004181

SCCS
Southern Community Cohort Study

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Please complete this survey ONLY if you are

FU4W1F

Marking Instructions

Please use a No. 2 pencil or black or blue ink only.
Print legible numbers and capital block letters in the boxes.

Correct Numbers and Letters	Correct Mark	Incorrect Marks
1 2 3 A B C	■ ☒	✓ ⬬ ⊙

1. What is your date of birth? Month ☐☐ Day ☐☐ 19☐☐

What is your CURRENT:

2. Marital status (please mark one)

☐ Married, or living as married with a partner ☐ Separated or divorced ☐ Single, never been married ☐ Widowed

3. Employment status (please mark the one that BEST describes your situation)

☐ Work for pay, full time ☐ Work for pay, part time ☐ Unemployed ☐ On disability ☐ Retired ☐ Housewife

4. Total household income, per year (please mark one)

☐ < $15,000 ☐ $15,000 - $24,999 ☐ $25,000 - $49,999 ☐ $50,000 - $99,999 ☐ $100,000 or more

5. How much do you currently weigh? ☐☐☐ **Pounds**

6. What is your CURRENT cigarette smoking status?

☐ Non-smoker
☐ Smoker → **How many cigarettes per day?** ☐☐☐

7. After joining this study in , have you been diagnosed with diabetes or high blood sugar?

☐ No ☐ Yes → **If yes, to the best of your memory, please tell us the month and year when this occurred.** Month ☐☐ Year 20☐☐

8. After joining this study in , have you been diagnosed with any type of CANCER?

☐ No ☐ Yes → **What type of cancer?**

☐ Breast ☐ Cervix ☐ Colon/rectum ☐ Lung ☐ Other (specify): ☐

Please tell us when and where your cancer was diagnosed:

Date of Diagnosis: Month ☐☐ Year 20☐☐

Name of Hospital or Clinic: _____

City and State of Hospital or Clinic: _____

9. In the past 10 years, how often have you had the following screening tests?

	Every year	Every 2-4 years	Every 5 years	Every 6 to 10 years	Never
Colonoscopy (a long tube inserted into the entire colon to look for colorectal polyps or cancer, while you are sedated)	☐	☐	☐	☐	☐
Sigmoidoscopy (a tube inserted partway into the colon to look for colorectal polyps or cancer)	☐	☐	☐	☐	☐
Mammogram (x-ray to check for breast cancer)	☐	☐	☐	☐	☐
Pap smear	☐	☐	☐	☐	☐
Blood test done by your doctor to check for diabetes	☐	☐	☐	☐	☐

10. Do you CURRENTLY take any of the following medications?

Insulin for diabetes	☐ No	☐ Yes
Other injectable medications for diabetes (such as Victoza, Bydureon or Byetta)	☐ No	☐ Yes
Metformin (such as Glucophage, Glumetza, Fortamet) for diabetes	☐ No	☐ Yes
Other oral medications (pills) for diabetes (such as Glucotrol, Januvia, or Amaryl)	☐ No	☐ Yes
High cholesterol medication (such as Lipitor, Zocor, Pravachol or Crestor)	☐ No	☐ Yes

11. In the PAST 3 MONTHS, how often have you used the following medication?

	Never	Once or Twice	Monthly	Weekly	Daily or almost daily	If daily or almost daily, how many years have you taken it? If less than 1 year, enter 0.
Aspirin (regular or low-dose)	☐	☐	☐	☐	☐ →	☐☐ Years
Acetaminophen (Tylenol)	☐	☐	☐	☐	☐ →	☐☐ Years
Other over-the-counter pain medications such as ibuprofen, Advil, Motrin, naproxen, or Aleve	☐	☐	☐	☐	☐ →	☐☐ Years
Opioid pain medications such as fentanyl, tramadol, codeine, morphine, oxycodone, Percocet, Roxicet, Oxycontin, hydrocodone, Vicodin, Lortab, hydromorphone, Dilaudid	☐	☐	☐	☐	☐ →	☐☐ Years
Methadone or buprenorphine	☐	☐	☐	☐	☐ →	☐☐ Years

12. Think about all of your medicines together. How many different medicines do you take each day? If you don't take any medicines, please mark "0". ☐☐ Medicines each day

13. What is your CURRENT usual source of medical care? (please mark only one)

☐ Community health center or free clinic ☐ Private doctor's office ☐ Emergency room ☐ Veteran's Affairs (VA)
☐ Hospital (not in the emergency room) ☐ Other source ☐ You have no source

14. In the PAST 12 MONTHS:

Was there a time when you needed to see a doctor but could **not** because of the cost?	☐ No ☐ Yes
How many times did you go to an **emergency room** to get care for yourself? (enter 0 if none)	☐☐ Times
How many times did you go to a **doctor's office or clinic** to get care for yourself? (enter 0 if none)	☐☐ Times
How many times did you go to the **dentist** to get care for yourself? (enter 0 if none)	☐☐ Times

