Medicare Health Outcomes Survey (HOS) Questionnaire (English)

2025

Medicare Health Outcomes Survey Instructions

This survey asks about you and your health. Answer each question, thinking about <u>yourself</u>. Please take the time to complete this survey. Your answers are very important to us. If you are unable to complete this survey, a family member or "proxy" can fill out the survey about you.

Please return the survey with your answers in the enclosed postage-paid envelope.

- Answer the questions by putting an 'X' in the box next to the appropriate answer like the example below.

  Are you male or female?

  1 ☒ Male
  2 ☐ Female

- Be sure to read <u>all</u> the answer choices given before marking a box with an 'X'.

- You are sometimes told to skip over some questions in this survey. When this happens you will see a note that tells you what question to answer next, like this:

  1 ☒ Yes ➔***Go to Question 32***
  2 ☐ No ➔***Go to Question 33***

If you are filling out this survey for someone else, please answer each question the way you think the person you are helping would answer about him or herself.

All information that would permit identification of any person who completes this survey is protected by the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). This information will be used only for purposes permitted by law and will not be disclosed or released for any other reason. If you have any questions or want to know more about the study, please call [survey vendor name] at [phone number].

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information that does not display a valid OMB control number. This applies to both mandatory and voluntary collections of information. The OMB control number for this information collection is **0938-0701.** The time required to complete this information collection is estimated to average **20 minutes** including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, C1-25-05, Baltimore, Maryland 21244-1850.

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Medicare Health Outcomes Survey

1. In general, would you say your health is:

   1 ☐ Excellent
   2 ☐ Very good
   3 ☐ Good
   4 ☐ Fair
   5 ☐ Poor

2. The following items are about activities you might do during a typical day. Does **your health <u>now</u> limit you** in these activities? If so, how much?

   a. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

      1 ☐ Yes, limited a lot
      2 ☐ Yes, limited a little
      3 ☐ No, not limited at all

   b. Climbing **several** flights of stairs

      1 ☐ Yes, limited a lot
      2 ☐ Yes, limited a little
      3 ☐ No, not limited at all

3. During the **<u>past 4 weeks</u>,** have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

   a. **Accomplished less** than you would like **as a result of your physical health?**

      1 ☐ No, none of the time
      2 ☐ Yes, a little of the time
      3 ☐ Yes, some of the time
      4 ☐ Yes, most of the time
      5 ☐ Yes, all of the time

   b. Were limited in the **kind** of work or other activities **as a result of your physical health?**

      1 ☐ No, none of the time
      2 ☐ Yes, a little of the time
      3 ☐ Yes, some of the time
      4 ☐ Yes, most of the time
      5 ☐ Yes, all of the time

4. During the **past 4 weeks,** 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)?

   a. **Accomplished less** than you would like **as a result of any emotional problems**

      1 ☐ No, none of the time
      2 ☐ Yes, a little of the time
      3 ☐ Yes, some of the time
      4 ☐ Yes, most of the time
      5 ☐ Yes, all of the time

   b. Didn't do work or other activities as **carefully** as usual **as a result of any emotional problems**

      1 ☐ No, none of the time
      2 ☐ Yes, a little of the time
      3 ☐ Yes, some of the time
      4 ☐ Yes, most of the time
      5 ☐ Yes, all of the time

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5. During the **past 4 weeks,** how much did **pain** interfere with your normal work (including both work outside the home and housework)?

1 ☐ Not at all
2 ☐ A little bit
3 ☐ Moderately
4 ☐ Quite a bit
5 ☐ Extremely

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.

6. How much of the time during the **past 4 weeks:**

a. Have you felt calm and peaceful?

1 ☐ All of the time
2 ☐ Most of the time
3 ☐ A good bit of the time
4 ☐ Some of the time
5 ☐ A little of the time
6 ☐ None of the time

b. Did you have a lot of energy?

