Public reporting burden for this collection of information is estimated to average 03 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2 - Acculturation Questionnaire

ID NUMBER:									FORM CODE: ACE VERSION: 1, 9/10/2014	Contact Occasion	0	2	SEQ #		

Administrative Information

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) 0b. Staff ID: ☐☐☐

***Instructions**: Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

A. Acculturation

Although you may speak many languages, the following questions refer to only English and Spanish.

1. In general, what language(s) do you read and speak?
   - Only Spanish 1 ☐
   - Spanish better than English 2 ☐
   - Both equally 3 ☐
   - English better than Spanish 4 ☐
   - Only English 5 ☐

2. What was the language(s) you used as a child?
   - Only Spanish 1 ☐
   - More Spanish than English 2 ☐
   - Both equally 3 ☐
   - More English than Spanish 4 ☐
   - Only English 5 ☐

3. What language(s) do you usually speak at home?
   - Only Spanish 1 ☐
   - More Spanish than English 2 ☐
   - Both equally 3 ☐
   - More English than Spanish 4 ☐
   - Only English 5 ☐

4. In which language(s) do you usually think?
   - Only Spanish 1 ☐
   - More Spanish than English 2 ☐
   - Both equally 3 ☐
   - More English than Spanish 4 ☐
   - Only English 5 ☐

5. What language(s) do you usually speak with your friends?
   - Only Spanish 1 ☐
   - More Spanish than English 2 ☐
   - Both equally 3 ☐
   - More English than Spanish 4 ☐
   - Only English 5 ☐

6. In general, what language(s) are the movies, T.V. and radio programs you prefer to watch and listen to?
   - Only Spanish 1 ☐
   - More Spanish than English 2 ☐
   - Both equally 3 ☐
   - More English than Spanish 4 ☐
   - Only English 5 ☐

7. Your close friends are…
   - All Hispanic/Latino 1 ☐
   - More Hispanic/Latino than non-Hispanic/non-Latino 2 ☐
   - About half and half 3 ☐
   - More non-Hispanic/non-Latino than Hispanic/Latino 4 ☐
   - All non-Hispanic/non-Latino 5 ☐

8. You prefer going to social gatherings/parties at which people are…
   - All Hispanic/Latino 1 ☐
   - More Hispanic/Latino than non-Hispanic/non-Latino 2 ☐
   - About half and half 3 ☐
   - More non-Hispanic/non-Latino than Hispanic/Latino 4 ☐
   - All non-Hispanic/non-Latino 5 ☐

9. The persons you visit or who visit you are…
   - All Hispanic/Latino 1 ☐
   - More Hispanic/Latino than non-Hispanic/non-Latino 2 ☐
   - About half and half 3 ☐
   - More non-Hispanic/non-Latino than Hispanic/Latino 4 ☐
   - All non-Hispanic/non-Latino 5 ☐

10. If you could choose your children's friends you would want them to be…
   - All Hispanic/Latino 1 ☐
   - More Hispanic/Latino than non-Hispanic/non-Latino 2 ☐
   - About half and half 3 ☐
   - More non-Hispanic/non-Latino than Hispanic/Latino 4 ☐
   - All non-Hispanic/non-Latino 5 ☐

B. Visits to Country of Origin

11. In the past year, how many separate times have you returned to your country of origin/your family's country of origin?

   ☐☐☐ Times (if=000, End Questionnaire)

12. Across all visits in the past year, for approximately how long did you stay in your country of origin/your family's country of origin?

   12.a. ☐☐☐ number Of: 12.a1. Days 1 ☐

   Months 3 ☐

Public reporting burden for this collection of information is estimated to average 03 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2 Alcohol Use Questionnaire

ID NUMBER:									FORM CODE: ALE VERSION: 1, 8/22/2014	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) 0b. Staff ID: ☐☐☐

Instructions: *Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

The next questions are about alcoholic beverages. Serving sizes for alcohol use in "standard drink" units are as follows: Beer = 12oz. glass or 355ml bottle; Wine = 5 oz glass, 1 bottle =750ml= 5 glasses; Hard spirits = 1.5oz. or 1 shot.

1. Do you presently drink alcoholic beverages?
   - No 0 ☐ → **GO TO QUESTION 7**
   - Yes 1 ☐

2. How many glasses of red wine do you usually have per week?
   ☐☐ *(if less than 1 per week enter "00")*

3. How many glasses of white wine do you usually have per week?
   ☐☐ *(if less than 1 per week enter "00")*

4. How many cans, bottles, or glasses of beer do you usually have per week? Beer includes more traditional beverages such as pulque and chicha.
   ☐☐ *(if less than 1 per week enter "00")*

5. How many drinks of liquor, spirits, or mixed drinks do you usually have per week? Spirits includes liquor such as whiskey, vodka, tequila, rum, and mixed drinks such as martinis, as well as more traditional beverages such as aguardiente and cañita. (1 serving = 1.5 oz or 1 shot)
   ☐☐ *(if less than 1 per week enter "00")*

6. How often did you have 4 or more drinks [for females] and 5 or more drinks [for males] containing any kind of alcohol within a two-hour period? *(Mark only one)*
   - Every day 1 ☐
   - 5 to 6 days a week 2 ☐
   - 3 to 4 days a week 3 ☐
   - 2 days a week 4 ☐
   - 1 day a week 5 ☐
   - 2 to 3 days a month 6 ☐
   - 1 day a month 7 ☐
   - Less than once a month 8 ☐
   - Never 9 ☐

E n d o f Q u e s t i o n n a i r e

7. Did you ever drink alcohol? No 0 ☐ → **END OF QUESTIONNAIRE**
Yes 1 ☐

8. About how long ago did you stop drinking alcohol? *(Mark only one)*
Less than 1 year ago 1 ☐
1 - 2 years ago 2 ☐
More than 2 years ago 3 ☐

9. Did you stop drinking alcohol for health reasons?
No 0 ☐
Yes 1 ☐

10. Did you stop drinking alcohol on the advice of a doctor (or health worker)?
No 0 ☐
Yes 1 ☐

Public reporting burden for this collection of information is estimated to average 7 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Anthropometry

ID NUMBER:									FORM CODE: ANT VERSION: 1, 06/27/2014	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

0b. Staff ID: ☐☐☐

***Instructions**: Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices. In order to measure bioimpedence, the participant must be barefoot. Set the Tanita analyzer to report metric units (cm/kg).*

A. DETERMINATION OF ABILITY TO STAND

1. Assessment of ability to stand (choose one): .... ☐
   - Can stand erectly on both feet. 1
   - Can stand on both feet, but posture not erect. 2
   - Cannot stand on both feet. .... 3 → **GO TO ITEM 10**

B. HEIGHT, WEIGHT, and BIO-IMPEDENCE

2. Standing height (round to nearest cm): .... ☐☐☐ cm
3. a) Self-reported weight (to the nearest lb or kg): .... ☐☐☐

   b) Units (check one): .... ☐ lb ☐ kg
4. Weight: .... ☐☐☐.☐ kg
5. Fat (%): .... ☐☐.☐ %
6. Impedance: .... ☐☐☐ Ohms
7. Fat mass: .... ☐☐☐.☐ kg
8. Lean body mass (FFM): .... ☐☐☐.☐ kg
9. Total body water (TBW): .... ☐☐☐.☐ kg

C. BODY SIZE

10. Girth (round to nearest cm)

    a) Waist: .... ☐☐☐ cm

    b) Hip: .... ☐☐☐ cm

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2 Family Cohesion

ID NUMBER:									FORM CODE: FCE VERSION: 1, 9/15/2014	Contact Occasion	0	2	SEQ #		

Administrative Information

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)   0b. Staff ID: ☐☐☐

Instructions: *Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

A. Family Cohesion

The following are statements about families. You are to decide which of these statements are true of your family and which are false. If you think the statement is True or mostly True of your family, please respond True. If you think the statement is False or mostly False of your family, please respond False. You may feel that some of the statements are true for some family members and false for others. Respond True if the statement is true for most members. Respond False if the statement is false for most members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly. Remember, we would like to know what your family seems like to you. So do not try to figure out how other members see your family, but do give us your general impression of your family for each statement.

	False	True
1. Family members really help and support one another.	0 ☐	1 ☐
2. We often seem to be killing time at home.	0 ☐	1 ☐
3. We put a lot of energy into what we do at home.	0 ☐	1 ☐
4. There is a feeling of togetherness in our family.	0 ☐	1 ☐
5. We rarely volunteer when something has to be done at home.	0 ☐	1 ☐
6. Family members really back each other up.	0 ☐	1 ☐
7. There is very little group spirit in our family.	0 ☐	1 ☐
8. We really get along well with each other.	0 ☐	1 ☐
9. There is plenty of time and attention for everyone in our family.	0 ☐	1 ☐

[The Family Cohesion questions are part of the Family Environment Scale© developed by B.S. Moos and R.H. Moos used by permission of the authors as licensed by Mind Garden, Inc. No unauthorized reproduction of these materials is permitted.]

B. Household Composition

***(Note –U.S. Census** definition in English and Spanish is included in the QxQ for reference if needed.)*

10. Including yourself, how many people are currently (in terms of the last month) living in your household?

☐☐ (If one**, END QUESTIONNAIRE**)

Could you please list each of the people who are currently living in your household. You don't need to tell me their names, just their relationship to you.

[Interviewer:** For questions 10a-10i select the option that matches the relationship from the list below.**]

1=Spouse	6=Sibling	10=Son-in-Law	14=Other
2=Daughter	7=Cousin	11=Daughter-in-Law	
3=Son	8=Niece	12=Mother-in-Law	
4=Mother	9=Nephew	13=Father-in-Law	
5=Father			

a. Relationship 1: ☐☐ a1. Age ☐☐ a2. If other, please Specify: ____________________

b. Relationship 2: ☐☐ b1. Age ☐☐ b2. If other, please Specify: ____________________

c. Relationship 3: ☐☐ c1. Age ☐☐ c2. If other, please Specify: ____________________

d. Relationship 4: ☐☐ d1. Age ☐☐ d2. If other, please Specify: ____________________

e. Relationship 5: ☐☐ e1. Age ☐☐ e2. If other, please Specify: ____________________

f. Relationship 6: ☐☐ f1. Age ☐☐ f2. If other, please Specify: ____________________

g. Relationship 7: ☐☐ g1. Age ☐☐ g2. If other, please Specify: ____________________

h. Relationship 8: ☐☐ h1. Age ☐☐ h2. If other, please Specify: ____________________

i. Relationship 9: ☐☐ i1. Age ☐☐ i2. If other, please Specify: ____________________

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OMB#: 0925-0584
Exp. 08/31/2017

HCHS/SOL- Visit 2- Health Care Questionnaire

ID NUMBER:									FORM CODE: HCE VERSION: 1, 11/20/2014	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

0c. Participant Gender: ☐ (1=Male, 2=Female) 0d. Age: ☐☐

0e. Does the participant have diabetes? ☐ (0=No, 1=Yes)

Instructions: *Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc for those questions that do not list these values as possible answer choices.*

A. This first block of questions [Q1-8a] is about health care sought and received in the preceding 12 months.

Next I will ask questions about health care, the type of care you may have received recently and where you received care. Some of these questions refer to different medical care given to women and to men. Can I proceed to ask these questions?

