HRS | HEALTH AND RETIREMENT STUDY at the University of Michigan

Health and Retirement Study:
Health and Well-Being Study 2009

HOW TO FILL IN THIS QUESTIONNAIRE

Please answer the questions by:
Marking a box like this:
Writing a number in a box like this:
Sometimes you will find an instruction telling you which question to answer next like this:

Yes
No - GO TO QUESTION B2

Please use a #2 pencil.

Erase unwanted marks completely.

Please enter all dollar amounts in whole dollars.

Like this:

$ ☐,☐☐4.00

PLEASE START THE QUESTIONNAIRE AT QUESTION W1 ON PAGE 1.

ABOUT THIS QUESTIONNAIRE

This questionnaire is a part of the Health and Retirement Study. We greatly value your past participation in the HRS, and we hope that you will find this questionnaire 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.

A Department of Health and Human Services Certificate of Confidentiality covers this research in order to help ensure your privacy. This certificate can help protect the investigators from being forced to release any research information that identifies you. Please note that we must report credible evidence of serious harm or abuse to any person to the authorities, but this questionnaire does not ask any questions about such topics.

It is very important that the questions be answered by the person whose name is printed on the front cover of this questionnaire (or by someone who knows this person well enough to answer the questions for them, if the addressee is unable to complete the questionnaire alone).

Many questions can be answered by placing an (X) in the box (☐) in front of your response. Some questions may not apply to you, and you will be instructed to skip them. When this occurs, you will find an arrow (➔) from your answer to the next appropriate question number. When no special instruction is given for your response choice, please continue with the next question.

If you have any questions about the questionnaire, please feel free to call us at 1-800-759-7947.

THANK YOU!

Section W: Well-Being

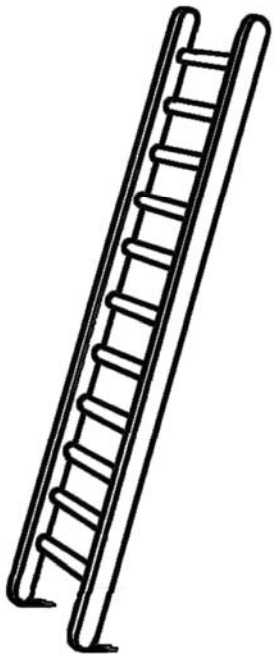
W1. Please think about your life-as-a-whole. Taking all things together how satisfied are you with your life as-a-whole these days? (P3W1)

(Mark one box with X)

Completely satisfied	Very satisfied	Somewhat satisfied	Not very satisfied	Not at all satisfied
☐	☐	☐	☐	☐

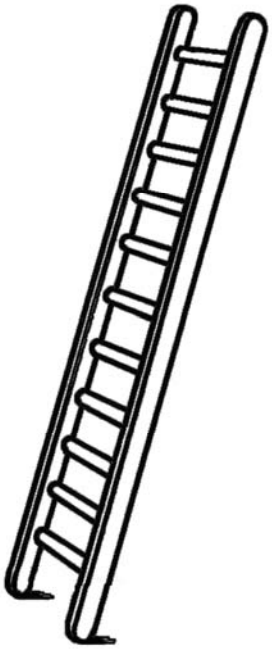
W2a. Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. Suppose we say that the top of the ladder represents the best possible life for you, and the bottom of the ladder represents the worst possible life for you.

