KAISER PERMANENTE

Division of Research

2002 KAISER PERMANENTE MEMBER HEALTH SURVEY

CONFIDENTIAL

Address Corrections (Please ***print***)

_____

_____

Daytime phone: (_____) _____

E-mail address: _____

This Member Health Survey has three main purposes:

- to help Kaiser learn about members' health related needs and interest in different health-related services (including patient education, alternative medicine, and support services)
- to help Kaiser monitor how well we are providing health care to our culturally diverse adult membership
- to help Kaiser conduct high quality health research that will hopefully lead to improving the health and health care services of our members and the larger community.

The survey is **confidential.** Your answers will not be shared with your doctor or employer, become part of your medical record, or affect your medical care, Health Plan membership, or dues.

If you have any questions about or need help with the survey, call us toll-free at (1-800) 723-8055 (choose "Member Health Survey" or email us at MHS2002@kp.org. Please write your phone number, e-mail, and any address corrections above**. This questionnaire should be filled out ONLY for the person named above.**

Please return your questionnaire to: Kaiser Permanente, Division of Research, P.O. Box 2087, Oakland, CA 94604. A pre-addressed, postage paid envelope has been enclosed for this purpose.

Thank you for your help.

These questions are about your health and health-related habits

1. During the <u>past 12 months</u>, did you have (or take medication for) any of the following health problems? *(Check ALL that you had or took medication for)*

- ☐ Heart attack or myocardial infarction
- ☐ Heart problems, including angina
- ☐ Stroke
- ☐ High blood pressure (diagnosed by a clinician)
- ☐ High cholesterol (diagnosed by a clinician)
- ☐ Cancer *(specify type)*:_____
- ☐ Diabetes
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Emphysema/chronic obstructive pulmonary disease
- ☐ Environmental allergy (e.g., hay fever)
- ☐ Parkinson's disease
- ☐ Enlarged prostate *(Men only)*
- ☐ Urine leaks (at least once a week) after feeling pressure to urinate or when coughing, lifting, exercising, etc.
- ☐ Osteoporosis (brittle bones)
- ☐ Arthritis or rheumatism
- ☐ Severe back pain or sciatica
- ☐ Severe neck or shoulder pain
- ☐ Migraine headaches
- ☐ Other type of severe headaches
- ☐ Chronic (frequent or ongoing) pain *(describe):*_____
- ☐ Problem seeing even with glasses
- ☐ Hearing problem or deafness
- ☐ Frequent problems with sleep
- ☐ Depression, sadness, or very low spirits lasting at least 2 weeks
- ☐ Anxiety or panic lasting at least 2 weeks
- ☐ Problem with alcohol or drugs

2. Have you <u>EVER</u> had: *(Check ALL that apply)*

- ☐ Heart problems or a heart attack
- ☐ A stroke
- ☐ High blood pressure (hypertension)
- ☐ Diabetes
- ☐ Cancer *(specify type)*: _____
- ☐ Chronic (ongoing) pain *(describe)*: _____
- ☐ Depression lasting at least 2 weeks as an adult
- ☐ Problems with alcohol or drugs

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

4. Health is often thought of as having two components, physical health (including pain) and emotional well-being or mental health (such as whether you feel depressed or anxious). In general, how would you rate:

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
a. Your physical health:	☐	☐	☐	☐	☐
b. Your emotional/mental health:	☐	☐	☐	☐	☐

5. During the <u>past 12 months</u>, did you use any of the following medicines? *(Check ALL that apply)*

- ☐ Asthma medicine or spray
- ☐ Heart medicine (not including aspirin)
- ☐ Baby aspirin (to prevent stroke/heart attack)
- ☐ High blood pressure medicine
- ☐ Insulin or other diabetes medicine
- ☐ Cholesterol/lipid lowering medicine
- ☐ Antacids for upset stomach, ulcer, etc.
- ☐ Prescription or non-prescription sleep medicine
- ☐ Nicotine patch, nicotine gum, or nicotine spray
- ☐ Prescription pain medicine
- ☐ Non-prescription pain medicine
- ☐ Anti-inflammatory medicine for joint, muscle or arthritis pain (e.g., Advil, ibuprofen)
- ☐ Prescription medicine for depression
- ☐ Prescription medicine for anxiety or panic