1. In the past 12 months, did you receive any health care? (Select only one.)

No 0 ☐ GO TO QUESTION 5
Yes 1 ☐
Refused 8 ☐ GO TO QUESTION 5
Don't Know/ Not Sure 9 ☐ GO TO QUESTION 5

2. What was the reason for seeking health care? (Select all that apply.)

	No	Yes
a. Annual check-up and/or preventive care	0 ☐	1 ☐
b. Pregnancy-related care	0 ☐	1 ☐
c. Acute care (sudden illness not requiring going to the emergency room)	0 ☐	1 ☐
d. Injury or accident	0 ☐	1 ☐
e. Emergency care	0 ☐	1 ☐
f. Chronic or regular care of a disease (e.g. diabetes, hypertension, cancer, asthma)	0 ☐	1 ☐
g. Obtaining a prescription or filling prescriptions	0 ☐	1 ☐
h. Hospitalization	0 ☐	1 ☐
i. Other	0 ☐	1 ☐
i.1. (Specify: _______________)		
j. Refused	0 ☐	1 ☐
k. Don't know/Not Sure	0 ☐	1 ☐

3. In the past 12 months, where did you receive your medical care?	All the time	Most of the time	Some of the time	None of the time
a. In the United States mainland	1 ☐	2 ☐	3 ☐	4 ☐
b. In Puerto Rico	1 ☐	2 ☐	3 ☐	4 ☐
c. In Mexico	1 ☐	2 ☐	3 ☐	4 ☐
d. In Canada	1 ☐	2 ☐	3 ☐	4 ☐
e. In another country not mentioned above	1 ☐	2 ☐	3 ☐	4 ☐

e.1. Specify:________________

4. In the past 12 months, where did you receive your dental care?	All the time	Most of the time	Some of the time	None of the time
a. In the United States mainland	1 ☐	2 ☐	3 ☐	4 ☐
b. In Puerto Rico	1 ☐	2 ☐	3 ☐	4 ☐
c. In Mexico	1 ☐	2 ☐	3 ☐	4 ☐
d. In Canada	1 ☐	2 ☐	3 ☐	4 ☐
e. In another country not mentioned above	1 ☐	2 ☐	3 ☐	4 ☐

e.1. Specify:________________

5. In the past 12 months, was there a time when you needed health care, but could not get it? (Select only one.)

- No 0 ☐ GO TO QUESTION 9
- Yes 1 ☐
- Refused 8 ☐ GO TO QUESTION 9
- Don't Know/ Not Sure 9 ☐

6. In the past 12 months, were you unable to get any of the following due to financial reasons? (Select all that apply.)	**No**	**Yes**
a. Prescription medications	0 ☐	1 ☐
b. To go to see a general health care professional	0 ☐	1 ☐
c. To go to see a specialist	0 ☐	1 ☐
d. Surgical procedure	0 ☐	1 ☐
e. Clinical procedure	0 ☐	1 ☐
f. Behavioral therapy, stress management/counseling/mental health services	0 ☐	1 ☐
g. Dental care	0 ☐	1 ☐
h. Eyeglasses	0 ☐	1 ☐
i. I had difficulty getting or affording other service(s)	0 ☐	1 ☐
i.1. Specify:________________		
j. Refused	0 ☐	1 ☐
k. Don't know/Not Sure	0 ☐	1 ☐

7. In the past 12 months, how many times did you go to an acute or urgent care center, or emergency room to get care for yourself?

☐☐ Number of times   If = 0, GO TO QUESTION 8

a. How many of these visits took place in the U.S. mainland? (Select only one.)

All 1 ☐
Most 2 ☐
Some 3 ☐
None 4 ☐

8. In the past 12 months, not counting times you went to an emergency room or urgent care facility, how many times did you go to a doctor, nurse or other health professional to get care for yourself for any reason?

☐☐ Number of times   If = 0, GO TO QUESTION 9

a. How many of these visits took place in the U.S. mainland? (Select only one.)

All 1 ☐
Most 2 ☐
Some 3 ☐
None 4 ☐

B. This second block of questions [Q9-12] is about routine medical care.

9. Do you have one person you think of as your personal doctor or health care provider? (Select only one.)

No 0 ☐
Yes, only one 1 ☐
More than one 2 ☐
Refused 8 ☐
Don’t know/Not Sure 9 ☐

10. What kind of place do you USUALLY go to when you need routine or preventive care, such as a physical examination or check-up? (Select all that apply.)

	No	**Yes**
a. Doesn't get preventive or routine care anywhere	0 ☐	1 ☐
b. Doesn't go to one place most often	0 ☐	1 ☐
c. Hospital emergency room	0 ☐	1 ☐

[If “Yes” to 10.a., 10.b., **or** 10.c., then GO TO QUESTION 12]

11. *[**Interviewer**: If "No" to 10.a., 10.b., **and** 10.c., then select all that apply from the choices below:]*

	No	Yes
a. Clinic or health center	0 ☐	1 ☐
b. Doctor's office or HMO	0 ☐	1 ☐
c. Hospital outpatient department	0 ☐	1 ☐
d. Some other place	0 ☐	1 ☐

11.d.1. Specify: ____________________

[GO TO QUESTION 13]

12. Why don't you have a usual source of medical care? (Select all that apply.)	No	Yes
a. Doesn't need a doctor/Haven't had any problems	0 ☐	1 ☐
b. Doesn't like/trust/believe in doctors	0 ☐	1 ☐
c. Doesn't know where to go	0 ☐	1 ☐
d. Previous doctor is not available/moved	0 ☐	1 ☐
e. Too expensive/no insurance/cost	0 ☐	1 ☐
f. Speak a different language	0 ☐	1 ☐
g. No care available/Care too far away, not convenient	0 ☐	1 ☐
h. Put it off/Didn't get around to it	0 ☐	1 ☐
i. Other	0 ☐	1 ☐
i.1. Specify ______________________________		
j. Refused	0 ☐	1 ☐
k. Don't know/Not Sure	0 ☐	1 ☐

C. **This third block of questions [Q13-30] is about utilization of screening and preventive services, and chronic care.** [Some of the questions will be asked to all participants, whereas others will be asked to participants of specific age, gender or who have specific chronic diseases.]

13. [**All participants**] About how long has it been since you had a routine check-up by a doctor or other health professional? (Select only one.)

Within past year [anytime less than 12 months ago]	1 ☐
Within past 2 years [1 year but less than 2 years ago]	2 ☐
Within past 3 years [2 years but less than 3 years ago]	3 ☐
Within past 5 years [3 years but less than 5 years ago]	4 ☐
5 or more years ago	5 ☐
Never	6 ☐
Refused	8 ☐
Don't know/Not Sure	9 ☐

14. [**All participants**] About how long has it been since you had a flu vaccination (shot or nasal spray)? (Select only one.)

Within past year [anytime less than 12 months ago] 1 ☐
Within past 2 years [1 year but less than 2 years ago] 2 ☐
Within past 3 years [2 years but less than 3 years ago] 3 ☐
Within past 5 years [3 years but less than 5 years ago] 4 ☐
5 or more years ago 5 ☐
Never 6 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

15. [**All participants**] A pneumonia shot or pneumococcal vaccine (Pneumovax®, Pnu-Imune ®) 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? (Select only one.)

No 0 ☐
Yes 1 ☐
Refused 8 ☐
Don't Know/ Not Sure 9 ☐

16. [**All participants**] About how long has it been since you received the tetanus vaccine for adults (booster)? (Select only one.)

Within past year [anytime less than 12 months ago] 1 ☐
Within past 2 years [1 year but less than 2 years ago] 2 ☐
Within past 3 years [2 years but less than 3 years ago] 3 ☐
Within past 5 years [3 years but less than 5 years ago] 4 ☐
5 or more years ago 5 ☐
Never 6 ☐ GO TO QUESTION 17
Refused 8 ☐ GO TO QUESTION 17
Don't know/Not Sure 9 ☐ GO TO QUESTION 17

a. If you have received the tetanus vaccine, was that tetanus vaccine combined with the pertussis or whooping cough vaccine? (Select only one.)

Yes, received the tetanus vaccine combined with the pertussis or whooping cough vaccine. 1 ☐
Received the tetanus vaccine, but it was not combined with the pertussis vaccine. 2 ☐
Received the tetanus vaccine, but do not know what type. 3 ☐

17. [**All participants**] About how long has it been since you had your vision checked (ability to see) by a doctor or an optometrist? (Select only one.)

Not medically indicated 0 ☐
Within past year [anytime less than 12 months ago] 1 ☐
Within past 2 years [1 year but less than 2 years ago] 2 ☐
Within past 3 years [2 years but less than 3 years ago] 3 ☐
Within past 5 years [3 years but less than 5 years ago] 4 ☐
5 or more years ago 5 ☐
Never 6 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

18. [**All participants**] Has a doctor or other health professional EVER told you to take a low-dose aspirin every day or every other day to prevent or control heart disease? (Select only one.)

No 0 ☐ GO TO QUESTION 19
Yes 1 ☐
Refused 8 ☐ GO TO QUESTION 19
Don't know/Not Sure 9 ☐ GO TO QUESTION 19

a. Are you NOW following this advice?

No 0 ☐
Yes 1 ☐
No, because I do not tolerate aspirin or have experienced an adverse reaction to it 2 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

19. [**All Participants**] Have you EVER had a test to detect colorectal cancer (cancer of the colon, large intestine and rectum)? (Select only one.)

No 0 ☐ GO TO QUESTION 20
Yes 1 ☐
Refused 8 ☐ GO TO QUESTION 20
Don't know/Not Sure 9 ☐

a. If "yes" or "not sure", what test?

a.1. Kit to detect occult blood or DNA in your stool?

No 0 ☐ GO TO QUESTION 19.a.2.
Yes 1 ☐

a.1.a. Date of test: ☐☐/☐☐/☐☐☐☐ (approximate date or year)

a.2. Sigmoidoscopy?

No 0 ☐ GO TO QUESTION 19.a.3.

Yes 1 ☐

a.2.a. Date of test:

☐☐/☐☐/☐☐☐☐ (approximate date or year)

a.3. Colonoscopy?

No 0 ☐ GO TO QUESTION 20

Yes 1 ☐

a.3.a. Date of test: ☐☐/☐☐/☐☐☐☐ (approximate date or year)

20. **[All participants]** Have you EVER had a human papilloma virus (HPV) vaccination? (Select only one.)

No 0 ☐ Women GO TO QUESTION 21
Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

Yes 1 ☐

Not recommended by a doctor or health professional 2 ☐ Women GO TO QUESTION 21
Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

Refused 8 ☐ Women GO TO QUESTION 21
Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

Don't know/Not Sure 9 ☐ Women GO TO QUESTION 21
Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

a. How many HPV shots did you receive?

☐☐ Number of shots

Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

21. **[Women only]** How long has it been since you had your last mammogram? (Select only one.)

Not medically indicated 0 ☐

Within past year [anytime less than 12 months ago] 1 ☐

Within past 2 years [1 year but less than 2 years ago] 2 ☐

Within past 3 years [2 years but less than 3 years ago] 3 ☐

Within past 5 years [3 years but less than 5 years ago] 4 ☐

5 or more years ago 5 ☐

Never 6 ☐

Refused 8 ☐

Don't know/Not Sure 9 ☐

22. **[Women only]** How long has it been since you had your last Pap test (test of cancer of the cervix)? (Select only one.)

Not medically indicated 0 ☐
Within past year [anytime less than 12 months ago] 1 ☐
Within past 2 years [1 year but less than 2 years ago] 2 ☐
Within past 3 years [2 years but less than 3 years ago] 3 ☐
Within past 5 years [3 years but less than 5 years ago] 4 ☐
5 or more years ago 5 ☐
Never 6 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

23. **[Women aged 65 years and older]** Have you EVER had a test to detect osteoporosis (low density of the bones)? (Select only one.)

No 0 ☐ Women with diabetes GO TO QUESTION 24
Women without diabetes GO TO QUESTION 31
Yes 1 ☐ Women with diabetes GO TO QUESTION 24
Women without diabetes GO TO QUESTION 31
Refused 8 ☐ Women with diabetes GO TO QUESTION 24
Women without diabetes GO TO QUESTION 31
Don't know/Not Sure 9 ☐ Women with diabetes GO TO QUESTION 24
Women without diabetes GO TO QUESTION 31

24. **[Participants with diabetes]** About how long has it been since you had your eyes checked, in which your pupils were dilated, to determine whether diabetes has affected your retina (the inner layer inside your eyes)? (Select only one.)

Not medically indicated 0 ☐
Within past year [anytime less than 12 months ago] 1 ☐
Within past 2 years [1 year but less than 2 years ago] 2 ☐
Within past 3 years [2 years but less than 3 years ago] 3 ☐
Within past 5 years [3 years but less than 5 years ago] 4 ☐
5 or more years ago 5 ☐
Never 6 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

25. **[Participants with diabetes]** About how long has it been since you had a urine test done to determine whether diabetes has affected your kidneys? (Select only one.)

