Kaiser Permanente

RESEARCH BANK SURVEY

Marking Instructions

1. **Use a Number 2 pencil or black pen. Please don't make any marks or comments in the margins so that we are able to count your responses correctly.**
2. **To answer the questions, fill in the square which bests shows your answer.** ☐ ■ ☐
3. **Fill the square completely. Do not use check marks ✓ or x's.**
4. **If you wish to change an answer, place an X through the wrong response and shade the correct square.** ☒ ☐ ■
5. **Please PRINT where applicable. Enter only one letter or number per box.** 2 1 D
6. **If you have questions about the survey, please call the Contact Center at 1-844-268-2947.**

Section A: General Information

1. How many people live in your household?
(Including yourself, spouse/partner, children, and other relatives.)

- ☐ 1 (Live Alone)
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more

2. What is your current marital status?

- ☐ Never Married
- ☐ Married
- ☐ Registered Domestic Partnership, Civil Union, or Common-Law Marriage
- ☐ Partnered and Living as Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

3. What is your current work status?
(Mark all that apply.)

- ☐ Full-time employed
- ☐ Part-time employed
- ☐ Retired
- ☐ Disabled
- ☐ Full-time student
- ☐ Part-time student
- ☐ Homemaker
- ☐ Unemployed
- ☐ Other (please specify):

4. In the last 12 months, have you visited any social networking sites, such as Facebook, LinkedIn, Instagram, Ello, or Twitter?

- ☐ No *(Go to Question 5)*
- ☐ Yes *(Go to Question 4a)*

4a. → If YES, how often do you visit social networking sites?

- ☐ Less than 1 time per month
- ☐ 1 - 3 times per month
- ☐ 1 - 3 times per week
- ☐ 4 - 6 times per week
- ☐ Every day

5. What was your physical sex assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Other

6. What is your current gender?

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Male to female transgender
- ☐ Female to male transgender
- ☐ Other (please specify):

Section B: Environment and Work-Related Exposure

7. How often do you walk to places in your neighborhood where you need or want to do things?
Examples of these types of activities include shopping, dining out, school, church, etc.

☐ Daily ☐ 3 - 4 times a month ☐ Almost never or never
☐ 3 - 6 times a week ☐ 1 - 2 times a month

8. In the area within a few blocks or streets of your home, how safe do you feel alone on the streets during the day?

☐ Very safe ☐ Somewhat safe
☐ Mostly safe ☐ Not safe at all

9. In the area within a few blocks or streets of your home, how safe do you feel alone on the streets during the night?

☐ Very safe ☐ Somewhat safe
☐ Mostly safe ☐ Not safe at all

10. In your work, are (or were) you regularly exposed to any of the following?

			If YES, mark the total number of years exposed			
	No / Don't Know	YES	Less than 5 years	5 – 10 years	11 – 20 years	21 or more years
Asbestos	☐	☐	☐	☐	☐	☐
Acids	☐	☐	☐	☐	☐	☐
Cement / Silica / Stone Dust	☐	☐	☐	☐	☐	☐
Coal Dust	☐	☐	☐	☐	☐	☐
Coal Tar / Pitch / Asphalt	☐	☐	☐	☐	☐	☐
Cutting Fluids or Degreasing Agents	☐	☐	☐	☐	☐	☐
Diesel Engine Exhaust	☐	☐	☐	☐	☐	☐
Gasoline Engine Exhaust	☐	☐	☐	☐	☐	☐
Dyes	☐	☐	☐	☐	☐	☐
Fiberglass	☐	☐	☐	☐	☐	☐
Formaldehyde	☐	☐	☐	☐	☐	☐
Herbicides	☐	☐	☐	☐	☐	☐
Insecticides	☐	☐	☐	☐	☐	☐
Fungicides	☐	☐	☐	☐	☐	☐
Metals or Metal Fumes (non-welding)	☐	☐	☐	☐	☐	☐
Paints	☐	☐	☐	☐	☐	☐
Plastics during molding/processing	☐	☐	☐	☐	☐	☐
Solvents - organic	☐	☐	☐	☐	☐	☐
Solvents - other	☐	☐	☐	☐	☐	☐
Textile Fibers or Textile Dust	☐	☐	☐	☐	☐	☐
Welding / Welding Fumes	☐	☐	☐	☐	☐	☐
Wood Dust	☐	☐	☐	☐	☐	☐
X-rays / Radioactive Materials	☐	☐	☐	☐	☐	☐

11. Have you ever worked <u>rotating</u> night shifts (working at least 3 nights per month in addition to working day shifts that month)?

