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Iowa Counties Health Study

Si lees español:

El objetivo del estudio es obtener información de los habitantes de Iowa para desarrollar mejores programas y políticas de salud para mejorar nuestra comprensión de las necesidades de salud en áreas seleccionadas, incluyendo cómo el coronavirus, o COVID-19, ha afectado su salud y el bienestar en nuestro estado. Obtuvimos su nombre y dirección de la lista de votantes registrados en Iowa.

Si está dispuesto a participar pero prefiere completar la encuesta en español, marque esta casilla y devuelva este folleto en el sobre prepagado: ☐

Le enviaremos otra copia de la encuesta en español a la misma dirección.
Puedes quedarte con los $5 en efectivo.

INSTRUCTIONS

- There are no right or wrong answers, so please give the answers that best describe your situation.
- Use a dark ink pen to mark an "X" in the box(es) ☐.
  - If you've made a mistake or want to change your answer, cross out the one that was wrong, and circle your final choice(s).
- Some of the questions may not apply to you. You do not need to answer these items.
- If possible, answer all of the questions in one sitting.
- We have enclosed a pre-addressed, postage paid envelope – please put your completed questionnaire into this envelope and put it in the mail.

The University of Iowa | College of Public Health

The coronavirus, or COVID-19, is a new disease with flu-like symptoms that is spreading across the world. We are interested in learning how COVID-19 has affected you, your health, your family, and your life. Throughout this survey we will use the term "COVID-19." This survey will help us understand how COVID-19 has affected health and wellbeing in our state.

SECTION A: COVID-19 EXPOSURE AND DIAGNOSIS

A.1. In the past 30 days have you had cold or flu-like symptoms?

- ☐ Yes, my symptoms are/were mild or minor
- ☐ Yes, my symptoms are/were moderate
- ☐ Yes, my symptoms are/were severe
- ☐ No, I have not had symptoms

A.2. Have you been tested for COVID-19 (coronavirus)?

- ☐ Yes, I was tested and it showed I had/have COVID-19
- ☐ Yes, I was tested and it showed I did NOT have COVID-19
- ☐ Yes, I was tested and I am waiting for the results
- ☐ No, I tried to get tested but could not get a test
- ☐ No, I have not tried to get tested

A.3. Have you been hospitalized for COVID-19?

- ☐ Yes
- ☐ No

A.4. In the past 30 days, have you been in close physical contact with a person who has tested positive for coronavirus or COVID-19?

- ☐ Yes
- ☐ No
- ☐ Don't know/not sure

A.5. In the past 30 days, have you been in close physical contact with someone with respiratory symptoms (e.g. cough or fever)?

- ☐ Yes
- ☐ No
- ☐ Don't know/not sure

A.6. Since January 1, 2020, do you or did you have any of the following?

Mark <u>ALL THAT APPLY.</u>

- ☐ Travel internationally or travel to COVID-19 cities with a high presence of COVID-19
- ☐ Work in a nursing home or hospital
- ☐ Work in meat packing/processing
- ☐ Work in construction
- ☐ Been told by a health professional that you have/had COVID-19
- ☐ None of the above

A.7. Do you have a condition or take a treatment that causes your immune system to not work as well as it should (such as treatment for cancer, organ transplant, HIV or AIDS, long term use of corticosteroids)?

- ☐ Yes
- ☐ No

		Yes	No
A.8.	Did a family member or a member of your household test positive for COVID-19?	☐	☐
A.9.	Were any friends, co-workers or neighbors diagnosed with COVID-19?	☐	☐
A.10.	Did a family member, friend, co-worker, or neighbor die as a result of COVID-19?	☐	☐

A.11. How concerned are you about coronavirus in your community?

- ☐ Not at all concerned
- ☐ Concerned a little
- ☐ Neither concerned nor unconcerned
- ☐ Somewhat concerned
- ☐ Very concerned

A.12. Social distancing, also called physical distancing, means keeping space between yourself and other people outside of your home.

Since March 17 when COVID-19 restrictions began, what types of social distancing are you doing all or most of the time?