Not medically indicated (or dialysis) 0 ☐
Within past year [anytime less than 12 months ago] 1 ☐
Within past 2 years [1 year but less than 2 years ago] 2 ☐
Within past 3 years [2 years but less than 3 years ago] 3 ☐
Within past 5 years [3 years but less than 5 years ago] 4 ☐
5 or more years ago 5 ☐
Never 6 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

26. **[Participants with diabetes]** In the past 12 months, have you, a family member, or a friend checked your feet for any sores or lesions? (Select only one.)

Never 3 ☐ GO TO QUESTION 27
Yes 1 ☐
Has no feet 2 ☐ GO TO QUESTION 28
Refused 8 ☐ GO TO QUESTION 27
Don't know/Not Sure 9 ☐ GO TO QUESTION 27

a. If yes, how often have you checked your feet for any sores or lesions? Include times when checked by the participant, a family member, or friend, but do NOT include times when checked by a health professional. (Select only one.)

Every day 1 ☐
Three or four times per week 2 ☐
Once a week 3 ☐
Once or twice a month 4 ☐

27. **[Participants with diabetes]** In the past 12 months, did a doctor, nurse, or other health professional check your feet for sores or lesions? (Select only one.)

Never 3 ☐ GO TO QUESTION 28
Yes 1 ☐
Refused 8 ☐ GO TO QUESTION 28
Don't know/Not Sure 9 ☐ GO TO QUESTION 28

a. If yes, about how many times? ☐☐ Number of times

28. **[Participants with diabetes]** Do you, a family member, or friend check your blood glucose (sugar)? (Select only one).

Never 3 ☐ GO TO QUESTION 29
Yes 1 ☐
Refused 8 ☐ GO TO QUESTION 29
Don't know/Not Sure 9 ☐ GO TO QUESTION 29

a. If yes, how often have you checked your blood glucose (sugar)? Include the times when checked by the participant, family member, or friend, but do NOT include times when checked by a health professional. (Select answer according to the protocol.)

a1.	☐☐	times per day	GO TO QUESTION 28.a.2
a2.	☐☐	number of days per week	If =00, GO TO QUESTION 28.a.3 If >00, GO TO QUESTION 29
a3.	☐☐	number of days per month	GO TO QUESTION 29

29. **[Participants with diabetes]** A test for hemoglobin A1c measures the average blood glucose (sugar in the blood) level in the previous 3 months. In the past 12 months, has a physician, a nurse or other health professional checked your hemoglobin A1c? (Select only one.)

No 0 ☐ GO TO QUESTION 31
Yes 1 ☐
Had never heard of the hemoglobin A1c test 3 ☐ GO TO QUESTION 31
Refused 8 ☐ GO TO QUESTION 31
Don't know/Not Sure 9 ☐ GO TO QUESTION 31

a. If yes, how many times? ☐☐ GO TO QUESTION 30

30. **[Participants with diabetes]** Do you know your hemoglobin A1c level? (Select only one)

No 0 ☐
Yes 1 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

D. This next block of questions [Q31-38] is about health insurance.

31. Do you have health insurance or health care coverage? (Select only one.)

No 0 ☐ GO TO QUESTION 36
Yes 1 ☐
Refused 8 ☐ GO TO QUESTION 36
Don't know/Not Sure 9 ☐

32. Are you CURRENTLY covered by any of the following types of health insurance or health coverage plans? *(Mark "Yes" or "No" for EACH type of coverage in items a – h.)*

		No	Yes
a.	Insurance through your current or former employer or union (or employer of your spouse, partner, or another family member)	0 ☐	1 ☐
b.	Insurance purchased directly from an insurance company (by you or another family member)	0 ☐	1 ☐
c.	Medicare, for people 65 and older, or people with certain disabilities	0 ☐	1 ☐
d.	Medicaid, Medi-Cal, or any kind of government-assistance plan for those with low income or a disability	0 ☐	1 ☐
e.	Veterans Administration (VA) (including those who have ever used or enrolled for VA health care)	0 ☐	1 ☐
f.	TRICARE, CHAMPUS or other military health care plan	0 ☐	1 ☐
g.	Indian Health Service	0 ☐	1 ☐
h.	Any other type of health insurance or health coverage plan	0 ☐	1 ☐
	h.1. Specify________________________________		
i.	Refused	0 ☐	1 ☐
j.	Don't know/Not Sure	0 ☐	1 ☐

33. The health reform law (commonly known as the Affordable Care Act or "Obamacare") establishes new federal and state marketplaces (also called exchanges) where the uninsured and workers in small businesses can go to purchase insurance. Have you acquired coverage through one of these new marketplaces (Covered California; nystateofhealth.ny.org; HealthCare.gov; CuidadodeSalud.gov)? (Select only one.)

No 0 ☐
Yes 1 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

34. <u>In the past 12 months</u>, have you received coverage for medical expenses through Emergency Medicaid? (Select only one.)

No 0 ☐
Yes 1 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

35. A catastrophic health insurance plan covers 3 annual primary care visits, and only provides coverage for medical expenses after the individual pays thousands of dollars (for example, the first $6,000 or more in medical expenses). <u>In the past 12 months,</u> have you purchased a catastrophic health insurance plan? [Note to the interviewers: Catastrophic health plans cover persons younger than age 30 years.] (Select only one.)

No	0 ☐	GO TO QUESTION 39
Yes	1 ☐	GO TO QUESTION 39
Refused	8 ☐	GO TO QUESTION 39
Don't know/Not Sure	9 ☐	GO TO QUESTION 39

36. About how long has it been since you last had health insurance coverage? (Select only one.)

6 months or less	1 ☐
More than 6 months, but not more than 1 year	2 ☐
More than 1 year, but not more than 3 years	3 ☐
More than 3 years	4 ☐
Never had insurance	5 ☐
Refused	8 ☐
Don't know/Not Sure	9 ☐

37. What are the main reasons you do not currently have health insurance? Check all that apply.

		No	**Yes**
a.	It is too expensive/ the cost is too high	0 ☐	1 ☐
b.	I am not eligible for coverage through my employer	0 ☐	1 ☐
c.	My employer (or the employer of my spouse, partner, or another relative) does not offer insurance coverage	0 ☐	1 ☐
d.	I was denied insurance coverage due to a previous medical condition	0 ☐	1 ☐
e.	I am not eligible for Medicaid/Medi-Cal or have recently lost my Medicaid/Medi-Cal coverage	0 ☐	1 ☐
f.	I lost the ability to purchase health insurance coverage through my spouse, partner or other relative	0 ☐	1 ☐
g.	I am not eligible for premium tax credits or other tax credits	0 ☐	1 ☐
h.	I am not eligible due to my citizenship status	0 ☐	1 ☐
i.	I don’t need insurance	0 ☐	1 ☐
j.	I don’t know how to get insurance	0 ☐	1 ☐
k.	Other k.1. Specify: ___________________________________	0 ☐	1 ☐
l.	Refused	0 ☐	1 ☐
m.	Don't know/Not Sure	0 ☐	1 ☐

38. In the past 12 months, have you received coverage for medical expenses through Emergency Medicaid? (Select only one).

No 0 ☐
Yes 1 ☐
Refused 8 ☐
Don't know/Not Sure 9 ☐

E. The following block of questions [Q39-41] is about place of birth and citizenship status.

In this last section of the questionnaire I will ask you some questions about your place of birth and citizenship status. Some people find these questions to be sensitive or private in nature. Some persons do not feel comfortable answering them. You may choose to answer some of them, or not answer them at all. We, the SOL team, respect your decision. If you choose to NOT answer some or any of the questions, we want to assure you that your participation in the study or any referrals that have been scheduled for you WILL NOT be affected. We will keep your answers confidential. We will block your answers so no one outside of the study will be able to see them.

These questions will be asked to all participants.

39. Where were you born? (Select only one.)

In the U.S. 1 ☐
Specify State or territory: ____________________
Outside of the U.S. 2 ☐
Specify country____________________
Specify province or state ____________________
Specify city or town____________________

40. Are you a U.S. citizen? (Select only one).

No, not a U.S. citizen 0 ☐
Yes, was born in the United States 1 ☐ End Questionnaire
Yes, was born in Puerto Rico, Guam, the U.S. Virgin Islands, or Northern Marianas 2 ☐ End Questionnaire
Yes, was born abroad to a U.S. citizen parent or parents 3 ☐ End Questionnaire
Yes, is a citizen by naturalization 4 ☐ End Questionnaire
Specify year: ____________________
Refused 8 ☐ End Questionnaire
Don’t know/Not Sure 9 ☐ End Questionnaire

41. If the previous answer is “No”, which of the following situations describes you best? (Select only one)

Permanent resident card holder (“Green card” holder)	1 ☐
Have applied for a “Green card”	2 ☐
Holder of another type of visa	3 ☐
Specify: ____________________________	
None of the above	4 ☐
Refused	8 ☐
Don’t know/Not Sure	9 ☐

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2- Personal Medical History

ID NUMBER:	☐☐☐☐☐☐☐☐	FORM CODE: MHE VERSION: 1, 9/1/2014	Contact Occasion	0 2	SEQ #	☐☐

ADMINISTRATIVE INFORMATION [SYSTEM PRE-FILLED]

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

0c. Participant Gender: ☐ (1=Male; 2=Female,) 0d.Age: ☐☐

Instructions: *Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

Introduction: *Next I would like to update our records for any health issues you may have experienced. Some are questions we asked before, but we want to make sure we don't miss anything.*

I will ask you some questions that may make you feel uncomfortable. You may not feel like answering them completely or at all. Please, take your time to think through your answers. We want to understand these aspects of your health, and at the same time we want you to feel respected and comfortable. You are important to us, and your participation in the study is extremely valuable.

A. Since the first SOL visit, has a doctor said that you had any of the following medical problems?	**No**	**Yes**	**Unsure**
1. Heart attack?	0 ☐	1 ☐	9 ☐
2. A balloon angioplasty, a stent, or bypass surgery to the arteries in your heart to improve the blood flow to your heart?	0 ☐	1 ☐	9 ☐
3. Angina?	0 ☐	1 ☐	9 ☐
4. Heart Failure?	0 ☐	1 ☐	9 ☐
5. Stroke?	0 ☐	1 ☐	9 ☐
6. A mini-stroke or TIA (transient ischemic attack)?	0 ☐	1 ☐	9 ☐
7. A balloon angioplasty or surgery to the arteries of your neck to prevent or correct a stroke?	0 ☐	1 ☐	9 ☐
8. An aortic aneurysm, an AAA, or ballooning of your aorta?	0 ☐	1 ☐	9 ☐
9. A blood clot in a leg vein or lung requiring blood thinning medicine?	0 ☐	1 ☐	9 ☐
10. Peripheral arterial disease (problems with circulation, blocked arteries to the legs)?	0 ☐	1 ☐	9 ☐
10a. (IF YES TO PAD) A balloon angioplasty, a stent, or an amputation for this condition?	0 ☐	1 ☐	9 ☐
11. Liver disease? ***If No/unsure to liver disease then Go to #12***	0 ☐	1 ☐	9 ☐

<u>IF YES to liver disease</u>, then what type of liver disease?

11a. Hepatitis
- No 0 ☐ → **Go to Question 11c**
- Yes 1 ☐

11b. What type?
- Type A 1 ☐
- Type B 2 ☐
- Type C 3 ☐
- Don't know 9 ☐

11c. Cirrhosis
- No 0 ☐
- Yes 1 ☐

12. Since our last telephone interview with you on (date), has a doctor or health professional told you that you had emphysema, chronic bronchitis, or chronic obstructive pulmonary disease (COPD)? This does not include doctor's visits for tuberculosis or TB.

No 0 ☐ **Go to Question 13** Yes 1 ☐ Unsure 9 ☐ **Go to Question 13**

12a. Did the doctor or health care professional prescribe a change in your medication, such as starting or increasing your inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

13. Since our last telephone interview with you on *(date)*, has a doctor or health professional told you that you had asthma?

