

**WEYMOUTH**  
*Health Needs Assessment*

**This survey is to be filled out by the adult in your household whose birthday is coming up next**

*If you need additional assistance in completing this survey please call Carolyn Mansfield at 617-482-9485.*

**May 2002**





26553



## Please Read Carefully

### Information and Instructions for Completing the Survey

**Thank you** for your willingness to complete this important survey. This survey is part of the Town of Weymouth's Health Needs Assessment. Your responses to this survey will be extremely helpful as the town works to set priorities, develop stronger health and social service programs, and advocate for the health of those living in Weymouth.

**Your responses are completely confidential** and your participation is voluntary. Information will never be presented in a way that could identify individual respondents. Access to completed surveys is restricted to members of the research team at John Snow, Inc. and questionnaires will be destroyed after the results have been compiled. If there is any question that you would prefer not to answer, you can skip over it. However, your response to each question is important to the project.

**The adult in your household whose birthday is coming up next should complete this survey.** This will help us to ensure that we obtain a representative sample of adults living in Weymouth. There are sections of the survey that will ask questions about different members of your household. In some sections you will be asked to answer questions about yourself. In other sections you will be asked about the children, adolescents or other adults in your household. The person filling out the survey should feel free to consult with other household members for information when completing the survey.

**Directions: Fill in circles darkly and completely.**

INCORRECT  
MARKS



CORRECT  
MARK



**For text boxes, please stay within the lines.**

INCORRECT  
MARK



CORRECT  
MARK



**r Please use a pen or #2 pencil to complete the survey. r**

**If you have any questions or comments about this survey,**  
please call Carolyn Mansfield at John Snow, Inc. (617-482-9485).

**THANK YOU**



## SECTION A. HOUSEHOLD

The questions in this section ask for information about you and your household.

### A1. How long have you lived in Weymouth?

- Less than 1 year
- 1 to 5 years
- 6 to 10 years
- 11 to 20 years
- More than 20 years

### A2. Please check the response that best describes your housing arrangement:

- In public/subsidized housing
- Rent a house, apartment or room
- Own a house or condo
- In a friend or relative's home
- "In-law" type apartment
- Other: \_\_\_\_\_

### A3. Was your home built before 1978?

- Yes
  - No
  - Don't know/not sure
- ↓  
[SKIP TO A5]

### A4. If yes, has your home been tested and professionally treated, if necessary, for lead?

- Not tested
- Tested, not treated
- Tested and treated
- Don't know/not sure

### A5. Have you had your home tested for radon (using a home test kit or a professional service)?

- Yes
- No
- Don't know/not sure

### A6. Do you have working smoke alarms in your home?

- Yes
- No
- Don't know/not sure

### A7. Have you tested the battery of the smoke detectors in your home (by pushing the "test" button) in the last month?

- Yes
- No
- Don't have smoke detectors.

### A8. Do you use a water treatment device or water filtration system in your home (for example, Brita tap or jug filters, undersink filter)?

- Yes
- No

### A9. Do you use public water for regular household use (including drinking, bathing and cooking)?

- Yes
- No

### A10. Do you have a swimming pool at your residence?

- Yes
- No [SKIP TO A12]

### A11. If yes, do you have a four-sided fence with a self-locking gate around the pool?

- Yes
- No

### A12. Do you have a wooden deck at your home?

- Yes
- No [SKIP TO A13]

### A12a. If yes, does it have any pressure-treated lumber?

- Yes
- No
- Don't know/not sure

### A13. Do you have wooden lawn furniture at your home?

- Yes
- No [SKIP TO A14]

### A13a. If yes, does it have any pressure-treated lumber?

- Yes
- No
- Don't know/not sure

**A14. Do you have a wooden swing or playset at your home?**

- Yes  No [SKIP TO A15]

**A14a. If yes, does it have any pressure-treated lumber?**

- Yes  No  Don't know/not sure

**A15. Which of the following transportation services within Weymouth have you used in the past 6 months? (MARK ALL THAT APPLY)**

- MBTA Buses
- Ferry/ Water Shuttle
- Commuter Rail
- The Ride
- Wheelchair Car
- Taxi
- Other Elder Services Transportation
- Other \_\_\_\_\_
- None of these

**A16. Have you missed any of the following because you did not have any transportation: (MARK ALL THAT APPLY)**

- Medical appointment
- Work
- Meetings
- School
- Social events
- Other \_\_\_\_\_
- Church
- None of the above

**A17. Please indicate your total annual household income including all sources and types of income (i.e., wages, public assistance, child support, interest income, social security):**

- \$0-\$14,999
- \$50,000-\$74,999
- \$15,000-\$24,999
- \$75,000-\$124,999
- \$25,000-\$34,999
- \$125,000 or more
- \$35,000-\$49,999

**A18. Do you have a personal computer in your home?**

- Yes  No [SKIP TO Page 3]

**A19. If yes, do you have access to the internet in your home?**

- Yes, dial-up access
- Yes, high-speed access
- No internet access in the home [SKIP TO Page 3]

**A20. Have you installed any parental control software that puts a block on adult sites?**

- Yes
- No children in the home
- No



## SECTION B. ADULTS IN THE HOUSEHOLD (18 AND ABOVE)

*The questions in this section ask for information about each adult (18 years old and above) living in your household. Please take care to report as accurately as possible. If there are more than 3 other adults besides yourself living in your household, please provide information on yourself and the three oldest members.*