		Yes	No
a.	Staying at home except for going to work, outdoors to exercise, or going to the grocery store, pharmacy, or to get medical care	☐	☐
b.	Not having relatives, friends, or neighbors come into your home	☐	☐
c.	Staying 6 feet away from people when you leave your home	☐	☐
d.	Wearing a face covering when you are outdoors	☐	☐
e.	Wearing a face covering when you are inside a store or other place besides your home	☐	☐

A.13. Please indicate the extent to which you agree or disagree with the following statements about SOCIAL DISTANCING.

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a.	Social distancing is keeping us safe	☐	☐	☐	☐	☐
b.	Social distancing is something that is easy for me to do	☐	☐	☐	☐	☐

A.14. Since March 17 when COVID-19 restrictions began, have you attended the following?

		Yes	No
a.	Any gatherings, not including work, with more than 2 people who do not live in the same house as you	☐	☐
b.	A rally or demonstration of 20 or more people	☐	☐
c.	Other large social gatherings of 20 or more people	☐	☐

A.15. How important do you think social distancing is during COVID-19?

- ☐ Very important
- ☐ Somewhat important
- ☐ A little important
- ☐ Not important

A.16. In the past 2 weeks, how often have you received support (e.g., emotional, material, or financial support) from friends or loved ones to help you during the COVID-19 pandemic?

- ☐ Every day
- ☐ Several times a week
- ☐ Once a week
- ☐ Once in 2 weeks
- ☐ Never

SECTION B: COVID-19 EFFECTS AND CHALLENGES

☛ COVID-19 has caused challenges for some people regardless of whether they are infected. The next set of questions will focus on changes that you and your family may have experienced because of the COVID-19 pandemic.

B.1. Due to COVID-19, did any of the following happen to you?

Mark <u>ALL THAT APPLY.</u>

- ☐ Lose your job or primary source of income
- ☐ Lose your health insurance
- ☐ Have to work in close contact with people who might be infected (e.g. customers, patients, co-workers)
- ☐ Have a hard time doing your job well because of needing to take care of people/children in the home
- ☐ Have to take over teaching or instructing a child
- ☐ Have difficulty taking care of children in the home
- ☐ Have to move or relocate
- ☐ None of the above

B.2. Please indicate the extent to which you agree or disagree with the following statements. Since the breakout of the COVID-19 pandemic…

Emotional and Physical Reactions	**Strongly Disagree** ▼	**Disagree** ▼	**Neutral** ▼	**Agree** ▼	**Strongly Agree** ▼
a. I feel nervous, anxious, or on edge.	☐	☐	☐	☐	☐
b. I feel anxious about getting COVID-19.	☐	☐	☐	☐	☐
c. I worry about possibly infecting others.	☐	☐	☐	☐	☐
d. I am concerned about a family member or close friend getting or dying from COVID-19.	☐	☐	☐	☐	☐
e. I worry about the possibility of dying from COVID-19.	☐	☐	☐	☐	☐
f. I feel I have no control over how COVID-19 will impact my life.	☐	☐	☐	☐	☐
g. I have experienced feelings of sadness or depression.	☐	☐	☐	☐	☐
h. I feel negative about the future.	☐	☐	☐	☐	☐
i. I have experienced changes in my sleep.	☐	☐	☐	☐	☐
j. I have experienced changes in my eating.	☐	☐	☐	☐	☐
k. I have experienced difficulty concentrating.	☐	☐	☐	☐	☐
l. I have experienced feelings of social isolation or loneliness.	☐	☐	☐	☐	☐

Disruption to Daily Activities and Social Interactions	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
m. I have experienced disruptions in day-to-day activities with family and/or friends.	☐	☐	☐	☐	☐
n. I have had trouble adequately taking care of family members or friends I provide for.	☐	☐	☐	☐	☐
o. I have been unable to follow my typical daily routines (e.g., work, exercise, leisure activities).	☐	☐	☐	☐	☐
p. I have experienced conflict with household members (e.g., spouse/partner, children, parents, others).	☐	☐	☐	☐	☐
q. I have had difficulty or been unable to do my work as usual.	☐	☐	☐	☐	☐
r. I have had difficulty taking care of my children's needs (e.g. providing care, supervising schoolwork), and/or balancing their needs with other responsibilities.	☐	☐	☐	☐	☐

