



Study ID


3. How much do you weigh? (in pounds) (Fill in one oval)

- 90 lbs. or less       131 - 140 lbs.       181 - 190 lbs.       231 - 240 lbs.       281 - 290 lbs.
- 91 - 100 lbs.       141 - 150 lbs.       191 - 200 lbs.       241 - 250 lbs.       291 - 300 lbs.
- 101 - 110 lbs.       151 - 160 lbs.       201 - 210 lbs.       251 - 260 lbs.       301 - 310 lbs.
- 111 - 120 lbs.       161 - 170 lbs.       211 - 220 lbs.       261 - 270 lbs.       311 - 320 lbs.
- 121 - 130 lbs.       171 - 180 lbs.       221 - 230 lbs.       271 - 280 lbs.       321 lbs. or more

4. How often do you engage in regular activities (e.g. brisk walking, jogging, bicycling, etc.) long enough to work up a sweat?

- NEVER
- LESS THAN ONCE A WEEK
- 1 - 2 TIMES A WEEK
- 3 - 4 TIMES A WEEK
- 5 OR MORE TIMES A WEEK

5. Do you now smoke cigarettes (i.e. within the last week)?

- YES
- NO

6. Do you have a father or brother who had a heart attack or angina before age 55?

- YES
- NO

7. Do you have a mother or sister who had a heart attack or angina before age 65?

- YES
- NO

Study ID


8. Have any of your relatives had what you would call a significant drinking problem (one that did or should have led to treatment)?

YES

NO

(If yes, fill in the ovals next to relatives that apply)

Mother's side:	<input type="radio"/> Mother	<input type="radio"/> Grandmother	<input type="radio"/> Grandfather	<input type="radio"/> Aunts	<input type="radio"/> Uncles
Father's side:	<input type="radio"/> Aunts	<input type="radio"/> Father	<input type="radio"/> Grandmother	<input type="radio"/> Grandfather	<input type="radio"/> Uncles
Siblings	<input type="radio"/> Sister	<input type="radio"/> Brother			

9. In the past 4 weeks have you been concerned about having enough food for you or your family?

YES

NO

10. In the past 4 weeks, have you been without a permanent address that you call home?

YES

NO

11. In the past 4 weeks, have you stayed one or more nights in the following: (mark all that apply)

ON THE STREET, AT A PARK, AN ABANDONED BUILDING, OR IN A CAR

A SHELTER OR AN EMERGENCY SHELTER

A SUBSIDIZED APARTMENT OR HOME AWAITING PERMANENT HOUSING

WITH FAMILY OR FRIENDS TEMPORARILY UNTIL YOU FIND YOUR OWN PLACE

NONE OF THE ABOVE

12. Have you ever stayed one or more nights in the following: (mark all that apply)

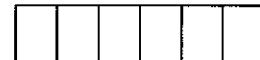
ON THE STREET, AT A PARK, AN ABANDONED BUILDING, OR IN A CAR

A SHELTER OR AN EMERGENCY SHELTER

A SUBSIDIZED APARTMENT OR HOME AWAITING PERMANENT HOUSING

WITH FAMILY OR FRIENDS TEMPORARILY UNTIL YOU FIND YOUR OWN PLACE

NONE OF THE ABOVE



**NOTE: For answering these questions, one "drink" is equal to 12 ounces of beer (1 can), or 4 ounces of wine (1 glass), or 1 ounce of liquor (1 shot).**

13. In the last 12 months have you ever had a drink containing alcohol?

- YES (If yes, please continue)
- NO, NEVER (If no, skip to question #28)

