HRS | HEALTH AND RETIREMENT STUDY
A Longitudinal Study of Health, Retirement, and Aging
Sponsored by the National Institute on Aging

HRS 2019 Health Survey

It is very important that the questions in this survey be answered by the person to whom the survey is addressed.

If the addressee is unable to complete the survey alone:
It can be filled out by someone who knows this person well enough to answer the questions.

If neither the addressee nor another person is able to complete the survey:
Please return the survey, with a short note of explanation, in the enclosed, prepaid envelope.

{First Name} – FPO
123456A (barcode) **<M. ID>**

Conducted by: The Survey Research Center at the University of Michigan.
Sponsored by: The National Institute on Aging

ABOUT THIS SURVEY

This Health Survey is a new part of the Health and Retirement Study. It will give us some information about health care access, health conditions, and medications.

This survey is not meant to be a test of your memory.
However, we would like you to try to be as accurate as possible.
You may find it useful to consult your spouse, another family member, or some personal files, medications, or notes as you go through the questions.

We hope that you will find this survey interesting to complete. As always, your answers are extremely important to us. Please remember that your participation is voluntary and that you may skip over any questions that you would prefer not to answer.

Please return your completed Health Survey in the pre-addressed postage paid envelope. If you have any questions, please feel free to call us at 1-866-611-6476.

HOW TO FILL IN THIS SURVEY

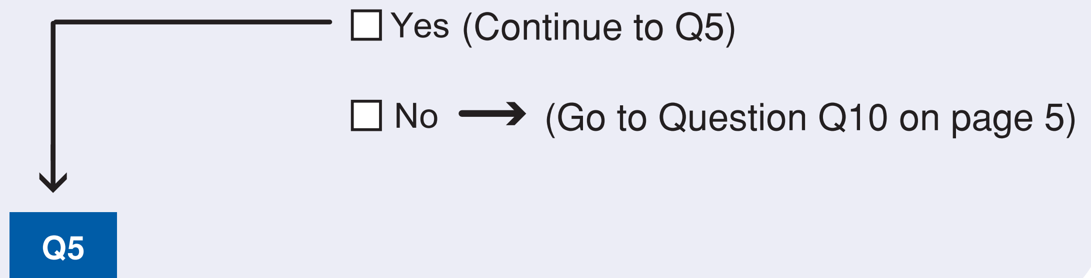
Please answer the questions by:

Marking a box like this: ☒

Or writing in a box like this: 2 5 | Answer

Please use a #2 pencil or a blue/black ink ballpoint pen. DO NOT use a felt tip pen.

Sometimes you may find instructions telling you which questions to answer like this:



Section A. Health Care Access

The first set of questions refer to your current health and recent health care experiences. Please answer the questions for the person whose first name is printed on the front cover of this questionnaire. Do not include information about health care for anyone else.

A1 Would you say your health is excellent, very good, good, fair, or poor? (Mark (X) one.)

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

A2 How many different times were you a patient in a hospital overnight in the last twelve months? (Please write a number in the box.)

☐☐☐

A3 Aside from any hospital stays, how many times have you seen or talked to a medical doctor about your health, including emergency room or clinic visits, in the last twelve months? (Please write a number in the box.)

☐☐☐

A4 In the last twelve months, have you obtained services from a Community Health Center or a free clinic? (Mark (X) one.)

- ☐ Yes
- ☐ No

A5 How confident are you filling out medical forms by yourself? (Mark (X) one.)

- ☐ Extremely confident
- ☐ Quite confident
- ☐ Somewhat confident
- ☐ A little confident
- ☐ Not at all confident

A6 Do you currently have any health insurance (including public programs like Medicare and Medicaid)? (Mark (X) one.)

- ☐ Yes
- ☐ No ⟶ Go to Question A18 on page 6

A7 What kind of coverage do you have? (Mark [X] all that apply.)

- ☐ Medicare
- ☐ Medicaid
- ☐ A plan provided by my employer, spouse's employer, or a former employer or union Insurance purchased directly from an insurance company or through a group such as AARP
- ☐ TRI-CARE, CHAMPUS, or CHAMP-VA
- ☐ Other public coverage such as the Indian Health Service, SCHIP, or a program run by the state or county
- ☐ I get care from the Department of Veterans Affairs (VA)
- ☐ Other, specify ________

A8 Which of these do you consider your PRIMARY coverage? (Mark [X] one.)

