



2009

**Behavioral Risk Factor Surveillance System
Questionnaire**

December 22, 2009

Behavioral Risk Factor Surveillance System

Indiana Statewide Survey Data, 2009

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Section 1: Health Status

1.1 Would you say that in general your health is—

Please read:

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

Or

- 5 Poor

Do not read:

- 7 Don't know / Not sure
- 9 Refused

Section 2: Healthy Days — Health-Related Quality of Life

2.1 Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

- — Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

2.2 Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

- — Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

2.3
health

During the past 30 days, for about how many days did poor physical or mental keep you from doing your usual activities, such as self-care, work, or recreation?

- – Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

Section 3: Health Care Access

3.1 Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

3.2 Do you have one person you think of as your personal doctor or health care provider?

If “No,” ask: “Is there more than one, or is there no person who you think of as your personal doctor or health care provider?”

- 1 Yes, only one
- 2 More than one
- 3 No
- 7 Don't know / Not sure
- 9 Refused

3.3 Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

3.4 About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

- 1 Within past year (anytime less than 12 months ago)
- 2 Within past 2 years (1 year but less than 2 years ago)
- 3 Within past 5 years (2 years but less than 5 years ago)

- 4 5 or more years ago
- 7 Don't know / Not sure
- 8 Never
- 9 Refused

Section 4: Sleep

The next question is about getting enough rest or sleep.

- 4.1** During the past 30 days, for about how many days have you felt you did not get enough rest or sleep?

- – Number of days
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

Section 5: Exercise

- 5.1** During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 6: Diabetes

- 6.1** Have you ever been told by a doctor that you have diabetes?

If “Yes” and respondent is female, ask: “Was this only when you were pregnant?”

- 1 Yes
- 2 Yes, but female told only during pregnancy
- 3 No
- 4 No, pre-diabetes or borderline diabetes
- 7 Don't know / Not sure
- 9 Refused

Module 2: Diabetes

1. How old were you when you were told you have diabetes?

— — Code age in years
9 8 Don't know / Not sure
9 9 Refused

2. Are you now taking insulin?

1 Yes
2 No
9 Refused

3. About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

1 — — Times per day
2 — — Times per week
3 — — Times per month
4 — — Times per year
8 8 8 Never
7 7 7 Don't know / Not sure
9 9 9 Refused

4. About how often do you check your feet for any sores or irritations? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

1 — — Times per day
2 — — Times per week
3 — — Times per month
4 — — Times per year
5 5 5 No feet
8 8 8 Never
7 7 7 Don't know / Not sure
9 9 9 Refused

5. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?

— — Number of times

- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

6.
three
other

A test for "A one C" measures the average level of blood sugar over the past months. About how many times in the past 12 months has a doctor, nurse, or health professional checked you for "A one C"?

- — Number of times
- 8 8 None
- 9 8 Never heard of "A one C" test
- 7 7 Don't know / Not sure
- 9 9 Refused

7.

About how many times in the past 12 months has a health professional checked your feet for any sores or irritations?

- — Number of times
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

8.

When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.

Read only if necessary:

- 1 Within the past month (anytime less than 1 month ago)
- 2 Within the past year (1 month but less than 12 months ago)
- 3 Within the past 2 years (1 year but less than 2 years ago)
- 4 2 or more years ago

Do not read:

- 7 Don't know / Not sure
- 8 Never
- 9 Refused

9.

Has a doctor ever told you that diabetes has affected your eyes or that you had retinopathy?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

10. Have you ever taken a course or class in how to manage your diabetes yourself?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 7: Hypertension Awareness

7.1 Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure?

If "Yes" and respondent is female, ask: "Was this only when you were pregnant?"

- 1 Yes
- 2 Yes, but female told only during pregnancy
- 3 No
- 4 Told borderline high or pre-hypertensive
- 7 Don't know / Not sure
- 9 Refused

7.2 Are you currently taking medicine for your high blood pressure?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 8: Cholesterol Awareness

8.1 Blood cholesterol is a fatty substance found in the blood. Have you EVER had your blood cholesterol checked?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

8.2 About how long has it been since you last had your blood cholesterol checked?

Read only if necessary:

- 1 Within the past year (anytime less than 12 months ago)
- 2 Within the past 2 years (1 year but less than 2 years ago)
- 3 Within the past 5 years (2 years but less than 5 years ago)
- 4 5 or more years ago

Do not read:

- 7 Don't know / Not sure
- 9 Refused

8.3 Have you EVER been told by a doctor, nurse or other health professional that
your blood cholesterol is high?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 9: Cardiovascular Disease Prevalence

Now I would like to ask you some questions about cardiovascular disease.