***You should feel free to consult with other household members for information when completing the survey.***

<b>B1. Including yourself, how many adults 18 years and older live in your household?</b>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 or more																			
	<b>Yourself</b>	<b>Adult #2</b>	<b>Adult #3</b>	<b>Adult #4</b>																
<b>B2. Adult's year of birth:</b>	<table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table> year					<table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table> year					<table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table> year					<table border="1" style="width: 100%; height: 30px; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table> year				
<b>B3. Adult's gender:</b>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female																
<b>B4. What is the adult's current marital status?</b>	<input type="radio"/> Married <input type="radio"/> Living with partner <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Single	<input type="radio"/> Married <input type="radio"/> Living with partner <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Single	<input type="radio"/> Married <input type="radio"/> Living with partner <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Single	<input type="radio"/> Married <input type="radio"/> Living with partner <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Single																
<b>B5. What is the relationship of the adult to you?</b>		<input type="radio"/> Spouse/Partner <input type="radio"/> Parent <input type="radio"/> Child <input type="radio"/> Grandparent <input type="radio"/> Other relative <input type="radio"/> Friend/roommate <input type="radio"/> Other: _____	<input type="radio"/> Spouse/Partner <input type="radio"/> Parent <input type="radio"/> Child <input type="radio"/> Grandparent <input type="radio"/> Other relative <input type="radio"/> Friend/roommate <input type="radio"/> Other: _____	<input type="radio"/> Spouse/Partner <input type="radio"/> Parent <input type="radio"/> Child <input type="radio"/> Grandparent <input type="radio"/> Other relative <input type="radio"/> Friend/roommate <input type="radio"/> Other: _____																
<b>B6. Adult's race: (MARK ALL THAT APPLY)</b>	<input type="radio"/> White <input type="radio"/> Black/African Amer. <input type="radio"/> Asian <input type="radio"/> Hispanic <input type="radio"/> Pacific Islander <input type="radio"/> Amer.Ind/AKNative <input type="radio"/> Other: _____	<input type="radio"/> White <input type="radio"/> Black/African Amer. <input type="radio"/> Asian <input type="radio"/> Hispanic <input type="radio"/> Pacific Islander <input type="radio"/> Amer.Ind/AKNative <input type="radio"/> Other: _____	<input type="radio"/> White <input type="radio"/> Black/African Amer. <input type="radio"/> Asian <input type="radio"/> Hispanic <input type="radio"/> Pacific Islander <input type="radio"/> Amer.Ind/AKNative <input type="radio"/> Other: _____	<input type="radio"/> White <input type="radio"/> Black/African Amer. <input type="radio"/> Asian <input type="radio"/> Hispanic <input type="radio"/> Pacific Islander <input type="radio"/> Amer.Ind/AKNative <input type="radio"/> Other: _____																



	<b>Yourself</b>	<b>Adult #2</b>	<b>Adult #3</b>	<b>Adult #4</b>
<b>B7. What is the adult's highest grade or level of school completed?</b>	<input type="radio"/> Up to 8th grade <input type="radio"/> Some high school <input type="radio"/> HS grad/GED <input type="radio"/> Some college <input type="radio"/> Associate's degree <input type="radio"/> Bachelor's degree <input type="radio"/> Grad/prof degree	<input type="radio"/> Up to 8th grade <input type="radio"/> Some high school <input type="radio"/> HS grad/GED <input type="radio"/> Some college <input type="radio"/> Associate's degree <input type="radio"/> Bachelor's degree <input type="radio"/> Grad/prof degree	<input type="radio"/> Up to 8th grade <input type="radio"/> Some high school <input type="radio"/> HS grad/GED <input type="radio"/> Some college <input type="radio"/> Associate's degree <input type="radio"/> Bachelor's degree <input type="radio"/> Grad/prof degree	<input type="radio"/> Up to 8th grade <input type="radio"/> Some high school <input type="radio"/> HS grad/GED <input type="radio"/> Some college <input type="radio"/> Associate's degree <input type="radio"/> Bachelor's degree <input type="radio"/> Grad/prof degree
<b>B8. What is the adult's sexual orientation?</b>	<input type="radio"/> Heterosexual <input type="radio"/> Bisexual <input type="radio"/> Gay/Lesbian	<input type="radio"/> Heterosexual <input type="radio"/> Bisexual <input type="radio"/> Gay/Lesbian	<input type="radio"/> Heterosexual <input type="radio"/> Bisexual <input type="radio"/> Gay/Lesbian	<input type="radio"/> Heterosexual <input type="radio"/> Bisexual <input type="radio"/> Gay/Lesbian
<b>B9. Check the option that best describes the adult's current employment status (Full-time is defined as more than 35 hours per week.)</b>	<input type="radio"/> Work full time <input type="radio"/> Work part time <input type="radio"/> Not working for pay	<input type="radio"/> Work full time <input type="radio"/> Work part time <input type="radio"/> Not working for pay	<input type="radio"/> Work full time <input type="radio"/> Work part time <input type="radio"/> Not working for pay	<input type="radio"/> Work full time <input type="radio"/> Work part time <input type="radio"/> Not working for pay
<b>B10. Has the adult ever had trouble getting services or help because of a language barrier?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B11. How many close friends or relatives does the adult see at least once a month?</b>	<input type="radio"/> 0 <input type="radio"/> 1-3 <input type="radio"/> 4-7 <input type="radio"/> More than 7	<input type="radio"/> 0 <input type="radio"/> 1-3 <input type="radio"/> 4-7 <input type="radio"/> More than 7	<input type="radio"/> 0 <input type="radio"/> 1-3 <input type="radio"/> 4-7 <input type="radio"/> More than 7	<input type="radio"/> 0 <input type="radio"/> 1-3 <input type="radio"/> 4-7 <input type="radio"/> More than 7
<b>B12. To which of the following groups does the adult belong?  (MARK ALL THAT APPLY)</b>	<input type="radio"/> No groups <input type="radio"/> Social groups(s) <input type="radio"/> Church group(s) <input type="radio"/> Volunteer group(s) <input type="radio"/> Other group(s)	<input type="radio"/> No groups <input type="radio"/> Social groups(s) <input type="radio"/> Church group(s) <input type="radio"/> Volunteer group(s) <input type="radio"/> Other group(s)	<input type="radio"/> No groups <input type="radio"/> Social groups(s) <input type="radio"/> Church group(s) <input type="radio"/> Volunteer group(s) <input type="radio"/> Other group(s)	<input type="radio"/> No groups <input type="radio"/> Social groups(s) <input type="radio"/> Church group(s) <input type="radio"/> Volunteer group(s) <input type="radio"/> Other group(s)