14. How often do you have a drink containing alcohol?

- NEVER
- MONTHLY OR LESS
- TWO TO FOUR TIMES A MONTH
- TWO TO THREE TIMES A WEEK
- FOUR OR MORE TIMES A WEEK

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

- 1 OR 2
- 3 OR 4
- 5 OR 6
- 7 TO 9
- 10 OR MORE

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

- NEVER
- LESS THAN MONTHLY
- MONTHLY
- WEEKLY
- DAILY OR ALMOST DAILY



17. How often during the last 12 months have you found that you were not able to stop drinking once you had started?
- NEVER
  - LESS THAN MONTHLY
  - MONTHLY
  - WEEKLY
  - DAILY OR ALMOST DAILY
18. How often during the last 12 months have you failed to do what was normally expected from you because of drinking?
- NEVER
  - LESS THAN MONTHLY
  - MONTHLY
  - WEEKLY
  - DAILY OR ALMOST DAILY
19. How often during the last 12 months have you needed a first drink in the morning to get yourself going after a heavy drinking session?
- NEVER
  - LESS THAN MONTHLY
  - MONTHLY
  - WEEKLY
  - DAILY OR ALMOST DAILY
20. How often during the last 12 months have you had a feeling of guilt or remorse after drinking?
- NEVER
  - LESS THAN MONTHLY
  - MONTHLY
  - WEEKLY
  - DAILY OR ALMOST DAILY



21. How often during the last 12 months have you been unable to remember what happened the night before because you had been drinking?

- NEVER
- LESS THAN MONTHLY
- MONTHLY
- WEEKLY
- DAILY OR ALMOST DAILY

22. Have you or someone been injured as a result of your drinking?

- NEVER
- YES, BUT NOT IN THE LAST YEAR
- YES, DURING THE LAST YEAR

23. Has a relative or friend or doctor or other health care worker been concerned about your drinking or suggested you cut down?

- NO
- YES, BUT NOT IN THE LAST YEAR
- YES, DURING THE LAST YEAR

24. How many drinks of alcohol does it take for you to begin to feel a "buzz" or high?

- 01  02  03  04  05  06  07  0>8  HAVE NEVER FELT A "BUZZ" OR HIGH

25. How many drinks of alcohol does it take for you to begin to lose control or feel drunk?

- 01  02  03  04  05  06  07  08  09  0>10  HAVE NEVER FELT THIS WAY



26. Here are a number of events that drinkers sometimes experience. Read each one carefully and please fill in the oval that indicates if this ever happened to you and how often it has happened to you during the past 3 months.

DURING THE PAST 3 MONTHS, ABOUT HOW OFTEN HAS THIS HAPPENED TO YOU?

	<u>NEVER</u>	<u>ONCE OR A FEW TIMES</u>	<u>ONCE OR TWICE A WEEK</u>	<u>DAILY OR ALMOST DAILY</u>
a. I have been unhappy because of my drinking.	0	0	0	0
b. Because of my drinking, I have not eaten properly.	0	0	0	0
c. I have failed to do what is expected of me because of my drinking.	0	0	0	0
d. I have felt guilty or ashamed because of my drinking.	0	0	0	0
e. I have taken foolish risks when I have been drinking.	0	0	0	0
f. When drinking, I have done impulsive things that I regret later.	0	0	0	0
g. My physical health has been harmed by my drinking.	0	0	0	0
h. I have had money problems because of my drinking.	0	0	0	0
i. My physical appearance has been harmed by my drinking.	0	0	0	0
j. My family has been hurt by my drinking.	0	0	0	0
k. A friendship or close relationship has been damaged by my drinking.	0	0	0	0
l. My drinking has gotten in the way of my growth as a person.	0	0	0	0
m. My drinking has damaged my social life, popularity, or reputation.	0	0	0	0
n. I have spent too much or lost a lot of money because of my drinking.	0	0	0	0
o. I have had an accident while drinking or intoxicated.	0	0	0	0

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27. Have you had any of the following symptoms in the last 12 months?  
 Mark all that apply. (Please note this question refers only to the last 12 months.)

- |   |  |
|---|--|
| <input type="checkbox"/> THE SHAKES   | <input type="checkbox"/> HEADACHES               |
| <input type="checkbox"/> BEING UNABLE TO SLEEP                                      | <input type="checkbox"/> NAUSEA OR VOMITING      |
| <input type="checkbox"/> FEELING VERY NERVOUS OR RESTLESS                           | <input type="checkbox"/> WEAKNESS                |
| <input type="checkbox"/> SWEATING   | <input type="checkbox"/> YOUR HEART BEATING FAST |
| <input type="checkbox"/> YOUR HEART BEATING FAST                                    | <input type="checkbox"/> FITS OR SEIZURES        |
| <input type="checkbox"/> SEEING OR HEARING THINGS THAT OTHERS COULD NOT SEE OR HEAR |  |

28. For each of the following drugs, please fill in the oval that best indicates how often in the past 12 months you used each drugs.

