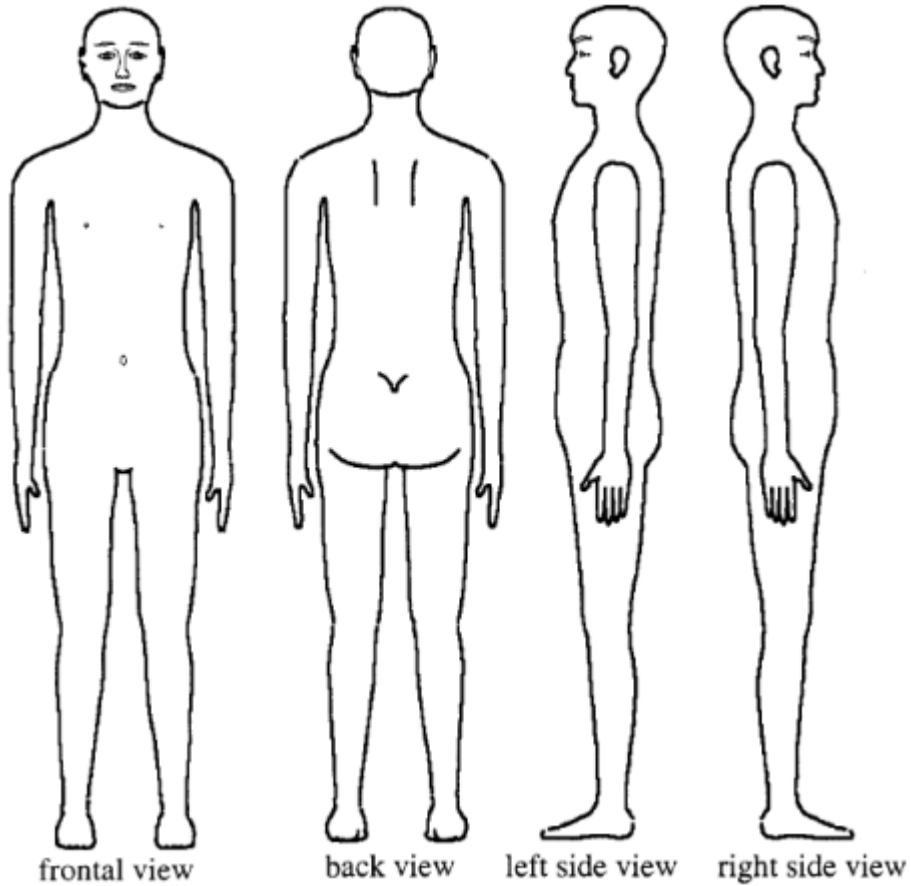


What was the name of the disease?

text

Where was the skin cancer located on your body?  
(Example: upper right arm, left ear)

Please mark an "X" at the location(s) of your skin cancer(s). We are interested in the most exact location(s) you can provide so please be as specific as possible.



When was this diagnosed?

scamo-2

--	--

Month (mm)

scayr-2

--	--	--	--

Year (yyyy)

If you don't remember the date when the skin cancer was diagnosed, please give your approximate age at the time, or a time period when it happened (*for example*, between 1980 and 1983).

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Please! Do not mark below this line

**A14. (Cont.) Where was this diagnosed?**

Doctor's name
Hospital or clinic
Address
City, State, Zip code

*Continue on next page.*

*If you had more than one occurrence of skin cancer, please use a separate sheet of paper.*

**Smoking**

**B1. Have you smoked cigarettes in the last month? cigmo**

- 2  No  
1  Yes

**B2. Have you used smokeless tobacco in the last month? tobmo**

- 2  No  
1  Yes

**B3. Have you smoked at least 100 cigarettes in your entire life? evsm**

- 2  No **→ Go to Question B9.**

- 1  Yes

**B4. How old were you when you started smoking? smstr**

Years

**B5. Do you smoke cigarettes now? smnow**

- 2  No  
1  Yes

**B6. On average, how many cigarettes a day do/did you smoke? cigd**

**B7. How many years, in total, have you smoked? smyr**

**B8. If you currently smoke, how many times in the past 12 months have you tried to quit smoking and not smoked for at least 24 hours? quit**

