

**2008 KAISER PERMANENTE MEMBER HEALTH SURVEY**

**CONFIDENTIAL**

<Name>

<Street Address>

<City, State, Zipcode>

***Do we have your correct information?***

***Please print any CHANGES below.***

Address: \_\_\_\_\_

\_\_\_\_\_

Daytime phone: ( \_\_\_\_ ) \_\_\_\_\_

Email address: \_\_\_\_\_

**Study ID:** 123456

**Passcode:** 1234567

**Your participation is very important to us, even if you rarely use Kaiser for your medical care.**

The survey results will be used to help Kaiser:

- Learn about the health-related needs and interests of our culturally diverse adult membership.
- Make decisions about current and new health information and services.
- Conduct research to improve the health of our members and the communities we serve.

**Your answers are absolutely confidential.** No reports using survey information will use your name, and your individual responses will not be given to anyone outside the research division. Your name and Study ID number are on the questionnaire so that we can note that you returned the questionnaire and re-contact you, if needed, to clarify your answers.

Please refer to the enclosed letter for more details. If you still have any questions about confidentiality, the purpose of the survey, or how to complete the survey, please call toll-free: **(800) 723-8055 (choose Member Health Surveys)** or email us: **dor.mhs@kp.org**.

Because people are specially selected for this survey based on their age, sex and medical facility, this questionnaire **must be filled out ONLY by or for the person named above.**

**To complete this survey online** at our secure website, go to **[www.dor.kaiser.org/studies/mhs2008/](http://www.dor.kaiser.org/studies/mhs2008/)** and use the Study ID and Passcode printed above to start the survey.

***Thank you for your participation!***



Nancy Gordon  
**Member Health Survey Director**

**Please return your survey in the enclosed postage-paid envelope to:**  
Kaiser Permanente, Division of Research, P.O. Box 12916  
Oakland, CA 94604

**These questions are about your health and health-related habits.**

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

- Excellent     Very good     Good     Fair     Poor

2. Health can be 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         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your emotional/mental health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. How much does your health interfere with your work or other regular daily activities?

- |  | NOT AT ALL               | A LITTLE BIT             | MODERATELY               | QUITE A BIT              |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Your physical health (including pain) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Your emotional/mental health          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. Overall, how satisfied are you with your health?

- Very satisfied     Satisfied     Dissatisfied     Very dissatisfied

5. During the past 12 months, which of the following health problems did you have or were you treated for? (Check **ALL** you had, were treated for, or took medication for)

- |   |   |
|---|---|
| <input type="checkbox"/> Heart attack or myocardial infarction          | <input type="checkbox"/> Severe neck or shoulder pain   |
| <input type="checkbox"/> Heart problems, including angina               | <input type="checkbox"/> Migraine headaches   |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Other type of severe headaches   |
| <input type="checkbox"/> High blood pressure (diagnosed by a clinician) | <input type="checkbox"/> Chronic (frequent or ongoing) pain (describe): _____   |
| <input type="checkbox"/> High cholesterol (diagnosed by a clinician)    | <input type="checkbox"/> Urine leaks (at least once a week) after feeling pressure to urinate or when coughing, lifting, exercising, etc. |
| <input type="checkbox"/> Cancer (specify type): _____                   | <input type="checkbox"/> Problem seeing even with glasses   |
| <input type="checkbox"/> Diabetes (other than only during pregnancy)    | <input type="checkbox"/> Hearing problem or deafness  |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Menopause symptoms (hot flashes, etc.)   |
| <input type="checkbox"/> Chronic bronchitis                             | <input type="checkbox"/> Frequent problems with sleep   |
| <input type="checkbox"/> Emphysema/COPD                                 | <input type="checkbox"/> Depression, sadness, or very low spirits spirits lasting at least 2 weeks  |
| <input type="checkbox"/> Environmental allergy (hay fever, etc.)        | <input type="checkbox"/> Anxiety or panic lasting at least 2 weeks  |
| <input type="checkbox"/> Parkinson's disease                            | <input type="checkbox"/> Problem with alcohol or drugs  |
| <input type="checkbox"/> Osteoporosis (brittle bones)                   |   |
| <input type="checkbox"/> Arthritis or rheumatism                        |   |
| <input type="checkbox"/> Frequent heartburn or acid reflux              |   |
| <input type="checkbox"/> Severe back pain or sciatica                   |   |