	<u>HAVE NEVER TRIED</u>	<u>NO USE IN THE LAST YEAR</u>	<u>LESS THAN ONCE A MONTH</u>	<u>1 - 3 TIMES A MONTH</u>	<u>1 - 3 TIMES A WEEK</u>	<u>4 - 6 TIMES A WEEK</u>	<u>EVERY DAY</u>																				
a. Marijuana or Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
b. Cocaine or Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
c. Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
d. Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
e. Prescription Opioids (Morphine, Codeine, Vicodin, Percocet, Oxycontin,)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
f. Prescription benzodiazepines (Valium, Deastat, Ativan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
g. Other (please specify):	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																										



29. In the past 12 months, did your use of drugs ever interfere with your work at school, or a job, or at home?

YES (If YES, please answer #30a)

NO (If NO, please skip to #33)

DID NOT USE DRUGS

30. How often in the past 12 months did drugs interfere with your work at school, or a job, or at home?

ONCE OR TWICE

BETWEEN 3 AND 5 TIMES

BETWEEN 6 AND 10 TIMES

BETWEEN 11 AND 20 TIMES

MORE THAN 20 TIMES

31. In the past 12 months, were you ever under the influence of a drug in a situation where you could get hurt -like when driving a car or boat, using knives, guns or machinery, or anything else?

YES

NO

32. In the past 12 months, have you ever used a needle to inject any drug? DO NOT include anything you took under a doctor's orders.

YES

NO



The next questions are about your sexual behavior. We recognize the following questions may be personal. We ask that you complete them to the best of your ability. By sex we mean oral, vaginal, or anal sex, but NOT masturbation. When we talk about condoms, we mean both male as well as female condoms.

33. During the past 12 months, have you had sex?

YES

NO

34. Thinking back about the last time you had sex, did you or your partner use a condom?

YES

NO

35. During the past 12 months, have you had sex with only males, only females, or with both males and females?

ONLY MALES

ONLY FEMALES

BOTH MALES AND FEMALES

36. How many sexual partners have you had in the past 12 months?

0  1  2  3  4  5  6  7  0>8

37. In the past 12 months, have you ever exchanged money or drugs for sex?

NO

YES, AND I HAD PROTECTED SEX

YES, AND I HAD UNPROTECTED SEX

YES, AND I HAD BOTH PROTECTED AND UNPROTECTED SEX

I PREFER NOT TO ANSWER THIS QUESTION

38. In the past 12 months, have you had sex with anyone that you did not know ahead of time (anonymous/casual sex)?

YES

NO

I PREFER NOT TO ANSWER THIS QUESTION



39. Have you been tested for HIV?
- NO, I HAVE NEVER BEEN TESTED
  - YES, AND MY LAST TEST WAS NEGATIVE
  - YES, AND MY LAST TEST WAS POSITIVE
  - YES, AND MY LAST TEST WAS INDETERMINATE
  - YES, I WAS TESTED BUT HAVE NOT RETURNED FOR MY RESULTS
  - I PREFER NOT TO ANSWER THIS QUESTION

40. In the past 12 months have you been diagnosed with any of the following sexually transmitted diseases (STDs)? Answer as many as apply.