**B9. In the past year, have you ever used any of these tobacco products? (Mark all that apply)**

	1 Never used	2 No longer use	3 Occasionally use	4 Regularly use
Chewing tobacco . . . . . <b>chew</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snuff tobacco . . . . . <b>snuff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pipes . . . . . <b>pipe</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars . . . . . <b>cigar</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-Cigarettes . . . . . <b>ecig</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B10. For any of those that you have used or are currently using, how long have you used it?**

	1 Less than 1 year	2 1 - 2 years	3 3 - 4 years	4 5 - 10 years	5 11+ years
Chewing tobacco . . . . . <b>chwt</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snuff tobacco . . . . . <b>snuff</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pipes . . . . . <b>pipt</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars . . . . . <b>cigrt</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-Cigarettes . . . . . <b>ecigt</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B11. If you are no longer using the listed tobacco products, how long ago did you quit? Mark one.**

1  Days 2  Months 3  Years

**quit** **quittyp**

**Continue on next page.**

The next questions ask about electronic “vaping” products, such as JUUL, Vuse, MarkTen, and blu. Electronic vaping products include e-cigarettes, vapes, vape pens, e-cigars, ehookahs, hookah pens, and mods. These products are battery-powered and usually contain nicotine and flavors such as fruit, mint, or candy.

**B11a. Have you ever used an electronic vaping product, even just one time in your entire life?**

- 2  No **→ Go to Question B12 on page 8.** vaping  
1  Yes  
3  Don't know/Not sure

**B11b. How old were you when you first used an electronic vaping product?** vaping\_age

--	--

 Years

**B11c. Do you use electronic vaping products now?** vaping\_now

- 2  No  
1  Yes

**B11d. What types of mist have you inhaled when you use an electronic vaping product (select all that apply)?** vaping\_inhale

- Nicotine vaping\_inhale\_nicotine  
 Marijuana or hash oil vaping\_inhale\_marijuana  
 Just Flavoring vaping\_inhale\_flavor  
 Other vaping\_inhale\_other  
 Don't know vaping\_inhale\_dontknow

**B11e. When you use an electronic vaping product, what mist do you use most often?** vaping\_mist

- 1  Nicotine  
2  Marijuana or hash oil  
3  Just Flavoring  
4  Other  
5  Don't know

**B11f. During the past 30 days, on how many days did you use an electronic vaping product?** vaping\_30days

- 0  0 days  
1  1 or 2 days  
2  3 to 5 days  
3  6 to 9 days  
4  10 to 19 days  
5  20 to 29 days  
6  All 30 days

**B11g. On the days that you vaped, how many times did you usually pick up your electronic vaping product to vape?** vaping\_times

- 0  0  
1  1  
2  2  
3  3-5  
4  6-9  
5  10-14  
6  15-20  
7  >20 times per day

**B11h. Each time you picked up your electronic vaping product to vape, how many puffs did you usually take before putting it away?** vaping\_puffs

- 0  0  
1  1  
2  2  
3  3-5  
4  6-9  
5  10-14  
6  15-20  
7  >20 puffs

**Drug Use**

**B12. During your life, how many times have you used...**

		6 100 or more times					
		5 40 - 99 times					
		4 20 - 39 times					
		3 10 - 19 times					
		2 3 - 9 times					
		1 1 - 2 times					
		0 Never					
Marijuana/Hashish/Cannabis . . . . .	pot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/Crack/Freebase . . . . .	crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy . . . . .	speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sniffing glue/breathing aerosol spray cans/inhaling paints . . . . .	inhale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin/Smack/Junk/White China . . . . .	heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms . . . . .	halluc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B13. During your life, how many times have you used without a doctor's prescription. . .**