- ☐ Medicare
- ☐ Medicaid
- ☐ A plan provided by my employer, spouse's employer, or a former employer or union Insurance purchased directly from an insurance company or through a group such as AARP
- ☐ TRI-CARE, CHAMPUS, or CHAMP-VA
- ☐ Other public coverage such as the Indian Health Service, SCHIP, or a program run by the state or county
- ☐ I get care from the Department of Veterans Affairs (VA)
- ☐ Other, specify ________

A9 In the last 12 months, did you try to get any kind of care, tests, or treatment through your health plan? (Mark (X) one.)

- ☐ Yes
- ☐ No ⟶ Go to Question A11

A10 In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A11 In the last 12 months, did you try to get information or help from your health plan's customer service? (Mark (X) one.)

- ☐ Yes
- ☐ No → Go to Question A14

A12 In the last 12 months, how often did your health plan's customer service give you the information or help you needed? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A13 In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A14 In the last 12 months, did your health plan give you any forms to fill out? (Mark (X) one.)

- ☐ Yes
- ☐ No → Go to Question A16

A15 In the last 12 months, how often were the forms from your health plan easy to fill out? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A16 In the last twelve months, how often did you use the Internet (including email) to communicate with your health plan? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A17 Overall, how satisfied are you with this health plan? (Mark (X) one.)

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Neutral
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

A18 Thinking now over your whole life, have you EVER been denied insurance coverage because of a pre-existing condition? (Mark (X) one.)

- ☐ Yes
- ☐ No

A19 In the past five years, have you been denied insurance coverage because of a pre-existing condition? (Mark (X) one.)

- ☐ Yes
- ☐ No

A20 Have you EVER had coverage with benefits that were limited because of a pre-existing condition? (Mark (X) one.)

- ☐ Yes
- ☐ No

A21 Do you have any insurance that covers dental bills?

- ☐ Yes
- ☐ No

A22 Is there a place that you USUALLY go to when you are sick or need advice about your health? (Mark (X) one.)

- ☐ Yes ⟶ Go to Question A23 on page 7
- ☐ No ⟶ Go to Question A24 on page 7

A23 What kind of place is it - a clinic, doctor's office, emergency room, or some other place? If there is more than one place you usually go, please tell us about the place you go most often. (Mark (X) one.)

- ☐ Doctor's office or health center
- ☐ Walk-in clinic, urgent care center, or retail clinic in a pharmacy or grocery store
- ☐ Emergency room
- ☐ A VA Medical Center or VA outpatient clinic
- ☐ Some other place
- ☐ I don't go to one place most often

The next questions are about medical care you have received in the last twelve months. If there is a place you usually go when you are sick (that is, if you answered YES to A22), please tell us about the care you receive at that place. If there is NOT a place you usually go, please tell us about your experiences getting medical care in the last twelve months.

A24 In the last twelve months, how often did the doctors and nurses explain things in a way that is easy to understand? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A25 In the last twelve months, how often did the doctors and nurses listen carefully to you? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A26 In the last twelve months, how often did the doctors and nurses show respect for what you had to say? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A27 In the last twelve months, how often did the doctors and nurses spend enough time with you? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A28 In the last twelve months, how often did you use the Internet (including email) to communicate with your doctors and nurses? (Mark (X) one.)

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A29 Overall, how satisfied are you with the doctors and nurses that you have seen in the past twelve months? (Mark (X) one.)

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Neutral
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

A30 In the last twelve months, did you have any trouble finding a general doctor or provider who would see you? (Mark (X) one.)

- [ ] Yes
- [ ] No, I was able to find a general doctor without difficulty ⟶ Go to Question A32
- [ ] No, I did not need to see a general doctor ⟶ Go to Question A32

A31 What was the difficulty? (Mark [X] all that apply.)

- [ ] They would not take my insurance
- [ ] They did not have any appointments soon enough
- [ ] They were not taking new patients at all
- [ ] There are no general doctors near where I live
- [ ] Other, specify ______

A32 In the last twelve months, did you have any trouble finding a specialist who would see you? (Mark (X) one.)