	<b>Yourself</b>	<b>Adult #2</b>	<b>Adult #3</b>	<b>Adult #4</b>
<b>B13. Does the adult sometimes have trouble understanding medical terminology that his/her health care provider tells him/her?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B14. Is the adult limited, because of physical, mental or emotional problems?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B15. Does the adult have any health problems that require the use of any of the following special equipment?  (MARK ALL THAT APPLY)</b>	<input type="radio"/> Not needed <input type="radio"/> Wheelchair <input type="radio"/> Cane/walker <input type="radio"/> Special bed <input type="radio"/> Special print/phone <input type="radio"/> Other: _____	<input type="radio"/> Not needed <input type="radio"/> Wheelchair <input type="radio"/> Cane/walker <input type="radio"/> Special bed <input type="radio"/> Special print/phone <input type="radio"/> Other: _____	<input type="radio"/> Not needed <input type="radio"/> Wheelchair <input type="radio"/> Cane/walker <input type="radio"/> Special bed <input type="radio"/> Special print/phone <input type="radio"/> Other: _____	<input type="radio"/> Not needed <input type="radio"/> Wheelchair <input type="radio"/> Cane/walker <input type="radio"/> Special bed <input type="radio"/> Special print/phone <input type="radio"/> Other: _____
<b>B16. Does the adult need help handling personal care needs such as eating, bathing or getting around the house?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B17. Does the adult need help handling every day chores such as going to the bank or shopping?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B18. Does the adult have any medications he/she takes on a regular basis?</b>	<input type="radio"/> Yes <input type="radio"/> No [SKIP TO B20]	<input type="radio"/> Yes <input type="radio"/> No [SKIP TO B20]	<input type="radio"/> Yes <input type="radio"/> No [SKIP TO B20]	<input type="radio"/> Yes <input type="radio"/> No [SKIP TO B20]
<b>B19. If yes, does the adult have trouble managing taking these medications?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B20. Has the adult ever had a heart attack?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B21. Has the adult ever been treated for heart failure? (For example, had fluid in the lungs or told the heart was not pumping well.)</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No





	Yourself	Adult #2	Adult #3	Adult #4
<b>B22. Has adult ever been diagnosed with any of the following:</b> <b>a. Lupus</b> <b>b. Myasthenia gravis</b> <b>c. Thyroid disorder</b> <b>d. Any other autoimmune disease?</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No
<b>B23. Has the adult ever been diagnosed with any disease of the kidney?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B24. Has the adult ever been diagnosed with diabetes?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B25. Has the adult ever been diagnosed with HIV/AIDS?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B26. Has the adult ever been diagnosed with hepatitis A or B?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B27. Has the adult ever been diagnosed with hepatitis C?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B28. Has adult ever been diagnosed with any of the following:</b> <b>a. Multiple Sclerosis</b> <b>b. Alzheimer's</b> <b>c. Parkinson's</b> <b>d. Lou Gehrig's Disease/ALS</b> <b>e. Any other neuro-degenerative disease?</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No



	<b>Yourself</b>	<b>Adult #2</b>	<b>Adult #3</b>	<b>Adult #4</b>
<b>B29. Has adult ever been diagnosed with any type of cancer?</b>	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____
<b>B30. Has adult ever been diagnosed with aplastic anemia?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B31. Has adult ever been diagnosed with any of the following:</b>  <b>a. Emphysema/COPD</b>  <b>b. Chronic Bronchitis</b>  <b>c. Asthma (even only as a child)</b>  <b>d. Any other problems with breathing?</b>	<input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No  <input type="radio"/> Yes <input type="radio"/> No
<b>B32. During the past 12 months, has the adult had a flu shot?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B33. During the past 12 months, has the adult had a pneumonia shot?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B34. Has the adult every received a vaccination for any type of hepatitis ?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B35. Does the adult smoke tobacco regularly?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>B36. Does the adult smoke tobacco in the home?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No



## SECTION C. YOUR PERSONAL MEDICAL CARE

The questions in this section ask for information about your health, your health care insurance coverage, and the health care services you have received over the past 12 months.