On which step of the ladder would you say you personally feel you stand at this time, assuming that the higher the step the better you feel about your life, and the lower the step the worse you feel about it? Which step comes closest to the way you feel? (Mark one box with X) (P3W2A)



- ☐ 10 Best possible life
- ☐ 9
- ☐ 8
- ☐ 7
- ☐ 6
- ☐ 5
- ☐ 4
- ☐ 3
- ☐ 2
- ☐ 1
- ☐ 0 Worst possible life

W2b. What is your best guess about which step you think you will stand on in the future, say about five years from now? (Mark one box with X) (P3W2B)



- ☐ 10 Best possible life
- ☐ 9
- ☐ 8
- ☐ 7
- ☐ 6
- ☐ 5
- ☐ 4
- ☐ 3
- ☐ 2
- ☐ 1
- ☐ 0 Worst possible life

W3. Are you satisfied or dissatisfied with your standard of living (all the things you can buy and do)? (P3W3)

Satisfied	Dissatisfied
☐	☐

W4. Right now, do you feel your standard of living is getting better or getting worse? (P3W4)

Getting better	The same (no change)	Getting worse
☐	☐	☐

W5. How difficult is it for (you/ your) family to meet monthly payments on (your/your family's) bills? (Mark one box with X) (P3W5)

Not at all difficult	Not very difficult	Somewhat difficult	Very difficult	Completely difficult
☐	☐	☐	☐	☐

W6. In the last seven days, on how many days did you exercise for 30 or more minutes? (P3W6)

0	1	2	3	4	5	6	Every day
☐	☐	☐	☐	☐	☐	☐	☐

W7. In the last seven days, on how many days did you have five or more servings of fruits or vegetables? (P3W7)

0	1	2	3	4	5	6	Every day
☐	☐	☐	☐	☐	☐	☐	☐

W8. Are you satisfied or dissatisfied with your personal life today? (P3W8)

Satisfied	Dissatisfied
☐	☐

Now, please think about **YESTERDAY**, from the morning until the end of the day. Think about where you were, what you were doing, who you were with, and how you felt.

W9. Did you smile or laugh a lot yesterday? (P3W9)

Yes	No
☐	☐

W10. Did you learn or do something interesting yesterday? (P3W10)

Yes	No
☐	☐

W11. Did you feel well-rested yesterday morning (that is, you slept well the night before)? (P3W11)

Yes	No
☐	☐

W12. How was your health yesterday? Was it…. (P3W12)

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

W13. What day-of-the-week was it yesterday? (P3W13)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
☐	☐	☐	☐	☐	☐	☐

W14. Was yesterday a normal day for you or did something special happen? (P3W14)

☐ Yes – just a normal day
☐ No – my day included unexpected bad (stressful) things
☐ No – my day included unexpected good things

Please think now about the **THINGS YOU DID YESTERDAY**. How did you spend your time and how did you feel?

W15a. How long did you spend yesterday **watching TV**?
(Write numbers)

☐☐ Hours (P3W15A1) ☐☐ Minutes (P3W15A2) ☐ Did not do this➔ **Go to Q16a.**

W15b. How did you feel when you were **watching TV**? Rate each experience on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong.
(In each line mark one box with X) (P3W15B)

	Did not experience the feeling at all						Feeling was extremely strong
I felt……	0	1	2	3	4	5	6
Happy	☐	☐	☐	☐	☐	☐	☐
Interested	☐	☐	☐	☐	☐	☐	☐
Frustrated	☐	☐	☐	☐	☐	☐	☐
Nervous	☐	☐	☐	☐	☐	☐	☐
Calm	☐	☐	☐	☐	☐	☐	☐
Bored	☐	☐	☐	☐	☐	☐	☐
Sad	☐	☐	☐	☐	☐	☐	☐

W16a. How long did you spend yesterday **eating meals**?

☐☐Hours (P3W16A1) ☐☐Minutes (P3W16A2) ☐ Did not do this➔ **Go to Q17a.**

W16b. How did you feel when you were **eating meals**?
Rate each experience on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong. (In each line mark one box with X) (P3W16B)

	Did not experience the feeling at all						Feeling was extremely strong
I felt……	0	1	2	3	4	5	6
Happy	☐	☐	☐	☐	☐	☐	☐
Interested	☐	☐	☐	☐	☐	☐	☐
Frustrated	☐	☐	☐	☐	☐	☐	☐
Nervous	☐	☐	☐	☐	☐	☐	☐
Calm	☐	☐	☐	☐	☐	☐	☐
Bored	☐	☐	☐	☐	☐	☐	☐
Sad	☐	☐	☐	☐	☐	☐	☐

W17a. How long did you spend yesterday **managing or spending money** (e.g., shopping, banking, balancing checkbook, paying bills)?