Financial Hardship	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
s. I have experienced financial difficulties.	☐	☐	☐	☐	☐
t. I have had difficulty purchasing or obtaining basic necessities (e.g., food, personal care products).	☐	☐	☐	☐	☐
u. I feel anxious about losing or having lost my job, or my primary source of income.	☐	☐	☐	☐	☐
v. I have been unable to adequately provide for people I financially support.	☐	☐	☐	☐	☐

Perceived Benefits	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
w. I have greater appreciation for my family and close friends.	☐	☐	☐	☐	☐
x. I have deeper appreciation for life.	☐	☐	☐	☐	☐
y. I have been more grateful for each day.	☐	☐	☐	☐	☐
z. I have been more accepting of things I cannot change.	☐	☐	☐	☐	☐

Social Support	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
aa I have received emotional support from family or friends when needed.	☐	☐	☐	☐	☐
bb I have received tangible support (e.g., financial, practical) from family or friends when needed.	☐	☐	☐	☐	☐
cc. I am or have been there to listen to others' problems when needed.	☐	☐	☐	☐	☐
dd. I have helped others with financial or practical support.	☐	☐	☐	☐	☐

Ability to Manage Stress	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
ee. I am able to recognize thoughts and situations that make me feel stressed or upset about COVID-19.	☐	☐	☐	☐	☐
ff. I am able to practice relaxation (e.g., deep breathing, meditation) when feeling stressed about COVID-19.	☐	☐	☐	☐	☐
gg. I am able to seek information and plan accordingly to address concerns over the COVID-19 pandemic.	☐	☐	☐	☐	☐
hh. I can re-examine negative thoughts and gain a new perspective when concerned about COVID-19.	☐	☐	☐	☐	☐
ii. I can give myself the caring and tenderness I need.	☐	☐	☐	☐	☐

Concerns About Medical Care	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
jj. My general medical care has been disrupted or delayed.	☐	☐	☐	☐	☐	☐
kk. My healthcare providers have taken the necessary measures to address COVID-19.	☐	☐	☐	☐	☐	☐
ll. My healthcare team shared adequate information on prevention, protection or care for COVID-19.	☐	☐	☐	☐	☐	☐

SECTION C: YOUR HEALTH AND MEDICAL CARE

C.1. In general, would you say that your health is?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

C.2. Has a doctor ever diagnosed you with any of the following conditions?
Mark ALL THAT APPLY.

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Lung disease
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Anemia or other blood disease
- ☐ Cancer
- ☐ Depression
- ☐ None of the above

C.3. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.
Mark only ONE.

- ☐ Within the past year
- ☐ More than 1 year ago but less than 2 years ago
- ☐ More than 2 years ago but less than 5 years ago
- ☐ 5 or more years ago

C.4. Was there a time in the year before the COVID-19 pandemic, that is between February 29, 2019 and March 1, 2020, when you needed mental health care or counseling, but could not get it?

- ☐ Yes, because of cost
- ☐ Yes, because of no transportation
- ☐ Yes, because no insurance
- ☐ Yes, for some other reason →
- ☐ No
- ☐ I did not need mental health care or counseling during the year before the pandemic

a. Please describe the other reason(s)

We are interested in whether COVID-19 has affected your access to health care.

C.5. Has your clinic, doctor's office, or dental practice closed or cancelled your appointment because of COVID-19?

- ☐ Yes
- ☐ No
- ☐ Did not need an appointment

C.6. Have you cancelled a clinic, doctor or dental appointment to avoid being around others?