☐ No

☐ Yes → **If YES** → Less than 1 year ☐ | 1 - 5 years ☐ | 6 - 10 years ☐ | 11 - 20 years ☐ | 21 - 30 years ☐ | 31 or more years ☐

12. Have you ever worked <u>permanent</u> night shifts?

☐ No

☐ Yes → **If YES** → Less than 1 year ☐ | 1 - 5 years ☐ | 6 - 10 years ☐ | 11 - 20 years ☐ | 21 - 30 years ☐ | 31 or more years ☐

Section C: General Health

13. Please respond to each item by marking <u>one</u> box per row.

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:	☐	☐	☐	☐	☐
In general, would you say your quality of life is:	☐	☐	☐	☐	☐
In general, how would you rate your physical health?	☐	☐	☐	☐	☐
In general, how would you rate your mental health, including your mood and your ability to think? *	☐	☐	☐	☐	☐
In general, how would you rate your satisfaction with your social activities and relationships?	☐	☐	☐	☐	☐
In general, please rate how well you carry out your usual social activities and roles. *(This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)*	☐	☐	☐	☐	☐

14. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

☐ Completely ☐ A little
☐ Mostly ☐ Not at all
☐ Moderately

15. In the <u>past 7 days</u>, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable? *

☐ Never ☐ Often
☐ Rarely ☐ Always
☐ Sometimes

*** Note: People who are experiencing depression or mood problems can have intense feelings. If you feel like you can't cope, life is very difficult, or your life isn't worth living, get help now. These are signs that you need to talk to someone. Contact Kaiser Permanente by calling your local member services number listed on the last page of this survey. Trained Kaiser Permanents staff will evaluate your situation and find the right care for you.*

16. In the <u>past 7 days</u>, how would you rate your fatigue on average?

☐ None ☐ Severe
☐ Mild ☐ Very severe
☐ Moderate

17. In the <u>past 7 days</u>, how would you rate your pain on average? *(Please mark <u>one</u> box.)*

No pain → **Worst pain imaginable**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

18. Have you <u>ever</u> had persistent pain; that is pain that lasted longer than one month? This pain may have come and gone, but stayed with you for over a month.

- ☐ No *(Go to Question 19)*
- ☐ Yes *(Go to Question 18a & 18b)*

18a. → If YES, about how many <u>total</u> months or years did you have this pain?

- ☐ 1 - 5 months
- ☐ 6 - 11 months
- ☐ 1 - 4 years
- ☐ 5 - 9 years
- ☐ 10 - 14 years
- ☐ 15 - 20 years
- ☐ 20 or more years

18b. → If YES, how many months or years has it been since you <u>last</u> had this pain?

- ☐ 1 - 5 months
- ☐ 6 - 11 months
- ☐ 1 - 4 years
- ☐ 5 - 9 years
- ☐ 10 - 14 years
- ☐ 15 - 20 years
- ☐ 20 or more years

Section D: Sleep and Exercise

19. During the <u>past month</u>, about how many hours of actual sleep do you get in a typical 24-hour period?
(This may be different than the time you spent in bed.)

- ☐ 5 hours or less
- ☐ 6 hours
- ☐ 7 hours
- ☐ 8 hours
- ☐ 9 hours
- ☐ 10 hours
- ☐ 10 or more hours

20. During the <u>past month</u>, how would you rate your sleep quality overall?

- ☐ Very good
- ☐ Fairly good
- ☐ Fairly bad
- ☐ Very bad

21. During the <u>past month</u>, how often have you had trouble staying awake while driving, eating meals, or engaging in social activities?

- ☐ Not at all
- ☐ Less than 1 time per week
- ☐ 1 or 2 times per week
- ☐ 3 or more times per week

22. During the <u>past month</u>, has anyone told you that you snore loudly (louder than talking or loud enough to be heard through a closed door)?