☐☐Hours (P3W17A1) ☐☐Minutes (P3W17A2) ☐ Did not do this➔ **Go to Q18a.**

W17b. How did you feel when you were **managing or spending money**? (P3W17B)
Rate each experience on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong. (In each line mark one box with X)

	Did not experience the feeling at all						Feeling was extremely strong
I felt……	0	1	2	3	4	5	6
Happy	☐	☐	☐	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐	☐	☐	☐
Frustrated	☐	☐	☐	☐	☐	☐	☐
Nervous	☐	☐	☐	☐	☐	☐	☐
Calm	☐	☐	☐	☐	☐	☐	☐
Bored	☐	☐	☐	☐	☐	☐	☐
Sad	☐	☐	☐	☐	☐	☐	☐

W18a. How long did you spend yesterday **doing health-related activities** (e.g., visit doctor, taking medications, doing treatments)?

☐☐ Hours (P3W18A1) ☐☐ Minutes (P3W18A2) ☐ Did not do this➔ **Go to Q19a.**

W18b. How did you feel when you were **doing health-related activities**? (P3W18B)

Rate each experience on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong. (In each line mark one box with X)

	Did not experience the feeling at all						Feeling was extremely strong
I felt……	0	1	2	3	4	5	6
Happy	☐	☐	☐	☐	☐	☐	☐
Interested	☐	☐	☐	☐	☐	☐	☐
Frustrated	☐	☐	☐	☐	☐	☐	☐
Nervous	☐	☐	☐	☐	☐	☐	☐
Calm	☐	☐	☐	☐	☐	☐	☐
Bored	☐	☐	☐	☐	☐	☐	☐
Sad	☐	☐	☐	☐	☐	☐	☐

W19a. How long did you spend yesterday **walking or exercising**?

☐☐ Hours (P3W19A1) ☐☐ Minutes (P3W19A2) ☐ Did not do this➔ **Go to Q20a.**

W19b. How did you feel when you were **walking or exercising**? (P3W19B)

Rate each experience on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong. (In each line mark one box with X)

	Did not experience the feeling at all						Feeling was extremely strong
I felt……	0	1	2	3	4	5	6
Happy	☐	☐	☐	☐	☐	☐	☐
Interested	☐	☐	☐	☐	☐	☐	☐
Frustrated	☐	☐	☐	☐	☐	☐	☐
Nervous	☐	☐	☐	☐	☐	☐	☐
Calm	☐	☐	☐	☐	☐	☐	☐
Bored	☐	☐	☐	☐	☐	☐	☐
Sad	☐	☐	☐	☐	☐	☐	☐

W20a. How long did you spend yesterday **socializing with friends, neighbors, or family** (not counting your spouse or partner)?

☐☐ Hours (P3W20A1) ☐☐ Minutes (P3W20A2) ☐ Did not do this➔ **Go to Q21a.**

W20b. How did you feel when you were **socializing with friends, neighbors, or family**?

Rate each experience on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong. (In each line mark one box with X) (P3W20B)

	Did not experience the feeling at all						Feeling was extremely strong
I felt……	0	1	2	3	4	5	6
Happy	☐	☐	☐	☐	☐	☐	☐
Interested	☐	☐	☐	☐	☐	☐	☐
Frustrated	☐	☐	☐	☐	☐	☐	☐
Nervous	☐	☐	☐	☐	☐	☐	☐
Calm	☐	☐	☐	☐	☐	☐	☐
Bored	☐	☐	☐	☐	☐	☐	☐
Sad	☐	☐	☐	☐	☐	☐	☐

W21a. How long did you spend yesterday **at home by yourself (without a spouse, partner, or anyone else present)**?