6. Have you **EVER** had: (Check **ALL** that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Heart problems or a heart attack            | <input type="checkbox"/> Cancer (specify type): _____              |
| <input type="checkbox"/> A stroke                                    | <input type="checkbox"/> Adult depression lasting at least 2 weeks |
| <input type="checkbox"/> High blood pressure (hypertension)          | <input type="checkbox"/> Problems with alcohol or drugs            |
| <input type="checkbox"/> Diabetes (other than only during pregnancy) | <input type="checkbox"/> Chronic (ongoing) pain (describe): _____  |

7. Have you had a hysterectomy (operation to remove the uterus or womb)?     Yes     No

8. Are you past menopause -- "the change of life" -- meaning you have not had a menstrual period for at least 12 months?     Yes     No

9. During the past 12 months, did you use any of the following prescription or OTC (not requiring a prescription) medicines? (Check **ALL** that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Asthma medicine or spray                            | <input type="checkbox"/> Prescription or OTC quit smoking medicine  |
| <input type="checkbox"/> Heart medicine (not including aspirin)              | <input type="checkbox"/> Prescription or OTC weight loss medicine   |
| <input type="checkbox"/> Aspirin (low dose) to prevent stroke/heart attack   | <input type="checkbox"/> Prescription pain medicine   |
| <input type="checkbox"/> High blood pressure medicine                        | <input type="checkbox"/> OTC pain medicine  |
| <input type="checkbox"/> Insulin or other diabetes medicine                  | <input type="checkbox"/> Anti-inflammatory medicine for joint/muscle or arthritis pain (Advil, Motrin, ibuprofen, etc.) |
| <input type="checkbox"/> Cholesterol/lipid lowering medicine                 | <input type="checkbox"/> Prescription medicine for depression   |
| <input type="checkbox"/> Osteoporosis medicine                               | <input type="checkbox"/> Prescription medicine for anxiety or panic   |
| <input type="checkbox"/> Medicine for heartburn/acid reflux (Prilosec, etc.) | <input type="checkbox"/> Progesterone cream   |
| <input type="checkbox"/> Antacids for upset stomach, ulcer, etc.             | <input type="checkbox"/> Hormone replacement therapy  |
| <input type="checkbox"/> Prescription or OTC sleep medicine                  |   |

10. During the past 12 months, did you use any herbals, nutritional supplements, or other “natural” remedies to treat or prevent your own health problems? (Check **ALL** that apply and list others)

- |  |   |
|--|---|
| <input type="checkbox"/> Daily multiple vitamin                            | <input type="checkbox"/> Black cohosh/formula containing black cohosh         |
| <input type="checkbox"/> Calcium with Vitamin D                            | <input type="checkbox"/> Ginkgo biloba  |
| <input type="checkbox"/> Calcium without Vitamin D (incl. Tums or Rolaids) | <input type="checkbox"/> St. John’s Wort                                      |
| <input type="checkbox"/> Vitamin C   | <input type="checkbox"/> Chinese herbal remedies for cold/flu: _____          |
| <input type="checkbox"/> Fish oil or Omega-3 Fatty Acid                    | <input type="checkbox"/> Herbal/homeopathic remedies for cold/flu: _____      |
| <input type="checkbox"/> Glucosamine                                       | <input type="checkbox"/> Other herbals, supplements, or medicinal teas: _____ |
| <input type="checkbox"/> Melatonin   |   |

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

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

12. How tall are you without shoes? \_\_\_\_\_ Feet \_\_\_\_\_ Inches

13. How much do you weigh without your shoes and clothes? (Skip if pregnant) \_\_\_\_\_ Pounds

13a. Compared to this time last year, do you weigh:  About the same  More  Less

14. How often do you usually get physical exercise (such as walking, swimming, gardening, golf, tennis, etc.)?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 5 or more times a week | <input type="checkbox"/> 1 to 2 times a week  | <input type="checkbox"/> Once a month or less               |
| <input type="checkbox"/> 3 to 4 times a week    | <input type="checkbox"/> 2 to 4 times a month | <input type="checkbox"/> Never ( <b>Go to Question 15</b> ) |