### C1. Would you say in general your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

### C2. Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

### C3. Do you currently have any health insurance?

- Yes
- No [SKIP TO C8]

### C4. During the past 12 months, was there any time that you did not have any health insurance or coverage?

- Yes
- No

### C5. What kind of health insurance do you have? (MARK ALL THAT APPLY)

- Medicare
- Medicaid/Mass Health
- The military, CHAMPUS, TriCare or VA
- Private health plan or managed care (HMO)

### C6. If you have Medicare, do you also purchase supplemental or Medigap insurance?

- No
- Yes
- Don't have Medicare

### C7. Who pays for your health insurance? (CHOOSE ONE ONLY)

- You or another individual pays all
- Employer pays a portion of the cost
- Employer pays all of the cost
- The government pays a portion of the cost
- The government pays all of the cost

[SKIP TO C9]

### C8. If you do not currently have health insurance or you have not had insurance in the past 12 months, what are the reasons why? (MARK ALL THAT APPLY)

- Always had health insurance in past 12 months
- My employer does not offer it
- I am self-employed
- I can't afford it
- I am healthy and don't think I need it
- Other: \_\_\_\_\_

### C9. Do you have at least one person who you think of as your personal doctor or primary care provider?

- Yes
- No

**C10. About how long has it been since you last visited a primary care provider for a routine check-up?**

- Within the past year
- 1 - 2 years ago
- 3 - 5 years ago
- More than 5 years ago
- Never

**C11. Where do you go most often when you are sick or need advice about your health? (CHOOSE ONE ONLY)**

- A doctor's office or HMO
- A clinic or health center
- A hospital outpatient department
- A hospital emergency room
- An urgent care center
- Someplace else

**C12. In the last 12 months, how many times did you go to an emergency room to receive medical care?**

- None
- 1-2
- 3-4
- 5 or more

**C13. How long has it been since you last visited a dentist or dental clinic for any reason?**

- Never [SKIP TO C15]
- Within the past year [SKIP TO C15]
- 1 - 2 years ago
- 3 - 5 years ago
- More than 5 years ago

**C14. What is the main reason you have not visited the dentist in the last year? (CHOOSE ONE ONLY)**

- Fear, apprehension, pain, dislike going
- Cost
- Do not have/know a dentist
- Cannot get to the office/clinic
- No reason to go (no problems with teeth)
- Other priorities

**C15. About how long has it been since you had your blood pressure taken by a doctor, nurse or other health professional?**

- Within the past 6 months
- 6 months - 1 year ago
- 1 - 2 years ago
- 3 - 5 years ago
- More than 5 years ago
- Never [SKIP TO C18]

**C16. Have you ever been told by a doctor, nurse or other health professional that you have high blood pressure?**

- Yes
- No [SKIP TO C18]

**C17. If yes, are you taking any medication for your high blood pressure?**

- Yes
- No

**C18. Have you received a colonoscopy in the past 12 months?**

- Yes
- No
- Don't know/not sure

**C19. About how long has it been since you last had your blood cholesterol checked?**

- Within the past 6 months
- 6 months - 1 year ago
- 1 - 2 years ago
- 3 - 5 years ago
- More than 5 years ago
- Never [SKIP TO C21]
- Don't know/not sure

**C20. Have you ever been told by a doctor, nurse or other health professional that your blood cholesterol is high?**

- Yes
- No
- Don't know/not sure



**C21. Have you ever been told by a doctor that you have asthma?**

- Yes  No [SKIP TO C24]

**C22. Do you still have asthma?**

- Yes  No [SKIP TO C24]

**C23. In the past 12 months, how many times have you received urgent (emergency) care services for your asthma?**

- None  1-2  3-5  6 or more

**C24. Have you ever been told by a doctor that you have diabetes?**

- Yes, but only during pregnancy  
 Yes  
 No [SKIP TO C29]

**C25. How long has it been since your last scheduled diabetes visit with a primary care provider, ophthalmologist, podiatrist or other diabetes-related medical provider?**

- Less than 6 months  
 6 to 12 months  
 1 to 2 years  
 2 or more years

**C26. Is your diabetes treated by any of the following:  
(MARK ALL THAT APPLY)**

- Modifying your diet  
 Medications taken by mouth  
 Insulin injections  
 Not being treated

**C27. Have you ever had any sores or irritations on your feet that took more than four weeks to heal?**

- Yes  No

**C28. Have you ever taken a course or class on how to manage your diabetes yourself?**

- Yes  No

**C29. Have you had shortness of breath either when hurrying on the level or walking up a slight hill?**

- Yes  No

**C30. Have you ever been awakened by trouble breathing or shortness of breath, other than when you had a cold?**

- Yes  No

**C31. Have you ever had swelling in both ankles and/or legs that worsens as the day goes on?**

- Yes, but only during pregnancy  
 Yes  
 No

**C32. What is your current height?**

--	--	--

feet    inches

- Don't know

**C33. What is your current weight?**

--	--	--

pounds

- Don't know

**C34. Do you perceive your weight to be:**

- Just right  Overweight  Underweight

**C35. Has a doctor ever given you advice about your weight?**

- Yes  No



**C36. During the past year, have you lost 10 pounds or more without wanting to?**

- Yes    No    Don't know/not sure

**C37. During the past year, have you gained 10 pounds or more without wanting to?**

- Yes    No    Don't know/not sure

**C38. Has a doctor or any other health care provider ever told you that you have any of the following major impairments or health problems?**

**(MARK ALL THAT APPLY)**

- Arthritis/rheumatism
- Back or neck injury
- Fractures, bone/joint injury
- Osteoporosis
- Eye/vision problem
- Hearing problem
- Stroke problem
- Depression/anxiety/emotional problem
- Sexually transmitted or venereal disease
- Other impairment/problem
- No major impairment or health problem