1 ☐ All of the time
2 ☐ Most of the time
3 ☐ A good bit of the time
4 ☐ Some of the time
5 ☐ A little of the time
6 ☐ None of the time

c. Have you felt downhearted and blue?

1 ☐ All of the time
2 ☐ Most of the time
3 ☐ A good bit of the time
4 ☐ Some of the time
5 ☐ A little of the time
6 ☐ None of the time

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

1 ☐ All of the time
2 ☐ Most of the time
3 ☐ Some of the time
4 ☐ A little of the time
5 ☐ None of the time

Now, we'd like to ask you some questions about how your health may have changed.

8. **Compared to <u>one year ago</u>,** how would you rate your **physical health** in general **now?**

1 ☐ Much better
2 ☐ Slightly better
3 ☐ About the same
4 ☐ Slightly worse
5 ☐ Much worse

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9. **Compared to one year ago,** how would you rate your **emotional problems** (such as feeling anxious, depressed, or irritable) in general **now?**
   - 1 ☐ Much better
   - 2 ☐ Slightly better
   - 3 ☐ About the same
   - 4 ☐ Slightly worse
   - 5 ☐ Much worse

Earlier in the survey you were asked to indicate whether you have any limitations in your activities. We are now going to ask a few additional questions in this area.

10. Because of a health or physical problem, do you have any difficulty doing the following activities **without special equipment or help from another person?**

    a. Bathing
    - 1 ☐ No, I do not have difficulty
    - 2 ☐ Yes, I have difficulty
    - 3 ☐ I am unable to do this activity

    b. Dressing
    - 1 ☐ No, I do not have difficulty
    - 2 ☐ Yes, I have difficulty
    - 3 ☐ I am unable to do this activity

    c. Eating
    - 1 ☐ No, I do not have difficulty
    - 2 ☐ Yes, I have difficulty
    - 3 ☐ I am unable to do this activity

    d. Getting in or out of chairs
    - 1 ☐ No, I do not have difficulty
    - 2 ☐ Yes, I have difficulty
    - 3 ☐ I am unable to do this activity

    e. Walking
    - 1 ☐ No, I do not have difficulty
    - 2 ☐ Yes, I have difficulty
    - 3 ☐ I am unable to do this activity

    f. Using the toilet
    - 1 ☐ No, I do not have difficulty
    - 2 ☐ Yes, I have difficulty
    - 3 ☐ I am unable to do this activity

Now we are going to ask some questions about specific medical conditions.

11. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
    - 1 ☐ Yes
    - 2 ☐ No

12. Are you deaf or do you have serious difficulty hearing, even with a hearing aid?
    - 1 ☐ Yes
    - 2 ☐ No

13. **Because of a physical, mental, or emotional condition**, do you have **serious** difficulty concentrating, remembering, or making decisions?
    - 1 ☐ Yes
    - 2 ☐ No

14. **Because of a physical, mental, or emotional condition**, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
    - 1 ☐ Yes
    - 2 ☐ No

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15. In the **past month**, how often did memory problems interfere with your daily activities?

1 ☐ Every day (7 days a week)
2 ☐ Most days (5-6 days a week)
3 ☐ Some days (2-4 days a week)
4 ☐ Rarely (once a week or less)
5 ☐ Never

Has a doctor ever told you that you had:

16. Hypertension or high blood pressure

1 ☐ Yes
2 ☐ No

17. Angina pectoris or coronary artery disease

1 ☐ Yes
2 ☐ No

18. Congestive heart failure

1 ☐ Yes
2 ☐ No

19. A myocardial infarction or heart attack

1 ☐ Yes
2 ☐ No

20. Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat

1 ☐ Yes
2 ☐ No

21. A stroke

1 ☐ Yes
2 ☐ No

Has a doctor ever told you that you had:

