

## Medicare Health Outcomes Survey Instructions

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

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

- Answer the questions by putting an ‘X’ in the box next to the appropriate answer category like this:

**43. Are you male or female?**

Male       Female

- Be sure to read all the answer choices given before marking a box with an ‘X’.
- You are sometimes told to answer some questions in this survey only when you have answered a previous question. When this happens, you will see an *italicized* instruction like the one below:

***If you answered “Yes” to question 29 or 30 above  
(you have arthritis), answer the next question.***

**All information that would permit identification of any person who completes this survey will be kept strictly confidential. This information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without your permission.**

**If you have any questions or want to know more about the study, please call [vendor name] at [toll-free number].**

**OMB 0938-0701 Version 02-1**

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# Medicare Health Outcomes Survey

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

**Excellent**

1

**Very good**

2

**Good**

3

**Fair**

4

**Poor**

5

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

**Much better  
now than one  
year ago**

1

**Somewhat  
better now than  
one year ago**

2

**About the  
same as one  
year ago**

3

**Somewhat  
worse now than  
one year ago**

4

**Much worse  
now than one  
year ago**

5

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

<b>ACTIVITIES</b>	<b>Yes, limited a lot</b>	<b>Yes, limited a little</b>	<b>No, not limited at all</b>
a. <b>Vigorous activities</b> , such as running, lifting heavy objects, participating in strenuous sports.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Lifting or carrying groceries.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Climbing <b>several</b> flights of stairs.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Climbing <b>one</b> flight of stairs.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Bending, kneeling, or stooping.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
g. Walking <b>more than a mile</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
h. Walking <b>several blocks</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
i. Walking <b>one block</b> .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
j. Bathing or dressing yourself.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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

	<b>Yes</b>	<b>No</b>
a. Cut down on the <b>amount of time</b> you spent on work or other activities .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b. <b>Accomplished less</b> than you would like .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c. Were limited in the <b>kind</b> of work or other activities .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d. Had <b>difficulty</b> performing the work or other activities (for example, it took extra effort) .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>

5. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	<b>Yes</b>	<b>No</b>
a. Cut down on the <b>amount of time</b> you spent on work or other activities .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b. <b>Accomplished less</b> than you would like .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c. Didn't do work or other activities as <b>carefully</b> as usual .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>

6. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

<b>Not at all</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Quite a bit</b>	<b>Extremely</b>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

7. How much **bodily** pain have you had during the **past 4 weeks**?

<b>None</b>	<b>Very mild</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Very severe</b>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

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

<b>Not at all</b>	<b>A little bit</b>	<b>Moderately</b>	<b>Quite a bit</b>	<b>Extremely</b>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

9. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <b>past 4 weeks</b> ...	<b>All of the time</b>	<b>Most of the time</b>	<b>A good bit of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
a. did you feel full of pep? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
b. have you been a very nervous person? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
c. have you felt so down in the dumps that nothing could cheer you up? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
d. have you felt calm and peaceful?.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
e. did you have a lot of energy? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
f. have you felt downhearted and blue? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
g. did you feel worn out? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
h. have you been a happy person?.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
i. did you feel tired?.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

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

<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

11. How TRUE or FALSE is **each** of the following statements for you?

	<b>Definitely true</b>	<b>Mostly true</b>	<b>Don't know</b>	<b>Mostly false</b>	<b>Definitely false</b>
a. I seem to get sick a little easier than other people .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. I am as healthy as anybody I know .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. I expect my health to get worse .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. My health is excellent.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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

12. Because of a health or physical problem, do you have any difficulty doing the following activities? (Please mark one response for each activity.)

	<b>I am unable to do this activity</b>	<b>Yes, I have difficulty</b>	<b>No, I do not have difficulty</b>
a. Bathing.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Dressing.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Eating.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Getting in or out of chairs.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Walking.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Using the toilet.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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

13. During the **past 4 weeks**, how often have you had any of the following problems?

	<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
a. Chest pain or pressure when you exercise.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Chest pain or pressure when resting.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

14. During the **past 4 weeks**, how often have you felt short of breath under the following conditions?

	<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
a. When lying down flat.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. When sitting or resting.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. When walking less than one block.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. When climbing one flight of stairs.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

15. During the **past 4 weeks**, how much of the time have you had any of the following problems with your legs and feet? (Mark one response for each item.)