6. During the <u>past 12 months</u>, did you use any herbs or other nutritional supplements <u>to treat or prevent your own health problems</u>? *(Check ALL that apply and list others)*

- ☐ Calcium (including Tums or Rolaids)
- ☐ Glucosamine
- ☐ Melatonin
- ☐ Gingko biloba
- ☐ Echinacea
- ☐ St. John's Wort
- ☐ Kava Kava
- ☐ Other herbals/supplements:_____

7. During the <u>past 12 months</u>, did you use any of the following methods <u>to help treat or prevent your own health problems</u>? *(Check ALL that apply)*

- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Acupressure
- ☐ Massage therapy
- ☐ Yoga
- ☐ Body work (Feldenkreis method, etc.)
- ☐ Tai Chi, Chi gong, other movement therapy
- ☐ Deep breathing, mindfulness, or other relaxation or meditation technique
- ☐ Guided imagery/visualization techniques
- ☐ Hypnosis or self-hypnosis
- ☐ Biofeedback
- ☐ Any herbal medicine or herbal supplement
- ☐ Any homeopathic medicine
- ☐ Megavitamin/high dose vitamin therapy (do not include daily multiple vitamins)
- ☐ Very low fat diet (Pritikin, Dean Ornish, etc.)
- ☐ Other special diet:_____
- ☐ Energy healing (magnets, laying on of hands, special energy-emitting machines, etc.)
- ☐ Prayer or spiritual practice you do yourself
- ☐ Religious or spiritual healing by others
- ☐ Psychological counseling or therapy
- ☐ 12-Step / other type of self-help group

8. How tall are you without shoes? ..... _____ Feet _____ Inches

9. How much do you weigh without your shoes and clothes? …….. _____ Pounds

10. During the <u>past 12 months</u>, how often did you usually get physical exercise (such as walking, swimming, gardening, golf, tennis, etc.)?

☐ 5 or more times a week ☐ 1 to 2 times a week ☐ Once a month or less
☐ 3 to 4 times a week ☐ 2 to 4 times a month ☐ Never

11. About how often do you try to eat reduced fat (low-fat or non-fat) foods?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ Never

12. During an average <u>day</u>, about how many servings of fruits and vegetables do you usually eat? *(1 serving = a half cup or a medium piece)* ..... _____ *Servings per Day*

13. Have you ever regularly smoked cigarettes (that is, smoked daily for at least a year)?

☐ Yes ☐ No ➜ ***Skip to Question 15***

14. Do you smoke cigarettes now, even occasionally?

☐ Yes ➜

a. How many cigarettes do you usually smoke per day?…….. _____ Cigarettes

b. How many years in total have you smoked?…… _____ Years

c. Have you made a serious quit attempt in the <u>past 12 months</u>? ☐ Yes ☐ No

d. Are you planning to try to quit smoking in the <u>next 6 months</u>? ☐ Yes ☐ No

☐ No ➜

a. How many cigarettes did you usually smoke per day?……. _____ Cigarettes

b. How many years in total did you smoke? ?…….. _____ Years

c. In what month and year did you <u>quit</u> smoking? _____ (Month) _____ (Year)

15. During the <u>past 12 months</u>, how often have you had a drink containing alcohol?

- ☐ Almost every day
- ☐ 5 to 6 times a week
- ☐ 3 to 4 times a week
- ☐ 1 to 2 times a week
- ☐ 2-4 times a month
- ☐ 1 time a month or less
- ☐ Never in the past 12 months (used to drink)
- ☐ Never in the past 12 months (never drank as adul