		6 100 or more times					
		5 40 - 99 times					
		4 20 - 39 times					
		3 10 - 19 times					
		2 3 - 9 times					
		1 1 - 2 times					
		0 Never					
Steroid Pills or Shots . . . . .	steroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drugs (OxyContin/Percocet/Vicodin/ Codeine/Adderall/Ritalin/ Xanax) . . . . .	rxdrg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B14. During the past 30 days, how many times did you use...**

		5 40 or more					
		4 20 - 39 times					
		3 10 - 19 times					
		2 3 - 9 times					
		1 1 - 2 times					
		0 Never					
Marijuana/Hashish/Cannabis . . . . .	pot30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine/Crack/Freebase . . . . .	crk30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy . . . . .	spd30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sniffing glue/breathing aerosol spray cans/inhaling paints . . . . .	inh30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin/Smack/Junk/White China . . . . .	her30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms . . . . .	hal30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B15. During the past 30 days, how many times did you use without a doctor's prescription. . .**

		5 40 or more					
		4 20 - 39 times					
		3 10 - 19 times					
		2 3 - 9 times					
		1 1 - 2 times					
		0 Never					
Steroid Pills or Shots . . . . .	strd30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drugs (OxyContin/Percocet/Vicodin/ Codeine/Adderall/Ritalin/ Xanax) . . . . .	rxdrg30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line



**B16. How old were you when you tried \_\_\_\_\_ for the first time?**

<u>Never tried</u>		Age at first use
1   <input type="checkbox"/> <b>potft</b>	Marijuana/Hashish/Cannabis . . . . . <b>pota</b>	<input type="text"/>
<input type="checkbox"/> <b>crkft</b>	Cocaine/Crack/Freebase . . . . . <b>crka</b>	<input type="text"/>
<input type="checkbox"/> <b>spdf</b>	Methamphetamine/Speed/Ice/Crystal Meth/Ecstasy . . . . . <b>spda</b>	<input type="text"/>
<input type="checkbox"/> <b>inhft</b>	Sniffing glue/breathing aerosol spray cans/inhaling paints . . . . . <b>inha</b>	<input type="text"/>
<input type="checkbox"/> <b>herft</b>	Heroin/Smack/Junk/White China . . . . . <b>hera</b>	<input type="text"/>
<input type="checkbox"/> <b>halft</b>	Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms . . . . . <b>hala</b>	<input type="text"/>

**B17. How old were you when you tried \_\_\_\_\_ for the first time without a doctor's prescription?**

<u>Never tried</u>		Age at first use
1   <input type="checkbox"/> <b>strdft</b>	Steroid Pills or Shots . . . . . <b>strda</b>	<input type="text"/>
<input type="checkbox"/> <b>rxdrft</b>	Prescription Drugs (OxyContin/Percocet/Vicodin/Codeine/Adderall/Ritalin/Xanax) . . . . . <b>rxdrga</b>	<input type="text"/>



If Never for all, Go to Question B20.

**B18. In total, how many years have you/did you use...?**

	Number of years	Avg # times used per year
Marijuana/Hashish/Cannabis . . . . .	<b>potyr</b> <input type="text"/>	<b>potty</b> <input type="text"/>
Cocaine/Crack/Freebase . . . . .	<b>crkyr</b> <input type="text"/>	<b>crkty</b> <input type="text"/>
Methamphetamine/Speed/Ice/Crystal Meth/Ecstasy . . . . .	<b>spdyr</b> <input type="text"/>	<b>spdty</b> <input type="text"/>
Sniffing glue/breathing aerosol spray cans/inhaling paints . . . . .	<b>inhyr</b> <input type="text"/>	<b>inhty</b> <input type="text"/>
Heroin/Smack/Junk/White China . . . . .	<b>heryr</b> <input type="text"/>	<b>herly</b> <input type="text"/>
Hallucinogenic Drugs/ LSD/acid/PCP/angel dust/mescaline/mushrooms . . . . .	<b>halyr</b> <input type="text"/>	<b>halty</b> <input type="text"/>