I was diagnosed with:

- CHLAMYDIA
- GONORRHEA
- SYPHILIS
- TRICHOMONAS
- CHANCROID
- LICE / SCABIES
- HERPES
- GENITAL WARTS
- NON-SPECIFIC URETHRITIS / NON-GONOCOCCAL URETHRITIS
- MONONUCLEOSIS ("MONO")
- ANOTHER SEXUALLY TRANSMITTED DISEASE
- I WAS NOT DIAGNOSED WITH ANY OF THESE INFECTIONS
- I PREFER NOT TO ANSWER THIS QUESTION



41. In the past 12 months, how often have you practiced safer sex (used a male or female condom)?
- EVERY TIME I HAVE SEX WITH EVERY PARTNER
  - WITH EACH PARTNER, I SOMETIMES PRACTICE SAFER SEX, BUT NOT ALWAYS
  - WITH SOME PARTNERS I ALWAYS PRACTICE SAFER SEX, AND WITH OTHER PARTNERS I DO NOT
  - I AM SEXUALLY ACTIVE BUT I NEVER PRACTICE SAFER SEX
  - I DO NOT HAVE TO PRACTICE SAFER SEX SINCE I AM NOT AT RISK FOR HIV OR OTHER STDs
  - I AM NOT SEXUALLY ACTIVE
  - I PREFER NOT TO ANSWER THIS QUESTION
42. Have you ever had sex with a person who had HIV or another STD?
- NO, NOT THAT I KNOW OF
  - NO, I AM CERTAIN THAT EVERYONE I HAD SEX WITH HAS NOT HAD AN STD OR HIV
  - YES, I HAD SEX WITH A PERSON DIAGNOSED WITH HIV
  - YES, I HAD SEX WITH A PERSON DIAGNOSED WITH AN STD OTHER THAN HIV
  - I PREFER NOT TO ANSWER THIS QUESTION
43. If you ever had sex with a person who you knew or suspected had HIV or another STD, did you:
- PRACTICE SAFER SEX EVERY TIME
  - PRACTICE SAFER SEX SOME OF THE TIME, BUT NOT ALWAYS
  - NEVER PRACTICE SAFER SEX
  - I NEVER HAD SEX WITH A PERSON I KNEW OR SUSPECTED HAD HIV OR ANOTHER STD
  - I PREFER NOT TO ANSWER THIS QUESTION
44. Thinking back about the last time you had sex, were you using alcohol or drugs?
- YES
  - NO
45. In the past 12 months, have you used alcohol to help you feel more comfortable with a sexual partner?
- YES
  - NO
46. In the past 12 months, have you done more sexually than you had planned because you were drinking?
- YES
  - NO



47. In the past 12 months, have you had unprotected sex (not used a condom) because you were drinking?

YES

NO

**SKIP if you have not had a drink in the past 12 months. (Go on to question #49)**

48. In this section, we would like to know about the effects that drinking alcohol has on you. Here is a list of some effects that many people feel after drinking alcohol. Please fill in the oval that describes how much alcohol affects you in each way.

Does alcohol have this effect on you?

Not at all

A little

Some

Very much

	<u>Not at all</u>	<u>A little</u>	<u>Some</u>	<u>Very much</u>
a. Feel less self conscious	0	0	0	0
b. Feel closer to a sexual partner	0	0	0	0
c. Am a better lover	0	0	0	0
d. Am more sexually responsive	0	0	0	0
e. Am less nervous about sex	0	0	0	0
f. Am more self confident	0	0	0	0
g. Become more sexually forward	0	0	0	0
h. Feel less shy	0	0	0	0
i. Get horny (want sex)	0	0	0	0
j. Enjoy sex more	0	0	0	0
k. Have sex with people that I wouldn't have sex with if I had not had a drink	0	0	0	0
l. Am more likely to do something sexually that is risky	0	0	0	0
m. Lose my inhibitions	0	0	0	0

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**SKIP if you have not used drugs in the last year. Go on to question #56**

49. Thinking back about the last time you had sex, were you under the influence of drugs?

YES

NO If no, SKIP to question #52

50. In the last 12 months, have you used drugs to help you feel more comfortable with a sexual partner?

YES

NO

51. Which of the following helped you feel more comfortable? (You may choose more than 1).

	YES	NO																				
Marijuana or Hashish	<input type="radio"/>	<input type="radio"/>																				
Cocaine or Crack	<input type="radio"/>	<input type="radio"/>																				
Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)	<input type="radio"/>	<input type="radio"/>																				
Heroin	<input type="radio"/>	<input type="radio"/>																				
Prescription Opioids (Morphine, Codeine, Vicodin, Percocet, Oxycontin)	<input type="radio"/>	<input type="radio"/>																				
Prescription benzodiazepines (Valium, Deastat, Ativan)	<input type="radio"/>	<input type="radio"/>																				
Other (please specify):	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																					

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52. In the past 12 months, have you done more sexually than you had planned because you were using drugs?