☐☐ Hours (P3W21A1) ☐☐ Minutes (P3W21A2) ☐ Did not do this➔ **Go to Q22a**

W21b. How did you feel when you were **at home by yourself**? (P3W21B)

Rate each experience on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong. (In each line mark one box with X)

	Did not experience the feeling at all						Feeling was extremely strong
I felt……	0	1	2	3	4	5	6
Happy	☐	☐	☐	☐	☐	☐	☐
Interested	☐	☐	☐	☐	☐	☐	☐
Frustrated	☐	☐	☐	☐	☐	☐	☐
Nervous	☐	☐	☐	☐	☐	☐	☐
Calm	☐	☐	☐	☐	☐	☐	☐
Bored	☐	☐	☐	☐	☐	☐	☐
Sad	☐	☐	☐	☐	☐	☐	☐

W22a. How long did you spend yesterday **working or doing volunteer work away from home?**

☐☐ Hours (P3W22A1) ☐☐ Minutes (P3W22A2) ☐ Did not do this➔ **Go to Section A Page 9**

W22b. How did you feel when you were **working or doing volunteer work away from home?** (P3W22B)

Rate each experience on a scale from 0 – did not experience at all – to 6 – the feeling was extremely strong. (In each line mark one box with X)

	Did not experience the feeling at all						Feeling was extremely strong
I felt……	0	1	2	3	4	5	6
Happy	☐	☐	☐	☐	☐	☐	☐
Interested	☐	☐	☐	☐	☐	☐	☐
Frustrated	☐	☐	☐	☐	☐	☐	☐
Nervous	☐	☐	☐	☐	☐	☐	☐
Calm	☐	☐	☐	☐	☐	☐	☐
Bored	☐	☐	☐	☐	☐	☐	☐
Sad	☐	☐	☐	☐	☐	☐	☐

Section A: Access to Prescription Medicines

A1a. Have you used prescription drugs in the past year? (P3A1A)

☐1 Yes ➔ **Go to Question A2.**

☐5 No ➔ **A1b.** Do you have any insurance that would cover some of the cost of prescription drugs if you did use them? (P3A1B)

☐1 Yes ➔ **Go to Section B on Page 12**

☐5 No ➔ **Go to Section D on Page 19**

A2. Who does most of the shopping for the prescription drugs that you take? (Mark (X) ONE.) (P3A2)

☐1 I do most of the shopping myself.

☐2 My spouse does most of the shopping.

☐3 My child or other family member does most of the shopping.

☐4 A nurse or other paid helper does most of the shopping.

☐5 Other (please specify: _____ (P3A2OTH)

A3. How many different prescription drugs did you use in the last month?

_____ # of prescription drugs (P3A3)

A4. Of those prescription drugs, how many are ones you take on a regular basis (for example every day or every week)? (P3A4)

_____ # of prescription drugs

A5a. How much do you typically spend of your own money for a one-month supply of your regular drugs? (Please round to nearest whole dollar amount.) (P3A5A)

$ ☐,☐☐☐.00

A5b. In the last year, what is the most you have spent for a one-month supply of your regular drugs? (Please round to nearest whole dollar amount.) (P3A5B)

$ ☐,☐☐☐.00

A6. In a typical month, how many different pharmacies do you get prescription drugs from (including mail order)? (P3A6)

_____ # of pharmacies

A7. Where do you typically get your prescription medicines? (Mark (X) all that apply.) (P3A7A - P3A7J)

- ☐1 Big drugstore chain pharmacy such as Walgreens or Osco
- ☐2 Pharmacy inside a grocery store or supermarket
- ☐3 Pharmacy inside a chain department store such as Target, Kmart or Wal-Mart
- ☐4 Independent pharmacy (pharmacy that is locally owned)
- ☐5 Veterans Administration pharmacy
- ☐6 Pharmacy inside a medical clinic or hospital
- ☐7 By mail order
- ☐8 Over the internet
- ☐9 Free samples from physician
- ☐10 Other (please specify:_____ (P3A7OTHM1, P3A7OTHM2)