No 0 ☐ **Go to Question 14** Yes 1 ☐ Unsure 9 ☐ **Go to Question 14**

13a. Did the doctor or health care professional prescribe a change in your medication, such as starting or increasing your inhalers, oxygen or pills for your lungs or prescribing a steroid pill for your lungs?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

14. Since our last telephone interview with you, has a doctor or health professional told you that you had diabetes or high sugar in the blood?

No 0 ☐ **Go to Question 15** Yes 1 ☐ Unsure 9 ☐ **Go to Question 15**

14a. Did the doctor recommend any new or different treatments?

No 0 ☐ **Go to Question 15** Yes 1 ☐ Unsure 9 ☐ **Go to Question 15**

14b. What treatment was recommended? (Do not prompt for specific response. Mark all that apply)

		No	**Yes**
b1.	Pills	0 ☐	1 ☐
b2.	Insulin Alone	0 ☐	1 ☐
b3.	Insulin and pills	0 ☐	1 ☐
b4.	Referred for eye exam	0 ☐	1 ☐
b5.	Advice to change diet	0 ☐	1 ☐
b6.	Advice to stop smoking	0 ☐	1 ☐
b7.	Advice to increase exercise	0 ☐	1 ☐
b8.	Other	0 ☐	1 ☐ Specify____________________________

15. Since our last telephone interview with you on *(date)*, has a doctor or health professional told you that you had high blood pressure or hypertension?

No 0 ☐ **Go to Question 16** Yes 1 ☐ Unsure 9 ☐ **Go to Question 16**

15a. Did the doctor recommend any new or different treatments?
No 0 ☐ **Go to Question 16** Yes 1 ☐ Unsure 9 ☐ **Go to Question 16**

15b. What treatment was recommended? *(Do not prompt for specific response. Mark all that apply)*

		No	Yes
b1.	Start new medicine	0 ☐	1 ☐
b2.	Increase dose of existing medicine	0 ☐	1 ☐
b3.	Advice to lose weight	0 ☐	1 ☐
b4.	Advice to change diet	0 ☐	1 ☐
b5.	Advice to stop smoking	0 ☐	1 ☐
b6.	Advice to increase exercise	0 ☐	1 ☐
b7.	Other	0 ☐	1 ☐ Specify___________________________

16. Since our last telephone interview with you on has a doctor or health professional told you that you had high blood cholesterol?
No 0 ☐ **Go to Question 17** Yes 1 ☐ Unsure 9 ☐ **Go to Question 17**

16a. Did the doctor recommend any new or different treatments?
No 0 ☐ **Go to Question 17** Yes 1 ☐ Unsure 9 ☐ **Go to Question 17**

16b. What treatment was recommended? *(Do not prompt for specific response. Mark all that apply.)*

		No	Yes
b1.	Start new medicine	0 ☐	1 ☐
b2.	Increase dose of existing medicine	0 ☐	1 ☐
b3.	Advice to lose weight	0 ☐	1 ☐
b4.	Advice to change diet	0 ☐	1 ☐
b5.	Advice to stop smoking	0 ☐	1 ☐
b6.	Advice to increase exercise	0 ☐	1 ☐
b7.	Other	0 ☐	1 ☐ Specify________________________

17. Has a doctor ever said that you have cancer or a malignant tumor?
No 0 ☐ **Go to Question 18** Yes 1 ☐

17a. What type?	No	Yes
a1. Lung	0 ☐	1 ☐
a2. Breast	0 ☐	1 ☐
a3. Cervical	0 ☐	1 ☐
a4. Blood/lymph glands	0 ☐	1 ☐
a5. Testes/scrotum	0 ☐	1 ☐
a6. Bone	0 ☐	1 ☐
a7. Melanoma	0 ☐	1 ☐

17a. What type?	No	Yes
a8. Skin (not melanoma)	0 ☐	1 ☐
a9. Brain	0 ☐	1 ☐
a10. Stomach	0 ☐	1 ☐
a11. Colon	0 ☐	1 ☐
a12. Uterine	0 ☐	1 ☐
a13. Prostate	0 ☐	1 ☐
a14. Liver	0 ☐	1 ☐
a15. Kidney/renal	0 ☐	1 ☐
a16. Other	0 ☐	1 ☐ Specify ______________________

18. Do you currently have a pacemaker or automatic defibrillator (AICD) for a heart rhythm problem?

No 0 ☐
Yes, pacemaker 1 ☐
Yes, automatic defibrillator (AICD) 2 ☐
Yes, both pacemaker, and automatic defibrillator (AICD) 3 ☐
Not sure 9 ☐

B. Since your last telephone interview on (date), have you had any of the following problems?

	No	Yes	Unsure
19. Do you often have swelling in your feet or ankles at the end of the day?	0 ☐	1 ☐	9 ☐
20. Are there times when you wake up at night because of difficulty breathing?	0 ☐	1 ☐	9 ☐
21. Are there times when you stop for breath when walking at your own pace on level ground?	0 ☐	1 ☐	9 ☐
22. Are there times when you have difficulty breathing when you are not walking or active?	0 ☐	1 ☐	9 ☐

23. Has a doctor ever told you that you had any of the following conditions that affect the brain?

	No	Yes
23a. Dementia?	0 ☐	1 ☐
23b. Alzheimer’s disease?	0 ☐	1 ☐
23c. Vascular dementia or hardening of the arteries of the brain?	0 ☐	1 ☐
23d. Mild Cognitive Impairment (or MCI)?	0 ☐	1 ☐
23e. Parkinson’s Disease?	0 ☐	1 ☐
23f. Brain Tumor?	0 ☐	1 ☐

C. Urinary Leakage (Incontinence)

Many people have leakage of urine. The next few questions ask about urine leakage.
(Other terms for urinary leakage are not being able to hold your urine until you can reach a toilet, not being able to control your bladder, loss of urine control.)

24. How often do you have urinary leakage? Would you say…

Never	1	☐	**Go to Question 26**
Less than once a month	2	☐	
A few times a month	3	☐	
A few times a week,	4	☐	
Every day and/or night	5	☐	
Unsure / Refused	9	☐	**Go to Question 26**

25. How much urine do you lose each time? Would you say…

Drops	1	☐
Small splashes	2	☐
More	3	☐
Unsure / Refused	9	☐

26. During the **past 12 months**, have you leaked or lost control of even a small amount of urine with an activity like coughing, lifting or exercise?

No	0	☐	**Go to Question 27**
Yes	1	☐	
Unsure / Refused	9	☐	**Go to Question 27**

26a. How frequently does this occur? Would you say this occurs . . .

Less than once a month	1	☐
A few times a month	2	☐
A few times a week	3	☐
Every day and/or night	4	☐
Unsure / Refused	9	☐

27. During the **past 12 months**, have you leaked or lost control of even a small amount of urine with an urge or pressure to urinate and you couldn't get to the toilet fast enough?

No	0	☐	**Go to Question 28**
Yes	1	☐	
Unsure / Refused	9	☐	**Go to Question 28**

27a. How frequently does this occur? Would you say this occurs. . .

Less than once a month 1 ☐
A few times a month 2 ☐
A few times a week 3 ☐
Every day and/or night 4 ☐
Unsure / Refused 9 ☐

28. During the **past 12 months**, have you leaked or lost control of even a small amount of urine without an activity like coughing, lifting, or exercise, or an urge to urinate?

No 0 ☐ **Go to Question 31**
Yes 1 ☐
Unsure / Refused 9 ☐ **Go to Question 31**

28a. How frequently does this occur? Would you say this occurs . . .

Less than once a month 1 ☐
A few times a month 2 ☐
A few times a week 3 ☐
Every day and/or night 4 ☐
Unsure / Refused 9 ☐

29. During the **past 12 months**, how much did your leakage of urine bother you? Please select one of the following choices:

Not at all 1 ☐
Only a little 2 ☐
Somewhat 3 ☐
Very much 4 ☐
Greatly 5 ☐
Unsure/ Refused 9 ☐

30. During the **past 12 months**, how much did your leakage of urine affect your day-to-day activities? Please select one of the following choices:

Not at all 1 ☐
Only a little 2 ☐
Somewhat 3 ☐
Very much 4 ☐
Greatly 5 ☐
Unsure/ Refused 9 ☐

31. During the **past 30 days**, how many times per night did you most typically get up to urinate, from the time you went to bed at night until the time you got up in the morning. Would you say..

Never 0 ☐
1 time 1 ☐
2 times 2 ☐
3 times 3 ☐
4 times 4 ☐
5 or more times 5 ☐
Unsure/ Refused 9 ☐

D. Kidney

32. Have you ever been told by a doctor or other health professional that you had weak or failing kidneys? Do not include kidney stones, bladder infections, or incontinence.

No 0 ☐ **Go to Question 34**
Yes 1 ☐
Unsure / Refused 9 ☐ **Go to Question 34**

33. In the **past 12 months**, have you received dialysis (either hemodialysis or peritoneal dialysis)?

No 0 ☐
Yes 1 ☐
Unsure / Refused 9 ☐

34. Have you ever had kidney stones?

No 0 ☐ **Go to Question 35**
Yes 1 ☐
Unsure / Refused 9 ☐ **Go to Question 35**

34a. How many times have you passed a kidney stone? ☐☐ ENTER NUMBER OF TIMES

E. Tuberculosis Screening

35. **Since visit 1**, have you been told that you had active tuberculosis or TB?

No 0 ☐ **Go to Question 36**
Yes 1 ☐
Unsure / Refused 9 ☐ **Go to Question 36**

35a. **Since visit 1**, have you been prescribed any medicine to treat active tuberculosis or TB?

No 0 ☐
Yes 1 ☐
Unsure / Refused 9 ☐

36. **Since visit 1**, have you been given a TB or tuberculosis skin test (e.g., PPD)?

No 0 ☐ **For men, Go to Question 37; for women, END of questionnaire**

Yes 1 ☐

Unsure / Refused 9 ☐ **For men, Go to Question 37; for women, END of questionnaire**

36a. Was it:

Positive 1 ☐

Negative 2 ☐ **For men, Go to Question 37; for women, END of questionnaire**

Unsure/Refused 9 ☐ **For men, Go to Question 37; for women, END of questionnaire**

36b. For this TB skin test, were you prescribed any medicine to keep you from getting sick with TB?

No 0 ☐
Yes 1 ☐
Unsure/ Refused 9 ☐
} **For WOMEN, END of questionnaire**

F. Men Only

The next set of questions is about men's health including urinary and prostate problems. The prostate is a gland located just below the bladder. Can I proceed to ask these questions?

For men less than 40 years of age, go to question 39.

37. For men age 40 years and older only: Do you usually have trouble starting to urinate (pass water)?

No 0 ☐

Yes 1 ☐

Unsure / Refused 9 ☐

38. For men age 40 years and older only: After urinating (passing water), does your bladder feel empty?

No 0 ☐

Yes 1 ☐

Unsure / Refused 9 ☐

The remainder is for men of all ages:

39. Have you ever been told by a doctor or health professional that you have any disease of the prostate? This includes an enlarged prostate.

No 0 ☐

Yes 1 ☐

Unsure / Refused 9 ☐

40. Have you ever been told by a doctor or health professional that you had an enlarged prostate gland?

No 0 ☐ **Go to Question 41**
Yes 1 ☐
Unsure / Refused 9 ☐ **Go to Question 41**

40a. Was it a benign enlargement – that is, not cancerous, also called benign prostatic hypertrophy?

No 0 ☐
Yes 1 ☐
Unsure / Refused 9 ☐

40b. How old were you when you were first told that you had benign enlargement of the prostate gland?

Enter age in years ☐☐

40c. Was the enlargement due to cancer?

No 0 ☐
Yes 1 ☐
Unsure / Refused 9 ☐

41. Have you ever had a blood test that your doctor told you was being used to check for prostate cancer, called PSA, or Prostate Specific Antigen?

No 0 ☐
Yes 1 ☐
Unsure / Refused 9 ☐

42. Have you ever had a rectal examination? A rectal exam is when a finger is inserted in the rectum or bottom to check for problems.

No 0 ☐ **Go to Question 43**
Yes 1 ☐
Unsure / Refused 9 ☐ **Go to question 43**

42a. Was this done to check for prostate cancer?

