



Medicare Health Outcomes Survey Instructions

This survey asks about you and your health. Answer each question, thinking about yourself. 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.

Sample Question:

- Answer the questions by putting an 'X' in the box next to the appropriate answer like the example below.
- Be sure to read all 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 35**
2 No → **Go to Question 36**

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 [vendor name] at [toll-free 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. The valid 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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Items 1–9: The VR-12 Health Survey item content was developed and modified from a 36-item health survey.

Medicare Health Outcomes Survey

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

- Excellent
- Very good
- Good
- Fair
- Poor

2. The following items are about activities you might do during a typical day. Does **your health now 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

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

b. Climbing **several flights of stairs**

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

3. 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 your physical health**?

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

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

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

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- 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**

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

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

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

5. 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

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?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

b. Did you have a lot of energy?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

c. Have you felt downhearted and blue?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- 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.)?

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

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

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

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

9. Compared to one year ago, how would you rate your **emotional problems** (such as feeling anxious, depressed or irritable) in general **now**?

- Much better
- Slightly better
- About the same
- Slightly worse
- 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

No, I do not have difficulty
1 Yes, I have difficulty
2 I am unable to do this activity
3

b. Dressing

No, I do not have difficulty
1 Yes, I have difficulty
2 I am unable to do this activity
3

c. Eating

No, I do not have difficulty
1 Yes, I have difficulty
2 I am unable to do this activity
3

d. Getting in or out of chairs

No, I do not have difficulty
1 Yes, I have difficulty
2 I am unable to do this activity
3

e. Walking

No, I do not have difficulty
1 Yes, I have difficulty
2 I am unable to do this activity
3

f. Using the toilet

No, I do not have difficulty
1 Yes, I have difficulty
2 I am unable to do this activity
3

11. Because of a health or physical problem, do you have any difficulty doing the following activities?

a. Preparing meals

No, I do not have difficulty
1 Yes, I have difficulty
2 I don't do this activity
3

b. Managing money

No, I do not have difficulty
1 Yes, I have difficulty
2 I don't do this activity
3

c. Taking medication as prescribed

No, I do not have difficulty
1 Yes, I have difficulty
2 I don't do this activity
3

These next questions ask about your physical and mental health during the past 30 days.

12. Now, thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your **physical health not good?**

Please enter a number between "0" and "30" days. If no days, please enter "0" days. Your best estimate would be fine.

days

13. 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?**

Please enter a number between "0" and "30" days. If no days, please enter "0" days. Your best estimate would be fine.

days

14. During the **past 30 days**, for about how many days did **poor physical or mental health** keep you from doing your usual activities, such as self-care, work, or recreation?

Please enter a number between "0" and "30" days. If no days, please enter "0" days. Your best estimate would be fine.

--	--

 days

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

15. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

Yes
1 No
2

16. Are you deaf or do you have serious difficulty hearing, even with a hearing aid?

Yes
1 No
2

17. **Because of a physical, mental, or emotional condition**, do you have **serious** difficulty concentrating, remembering or making decisions?

Yes
1 No
2

18. **Because of a physical, mental, or emotional condition**, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

Yes
1 No
2

19. 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:

20. Hypertension or high blood pressure

1 Yes
2 No

21. Angina pectoris or coronary artery disease

1 Yes
2 No

22. Congestive heart failure

1 Yes
2 No

23. A myocardial infarction or heart attack

1 Yes
2 No

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

1 Yes
2 No

25. A stroke

1 Yes
2 No

Has a doctor ever told you that you had:

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

Yes
1
 No
2

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

Yes
1
 No
2

28. Arthritis of the hip or knee

Yes
1
 No
2

29. Arthritis of the hand or wrist

Yes
1
 No
2

30. Osteoporosis, sometimes called thin or
brittle bones

Yes
1
 No
2

31. Sciatica (pain or numbness that travels
down your leg to below your knee)

Yes
1
 No
2

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

Yes
1
 No
2

33. Depression

Yes
1
 No
2

34. Any cancer (other than skin cancer)

Yes → **Go to Question 35**
1
 No → **Go to Question 36**
2

35. Are you currently under treatment for:

a. Colon or rectal cancer

Yes
1
 No
2

b. Lung cancer

Yes
1
 No
2

c. Breast cancer

Yes
1
 No
2

d. Prostate cancer

Yes
1
 No
2

e. Other cancer (other than skin cancer)