- ☐ No
- ☐ Yes

23. During the <u>past month</u>, has anyone observed you stop breathing during your sleep?

- ☐ No
- ☐ Yes

24. During the <u>past month,</u> about how many hours did you spend sitting each day while <u>at work</u>?

- ☐ Retired or did not work outside the home
- ☐ Less than 1 hour per day
- ☐ 1 - 2 hours per day
- ☐ 3 - 4 hours per day
- ☐ 5 - 6 hours per day
- ☐ 7 or more hours per day

25. During the <u>past month</u>, about how many hours did you spend sitting each day while <u>not at work</u>?
(Provide a response for weekdays and weekends separately. Include time spent sitting while watching television, at a computer, reading, riding in a car, riding public transportation, etc.)

25a. Weekdays (Monday – Friday):

- ☐ Less than 1 hour per day
- ☐ 1 - 2 hours per day
- ☐ 3 - 4 hours per day
- ☐ 5 - 6 hours per day
- ☐ 7 or more hours per day

25b. Weekends (Saturday – Sunday):

- ☐ Less than 1 hour per day
- ☐ 1 - 2 hours per day
- ☐ 3 - 4 hours per day
- ☐ 5 - 6 hours per day
- ☐ 7 or more hours per day

26. During the past 7 days, please record the number of days that you did each of the following activities. Also, record the average minutes per day that you did each activity on the days that you did that activity.

	Number of Days *(select only one choice for each exercise category)*	**Minutes per Day** *(select only one choice for each exercise category)*
Mild Exercise Walking fast enough to cause your heart rate to increase somewhat	☐ None ☐ 1 - 2 days ☐ 3 - 4 days ☐ 5 - 6 days ☐ Every day	☐ 0 - 9 min. ☐ 10 - 19 min. ☐ 20 - 29 min. ☐ 30 - 59 min. ☐ 60 or more min.
Moderate Exercise Sports or other physical activity that caused your heart rate to increase somewhat **(other than walking)**	☐ None ☐ 1 - 2 days ☐ 3 - 4 days ☐ 5 - 6 days ☐ Every day	☐ 0 - 9 min. ☐ 10 - 19 min. ☐ 20 - 29 min. ☐ 30 - 59 min. ☐ 60 or more min.
Vigorous Exercise Sports or other physical activity that caused you to work up a sweat or caused your heart rate to greatly increase	☐ None ☐ 1 - 2 days ☐ 3 - 4 days ☐ 5 - 6 days ☐ Every day	☐ 0 - 9 min. ☐ 10 - 19 min. ☐ 20 - 29 min. ☐ 30 - 59 min. ☐ 60 or more min.

Section E: Vitamins, Supplements, Common Medicines, and Diet

27. During the past 12 months, how often did you take each of the following? *(Please respond to each item by marking one box per row.)*

	Never taken	**Took before but have not taken in the past 12 months**	**In the past 12 months, I took this:**				
			Less than once/week	1 - 2 times/ week	3 - 4 times/ week	5 - 6 times/ week	Every day
Multivitamin	☐	☐	☐	☐	☐	☐	☐
Vitamin D	☐	☐	☐	☐	☐	☐	☐
Calcium	☐	☐	☐	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐	☐	☐	☐
Ibuprofen (e.g., Advil, Motrin, etc.)	☐	☐	☐	☐	☐	☐	☐

28. Using the <u>past 12 months</u> as a guide, how often did you eat or drink the foods and beverages below?
(Please respond to each item by marking <u>one</u> box per row.)

