

**2017 KAISER PERMANENTE MEMBER HEALTH SURVEY****CONFIDENTIAL**

This questionnaire should only be completed for:

Do we have your correct information?  
Please print any CHANGES below.

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

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

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

We are doing this survey to learn about our adult membership's health-related needs and preferred methods of communication with Kaiser Permanente about their health and health care.

**IMPORTANT:**

- ☞ **YOUR information is very important** even if you are healthy, rarely use Kaiser Permanente services, or are not totally happy with the services you have received.
- ☞ **YOU will be entered into a drawing for one of 100 \$100 gift cards** when we receive your completed questionnaire (*make your selection below*).
- ☞ This questionnaire should be filled out only for the person whose name is printed above.
- ☞ **To complete this online**, go to [www.mhs2017.kaiser.org/sr](http://www.mhs2017.kaiser.org/sr) or email me at [nancy.gordon@kp.org](mailto:nancy.gordon@kp.org) and I will email you a link to the online questionnaire.
- ☞ **Mark the box with an X or ✓ to indicate your answer**. If none of the answers in a list applies to you, leave that question blank.

Your answers are absolutely confidential. They will not become part of your health records or shared with your doctors or anyone outside the Division of Research in a way that identifies you. Your name and Study ID are on the questionnaire so we can note that you returned it and contact you if needed. If you have any questions about the survey, please call toll-free: **(800) XXX-XXXX (choose Member Health Surveys)** or email me at [nancy.gordon@kp.org](mailto:nancy.gordon@kp.org).

Please return your completed survey in the enclosed postage-paid envelope to:  
Kaiser Permanente Division of Research, 2000 Broadway, Oakland, CA 94612 attn: NPG

***Thank you for taking the time to do this!***

Dr. Nancy Gordon  
Member Health Survey Director

**Which of these \$100 gift cards would you choose if you win the drawing?**

Target

Safeway

Amazon.com

## 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. During the past 12 months, which of these health conditions or problems did you have or were you treated for? (**Check ALL you had, were treated for, or used medication or special diet for**)

- |   |   |
|---|---|
| <input type="checkbox"/> High blood pressure ( <i>diagnosed by a clinician</i> )<br><input type="checkbox"/> Heart disease (e.g., heart attack, angina, blocked artery, atrial fibrillation, congestive heart failure)<br><input type="checkbox"/> Diabetes ( <i>other than only during pregnancy</i> )<br><input type="checkbox"/> Prediabetes<br><input type="checkbox"/> High cholesterol ( <i>diagnosed by a clinician</i> )<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Cancer ( <i>specify type</i> ): _____<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> COPD, emphysema, or chronic bronchitis<br><input type="checkbox"/> Osteoarthritis ( <i>“wear and tear” arthritis</i> )<br><input type="checkbox"/> Severe back pain or sciatica<br><input type="checkbox"/> Severe neck or shoulder pain<br><input type="checkbox"/> Migraine headaches<br><input type="checkbox"/> Other type of severe headaches<br><input type="checkbox"/> Chronic (frequent or ongoing) pain<br><input type="checkbox"/> Frequent heartburn or acid reflux (GERD)<br><input type="checkbox"/> Frequent constipation or very hard stools (“poops”) | <input type="checkbox"/> Urine leakage at least once a week ( <i>describe</i> ):<br><input type="checkbox"/> After feeling pressure to urinate<br><input type="checkbox"/> When coughing, lifting, exercising, etc.<br><input type="checkbox"/> Vision problem (with or without glasses/lenses)<br><input type="checkbox"/> Problems with hearing and/or deafness<br><input type="checkbox"/> Frequent problems with balance or walking<br><input type="checkbox"/> Frequent problems with memory<br><input type="checkbox"/> Frequent problems falling or staying asleep<br><input type="checkbox"/> Frequently felt <i>very</i> sleepy/tired during the time of day you normally work or do other daily activities<br><input type="checkbox"/> Frequent very loud snoring<br><input type="checkbox"/> Sometimes stopped breathing in your sleep or woke up feeling like you were choking or gasping for air<br><input type="checkbox"/> Depression, sadness, or very low spirits that lasted at least 2 weeks<br><input type="checkbox"/> Anxiety or panic that lasted at least 2 weeks<br><input type="checkbox"/> <b>None of these problems or conditions</b> |
|---|---|