No 0 ☐
Yes 1 ☐
Unsure / Refused 9 ☐

42b. Was this done to check for blood?

No 0 ☐
Yes 1 ☐
Unsure / Refused 9 ☐

43. Many men experience problems with sexual intercourse. How would you describe your ability to get and keep an erection adequate for satisfactory intercourse? Would you say that you are..

VERBAL INSTRUCTION: *Always able or almost always able to get and keep an erection? Usually able to get and keep an erection? Sometimes able to get and keep an erection? Never able to get and keep an erection?]*

Always or almost always able 3 ☐

Usually able 2 ☐

Sometimes able 1 ☐

Never able 0 ☐

Unsure/ Refused 9 ☐

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OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2 Medication Use Questionnaire

ID NUMBER:									FORM CODE: MUE VERSION: 1, 6/3/2016	Contact Occasion	0	2	SEQ #		1

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)   0b. Staff ID: ☐☐☐

Instructions: *This form should be completed during the participant's visit. Enter information provided by the participant for each question. Record medication information in the "Medication record" section as it applies. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

A. Reception

As you know, the SOL records all prescription and over-the-counter medications used in the past four weeks, including cold, allergy, vitamins, minerals and dietary supplements. These medications include solid and non-solid medications that you may swallow, inhale, apply to the skin, inject, implant, or place in the ears, eyes, nose, mouth, or any other part of the body. The materials mailed for your appointment included a bag for all your current medications and asked you to bring them to the clinic.

1. Did you bring all the medications that you used in the past four weeks, or their containers?

   Yes, all of them 1 ☐ **GO TO SECTION B, QUESTION 5**

   No, some of them 2 ☐ **GO TO SECTION A, QUESTION 3**

   No, none of them 3 ☐

2. Is this because you forgot, because you have not taken any medications at all in the last four weeks, or because you could not bring your medications?

   Took no medication 1 ☐ → **STOP; Thank ppt. and close form**

   Forgot or was unable to bring medication 2 ☐ *That's alright. Since the information on medications is so important, we would still like to ask you about it during the interview.*

3. May we follow up on this after the visit so that we can get the information from the other medication labels? *(Explain follow-up options)*

   No or not applicable 0 ☐ **GO TO SECTION C, QUESTION 26**

   Yes 1 ☐

4. Describe method of follow-up to be used: ____

B. Medication Record

Confirm, or carefully copy the MEDICATION NAME into "a" using upper case letters. Confirm, or copy the formulation STRENGTH (weight for solids and concentration for non-solids), using periods to indicate decimal points. Confirm, or copy the UNITS used to measure strength, using upper case letters and standard abbreviations. For combination medications, use a forward slash (/) to separate active ingredients, corresponding strengths, and units.

#			Medication name (a)
5.	(b) Strength	(c) Units	
6.	(b) Strength	(c) Units	
7.	(b) Strength	(c) Units	
8.	(b) Strength	(c) Units	
9.	(b) Strength	(c) Units	
10.	(b) Strength	(c) Units	
11.	(b) Strength	(c) Units	
12.	(b) Strength	(c) Units	
13.	(b) Strength	(c) Units	
14.	(b) Strength	(c) Units	
15.	(b) Strength	(c) Units	
16.	(b) Strength	(c) Units	
17.	(b) Strength	(c) Units	
18.	(b) Strength	(c) Units	
19.	(b) Strength	(c) Units	
20.	(b) Strength	(c) Units	

21.	(b) Strength	(c) Units	
22.	(b) Strength	(c) Units	
23.	(b) Strength	(c) Units	
24.	(b) Strength	(c) Units	

25. Total number of medications in bag ☐☐

C. Medication Use Interview

Now I would like to ask about a few specific medications.

26. Were any of the medications you took during the last four weeks for:	No	Yes	Unknown
a. Asthma	0 ☐	1 ☐	9 ☐
b. Chronic bronchitis or emphysema	0 ☐	1 ☐	9 ☐
c. High blood sugar or diabetes	0 ☐	1 ☐	9 ☐
d. High blood pressure or hypertension	0 ☐	1 ☐	9 ☐
e. High blood cholesterol	0 ☐	1 ☐	9 ☐
f. Chest pain or angina	0 ☐	1 ☐	9 ☐
g. Abnormal heart rhythm	0 ☐	1 ☐	9 ☐
h. Heart failure	0 ☐	1 ☐	9 ☐
i. Blood thinning	0 ☐	1 ☐	9 ☐
j. Stroke	0 ☐	1 ☐	9 ☐
k. Mini-stroke or TIA	0 ☐	1 ☐	9 ☐
l. Leg pain while walking or claudication	0 ☐	1 ☐	9 ☐
m. Depression	0 ☐	1 ☐	9 ☐
n. Anxiety	0 ☐	1 ☐	9 ☐
o. Glaucoma	0 ☐	1 ☐	9 ☐
p. A disease of the thyroid	0 ☐	1 ☐	9 ☐

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OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2- Pregnancy Complications History

ID NUMBER:									FORM CODE: PCE VERSION: 1, 9/5/2014	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: *Enter the answer given by the participant for each response. Complete one form for each pregnancy of 6 or more months in duration. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc for those questions that do not list these values as possible answer choices.*

A. PREGNANCY HISTORY QUESTIONS

Now, we would like to ask you some more detailed questions about pregnancies that occurred ***AFTER*** *your visit to our center on [SOL Visit 1* DATE] *and lasted 6 months or longer.*

1. We will start with the first of all the pregnancies that happened since your visit to our center on [SOL Visit 1 date of examination] and lasted 6 months or longer.

a. Pregnancy Number ☐

b. What was the date of this birth [or when did this pregnancy end]?

☐☐/☐☐/☐☐☐☐
month day year

c. For this pregnancy, did you receive prenatal care, and if so was care received both inside and outside of the United States, in the United States only, or outside the United States only?

No prenatal care 0 ☐
Both in and out of US 1 ☐
Only in the US 2 ☐
Only outside of the US 3 ☐
Unsure/don't know 9 ☐

d. Did you have high blood pressure or hypertension during this pregnancy?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

d.1. Did you have high blood pressure or hypertension before this pregnancy [and at a time when you weren't pregnant]?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

e. Did you have preeclampsia or toxemia during this pregnancy?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

f. Did you have eclampsia or a seizure during this pregnancy?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

g. Did you have diabetes or high blood sugar during this pregnancy?

No 0 ☐ Go to Question 1.g2 Yes 1 ☐ Unsure 9 ☐

g.1. Did you take medication for your blood sugar during this pregnancy? [If YES] did you take pills, insulin, or both pills and insulin?

- No 0 ☐
- Yes, pills only 1 ☐
- Yes, insulin only 2 ☐
- Yes, pills and insulin 3 ☐
- Unsure/don't know 9 ☐

g.2. Did you have diabetes before this pregnancy? [and at a time when you weren't pregnant]?

No 0 ☐ Yes 1 ☐ Unsure 9 ☐

h. During the last 3 months of your pregnancy did you smoke daily, occasionally, or not at all?

Not at all 0 ☐ Occasionally 1 ☐ Daily 2 ☐ Unsure 9 ☐

i. In the three months before your pregnancy, or before you realized you were pregnant, did you smoke daily, occasionally, or not at all?

Not at all 0 ☐ Occasionally 1 ☐ Daily 2 ☐ Unsure 9 ☐

j. How much weight did you gain during this pregnancy?

☐☐☐.☐ Weight (on paper form enter "999" if unsure)

j.1. lbs 1 ☐

kgs 2 ☐

2. How many months or weeks had you been pregnant when [the baby was born/the babies were born/the pregnancy ended]?

2a. ☐☐ number OF
(on paper form enter "99" if Unsure/don't know)

a.1. Weeks 2 ☐
Month 3 ☐

I completely understand that the following question may be very sensitive.

3. Was the baby or were the babies born alive, or was this a miscarriage, an ectopic pregnancy or stillbirth?

- Miscarriage 0 ☐ **End of form**
- Live birth (or at least one live birth if multiples) 1 ☐
- Stillbirth (s) 2 ☐ **Go to Question 4 &5; Then End**
- Tubal or Ectopic pregnancy 3 ☐ **End of form**
- Other 4 ☐ **End of form**
- Refuse 7 ☐ **End of form**
- Unsure/don't know 9 ☐ **End of form**

3.a. [If at least one live birth] How many babies were born from this pregnancy? ☐☐

4. Was this birth by C-section or vaginal delivery?

Vaginal Delivery ☐

C-section ☐

Unsure or refused ☐

5. Where did you give birth (check one)?

In a hospital 1 ☐

In a birthing center 2 ☐

In your home or other place 3 ☐

Unsure 9 ☐

If this birth happened in a hospital or birthing center, ask:

a. What was the name of the facility where you gave birth?______________________________

b. What was the address of the facility? ____

c. Just to be clear, under what name is this in the records?

c.1. First name: ____

c.2. Second name: ____

c.3. Last Name: ____

c.4. Maternal Last Name: ____

6. ☐ Babies → For each baby born in this birth, complete a column in **Table below.**

7. Baby 1	**8. Baby 2**	**9. Baby 3**	**10. Baby 4**
a. Birth: Stillbirth=0 ☐ Live=1 ☐ Unsure=9 ☐	**a. Birth**: Stillbirth=0 ☐ Live=1 ☐ Unsure=9 ☐	**a. Birth**: Stillbirth=0 ☐ Live=1 ☐ Unsure=9 ☐	**a. Birth**: Stillbirth=0 ☐ Live=1 ☐ Unsure=9 ☐
b. Gender: **M**=1 ☐ **F**=2 ☐ Unsure=9 ☐	**b. Gender:** **M**=1 ☐ **F**=2 ☐ Unsure=9 ☐	**b. Gender:** **M**=1 ☐ **F**=2 ☐ Unsure=9 ☐	**b. Gender:** **M**=1 ☐ **F**=2 ☐ Unsure=9 ☐
c. Weight: ☐☐ lbs c.1. ☐☐ oz OR c.2. ☐☐☐☐ g	**c. Weight:** ☐☐ lbs c.1. ☐☐ oz OR c.2. ☐☐☐☐ g	**c. Weight:**. ☐☐ lbs c.1. ☐☐ oz OR c.2. ☐☐☐☐ g	**c. Weight:** ☐☐ lbs c.1. ☐☐ oz OR c.2. ☐☐☐☐ g
d. If uncertain in Weight: Less than 5 ½ lbs (2500g)? 1 ☐ Between 5 ½ and 9 lbs? 2 ☐ More than 9 lbs (4000g)? 3 ☐ Unsure 9 ☐	**d. If uncertain in Weight:** Less than 5 ½ lbs (2500g)? 1 ☐ Between 5 ½ and 9 lbs? 2 ☐ More than 9 lbs (4000g)? 3 ☐ Unsure 9 ☐	**d. If uncertain in Weight:** Less than 5 ½ lbs (2500g)? 1 ☐ Between 5 ½ and 9 lbs? 2 ☐ More than 9 lbs (4000g)? 3 ☐ Unsure 9 ☐	**d. If uncertain in Weight:** Less than 5 ½ lbs (2500g)? 1 ☐ Between 5 ½ and 9 lbs? 2 ☐ More than 9 lbs (4000g)? 3 ☐ Unsure 9 ☐
e. If Live Birth: Are you currently breastfeeding this baby or pumping milk? 0 ☐ No, never breastfed this baby (**Go to e3 then to 8**) 1 ☐ No, I stopped breastfeeding this baby 2 ☐ Yes, I am still breastfeeding this baby (**Go to e4**) 9 ☐ Unsure/don't know (**Go to Question 8**)	**e. If Live Birth:** Are you currently breastfeeding this baby or pumping milk? 0 ☐ No, never breastfed this baby (**Go to e3 then to 9**) 1 ☐ No, I stopped breastfeeding this baby 2 ☐ Yes, I am still breastfeeding this baby (**Go to e4**) 9 ☐ Unsure/don't know (**Go to Question 9**)	**e. If Live Birth:** Are you currently breastfeeding this baby or pumping milk? 0 ☐ No, never breastfed this baby (**Go to e3 then to 10**) 1 ☐ No, I stopped breastfeeding this baby 2 ☐ Yes, I am still breastfeeding this baby (**Go to e4**) 9 ☐ Unsure/don't know (**Go to Question 10**)	**e. If Live Birth:** Are you currently breastfeeding this baby or pumping milk? 0 ☐ No, never breastfed this baby (**Go to e3 then End**) 1 ☐ No, I stopped breastfeeding this baby 2 ☐ Yes, I am still breastfeeding this baby (**Go to e4**) 9 ☐ Unsure/don't know (**End Questionnaire**)