- ☐ Yes
- ☐ No
- ☐ Did not need an appointment

C.7. Have you been unable to obtain any of the following <u>because of the COVID-19 pandemic?</u>

		Able to Obtain	Unable to Obtain	Did Not Need
a.	Prescription medication	☐	☐	☐
b.	Non-prescription (i.e. Over-the-Counter) medication	☐	☐	☐
c.	Treatment or counseling for alcohol or drug use	☐	☐	☐
d.	Mental health care or counseling	☐	☐	☐

C.8. Have you been <u>unable</u> to get transportation to places you need to go because of the COVID-19 pandemic?

- ☐ Yes
- ☐ No

C.9. Do you have a device (smartphone, laptop, tablet, or desktop computer with webcam) that would allow you to video conference with your healthcare provider (also called 'telehealth')?

- ☐ Yes **IF YES →** **a.** Would you feel comfortable communicating with your healthcare provider in a video conference format through a device (smartphone, laptop, tablet, or desktop computer with a webcam)?
  - ☐ Yes
  - ☐ No
- ☐ No

C.10. Have you engaged in a video conference visit with any of your healthcare providers?

- ☐ Yes **IF YES →** **a.** Did you feel comfortable communicating with your healthcare provider in a video conference visit?
  - ☐ Yes
  - ☐ No
- ☐ No

SECTION D: BEHAVIORS THAT AFFECT HEALTH

D.1. Thinking about the last 30 days, in a typical week, how many days did you do any physical activity or exercise of at least moderate intensity for at least 30 minutes, such as brisk walking, bicycling at a regular pace, and swimming at a regular pace?

☐☐ Days

D.2. Have you changed the frequency of your physical activity compared to before the COVID-19 pandemic?

- ☐ Yes, I have engaged in MORE physical activity compared to before the pandemic
- ☐ Yes, I have engaged in LESS physical activity compared to before the pandemic
- ☐ No, I have been doing the SAME amount of physical activity compared to before the pandemic

D.3. During the past 30 days, not including juices, how often did you eat fruit? Include fresh, frozen or canned fruit. Do not include dry fruits.

You may specify the number of times per day, per week or per month, whichever is easiest for you. Write the number of times in the box below, and then check if it is the number of times per day, per week or per month.

☐☐☐ Number of times

- ☐ Per day
- ☐ Per week
- ☐ Per month

D.4. During the past 30 days, how often did you eat vegetables other than potatoes? Include things like salad, cooked dried beans, corn, and broccoli.

You may specify the number of times per day, per week or per month, whichever is easiest for you. Write the number of times in the box below, and then check if it is the number of times per day, per week or per month.

☐☐☐ Number of times

- ☐ Per day
- ☐ Per week
- ☐ Per month

D.5. Have you changed the amount of fruit and vegetables you consume per day compared to before the COVID-19 pandemic?

- ☐ Yes, I consumed MORE fruit and vegetables compared to before the pandemic
- ☐ Yes, I consumed LESS fruit and vegetables compared to before the pandemic
- ☐ No, I have consumed the SAME amount of fruit and vegetables compared to before the pandemic

D.6. Have you smoked at least 100 cigarettes in your entire life?

Do not include: electronic cigarettes, herbal cigarettes, cigars, cigarillos, little cigars, pipes, bidis, water pipes (hookahs) or Marijuana.

- ☐ Yes
- ☐ No

D.7. During the past 30 days have you used any of the following smoking/tobacco products?

Mark ALL THAT APPLY.

- ☐ Cigarettes
- ☐ Cigars
- ☐ Chewing tobacco
- ☐ Electronic cigarettes or other vaping products
- ☐ Other smoking/tobacco products → **a.** Please describe:
- ☐ None of the above

D.8. Have you changed your amount of smoking/tobacco use compared to before the COVID-19 pandemic?

- ☐ Yes, I used these products MORE compared to before the pandemic
- ☐ Yes, I used these products LESS compared to before the pandemic
- ☐ No, I used these products the SAME amount compared to before the pandemic
- ☐ No, I did not use these products before or during the pandemic

D.9. During the past 7 days, on how many days has anyone smoked inside your home, in your presence?

- ☐ 0 days
- ☐ 1 to 2 days
- ☐ 3 to 4 days
- ☐ 5 to 6 days
- ☐ 7 days

D.10. Was this more or less than before the COVID-19 pandemic?