Has a doctor, nurse, or other health professional EVER told you that you had any of the following? For each, tell me "Yes," "No," or you're "Not sure."

9.1 (Ever told) you had a heart attack, also called a myocardial infarction?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

9.2 (Ever told) you had angina or coronary heart disease?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

9.3 (Ever told) you had a stroke?

- 1 Yes
- 2 No
- 7 Don't know / Not sure

Section 10: Asthma

10.1 Have you ever been told by a doctor, nurse, or other health professional that you had asthma?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

10.2 Do you still have asthma?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 11: Tobacco Use

11.1 Have you smoked at least 100 cigarettes in your entire life?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

11.2 Do you now smoke cigarettes every day, some days, or not at all?

- 1 Every day
- 2 Some days
- 3 Not at all
- 7 Don't know / Not sure
- 9 Refused

11.3 During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

- 1 Yes
- 2 No
- 7 Don't know / Not sure

9 Refused

11.4 How long has it been since you last smoked cigarettes regularly?

- 0 1 Within the past month (less than 1 month ago)
- 0 2 Within the past 3 months (1 month but less than 3 months ago)
- 0 3 Within the past 6 months (3 months but less than 6 months ago)
- 0 4 Within the past year (6 months but less than 1 year ago)
- 0 5 Within the past 5 years (1 year but less than 5 years ago)
- 0 6 Within the past 10 years (5 years but less than 10 years ago)
- 0 7 10 years or more
- 0 8 Never smoked regularly
- 7 7 Don't know / Not sure
- 9 9 Refused

11.5 Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?

- 1 Every day
- 2 Some days
- 3 Not at all

Do not read:

- 7 Don't know / Not sure
- 9 Refused

Section 12: Demographics

12.5 Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit? Active duty does not include training for the Reserves or National Guard, but DOES include activation, for

example, for the Persian Gulf War.

- 1 Yes, now on active duty
- 2 Yes, on active duty during the last 12 months, but not now
- 3 Yes, on active duty in the past, but not during the last 12 months
- 4 No, training for Reserves or National Guard only
- 5 No, never served in the military
- 7 Don't know / Not sure
- 9 Refused

12.15 What county do you live in?

_ _ _ FIPS county code

7 7 7 Don't know / Not sure
9 9 9 Refused

12.21 To your knowledge, are you now pregnant?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

Section 13: Caregiver Status

People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

13.1 During the past month, did you provide any such care or assistance to a friend or family member?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

Section 14: Disability

The following questions are about health problems or impairments you may have.

14.1 Are you limited in any way in any activities because of physical, mental, or emotional problems?

1 Yes
2 No
7 Don't know / Not Sure
9 Refused

14.2 Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?

Include occasional use or use in certain circumstances.

1 Yes
2 No

- 7 Don't know / Not Sure
- 9 Refused

Section 15: Alcohol Consumption

15.1 During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

15.2 During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage?

- 1 _ _ Days per week
- 2 _ _ Days in past 30 days
- 8 8 8 No drinks in past 30 days
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

15.3 One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?

- _ _ Number of drinks
- 7 7 Don't know / Not sure
- 9 9 Refused

15.4 Considering all types of alcoholic beverages, how many times during the past 30 days did you have X [5 for men, 4 for women] or more drinks on an occasion?

- _ _ Number of times
- 8 8 None
- 7 7 Don't know / Not sure
- 9 9 Refused

15.5 During the past 30 days, what is the largest number of drinks you had on any occasion?

- — Number of drinks
- 7 7 Don't know / Not sure
- 9 9 Refused

Section 16: Immunization

16.1 A flu shot is an influenza vaccine injected into your arm. During the past 12 months, have you had a flu shot?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

16.3 During the past 12 months, have you had a flu vaccine that was sprayed in your nose?
The flu vaccine sprayed in the nose is also called FluMist™.

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

16.5 A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 17: Arthritis Burden

Next I will ask you about arthritis.

17.1 Have you EVER been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?

- 1 Yes
- 2 No
- 7 Don't know / Not sure

9 Refused

Arthritis can cause symptoms like pain, aching, or stiffness in or around the joint.