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

- |   |   |
|---|---|
| <input type="checkbox"/> Heart disease, heart surgery, or a heart attack<br><input type="checkbox"/> Cancer ( <i>specify type</i> ): _____<br><input type="checkbox"/> A stroke<br><input type="checkbox"/> High blood pressure (hypertension)<br><input type="checkbox"/> Diabetes ( <i>other than only during pregnancy</i> )<br><input type="checkbox"/> Sleep apnea (OSA) | <input type="checkbox"/> Adult depression lasting at least 2 weeks<br><input type="checkbox"/> Chronic (ongoing) pain ( <i>describe</i> ): _____<br><input type="checkbox"/> Problems with alcohol or drugs<br><input type="checkbox"/> A hysterectomy ( <b>Women only</b> )<br><input type="checkbox"/> <b>None of these</b> |
|---|---|

6. In the past 12 months, how many times have you fallen to the ground or fallen on stairs? \_\_\_\_ Falls

7. Do you have problems with your teeth, gums, or mouth that make it difficult to eat or talk?  Yes  No

8. Do you regularly use a hearing aid?

- Yes     No     I am deaf or have a hearing problem that a hearing aid won't help

9. Do you have difficulty driving, or watching TV or reading, or doing any of your daily activities because of your eyesight?  Yes  No  I am legally blind

10. Which of the following describes your situation? *(Check ALL that apply)*

- I usually need help from another person to move around
- I usually use a motorized wheel chair or motorized scooter to move around
- I usually use a cane, walker, or poles when I walk around
- I don't need help from another person or special aid, but have some trouble getting around
- I am not limited at all in my ability to get around

11. Do you need help from another person with any of these activities? *(Check ALL that apply)*

- Getting to places out of walking distance
- Shopping for groceries, etc.
- Doing routine household chores
- Preparing meals
- Managing money
- Managing and taking your medicines
- Communicating with your health care providers
- Getting in and out of bed or chairs
- Using the telephone
- Bathing in a tub or shower
- Dressing
- Eating food and drinking liquids
- Using the toilet
- Cutting your toe nails

12. If for any reason you need help with activities of daily living such as bathing, preparing meals, shopping, managing finances, etc., do you get the help that you need? *(Check ONE only)*

- Don't need any help
- Get all the help I need
- Could use a little more help
- Could use a lot more help

13. Considering all things, how well can you take care of yourself at this time? *(Check ONE only)*

- Not at all able
- Not very well
- Fairly well
- Very well
- Completely able

14. If you became too sick, injured or frail to take care of yourself, is there at least one person living near you who would help take care of your needs or arrange for the help/care you would need?

- Yes → 

Who would be available to help you? <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other
--
- No

15. During the past 12 months, did you use any of the following prescription or non-prescription (“over the counter”) medicines at least twice a week? *(Check ALL that apply)*

- Low dose aspirin to prevent stroke, heart attack, or cancer
- Asthma medicine or spray
- Heart medicine (not including aspirin)
- High blood pressure medicine
- Insulin or other diabetes medicine
- Cholesterol/lipid lowering medicine
- Osteoporosis medicine
- Heartburn/acid reflux medicine (*Pepcid, etc.*)
- Laxatives/other products for constipation
- Anti-inflammatory medicine (*NSAIDS like Advil, ibuprofen, etc.*)
- Prescription pain medicine
- Non-prescription (OTC) pain medicine
- Prescription or non-prescription sleep medicine
- Nicotine gum or patch, other quit smoking medicine
- Prescription or non-prescription weight loss medicine
- Prescription medicine for depression
- Prescription medicine for anxiety or panic
- None of these**