22. Emphysema, or asthma, or COPD (chronic obstructive pulmonary disease)

1 ☐ Yes
2 ☐ No

23. Crohn's disease, ulcerative colitis, or inflammatory bowel disease

1 ☐ Yes
2 ☐ No

24. Osteoporosis, sometimes called thin or brittle bones

1 ☐ Yes
2 ☐ No

25. Diabetes, high blood sugar, or sugar in the urine

1 ☐ Yes
2 ☐ No

26. Depression

1 ☐ Yes
2 ☐ No

27. Any cancer (other than skin cancer)

1 ☐ Yes ➔ ***Go to Question 28***
2 ☐ No ➔ ***Go to Question 29***

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28. Are you **currently** under treatment for:

a. Colon or rectal cancer

1 ☐ Yes
2 ☐ No

b. Lung cancer

1 ☐ Yes
2 ☐ No

c. Breast cancer

1 ☐ Yes
2 ☐ No

d. Prostate cancer

1 ☐ Yes
2 ☐ No

e. Other cancer (other than skin cancer)

1 ☐ Yes
2 ☐ No

29. In the **past 7 days,** how much did pain interfere with your day to day activities?

1 ☐ Not at all
2 ☐ A little bit
3 ☐ Somewhat
4 ☐ Quite a bit
5 ☐ Very much

30. In the **past 7 days**, how often did pain keep you from socializing with others?

1 ☐ Never
2 ☐ Rarely
3 ☐ Sometimes
4 ☐ Often
5 ☐ Always

31. Over the **past 2 weeks**, how often have you been bothered by any of the following problems?

a. Little interest or pleasure in doing things

1 ☐ Not at all
2 ☐ Several days
3 ☐ More than half the days
4 ☐ Nearly every day

b. Feeling down, depressed, or hopeless

1 ☐ Not at all
2 ☐ Several days
3 ☐ More than half the days
4 ☐ Nearly every day

32. In general, compared to other people your age, would you say that your health is:

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

33. Many people experience leakage of urine, also called urinary incontinence. In the **past six months**, have you experienced leaking of urine?

1 ☐ Yes ➔ ***Go to Question 34***
2 ☐ No ➔ ***Go to Question 37***

34. During the **past six months**, how much did leaking of urine make you change your daily activities or interfere with your sleep?

1 ☐ A lot
2 ☐ Somewhat
3 ☐ Not at all

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35. Have you **ever** talked with a doctor, nurse, or other health care provider about leaking of urine?

1 ☐ Yes
2 ☐ No

36. There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery. Have you **ever** talked with a doctor, nurse, or other health care provider about any of these approaches?

1 ☐ Yes
2 ☐ No

37. In the **past 12 months,** did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.

1 ☐ Yes ➔ ***Go to Question 38***
2 ☐ No ➔ ***Go to Question 38***
3 ☐ I had no visits in the past 12 months ➔ ***Go to Question 39***

38. In the **past 12 months,** did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

1 ☐ Yes
2 ☐ No

39. A fall is when your body goes to the ground without being pushed. In the **past 12 months,** did you talk with your doctor or other health provider about falling or problems with balance or walking?

1 ☐ Yes
2 ☐ No
3 ☐ I had no visits in the past 12 months

40. Did you fall in the **past 12 months?**

1 ☐ Yes
2 ☐ No

41. In the **past 12 months,** have you had a problem with balance or walking?

1 ☐ Yes
2 ☐ No

42. Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include:

- Suggest that you use a cane or walker.
- Suggest that you do an exercise or physical therapy program.
- Suggest a vision or hearing test.

1 ☐ Yes
2 ☐ No
3 ☐ I had no visits in the past 12 months

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43. During the **past month**, on average, how many hours of actual sleep did you get at night? (This may be different from the number of hours you spent in bed.)