Food, food group, or beverage	I don't eat or drink this food	I eat or drink this food:				
		Less than once/week	1 - 2 times/ week	3 - 4 times/ week	5 - 6 times/ week	Every day
Vegetables	☐	☐	☐	☐	☐	☐
Fruits (Do not count juices)	☐	☐	☐	☐	☐	☐
Milk (e.g., whole, low-fat or skim)	☐	☐	☐	☐	☐	☐
Other dairy products (e.g., hard cheese, butter, ice cream, yogurt, cottage cheese)	☐	☐	☐	☐	☐	☐
Whole eggs	☐	☐	☐	☐	☐	☐
Margarine (stick-type, not tub)	☐	☐	☐	☐	☐	☐
Whole grain foods (e.g., whole grain breads, brown rice)	☐	☐	☐	☐	☐	☐
Oatmeal	☐	☐	☐	☐	☐	☐
Pasta, white rice, noodles	☐	☐	☐	☐	☐	☐
Sweet baked products (e.g., donuts, cookies, muffins, cakes, sweet rolls, pastries)	☐	☐	☐	☐	☐	☐
Beans, peas, lentils	☐	☐	☐	☐	☐	☐
Nuts, seeds	☐	☐	☐	☐	☐	☐
Peanut butter	☐	☐	☐	☐	☐	☐
Beef, pork or lamb as main dish	☐	☐	☐	☐	☐	☐
Processed meats (e.g., sausages, salami, bologna, hot dogs, bacon)	☐	☐	☐	☐	☐	☐
Poultry (e.g., chicken, turkey)	☐	☐	☐	☐	☐	☐
Fish/seafood	☐	☐	☐	☐	☐	☐
Deep fried foods (e.g., deep fried chicken, fish or seafood; french fries, onion rings)	☐	☐	☐	☐	☐	☐
Vegetable oil (e.g., olive or sunflower)	☐	☐	☐	☐	☐	☐
Caffeinated coffee	☐	☐	☐	☐	☐	☐
Black/green tea	☐	☐	☐	☐	☐	☐
Soft drinks or sodas (e.g., regular sweetened soft drinks, diet soft drinks)	☐	☐	☐	☐	☐	☐
Sport or energy drinks (e.g., Gatorade, Red Bull, Vitamin Water)	☐	☐	☐	☐	☐	☐
100% fruit juice	☐	☐	☐	☐	☐	☐
Fast food (e.g., McDonald's, KFC, Panda Express, or Taco Bell), *Include fast food meals eaten at work, at home, or at fast-food restaurants, carryout or drive through.*	☐	☐	☐	☐	☐	☐

Section F: Medical and Family History

29. Do you have any allergies that are serious enough that you had to go to the doctor or hospital for treatment?

- ☐ No *(Go to Question 30)*
- ☐ Yes *(Go to Question 29a)*

29a. → If YES, to which of the following are you allergic? *(Mark all that apply.)*

- ☐ Food allergies (e.g., shellfish, nuts)
- ☐ Grasses, pollen or dust
- ☐ Pets
- ☐ Insect stings or bites
- ☐ Common medicines (e.g., penicillin)
- ☐ Other (please specify):

30. Have you ever had a bad reaction (or side effect) to a prescription medicine that was serious enough that you had to go to the doctor or hospital for treatment of the reaction?

- ☐ No *(Go to Question 31)*
- ☐ Yes *(Go to Question 30a)*

30a. → If YES, what is the name of the medication?
(If you had a reaction to more than 1 type of medication, please write separate types on each line.)

Medicine 1:

Medicine 2:

Medicine 3:

31. What is your current weight with your shoes off?

Current weight: ☐☐☐ **pounds**

32. What is your current height with your shoes off?

Current height: ☐ **feet** ☐☐ **inches**

33. How much did you weigh at age 18?

Weight at 18: ☐☐☐ **pounds**

34. What has been your highest weight after age 18?
(Report your highest weight while not pregnant and not in the 12 months following the birth of a child.)

Highest weight: ☐☐☐ **pounds**

Age at highest weight: ☐☐ **years**

35. Are you a twin, triplet (or more)?

- ☐ No
- ☐ Yes, I am an identical twin
- ☐ Yes, I am a fraternal twin
- ☐ Yes, I am a triplet or more
- ☐ Don't know

36. Are you adopted?

- ☐ No *(Go to Question 37)*
- ☐ Yes *(Go to Question 39)*
- ☐ Don't know *(Go to Question 39)*

37. How many full brothers and sisters do you have?
(Include only brothers and sisters who have your same biological mother and father. Include those who are alive and any who may have died.)

Brother(s): ☐☐ **Sister(s):** ☐☐

38. Has anyone in your immediate family (mother, father, or siblings) ever had any of the conditions below?
(Please mark the boxes only for your biological father and mother, and for brothers and sisters who have your same mother and father (include those who are alive and any who may have died.)) Mark all that apply.

