1. **What is your ZIP code**? \_\_\_\_\_\_\_\_\_\_
2. **Gender**?  
   Male

Female

1. **What is your race**?

White

Black or African American

American Indian or Alaska Native

Asian

Hispanic or Latino

Native Hawaiian & Other Pacific Islander

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What are the ages of the people who live in your household**?

Yourself 18-24 25-44 45-54 55-64 65+   
Person 2 0-35 mos. 3-5 6-12 13-17 18-24 25-44 45-54 55-64 65+

Person 3 0-35 mos. 3-5 6-12 13-17 18-24 25-44 45-54 55-64 65+

Person 4 0-35 mos. 3-5 6-12 13-17 18-24 25-44 45-54 55-64 65+

Person 5 0-35 mos. 3-5 6-12 13-17 18-24 25-44 45-54 55-64 65+

Person 6 0-35 mos. 3-5 6-12 13-17 18-24 25-44 45-54 55-64 65+

1. **About how long have you lived in the area**?

Less than a year

1-2 years

3-5 years

6-10 years

11-20 years

More than 20 years

**HEALTH BEHAVIORS**

1. **How often do you use seat belts when you drive or ride in a car**?

Always

Nearly always

Sometimes

Seldom

Never

1. **During the past 12 months, have you received a flu shot?**

Yes

No

1. **Have you ever been told by a doctor you had high blood pressure**?

Yes

No

**8a**. If yes, is any medication currently prescribed for your high blood pressure?

1. Yes
2. No
3. **Have you ever been told by a doctor you should lose weight for health reasons**?

Yes

No

1. **During the past month have you participated in any physical activities or exercise, such as running, walking, golf, etc**.?

Yes

No

**10a**. If yes, how many times a week do you take part in this activity?

1. 1-2 days
2. 3-4 days
3. 5-7 days

**10b**. How many minutes or hours do you usually keep at this activity?

1. **Are you currently trying to lose weight**?

Yes

No

**11a**. If yes, how are you trying to lose weight? *(circle all that apply)*

1. Eating fewer calories
2. Increasing physical activity
3. Both
4. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Have you smoked at least 100 cigarettes in your life**?

Yes

No

**12a**. If yes, how old were you when you first started smoking regularly? \_\_\_\_\_\_\_\_\_\_

1. **Do you smoke now**?

Yes

No

**13a**. If yes, how many cigarettes do you smoke on an average day? \_\_\_\_\_\_\_\_\_\_

1. **Have you ever been told by a doctor that you have one of the following conditions**? *(circle all that apply)*

Adult asthma

Angina or coronary artery disease

Bacterial pneumonia

Cancer If yes, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHF (congestive heart failure)

COPD (chronic obstructive pulmonary disease)

Diabetes or high blood sugar

Heart attack

High cholesterol

Hypertension (high blood pressure)

Stroke

1. **Has a child in your household (age 17 or younger) been told by a doctor that they have one of the following conditions**? *(circle all that apply)*

Asthma

Diabetes

Overweight or obesity

1. **If a child in your household has asthma, how many times during the past 12 months did you visit an emergency room because of the asthma**? \_\_\_\_\_\_\_\_\_
2. **Has a child in your household (age 17 or younger) used the following**? *(circle all that apply)*

Alcohol

Drugs

Tobacco

1. **Has a child in your household (age 17 or younger) become pregnant?**

Yes

No

**MEDICAL CARE AND SERVICES**

1. **Including yourself, how many members of your household are disabled?**

0

1

2

3 or more

1. **Including yourself, how many adults (age18 or older) in your household are in fair-to-poor health?**

0

1

2

3 or more

1. **Is any child (age 17 or younger) in your household in fair-to-poor health?**

Yes, 1

Yes, 2 or more

No

1. **Are you or any household member a PRIMARY caregiver for an aged, disabled or chronically ill person?** *(including a parent, spouse or other relative)*

Yes

No

1. **How long has it been since you last visited a doctor for a routine check up**? A routine check-up is a general visit, not a visit for a specific injury, illness or condition.