**C39. Thinking about your physical health, which includes physical illness or injury, for how many days during the past 30 days was your physical health not good?**

--	--

 days

**C40. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?**

--	--

 days

**C41. Do you have someone you can trust and confide in?**

- Yes    No

**C42. During the past 30 days, for about how many days have you felt sad, blue, or depressed?**

--	--

 days

**C43. During the past 30 days, for about how many days have you felt worried, tense, or anxious?**

--	--

 days

**C44. During the past 30 days, for about how many days have you felt you did not get enough rest or sleep?**

--	--

 days

**C45. During the past 30 days, for about how many days have you felt very healthy and full of energy?**

--	--

 days

--



**C46. Are you the primary caregiver for another adult with a chronic, long-term health condition?**

Yes  No [SKIP TO C53 if female /C58 if male]



**C47. What is your relationship to the care recipient?**

- Spouse/Partner       Sibling
- Daughter               Friend
- Son                       Neighbor
- Daughter-in-law       Grandchild
- Son-in-law               Other relative
- Parent

**C48. Do you receive formal support or services from an organization or group to help with your caregiving responsibilities?**

Yes  No

**C49. Do you reside in the same household with the care recipient?**

Yes  No

**C50. Are other family or friends involved with providing care for this individual?**

Yes  No

**C51. Have you missed work, school or other important appointments as a result of your caregiving role?**

Yes  No

**C52. Would you say that providing this care is:**

- Not at all stressful
- Somewhat stressful
- Quite stressful
- Extremely stressful

**FEMALE RESPONDENTS ONLY:**

**C53. Indicate which of the following services you have received in the past 12 months: (MARK ALL THAT APPLY)**

- Pap smear
- Breast exam (by a medical provider)
- Mammogram
- Bone density check
- None of the above

**C54. Have you ever tried to conceive a child for a period of 12 months or more and been unable to get pregnant?**

Yes  No

**C55. Have you ever been pregnant, even if it did not result in a live birth?**

Yes  No [SKIP TO PAGE 12]

**C56. If yes, how many times have you been pregnant?**

pregnancies

**C57. How many babies have been born (alive at birth) to you?**

live births

**MALE RESPONDENTS ONLY:**

**C58. Indicate which of the following services you have received in the past 12 months: (MARK ALL THAT APPLY)**

- Prostate exam
- Testicular exam (by a medical provider)
- None of the above

**C59. Have you ever tried for a period of 12 months or more to father a child and have been unsuccessful?**

Yes  No

## SECTION D. BEHAVIOR, SAFETY & ENVIRONMENT

The questions in this section ask for information about your health-related behaviors, overall safety, and work and home environments.

**D1. When you drive or ride in a vehicle, how often do you use a seat belt?**

- I don't ride in any cars or trucks
- Never
- Rarely
- Sometimes
- Most of the time
- Always

**D2. In the past 12 months, how often have you worn a helmet when riding a bike?**

- I haven't ridden a bike in the past year
- Never
- Rarely
- Sometimes
- Most of the time
- Always

**D3. During the past 30 days, other than your regular job, did you participate in any physical activity such as running, calisthenics, golf, gardening, or walking for exercise?**

- Yes
- No

**D4. What is your cigarette smoking behavior? (CHOOSE ONLY ONE)**

- Currently a smoker
  - Never smoked
  - Ex-smoker
- } [SKIP TO D8]

**D5. On average, how many cigarettes a day do you smoke now?**

- None [SKIP TO D8]
- 1-10
- 11-20
- 21-40
- More than 40

**D6. Are you thinking about quitting smoking in the next 6 months?**

- Yes
- No [SKIP TO D8]

**D7. When are you thinking about quitting?**

- In the next 6 months
- In the next 3 months
- In the next month

**D8. During the past month, about how many days did you have any beer, wine or liquor?**

- No days [SKIP TO D11]
- 1-4 days
- 5-10 days
- 11-20 days
- 21 or more days

**D9. In the past month, on a typical day that you drank, about how much did you have to drink?**

*One drink means: a 12-ounce can or bottle of beer, or a 4-ounce glass of wine, or a 12-ounce wine cooler, or a 1-ounce shot glass of liquor or spirits (alone or in a mixed drink).*

- No drinks
- One drink
- Two drinks
- Three drinks
- Four drinks
- Five drinks
- Six drinks
- Seven drinks
- Eight or more drinks

**D10. In the past month, how often have you had 4 or more drinks in one sitting?**

- Never
- 1-4 days this past month
- Once a week
- Several times/week

**D11. In the past 12 months, have you used any of the following substances? (MARK ALL THAT APPLY)**

- Marijuana/Hashish
- Cocaine
- Heroin
- Ecstasy (X)
- Special K (Ketamine)
- Other
- None



**D12. In the past month, have you driven a car while under the influence of alcohol or drugs?**

- Yes  No

**D13. In the past month, have you been in the car with a driver who was under the influence of alcohol or drugs?**

- Yes  No

**D14. In the past 12 months, have you ever been hit, kicked, punched, threatened, or made to feel afraid by someone you know?**

- Yes  No

**D15. In your home, do you have: (include those in a car, truck, or outdoor storage area)**

**a. Handgun(s):**

- Yes, some without a child safety lock or lock-up  
 Yes, all with a child safety lock or lock-up  
 No

**b. Rifle(s) or shotgun(s):**

- Yes, some without a child safety lock or lock-up  
 Yes, all with a child safety lock or lock-up  
 No