	No immediate family members have had this	Father	Mother	Brothers		Sisters	
				One	2 or more	One	2 or more
Heart attack or sudden cardiac arrest	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Brain aneurysm	☐	☐	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐	☐	☐
Colon or rectal cancer	☐	☐	☐	☐	☐	☐	☐
Ovarian cancer	☐		☐			☐	☐
Prostate cancer	☐	☐		☐	☐		
Lung cancer	☐	☐	☐	☐	☐	☐	☐
Thyroid cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Bleeding disorder (e.g., easy bruising or bleeding)	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Alzheimer's disease	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Bipolar disorder	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Reaction to anesthesia	☐	☐	☐	☐	☐	☐	☐
Rheumatic disease (e.g., lupus, rheumatoid arthritis, scleroderma)	☐	☐	☐	☐	☐	☐	☐

Section G: Smoking, Alcohol, and Drugs

39. How often did you have a drink with alcohol in the past year?

- ☐ Never *(Go to Question 42)*
- ☐ 1 time per month or less
- ☐ 2 - 4 times per month
- ☐ 2 - 3 times per week
- ☐ 4 - 6 times per week
- ☐ Every day

40. On the days that you did drink alcohol during the past year, on average, how many drinks did you have per day?
(1 drink = 12 oz. of beer, 5 oz. of wine, or 1 oz. shot of hard liquor. For reference, a typical can of soda = 12 oz.)

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

41. During the past year, how often did you have six or more drinks at one occasion?

- ☐ Never
- ☐ Less than once per month
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

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

- ☐ No *(Go to Question 48)*
- ☐ Yes *(Go to Question 43)*

43. On the average, how many cigarettes per day do you smoke (or did you smoke when you did smoke)? (1 Pack = 20 cigarettes)

☐☐☐ Number of cigarettes (per day)

44. How old were you when you first smoked a cigarette?

Age: ☐☐ **years**

45. Do you currently smoke cigarettes every day, some days, or not at all?

- ☐ Every day *(Go to Question 46)*
- ☐ Some days *(Go to Question 46)*
- ☐ Not at all *(Go to Question 45a)*

45a. → If NOT AT ALL, how old were you when you last smoked cigarettes regularly?

Age: ☐☐ **years**

→ If former smoker, skip to question 48.

46. How soon after you wake up do you smoke your first cigarette?

- ☐ Within 5 minutes
- ☐ 6 - 30 minutes
- ☐ 31 - 60 minutes
- ☐ After 60 minutes

47. In the past year, how many times have you quit smoking for 24 hours or more? (Do not count being in a hospital or in a prison.)

☐☐ **time(s)**

48. Do you smoke other types of tobacco (e.g., pipe, cigars, hookah (water pipe))?

- ☐ Never used
- ☐ Former user
- ☐ Current user

49. Do you use smokeless tobacco (e.g., snuff, chew, dip, snus, betel quid)?

- ☐ Never used
- ☐ Former user
- ☐ Current user

50. Have you ever used electronic cigarettes or other forms of Electronic Nicotine Delivery Systems (ENDS) such as E-Hookah or vape pen?

- ☐ No *(Go to Question 51)*
- ☐ Yes, more than a year ago but not in the past year *(Go to Question 51)*
- ☐ Yes, in the past year but more than a month ago *(Go to Question 51)*
- ☐ Yes, in the past month *(Go to Question 50a)*

50a. → If YES, in the past 30 days, on how many days did you use an E-cigarette/E-Hookah/vape pen?

☐☐ **day(s)**

51. Have you ever used marijuana?

- ☐ No *(Go to Question 55)*
- ☐ Yes *(Go to Question 52)*
- ☐ Prefer not to answer *(Go to Question 55)*

52. In your lifetime, about how many times have you used marijuana?

- ☐ 1 or 2 times
- ☐ 3 - 10 times
- ☐ 11 - 99 times
- ☐ 100 - 499 times
- ☐ 500 or more times

53. During the last 30 days, on how many days did you use marijuana? *(If you did not use it in the last 30 days, write "00" and go to Question 55.)*

☐☐ **day(s)**

54. During the last 30 days, you used marijuana for:

- ☐ Medical or health reasons only
- ☐ Recreational reasons only
- ☐ Both medical and recreational reasons