- ☐ More
- ☐ Less
- ☐ About the same

☛ **Please Read:**

- **One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor.**
- **A 40-ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.**

D.11. In the past 30 days, on how many days have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?

If you did not have at least one drink of any alcoholic beverage in the past 30 days, please enter '0' in the box directly below and GO TO D.14. below.

☐☐ Days

D.12. In the past 30 days, on the days when you drank, about how many drinks did you drink on the average?

☐☐ Number of drinks

D.13. In the past 30 days, on how many days did you have 5 or more drinks on the same occasion?

☐☐ Days

D.14. Have you changed the amount of alcohol (e.g. number of days per week or number of drinks on the same occasion) you drink compared to before the COVID-19 pandemic?

☐ Yes, I have drunk MORE alcohol than before the pandemic

☐ Yes, I have drunk LESS alcohol than before the pandemic

☐ No, I have drunk the SAME amount of alcohol as before the pandemic

☐ No, I have not drunk alcohol before or during the pandemic

D.15. During the past 12 months, did you use any complementary, alternative, or unconventional therapies such as vitamins, minerals, herbal supplements, or homeopathy?

☐ Yes

☐ No

D.16. Have you changed your use of complementary, alternative or unconventional therapies compared to before the COVID-19 pandemic?

☐ Yes, I am using these MORE compared to before the pandemic

☐ Yes, I am using these LESS compared to before the pandemic

☐ No, I am using these the SAME amount compared to before the pandemic

☐ No, I did not use any complementary, alternative, or unconventional therapies before or during the pandemic

SECTION E: CANCER SCREENING AND PREVENTION

The next set of questions are related to cancer and cancer screening.

If you are male, please GO TO E.5. on the next page.

E.1. A mammogram is a low-dose X-ray of each breast to look for breast cancer. A machine uses an adjustable plastic plate to press against the breast while a picture is taken. Have you ever had a mammogram?

☐ Yes **IF YES** → **a.** How long has it been since you had your last mammogram?

Mark only ONE.

☐ No

- ☐ Within the past year
- ☐ More than 1 year ago but less than 2 years ago
- ☐ More than 2 years ago but less than 3 years ago
- ☐ More than 3 years ago but less than 5 years ago
- ☐ 5 or more years ago

E.2. Were you planning to have a mammogram between March 1, 2020 and the end of the year?

☐ Yes **IF YES** → **a.** Did you or your doctor postpone your mammogram because of the COVID-19 pandemic?

☐ No

- ☐ Yes
- ☐ No

E.3. A Pap test (sometime called a Pap smear) is a test to detect cancer of the cervix. A small sample of cells is taken from a woman's cervix and tested in a laboratory for signs of cancer. Have you ever had a Pap test?

☐ Yes **IF YES** → **a.** How long ago did you have your most recent Pap test to check for cervical cancer?

Mark only ONE.

☐ No

- ☐ Within the past year
- ☐ More than 1 year ago but less than 2 years ago
- ☐ More than 2 years ago but less than 3 years ago
- ☐ More than 3 years ago but less than 5 years ago
- ☐ 5 or more years ago

E.4. Were you planning to have a Pap test between March 1, 2020 and the end of the year?

☐ Yes **IF YES** → **a.** Did you or your doctor postpone your Pap test because of the COVID-19 pandemic?

☐ No

- ☐ Yes
- ☐ No

If you are 49 years of age or younger GO TO E.9. on the next page.

E.5. There are several ways to screen for colon cancer. One way is a stool blood test. A stool blood test is something you do at home by placing a small sample of your stool or bowel movement in a home collection kit or on a special card that comes in a kit. Have you ever had this test using a home kit?

☐ Yes **IF YES** → **a.** How long has it been since you had your last stool test using a home kit?

☐ No

Mark only ONE.

- ☐ Within the past year
- ☐ More than 1 year ago but less than 2 years ago
- ☐ More than 2 years ago but less than 3 years ago
- ☐ More than 3 years ago but less than 5 years ago
- ☐ 5 or more years ago

E.6. Were you planning to have a stool test between March 1, 2020 and the end of the year?