- 1 ☐ Less than 5 hours
- 2 ☐ 5 – 6 hours
- 3 ☐ 7 – 8 hours
- 4 ☐ 9 or more hours

44. During the **past month**, how would you rate your overall sleep quality?

- 1 ☐ Very Good
- 2 ☐ Fairly Good
- 3 ☐ Fairly Bad
- 4 ☐ Very Bad

45. How much do you weigh in pounds (lbs.)?

☐☐☐ **lbs.**

46. How tall are you without shoes on, in feet and inches? Please fill in both feet and inches, for example: 5 feet 00 inches, or 5 feet 04 inches (if 1/2 inch, please round up).

☐ **feet** ☐☐ **inches**

47. Are you Hispanic, Latino/a or Spanish origin? (One or more categories may be selected)

- 1 ☐ No, not of Hispanic, Latino/a, or Spanish origin
- 2 ☐ Yes, Mexican, Mexican American, Chicano/a
- 3 ☐ Yes, Puerto Rican
- 4 ☐ Yes, Cuban
- 5 ☐ Yes, another Hispanic, Latino/a, or Spanish origin

48. What is your race? (One or more categories may be selected)

- 01 ☐ White
- 02 ☐ Black or African American
- 03 ☐ American Indian or Alaska Native
- 04 ☐ Asian Indian
- 05 ☐ Chinese
- 06 ☐ Filipino
- 07 ☐ Japanese
- 08 ☐ Korean
- 09 ☐ Vietnamese
- 10 ☐ Other Asian
- 11 ☐ Native Hawaiian
- 12 ☐ Guamanian or Chamorro
- 13 ☐ Samoan
- 14 ☐ Other Pacific Islander

49. What language do you **mainly** speak at home?

- 1 ☐ English
- 2 ☐ Spanish
- 3 ☐ Chinese
- 4 ☐ Russian
- 7 ☐ Some other language (please specify)

_____

50. What is your current marital status?

- 1 ☐ Married
- 2 ☐ Divorced
- 3 ☐ Separated
- 4 ☐ Widowed
- 5 ☐ Never married

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51. What is the highest grade or level of school that you have completed?

- 1 ☐ 8th grade or less
- 2 ☐ Some high school, but did not graduate
- 3 ☐ High school graduate or GED
- 4 ☐ Some college or 2-year degree
- 5 ☐ 4-year college graduate
- 6 ☐ More than a 4-year college degree

52. Do you live alone or with others? (One or more categories may be selected)

- 1 ☐ Alone
- 2 ☐ With spouse/significant other
- 3 ☐ With children/other relatives
- 4 ☐ With non-relatives
- 5 ☐ With paid caregiver

53. Where do you live?

- 1 ☐ House, apartment, condominium, or mobile home ➔***Go to Question 54***
- 2 ☐ Assisted living or board and care home ➔***Go to Question 54***
- 3 ☐ Nursing home ➔***Go to Question 55***
- 4 ☐ Other ➔***Go to Question 55***

54. Is the house or apartment you currently live in:

- 1 ☐ Owned or being bought by you
- 2 ☐ Owned or being bought by someone in your family other than you
- 3 ☐ Rented for money
- 4 ☐ Not owned and one in which you live without payment of rent
- 5 ☐ None of the above

55. Who completed this survey form?

- 1 ☐ Person to whom survey was addressed ➔ ***STOP HERE***
- 2 ☐ Family member or relative of person to whom the survey was addressed ➔ ***Go to Question 56***
- 3 ☐ Friend of person to whom the survey was addressed ➔ ***Go to Question 56***
- 4 ☐ Professional caregiver of person to whom the survey was addressed ➔ ***Go to Question 56***

56. Did someone help you complete this survey? If so, please fill in that person's name.

DO NOT enter the name of the person to whom this survey was addressed.

Please **print** clearly.

First Name: _____

Last Name: _____

YOU HAVE COMPLETED THE SURVEY. THANK YOU.

Please use the enclosed prepaid envelope to mail your completed survey to:

Centers for Medicare & Medicaid Services
c/o Survey Processing
[Insert Survey Vendor
Return Address Here]

If you have questions about this survey, please contact the survey organization working with Medicare at [survey vendor phone number] or [survey vendor email].

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