- [ ] Yes
- [ ] No, I was able to find a specialist without difficulty ⟶ Go to Question A35
- [ ] No, I did not need to see a specialist ⟶ Go to Question A35

A33 What was the difficulty? (Mark [X] all that apply.)

- [ ] I had trouble obtaining a referral
- [ ] They would not take my insurance
- [ ] They did not have any appointments soon enough
- [ ] They were not taking new patients at all
- [ ] There are no specialists of the kind I needed near where I live

A34 What type of specialist(s) did you have trouble finding? (Mark [X] all that apply.)

- ☐ Allergist
- ☐ Cardiologist (heart doctor)
- ☐ Dermatologist (skin doctor)
- ☐ Gastroenterologist
- ☐ General surgeon
- ☐ Gynecologist/obstetrician
- ☐ Orthopedist/orthopedic surgeon
- ☐ Neurologist or neurosurgeon (nerve / brain specialist)
- ☐ Oncologist (cancer doctor)
- ☐ Ophthalmologist (eye doctor)
- ☐ Otolaryngologist (ear, nose, and throat doctor)
- ☐ Psychiatrist or other mental health provider
- ☐ Pulmonologist (lung doctor)
- ☐ Rheumatologist (arthritis / immune system doctor)
- ☐ Urologist
- ☐ Other, specify ____________

A35 In the last twelve months, did you have any trouble finding a provider of some other type (for example, a dentist or physical therapist) who would see you? (Mark [X] ONE box.)

- ☐ Yes
- ☐ No, I was able to find other providers without difficulty → Go to Question A38
- ☐ No, I did not need to see any other types of providers → Go to Question A38

A36 What type of provider did you have difficulty finding? (Mark [X] all that apply.)

- ☐ Dentist
- ☐ Physical therapist
- ☐ Occupational therapist
- ☐ Home care provider / visiting nurse
- ☐ Pharmacist
- ☐ Other, specify ____________

A37 What was the difficulty? (Mark [X] all that apply.)

- ☐ I had trouble obtaining a referral
- ☐ They would not take my insurance
- ☐ They did not have any appointments soon enough
- ☐ They were not taking new patients at all
- ☐ There are no specialists of the kind I needed near where I live

A38 In the last twelve months, have you delayed medical care because of worry about the cost? (Do not include dental care) (Mark (X) one.)

- ☐ Yes
- ☐ No

A39 In the last twelve months, was there any time when you needed medical care, but did not get it because you couldn't afford it? (Mark (X) one.)

- ☐ Yes
- ☐ No

A40 There are many reasons besides cost that people delay getting medical care. Have you delayed getting medical care for any of the following reasons in the last twelve months? (Mark [X] all that apply.)

- ☐ I couldn't get through on the telephone
- ☐ I couldn't get an appointment soon enough
- ☐ Once I get there, I have to wait too long to see the doctor
- ☐ The clinic/doctor's office wasn't open when I could get there
- ☐ I didn't have transportation
- ☐ I am too busy to go to the doctor
- ☐ I am afraid of what I might find out
- ☐ I don't believe in going to doctors
- ☐ I don't like going to the doctor
- ☐ I have not delayed getting medical care in the last twelve months → Go to Question A42
- ☐ Other, specify ____________

A41 What type(s) of care did you delay? (Mark [X] all that apply.)

- [ ] Major surgery that would have required a hospital stay of one or more nights
- [ ] Outpatient surgery
- [ ] Seeing the doctor about a symptom or a problem
- [ ] Getting a check-up
- [ ] Routine screening, like a colonoscopy
- [ ] Filling a prescription
- [ ] Other, specify ______

A42 In the last twelve months, have you delayed medical care because of worry about the cost? (Do not include dental care) (Mark (X) one.)

- [ ] Yes
- [ ] No

A43 In the last twelve months, was there any time when you needed medical care, but did not get it because you couldn't afford it? (Mark (X) one.)

- [ ] Yes
- [ ] No

A44 Overall, how satisfied are you with the **quality** of your health care? (Mark (X) one.)