☐ Yes **IF YES** → **a.** Did you or your doctor postpone your stool test because of the COVID-19 pandemic?

☐ No

- ☐ Yes
- ☐ No

E.7. Sigmoidoscopy and colonoscopy are other exams to screen for colon cancer. A tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams?

☐ Yes **IF YES** → **a.** How long has it been since you had your last sigmoidoscopy or colonoscopy?

☐ No

Mark only ONE.

- ☐ Within the past year
- ☐ More than 1 year ago but less than 2 years ago
- ☐ More than 2 years ago but less than 3 years ago
- ☐ More than 3 years ago but less than 5 years ago
- ☐ More than 5 years ago, but less than 10 years ago
- ☐ 10 or more years ago

E.8. Were you planning to get a sigmoidoscopy or colonoscopy screening between March 1, 2020 and the end of the year?

☐ Yes **IF YES** → **a.** Did you or your doctor postpone a sigmoidoscopy or colonoscopy screening because of the COVID-19 pandemic?

☐ No

- ☐ Yes
- ☐ No

E.9. Human Papilloma Virus (HPV) vaccine is given to prevent cancer in males and females. Were you planning to get a dose of the HPV vaccination for yourself between March 1, 2020 and the end of the year? It may have been called Gardasil, Gardasil 9 or Cervarix

☐ Yes **IF YES** → **a.** Did you or your doctor postpone your HPV vaccination because of COVID-19?
- ☐ Yes
- ☐ No

☐ No

Questions E.10. and E.11. are for people who have children between the ages of 9 and 18. If you do not have children between 9 and 18, GO TO E.12. below.

E.10. Have any of your children ages 9-18 received one or more doses of the HPV vaccine?

- ☐ Yes
- ☐ No

E.11. Were you planning to get the HPV vaccine for your child/any of your children between March 1, 2020 and the end of the year?

☐ Yes **IF YES** → **a.** Did you or your children's doctor postpone an appointment for a HPV vaccination for your child/children because of the COVID-19 pandemic?
- ☐ Yes
- ☐ No

☐ No

E.12. If you have been diagnosed with cancer, please answer the following question. If not, please GO TO F.1. on the next page.

Were you scheduled for any cancer-related medical care that you had to cancel or reschedule during the COVID-19 restrictions?

☐ Yes **IF YES** → **a.** What did you have to cancel or reschedule?
Mark ALL THAT APPLY.
- ☐ Routine appointment
- ☐ Screening or cancer follow-up test (e.g., colonoscopy, CT, MRI)
- ☐ Blood test
- ☐ Surgery
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Therapy (physical or occupational)
- ☐ Other → Please specify:_____
- ☐ None of the above

☐ No

SECTION F: HEALTH INFORMATION

F.1. Overall, how confident are you that you could get advice or information about health or medical topics if you needed it?

- ☐ Completely confident
- ☐ Very confident
- ☐ Somewhat confident
- ☐ A little confident
- ☐ Not confident at all

F.2. Based on the results of your most recent search for information about health or medical topics, how much do you agree or disagree with each of the following statements?

		Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
a.	It took a lot of effort to get the information I needed	☐	☐	☐	☐
b.	I felt frustrated during my search for information	☐	☐	☐	☐
c.	I was concerned about the quality of the information	☐	☐	☐	☐
d.	The information I found was hard to understand	☐	☐	☐	☐

F.3. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

F.4. We would like to ask you for your opinion and about your experience using the Internet for health information. How much do you agree or disagree with this statement?

"I feel confident in using information from the Internet to make health decisions"

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Undecided
- ☐ Agree
- ☐ Strongly agree

F.5. Do you ever go online to access the Internet or World Wide Web, or to send and receive e-mail?

- ☐ Yes
- ☐ No

SECTION G: ABOUT YOU

G.1. What is your age?

☐☐☐ Years

G.2. What sex were you assigned at birth, on your original birth certificate?