**D16. In the past 12 months, have you had a problem with any of the following pests in or around your home?**

- a. Rodents  Yes  No  
b. Cockroaches  Yes  No  
c. Other insects  Yes  No

**D17. In the past 12 months, which of the following pesticides have been used in or around your home?  
(MARK ALL THAT APPLY)**

- Indoor household pest control  
 Outdoor pest control (for the lawn)  
 Pest control for fresh foods you grow  
 Pet care (flea collars, shampoos)  
 No pesticides

**D18. Do you have any dogs, cats or birds as pets in your home?**

- Yes  No

**D19. Over the past year, have you noticed mold or mildew in your home?**

- Yes  No

**D20. In the past 12 months, how often have you used sunblock/protection?**

- Never  
 Rarely (sunny beach days, boating, etc.)  
 Sometimes (most or all summer days)  
 Most of the time (most days year round)

**D21. How afraid are you that you will fall and hurt yourself in the next year?**

- Very afraid  
 Somewhat afraid  
 Not at all afraid

**D22. Are there things you have stopped doing because you are worried that you might fall?**

- Yes  No

**D23. Have you fallen all the way to the ground in the last 12 months?**

- Yes  No

**D24. In the past year, have you had an accident resulting in a doctor's or emergency room visit?**

- Yes  No [SKIP TO D26]

**D25. Did this accident result from a fall?**

- Yes  No

**D26. During the past 12 months, have you had a fire in your home?**

- Yes, called fire department  
 Yes, extinguished fire myself  
 No

**D27. During the past 12 months, have you called 911 for emergency medical services?**

- Yes  No

## SECTION E. CHILDREN IN THE HOUSEHOLD (12 AND UNDER)

The questions in this section ask for information about each child (12 years old or younger) living in your household. Please take care to report as accurately as possible.

**If there are more than four children living in your household, please provide information for the four youngest children.**

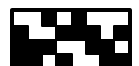
<b>E1. Are there children 12 years or younger living in the home?</b>	<input type="radio"/> Yes <input type="radio"/> No <b>[GO TO PAGE 19]</b>																																											
<b>E2. How many CHILDREN aged 0-5 live in your household?</b>	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 or more																																											
<b>E3. How many CHILDREN aged 6-12 live in your household?</b>	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 or more																																											
	<b>Child #1</b>	<b>Child #2</b>	<b>Child #3</b>	<b>Child #4</b>																																								
<b>E4. Child's date of birth:</b>	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 1.2em; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">month</td> <td style="text-align: center; font-size: 0.8em;">year</td> <td></td> <td style="text-align: center; font-size: 0.8em;">month</td> <td style="text-align: center; font-size: 0.8em;">year</td> </tr> </table>			/			month	year		month	year	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 1.2em; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">month</td> <td style="text-align: center; font-size: 0.8em;">year</td> <td></td> <td style="text-align: center; font-size: 0.8em;">month</td> <td style="text-align: center; font-size: 0.8em;">year</td> </tr> </table>			/			month	year		month	year	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 1.2em; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">month</td> <td style="text-align: center; font-size: 0.8em;">year</td> <td></td> <td style="text-align: center; font-size: 0.8em;">month</td> <td style="text-align: center; font-size: 0.8em;">year</td> </tr> </table>			/			month	year		month	year	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 1.2em; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">month</td> <td style="text-align: center; font-size: 0.8em;">year</td> <td></td> <td style="text-align: center; font-size: 0.8em;">month</td> <td style="text-align: center; font-size: 0.8em;">year</td> </tr> </table>			/			month	year		month	year
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<b>E5. Child's gender:</b>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female																																								
<b>E6. What is the child's height?</b>	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">feet</td> <td style="text-align: center; font-size: 0.8em;">inches</td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;"><input type="radio"/> Don't know</td> </tr> </table>				feet	inches		<input type="radio"/> Don't know			<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">feet</td> <td style="text-align: center; font-size: 0.8em;">inches</td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;"><input type="radio"/> Don't know</td> </tr> </table>				feet	inches		<input type="radio"/> Don't know			<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">feet</td> <td style="text-align: center; font-size: 0.8em;">inches</td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;"><input type="radio"/> Don't know</td> </tr> </table>				feet	inches		<input type="radio"/> Don't know			<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">feet</td> <td style="text-align: center; font-size: 0.8em;">inches</td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;"><input type="radio"/> Don't know</td> </tr> </table>				feet	inches		<input type="radio"/> Don't know						
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<b>E7. What is the child's weight?</b>	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="3" style="text-align: center; font-size: 0.8em;">pounds</td> </tr> <tr> <td colspan="3" style="text-align: center;"><input type="radio"/> Don't know</td> </tr> </table>				pounds			<input type="radio"/> Don't know			<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="3" style="text-align: center; font-size: 0.8em;">pounds</td> </tr> <tr> <td colspan="3" style="text-align: center;"><input type="radio"/> Don't know</td> </tr> </table>				pounds			<input type="radio"/> Don't know			<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="3" style="text-align: center; font-size: 0.8em;">pounds</td> </tr> <tr> <td colspan="3" style="text-align: center;"><input type="radio"/> Don't know</td> </tr> </table>				pounds			<input type="radio"/> Don't know			<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="3" style="text-align: center; font-size: 0.8em;">pounds</td> </tr> <tr> <td colspan="3" style="text-align: center;"><input type="radio"/> Don't know</td> </tr> </table>				pounds			<input type="radio"/> Don't know						
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<b>E8. Do you think that the child is overweight?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																																								
<b>E9. Does the child have health care coverage or insurance?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																																								
<b>E10. Does the child have a doctor he or she sees regularly?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																																								
<b>E11. Has the child been seen by a dentist in the past 12 months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No																																								