- [ ] Very satisfied
- [ ] Somewhat satisfied
- [ ] Neutral
- [ ] Somewhat dissatisfied
- [ ] Very dissatisfied

A45 Overall, how satisfied are you with the **cost** of your health care? (Mark (X) one.)

- [ ] Very satisfied
- [ ] Somewhat satisfied
- [ ] Neutral
- [ ] Somewhat dissatisfied
- [ ] Very dissatisfied

A46 Overall, how satisfied are you with the **convenience** of your health care? (Mark (X) one.)

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Neutral
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

A47 Thinking about the quality, cost, **and** convenience of your health care, how satisfied are you overall? (Mark (X) one.)

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Neutral
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

End of Section A

Section B. Health Conditions

In our regular interviews, we ask you about common health conditions. In this section, we want to ask you about conditions that are less common but can be important to the people that have them.

B1 Have you EVER been told by a doctor or other health professional that your immune system is weakened?

- ☐ Yes
- ☐ No
- ☐ Don't know

B1a If yes, based on what a doctor or other health professional has told you, do you still have a weakened immune system?

- ☐ Yes
- ☐ No
- ☐ Don't know

B2 During the past six months, have you taken prescription medication or had any medical treatments that a doctor or other health professional told you would weaken your immune system? Examples include steroid or corticosteroid pills, such as prednisone, or other oral or injected medications for treating many types of autoimmune conditions or certain cancers.

- ☐ Yes
- ☐ No
- ☐ Don't know

B3 Do you currently have a health condition that a doctor or other health professional told you weakens the immune system, even without related medications or treatments? Examples include certain kinds of leukemia, lymphoma, or HIV infection.

- ☐ Yes
- ☐ No
- ☐ Don't know

B4 Has a doctor or other health professional EVER told you that your immune system is weakened because you have kidney disease, lung disease, liver disease, diabetes, poor nutrition, or general frailty?

- ☐ Yes
- ☐ No
- ☐ Don't know

B5 Has a doctor or other health care professional EVER told you that your immune system is weakened because you seem to get many infections and colds or that you can't seem to get over them?

- ☐ Yes
- ☐ No
- ☐ Don't know

B6 Has a doctor or other health professional EVER told you that any of your blood cells had an abnormal count?

- ☐ Yes
- ☐ No
- ☐ Don't know

B7 Has a doctor or other health care professional EVER told you that you had any of the following conditions as an adult?

	Yes	No	Don't know
a. Asthma	☐	☐	☐
b. Allergies that cause runny nose, sneezing, congestion (including hay fever)	☐	☐	☐
c. Allergies that make your eyes red and watery (also called allergic conjunctivitis)	☐	☐	☐
d. Eczema or atopic dermatitis	☐	☐	☐
e. Angioedema or allergic skin swelling	☐	☐	☐
f. Rheumatoid arthritis	☐	☐	☐
g. Hives	☐	☐	☐
h. Lupus	☐	☐	☐
i. Multiple sclerosis (MS)	☐	☐	☐
j. Graves' disease	☐	☐	☐
k. Hypothyroidism	☐	☐	☐
l. Vitiligo	☐	☐	☐
m. Psoriasis	☐	☐	☐
n. Celiac disease (also known as coeliac disease or gluten sensitivity)	☐	☐	☐
o. Inflammatory bowel disease (such as Crohn's disease or ulcerative colitis)	☐	☐	☐
p. Scleroderma (also known as systemic sclerosis)	☐	☐	☐
q. Cold sores or fever blisters	☐	☐	☐
r. Genital herpes	☐	☐	☐
s. Fibromyalgia	☐	☐	☐
t. Sjogren's syndrome	☐	☐	☐
u. Migraine headaches	☐	☐	☐
v. Cluster headaches	☐	☐	☐
w. Alopecia areata	☐	☐	☐
x. Skin infection (also called cellulitis)	☐	☐	☐
y. Familial hypercholesteremia (very high blood cholesterol that runs in families)	☐	☐	☐
z. Autoimmune disease or problem not already listed	☐	☐	☐
aa. Parkinson's Disease	☐	☐	☐

B7 CONT Has a doctor or other health care professional EVER told you that you had any of the following conditions as an adult?