**B19. In total, how many years have you/did you use without a doctor's prescription...?**

	Number of years	Avg # times used per year
Steroid Pills or Shots . . . . .	<b>strdyr</b> <input type="text"/>	<b>strdty</b> <input type="text"/>
Prescription Drugs (OxyContin/Percocet/Vicodin/Codeine/Adderall/Ritalin/Xanax) . . . . .	<b>rxdrgyr</b> <input type="text"/>	<b>rxdrdty</b> <input type="text"/>

**B20. Have you ever been prescribed medical marijuana by your medical doctor? **rxpot****

2  No → Go to Question B21.

1  Yes ↓

**B20a. If yes, have you only used marijuana for medical purposes? **orxp****

2  No

1  Yes

**B21. During your life, how many times have you used a needle to inject any illegal drug into your body?**

**drgned**


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**Alcohol**

**B22. In your entire life, have you ever had at least 2 drinks of any kind of alcoholic beverage?** *evdrk*

2  No → Go to Question B28, next page.

1  Yes 

**B23. How old were you when you first started drinking alcohol?** *agdrk*

--	--

 Years

**B24. During the last 12 months, how many alcoholic drinks did you have on a typical day when you drank alcohol? (If less than one per day, enter 0.)**

Wine (4 oz. glass):	Beer (12 oz. can):	Mixed drink (1 shot):						
<table border="1"><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr></table>			<table border="1"><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr></table>			<table border="1"><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr></table>		
Glasses a day <i>wine</i>	Cans a day <i>beer</i>	Drinks a day <i>mix</i>						

**B25. During the last 12 months, what is the largest number of drinks you had on any single day?** *mostdrk*  
Was it. . .

- 8  24+ drinks
- 7  12-23 drinks
- 6  8-11 drinks
- 5  5-7 drinks
- 4  4 drinks
- 3  3 drinks
- 2  2 drinks
- 1  1 drink
- 0  0 drinks → Go to Question B28, next page.

**B26. During the last 12 months, how often did you usually have any kind of drink containing alcohol?** *frdrk*










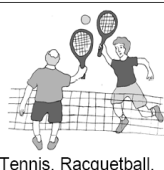
- 1  Every day
- 2  5 to 6 times a week
- 3  3 to 4 times a week
- 4  twice a week
- 5  once a week
- 6  2 to 3 times a month
- 7  once a month
- 8  3 to 11 times in the past year
- 9  1 or 2 times in the past year
- 10  Never in the past year

**B27. During the last 12 months, how often did you have 5 or more (males) or 4 or more (females) drinks containing any kind of alcohol in a single day?** *drk5*

- 1  Every day
- 2  5 to 6 days a week
- 3  3 to 4 days a week
- 4  two days a week
- 5  one day a week
- 6  2 to 3 days a month
- 7  one day a month
- 8  3 to 11 days in the past year
- 9  1 or 2 days in the past year
- 10  Never in the past year

## Physical Activity

Examples of physical activity intensity levels:

<p><b>Light activities</b></p> <ul style="list-style-type: none"> <li>• your heart beats slightly faster than normal</li> <li>• you can talk and sing</li> </ul>	   <p>Walking Leisurely      Stretching      Vacuuming or Light Yard Work</p>
<p><b>Moderate activities</b></p> <ul style="list-style-type: none"> <li>• your heart beats faster than normal</li> <li>• you can talk but not sing</li> </ul>	    <p>Fast Walking      Aerobics Class      Strength Training      Swimming Gently</p>
<p><b>Vigorous activities</b></p> <ul style="list-style-type: none"> <li>• your heart rate increases a lot</li> <li>• you can't talk or your talking is broken up by large breaths</li> </ul>	   <p>Stair Machine      Jogging or Running      Tennis, Racquetball, Badminton</p>

For questions B28 through B36b, refer to the activity graphic above.