14a. On days you exercise, how many total minutes do you usually exercise? \_\_\_\_\_ Minutes per Day

14b. On days you exercise, what type of exercise do you usually get? (Check **ONE** answer only)

- |  |
|--|
| <input type="checkbox"/> Low impact (barely increasing your breathing and heart rate, like an easy walk or swim)             |
| <input type="checkbox"/> Moderate (noticeably increasing your breathing and heart rate, like walking fast or uphill)         |
| <input type="checkbox"/> Vigorous (causing a large increase in your breathing and heart rate, like running or swimming fast) |

15. How often do you usually try to eat reduced fat (low-fat or non-fat) foods?

- |                                       |   |   |   |                                |
|---------------------------------------|---|---|---|--------------------------------|
| <input type="checkbox"/> All the time | <input type="checkbox"/> Most of the time | <input type="checkbox"/> Some of the time | <input type="checkbox"/> A little of the time | <input type="checkbox"/> Never |
|---------------------------------------|---|---|---|--------------------------------|

16. During an average day, about how many servings of fruits and vegetables do you usually eat? (1 serving = a half cup or a medium piece) \_\_\_\_\_ Servings per day

17. Have you ever regularly smoked cigarettes (that is, smoked daily for at least a year)?  
 Yes    No    I have never smoked cigarettes (If Never, go to Question 19)

18. Do you smoke cigarettes now, even occasionally?

YES →

a. How often do you usually smoke? <input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Very rarely
b. How many cigarettes do you usually smoke per day? _____ Cigarettes
c. How many total years have you smoked? _____ Years
d. Have you made a serious attempt to quit in the <u>past 12 months</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Are you planning to try to quit smoking in the <u>next 6 months</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No

NO →

a. How many cigarettes did you usually smoke per day? _____ Cigarettes
b. How many total years did you smoke? _____ Years
c. When did you last smoke? <input type="checkbox"/> Less than 6 months ago <input type="checkbox"/> 1-5 years ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> Over 5 years ago

19. During the past 12 months, how often have you usually had a drink containing alcohol?

Almost every day    2-4 times a month  
 5 to 6 times a week    1 time a month or less  
 3 to 4 times a week    Never in the past 12 months (used to drink)  
 1 to 2 times a week    Never in the past 12 months (never drank as adult) } If Never, go to Question 20

19a. 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

20. How many total hours of sleep do you usually get in a 24 hour day, including naps? \_\_\_\_\_ Hours

21. 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

22. During the past 12 months, did any of these situations or problems occur? (Check ALL that apply)

Feared for your **safety because of anger or threats** of a current or former spouse, partner, or boyfriend/girlfriend → Did you get help from Kaiser with this situation?    Yes    No  
 Felt **harassed or discriminated against**  
 Worried about your or your family's **safety due to neighborhood violence**, robberies, etc.  
 Worried a great deal about your or your family's **financial security**

23. How satisfied have you been with your life in general over the past 12 months?

Very satisfied    Satisfied    Dissatisfied    Very dissatisfied

24. How much do you think habits/lifestyle (such as exercise, what you eat, and your weight) can affect your health?

Not at all    A little bit    Moderately    Quite a bit    Extremely

25. How much do you think stress and emotional troubles (such as depression or anxiety) can affect your health?

Not at all    A little bit    Moderately    Quite a bit    Extremely

26. Are you currently doing any of the following to improve or maintain your health?

(Check ALL that apply)

Try to get moderate or vigorous exercise most days    Try to manage stress effectively  
 Take daily walks or doing 10,000 Steps program    Try to get enough sleep to feel well-rested  
 Try to eat mostly healthy foods    Limit alcohol to 1-2 drinks daily or don't drink  
 Trying to lose weight by exercising and/or dieting    Do enjoyable activities at least 1-2 times a week  
 Taking steps to quit smoking or stay off cigarettes

**This next section asks about your use of and opinions about health services.**

27. Do you have a Kaiser Permanente health provider you consider to be your regular or personal doctor/nurse practitioner?