A8. How often do you purchase prescription drugs from a supplier in another country such as Canada or Mexico? (Mark (X) ONE.) (P3A8)

- ☐1 Never
- ☐2 Rarely
- ☐3 Often

A9. In addition to your prescription medications, which of the following types of medicines do you regularly use that you buy without a doctor's prescription? (Mark (X) all that apply.) (P3A9A – P3A9F)

- ☐1 Pain relievers
- ☐2 Antacids or other stomach medicines
- ☐3 Allergy or cold medicine
- ☐4 Sleep aids
- ☐5 Herbal medications
- ☐9 I do not regularly use any of these medications

End of Section A

Section B: Coverage and Cost of Prescriptions

B1. Which of the following best describes how your insurance works when you buy prescription drugs? (Mark (X) ONE.) (P3B1)

- ☐1 I pay some of the price and insurance pays the rest.
- ☐2 I get a small discount off of full price with a discount card and pay the rest myself.
- ☐3 I pay full price for all medications out of my own pocket, with no insurance. ➔ **Go to Section C on Page 16**
- ☐4 I don't pay anything.
- ☐5 Other

B2. What is the source of your most important prescription drug insurance? (Mark (X) ONE.) (P3B2)

- ☐1 A plan provided by my employer, a family member's employer, or a former employer or union
- ☐2 A Medicare Part D plan
- ☐3 A Medicare HMO or Medicare Advantage Plan
- ☐4 Medicaid
- ☐5 Veterans Administration
- ☐6 State Pharmacy Assistance Program
- ☐7 Other (please specify:_____ (P3B2OTHM1, P3B2OTHM2)
- ☐8 Don't Know

B3. What is the name of your most important prescription drug insurance plan?

_____

- ☐9 Don't Know

B4. Does your prescription drug coverage have an annual deductible, that is, an amount you have to pay yourself each year before the insurance will start to help pay? (Mark (X) ONE.) (P3B4)

- ☐1 Yes
- ☐5 No ➔ **Go to Question B6**
- ☐9 Don't Know ➔ **Go to Question B6**

B5. If yes, how much is your deductible? (P3B5)

$☐,☐☐☐.00 Deductible per year

B6. What kind of monthly premium is there for your prescription drug insurance? (Mark (X) ONE.) (P3B6)

☐1 I pay it myself

☐2 It's included in the premium for my HMO, Medicare Advantage, Medigap coverage, or other health insurance

☐3 It's deducted from my Social Security check.

☐4 It's deducted from my or my spouse's paycheck

☐5 Other (please specify :_____) (P3B6OTH)

☐6 There is no monthly premium ➔ **Go to Question B8**

B7. How much is your monthly premium? (P3B7)

$☐,☐☐☐.00 per month

B8. Some prescription drug insurance plans restrict the number, type or dollar amount of prescriptions they will pay for. Check any of the following types of restrictions that your plan has. (Mark (X) all that apply.) (P3B8A – P3B8H)

☐1 My plan won't pay at all for some types of drugs.

☐2 My plan makes me pay more for some types of drugs.

☐3 My plan only pays for a certain number of prescriptions per month.

☐4 My plan only pays up to a certain amount of money each month.

☐5 My plan only pays up to a certain amount of money each year.

☐6 Other restriction.

☐7 My plan has no restrictions.