Do the following statements accurately describe your level of physical activity?

	1	2	Yes	No
B28. I rarely or never do any physical activities . . . . .	nopa			
B29. I do some light or moderate physical activities, but not every week . . . . .	ltpa			
B30. I do some light physical activity every week . . . . .	ltpaw			
B31. I do activities to increase muscle strength, such as lifting weights or aerobics, once a week or more . . . . .	wtlt			
B32. I do activities to improve flexibility, such as stretching or yoga, once a week or more . . . . .	yoga			

For questions B33 through B36b, continue to refer to the activity graphic.

**B33. On how many of the past 7 days did you exercise or do sports for at least 20 minutes that made you sweat or breathe hard (e.g., dancing, jogging, basketball, etc.)?** pa20

- 1  0 days  
 2  1 day  
 3  2 days  
 4  3 days  
 5  4 days  
 6  5 days  
 7  6 days  
 8  7 days

**B34. Now thinking about the vigorous physical activities you do in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, wheelchair basketball, heavy yard work, or anything else that causes large increases in breathing or heart rate?** vpa10

- 2  No → **Go to Question B35.**  
 1  Yes ↓

**B34a. How many days per week do you do these vigorous activities for at least 10 minutes at a time?** vpadays











days per week

**B34b. On days when you do vigorous activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?** vpamin

minutes per day

Please! Do not mark below this line

Examples of physical activity intensity levels:

<p><b>Light activities</b></p> <ul style="list-style-type: none"> <li>• your heart beats slightly faster than normal</li> <li>• you can talk and sing</li> </ul>	   <p>Walking Leisurely      Stretching      Vacuuming or Light Yard Work</p>
<p><b>Moderate activities</b></p> <ul style="list-style-type: none"> <li>• your heart beats faster than normal</li> <li>• you can talk but not sing</li> </ul>	    <p>Fast Walking      Aerobics Class      Strength Training      Swimming Gently</p>
<p><b>Vigorous activities</b></p> <ul style="list-style-type: none"> <li>• your heart rate increases a lot</li> <li>• you can't talk or your talking is broken up by large breaths</li> </ul>	   <p>Stair Machine      Jogging or Running      Tennis, Racquetball, Pickleball or Badminton</p>

**B35. Now thinking about moderate physical activities you do in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, gardening, manual operation of a wheelchair, or anything else that causes small increases in breathing or heart rate?**

mpa10

2  No → Go to Question B36.

1  Yes ↓

**B35a. How many days per week do you do these moderate activities for at least 10 minutes at a time?** mpadays

days per week

**B35b. On days when you do moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?** mpamin

minutes per day

**B36. Now thinking about light physical activities you do in a usual week, do you do light activities for at least 10 minutes at a time, such as a slow casual walk, or anything else that does not cause an increase in your breathing or heart rate?** Ipa10

2  No → Go to Question B37.

1  Yes ↓

**B36a. How many days per week do you do these light activities for at least 10 minutes at a time?** Ipadays

days per week

**B36b. On days when you do light activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?** Ipamin

minutes per day

**B37. Over the last 2 years, how long (if at all) has your health limited you in each of the following activities? (Mark one box for each item.)**

	3 Not limited at all	2 Limited for 3 months or less	1 Limited for more than 3 months
a. The kinds or amounts of vigorous activities you can do, like lifting heavy objects, running or participating in strenuous sports. . . . . limvi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The kinds or amounts of moderate activities you can do, like moving a table, carrying groceries or bowling . . . . . limm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Walking uphill or climbing a few flights of stairs. . . . . hill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Bending, lifting, or stooping . . . . . bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Walking one block . . . . . block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Eating, dressing, bathing, or using the toilet . . . . . self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

Please indicate which statements best describe your own health state today. (Check only one for each group)

**B38a. Mobility** hsmob

- 1  I have no problems in walking about
- 2  I have some problems walking about
- 3  I am confined to bed

**B38b. Self-Care** hsself

- 1  I have no problems with self-care
- 2  I have some problems washing or dressing myself
- 3  I am unable to wash or dress myself

**B38c. Usual Activities (e.g. work, study, housework, family, or leisure activities)** husual

- 1  I have no problems with performing my usual activities
- 2  I have some problems with performing my usual activities
- 3  I am unable to perform my usual activities

**B38d. Pain/Discomfort** hspain

- 1  I have no pain or discomfort
- 2  I have moderate pain or discomfort
- 3  I have extreme pain or discomfort

**B38e. Anxiety/Depression** hsanx

- 1  I am not anxious or depressed
- 2  I am moderately anxious or depressed
- 3  I am extremely anxious or depressed

Continue on next page.

Please! Do not mark below this line

## Daily Activity

**B39. Which statement best describes your usual daily activities? act**

- 1  I mostly sit during the day and do not walk about very much
- 2  I stand or walk about quite a lot during the day, but do not have to carry or lift things very often
- 3  I carry light loads, or have to climb stairs or hills often
- 4  I do heavy work or carry heavy loads

**B40. Over the past 30 days, on a typical day how much time altogether did you spend sitting and watching TV or videos or using a computer or other electronic portable device outside of work? Would you say ... screen**

- 0  Don't watch TV or videos or use a computer or electronic portable device
- 1  <1 hour
- 2  1 - 2 hours
- 3  3 - 4 hours
- 4  5 - 6 hours
- 5  7 - 8 hours
- 6  9 hours or more

**B41. Because of any impairment or health problems, do you need the help of other persons with personal care needs, such as eating, bathing, dressing, or getting around your home? help**

- 2  No
- 1  Yes

**B42. Because of any impairment or health problems, do you need the help of other persons in handling routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? chore**

- 2  No
- 1  Yes

**B43. Does any impairment or health problem keep you from holding a job or attending school? nojob**

- 2  No
- 1  Yes

**B44. Do you currently have a driver's license? drive**

- 2  No
- 1  Yes

## HEALTH STATUS

**C1. Would you rate yourself as being: disable**

- 1  Completely disabled
- 2  Severely disabled
- 3  Moderately disabled
- 4  Mildly disabled
- 5  Not at all disabled

**C2. In general, would you say your health is: health**

- 1  Excellent
- 2  Very good
- 3  Good
- 4  Fair
- 5  Poor

**C3. Compared to one year ago, how would you rate your health in general now? hlthcomp**

- 1  Much better now than one year ago
- 2  Somewhat better now than one year ago
- 3  About the same as one year ago
- 4  Somewhat worse now than one year ago
- 5  Much worse now than one year ago

*Continue on next page.*

**C4. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

		3 No, not limited at all		
		1 Yes, limited a little		
		2 Yes, limited a lot		
a. <u>Vigorous Activities</u> , such as running, lifting heavy objects, participating in strenuous sports . . . . .	<b>vigorous</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. <u>Moderate Activities</u> , such as moving a table, bowling, or playing golf . . . . .	<b>moderate</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lifting or carrying groceries . . . . .	<b>lift</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Climbing <u>several</u> flights of stairs . . . . .	<b>stairs</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Climbing <u>one</u> flight of stairs . . . . .	<b>stair</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Bending, kneeling, or stooping . . . . .	<b>bending</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking <u>more than a mile</u> . . . . .	<b>miles</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Walking <u>several hundred yards</u> . . . . .	<b>yardss</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Walking <u>one hundred yards</u> . . . . .	<b>yardso</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Bathing or dressing yourself . . . . .	<b>bathe</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

		5 None of the time		
		4 A little of the time		
		3 Some of the time		
		2 Most of the time		
		1 All of the time		
a. Cut down on the <u>amount of time</u> you spent on work or other activities . . . . .	<b>phtime</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. <u>Accomplished less</u> than you would like . . . . .	<b>phless</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Were limited in the <u>kind</u> of work or other activities . . . . .	<b>phkind</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort) . . . . .	<b>phhard</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C6. During the past 4 weeks, how much of the time 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)?**

		5 None of the time		
		4 A little of the time		
		3 Some of the time		
		2 Most of the time		
		1 All of the time		
a. Cut down on the amount of time you spent on work or other activities . . . . .	<b>eptime</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Accomplished less than you would like . . . . .	<b>epless</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Did work or activities less carefully than usual . . . . .	<b>epcare</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C7. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? **social1****

- 1  Not at all
- 2  Slightly
- 3  Moderately
- 4  Quite a bit
- 5  Extremely

Continue on next page.

**C8. How much bodily pain have you had during the past 4 weeks? painmuch**

- 1  None
- 2  Very mild
- 3  Mild
- 4  Moderate
- 5  Severe
- 6  Very severe

**C9. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? painintf**

- 1  Not at all
- 2  A little bit
- 3  Moderately
- 4  Quite a bit
- 5  Extremely

**C10. For pain that you have had during the past 4 weeks, where has this pain been located? painloct (Check all that apply)**

- Head painloct\_head
- Neck painloct\_neck
- Chest painloct\_chst
- Hands/Arms painloct\_arm
- Abdomen painloct\_adb
- Back painloct\_back
- Pelvis painloct\_pel
- Legs/Feet painloct\_leg
- Other painloct\_oth

**Specify**

painspe1-10 coded

**C11. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please mark the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks. . .**

- |  |                               |                          |                          |                          |                          |
|--|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  | <b>5</b> None of the time     |                          |                          |                          |                          |
|  | <b>4</b> A little of the time |                          |                          |                          |                          |
|  | <b>3</b> Some of the time     |                          |                          |                          |                          |
|  | <b>2</b> Most of the time     |                          |                          |                          |                          |
|  | <b>1</b> All of the time      |                          |                          |                          |                          |
| a. Did you feel full of life? . . . . . <span style="color:red">lifefull</span> . . . . .                                      | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you been very nervous? . . . . . <span style="color:red">nervous</span> . . . . .                                      | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you felt so down in the dumps that nothing could cheer you up? . . . . . <span style="color:red">down</span> . . . . . | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you felt calm and peaceful? . . . . . <span style="color:red">calm</span> . . . . .                                    | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Did you have a lot of energy? . . . . . <span style="color:red">energy</span> . . . . .                                     | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have you felt downhearted and depressed? . . . . . <span style="color:red">depres</span> . . . . .                          | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Did you feel worn out? . . . . . <span style="color:red">wornout</span> . . . . .   | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Have you been happy? . . . . . <span style="color:red">happy</span> . . . . .   | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Did you feel tired? . . . . . <span style="color:red">tired</span> . . . . .  | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**C12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? social2**

- 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

**C13. How TRUE or FALSE is each of the following statements for you?**

- |   |                           |                          |                          |                          |                          |
|---|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|   | <b>5</b> Definitely false |                          |                          |                          |                          |
|   | <b>4</b> Mostly false     |                          |                          |                          |                          |
|   | <b>3</b> Don't know       |                          |                          |                          |                          |
|   | <b>2</b> Mostly true      |                          |                          |                          |                          |
|   | <b>1</b> Definitely true  |                          |                          |                          |                          |
| a. I seem to get sick a little easier than other people . . . . . <span style="color:red">sick</span> . . . . . | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I am as healthy as anybody I know . . . . . <span style="color:red">healthy</span> . . . . .                 | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I expect my health to get worse . . . . . <span style="color:red">worse</span> . . . . .                     | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My health is excellent . . . . . <span style="color:red">excellent</span> . . . . .                          | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please! Do not mark below this line