} ➜ ***Skip to Question 17***

16. On days when you had a drink, how many drinks did you usually have?
(1 drink = a 12-oz. can of beer, 4 oz. of wine, or 1 oz. shot of hard liquor)..... _____ Drinks

17. How many total hours of sleep per 24 hour day do you usually get (including naps)? ____ Hours

18. During the past 12 months, how often have you felt very stressed, tense or anxious?

☐ Most of the time ☐ Much of the time ☐ Some of the time ☐ A little of the time ☐ Never

19. How much can lifestyle/habits like what you eat, exercise, and weigh affect your health?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

20. How much can stress and emotional troubles (such as depression or anxiety) affect your health?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

21. In the past 12 months, have you received advice or counseling from a Kaiser doctor, nurse, health educator, or other Kaiser health care professional about: *(Check ALL that apply)*

☐ Your diet (what you eat)
☐ Losing weight
☐ Getting more exercise
☐ Quitting smoking
☐ Stress or emotional problems (like depression)
☐ Health screening tests recommended for you

22. When did you last have the following health screening procedures? *Check the FIRST box that applies to you for EACH procedure. For example, if you had a checkup more than 1 year ago but not more than 2 years ago, you would check the box under " within the past" 2 years.*

	NEVER HAD THIS	HAD THIS WITHIN THE PAST: 12 MONTHS	2 YEARS	3-5 YEARS	6-10 YEARS	11 + YEARS
a. Routine health checkup or health appraisal	☐	☐	☐	☐	☐	☐
b. Blood cholesterol test	☐	☐	☐	☐	☐	☐
c. Blood pressure check by a health professional	☐	☐	☐	☐	☐	☐
d. Test to check for blood in your stool/bowel movement (uses a special kit you take home)	☐	☐	☐	☐	☐	☐
e. Sigmoidoscopy or colonoscopy to check for colon/rectal cancer or polyps (flexible tube inserted into the rectum [hole in buttocks])	☐	☐	☐	☐	☐	☐
f. Dental exam by a dentist or hygienist	☐	☐	☐	☐	☐	☐
g. Eye and vision exam by an eye doctor	☐	☐	☐	☐	☐	☐

23. Did you get a flu (influenza) shot between September 2001 and March 15, 2002? ☐ Yes ☐ No

24. During the past 12 months, how many visits to non-Kaiser health professionals (doctor, chiropractor, etc.) did you make for your own health? (*Do not include dentists*) ..... ____Visits

25. During the last 12 months, how many of your own prescriptions did you get filled at non-Kaiser pharmacies? .....____ Prescriptions

26. How would you rate Kaiser Permanente on:

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
a. Medical care you've received when sick or injured?	☐	☐	☐	☐	☐
b. Preventive medicine services you've received (e.g., screening tests and immunizations)?	☐	☐	☐	☐	☐
c. The information and advice you've received about how to improve your health and well-being?	☐	☐	☐	☐	☐

27. Do you have a Kaiser Permanente doctor or nurse practitioner whom you consider to be your regular or personal doctor/clinician? ..... ☐ Yes ☐ No

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These questions will help us describe the Health Plan members who participated in this survey and analyze how their experiences and needs differ.

28. What is your sex? ..... ☐ Male ☐ Female ☐ Transgender *(describe)*: _____

29. What is your date of birth? *(Write month, day, and year. Year should not be 2002)* _____

30. What describes your race and ethnicity? *(Check ALL that apply)*

☐ White or Euro-American
☐ African-American
☐ Other Black *(specify)*:_____
☐ Mexican or Central American ancestry
☐ Other Hispanic/Latino *(specify)*:_____
☐ Middle Eastern (Arab, Israeli sabra)
☐ Indian or Pakistani
☐ Chinese
☐ Southeast Asian *(specify)*:_____
☐ Japanese
☐ Korean
☐ Filipino
☐ Other Asian *(specify)*:_____
☐ Hawaiian/Pacific Islander *(specify)*:_____
☐ Native American Indian or Alaska Native
☐ Other *(specify)*:_____