	Yes	No	Don't know
ab. Atrial fibrillation	☐	☐	☐
ac. Cataracts	☐	☐	☐
ad. Glaucoma	☐	☐	☐
ae. Macular degeneration	☐	☐	☐
af. Anemia	☐	☐	☐
ag. Chronic liver disease, including chronic hepatitis or cirrhosis	☐	☐	☐
ah. Alcohol-related liver disease	☐	☐	☐
ai. (Men only) Benign Prostatic Hypertrophy (also known as BPH)	☐	☐	☐

B8 Have you ever had any of the following medical procedures and if so, when?

	No	Don't know	Yes	If yes, when
a. Splenectomy (spleen removal)	☐	☐	☐	M M / Y Y Y Y
b. Appendectomy (appendix removal)	☐	☐	☐	M M / Y Y Y Y
c. Cardiac stent	☐	☐	☐	M M / Y Y Y Y
Organ or tissue transplant:				
d. Kidney	☐	☐	☐	M M / Y Y Y Y
e. Heart	☐	☐	☐	M M / Y Y Y Y
f. Lung	☐	☐	☐	M M / Y Y Y Y

B8 CONT Have you ever had any of the following medical procedures and if so, when?

Organ or tissue transplant:	No	Don't know	Yes	If yes, when
g. Liver	☐	☐	☐	M M / Y Y Y Y
h. Bone marrow	☐	☐	☐	M M / Y Y Y Y
i. Cornea	☐	☐	☐	M M / Y Y Y Y
j. Other type of transplant	☐	☐	☐	M M / Y Y Y Y

B9 Have you ever had a serious allergic reaction AS AN ADULT to any of the following?

	No	Don't know	Yes	→	If yes, please specify the cause of your reaction(s).
Food	☐	☐	☐	→	
Medication	☐	☐	☐	→	
Vaccines	☐	☐	☐	→	
Other allergic reaction to a food or medication that you have not already told us about	☐	☐	☐	→	

B10 Please indicate how often you have had the following complaints in the past year:

	Never	Sometimes	Regularly	Often	(Almost) always
a. Sore throat	☐	☐	☐	☐	☐
b. Headaches	☐	☐	☐	☐	☐
c. Flu	☐	☐	☐	☐	☐
d. Runny nose	☐	☐	☐	☐	☐
e. Coughing	☐	☐	☐	☐	☐
f. Cold sores	☐	☐	☐	☐	☐
g. Boils	☐	☐	☐	☐	☐
h. Mild fever	☐	☐	☐	☐	☐
i. Warts	☐	☐	☐	☐	☐
j. Pneumonia	☐	☐	☐	☐	☐
k. Bronchitis	☐	☐	☐	☐	☐
l. Sinusitis	☐	☐	☐	☐	☐
m. Sudden high fever	☐	☐	☐	☐	☐
n. Ear infection	☐	☐	☐	☐	☐
o. Diarrhea	☐	☐	☐	☐	☐
p. Meningitis	☐	☐	☐	☐	☐
q. Eye infection	☐	☐	☐	☐	☐
r. Sepsis	☐	☐	☐	☐	☐
s. Skin ulcers that are slow to heal	☐	☐	☐	☐	☐
t. Skin problems (e.g. acne and eczema)	☐	☐	☐	☐	☐
u. Muscle and joint pain	☐	☐	☐	☐	☐
v. Joint infection	☐	☐	☐	☐	☐
w. Urinary tract infections	☐	☐	☐	☐	☐
x. Hepatitis B	☐	☐	☐	☐	☐
y. Hepatitis C	☐	☐	☐	☐	☐

B11 In the past year, have you taken 3 or more courses of antibiotics?

- ☐ Yes
- ☐ No
- ☐ Don't know

B12 How many times in the past ten years have you been hospitalized specifically for an infection?

- ☐ Never
- ☐ 1-2 times
- ☐ 3-4 times
- ☐ 5-9 times
- ☐ 10 or more times

End of Section B

Section C. Medicines

This section asks you to provide some information about each of the different medications you take. Please list all the medications prescribed, including those you only take occasionally, for the person whose first name is printed on the front cover of this questionnaire. Do not include any medications prescribed for someone else. There are fifteen spaces provided for up to fifteen medications. If you take fifteen or fewer, fill out this section for the ones you take and then go on to Section E on page 37. If you take more than fifteen, fill out this section for the fifteen medications you consider most important and then please give just the names of the other medications in Section D on page 36. The first part of the page for each medication asks for some information that should be printed right on the label of the pill bottle or other container. An example of a medication label and how to fill out the top part of the medication page is shown below.