YES

NO If no, SKIP to question #54

53. Which of the following caused you to do more sexually than you had planned (you may choose more than 1).

	YES	NO																				
Marijuana or Hashish	0	0																				
Cocaine or Crack	0	0																				
Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)	0	0																				
Heroin	0	0																				
Prescription Opioids (Morphine, Codeine, Vicodin, Percocet, Oxycontin,)	0	0																				
Prescription benzodiazepines (Valium, Deastat, Ativan)	0	0																				
Other (please specify):	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																					

54. In the past 12 months, have you had unprotected sex (not used a condom) because you were using drugs?

YES

NO If no, SKIP to question #56

MIGHT HAVE





57. During the last 3 months, were you seen in any of the following for these reasons. If yes, please fill in the oval. If no, SKIP to question #58.

	VA	OUTSIDE CARE
a. In a hospital for medical problems	0	0
b. In a hospital for psychological or emotional problems	0	0
c. In a hospital for detoxification	0	0
d. In an outpatient program for alcohol treatment	0	0
e. In an outpatient program for other drug treatment	0	0
f. In a residential program for alcohol treatment	0	0
g. In a residential program for other drug treatment	0	0
h. In a halfway house	0	0
i. In a holding unit; a place where someone can stay while they wait for a bed to open up in a program. (generally no services are provided in the holding unit).	0	0

58. During the last 3 months, did you do any of the following? If yes, please fill in the oval. If no, SKIP to question #60.

	VA	OUTSIDE CARE
a. Go to an Emergency Room for medical care	0	0
b. Fill your prescription medication	0	0
c. Call for Telephone Advice	0	0

59. If you received care outside the VA, what were your reasons? (please fill in the ovals).

- LOCATION
  UNABLE TO GET APPOINTMENT WITH VA CARE  
 INSURANCE
  RELATIONSHIP WITH PROVIDER OUTSIDE THE VA  
 DISSATISFACTION WITH VA CARE
  OTHER REASONS



60. During the last 3 months, did you go to meetings of Alcoholics Anonymous (AA), self-help, mutual-help, or another 12-step program?

	YES	NO
a. For alcohol?	<input type="radio"/>	<input type="radio"/>
b. For drugs?	<input type="radio"/>	<input type="radio"/>

61. During the last 3 months, did you receive counseling for alcohol problems from:

- A PRIEST/MINISTER/RABBI OR OTHER CLERGY
- AN EMPLOYEE ASSISTANCE PROGRAM
- ALCOHOLICS ANONYMOUS
- EMERGENCY ROOM
- OTHER
- DID NOT RECEIVE COUNSELING

62. During the last 3 months, have you taken any medications prescribed by a physician:

	YES	NO
a. To prevent you from drinking.	<input type="radio"/>	<input type="radio"/>
b. To help you detoxify/come off alcohol.	<input type="radio"/>	<input type="radio"/>
c. To help you stabilize or change your use of drugs other than alcohol.	<input type="radio"/>	<input type="radio"/>
d. For your psychological or emotional problems.	<input type="radio"/>	<input type="radio"/>

**Many people have many pills to take at different times during the day and find it hard to always remember their pills. Please tell us what you are doing. Don't worry about telling us that you don't take all your doses. We need to know what is really happening, not what you think we "want to hear." Please fill in the oval for the one response that best describes how you take your medications.**

**If you do not take medications regularly, please SKIP to question #70**

63. In the past 12 months, when you take your prescription medications, how often do you take all the medications you're supposed to?

- NEVER
- SOME OF THE TIME
- ABOUT HALF OF THE TIME
- MOST OF THE TIME
- ALL OF THE TIME



64. In the past 12 months, is there a particular medication that you are more likely to miss than the others?

YES If yes, do any of these reasons explain why?