☐9 Don't Know

B9. Overall, how satisfied are you with your current prescription drug coverage? (Mark (X) ONE.) (P3B9)

- ☐1 Very satisfied
- ☐2 Somewhat satisfied
- ☐3 Somewhat dissatisfied
- ☐4 Very dissatisfied

B10. Over the last year, would you say your prescription drug coverage has: (Mark (X) ONE.) (P3B10)

- ☐1 Gotten better
- ☐2 Stayed the same
- ☐3 Gotten worse

B11. In the last year (twelve months), have you done any of the following? (Mark (X) all that apply.) (P3B11A – P3B11C)

- ☐1 Switched to a different prescription drug plan.
- ☐2 Changed the brand of a drug you use or switched to generic drugs to save money
- ☐3 Talked to your doctor about changing drugs to save money

B12. In the last year, have you thought about switching to a different provider or a different plan of the same provider? (Mark (X) ONE.) (P3B12)

- ☐1 No, I have not thought about switching. I am happy with my plan.
- ☐2 No, I have not thought about switching. I wanted to avoid the trouble of going through the whole plan comparison and choice process again.
- ☐3 Yes, I have briefly considered switching to a different plan or provider.
- ☐4 Yes, I have thoroughly considered switching to a different plan or provider and compared plan details

B13. How would you rate your current prescription drug plan (i.e. the plan in which you are enrolled for 2007) overall? (Mark (X) ONE.) (P3B13)

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

B14. How would you rate these features of your current prescription drug plan? (Mark (X) one answer for each line.) (P3B14)

	Excellent	Very good	Good	Fair	Poor
a. Cost of monthly premium	☐1	☐2	☐3	☐4	☐5
b. Deductible	☐1	☐2	☐3	☐4	☐5
c. Amount you pay for each prescription (co-pay)	☐1	☐2	☐3	☐4	☐5
d. Keeping your costs the same from month to month	☐1	☐2	☐3	☐4	☐5
e. The drugs it covers and doesn't cover (formulary)	☐1	☐2	☐3	☐4	☐5
f. Choice of pharmacies or mail order options	☐1	☐2	☐3	☐4	☐5
g. Customer service	☐1	☐2	☐3	☐4	☐5

B15. How important are the following features of a prescription drug insurance plan for you? (Mark (X) one answer for each line.) (P3B15)

	Critical	Very important	Important	Less important	Not at all important
a. Cost of monthly premium	☐1	☐2	☐3	☐4	☐5
b. Deductible	☐1	☐2	☐3	☐4	☐5
c. Amount you pay for each prescription (co-pay)	☐1	☐2	☐3	☐4	☐5
d. Keeping your costs the same from month to month	☐1	☐2	☐3	☐4	☐5
e. The drugs it covers and doesn't cover (formulary)	☐1	☐2	☐3	☐4	☐5
f. Choice of pharmacies or mail order options	☐1	☐2	☐3	☐4	☐5
g. Customer service	☐1	☐2	☐3	☐4	☐5

B16. Please tell us anything else about your prescription drug insurance that you think is important that we have not asked about.

(All comments should be written inside the box)

End of Section B.

Section C: Use of Prescription Medications

C1. The next set of questions is about problems you may have had because of the cost of prescription medications. (Mark (X) one answer for each line.) (P3C1)

	Never	1 or 2 times	3 or 4 times	More than 4 times
a. In the past year, how often did you not fill a new prescription because of the cost?	☐0	☐1	☐2	☐3
b. In the past year, how often did you stop taking a prescription medication because of the cost?	☐0	☐1	☐2	☐3
c. In the past year, how often did you skip doses of a prescription medication in order to save money?	☐0	☐1	☐2	☐3

C2. In the past year, have you had any side effects, unwanted reactions, or other health problems from medications you were taking? (Mark (X) ONE.) (P3C2)

☐1 Yes

☐5 No ➔ **Go to Section D on Page 19**

☐9 Not sure ➔ **Go to Section D on Page 19**

C3. Thinking about the MOST SEVERE of the reactions you experienced in the past year, what did you do in response? (Mark (X) one answer for each line.) (P3C3)

	Yes	No
a. Did you cut down or stop taking the drug on your own?	☐1	☐5
b. Did you talk to a doctor about this reaction?	☐1	☐5
c. Did you visit a doctor's office or emergency room mostly because of this reaction?	☐1	☐5
d. Did your doctor ask you to cut down or stop taking the medication because of this reaction?	☐1	☐5
e. Did you take another medication or treatment to treat this reaction?	☐1	☐5
f. Were you admitted to a hospital overnight mostly because of this reaction?	☐1	☐5

End of Section C.