31. What is the highest level of school you completed? *(Check only ONE answer)*

☐ 8th grade or less
☐ 9th - 11th grade
☐ 12th grade (high school graduate or G.E.D.)
☐ Some college or technical school
☐ Completed 4-year college (eg., B.A., B.S.)
☐ Completed graduate degree

32. What language do you most prefer to use when talking about or learning about your health?

☐ English ☐ Spanish ☐ Cantonese ☐ Other:_____

33. Do you have access to a personal computer? ☐ Yes, at home ☐ Yes, at other location ☐ No

34. Do you have access to the Internet? ☐ Yes, at home ☐ Yes, at other location ☐ No

35. Can you receive e-mail? ☐ Yes, at home ☐ Yes, at other location ☐ No

36. What is your current work status? *(Check only ONE answer)*

☐ Working for pay ➜ How many hours/week?_____
☐ Unemployed, laid off, on strike
☐ Retired or unable to work due to health/disability
☐ Fulltime homemaker, parent or unpaid caregiver
☐ Fulltime or almost fulltime student
☐ Other:_____

37. Are you currently: *(Check only ONE answer)*

☐ Married ☐ In a committed relationship ☐ Widowed ☐ Single, divorced, or separated

38. *(Optional)* **Are you gay or bisexual?** ☐ No ☐ Yes, gay ☐ Yes, bisexual

39. Which of the following best describes your total household (family) income from all sources in 2001, before taxes? *(Check ONE answer only)*

☐ Under $15,000
☐ $15,000 - $25,000
☐ $25,001 - $35,000
☐ $35,001 - $50,000
☐ $50,001 - $65,000
☐ $65,001 - $80,000
☐ $80,001 - $100,000
☐ More than $100,000

LAST SECTION: PREFERRED METHODS OF RECEIVING HEALTH INFORMATION

The information from this last section (see following page) will be useful to Kaiser Permanente for planning patient and member education services.

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40. During the <u>past 12 months</u>, have you done any of the following? *(Check ALL that apply)*

☐ Participated in a Kaiser-sponsored health education or patient education program
☐ Used ANY Kaiser or non-Kaiser smoking cessation services (group program or one-on-one counseling)
☐ Received one-on-one counseling from Kaiser staff to help you change other health-relation behaviors or manage a chronic health condition like diabetes or hypertension
☐ Used the Kaiser Permanente *Healthwise Handbook* to look up health or self-care information
☐ Listened to taped health messages on the Kaiser Permanente Healthphone (1-800-33 ASK ME)
☐ Used Kaiser-provided health education materials (pamphlets, videos, etc.)
☐ Read Kaiser Permanente's member newsletter *Partners in Health*
☐ Obtained health information or health advice from any Internet website
☐ Used KP Online to get health information or participate in a health chat room or group
☐ Used KP Online to make an appointment or communicate with Kaiser health professionals

41. In addition to talking directly with your doctor, how would you like to learn about your health, such as how to take care of health problems and how to improve your health)? *(Check ALL that apply)*

☐ Small group appointments with a clinician (for problems like diabetes and blood pressure)
☐ Individual counseling from a health educator
☐ Brief telephone counseling sessions
☐ 1/2 to all day health education workshop
☐ 1 session (2-hour) introductory program
☐ Multi-session class to learn skills
☐ Health newsletters mailed to your home
☐ Listen to taped health messages by phone
☐ Watch a health video
☐ Use a PC computer program at Kaiser
☐ Use a PC computer program at home/work/other
☐ Access information from internet websites
☐ Watch health programs on cable TV
☐ Read short articles or brochures
☐ Read 1-2 page self-care tip sheets
☐ Other:_____

This is the end of the survey. <u>Thank you for your help</u>.