Prescription Label Example

VAMC Ann Arbor, MI 48104-2300
506 (DD/) Ph: 866-316-9350
RX#4599773 Sept. 6, 2005 Fill 1 of 1
John Doe 60-4596
Take one capsule by mouth as directed in
morning and at bedtime
Discard after Sept. 6, 2006 Mfr________
Qty: 60 CAP Kroll, Phil MD
Phenytoin NA (Dilantin) 100MG SA CAP

Take one capsule by mouth as directed in the morning and at bedtime

Medication Form Example:

C1 Please write down some information from the label on the prescription bottle:

a. Name of medication: Phenytoin NA

b. Strength: mgs/other units: 100 ☒ mgs or ☐ other units

c. Medication format: ☒ Capsule ☐ Tablet ☐ Inhalant ☐ Liquid ☐ Drop ☐ Other

d. Dosage instructions: 1 (# of units) 2 (# of times) per ☒ Day ☐ Month ☐ Week

Medication #1:

C1 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐
- ☐ mgs or
- ☐ other units

c. Medication format:
- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per
- ☐ Day
- ☐ Month
- ☐ Week

C2 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C3 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #2:

If you take only one or fewer medications, please Go to Section E on page 37.

C4 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐

- ☐ mgs or
- ☐ other units

c. Medication format:

- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per

- ☐ Day
- ☐ Month
- ☐ Week

C5 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C6 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don’t know

Medication #3:

If you take only two or fewer medications, please Go to Section E on page 37.

C7 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐ ☐ mgs or ☐ other units

c. Medication format: ☐ Capsule ☐ Tablet ☐ Inhalant ☐ Liquid ☐ Drop ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per ☐ Day ☐ Month ☐ Week

C8 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C9 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #4:

If you take only three or fewer medications, please Go to Section E on page 37.

C10 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐
- ☐ mgs or
- ☐ other units

c. Medication format:
- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per
- ☐ Day
- ☐ Month
- ☐ Week

C11 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C12 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #5:

If you take only four or fewer medications, please Go to Section E on page 37.

C13 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐ ☐ mgs or ☐ other units

c. Medication format: ☐ Capsule ☐ Tablet ☐ Inhalant ☐ Liquid ☐ Drop ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per ☐ Day ☐ Month ☐ Week

C14 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C15 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #6:
If you take only five or fewer medications, please Go to Section E on page 37.

C16 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐ ☐ mgs or ☐ other units

c. Medication format:
- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per ☐ Day ☐ Month ☐ Week

C17 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C18 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don’t know

Medication #7:

If you take only six or fewer medications, please Go to Section E on page 37.

C19 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐ ☐ mgs or ☐ other units

c. Medication format:
- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per ☐ Day ☐ Month ☐ Week

C20 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C21 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #8:

If you take only seven or fewer medications, please Go to Section E on page 37.

C22 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐ ☐ mgs or ☐ other units

c. Medication format: ☐ Capsule ☐ Tablet ☐ Inhalant ☐ Liquid ☐ Drop ☐ Other

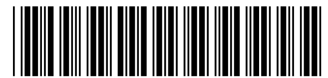
d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per ☐ Day ☐ Month ☐ Week

C23 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C24 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know



Medication #9:

If you take only eight or fewer medications, please Go to Section E on page 37.

C25 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐
- ☐ mgs or
- ☐ other units

c. Medication format:
- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per
- ☐ Day
- ☐ Month
- ☐ Week

C26 About how long have you been taking this medication? (Mark (X) one.)
- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C27 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?
- ☐ Yes
- ☐ No
- ☐ Don’t know

Medication #10:

If you take only nine or fewer medications, please Go to Section E on page 37.