17.2 Are you now limited in any way in any of your usual activities because of arthritis or joint symptoms?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

17.3 In this next question, we are referring to work for pay. Do arthritis or joint symptoms now affect whether you work, the type of work you do, or the amount of work you do?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

17.4 During the past 30 days, to what extent has your arthritis or joint symptoms interfered with your normal social activities, such as going shopping, to the movies, or to religious or social gatherings?

Please read [1-3]:

- 1 A lot
- 2 A little
- 3 Not at all

Do not read:

- 7 Don't know / Not sure
- 9 Refused

17.5 Please think about the past 30 days, keeping in mind all of your joint pain or aching and whether or not you have taken medication. DURING THE PAST 30 DAYS, how bad was your joint pain ON AVERAGE? *Please answer on a scale of 0 to 10 where 0 is no pain or aching and 10 is pain or aching as bad as it can be.*

- — Enter number [00-10]
- 7 7 Don't know / Not sure
- 9 9 Refused

Section 18: Fruits and Vegetables

These next questions are about the foods you usually eat or drink. Please tell me how often you eat or drink each one, for example, twice a week, three times a month, and so forth. Remember, I

am only interested in the foods **you** eat. Include all foods *you* eat, both at home and away from home.

18.1 How often do you drink fruit juices such as orange, grapefruit, or tomato?

- 1 __ Per day
- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

18.2 Not counting juice, how often do you eat fruit?

- 1 __ Per day
- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

18.3 How often do you eat green salad?

- 1 __ Per day
- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

18.4 How often do you eat potatoes not including French fries, fried potatoes, or potato chips?

- 1 __ Per day
- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

18.5 How often do you eat carrots?

- 1 __ Per day

- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

18.6 Not counting carrots, potatoes, or salad, how many servings of vegetables do you usually eat? (Example: A serving of vegetables at both lunch and dinner would be two servings.)

- 1 __ Per day
- 2 __ Per week
- 3 __ Per month
- 4 __ Per year
- 5 5 5 Never
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

Section 19: Physical Activity

19.1 When you are at work, which of the following best describes what you do? Would you say—

If respondent has multiple jobs, include all jobs.

Please read:

- 1 Mostly sitting or standing
- 2 Mostly walking
- 3 Mostly heavy labor or physically demanding work

Do not read:

- 7 Don't know / Not sure
- 9 Refused

Please read:

We are interested in two types of physical activity - vigorous and moderate. Vigorous activities cause large increases in breathing or heart rate while moderate activities cause small increases in breathing or heart rate.

19.2 Now, thinking about the moderate activities you do **[fill in “when you are not working” if “employed” or self-employed]** in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate?

- 1 Yes

- 2 No
- 7 Don't know / Not sure
- 9 Refused

19.3 How many days per week do you do these moderate activities for at least 10 minutes at a time?

- Days per week
- 8 8 Do not do any moderate physical activity for at least 10 minutes at a time?
- 7 7 Don't know / Not sure
- 9 9 Refused

19.4 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?

- : Hours and minutes per day
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

19.5 Now, thinking about the vigorous activities you do **[fill in “when you are not working” if “employed” or “self-employed”]** in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

19.6 How many days per week do you do these vigorous activities for at least 10 minutes at a time?

- Days per week
- 8 8 Do not do any vigorous physical activity for at least 10 minutes at a time
- 7 7 Don't know / Not sure
- 9 9 Refused

19.7 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?

- : Hours and minutes per day
- 7 7 7 Don't know / Not sure
- 9 9 9 Refused

Section 20: HIV/AIDS

The next few questions are about the national health problem of HIV, the virus that causes AIDS. Please remember that your answers are strictly confidential and that you don't have to answer every question if you do not want to. Although we will ask you about testing, we will not ask you about the results of any test you may have had.

20.1 Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation. Include testing fluid from your mouth.

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

20.3 Where did you have your last HIV test — at a private doctor or HMO office, at a counseling and testing site, at a hospital, at a clinic, in a jail or prison, at a drug treatment facility, at home, or somewhere else?

- 0 1 Private doctor or HMO office
- 0 2 Counseling and testing site
- 0 3 Hospital
- 0 4 Clinic
- 0 5 Jail or prison (or other correctional facility)
- 0 6 Drug treatment facility
- 0 7 At home
- 0 8 Somewhere else
- 7 7 Don't know / Not sure
- 9 9 Refused

20.4 Was it a rapid test where you could get your results within a couple of hours?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

20.5 I'm going to read you a list. When I'm done, please tell me if any of the situations apply to you. You do not need to tell me which one.