Section D: Opinions about Medicare

The following questions have to do with the Medicare program. Whether you participate in Medicare or not, please try to answer the following as best you can.

D1. Based on what you know right now, how favorable is your opinion of the Medicare program overall? (P3D1)

(Mark (X) ONE.)

Very favorable	Somewhat favorable	No strong opinion	Somewhat unfavorable	Very unfavorable	Don't know
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ D

D2. Based on what you know right now, how favorable is your opinion of the Medicare prescription drug benefit, also known as Medicare Part D? (P3D2)

(Mark (X) ONE.)

Very favorable	Somewhat favorable	No strong opinion	Somewhat unfavorable	Very unfavorable	Don't know
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ D

End of Section D

Section E. Medicines

To really understand the impact of prescription medications on the health and economic security of Americans like you, it is important to know something about the specific medications that people actually take. 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 ten pages provided for up to ten medications.

- If you take fewer than ten, fill out pages for the ones you take and then go on to **Section G on page 30.**
- If you take more than ten, fill out all the pages for the ten medications you consider most important and then please give just the names of the other medications in **Section F on page 29.**

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

Medication Form Example:

Medication #1.

E1. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) ___ **Phenytoin**___

b. Strength: **100** mgs __other units Medication Format/Units: (Capsule), Tablet, Inhalant, Liquid, Drop, Other

c. Dosage Instructions: **1** (# of units) **2** (# times) per (Day) Week Month

Medication #1.

E1. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage Instructions: __ (# of units) ___ (# times) per Day Week Month

E2. 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

E3. How much did you pay the last time you filled this prescription? $ _____

E4. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E5. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE).

☐1 Yes

☐5 No ➔ **Go to Question E7.**

☐9 Don't Know ➔ **Go to Question E7.**

E6. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

Medication #2.

If you take only one or fewer medications, please Go to Section G on page 31.

E7. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage Instructions: __ (# of units) ___ (# times) per Day Week Month

E8. 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

E9. How much did you pay the last time you filled this prescription? $_____

E10. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E11. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE).

☐1 Yes

☐5 No ➔ **Go to Question E13.**

☐9 Don't Know ➔ **Go to Question E13.**

E12. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

Medication #3.

If you take only two or fewer medications, please Go to Section G on page 31.

E13. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage instructions: __ (# of units) ___ (# times) per Day Week Month

E14. 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

E15. How much did you pay the last time you filled this prescription? $ _____

E16. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E17. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE).

☐1 Yes

☐5 No ➔ **Go to Question E19.**

☐9 Don't Know ➔ **Go to Question E19.**

E18. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

Medication #4.

If you take only three or fewer medications, please Go to Section G on page 31.

E19. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage instructions: __ (# of units) ___ (# times) per Day Week Month

E20. 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

E21. How much did you pay the last time you filled this prescription? $_____

E22. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E23. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE.)

☐1 Yes

☐5 No ➔ **Go to Question E25.**

☐9 Don't Know ➔ **Go to Question E25.**

E24. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

Medication #5.

If you take only four or fewer medications, please Go to Section G on page 31.

E25. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage instructions: __ (# of units) ___ (# times) per Day Week Month

E26. About how long have you been taking this medication? _____

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

E27. How much did you pay the last time you filled this prescription? $ _____

E28. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E29. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (**Mark (X) ONE.**)

☐1 Yes

☐5 No ➔ **Go to Question E31.**

☐9 Don't Know ➔ **Go to Question E31.**

E30. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

Medication #6.

If you take only five or fewer medications, please Go to Section G on page 31.

E31. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage instructions: __ (# of units) ___ (# times) per Day Week Month

E32. 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

E33. How much did you pay the last time you filled this prescription? $ _____

E34. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E35. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE).