Within the past year

Within the past two years

Within the past five years

5 or more years ago

Never

1. **If your last visit was more than two years ago, is it because you –**

Do not have a medical condition that requires any care and I receive health screenings from another provider service

Do not routinely receive any health screenings

Could not schedule due to work or personal conflicts with normal business hours

Could not afford the payments due, regardless of insurance status

Could not arrange transportation

1. **If you or a household member have a health care need**:

**25a**. Do you have a doctor you can go to? Yes or No

**25b**. Do you have a dentist you can go to? Yes or No

**25c**. Do you have a mental health specialist you can go to? Yes or No

**25d**. Do you have a substance abuse counselor you can go to? Yes or No

1. **How many times during the past 12 months have you or any household member used a hospital emergency room**? *(circle only one)*

None

1-2 times

3-5 times

6 or more times

1. **If you or a household member used a hospital emergency room in the past 12 months, was it due to:**

An injury that required immediate attention

An injury that did not require immediate attention but it was the most convenient/only service available

An ongoing illness

1. **Have you or anyone in your household had any difficulty finding a doctor within the past two years**?

Yes

No

**28a**. If yes, briefly, why would you say you had trouble finding a doctor?

1. Couldn’t get a convenient appointment
2. Didn’t know how to get in contact with one
3. Doctor was not taking new patients
4. No transportation
5. Would not accept your insurance
6. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **Have you or anyone in your household had any difficulty finding a doctor that treats specific illnesses or conditions in your area within the past 2 years**?

Yes

No

**29a.** If yes, what kind of specialist did you look for?

1. Bone and joint specialist
2. Cancer specialist
3. Children’s specialist
4. Dentist
5. Diabetes specialist
6. Heart specialist
7. Lung and Breathing specialist
8. Mental Health specialist
9. Nerve and Brain specialist
10. Women’s health specialist
11. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**29b.** Why were you unable to visit the specialist when you needed one?

* 1. No appointments were available
  2. No specialist was available in this area
  3. Did not have a car or transportation to get to the office
  4. Could not get to the office while they were open
  5. Did not know how to find one
  6. Could not afford to pay for the specialist
  7. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Within the past year

Within the past two years

Within the past five years

Over five years ago

Never

1. **Have you ever been told by a doctor or other health care professional that your blood cholesterol level is too high**?

Yes

No

1. **About how long has it been since your blood was checked for diabetes**?

Within the past year

Within the past two years

Within the past five years

Over five years ago

Never

1. **Have you ever been told by a doctor or health care professional you have high blood sugar or diabetes**?

Yes

No

1. **How long has it been since you had an exam or screening for colon cancer?**

Within the past year

Within the past 2 years

Within the past 5 yeas

6 years or more

Never

1. **How long has it been since your last mammogram for breast cancer?**

Within the past year

Within the past 2 years

Within the past 5 years

6 years or more

Never

1. **How long has it been since your last breast exam by a doctor or nurse?**

Within the past year

Within the past 2 years

Within the past 5 years

6 years or more

Never

1. **How long has it been since your last Pap Smear for female-related cancers?**

Within the past year

Within the past 2 years

Within the past 5 years

6 years or more

Never

1. **What do you think are the most pressing health problems in your community**?   
   *(circle all that apply)*

Ability to pay for care

Alcohol – dependency or abuse

Alcohol – underage binge or abuse

Drug abuse – prescription medications

Drug abuse – illegal substances

Cancer

Child abuse

Cost of health care

Domestic violence

Lack of health insurance

Lack of transportation to health care services

Lack of dental care

Lack of prenatal care

Mental health

Obesity in adults

Obesity in children and teenagers

Prescription medication too expensive

Teen pregnancy

Tobacco use/smoking among adults

Tobacco use/smoking among teenagers

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What medical services are most needed in your community**? *(circle all that apply)*

Adult primary care services

Alcohol and drug abuse treatment

Cancer treatment

Counseling/mental health services

Diabetes care

Emergency/trauma care

Heart care services

Orthopedic care (bone and joint)

Pediatric services

Women’s services, such as obstetrics/gynecological services

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Please circle the types of health education services most needed in your community**?