- You have used intravenous drugs in the past year.

- You have been treated for a sexually transmitted or venereal disease in the past year.
- You have given or received money or drugs in exchange for sex in the past year.
- You had anal sex without a condom in the past year.

Do any of these situations apply to you?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Section 21: Emotional Support and Life Satisfaction

The next two questions are about emotional support and your satisfaction with life.

21.1 How often do you get the social and emotional support you need?

Please read:

- 1 Always
- 2 Usually
- 3 Sometimes
- 4 Rarely
- 5 Never

Do not read:

- 7 Don't know / Not sure
- 9 Refused

21.2 In general, how satisfied are you with your life?

Please read:

- 1 Very satisfied
- 2 Satisfied
- 3 Dissatisfied
- 4 Very dissatisfied

Do not read:

- 7 Don't know / Not sure
- 9 Refused

Section 22: Cancer Survivors

22.1 Have you EVER been told by a doctor, nurse, or other health professional that you had cancer?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

22.2 How many different types of cancer have you had?

- 1 Only one
- 2 Two
- 3 Three or more
- 7 Don't know / Not sure
- 9 Refused

22.3 At what age were you told that you had cancer?

- -- Code age in years **[97 = 97 and older]**
- 9 8 Don't know / Not sure
- 9 9 Refused

22.4 What type of cancer was it?

Optional Modules

Module 4: Visual Impairment and Access to Eye Care

CATI note: If respondent is less than 40 years of age, go to next module.

Now I would like to ask you questions about your vision. These questions are for all respondents regardless of whether or not you wear glasses or contact lenses. If you wear glasses or contact lenses, answer questions as if you are wearing them.

1. How much difficulty, if any, do you have in recognizing a friend across the street? Would you say—

Please read:

- 1 No difficulty
- 2 A little difficulty
- 3 Moderate difficulty
- 4 Extreme difficulty
- 5 Unable to do because of eyesight

Or

- 6 Unable to do for other reasons

Do not read:

- 7 Don't know / Not sure
- 8 Not applicable (Blind)
- 9 Refused

2. How much difficulty, if any, do you have reading print in newspapers, magazines, recipes, menus, or numbers on the telephone? Would you say—

Please read:

- 1 No difficulty
- 2 A little difficulty
- 3 Moderate difficulty
- 4 Extreme difficulty
- 5 Unable to do because of eyesight

Or

- 6 Unable to do for other reasons

Do not read:

- 7 Don't know / Not sure
- 8 Not applicable (Blind)
- 9 Refused

3. When was the last time you had your eyes examined by any doctor or eye care provider?

Read only if necessary:

- 1 Within the past month (anytime less than 1 month ago)
- 2 Within the past year (1 month but less than 12 months ago)
- 3 Within the past 2 years (1 year but less than 2 years ago)
- 4 2 or more years ago
- 5 Never

Do not read:

- 7 Don't know / Not sure
- 8 Not applicable (Blind)
- 9 Refused

4. What is the main reason you have not visited an eye care professional in the past 12 months?

Read only if necessary:

- 0 1 Cost/insurance
- 0 2 Do not have/know an eye doctor
- 0 3 Cannot get to the office/clinic (too far away, no transportation)
- 0 4 Could not get an appointment
- 0 5 No reason to go (no problem)
- 0 6 Have not thought of it
- 0 7 Other

Do not read:

- 7 7 Don't know / Not sure
- 0 8 Not Applicable (Blind)
- 9 9 Refused

5. When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.

Read only if necessary:

- 1 Within the past month (anytime less than 1 month ago)
- 2 Within the past year (1 month but less than 12 months ago)
- 3 Within the past 2 years (1 year but less than 2 years ago)
- 4 2 or more years ago
- 5 Never

Do not read:

- 7 Don't know / Not sure
- 8 Not applicable (Blind)
- 9 Refused

6. Do you have any kind of health insurance coverage for eye care?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 8 Not applicable (Blind)
- 9 Refused

7. Have you been told by an eye doctor or other health care professional that you NOW have cataracts?

- 1 Yes
- 2 Yes, but had them removed
- 3 No
- 7 Don't know / Not sure
- 8 Not applicable (Blind)
- 9 Refused