16. How many prescription medicines do you regularly take? \_\_\_\_\_ Prescription medicines

17. 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)*

- Daily multivitamin
- Calcium with or without vitamin D included
- Vitamin D (separate from calcium or multivitamin)
- Fish oil, flaxseed oil, other omega-3 fatty acids
- Probiotics
- Glucosamine
- Melatonin or sleep formula containing melatonin
- Any herbal medicines/remedies/supplements
- Other vitamins or supplements: \_\_\_\_\_

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

- Chiropractic
- Acupuncture
- Massage therapy
- Yoga or Pilates
- Tai Chi, Chi Gong
- Deep breathing, mindfulness meditation, or other mind-body stress management technique
- Vegetarian or vegan diet
- Other special diet: \_\_\_\_\_
- Prayer or spiritual practice you do yourself
- Religious or spiritual healing by others
- Psychological counseling or therapy
- 12-Step program or other self-help/support group
- None of these**

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

20. How much do you weigh without your shoes and clothes? \_\_\_\_\_ Pounds

21. 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

22. How many **days per week** do you usually drink one or more sugar- or corn syrup-sweetened drinks like **regular soda, fruit drinks, vitamin water, bottled teas, coffee drinks, sports drinks (e.g., Gatorade), and energy drinks (e.g., Red Bull)?** *Do not count diet drinks.*

- Every day  6 days  5 days  4 days  3 days  2 days  1 day  Less than once a week/never

23. How often do you **try to avoid eating** foods that are high in salt or sodium (like most canned, packaged, processed, and "fast" foods and foods seasoned with a lot of salt)?

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

24. How often do you usually do physical activity or exercise (such as walking, running, swimming, tennis, soccer, gardening, dancing, yoga, exercise class, etc.)?

- 7 days/week  5 days/week  3 days/week  1 day/week  Never → *If NEVER, go to Question 25*  
 6 days/week  4 days/week  2 days/week  Less than once a week

24a. On days you exercise, how many **total minutes** do you usually exercise? \_\_\_\_\_ Minutes per day

24b. On days you exercise, what type of exercise do you usually get? (*Check ONE only*)

- Light (barely increasing your breathing and heart rate, like an easy walk or swim)  
 Moderate (noticeably increasing your breathing and heart rate, like walking fast or uphill)  
 Vigorous (causing a large increase in your breathing and heart rate, like running or swimming fast)

25. Do you smoke cigarettes now, even occasionally?

- NO, and I never smoked or I smoked less than 100 cigarettes in my lifetime

- NO, but I used to smoke regularly  
→ *Answer a-c*

- |   |   |   |
|---|---|---|
| <b>a. When did you last smoke?</b>            | <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                               |
| <b>b. How many total years did you smoke?</b> | _____ Years                                     |   |
| <b>c. How often did you usually smoke?</b>    | <input type="checkbox"/> Every day              | <input type="checkbox"/> Some days <input type="checkbox"/> Very rarely |

- YES, I smoke  
→ *Answer d-g*

- |  |                                    |                                    |                                      |
|--|------------------------------------|------------------------------------|--------------------------------------|
| <b>d. How often do you usually smoke?</b>                                  | <input type="checkbox"/> Every day | <input type="checkbox"/> Some days | <input type="checkbox"/> Very rarely |
| <b>e. How many cigarettes do you usually smoke per day?</b>                | _____ Cigarettes                   |                                    |                                      |
| <b>f. How many total years have you smoked?</b>                            | _____ Years                        |                                    |                                      |
| <b>g. Did you make a serious attempt to quit smoking in the past year?</b> | <input type="checkbox"/> Yes       | <input type="checkbox"/> No        |                                      |

26. During the **past 12 months**, did you use any of the following? (*Check ALL that apply*)

- E-cigarettes, vape pens, or e-hookah
- Pipe
- Cigars
- Bidis
- Hookah or water pipe
- Smokeless tobacco (e.g., snuff, chew, dip, paan, snus, betel)
- Nicotine gum

27. 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 28

27a. On days when you had a drink, how many drinks did you usually have?