Alcohol abuse

Alzheimer’s disease

Asthma

Cancer screening

Child abuse/family violence

Diabetes

Diet and/or exercise

Drug abuse

HIV/AIDS

Sexually transmitted diseases

Smoking cessation and/or prevention

Stress management

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What health or community services should [Hospital Name] provide that currently are not available**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **What ideas or suggestions do you have for improving the overall health of the area community? (open text)**

**SOCIAL AND ECONOMIC FACTORS**

1. **What is your highest level of education?**

Left high school without a diploma

High school diploma

GED

Currently attending or have some college

2-year college degree

4-year college degree

Graduate-level degree

1. **Including yourself, how many adults in your household are retired?**

None 1 2 3 4 or more

1. **Including yourself, how many adults (18+) in your household are employed full time,   
   year-round?**

None 1 2 3 4 or more

1. **How many household members are currently covered by health insurance**?

Number of **adults** covered by health insurance: \_\_\_\_\_\_\_\_\_\_

Number of **children** covered by health insurance: \_\_\_\_\_\_\_\_\_\_

Number of household members **not covered** by insurance: \_\_\_\_\_\_\_\_\_\_

1. **If you or members of your household have health insurance coverage, how is it obtained**? *(check all that apply)*

Medicare A

Medicare B

Medicaid

Through a retirement insurance plan

Through an employer’s health insurance plan

Veterans’ Administration

Privately purchased

**47a**. Do any of these insurance policies provide dental coverage? Yes or No

**47b**. Do any of these insurances pay for prescription drugs?

1. yes, with co-payment
2. yes, with no co-payment
3. no

**47c**. Are medical, dental or prescription co-pays a large enough problem that you postpone   
or go without services or prescriptions? Yes or No

1. **Do you have trouble getting transportation to health care services**?

Yes

No

**48a. How many miles do you travel, one way:**

To see a doctor? 1-5 6-10 11-20 21-30 >30

To a hospital? 1-5 6-10 11-20 21-30 >30

To school or job training

Child care

Job

1. **Counting all income sources from everyone in your household, what was the combined household income last year?** *(circle only one)*

Less than $20,000

$20-000 - $29,999

$30,000 - $39,999

$40,000 - $49,999

$50,000 - $59,999

$60,000 - $69,999

$70,000 - $79,999

$80,000 - $89,999

$90,000 - $99,999

$100,000 - $199,999

$200,000 or more

**PHYSICAL ENVIRONMENT**

1. **How would you describe your housing situation**? *(circle only one)*

Own house or condo

Rent a house, apartment or room

Living in a group home

Living temporarily with a friend or relative

Multiple households sharing an apartment or house

Living in a shelter

Living in a motel

Living in senior housing or assisted living

Other (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Household issues**

*Some of the following may have been a problem for you or someone in your household. If it has been a problem in your household during the* ***past 12 months****, please tell us how much of a problem it has been. (circle one on each line)*

**Adult substance abuse** (alcohol or legal medications)

Not a problem Minor Problem Major Problem Don’t know

**Adult substance abuse** (illegal drugs)

Not a problem Minor Problem Major Problem Don’t know

**Youth substance abuse** (alcohol, drugs, etc.)

Not a problem Minor Problem Major Problem Don’t know

**Caring for an adult with disabilities**

Not a problem Minor Problem Major Problem Don’t know

**Caring for a child with disabilities**

Not a problem Minor Problem Major Problem Don’t know

**Child abuse**

Not a problem Minor Problem Major Problem Don’t know

**Physical violence against adults**

Not a problem Minor Problem Major Problem Don’t know

**Depression**

Not a problem Minor Problem Major Problem Don’t know

**Not having enough money for food**

Not a problem Minor Problem Major Problem Don’t know

**Not able to afford nutritious food** (fresh vegetables and fruits)

Not a problem Minor Problem Major Problem Don’t know

**Not able to afford transportation**

Not a problem Minor Problem Major Problem Don’t know

**Not having enough money to pay for housing**

Not a problem Minor Problem Major Problem Don’t know

**Not having enough money to pay the doctor, dentist or pharmacy**

Not a problem Minor Problem Major Problem Don’t know

**Not having enough money to pay for mental health counselor**

Not a problem Minor Problem Major Problem Don’t know

**Use of tobacco products**

Not a problem Minor Problem Major Problem Don’t know

**Not being able to find or afford after-school child care**

Not a problem Minor Problem Major Problem Don’t know

**Sexual abuse**

Not a problem Minor Problem Major Problem Don’t know

**Teen pregnancy**

Not a problem Minor Problem Major Problem Don’t know

**Other issues** (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for taking time to complete this survey.

Follow-up instructions for survey submission and incentive, if applicable: