14243

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2020

# 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.

**This Booklet Should Be Completed By →**

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

**NAME:** _____

_____

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



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

14243

# Your Health And Health Choices

**START HERE:**

**1.** Are you male or female?

- ☐ Male ➔ Please call Alex Scott, toll free at 1-800-945-6377 before completing.
- ☐ Female

**2.** What is your age?

- ☐ Under 18
- ☐ 18 to 34
- ☐ 35 to 49
- ☐ 50 or older

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

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

**4.** 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

**5.** 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

**6.** 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

**7.** 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.

**8.** 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

**9.** 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

**10.** 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? | ☐ | ☐ | ☐ | ☐ | ☐ |

**11.** 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 | ☐ | ☐ | ☐ | ☐ |

**12.** 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

## Alcohol and Drug Use

**13.** Think about your drinking in the past 12 months. A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

How often do you have a drink containing alcohol?

- ☐ Never ➔ **If Never, go to 16**
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ 2-3 times a week
- ☐ 4-6 times a week
- ☐ Daily

**14.** How many drinks containing alcohol do you have on a typical day you are drinking? A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

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

**15.** How often do you have 4 or more drinks on one occasion? A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

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

**16.** 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

**17.** 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

**18.** How many days in the past 12 months have you used drugs other than alcohol?

☐☐☐ **Days**

**19.** How many days in the past 12 months have you used drugs more than you meant to?

☐☐☐ **Days**

## 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 ➔ **If No, go to 25**

**21.** Using **any number from 0 to 10**, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all your **counseling or treatment** in the last 12 months?

- ☐ 0 Worst counseling or treatment possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best counseling or treatment possible

**22.** In the last 12 months, how much were you helped by the counseling or treatment you got?

- ☐ Not at all
- ☐ A little
- ☐ Somewhat
- ☐ A lot

**23.** How much of the counseling or treatment you got in the last 12 months was paid for by another source besides you or your family?

- ☐ All of it
- ☐ Most of it
- ☐ Some of it
- ☐ None of it

**24.** 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

## Counseling Needs and Alternative Treatments

**25.** During the past 12 months, was there any time when you felt you **needed** counseling or treatment for yourself but **didn't get it**? Think about counseling or treatment for difficult feelings, personal or family problems, drug or alcohol use, or any mental or emotional illness.

- ☐ Yes
- ☐ No

**26.** During the past 12 months, did you ever receive any treatment, counseling, or support including self-help for problems with your emotions, mental health, family or personal problems, or substance use from any of the following other sources?

| | Yes | No |
|---|---|---|
| a. A spiritual or religious advisor | ☐ | ☐ |
| b. A school-based resource | ☐ | ☐ |
| c. An in-person peer support or self-help group | ☐ | ☐ |
| d. An internet website or online support forum or group | ☐ | ☐ |
| e. A telephone hotline | ☐ | ☐ |
| f. A smartphone app | ☐ | ☐ |

**27.** 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

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

- ☐ Yes
- ☐ No

**29.** 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

**30.** 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

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

- ☐ Yes
- ☐ No

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

☐☐☐ **Weight (pounds)**

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

☐ **Feet** ☐☐ **Inches**

**34.** 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

**35.** 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

**36.** 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 40**

**37.** 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

**38.** 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

**39.** 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

**40.** 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

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

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

**44.** **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

**45.** 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 50 or older, please continue with the questions.**
**If you are under 50 years old, please go to the "Date Completed" box on the last page.**

**46.** 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

**47.** 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

**48.** 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 50**
- ☐ No

**49.** 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

**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 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 54**
- ☐ 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

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

- ☐ Yes ➔ **If Yes, go to the "Date Completed" box on the next page**
- ☐ No

**55.** **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

**56.** **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

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**57. 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

**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 COMPLETING THE QUESTIONNAIRE!

- Please place this survey in the envelope provided to you and give it to the MEPS interviewer.
- If the interviewer is no longer available, place the survey in the return envelope provided to you by the interviewer. If the envelope is missing, mail this survey to:

MEPS
c/o Westat
1600 Research Blvd, Room GA51
Rockville, MD 20850

20-233.F