(1 drink = a 12-oz. can of beer, 5 oz. of wine, or a 1 oz. shot of hard liquor) \_\_\_\_\_ Drinks

28. On a typical **weekday**, how many **total hours** of sleep do you usually get, including naps? \_\_\_\_\_ Hours

29. How would you rate the usual quality of your sleep?

- Very good
- Good
- Fair
- Poor
- Very poor

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

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

31. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, irritable, depressed or sad?

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

32. How often do you feel lonely or isolated from those around you?

- Never
- Rarely
- Sometimes
- Often
- Always

33. In general, how satisfied are you with your life?

- Very satisfied
- Satisfied
- Dissatisfied
- Very dissatisfied

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

(Check ALL that apply)

- Getting moderate or vigorous exercise most days
- Trying to manage stress effectively
- Taking walks for at least 30 minutes most days
- Trying to get enough sleep to feel well-rested
- Taking steps to quit smoking or stay off cigarettes
- Doing enjoyable activities at least once a week
- Taking steps to lose weight or maintain weight loss
- Doing activities to keep your brain stimulated
- Learning what is in food by reading labels/recipes
- Visiting with people at least once a week
- Trying to eat mostly healthy foods
- Taking all medicines as prescribed
- Limiting alcohol to 1 drink a day or none at all
- Taking actions to reduce risk of falling

35. 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

36. 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

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

- You were **physically or emotionally hurt or felt threatened** by a current or former spouse/partner or someone else you knew → **Who?**  Current spouse/partner  Former spouse/partner  Someone else
- You felt **harassed or discriminated against**
- You worried about your or your family's **safety due to neighborhood violence**, robberies, etc.
- You worried a great deal about your or your family's **financial security**
- You worried that **your food might run out** before you had money to buy more
- You worried that you **might not be able to pay for needed medical care** or medicine/medical supplies
- You had **problems making ends meet** at the end of a month
- Other major life stress** such as loss of a job, separation/divorce, death of a loved one, etc.

38. During the **past 12 months**, did you provide **unpaid care** to a relative or friend who is or was seriously ill or has a physical, developmental, mental, or emotional disability?

(Helping with personal needs, managing finances, arranging for services, etc.)

- Yes
- No

39. During the past 12 months, did you:

- a. Start to take a medicine in smaller doses or less frequently than prescribed, or decide not to fill a prescription because of the cost?  Yes  No
- b. Delay or not get medical care you thought you needed because of the cost?  Yes  No
- c. Delay or not get dental care you thought you needed because of the cost?  Yes  No
- d. Eat less fruit and vegetables than you wanted to because of the cost?  Yes  No

## Health-Related Care Inside and Outside of Kaiser Permanente

40. Did you get a flu (influenza) shot between September 2016 and March 31, 2017?

- Yes, at Kaiser Permanente  Yes, outside Kaiser Permanente  No

41. When did you last have your teeth cleaned and checked by a dentist or dental hygienist?

- Less than 7 months ago  7-12 months ago  More than 1 year ago  Never had this done

42. Do you have insurance that pays for routine dental check-ups and teeth cleaning?  Yes  No

43. During the past 12 months, how many visits to non-Kaiser Permanente health professionals (doctor, chiropractor, etc.) did you make for your own health? (*Do NOT include dentists*) \_\_\_\_\_ Visits

44. Do you have insurance that helps pay for costs of non-Kaiser Permanente medical visits?  Yes  No

45. During the past 12 months, how many of your own prescriptions did you get filled at non-Kaiser Permanente (KP) pharmacies and/or through non-KP websites? \_\_\_\_\_ Prescriptions

46. During the past 12 months, did you frequently use any of the following services for yourself? (*Check ALL that apply*)