- ☐ Male
- ☐ Female
- ☐ Prefer not to answer

G.3. How do you describe yourself?
Mark only ONE.

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Do not identify as female, male, or transgender
- ☐ Prefer not to answer

G.4. Do you consider yourself to be:
Mark only ONE.

- ☐ Heterosexual or straight
- ☐ Gay or lesbian
- ☐ Bisexual
- ☐ Prefer not to answer

G.5. About how much do you weigh without shoes?

☐☐☐ Pounds

G.6. Has your weight changed compared to before the COVID-19 pandemic?

- ☐ I weigh MORE now than before the pandemic
- ☐ I weigh LESS now than before the pandemic
- ☐ I weigh the SAME now as before the pandemic

G.7. About how tall are you without shoes?

☐ Feet ☐☐ Inches

G.8. Which one or more of the following would you say is your race?
Mark <u>ALL THAT APPLY</u>.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian or Asian American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other race → Please specify: _____

G.9. Are you of Hispanic, Latino/Latina, or Spanish origin?
Mark <u>ALL THAT APPLY</u>.

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

G.10. How many people 18 years of age or older live in your household, including yourself?

☐☐ Number of persons 18 years or older

G.11. How many children less than 18 years of age live in your household?

☐☐ Number of children

G.12. Thinking about members of your family living in your household, what is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?

- ☐ $0 to $9,999
- ☐ $10,000 to $14,999
- ☐ $15,000 to $19,999
- ☐ $20,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $199,999
- ☐ $200,000 or more
- ☐ Prefer not to answer

G.13. Which one of these comes closest to your own feelings about your household's income these days?

Mark only ONE.

- ☐ Living comfortably on present income
- ☐ Getting by on present income
- ☐ Finding it difficult on present income
- ☐ Finding it very difficult on present income

G.14. Do you have any kind of healthcare coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, or Indian Health Service?

- ☐ Yes **IF YES** →
- ☐ No

a. What is the primary source of your healthcare coverage?

Mark only ONE.

- ☐ A plan provided through an employer or union (including plans purchased through another person's employer)
- ☐ A plan that you or another family member buys on your own
- ☐ Medicare
- ☐ Medicaid or other state program
- ☐ TRICARE (formerly CHAMPUS), VA, or Military
- ☐ Alaska Native, Indian Health Service, Tribal Health Services
- ☐ Some other source → Please describe:

_____

G.15. What is the highest grade or level of schooling you completed?

Mark only ONE.

- ☐ Less than 8 years
- ☐ 8 through 11 years
- ☐ 12 years or completed high school or GED
- ☐ Post high school training other than college (vocational or technical)
- ☐ Some college
- ☐ College graduate
- ☐ Postgraduate

G.16. What is your marital status?

Mark only ONE.

- ☐ Single, never been married
- ☐ Married
- ☐ Not married but living with a romantic partner
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

G.17. Are you currently being paid for a full or part-time job, including being paid by an employer while you stay home? Do not include unemployment compensation.

☐ Yes **IF YES** →
☐ No

a. Are you currently commuting to work?
- ☐ Yes
- ☐ No

b. Are you currently working from home?
- ☐ Yes
- ☐ No

G.18. Select the category that best describes you:
Mark only ONE.

- ☐ Employed for wages
- ☐ Self-employed
- ☐ Out of work for 1 year or more
- ☐ Out of work for less than 1 year
- ☐ A homemaker
- ☐ A student
- ☐ Retired
- ☐ Unable to work

G.19. Who filled out this questionnaire?

- ☐ The person it was addressed to
- ☐ Someone else, but for the person it was addressed to
- ☐ Other → Please describe: _____

G.20. What date did you complete this questionnaire: (month/day/year)?

☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

In case we need to contact you to clarify any of your responses, please enter your current telephone number, and email address, if you have one, as well as any recent changes to your address (optional).

Name (please print): _____
Street/City/State/Zip: _____
E-mail: _____
Telephone: _____

If there is anything else you would like to share about your responses, or access to health care in your area, please include it in the box below.