ID NUMBER:									FORM CODE: PCE VERSION: 1, 9/5/2014	Contact Occasion	0	2	SEQ #		

7. **Baby 1**	8. **Baby 2**	9. **Baby 3**	10. **Baby 4**
e.1. How old was the baby when you completely stopped breastfeeding? (on paper form enter "99" if unsure) ☐☐.☐ age of baby	e.1. How old was the baby when you completely stopped breastfeeding? (on paper form enter "99" if unsure) ☐☐.☐ age of baby	e.1. How old was the baby when you completely stopped breastfeeding? (on paper form enter "99" if unsure) ☐☐.☐ age of baby	e.1. How old was the baby when you completely stopped breastfeeding? (on paper form enter "99" if unsure) ☐☐.☐ age of baby
e.2. Days 1 ☐ Weeks 2 ☐ Months 3 ☐	e.2. Days 1 ☐ Weeks 2 ☐ Months 3 ☐	e.2. Days 1 ☐ Weeks 2 ☐ Months 3 ☐	e.2. Days 1 ☐ Weeks 2 ☐ Months 3 ☐
e.3. Did you breastfeed as long as you wanted to? No=0 ☐ Yes=1 ☐ Unsure=9 ☐	e.3. Did you breastfeed as long as you wanted to? No=0 ☐ Yes=1 ☐ Unsure=9 ☐	e.3. Did you breastfeed as long as you wanted to? No=0 ☐ Yes=1 ☐ Unsure=9 ☐	e.3. Did you breastfeed as long as you wanted to? No=0 ☐ Yes=1 ☐ Unsure=9 ☐
e.4. How old was this baby when first fed formula or solid foods? ☐☐.☐ age of baby (on paper form enter "99" if unsure, **Go to Question 8**)	e.4. How old was this baby when first fed formula or solid foods? ☐☐.☐ age of baby (on paper form enter "99" if unsure, **Go to Question 9**)	e.4. How old was this baby when first fed formula or solid foods? ☐☐.☐ age of baby (on paper form enter "99" if unsure, **Go to Question 10**)	e.4. How old was this baby when first fed formula or solid foods? ☐☐.☐ age of baby (on paper form enter "99" if unsure, **End Questionnaire**)
e.5. Days 1 ☐ Weeks 2 ☐ Months 3 ☐	e.5. Days 1 ☐ Weeks 2 ☐ Months 3 ☐	e.5. Days 1 ☐ Weeks 2 ☐ Months 3 ☐	e.5. Days 1 ☐ Weeks 2 ☐ Months 3 ☐

If there is another baby then continue to answer questions for each baby, otherwise this is the end of the form.

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OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2 Participant Disability Screening Form

ID NUMBER:									FORM CODE: PDE VERSION: 1, 9/10/2014	Contact Occasion	0	2	SEQ #	0	1

ADMINISTRATIVE INFORMATION

0a. Completion Date (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: *This disability screening form must be completed after informed consent administration and before the participant has their examination. Positive responses to Questions 1 – 6 should be noted on the Exam Itinerary Checklist for routing purposes during the visit.*
Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.

Introductory Script for staff:

Now I would like to ask you about difficulties you may have in usual activities of daily living:

A. Disability Status	**No**	**Yes**
1. Are you deaf or do you have serious difficulty hearing?	0 ☐	1 ☐
2. Are you blind or do you have serous difficulty seeing, even when wearing glasses?	0 ☐	1 ☐
3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	0 ☐	1 ☐
4. Do you have serious difficulty walking or climbing stairs?	0 ☐	1 ☐
5. Do you have difficulty walking a half mile (approximately 1 kilometer)?	0 ☐	1 ☐
6. Do you have difficulty climbing 10 steps?	0 ☐	1 ☐
7. Do you have difficulty dressing or bathing?	0 ☐	1 ☐
8. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	0 ☐	1 ☐

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OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL- Visit 2- Participant Feedback

ID NUMBER:									FORM CODE: PFE VERSION: 1 , 6/28/2014	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

***Instructions**: Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

<u>Participant Feedback</u>
Thank you for your participation in the HCHS/SOL. We are interested in your feedback. Please take a few minutes to tell us about your experience and how we can make this a successful study for the Hispanic/Latino community.

1. What are the main reason(s) for your continued participation in the HCHS/SOL study?	**No**	**Yes**
a. To help my community	0 ☐	1 ☐
b. To learn more about my health and what questions to ask my doctor	0 ☐	1 ☐
c. To receive the monetary incentive	0 ☐	1 ☐
d. To receive free medical tests and referrals	0 ☐	1 ☐
e. To have an opportunity to participate in other studies	0 ☐	1 ☐
f. Other	0 ☐	1 ☐

Please specify: ______________________

2. Overall, how motivated are you to continue participating with the study?

Not Motivated 1 ☐ Motivated 2 ☐ Very motivated 3 ☐

3. For the past several years, we have contacted you every year to follow-up and see how you are doing. Please let us know how satisfied you were with the following:	**Not Satisfied**	**Satisfied**	**Very Satisfied**
a. The opportunity to be interviewed in either English or Spanish	1 ☐	2 ☐	3 ☐
b. The respect and professionalism of the staff	1 ☐	2 ☐	3 ☐
c. The health information and community resources received	1 ☐	2 ☐	3 ☐
d. The length of time required to complete each follow-up interview	1 ☐	2 ☐	3 ☐

4. Have you experienced any of the following during your visit:	**No**	**Yes**
a. Problems communicating with the staff	0 ☐	1 ☐
b. Difficulty finding transportation to the clinic	0 ☐	1 ☐
c. Difficulty or discomfort with the clinic visit and the tests	0 ☐	1 ☐
d. Unfriendly or disrespectful staff	0 ☐	1 ☐

5. At times, it has been difficult to continue regular contact with the study because…

	No	Yes
a. I have changed my address or phone number many times	0 ☐	1 ☐
b. I have many family obligations	0 ☐	1 ☐
c. I am not very interested in the study	0 ☐	1 ☐
d. The study is time consuming	0 ☐	1 ☐
e. I have a busy work schedule	0 ☐	1 ☐
f. Other	0 ☐	1 ☐

Please specify:___________________________

6. Throughout the year, we like to stay in touch by mailing you study updates. How much do you like receiving the following?

	Very Little	Somewhat	Very Much
a. ¡Salud SOL! Newsletters	1 ☐	2 ☐	3 ☐
b. Cards such as: Thank you /Birthday/Holiday/Sorry I missed you	1 ☐	2 ☐	3 ☐
c. Annual Follow-Up Reminder letter	1 ☐	2 ☐	3 ☐
d. Health Education Materials	1 ☐	2 ☐	3 ☐
e. Other	1 ☐	2 ☐	3 ☐

Please specify:____________________

7. Do you have any additional comments?

No	Yes	
0 ☐	1 ☐	*(If yes, please write comment):*

____

Thank you for being part of HCHS/SOL!

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OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2- Reproductive and Medical History

ID NUMBER:									FORM CODE: RME VERSION: 1, 9/5/2014	Contact Occasion	0	2	SEQ number		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: *Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc for those questions that do not list these values as possible answer choices.*

This next interview includes questions for women about your menstrual periods and pregnancies, and about hormones that you may have used or are using. Can I proceed to ask these questions? [If yes] *Some questions I ask may make you feel uncomfortable, and may include questions you may not feel like answering. Please, take your time to think through your answers. We want to understand these aspects of women's health, and at the same time we want you to feel respected and comfortable. You are important to us, and your participation in the study is extremely valuable.*

A. HORMONE AND MENSTRUAL HISTORY QUESTIONS

1. Have you ever used a birth control method, including birth control pills or other hormonal methods?

No 1 ☐ Go to Question 4
Yes 2 ☐
Refused 7 ☐ Go to Question 4
Unsure/Don't know 9 ☐

2. Which of the following hormonal preparations have you ever used for birth control or for other medical purposes? Tell us whether you have ever used them or you are currently using these treatments.

	Never	Ever	Current	Not Sure
a. Birth control pills	0 ☐	1 ☐	2 ☐	9 ☐
b. Birth control ring (Nuvaring) or patch (OrthoEvra)	0 ☐	1 ☐	2 ☐	9 ☐
c. Depo-Provera Shots	0 ☐	1 ☐	2 ☐	9 ☐
d. Birth control implant (Norplant, Implanon, or Nexplanon)	0 ☐	1 ☐	2 ☐	9 ☐
e. Intrauterine device (IUD) with hormones (Mirena)	0 ☐	1 ☐	2 ☐	9 ☐

[If "Never" or "Not Sure" to all alternatives, go to Question 4.]

3. [If "Ever" or "Current" to any hormonal preparations], Why have you used this/these hormonal preparations? What was it [were they] indicated for?

Did you use them/it for: [ask for each item]	No	Yes	Not Sure
a. Birth control	0 ☐	1 ☐	9 ☐
b. Acne	0 ☐	1 ☐	9 ☐
c. Menstrual cramps or painful periods	0 ☐	1 ☐	9 ☐
d. To regulate periods	0 ☐	1 ☐	9 ☐
e. To treat vaginal bleeding	0 ☐	1 ☐	9 ☐
f. Other	0 ☐	1 ☐	9 ☐

Specify:_________________________________

4. Have you ever tried to become pregnant for more than 1 year without success?

   No 0 ☐ →**Go to Question 5**
   Yes 1 ☐
   Refused 7 ☐ →**Go to Question 5**
   Unsure 9 ☐ →**Go to Question 5**

   4a. What was the cause for not becoming pregnant? (Check one)

   Medical problem with you? 0☐
   Medical problem with your partner? 1☐
   Medical problems with both you and your partner? 2☐
   Refused 7 ☐
   Unsure 9 ☐

5. Have your natural periods stopped PERMANENTLY? [if YES] do you still have periods from taking hormones?

   No 0 ☐
   Yes, I have no menstrual periods 1 ☐→**GO TO QUESTION 6**
   Yes, but I have periods induced by hormones 2 ☐→**GO TO QUESTION 6**
   Refused 7 ☐
   Unsure 9 ☐

   5a. **IF UNSURE, REFUSED or NO**: What was the date that your **most recent** menstrual period started? *[Prompt for month and year, even if day is unknown.]*

   ☐☐/☐☐/☐☐☐☐ →**GO TO QUESTION 8**
   mm /dd /yyyy

6. At what age did your natural periods stop? ☐☐ age in years

7. Why did you periods stop (check one)?

   They stopped naturally 1 ☐
   Surgery to remove ovaries or uterus 2 ☐
   Endometrial ablation 3 ☐
   Radiation/chemotherapy 4 ☐
   Other 5 ☐
   Specify: ___________________
   Refused 7 ☐
   Unsure 9 ☐

8. Have you had a hysterectomy? (This is an operation to take out your uterus or womb)

No 0 ☐ → **GO TO QUESTION 9**
Yes 1 ☐
Refused 7 ☐ → **GO TO QUESTION 9**
Unsure 9 ☐ → **GO TO QUESTION 9**

8a. **Age at surgery?** ☐☐ Age in years

9. Have you had either of your ovaries surgically removed? [If yes, then ask, "Have you had one ovary or both ovaries removed?]