Yes → In department of:  Adult/Internal Medicine  Ob/Gyn  
 Family Practice  Other (specify): \_\_\_\_\_

No

28. 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

29. During the last 12 months, how many of your own prescriptions did you get filled at non-Kaiser pharmacies (including through non-Kaiser websites)? \_\_\_\_\_ Prescriptions

30. 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

31. 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 "HAD THIS WITHIN THE PAST 2 YRS."

	NEVER HAD THIS	HAD THIS WITHIN THE PAST:					
		12 MONTHS	2 YRS	3 YRS	4-5 YRS	6-10 YRS	HAD 11+ YRS AGO
a. Routine health checkup or health appraisal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Blood cholesterol test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood pressure check by a health professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. FOBT test to check for colon/rectal cancer (using a special kit at home, a bit of stool/bowel movement is put in a test tube or on paper and then sent or brought to a Kaiser lab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Sigmoidoscopy or colonoscopy to check for colon/rectal cancer or polyps (flexible tube inserted into the rectum [hole in buttocks])	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Dental exam by a dentist or hygienist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Eye and vision exam by an eye doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Pap test (check for cervical cancer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Mammogram (X-ray check for breast cancer where breast is pressed between 2 plastic plates)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Breast exam by a clinician to check for lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Bone mineral density (BMD) test for osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Did you get a flu (influenza) shot or intranasal FluMist immunization between October 2007 and March 31, 2008?  Yes  No

33. During the **past 12 months**, have you done any of the following? (Check **ALL** that apply)
- Participated in a Kaiser group or individual **health education program**
  - Visited a Kaiser **Health Education Center** or **Resource Desk**
  - Used Kaiser or non-Kaiser **smoking cessation services** (group, one-on-one counseling, or online)
  - Used any Kaiser or non-Kaiser **weight loss or Healthy Eating, Active Living** program (group, one-on-one counseling, or online)
  - Got **health information** or advice from any Kaiser or non-Kaiser **Internet website**
  - Got **one-on-one counseling** from Kaiser to help **change health-related behaviors** (smoking, diet, etc.) or **manage a chronic health condition** (diabetes, hypertension, heart disease, etc.)
  - Used Kaiser **health education materials** (handouts, pamphlets, DVDs, videos, tapes, etc.)
  - Read one of Kaiser's **member newsletters** (*Partners in Health* or *Senior Outlook*)
  - Used Kaiser's **Healthwise Handbook** to look up health information
  - Used Kaiser's **online Health Encyclopedia** or **Drug Encyclopedia** on the Kaiser website
  - Used **online health education programs** (preparing for a procedure, health calculator, or Healthy Lifestyle programs for nutrition, weight, stress, walking) on the Kaiser website
  - Used the **Kaiser website** to **make appointments, refill prescriptions, or email** Kaiser doctors/staff
34. In addition to talking with your doctor, how would you **prefer** to learn about taking care of health problems and improving your health? (Check **ALL** that apply)
- Small group appointments** with a clinician or health educator (for diabetes, etc.)
  - Individual counseling** with a health educator
  - Brief telephone counseling** sessions
  - ½ to all day health education workshop**
  - Multi-session group** program to learn skills
  - Multi-session group** program over the **phone**
  - Multi-session** program using **email/Internet**
  - Listen to **"podcasts"** or **online audio downloads**
  - Watch a **health video or DVD at home**
  - Read **newsletters mailed to your home**
  - Use an **interactive computer program**
  - Get health information from **Internet websites**
  - Watch **health programs on TV**
  - Read **printed tip sheets and other handouts**
  - Read **tip sheets/articles on doctor's Home Page**
35. Do you have access to a personal computer?     Yes, at home     Yes, at other location     No
36. Do you have access to the Internet?     Yes, at home     Yes, at other location     No  
**IF YES** → Is it:     Dial up (*not high speed*)     High Speed DSL     Broadband (cable)     Other: \_\_\_\_\_
37. Can you receive email?     Yes, at home     Yes, at other location     No
38. How would you rate Kaiser Permanente on:
- |  | EXCELLENT                | VERY GOOD                | GOOD                     | FAIR                     | POOR                     |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. <b>Medical care you've received when sick or injured</b>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. <b>Preventive medicine services you've received</b><br>(screening tests, immunizations, etc.)     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. <b>The information and advice you've received about how to improve your health and well-being</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
39. An Advance Health Care Directive (AHCD) is a legal document that names someone who can legally give instructions about your medical care or make end-of-life care decisions for you if you are unable to speak for yourself. Have you filled out (or had someone fill out for you) an Advance Health Care Directive form? \*
- Yes     No     Don't Know

\* To get an AHCD, go to "Contact Member Services" at [www.kp.org](http://www.kp.org) or call (800) 464-4000

**Your answers to these last questions will help us describe the group of members who participated in this survey and analyze how their experiences and needs differ. This is confidential and will only be used for research purposes.**

40. What is your sex?  Male  Female  Transgender (describe): \_\_\_\_\_

41. What is your date of birth? (Year should not be 2008) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MONTH DAY YEAR

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

- |  |   |
|--|---|
| <input type="checkbox"/> White or Euro-American                          | <input type="checkbox"/> Filipino                                   |
| <input type="checkbox"/> African-American                                | <input type="checkbox"/> Japanese                                   |
| <input type="checkbox"/> Other Black (specify): _____                    | <input type="checkbox"/> Korean                                     |
| <input type="checkbox"/> Mexican or Central American ancestry            | <input type="checkbox"/> Southeast Asian (specify): _____           |
| <input type="checkbox"/> Other Hispanic/Latino (specify): _____          | <input type="checkbox"/> Other Asian (specify): _____               |
| <input type="checkbox"/> Middle Eastern, North African, or Central Asian | <input type="checkbox"/> Hawaiian/Pacific Islander (specify): _____ |
| <input type="checkbox"/> South Asian (Indian, Pakistani, etc.)           | <input type="checkbox"/> Native American Indian or Alaska Native    |
| <input type="checkbox"/> Chinese   | <input type="checkbox"/> Other (specify): _____                     |

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

- |  |   |
|--|---|
| <input type="checkbox"/> 8th grade or less                           | <input type="checkbox"/> Some college or technical school (incl. AA degree) |
| <input type="checkbox"/> 9th - 11th grade                            | <input type="checkbox"/> Completed 4-year college degree (B.A., B.S., etc.) |
| <input type="checkbox"/> 12th grade (high school graduate or G.E.D.) | <input type="checkbox"/> Completed graduate degree                          |

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

- English  Spanish  Cantonese  Other: \_\_\_\_\_

45. What is your current work status? (Check **ALL** that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Working for pay → How many hours/week? ____        | <input type="checkbox"/> Part-time or full-time student   |
| <input type="checkbox"/> Unemployed, laid off, on strike                    | <input type="checkbox"/> Part-time or full-time volunteer |
| <input type="checkbox"/> Retired or unable to work due to health/disability | <input type="checkbox"/> Other (specify): _____           |
| <input type="checkbox"/> Fulltime homemaker, parent or unpaid caregiver     |   |

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

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

47. (Optional) Are you lesbian or bisexual?  No  Yes, lesbian  Yes, bisexual

48. Which of the following best describes your total household (family) income from all sources in 2007, before taxes? (Check only **ONE** answer)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Under \$15,000      | <input type="checkbox"/> \$35,001 - \$50,000 | <input type="checkbox"/> \$80,001 - \$100,000  |
| <input type="checkbox"/> \$15,000 - \$25,000 | <input type="checkbox"/> \$50,001 - \$65,000 | <input type="checkbox"/> \$100,001 - \$150,000 |
| <input type="checkbox"/> \$25,001 - \$35,000 | <input type="checkbox"/> \$65,001 - \$80,000 | <input type="checkbox"/> More than \$150,000   |

49. Do you have any comments about **health education and health improvement services** Kaiser currently provides or that you would like Kaiser to consider offering?

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***Thank you very much for your help!***