☐1 Yes

☐5 No ➔ **Go to Question E37.**

☐9 Don't Know ➔ **Go to Question E37.**

E36. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

Medication #7.

If you take only six or fewer medications, please Go to Section G on page 31.

E37. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage instructions: __ (# of units) ___ (# times) per Day Week Month

E38. 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

E39. How much did you pay the last time you filled this prescription? $ _____

E40. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E41. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE).

☐1 Yes

☐5 No ➔ **Go to Question E42.**

☐9 Don't Know ➔ **Go to Question E43.**

E42. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

Medication #8.

If you take only seven or fewer medications, please Go to Section G on page 31.

E43. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage instructions: __ (# of units) ___ (# times) per Day Week Month

E44. 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

E45. How much did you pay the last time you filled this prescription? $ _____

E46. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E47. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE).

☐1 Yes

☐5 No ➔ **Go to Question E49.**

☐9 Don't Know ➔ **Go to Question E49.**

E48. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

Medication #9.

If you take only eight or fewer medications, please Go to Section G on page 31.

E49. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage instructions: __ (# of units) ___ (# times) per Day Week Month

E50. 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

E51. How much did you pay the last time you filled this prescription? $ _____

E52. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E53. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE).

☐1 Yes

☐5 No ➔ **Go to Question E55.**

☐9 Don't Know ➔ **Go to Question E55.**

E54. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

Medication #10.

If you take only nine or fewer medications, please Go to Section G on page 31.

E55. Please write down some information from the label on the prescription bottle:

a. Name of the medication: (Please PRINT clearly) _____

b. Strength: __mgs __other units Medication Format/Units: Capsule, Tablet, Inhalant, Liquid, Drop, Other

c. Dosage instructions: __ (# of units) ___ (# times) per Day Week Month

E56. 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

E57. How much did you pay the last time you filled this prescription? $ _____

E58. Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know
a. This medication is very important for my health.	☐1	☐2	☐3	☐4	☐5	☐9
b. It often gives me unpleasant side effects.	☐1	☐2	☐3	☐4	☐5	☐9
c. It is too expensive.	☐1	☐2	☐3	☐4	☐5	☐9
d. It is the best one available for what it does.	☐1	☐2	☐3	☐4	☐5	☐9

E59. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE).

☐1 Yes

☐5 No ➔ **Go to Question F1.**

☐9 Don't Know ➔ **Go to Question F1.**

E60. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)

	Not at all Important	Somewhat Important	Very Important
a. Cost	☐1	☐2	☐3
b. Unpleasant side effects	☐1	☐2	☐3
c. Away from home	☐1	☐2	☐3
d. Forgot	☐1	☐2	☐3

End of Section E.

Section F: Other Prescription Medications

If you take ten or fewer medications, please Go to Section G on page 31.

F1. Please list any other prescription medications that you take (do not include any medications you told us about before in Section E).

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

g. _____

h. _____

i. _____

j. _____

End of Section F.

Section G: Over-the-Counter Medications

G1. Please list any medications that you take regularly or as often as needed without a doctor's prescription (do not include any medications you told us about before in Section E). Examples could be things like aspirin, antacids, allergy medicine, or herbal medications.

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

g. _____

h. _____

i. _____

j. _____

End of Section G.

Section H: Comments

H1. 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.) (P3H1)

☐1 Yes, the questions were answered by the person to whom the questionnaire was addressed.

☐2 The questions were answered by that person's spouse or partner.

☐3 The questions were answered by that person's son or daughter.

☐4 The questions were answered by someone else: Please say if you are a relative, a friend, a care provider, or what: _____ (P3H1OTH)

H2. Approximately, how long did it take you to complete this questionnaire? (P3H2)

_____ # of minutes

H3. Please add any comments that you wish in the space below:
(All comments should be written inside the box.)

Thank you for your participation in this important survey!

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

THANK YOU!

Conducted by:
The Survey Research Center
The University of Michigan

Sponsored by:
The National Institute on Aging