No 0 ☐ **→Go to question 10**
Yes, one removed 1 ☐
Yes, both removed 2 ☐
Yes, unsure if one or both removed 3 ☐
Refused 7 ☐ **→Go to question 10**
Unsure 9 ☐ **→Go to question 10**

9a. **Age at surgery?** ☐☐ Age in years

***For the next question**, I would like to ask you to think about your menstrual periods when you were 20 to 40 years old. Think about what your periods were like when you were not using birth control pills or other hormone medications and were not pregnant or breastfeeding. Think carefully; take your time.*

10. How many days did your typical menstrual cycle last, that is, how many days were between the beginning of one menstrual period to the beginning of bleeding of the next period?

Less than 24 days 0 ☐
24-35 days 1 ☐
More than 35 days 2 ☐
Too variable or irregular to say 3 ☐
Refused 7 ☐
Don't know 9 ☐

11. Has a health care provider ever told you that you have polycystic ovary syndrome or PCOS?

No 0 ☐
Yes 1 ☐
Refused 7 ☐
Unsure 9 ☐

B. PREGNANCY HISTORY QUESTIONS

Next, I will be asking you about any pregnancies you have ever had. Before or after SOL visit 1 on [date].	**Before visit 1?**	**After visit 1?**
12. How many times have you been pregnant before visit 1? After visit 1? [If 12a=0 and 12b=0, then End Questionnaire and do not administer PCE Questionnaire] [If all pregnancies are after visit 1, End Questionnaire after Q18]	12a. ☐☐	12b. ☐☐
13. How many pregnancies have you had that lasted 6 months or longer before visit 1? After visit 1?	13a. ☐☐	13b. ☐☐
14. How many miscarriages have you had before visit 1? A miscarriage is a pregnancy loss before 24 weeks.	14a. ☐☐	
15. How many tubal or ectopic pregnancies have you had before visit 1?	15a. ☐☐	
16. How many C-sections have you had before visit 1?	16a. ☐☐	

[If 16a is greater than 12 a, prompt the participant to reconcile the discrepency. Sum answers to 13a, 14a, and 15a. If the sum of these three is greater than 12a, prompt the participant and reconcile the discrepancy. If 13a+14a+15a is smaller that 12a, we assume that the other pregnancies ended with abortions.]

[Question 17 and 18, are asking about any pregnancies, both before and after Visit 1]

17. During any of your pregnancies (or pregnancy), did you feel sad, miserable, or very anxious? By this, we mean a period of at least 2 weeks when you were not yourself and which was worse than the normal ups and downs of life? **By "two weeks," I mean most of the day, nearly every day.**

No 0 ☐
Yes 1 ☐
Unsure or refused 9 ☐

18. After any of your pregnancies (or pregnancy), and within the first 6 months after delivery [or postpartum] did you feel sad, miserable, or very anxious? By this, we mean a period of at least 2 weeks, when you were not yourself and which was worse than the normal ups and downs of life? **By "for two weeks," I mean most of the day, nearly every day.**

No 0 ☐
Yes 1 ☐
Unsure or refused 9 ☐

[If all pregnancies after visit 1, end questionnaire and complete one PCE per pregnancy after visit 1 that lasted 6 months or longer.]

Now for the remaining questions on this form, we would like to ask you questions about pregnancies that happened before visit 1 on [date].

19. How many babies (or baby) were born alive before visit 1? [If none, enter 0].

☐☐

19a. And how many babies (or baby) were stillborn before visit 1? [If none, enter 0].

☐☐

20. Did you ever have any of these illnesses or complications during any of your pregnancies before Visit 1 [this pregnancy before visit 1] on [date]?

	No	Yes	Refused	Not Sure
20.a. High blood pressure first diagnosed during pregnancy?	0 ☐	1 ☐	7 ☐	9 ☐
20.b. Preeclampsia or toxemia?	0 ☐	1 ☐	7 ☐	9 ☐
20.c. Seizures, convulsions or eclampsia?	0 ☐	1 ☐	7 ☐	9 ☐
20.d. Diabetes first diagnosed during pregnancy?	0 ☐	1 ☐	7 ☐	9 ☐
20.e. Birth of an infant weighing less than 5.5 lbs (2.5kg)?	0 ☐	1 ☐	7 ☐	9 ☐
20.f. Birth of an infant weighing more than 9 lbs (4.09kg)?	0 ☐	1 ☐	7 ☐	9 ☐
20.g. Birth of a premature infant, or infant born earlier than 37 weeks?	0 ☐	1 ☐	7 ☐	9 ☐
20.h. Birth of twins, triplets or more babies	0 ☐	1 ☐	7 ☐	9 ☐

21. You indicated above that you had [12a-13a] pregnancies that lasted less than 6 months and before visit 1. How many of these pregnancies (or pregnancy) did you receive prenatal care, and if so was care received both inside and outside of the United States, in the United States only, or outside the United States only?

21a. No prenatal care	☐☐	[*enter 77 for refusals]*
21b. Both in and out of the United States	☐☐	[*enter 77 for refusals]*
21c. Only in the United States	☐☐	[*enter 77 for refusals]*
21d. Only outside of the United States	☐☐	[*enter 77 for refusals]*

[sum 21a, b, c and d. If this sum is greater than (12a-13a), prompt the patient to reconcile]

22. You indicated that you had [13a] pregnancies that lasted 6 months or longer and before visit 1, how many of these pregnancies (or pregnancy) did you receive prenatal care, and if so was care received both inside and outside of the United States, in the United States only, or outside the United States only?

22a. No prenatal care	☐☐	[*enter 77 for refusals]*
22b. Both in and out of the United States	☐☐	[*enter 77 for refusals]*
22c. Only in the United States	☐☐	[*enter 77 for refusals]*
22d. Only outside of the United States	☐☐	[*enter 77 for refusals]*

[sum 22a, b, c and d. If this sum is greater than 13a, prompt the patient to reconcile]

End of Questionnaire
If the number reported for Q12b is "0", then do not fill out a PCE/PCS form. If the number reported for Q13b is 1 or greater, then fill out a PCE/PCS form for each pregnancy that lasted 6 months or longer; and you may say, *"Now, we would like to ask you some more detailed questions about the pregnancies [pregnancy] that occurred after SOL Visit 1 on [DATE] and lasted 6 months or longer."*

GO to PREGNANCY COMPLICATIONS Form to collect details of each pregnancy after SOL Visit 1 that lasted 6 months or longer.

Public reporting burden for this collection of information is estimated to average 9 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Sitting Blood Pressure

ID NUMBER: ☐☐☐☐☐☐☐☐ FORM CODE: SBP VERSION: 1, 9/18/2014 Contact Occasion 0 2 SEQ # ☐☐

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) 0b. Staff ID: ☐☐☐

***Instructions**: Enter results as measured. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those measures that are unattainable.*

A. Arm measurements

1. Arm used for sitting blood pressure measurement (choose one): ☐
   - Right (preferred).....................................1
   - Left...2
   - Other {note log}......................................3

2. Arm circumference (cm) ☐☐

3. Cuff size: (OMRON cuff in brackets) ☐

[Select the OMRON cuff size that matches the *measured* arm circumference in cm as follows:
Small (CS19) = 17.0 to 21.5; Adult (CR19) = 22.0 to 31.5;
Large (CL19) = 32.0 to 41.5; X-Large(CX19)= 42.0 to 50.0+]

- Small {CS19}...1
- Adult {CR19} 2
- Large {CL19}...3
- X Large {CX19}......................................4

4. Time of measurement (24-hr. format): ☐☐:☐☐ (H H : M M)

B. Average blood pressure / pulse rate

5. Systolic .... ☐☐☐

6. Diastolic .... ☐☐☐

7. Pulse:... ☐☐☐

C. First blood pressure / pulse rate

8. Systolic ....

9. Diastolic ....

10. Pulse:..

D. Second blood pressure / pulse rate

11. Systolic ....

12. Diastolic ....

13. Pulse:..

E. Third blood pressure / pulse rate

14. Systolic ....

15. Diastolic ....

16. Pulse:..

Public reporting burden for this collection of information is estimated to average 03 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL- Socio Economic/Occupation Questionnaire

ID NUMBER:									FORM CODE: SEE VERSION: 1, 9/23/2014	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: *Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

A. Assets

1. Is your house, apartment, or mobile home…?

- Owned by you or someone in the household free and clear without a mortgage or loan 1 ☐
- Owned by you or someone in the household with a mortgage or loan 2 ☐
- Rented 3 ☐
- Occupied without payment 4 ☐

(1–4) **Go to Question 2**

- Other arrangement 5 ☐ **Go to Question 1.a.**

a. [If other arrangement, ask] Can you please describe the other arrangement?

- Motel/Hotel 1 ☐
- Residential drug/alcohol treatment facility 2 ☐
- Senior Assisted Living Facility 3 ☐
- Nursing home 4 ☐
- Homeless shelter 5 ☐
- Emergency shelter 6 ☐
- Living in the streets (Abandoned building, park, train station, car) 7 ☐
- Recreational Vehicle (RV) campgrounds 8 ☐

(1–8) **Go to Question 2**

- Other 9 ☐ **Go to Question 1.b.**

b. If other, please specify: ____________________________

2. Do you have a bank account (for example, savings, checking), mortgage loan or credit card with a bank in the U.S. or Puerto Rico?

- No 0 ☐
- Yes 1 ☐
- Don’t know/Not sure 2 ☐
- Refused 9 ☐

B. Annual Household Income

3. Counting the income of all the members of your household, was your household income for the year… (Include all money received from all sources)

Less than $30,000 1 ☐ → **GO TO QUESTION 4**

$30,000 or more 2 ☐ → **GO TO QUESTION 5**

4. Is that income…

Less than $10,000 1 ☐
$10,001-$15,000 2 ☐
$15,001-$20,000 3 ☐
$20,001-$25,000 4 ☐
$25,001-$29,999 5 ☐

5. Is that income…

$30,000-$40,000 1 ☐
$40,001-$50,000 2 ☐
$50,001-$75,000 3 ☐
$75,001-$100,000 4 ☐
More than $100,000 5 ☐

6. How many people, including yourself, were supported by this income during the year?

☐☐ Number of people

C. Occupation

7. Are you retired? No 0 ☐ Go to Question 8 Yes 1 ☐

a. - In what year did you retire? ☐☐☐☐

8. In the **past 12 months**, did you have any paid employment?

No 0 ☐ **Go to Question 12** Yes 1 ☐

9. In the **past 12 months**, how many months did you work?

☐☐ Number of months **For less than one month record 01**

10. When you were working **during the past 12 months**, in an average month, how many full-time jobs (30 or more hours/week) did you have?

☐☐ Number of full-time job(s) **if=0, Go to Question 11 ; if 1 or more, Go to Question 10a**

10a. On average, how many hours per week did you work in those full-time jobs?

☐☐ Total average hours per week in full-time job(s)

10b. Approximately, how many full-time employees work for your PRIMARY employer (check one).

I am self-employed and have no full-time employees. 1 ☐

Under 50. I work for a small business 2 ☐

50 or more. I work for a large company 3 ☐

11. When you were working **during the past 12 months**, in an average month, how many part-time jobs (less than 30 hours/week) did you have?

☐☐ Number of part-time job(s) **if=0, Go to Question 14; if 1 or more, go to Questions 11a**

a. On average, how many hours a week did you work in those part -time jobs?

☐☐ Total average hours per week in part-time job(s) **Go to Question 14**

Participants with NO paid employment, in the past 12 months

12. Were you looking for any kind of paid work at any time in the **past 12 months**?

No 0 ☐ **Go to Question 13** Yes 1 ☐ **Go to Question 12a**

12a. If yes, how long did you look for work?