15. A personal doctor is the doctor you see most often and who knows you best.

Do you currently have a personal doctor? ☐ No ☐ Yes

During the PAST 12 MONTHS:

Did you look for a new personal doctor?	☐ No	☐ Yes
Were you able to find a new personal doctor who could see you?	☐ No	☐ Yes
Were you told by a personal doctor that they would **not** accept your health insurance?	☐ No	☐ Yes
Were you told by a personal doctor that they would **not** accept you as a new patient?	☐ No	☐ Yes

16. A specialist doctor is a doctor who has more training in a specific area of medicine – like a cardiologist for heart disease, or a podiatrist for foot problems. During the PAST 12 MONTHS, did you look for a new specialist? ☐ No ☐ Yes → **If yes, were you able to find a new specialist who could see you?** ☐ No ☐ Yes

17. What is your current health insurance coverage? (please mark all that apply)

- ☐ None →
- ☐ Medicaid
- ☐ Medicare
- ☐ Private Insurance
- ☐ Military
- ☐ Other type

18. If you do NOT have any health insurance: What is the MAIN REASON you do not have health insurance? (please mark only one)

- ☐ It is too expensive
- ☐ It doesn't cover the services you need
- ☐ You do not need or want health insurance
- ☐ It is too hard to enroll
- ☐ Some other reason

19. Who do you live with? (mark all that apply)

☐ Live alone ☐ A spouse or partner ☐ Children ☐ Grandchildren ☐ Other family ☐ Other people

20. In a 24-hour period, how many HOURS do you typically spend:

☐☐ Hours **Sitting** ☐☐ Hours **Sleeping**

21. How is your eyesight (including when using glasses or contact lenses if you usually do)?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

22. How is your hearing (including when using a hearing aid if you usually do)?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

23. The following questions are about your memory:

	No	Yes
a. Have you recently experienced any change in your ability to remember things?	☐	☐
b. Do you have more trouble than usual remembering recent events?	☐	☐
c. Do you have more trouble than usual remembering a short list of items, such as a shopping list?	☐	☐
d. Do you have trouble remembering things from one second to the next?	☐	☐
e. Do you have any difficulty in understanding or following spoken instructions?	☐	☐
f. Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory?	☐	☐
g. Do you have trouble finding your way around familiar streets?	☐	☐

24. For each of the below items, please tell us how much you agree or disagree with the statement. Think about the area where you live, would you say it....

	Strongly disagree	Disagree	Neither agree nor disagreee	Agree	Strongly Agree
a. ... has enough pharmacies and health care facilities nearby?	☐	☐	☐	☐	☐
b. ... has enough grocery stores nearby?	☐	☐	☐	☐	☐
c. ... has enough public transportation (buses, trains)?	☐	☐	☐	☐	☐
d. ... has pollution, noise or other environmental problems?	☐	☐	☐	☐	☐
e. ... has problems with vandalism or crime?	☐	☐	☐	☐	☐

25. Do you have access to the internet?

- ☐ No (skip to 28)
- ☐ Yes →

26. If yes, how often do you use the internet (such as for email or web browsing)?

☐ Never ☐ Less than once a week ☐ A few times a week ☐ Every day

27. How often do you use or visit social media or networking sites such as Facebook, Twitter, or other social media?

☐ Never ☐ Less than once a week ☐ A few times a week ☐ Every day

28. In general, would you say your health is?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

29. The following questions are about the activities you might do during a typical day. Does your HEALTH now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b. Climbing several flights of stairs	☐	☐	☐

30. During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your PHYSICAL HEALTH?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Were limited in the kind of work or other activities	☐	☐	☐	☐	☐

31. During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Did work or activities less carefully than usual	☐	☐	☐	☐	☐

32. During the PAST 4 WEEKS, how much did pain interfere with your normal work (including both work outside the home and housework)?

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

33. These questions are about how you feel and how things have been with you during the PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐
c. Have you felt downhearted and depressed?	☐	☐	☐	☐	☐

34. During the PAST 4 WEEKS, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

35. The SCCS is beginning an important new "microbiome" research project looking into the way the bacteria in our intestines (gut) might cause or prevent diseases. We will be asking SCCS participants to provide a stool sample (a tiny scoop of a bowel movement). We hope you would be willing to help with this project. If so, we will mail you a kit with everything you need for collecting and sending back the small stool sample. As a thank you for taking time to do this, we will mail you another check for $10 when we receive your stool sample. Would you be willing to provide a stool sample? ☐ No ☐ Yes

Please update YOUR information below:

Name:

Address:

City: **State:** **ZIP Code:**

Email Address:

Please update YOUR telephone numbers for our records:

YOUR HOME NUMBER (☐☐☐) ☐☐☐ - ☐☐☐☐ **YOUR CELL NUMBER** (☐☐☐) ☐☐☐ - ☐☐☐☐