8. Have you EVER been told by an eye doctor or other health care professional that you had glaucoma?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 8 Not applicable (Blind)
- 9 Refused

9. Have you EVER been told by an eye doctor or other health care professional that you had age-related macular degeneration?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 8 Not applicable (Blind)
- 9 Refused

Module 6: Cardiovascular Health

1. Following your heart attack, did you go to any kind of outpatient rehabilitation? This is sometimes called "rehab."

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

2. Following your stroke, did you go to any kind of outpatient rehabilitation? This is sometimes called "rehab."

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

3. Do you take aspirin daily or every other day?

- 1 Yes **[Go to next module]**

- 2 No
- 7 Don't know / Not sure
- 9 Refused

4. Do you have a health problem or condition that makes taking aspirin unsafe for you?

- 1 Yes, not stomach related
- 2 Yes, stomach problems
- 3 No
- 7 Don't know / Not sure
- 9 Refused

Module 8: Heart Attack and Stroke

1. (Do you think) pain or discomfort in the jaw, neck, or back (are symptoms of a heart attack?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

2. (Do you think) feeling weak, lightheaded, or faint (are symptoms of a heart attack?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

3. (Do you think) chest pain or discomfort (are symptoms of a heart attack?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

4. (Do you think) sudden trouble seeing in one or both eyes (is a symptom of a heart attack?)

- 1 Yes
- 2 No

- 7 Don't know / Not sure
- 9 Refused

5. (Do you think) pain or discomfort in the arms or shoulder (are symptoms of a heart attack?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

6. (Do you think) shortness of breath (is a symptom of a heart attack?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Which of the following do you think is a symptom of a stroke? For each, tell me "yes," "no," or you're "not sure."

7. (Do you think) sudden confusion or trouble speaking (are symptoms of a stroke?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

8. (Do you think) sudden numbness or weakness of face, arm, or leg, especially on one side, (are symptoms of a stroke?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

9. (Do you think) sudden trouble seeing in one or both eyes (is a symptom of a stroke?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

10. (Do you think) sudden chest pain or discomfort (are symptoms of a stroke?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

11. (Do you think) sudden trouble walking, dizziness, or loss of balance (are symptoms of a stroke?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

12. (Do you think) severe headache with no known cause (is a symptom of a stroke?)

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

13. If you thought someone was having a heart attack or a stroke, what is the first thing you would do?

Please read:

- 1 Take them to the hospital
- 2 Tell them to call their doctor
- 3 Call 911
- 4 Call their spouse or a family member

Or

- 5 Do something else

Do not read:

- 7 Don't know / Not sure
- 9 Refused

Module 20: Reactions to Race

1. How do other people usually classify you in this country? Would you say: White, Black or African American, Hispanic or Latino, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, or some other group?

- 1 White
- 2 Black or African American
- 3 Hispanic or Latino
- 4 Asian
- 5 Native Hawaiian or Other Pacific Islander
- 6 American Indian or Alaska Native
- 8 Some other group (please specify) _____
- 7 Don't know / Not sure
- 9 Refused

2. How often do you think about your race? Would you say never, once a year, once a month, once a week, once a day, once an hour, or constantly?

- 1 Never
- 2 Once a year
- 3 Once a month
- 4 Once a week
- 5 Once a day
- 6 Once an hour
- 8 Constantly
- 7 Don't know / Not sure
- 9 Refused

3. Within the past 12 months at work, do you feel you were treated worse than, the same as, or better than people of other races?

- 1 Worse than other races
- 2 The same as other races
- 3 Better than other races

Do not read:

- 4 Worse than some races, better than others
- 5 Only encountered people of the same race
- 7 Don't know / Not sure
- 9 Refused

4. Within the past 12 months, when seeking health care, do you feel your experiences were worse than, the same as, or better than for people of other races?

- 1 Worse than other races
- 2 The same as other races
- 3 Better than other races

Do not read:

- 4 Worse than some races, better than others
- 5 Only encountered people of the same race
- 6 No health care in past 12 months
- 7 Don't know / Not sure
- 9 Refused

5. Within the past 30 days, have you experienced any physical symptoms, for example, a headache, an upset stomach, tensing of your muscles, or a pounding heart, as a result of how you were treated based on your race?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

6. Within the past 30 days, have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on your race?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Module 26: Childhood Asthma Prevalence

1. Has a doctor, nurse or other health professional EVER said that the child has asthma?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

2. Does the child still have asthma?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