☐☐☐ number Of: 12.a.1. Days 1 ☐

Months 3 ☐

(if participant reports less than one month) **Go to Question 13**

13. What was the main reason you did not work for pay in the **past 12 months** (Check only one)?

Retired 1 ☐

Going to school 2 ☐

Homemaker 3 ☐

Unable to work for health reasons 4 ☐

Disabled 5 ☐

On layoff/unemployed 6 ☐

Other: 7 ☐

Specify: ______________________

D. Education

14. Have you been involved in any educational or training program since the first SOL center visit? (add a field to provide V1 Date)

No 0 ☐ **If no, End Questionnaire** Yes 1 ☐

15. What was the highest grade/level of education achieved? *(Mark only one, If exact level is not listed, mark the closest equivalent.)*

Elementary/primary school (includes grades 1 – 5) 1 ☐
Middle school/junior high (includes grades 6 – 8) 2 ☐
High School/preparatory school/GED 3 ☐
Trade school/vocational school 4 ☐
University/college 5 ☐
Other 6 ☐
If other, please specify: ___________________________

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OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2 Social Support

ID NUMBER:									FORM CODE: SSE VERSION: 1, 12/10/2013	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)   0b. Staff ID: ☐☐☐

***Instructions**: Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

Social Support

*This scale is made up of a **list** of statements each of which may or may not be true about you. For each statement respond "definitely true" if you are sure it is true about you and "probably true" if you think it is true but are not absolutely certain. Similarly, you should respond "definitely false" if you are sure the statement is false and "probably false" if you think it is false but are not absolutely certain.*

	Definitely False	Probably False	Probably True	Definitely True
1. If I wanted to go on a trip for a day (for example to the beach, the country or mountains), I would have a hard time finding someone to go with me.	1 ☐	2 ☐	3 ☐	4 ☐
2. I feel that there is no one I can share my most private worries and fears with.	1 ☐	2 ☐	3 ☐	4 ☐
3. If I were sick, I could easily find someone to help me with my daily chores.	1 ☐	2 ☐	3 ☐	4 ☐
4. There is someone I can turn to for advice about handling problems with my family.	1 ☐	2 ☐	3 ☐	4 ☐
5. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.	1 ☐	2 ☐	3 ☐	4 ☐
6. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.	1 ☐	2 ☐	3 ☐	4 ☐
7. I don't often get invited to do things with others.	1 ☐	2 ☐	3 ☐	4 ☐
8. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).	1 ☐	2 ☐	3 ☐	4 ☐
9. If I wanted to have lunch with someone, I could easily find someone to join me.	1 ☐	2 ☐	3 ☐	4 ☐
10. If I was stranded 10 miles from home, there is someone I could call who could come and get me.	1 ☐	2 ☐	3 ☐	4 ☐
11. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.	1 ☐	2 ☐	3 ☐	4 ☐
12. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.	1 ☐	2 ☐	3 ☐	4 ☐

Public reporting burden for this collection of information is estimated to average 04 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2 Chronic Stress

ID NUMBER:									FORM CODE: STE VERSION: 1, 4/29/2014	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) 0b. Staff ID: ☐☐☐

Instructions: *Enter the answer given by the participant for each response. Use the CDART Notelog window to code 'Don't know/refused, Missing, etc.' for those questions that do not list these as an option.*

A. **Chronic Stress**

Many people experience ongoing problems with their everyday lives. Please tell us whether any of the following has been a problem for you.

1. Have you had a serious ongoing health problem?

   No 0 ☐ → **GO TO QUESTION 2** Yes 1 ☐

   1a. Has this been a problem for six months or more?

   No 0 ☐ Yes 1 ☐

   1b. Would you say this problem has been

   Not very stressful 1 ☐
   Moderately Stressful 2 ☐
   Very Stressful 3 ☐

2. Has someone close to you had a serious ongoing health problem?

   No 0 ☐ → **GO TO QUESTION 3** Yes 1 ☐

   2a. Has this been a problem for six months or more?

   No 0 ☐ Yes 1 ☐

   2b. Would you say this problem has been

   Not very stressful 1 ☐
   Moderately Stressful 2 ☐
   Very Stressful 3 ☐

3. Have you had ongoing difficulties with your job or ability to work?

   No 0 ☐ → **GO TO QUESTION 4** Yes 1 ☐

   3a. Has this been a problem for six months or more?

   No 0 ☐ Yes 1 ☐

3b. Would you say this problem has been

Not very stressful 1 ☐
Moderately Stressful 2 ☐
Very Stressful 3 ☐

4. Have you experienced ongoing financial strain?

No 0 ☐ → **GO TO QUESTION 5** Yes 1 ☐

4a. Has this been a problem for six months or more?

No 0 ☐ Yes 1 ☐

4b. Would you say this problem has been

Not very stressful 1 ☐
Moderately Stressful 2 ☐
Very Stressful 3 ☐

5. Have you had ongoing difficulties in a relationship with someone close to you?

No 0 ☐ → **GO TO QUESTION 6** Yes 1 ☐

5a. Has this been a problem for six months or more?

No 0 ☐ Yes 1 ☐

5b. Would you say this problem has been

Not very stressful 1 ☐
Moderately Stressful 2 ☐
Very Stressful 3 ☐

6. Has someone close to you had an ongoing problem with alcohol or drug use?

No 0 ☐ → **GO TO QUESTION 7** Yes 1 ☐

6a. Has this been a problem for six months or more?

No 0 ☐ Yes 1 ☐

6b. Would you say this problem has been

Not very stressful 1 ☐
Moderately Stressful 2 ☐
Very Stressful 3 ☐

7. Have you been helping someone close to you, who is sick, limited or frail?

No 0 ☐ → **GO TO QUESTION 8** Yes 1 ☐

7a. Has this been a problem for six months or more?

No 0 ☐ Yes 1 ☐

7b. Would you say this problem has been

Not very stressful 1 ☐
Moderately Stressful 2 ☐
Very Stressful 3 ☐

8. Have you had another ongoing problem not listed here?

No 0 ☐ → **End questionnaire** Yes 1 ☐

8a. If yes, please describe: ______________________________

8b. Has this been a problem for six months or more?

No 0 ☐ Yes 1 ☐

8c. Would you say this problem has been

Not very stressful 1 ☐
Moderately Stressful 2 ☐
Very Stressful 3 ☐

Public reporting burden for this collection of information is estimated to average 07 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL- Visit 2- Tobacco Use Questionnaire

ID NUMBER:									FORM CODE:TBE VERSION: 1, 8/22/2014	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: *Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

The following questions are about tobacco and tobacco use.

A. Cigarette Smoking

1. Have you ever smoked at least 100 cigarettes in your entire life?

   No 0 ☐ → **Go to Question 13** Yes 1 ☐

2. How old were you when you first started to smoke cigarettes fairly regularly?

   ☐☐ Years old ☐ Never smoked cigarettes regularly *(enter 99)*

3. When you first started smoking cigarettes, did you start with cigarettes flavored to taste like menthol or mint?

   No 0 ☐ Yes 1 ☐

4. Do you NOW smoke daily, some days or not at all?

   Daily 1 ☐ → **Go to Question 5**
   Some days 2 ☐ → **Go to Question 6**
   Not at all 3 ☐ → **Go to Question 7**

B. Smoke Daily

5. How many cigarettes do you smoke per day now?

   ☐☐ Cigarettes per day (= *1 for 1 or fewer per day)* **Go to Question 9**

C. Smoke Some Days

6. During the past 30 days, how many days did you smoke cigarettes?

   ☐☐ Number of days

   6.a. During the past 30 days, on days that you smoked, how many cigarettes did you smoke per day?

   ☐☐ Cigarettes per day (= *1 for 1 or fewer per day)* **Go to Question 9**

D. Currently Smoke Not at All

7. How old were you when you completely stopped smoking? ☐☐ Years old

8. What is the main reason you quit smoking cigarettes?
   - Advice of physician 1 ☐
   - Health reasons, self-initiated, including disease prevention 2 ☐
   - Pressure from others, excluding physician 3 ☐
   - Other 4 ☐

   If other, please specify: ________________________

E. Smoking Cessation Aids

9. Has a doctor ever prescribed any aids to help you quit smoking, such as nicotine replacement gum, the patch, or any type of medication?
   - No 0 ☐
   - Yes, currently using 1 ☐
   - Yes, past use 2 ☐

10. Have you ever used any over-the-counter aids to help you quit smoking, such as nicotine replacement gum, the patch, or any type of medication?
    - No 0 ☐
    - Yes, currently using 1 ☐
    - Yes, past use 2 ☐

11. Have you ever used behavioral or group therapy to help you quit smoking?
    No 0 ☐ Yes 1 ☐

12. Of the ENTIRE time you have or had smoked, on average how many cigarettes do you or did you smoke per day?
    ☐☐ Cigarettes per day *(=1 for 1 or fewer per day)*

F. Products other than cigarettes

13. Have you ever smoked tobacco using a hookah (waterpipe), even once?
    No 0 ☐ **Go to Question 14** Yes 1 ☐

    13.a. During the past 30 days, did you smoke tobacco using a hookah (waterpipe)?
    No 0 ☐ **Go to Question 14** Yes 1 ☐

    13.a.1. How many days ☐☐

14. Have you ever used spit tobacco, chew, dip, or “snus” tobacco (Copenhagen, Skoal, Grizzly), even once?
    No 0 ☐ **Go to Question 15** Yes 1 ☐

14.a. During the past 30 days, did you spit tobacco, chew, dip, or "snus" tobacco (Copenhagen, Skoal, Grizzly)?

No 0 ☐ **Go to Question 15** Yes 1 ☐

14.a.1. How many days ☐☐

15. Have you ever smoked an e-cigarette or electronic cigarette (Blue, V2), even once?

No 0 ☐ **Go to Question 16** Yes 1 ☐

15.a. During the past 30 days, did you smoke an e-cigarette or electronic cigarette (Blu, V2)?

No 0 ☐ **Go to Question 16** Yes 1 ☐

15.a.1. How many days ☐☐

16. Have you ever smoked a cigar, cigarillo or flavored cigar (Black & Mild, Swisher Sweets), even once?

No 0 ☐ **Go to Question 17** Yes 1 ☐

16.a. During the past 30 days, did you smoke a cigar, cigarillo or flavored cigar (Black & Mild, Swisher Sweets)?

No 0 ☐ **Go to Question 17** Yes 1 ☐

16.a.1. How many days ☐☐

17. Not counting yourself, how many people currently living in your household smoke regularly in the home?

None 0 ☐
1 person 1 ☐
2 people 2 ☐
3 people 3 ☐
4 or more people 4 ☐

18. During the past year, how many hours per week, on average, were you in close contact with people who were smoking? This includes time at home, at work, in a car, or other close quarters.

☐☐☐ Hours per week

19. During the past 7 days, were you exposed to smoke from cigarettes, cigars, or pipes that someone else was smoking?

	No	Yes
Anywhere inside your home?	0 ☐	1 ☐
In your work area?	0 ☐	1 ☐
In a car?	0 ☐	1 ☐
In an indoor or outdoor public space?	0 ☐	1 ☐

Public reporting burden for this collection of information is estimated to average 04 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL- Visit 2- Well-Being Questionnaire

ID NUMBER:									FORM CODE: WBE VERSION: 1, 6/28/2014	Contact Occasion	0	2	SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

***Instructions**: Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.*

A. CES-D 10

I am going to read a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week. Respond by saying “rarely or none of the time’, meaning less than one day during the past week, ‘some or a little of the time’, meaning one to two days during the past week, ‘occasionally or a moderate amount of time, meaning three to four days, or ‘all of the time’ meaning five to seven days. Choose only one of these categories for each statement I read.

	Rarely or none of the time (<1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
1. I was bothered by things that usually don’t bother me.	0 ☐	1 ☐	2 ☐	3 ☐
2. I had trouble keeping my mind on what I was doing.	0 ☐	1 ☐	2 ☐	3 ☐
3. I felt depressed.	0 ☐	1 ☐	2 ☐	3 ☐
4. I felt that everything I did was an effort.	0 ☐	1 ☐	2 ☐	3 ☐
5. I felt hopeful about the future.	0 ☐	1 ☐	2 ☐	3 ☐
6. I felt fearful.	0 ☐	1 ☐	2 ☐	3 ☐
7. My sleep was restless.	0 ☐	1 ☐	2 ☐	3 ☐
8. I was happy.	0 ☐	1 ☐	2 ☐	3 ☐
9. I felt lonely.	0 ☐	1 ☐	2 ☐	3 ☐
10. I could not “get going”.	0 ☐	1 ☐	2 ☐	3 ☐

B. GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
11. Feeling nervous, anxious or on edge	0 ☐	1 ☐	2 ☐	3 ☐
12. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
13. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
14. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
15. Being so restless that it is hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
16. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
17. Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