55. Not including marijuana, how often in the past year have you used an illegal drug or used a prescription medicine for non-medical reasons?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily
- ☐ Prefer not to answer

56. How many times in the past year have you used prescription opioid medicine (e.g., Vicodin, Norco, morphine, OxyContin, Opana, Fentanyl) for non-medical reasons?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily
- ☐ Prefer not to answer

Section H: Emotional Health and Support

57. The questions below ask you about your feelings and thoughts during the last month. In each case, you will be asked how often you felt or thought a certain way. *(Please respond to each item by marking one box per row.)*

	Never	Almost never	Sometimes	Fairly often	Very often
In the last month, how often have you felt that you were unable to control the important things in your life?	☐	☐	☐	☐	☐
In the last month, how often have you felt confident about your ability to handle your personal problems?	☐	☐	☐	☐	☐
In the last month, how often have you felt that things were going your way?	☐	☐	☐	☐	☐
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	☐	☐	☐	☐	☐

58. Do you have someone to help you if you are confined to a bed?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Usually
- ☐ Always

59. Do you have someone to take you to the doctor if you need it?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Usually
- ☐ Always

60. Do you have someone to help with your daily chores if you are sick?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Usually
- ☐ Always

61. Do you have someone to run errands if you need it?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Usually
- ☐ Always

62. Please respond to each item by marking <u>one</u> box per row.

	Never	Rarely	Sometimes	Usually	Always
I have someone who will listen to me when I need to talk	☐	☐	☐	☐	☐
I have someone to confide in or talk to about myself or my problems	☐	☐	☐	☐	☐
I have someone who makes me feel appreciated	☐	☐	☐	☐	☐
I have someone to talk with when I have a bad day	☐	☐	☐	☐	☐
I feel left out	☐	☐	☐	☐	☐
I feel that people barely know me	☐	☐	☐	☐	☐
I feel isolated from others	☐	☐	☐	☐	☐
I feel that people are around me but not with me	☐	☐	☐	☐	☐

63. In your day-to-day life how often have any of the following things happened to you?

	Never	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day
You are treated with less courtesy or respect than other people	☐	☐	☐	☐	☐	☐
You receive poorer service than other people at restaurants or stores	☐	☐	☐	☐	☐	☐
People act as if they think you are not smart	☐	☐	☐	☐	☐	☐
People act as if they are afraid of you	☐	☐	☐	☐	☐	☐
You are threatened or harassed	☐	☐	☐	☐	☐	☐

→ If you answered <u>"A few times a year" or more frequently</u> to at least one above, please answer the following:

63a. What do you think is the reason for these experiences? *(Mark all that apply.)*

- ☐ Ancestry or National origins
- ☐ Gender
- ☐ Race
- ☐ Age
- ☐ Religion
- ☐ Height
- ☐ Weight
- ☐ Sexual orientation
- ☐ Education or Income
- ☐ Physical disability
- ☐ Other (please specify):

Complete this section if you identify as Female. If you identify as Male, go to Question 70.

Section I: Reproductive Health

64. At what age did you have your first menstrual period? *(Your best guess)*

- ☐ 9 years or younger
- ☐ 10 years
- ☐ 11 years
- ☐ 12 years
- ☐ 13 years
- ☐ 14 years
- ☐ 15 years
- ☐ 16 years
- ☐ 17 years and older
- ☐ Never had a menstrual period
  (Go to Question 66)

65. What best describes your menstrual cycle in the past year?

- ☐ I have regular periods *(Go to Question 66)*
- ☐ I have irregular periods *(Go to Question 66)*
- ☐ I did not have a period in the past year
  (Go to Question 65a)

65a. → If you did not have a period, why?

- ☐ Natural menopause at **age →** ☐☐ **year(s)**
- ☐ Hysterectomy (removal of the womb/uterus) at **age →** ☐☐ **year(s)**
- ☐ Removal of both ovaries at **age →** ☐☐ **year(s)**
- ☐ Recent pregnancy / breastfeeding
- ☐ Medical treatment, such as hormones or hormonal IUD (e.g., Mirena or Skyla)
- ☐ Don't know
- ☐ Other (please specify):

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

66. Have you ever used prescription hormones (other than birth control pills) for relief of menopausal symptoms, irregular periods, or prevention of disease, such as bone loss?