- |   |  |
|---|--|
| <input type="checkbox"/> Housekeeper or house cleaner   | <input type="checkbox"/> Transportation service (e.g., paratransit)  |
| <input type="checkbox"/> Home-delivered meals           | <input type="checkbox"/> Paid caregiver, companion or attendant      |
| <input type="checkbox"/> Shopping/food delivery service | <input type="checkbox"/> Unpaid caregiver (e.g., relative or friend) |

47. Do you have an Advance Directive for Health Care and/or someone who will legally be able to make medical and end-of-life health care decisions for you if the need arises?  Yes  No

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

- |  |  |
|--|--|
| <input type="checkbox"/> Your diet (salt, fats, fiber, etc.) | <input type="checkbox"/> Stress or emotional problems like depression or anxiety |
| <input type="checkbox"/> Losing weight                       | <input type="checkbox"/> How to reduce your risk of falling                      |
| <input type="checkbox"/> Getting enough exercise             | <input type="checkbox"/> Health screening tests recommended for you              |
| <input type="checkbox"/> Getting enough sleep                | <input type="checkbox"/> Immunizations (shots) recommended for you               |
| <input type="checkbox"/> Quitting smoking                    | <input type="checkbox"/> A review of all the medicines and supplements you take  |

49. How would you rate Kaiser Permanente on the information and advice you've received about how to improve your health and well-being?

- Excellent  Very good  Good  Fair  Poor

## Your Communication Tools and Preferences

50. Do you have any of the following types of mobile devices? (*Check ALL that apply*)

- Cell phone  Smartphone (e.g., iPhone, Android)  Tablet enabled for wi-fi  None of these

51. Do you have access to a desktop, laptop or tablet computer that you can (or could) use to go online (use the Internet)? (*Check ALL that apply*)

- Yes, at home  Yes, at work  Yes, at another location (library, neighbor, etc.)  No access

52. Do you use the Internet (go online) to get information, watch videos, fill out forms, pay for things, etc.?

- Yes, I use it by myself
- Yes, but someone else helps or uses it for me
- No, I don't use the Internet

a. What device(s) do you/your helper usually use to go online?

- Desktop or laptop computer
- Tablet (e.g., iPad)
- E-reader
- Cell phone
- Smartphone
- Other: \_\_\_\_\_

b. Can you easily print information/forms you get from the Internet?

- Yes
- No

53. If you use the Internet, where do you use it:  At home  At work  Other: \_\_\_\_\_  Don't use it

54. Are you able to send and receive/check email, and if so, what type of device do you use for email?

- Yes, I do this myself
- Yes, but someone else helps or does this for me
- No, I don't use email

What device(s) do you/your helper usually use to send/check email?

- Desktop or laptop computer
- Cell phone
- Smartphone
- Tablet (e.g., iPad)
- Other: \_\_\_\_\_

55. Are you able to:  Send and receive text messages  Use apps

56. Would you be willing to enter information into an online questionnaire/form on the kp.org website if you were sent a link by email or kp.org secure message?  Yes  No  Not sure

57. During the past 12 months, have you done any of the following? (*Check ALL that apply*)

- Participated in any Kaiser Permanente group or individual **health education program/service**
- Used any **quit smoking program/service** (wellness coach, group, phone quit line, web-based, etc.)
- Used any **weight loss or Healthy Eating, Active Living program/service** (wellness coach, group, individual in-person counseling, web-based, email-based, etc.)
- Got help from a Kaiser Permanente **health educator** or **wellness coach** with **changing health-related behaviors** (e.g., diet, exercise) or **managing a chronic health condition** like diabetes
- Used Kaiser Permanente **print health education materials** (handouts, pamphlets, etc.)
- Got health or medication-related **information** or advice from **Kaiser Permanente's website**
- Got health or medication-related **information** or advice from a **non-Kaiser Permanente website**
- Got health information from your **doctor's home page on the Kaiser Permanente website**
- Used any **online education videos on a Kaiser Permanente website** (preparing for a procedure or surgery, managing pain, or healthy lifestyle for weight loss, stress, etc.)
- Listened to a **kp.org podcast**
- Used any **health app** to help with diet, exercise, sleep, monitoring a health condition, etc.
- Used the **kp.org website** to **view lab results, refill prescriptions, or email** doctors/other staff
- Used a **Kaiser Permanente app** to use the kp.org website's secure features or get reminders