C28 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐ ☐ mgs or ☐ other units

c. Medication format: ☐ Capsule ☐ Tablet ☐ Inhalant ☐ Liquid ☐ Drop ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per ☐ Day ☐ Month ☐ Week

C29 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C30 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #11:
If you take only ten or fewer medications, please Go to Section E on page 37.

C31 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐
- ☐ mgs or
- ☐ other units

c. Medication format:
- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per
- ☐ Day
- ☐ Month
- ☐ Week

C32 About how long have you been taking this medication? (Mark (X) one.)
- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C33 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?
- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #12

If you take only eleven or fewer medications, please Go to Section E on page 37.

C34 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐

- ☐ mgs or
- ☐ other units

c. Medication format:

- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per

- ☐ Day
- ☐ Month
- ☐ Week

C35 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C36 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #13

If you take only twelve or fewer medications, please Go to Section E on page 37.

C37 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐ ☐ mgs or ☐ other units

c. Medication format: ☐ Capsule ☐ Tablet ☐ Inhalant ☐ Liquid ☐ Drop ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per ☐ Day ☐ Month ☐ Week

C38 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C39 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #14

If you take only thirteen or fewer medications, please Go to Section E on page 37.

C40 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐
- ☐ mgs or
- ☐ other units

c. Medication format:
- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per
- ☐ Day
- ☐ Month
- ☐ Week

C41 About how long have you been taking this medication? (Mark (X) one.)
- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C42 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?
- ☐ Yes
- ☐ No
- ☐ Don't know

Medication #15

If you take only fourteen or fewer medications, please Go to Section E on page 37.

C43 Please write down some information from the label on the prescription bottle:

a. Name of medication: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. Strength: mgs/other units: ☐☐☐☐ ☐ mgs or ☐ other units

c. Medication format:
- ☐ Capsule
- ☐ Tablet
- ☐ Inhalant
- ☐ Liquid
- ☐ Drop
- ☐ Other

d. Dosage instructions: ☐☐ (# of units) ☐☐ (# of times) per ☐ Day ☐ Month ☐ Week

C44 About how long have you been taking this medication? (Mark (X) one.)

- ☐ Just started
- ☐ 1-5 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 3-5 years
- ☐ more than 5 years

C45 In the past year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it because of cost?

- ☐ Yes
- ☐ No
- ☐ Don't know

If you take more than fifteen medications, please give just the names of the other medications in Section D on page 36.

End of Section C

Section D: Other Medications

D1 If you take fifteen or fewer medications, please go to Section E on page 37. Please list any other medications that you take (do not include any medications you told us about before in Section C).

Name of medication

a.

b.

c.

d.

e.

f.

g.

h.

i.

j.

End of Section D

Section E. Special Food Consumption

E1 Many people take food supplements or consume particular foods for general health improvement as well as sometimes for improving the immune system or for a specific condition. Please check any of the following that you may have consumed on a regular basis any time in your life for health reasons:

- ☐ Probiotics in a capsule, liquid, or other supplement form
- ☐ Kefir
- ☐ Sauerkraut
- ☐ Kimchi
- ☐ Kombucha
- ☐ Natto
- ☐ Yogurt
- ☐ Miso
- ☐ Apple cider vinegar
- ☐ Gherkin pickles
- ☐ Brine cured olives
- ☐ Tempeh

End of Section E

Section F: Comments

F1 Were the questions in this questionnaire answered by the person to whom this questionnaire was addressed, or did someone else answer for that person? (Mark (X) one.)

- ☐ Yes, the questions were answered by the person to whom the questionnaire was addressed.
- ☐ The questions were answered by that person's spouse or partner.
- ☐ The questions were answered by that person's son or daughter.
- ☐ The questions were answered by someone else: Please say if you are a relative, a friend, a care provider, or what: ____________

F2 Approximately, how long did it take you to complete this questionnaire?

☐☐☐ # of minutes

F3 Please add any comments that you wish in the space below.

9 7 4 9 1 1 3 8

End of Section F

We thank you for taking your time for this important study!

Please return your completed Life History Survey in the pre-addressed postage paid envelope to University of Michigan.

If you have any questions about the survey, please feel free to call us at 866-611-6476

THANK YOU!

Conducted by:
The Survey Research Center
The University of Michigan

Sponsored by:
The National Institute on Aging

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