NO

	YES	NO
I have to take it at an inconvenient time	0	0
I have to worry about taking it with or without food	0	0
I don't like the side effects	0	0
The pill is hard to swallow or tastes bad	0	0

65. Do you ever stop taking your medications for a while or take a "drug holiday" that was not recommended by your doctor?

NEVER

LESS THAN MONTHLY

MONTHLY

WEEKLY

MORE THAN WEEKLY

***If you do stop taking your medications for a while,***

**A. How often is this something you do on purpose?**

NEVER

SOME OF THE TIME

ABOUT HALF OF THE TIME

MOST OF THE TIME

ALL OF THE TIME

**B. How long does it last for?**

- 2 DAYS
- 3 OR 4 DAYS
- BETWEEN 5 AND 7 DAYS
- BETWEEN 1 WEEK AND 1 MONTH
- MORE THAN 1 MONTH

**C. Does it tend to occur around the following times?****WEEKENDS:**

- NEVER
- SOME OF THE TIME
- ABOUT HALF OF THE TIME
- MOST OF THE TIME
- ALL OF THE TIME

**VACATIONS:**

- NEVER
- SOME OF THE TIME
- ABOUT HALF OF THE TIME
- MOST OF THE TIME
- ALL OF THE TIME

**PAYDAYS (WHEN YOU RECEIVE EMPLOYER OR GOVERNMENT CHECKS):**

- NEVER
- SOME OF THE TIME
- ABOUT HALF OF THE TIME
- MOST OF THE TIME
- ALL OF THE TIME

66. Did you miss any of your prescription medications last weekend--(last Saturday or Sunday)?

- YES
- NO

67. When was the last time you missed any of your prescription medications?

- WITHIN THE PAST WEEK
- 1-2 WEEKS AGO
- 2-4 WEEKS AGO
- 1-3 MONTHS AGO
- OVER 3 MONTHS AGO
- NEVER MISSED



68. During the past 4 days, on how many days have you missed taking any of your doses?

- NONE
- ONE DAY
- TWO DAYS
- THREE DAYS
- FOUR DAYS

69. The following questions ask about symptoms you might have had during the past four weeks. Please fill in the oval of the one response that best describes this symptom.

	I DO NOT HAVE THIS SYMPTOM	I HAVE THIS SYMPTOM AND...			
		IT DOESN'T BOTHER ME	IT BOTHERS ME A LITTLE	IT BOTHERS ME	IT BOTHERS ME A LOT
a. Fatigue or loss of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Fevers, chills, or sweats?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Feeling dizzy or light headed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Pain, numbness, or tingling in the hands or feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Trouble remembering?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Nausea or vomiting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Diarrhea or loose bowel movements?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Felt sad, down, or depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Felt nervous or anxious?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Difficulty falling or staying asleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Skin problems, such as rash, dryness, or itching?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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I HAVE THIS SYMPTOM AND...					
	I DO NOT HAVE THIS SYMPTOM	IT DOESN'T BOTHER ME	IT BOTHERS ME A LITTLE	IT BOTHERS ME	IT BOTHERS ME A LOT
l. Cough or trouble catching your breath?	0	0	0	0	0
m. Headache?	0	0	0	0	0
n. Loss of appetite or change in the taste of food?	0	0	0	0	0
o. Bloating, pain, or gas in your stomach?	0	0	0	0	0
p. Muscle aches or joint pain?	0	0	0	0	0
q. Problems with having sex, such as loss of interest or lack of satisfaction?	0	0	0	0	0
r. Changes in the way your body looks, such as fat deposits or weight gain?	0	0	0	0	0
s. Problems with weight loss or wasting?	0	0	0	0	0
t. Hair loss or changes in the way your hair looks?	0	0	0	0	0

70. Do you think your symptoms are caused by drugs you take to treat medical conditions?

YES

NO

UNSURE

71. Do you think your symptoms are caused by drinking alcohol?

YES

NO

UNSURE



72. During the past year, how often did you attend religious services?

- NEVER
- LESS THAN TWICE A YEAR
- SEVERAL TIMES A YEAR
- ABOUT ONCE A MONTH
- TWO TO THREE TIMES A MONTH
- EVERY WEEK
- SEVERAL TIMES A WEEK
- EVERYDAY