	Child #1	Child #2	Child #3	Child #4
<b>E12. Has the child received an eye exam in the past 12 months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E13. Did the mother receive regular prenatal care during her pregnancy?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E14. Did the mother smoke during pregnancy?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E15. Did the mother use alcohol or drugs during pregnancy?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E16. Was the child breast-fed?</b>	<input type="radio"/> No <input type="radio"/> less than 1 month <input type="radio"/> 1 - 6 months <input type="radio"/> 7 months or more	<input type="radio"/> No <input type="radio"/> less than 1 month <input type="radio"/> 1 - 6 months <input type="radio"/> 7 months or more	<input type="radio"/> No <input type="radio"/> less than 1 month <input type="radio"/> 1 - 6 months <input type="radio"/> 7 months or more	<input type="radio"/> No <input type="radio"/> less than 1 month <input type="radio"/> 1 - 6 months <input type="radio"/> 7 months or more
<b>E17. Was the child born with any birth defect? The birth defect may have been diagnosed at birth or another age.</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E18. Did the child receive services through the Early Intervention Program when the child was 0-3 years old? (This is a program run by the state to aid children at risk.)</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E19. Has the child received all required vaccinations?</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
<b>E20. Has the child been tested for lead?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E21. Has the child been diagnosed with any type of cancer?</b>	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____
<b>E22. Has the child been diagnosed with aplastic anemia?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No



	Child #1	Child #2	Child #3	Child #4
<b>E23. Has the child had wheezing or whistling in his or her chest at all during the last 12 months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E24. Does the child have asthma?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E25. Has the child been hospitalized for asthma in the last twelve months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E26. Has the child missed school because of asthma in the last twelve months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E27. Has the child ever been diagnosed with depression or other emotional illness?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>E28. On average, how many hours a week does the child watch TV or play video games?</b>	<input type="radio"/> less than 5 <input type="radio"/> 5-9 <input type="radio"/> 10-14 <input type="radio"/> 15-19 <input type="radio"/> 20 or more	<input type="radio"/> less than 5 <input type="radio"/> 5-9 <input type="radio"/> 10-14 <input type="radio"/> 15-19 <input type="radio"/> 20 or more	<input type="radio"/> less than 5 <input type="radio"/> 5-9 <input type="radio"/> 10-14 <input type="radio"/> 15-19 <input type="radio"/> 20 or more	<input type="radio"/> less than 5 <input type="radio"/> 5-9 <input type="radio"/> 10-14 <input type="radio"/> 15-19 <input type="radio"/> 20 or more
<b>E29. What kind (if any) of safety device does the child most frequently use in the car?</b>	<input type="radio"/> Car seat <input type="radio"/> Booster seat <input type="radio"/> Seat belt <input type="radio"/> None <b>[SKIP TO E31]</b>	<input type="radio"/> Car seat <input type="radio"/> Booster seat <input type="radio"/> Seat belt <input type="radio"/> None <b>[SKIP TO E31]</b>	<input type="radio"/> Car seat <input type="radio"/> Booster seat <input type="radio"/> Seat belt <input type="radio"/> None <b>[SKIP TO E31]</b>	<input type="radio"/> Car seat <input type="radio"/> Booster seat <input type="radio"/> Seat belt <input type="radio"/> None <b>[SKIP TO E31]</b>
<b>E30. How often does the child use the safety device described in the question above?</b>	<input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always	<input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always	<input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always	<input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always
<b>E31. How often does the child ride in the front seat of the car?</b>	<input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always	<input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always	<input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always	<input type="radio"/> Never <input type="radio"/> Rarely <input type="radio"/> Sometimes <input type="radio"/> Most of the time <input type="radio"/> Always



	Child #1	Child #2	Child #3	Child #4
<b>E32. How often does the child use a helmet when bicycling?</b>	<input type="radio"/> Doesn't bike <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always	<input type="radio"/> Doesn't bike <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always	<input type="radio"/> Doesn't bike <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always	<input type="radio"/> Doesn't bike <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always
<b>E33. How often does the child use a helmet when skateboarding or scootering?</b>	<input type="radio"/> Doesn't board <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always	<input type="radio"/> Doesn't board <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always	<input type="radio"/> Doesn't board <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always	<input type="radio"/> Doesn't board <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always
<b>E34. How often does the child use a helmet when roller blading or in line skating?</b>	<input type="radio"/> Doesn't blade <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always	<input type="radio"/> Doesn't blade <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always	<input type="radio"/> Doesn't blade <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always	<input type="radio"/> Doesn't blade <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Always

**E35. Do you think that the children in this household have enough positive relationships with friends and family members?**

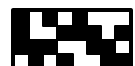
- Both friends and family   
  Friends only   
  Family only   
  Neither friends nor family

**E36. How often do the children in your household come to talk to you or another adult family member when they are troubled by their friends or issues at school?**

- Never   
  Rarely   
  Sometimes   
  Often

**E37. In the past 12 months, how frequently have you had meaningful conversations about the following subjects with the children in your household?**

	Never	Rarely	Sometimes	Often
a. Tobacco use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Drinking alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Drug use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Riding with a drunk driver	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Gun safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Acting violently towards others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Being bullied or treated abusively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Feeling left out or ostracized	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Talking with or accepting rides from strangers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Internet safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Fire safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## SECTION F. ADOLESCENTS IN THE HOUSEHOLD (AGES 13 TO 17)

The questions in this section ask for information about each adolescent (Ages 13 to 17 years old) living in your household. Please take care to report as accurately as possible.