- ☐ No, never *(Go to Question 67)*
- ☐ Yes, I currently use them
  (Go to Question 66a & 66b)
- ☐ Yes, but I no longer use them
  (Go to Question 66a & 66b)

66a. → If YES, how many years in total have you, or did you, take them? *Do not include times when you briefly stopped. (If less than 1 year, enter 1.)*

☐☐ **year(s)**

66b. → If YES, what type of hormones do you, or did you, take? *(Mark all that apply.)*

- ☐ **Combined estrogen and progestin pill or patch** (e.g., Climara-Pro, Prempro, FemHRT)
- ☐ **Estrogen in pill, patch, or vaginal estrogen** (e.g., Premarin, Estring, Cenestin, Alora)
- ☐ **Progesterone/Progestin** (e.g., Provera, Prometrium)
- ☐ **Other hormones** (e.g., Testosterone)
- ☐ **Don't know**

67. Have you <u>ever used</u> any of these types of birth control methods?

	No	YES, currently	YES, but no longer using	If YES, total years of use *If less than 1 year, write 1*
Birth Control Pills	☐	☐	☐	☐☐ **year(s)**
Norplant (inserted under the skin of your upper arm)	☐	☐	☐	☐☐ **year(s)**
Depo Provera (birth control shot)	☐	☐	☐	☐☐ **year(s)**
Hormonal Intrauterine Device (IUD), such as Mirena or Skyla	☐	☐	☐	☐☐ **year(s)**
Vaginal Ring, such as Nuva Ring	☐	☐	☐	☐☐ **year(s)**
Birth Control Patch, such as Ortha Evra	☐	☐	☐	☐☐ **year(s)**

68. Have you ever been pregnant, including pregnancies that resulted in miscarriages, stillbirths, tubal or ectopic pregnancies, abortion and live births?

☐ No *(Go to Question 69)*
☐ Yes *(Go to Question 68a & 68b)*

68a. → If YES, how many times have you been pregnant?

☐ 1
☐ 2
☐ 3
☐ 4 or more

68b. → How many live births have you had?

☐ None *(Go to Question 69)*
☐ 1 *(Go to Question 68c)*
☐ 2 *(Go to Question 68c)*
☐ 3 *(Go to Question 68c)*
☐ 4 or more *(Go to Question 68c)*

68c. → How old were you when you gave birth for the first time?

☐ Less than 16 yrs.
☐ 16 - 19 yrs.
☐ 20 - 24 yrs.
☐ 25 - 29 yrs.
☐ 30 - 34 yrs.
☐ 35 - 39 yrs.
☐ 40 or more yrs.
☐ Don't know

69. Have you ever tried to become pregnant for more than one year without success?

☐ No *(Go to Question 73)*
☐ Yes *(Go to Question 69a & 69b)*

69a. → If YES, how old were you when this first occurred?

Age ☐☐ **year(s)**

69b. → What was the cause of the fertility problems? *(Mark all that apply.)*

☐ Tubal blockage
☐ Ovary or hormone problem (e.g., polycystic ovary syndrome (PCOS))
☐ Endometriosis
☐ Cervical mucus factors
☐ Spouse/Partner
☐ Not investigated
☐ Investigated, but no cause found
☐ Other (please specify):

Complete this section if you identify as Male. If you identify as Female, go to Question 73.

Section I: Urinary and Reproductive Health

70. Over the past month, how often did you have any of these urinary symptoms?

	Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always
Feeling of incomplete bladder emptying	☐	☐	☐	☐	☐	☐
Having to urinate again after less than 2 hours	☐	☐	☐	☐	☐	☐
Stopping and starting several times during urination	☐	☐	☐	☐	☐	☐
Finding it difficult to postpone urinating	☐	☐	☐	☐	☐	☐
Weak urinary stream	☐	☐	☐	☐	☐	☐
Having to push or strain to begin urination	☐	☐	☐	☐	☐	☐

71. Over the past month, how many times per night did you usually get up to urinate?

- ☐ 0 times
- ☐ 1 time
- ☐ 2 times
- ☐ 3 times
- ☐ 4 times or more

72. Many men have problems getting and keeping an erection that is rigid enough for satisfactory sexual activity. How would you describe your experience during the past year?
(Without the use of a medication like Viagra, Cialis, Levitra, injectable drugs or penis implant or pump device.)

