Form 161 - Supplemental Questionnaire

Please complete the survey below.

Thank you!

1. Think about the walking you do inside and outside the home. How often do you walk inside or outside the home for more than 10 minutes without stopping? **Mark only one:**

- ○ Rarely or never
- ○ 1 to 3 times each month
- ◉ 1 time each week
- ○ 2 to 3 times each week
- ○ 4 to 6 times each week
- ○ 7 or more times each week

When you walk inside or outside the home for more than 10 minutes without stopping,

1.1. For how many minutes do you usually walk?

- ○ Less than 20 minutes
- ○ 20 to 39 minutes
- ○ 40 to 59 minutes
- ○ 1 hour or more

1.2. What is your usual speed?

- ○ Casual strolling or walking (less than 2 miles an hour)
- ○ Average or normal (2-3 miles an hour)
- ○ Fairly fast (3-4 miles an hour)
- ○ Very fast (more than 4 miles an hour)
- ○ Don't know

2. During a usual day and night, about how many hours do you spend sitting? Be sure to

- ○ Less than 4 hours
- ○ 4-5 hours

include the time you spend sitting at work, sitting at the table eating, driving or riding in a car or bus, and sitting up watching TV or talking. **Mark only one.**

- ○ 6-7 hours
- ○ 8-9 hours
- ○ 10-11 hours
- ○ 12-13 hours
- ○ 14-15 hours
- ○ 16 or more hours

3. Which of the following best describes the home where you are **currently** living? **Mark only one home type.**

Choices 1 through 3 = A detached, single-family home with

Choices 4 through 6 = A multi-unit building of rooms, apartments, condos, or townhomes with

Choices 7 through 8 = Another type of home

- ○ A full or partial basement
- ○ No basement, but with a crawl space below ground level
- ○ No areas below ground level (e.g, a crawl space or concrete slab at ground level)
- ○ One or more floors of **your** home at or below ground level
- ○ All floors of **your** home above ground level (on the second floor or higher)
- ○ Don't know how the floors of **your** home relate to ground level
- ○ A mobile home or trailer
- ○ Other

4. Which of these statements are true in the home where you are **currently** living?

	Yes	No	Don't Know
4.1. Natural gas is used most for cooking (Note: liquid propane, LP & bottled gas are not natural gas)	○	○	○
4.2. Most of the water comes from a well	○	○	○
4.3. The air has been tested for radon	◉	○	○

4.4. Was the radon level ever high enough for you or someone else to do anything to lower it?

- ○ Level was low
- ○ Level was high, nothing was done
- ○ Level was high, something was done

	○ Don't know test result or don't know if anything was done
5. In general, how healthy is your overall diet? Would you say?	○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
6. How many full meals do you eat each day?	○ Fewer than one ○ One ○ Two ○ Three ○ More than three
7. I drink the following amount of beverages (water, tea, coffee, Boost, Ensure, juice, regular or diet soda, and other drinks) **each day**: (Note: One cup = 8 fluid ounces)	○ Less than four cups (32 fluid ounces) per day ○ Four cups (32 fluid ounces) to less than eight cups (64 fluid ounces) per day ○ Eight cups (64 fluid ounces) or more per day

	Yes	No
8. I eat alone most of the time.	○	○
9. I have tooth or mouth problems that make it hard for me to eat.	○	○
10. I have problems with swallowing that make it hard for me to eat.	○	○
11. I have difficulty smelling odors, including smelling my food.	○	○

12. I have difficulty tasting flavors, including tasting my food.	○	○
13. I don't always have enough money to buy the food I need.	○	○
14. I take pleasure in my food and eating.	○	○
15. I enjoy eating with others.	○	○

16. Which statement best describes your hearing **without** a hearing aid, personal sound amplifier, or other listening devices?

- ○ Excellent
- ○ Good
- ○ A little trouble
- ○ Moderate trouble
- ○ A lot of trouble
- ○ Deaf
- ○ Don't know

17. Do you regularly wear a hearing aid or other listening device?

- ◉ Yes
- ○ No

18. Which statement best describes your hearing **with** your listening device?

- ○ Excellent
- ○ Good
- ○ A little trouble
- ○ Moderate trouble
- ○ A lot of trouble
- ○ Deaf
- ○ Don't know

19. At the present time, would you say that your eyesight, with glasses or contacts if you wear them, is:

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ Very Poor
- ○ Don't know

20. The next questions ask about companionship.

	Hardly ever	Some of the time	Often
20.1. How often do you feel that you lack companionship?	○	○	○
20.2. How often do you feel left out?	○	○	○
20.3. How often do you feel isolated from others?	○	○	○

Questions 21-26 ask about your feelings during the past week. For each of the statements, indicate the choice that tells how often you felt this way.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
21. You felt depressed (blue or down)	○	○	○	○
22. Your sleep was restless	○	○	○	○
23. You enjoyed life	○	○	○	○
24. You had crying spells	○	○	○	○
25. You felt sad	○	○	○	○
26. You felt that people disliked you	○	○	○	○

27. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed, or lost pleasure in things that you usually cared about or enjoyed?

- ○ Yes
- ○ No

28. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

- ◉ Yes
- ○ No

28.1. If yes, have you felt depressed or sad much of the time in the past year?

- ○ Yes
- ○ No

29. Have you taken medication during the past four weeks for:

	Yes	No	Don't Know
29.1. High cholesterol, e.g. statins?	○	○	○
29.2. High blood pressure or hypertension?	○	○	○
29.3. High blood sugar or diabetes?	○	○	○
29.4. Blood thinning (*not* including aspirin)?	○	○	○
29.5. Trouble sleeping?	○	○	○
29.6. Pain management?	○	○	○

30. Do you currently take any of the following regularly?

	Yes	No	Don't Know
30.1. Calcium supplements	○	○	○
30.2. Vitamin D supplements	○	○	○
30.3. Multivitamins	○	○	○

Submit