58. In which of these ways would you prefer to get information and advice about how to manage health conditions and make changes in health behaviors (diet, exercise, etc.)? (*Check ALL that apply*)

- Telephone sessions with a **wellness coach**
- In-person counseling with a patient educator
- Video visit with a patient educator
- Video visit with a doctor
- Information/advice by **text messages**
- Information/advice by **kp.org secure email**
- Print materials** (e.g., brochures, tip sheets)
- Health **information/newsletters by mail**
- Health **information/newsletters by email**
- Get information from **Internet websites**
- Get information from **your doctor's home page**
- Watch **DVDs at home**
- Watch **online videos about health topics**
- Listen to **podcasts or online audio** programs
- Watch live **webinars or talks**
- One-session** class, workshop or group **program**
- Multi-session** class or group **program**
- Online** interactive **program**
- Use a **health app** on your tablet or smartphone
- Join an **online chat room/online community**

## Information Describing Who Participated in this Survey

59. What is your gender?  Male  Female  Transgender Male  Transgender Female  Other

60. What is your date of birth? (*Year should not be 2017*) \_\_\_ / \_\_\_ / \_\_\_  
MONTH DAY YEAR

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

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

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

- |  |   |
|--|---|
| <input type="checkbox"/> 8th grade or less ( <i>primary or middle school</i> ) | <input type="checkbox"/> Some college ( <i>no degree</i> )                          |
| <input type="checkbox"/> 9th - 11th grade ( <i>some high school</i> )          | <input type="checkbox"/> Associate's Degree ( <i>e.g., AA, AS</i> )                 |
| <input type="checkbox"/> 12th grade ( <i>high school graduate or G.E.D.</i> )  | <input type="checkbox"/> Bachelor's Degree ( <i>e.g., BA</i> ), teaching credential |
| <input type="checkbox"/> Technical/trade school certificate                    | <input type="checkbox"/> Graduate or professional degree ( <i>e.g., MA, MD</i> )    |

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

- |   |  |
|---|--|
| <input type="checkbox"/> Working for pay → How many hours/week? ___   | <input type="checkbox"/> Retired                                 |
| <input type="checkbox"/> Self-employed → How many hours/week? ___     | <input type="checkbox"/> Full-time homemaker or unpaid caregiver |
| <input type="checkbox"/> Unemployed or laid off                       | <input type="checkbox"/> Part-time or full-time student          |
| <input type="checkbox"/> Unable to work due to health or a disability | <input type="checkbox"/> Do volunteer work at least once a week  |

64. Are you currently: (*Check ONE only*)

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

65. (*Optional*) Are you gay/lesbian or bisexual?  No  Yes, gay or lesbian  Yes, bisexual

66. Which of the following best describes your total household (family) income from all sources in 2016, before taxes? (*Check ONE only*)

- |  |  |  |
|--|--|--|
| <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   |

67. Which of the following best describes your current living situation? (*Check ONE only*)

- Live alone (or just with a pet) in your own home (house, apartment, condo, trailer, etc.)
- Live in a household with spouse/partner, family, or other people
- Live in a residence or community where meals, help, and social activities are available
- Temporarily living with a relative or friend
- Other (*describe*): \_\_\_\_\_

68. When you are going someplace that is too far to walk, how do you usually get there? (*Check ALL that apply*)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> I drive myself                    | <input type="checkbox"/> Take a taxi or Uber/Lyft                                   | <input type="checkbox"/> Other ( <i>specify</i> ): _____ |
| <input type="checkbox"/> Spouse or housemate drives me     | <input type="checkbox"/> Take the bus or BART                                       |  |
| <input type="checkbox"/> Family member or friend drives me | <input type="checkbox"/> Use a ride service for seniors or people with disabilities |  |

**Thank you!**