- ☐ Always able to get and keep an erection good enough for sexual activity
- ☐ Usually able to get and keep an erection good enough for sexual activity
- ☐ Sometimes able to get and keep an erection good enough for sexual activity
- ☐ Never able to get and keep an erection good enough for sexual activity
- ☐ Prefer not to answer

Section J: Demographics and Other Factors

73. What best describes your race or ethnicity?
(Mark all that apply.)

- ☐ African
- ☐ African American or Black
- ☐ Afro-Caribbean
- ☐ Ashkenazi Jewish
- ☐ Central/South American
- ☐ Chinese
- ☐ Cuban
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Mexican
- ☐ Middle Eastern
- ☐ Native American Indian or Alaska Native
- ☐ Native Hawaiian
- ☐ Puerto Rican
- ☐ Samoan
- ☐ South Asian (Indian, Pakistani, etc.)
- ☐ Vietnamese
- ☐ White or European-American
- ☐ Other Latino/Hispanic
- ☐ Other Pacific Islander
- ☐ Other Southeast Asian (Cambodian, Laotian, etc.)
- ☐ Prefer not to answer
- ☐ Other (please specify):

74. What is the highest level of school that you have finished?

- ☐ Grade school (grades 1 - 8)
- ☐ Some high school (grades 9 - 12), no diploma
- ☐ High school graduate or GED
- ☐ Some college, no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Professional school degree (e.g., MD, DDS, DVM, JD) or Doctoral degree
- ☐ Other (please specify):

75. What best describes your household income in the past year (before taxes)?

- ☐ Less than $10,000/year
- ☐ $10,000 - 14,999/year
- ☐ $15,000 - 19,999/year
- ☐ $20,000 - 39,999/year
- ☐ $40,000 - 59,999/year
- ☐ $60,000 - 99,999/year
- ☐ $100,000 - 199,999/year
- ☐ $200,000 or more/year
- ☐ Don't know or decline to state

76. During the past year, how hard has it been for you to pay for the very basics like food, housing, medical care, and heating?

- ☐ Very hard
- ☐ Somewhat hard
- ☐ Not hard at all

77. Were you born in the United States?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

78. Were both of your parents born in the United States?

- ☐ Yes
- ☐ No, my mother was not born in the U.S.
- ☐ No, my father was not born in the U.S.
- ☐ No, neither of my parents were born in the U.S.
- ☐ Don't know
- ☐ Prefer not to answer

79. Is English the main language spoken in your home?

- ☐ No *(Go to Question 79a)*
- ☐ Yes *(Go to Question 80)*

79a. → If NO, what is the main language spoken in your home?

Please specify language:

80. You consider yourself to be:

- ☐ Heterosexual or straight
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Don't know
- ☐ Prefer not to answer
- ☐ Other (please specify):

81. In the past year, your sexual partner(s) have been:

- ☐ Men only
- ☐ Women only
- ☐ Both men and women
- ☐ I have not had sex in the past year
- ☐ Prefer not to answer

82. How often do you need to have someone help you when you read instructions, pamphlets or other written materials from your doctor or pharmacy?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

83. How confident are you filling out medical forms by yourself?

- ☐ Extremely
- ☐ Quite a bit
- ☐ Somewhat
- ☐ A little bit
- ☐ Not at all

84. How would you rate your ability to read?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Okay
- ☐ Poor
- ☐ Very poor

85. Date you completed this survey:

Month / Day / Year

Thank you for taking the time to complete this survey!

If you have any questions or comments about the survey, please call the Contact Center at 1-844-268-2947 or email ResearchBank@kp.org

Member Services by Region

KPCA (both KPNC & KPSC)
800-464-4000
24 hours

KPCO
800-632-9700
Mon-Fri: 8am-6pm MST

KPGA
888-865-5813
Mon-Fri: 7am-7pm EST

KPHI
800-966-5955
Mon-Fri: 8am-5pm & Sat: 8am-Noon HST

KPMA
800-777-7902
Mon-Fri: 7:30am-5:30pm EST

KPNW
800-813-2000
Mon-Fri: 9am-7pm PST