73. How frequently do you pray?

- NEVER
- LESS THAN TWICE A YEAR
- SEVERAL TIMES A YEAR
- ABOUT ONCE A MONTH
- TWO TO THREE TIMES A MONTH
- EVERY WEEK
- SEVERAL TIMES A WEEK
- EVERYDAY

74. How important is religion to you?

- VERY IMPORTANT
- IMPORTANT
- SOMEWHAT IMPORTANT
- NOT VERY IMPORTANT
- NOT AT ALL IMPORTANT

75. In the last 12 months, when you have problems or difficulties in your life, how often do you seek spiritual comfort and support?

- ALMOST ALWAYS
- OFTEN
- SOMETIMES
- RARELY
- NEVER



76. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
a. Little interest or pleasure in doing things	0	0	0	0
b. Feeling down, depressed, or hopeless	0	0	0	0
c. Trouble falling/staying asleep, sleeping too much	0	0	0	0
d. Feeling tired or having little energy	0	0	0	0
e. Poor appetite or overeating	0	0	0	0
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	0	0	0
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	0	0	0
h. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	0	0	0
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	0	0	0

77. If you checked off any problem listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

NOT DIFFICULT AT ALL

SOMEWHAT DIFFICULT

VERY DIFFICULT

EXTREMELY DIFFICULT



78. These questions are about any physical limitations you might have. For these activities, please indicate which response best describes you by filling in the oval under the appropriate response after each statement

	YES, I CAN DO THIS	YES, BUT ONLY SLOWLY	NO, I CANNOT DO THIS
a. Can you do heavy work at home, like scrubbing floors, lifting or moving heavy furniture?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Can you do moderate work at home like moving a chair or table, or pushing a vacuum cleaner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Can you do light work around the house like dusting or washing dishes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. If you want to, can you participate in active sports such as swimming, tennis, basketball, volleyball or rowing a boat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. If you want to, can you run a short distance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Can you walk uphill or upstairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Can you walk a block or more?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Can you walk around inside the house?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Can you walk to a table for meals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Can you dress yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Can you eat without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Can you use the bathroom without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer each question by filling in the oval. If you are unsure about how to answer, please try your best.

79. In general, would you say your health is:

EXCELLENT

VERY GOOD

GOOD

FAIR

POOR



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?

	YES, LIMITED A LOT	YES, LIMITED A LITTLE	NO, NOT LIMITED AT ALL
80. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	0	0	0
81. Climbing several flights of stairs	0	0	0

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

82. Accomplished less than you would like

YES

NO

83. Were limited in the kind of work or other activities

YES

NO

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)?

84. Accomplished less than you would like

YES

NO

85. Didn't do work or other activities as carefully as usual

YES

NO



86. 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. How much of the time during the past 4 weeks -

	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
87. Have you felt downhearted and blue?	0	0	0	0	0	0
88. Did you have a lot of energy?	0	0	0	0	0	0
89. Have you felt calm and peaceful?	0	0	0	0	0	0

90. 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

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91. In the past 12 months, what is your annual household income?

- LESS THAN \$6,000
- \$6,000 TO \$11,999
- \$12,000 TO \$24,999
- \$25,000 TO \$49,999
- OVER \$50,000

92. In the past 12 months, how many persons live in your household (including yourself)?

--	--

93. Are you currently...(mark all that apply)

- EMPLOYED FOR WAGES
- SELF - EMPLOYED
- LOOKING FOR WORK AND UNEMPLOYED FOR MORE THAN ONE YEAR
- LOOKING FOR WORK AND UNEMPLOYED FOR LESS THAN ONE YEAR
- HOMEMAKER
- STUDENT
- RETIRED
- UNABLE TO WORK

94. What is your current marital status?

- MARRIED
- DIVORCED
- SEPARATED
- WIDOWED
- NEVER MARRIED
- LIVING WITH PARTNER

**Thank you for completing our questionnaire.  
Please return this to the Survey coordinator who gave it to you.**