If there are more than four adolescents living in your household, please provide information for the four youngest adolescents.

**F1. Are there adolescents aged 13 - 17 years living in the home?**

- Yes     No [GO TO G1 on PAGE 21]

**F2. How many ADOLESCENTS aged 13- 17 live in your household?**

- None     1     2     3     4     5 or more

**F3. Do you think that the adolescents in your household have enough positive relationships with friends and family members?**

- Both friends and family     Friends only     Family only     Neither friends nor family

**F4. How often do the adolescents in your household come to talk to you or another adult family member when they are troubled by friends or issues at school?**

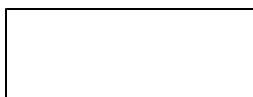
- Never     Rarely     Sometimes     Often

**F5. In the past 12 months, how frequently have you had meaningful conversations about the following subjects with the adolescents in your household?**

	Never	Rarely	Sometimes	Often
a. Tobacco use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Drinking alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Drug use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Riding with a drunk driver	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Driving drunk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Maintaining sexual abstinence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Sexual health and sexually transmitted disease (STD) prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Gun safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Acting violently towards others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Being bullied or treated abusively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Feeling left out or ostracized	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Talking with or accepting rides from strangers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Internet safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Fire safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



	Adolescent #1	Adolescent #2	Adolescent #3	Adolescent #4
<b>F6. Adolescent's date of birth:</b>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> / <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> month      year	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> / <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> month      year	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> / <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> month      year	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> / <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> month      year
<b>F7. Adolescent's gender:</b>	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female
<b>F8. What is the adolescent's height?</b>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> feet      inches <input type="radio"/> Don't know	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> feet      inches <input type="radio"/> Don't know	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> feet      inches <input type="radio"/> Don't know	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> feet      inches <input type="radio"/> Don't know
<b>F9. What is the adolescent's weight?</b>	<div style="border: 1px solid black; width: 60px; height: 30px;"></div> pounds <input type="radio"/> Don't know	<div style="border: 1px solid black; width: 60px; height: 30px;"></div> pounds <input type="radio"/> Don't know	<div style="border: 1px solid black; width: 60px; height: 30px;"></div> pounds <input type="radio"/> Don't know	<div style="border: 1px solid black; width: 60px; height: 30px;"></div> pounds <input type="radio"/> Don't know
<b>F10. Do you think the adolescent is overweight?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>F11. Does the adolescent have health care coverage or insurance?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>F12. Does the adolescent have a doctor he or she sees regularly?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>F13. Has the adolescent had wheezing or whistling in his or her chest at all during the last 12 months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>F14. Does the adolescent have asthma?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>F15. Has the adolescent been hospitalized for asthma in the last 12 months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>F16. Has the adolescent missed school because of asthma in the last 12 months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No



	Adolescent #1	Adolescent #2	Adolescent #3	Adolescent #4
<b>F17. Has the adolescent been diagnosed with any type of cancer?</b>	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____	<input type="radio"/> Yes <input type="radio"/> No If yes, what type? _____
<b>F18. Has the adolescent been diagnosed with aplastic anemia?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>F19. Has the adolescent received an eye exam in the past 12 months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>F20. Has the adolescent been seen by a dentist in the past 12 months?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>F21. Has the adolescent ever been diagnosed with depression or other emotional illness?</b>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

## SECTION G. WEYMOUTH CONCERNS

**G1. Have you ever felt ill or had a health problem you believe was caused by the air, water, or soil in your neighborhood?**

Yes  No

**G1a. What is it?** \_\_\_\_\_  
\_\_\_\_\_

**G2. How much do you think each of the following influences illnesses such as multiple sclerosis, lupus, kidney disease, or cancer?**

	A lot	A little	Not at all	Don't know
a. Heredity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Diet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Chemicals and pollutants in the air or water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**G3. How concerned are you that the South Weymouth Naval Air Station (SWNAS) is affecting people's health?**

Very concerned  Somewhat concerned  Not very concerned  Not at all concerned





**G4. Do you think Weymouth should spend more, about the same, or fewer tax dollars on the following:**

	More	About the same	Fewer	Don't know
a. Public safety (Fire or Police Department)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Education in schools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Extracurricular activities in the schools (sports, music, arts)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Parks and recreational facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Monitoring the environment for air quality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Monitoring the environment for water safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Monitoring the environment for industrial pollutants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Public maintenance (street repair, garbage collection)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Public health (Emergency services, Health Department)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Transportation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**G5. Which of these is the most important area in which Weymouth should spend more tax dollars? (CHOOSE ONE ONLY)**

- Public safety
- Education in schools
- Extracurricular activities in schools
- Parks and recreational facilities
- Monitoring the environment
- Public maintenance
- Public health
- Transportation

**G6. Do you have any additional comments you would like to share with the Town?**

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***Thank you for your time and for the effort you have taken to provide us with this information. We want to assure you that your responses are completely confidential and the information from this survey will never be presented in a way that could identify individual respondents.***

*If you have any questions about this project, please feel free to contact Carolyn Mansfield at JSI, (617) 482 - 9485.*

**Please return this survey in the enclosed postage paid envelope or mail it to:**

**JSI Research & Training  
44 Farnsworth Street  
Boston, MA 02210**

***THANK YOU!***