Yes
1
 No
2

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

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

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

Never
1
 Rarely
2
 Sometimes
3
 Often
4
 Always
5

38. In the **past 7 days**, how would you rate your pain **on average**?

<input type="checkbox"/> 1 No pain
01
<input type="checkbox"/> 2
02
<input type="checkbox"/> 3
03
<input type="checkbox"/> 4
04
<input type="checkbox"/> 5
05
<input type="checkbox"/> 6
06
<input type="checkbox"/> 7
07
<input type="checkbox"/> 8
08
<input type="checkbox"/> 9
09
<input type="checkbox"/> 10 Worst imaginable pain
10

39. 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

<input type="checkbox"/> Not at all
1
<input type="checkbox"/> Several days
2
<input type="checkbox"/> More than half the days
3
<input type="checkbox"/> Nearly every day
4

b. Feeling down, depressed or hopeless

<input type="checkbox"/> Not at all
1
<input type="checkbox"/> Several days
2
<input type="checkbox"/> More than half the days
3
<input type="checkbox"/> Nearly every day
4

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

<input type="checkbox"/> Excellent
1
<input type="checkbox"/> Very good
2
<input type="checkbox"/> Good
3
<input type="checkbox"/> Fair
4
<input type="checkbox"/> Poor
5

41. Do you **now** smoke every day, some days, or not at all?

<input type="checkbox"/> Every day
1
<input type="checkbox"/> Some days
2
<input type="checkbox"/> Not at all
3
<input type="checkbox"/> Don't know
4

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

<input type="checkbox"/> Yes → Go to Question 43
1
<input type="checkbox"/> No → Go to Question 46
2

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

<input type="checkbox"/> A lot
1
<input type="checkbox"/> Somewhat
2
<input type="checkbox"/> Not at all
3

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

<input type="checkbox"/> Yes
1
<input type="checkbox"/> No
2

45. 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?

<input type="checkbox"/> Yes
1
<input type="checkbox"/> No
2

46. 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 47**
2 No → **Go to Question 47**
3 I had no visits in the past 12 months → **Go to Question 48**

47. 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

48. 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

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

1 Yes
2 No

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

1 Yes
2 No

51. 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.
- Check your blood pressure lying or standing.
- Suggest that you do an exercise or physical therapy program.
- Suggest a vision or hearing testing.

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

52. Have you **ever** had a **bone density test** to check for **osteoporosis**, sometimes thought of as “brittle bones”? This test would have been done to your back or hip.

1 Yes
2 No

53. 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

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

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

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

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 lbs.

56. How tall are you without shoes on in feet (ft.) and inches (in.)? Please remember to fill in both feet and inches (for example, 5 ft. 00 in.) If 1/2 in., please round up.

ft.

in.

57. Are you male or female?

Male

Female

58. 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

59. 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

60. What language do you mainly speak at home?

1 English

2 Spanish

3 Chinese

4 Some other language (please specify)

61. What is your current marital status?

1 Married

2 Divorced

3 Separated

4 Widowed

5 Never married

62. 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

63. 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

64. Where do you live?

1 House, apartment, condominium or mobile home → **Go to Question 65**

2 Assisted living or board and care home → **Go to Question 65**

3 Nursing home → **Go to Question 66**

4 Other → **Go to Question 66**

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

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

66. Who completed this survey form?

- Person to whom survey was addressed → **Go to Question 68**
- Family member or relative of person to whom the survey was addressed
- Friend of person to whom the survey was addressed
- Professional caregiver of person to whom the survey was addressed

67. If you completed the survey for someone else, please fill in your name. **DO NOT** complete this question if you completed the survey for yourself. Please **print** clearly.

First Name: _____

Last Name: _____

68. Which of the following categories best represents the **combined income for all family members in your household** for the **past 12 months**?

- Less than \$5,000
- \$5,000–\$9,999
- \$10,000–\$19,999
- \$20,000–\$29,999
- \$30,000–\$39,999
- \$40,000–\$49,999
- \$50,000–\$79,999
- \$80,000–\$99,999
- \$100,000 or more
- Don't know

**YOU HAVE COMPLETED THE SURVEY.
THANK YOU.**

Insert Survey Vendor
Contact Information Here