	<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
a. Numbness or loss of feeling in your feet.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Ankles or legs that swell as the day goes on.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Tingling or burning sensation in your feet especially at night.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. Decreased ability to feel hot or cold with your feet.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e. Sores or wounds on your feet that did not heal.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

16a. Have you **ever** had paralysis or weakness on one side of the body?

<b>Yes, I have it</b>	<b>Yes, but it went away</b>	<b>No</b>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

16b. Have you **ever** lost the ability to talk?

<b>Yes, I have lost it</b>	<b>Yes, but it returned</b>	<b>No</b>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

	<b>Yes</b>	<b>No</b>
17. Can you see well enough to read newspaper print (with your glasses or contacts if that's how you see best)?.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
18. Can you hear <b>most</b> of the things people say (with a hearing aid if that's how you hear best)? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
19. Do you now have acid indigestion or heartburn? .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
20. Do you have difficulty controlling urination?.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>

<b>Has a doctor ever told you that you had:</b>	<b>Yes</b>	<b>No</b>
21. Hypertension or high blood pressure .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
22. Angina pectoris or coronary artery disease.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
23. Congestive heart failure .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
24. A myocardial infarction or heart attack.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
25. Other heart conditions, such as problems with heart valves or the rhythm of your heartbeat .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
26. A stroke .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
27. Emphysema, or asthma, or COPD (Chronic Obstructive Pulmonary Disease).....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
28. Crohn's disease, ulcerative colitis, or inflammatory bowel disease.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>

<b>Has a doctor ever told you that you had:</b>	<b>Yes</b>	<b>No</b>
29. Arthritis of the hip or knee .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
30. Arthritis of the hand or wrist .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
31. Sciatica (pain or numbness that travels down your leg to below your knee).....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
32. Diabetes, high blood sugar, or sugar in the urine .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
33. Any cancer (other than skin cancer) .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>

***If you answered "yes" to questions 29 or 30 above (that you have arthritis),***

34. During the **past 4 weeks**, how would you describe the arthritis pain you usually had? (Mark one answer.)

<b>None</b>	<b>Very Mild</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

**If you answered "yes" to question 33 above (that you have had cancer),**

35. Are you currently under treatment for:

	<b>Yes</b>	<b>No</b>
a. Colon or rectal cancer .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
b. Lung cancer .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
c. Breast cancer .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
d. Prostate cancer .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>

36. In the **past 4 weeks**, how often has low back pain interfered with your usual daily activities (work, school or housework)?

<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

37. In the **past 4 weeks**, how often did you have pain, numbness or tingling that travels down your leg and below your knee?

<b>All of the time</b>	<b>Most of the time</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

38. In the past **year**, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost interest or pleasure in things that you usually cared about or enjoyed? .....

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

39. In the past **year**, have you felt depressed or sad much of the time?.....

1 <input type="checkbox"/>	2 <input type="checkbox"/>
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40. Have you ever had **2 years or more** in your life when you felt depressed or sad most days, even if you felt okay sometimes? .....

1 <input type="checkbox"/>	2 <input type="checkbox"/>
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41. In general, compared to other people your age, would you say that your health is:

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

42. Have you ever smoked at least 100 cigarettes in your entire life?

- 1  Yes → **Go to Question 43**
- 2  No → **Go to Question 46**
- 3  Don't know → **Go to Question 46**

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

- 1  Every day → **Go to Question 45**
- 2  Some days → **Go to Question 45**
- 3  Not at all → **Go to Question 44**
- 4  Don't know → **Go to Question 46**

44. How long has it been since you quit smoking cigarettes?

- 1  Less than 6 months → **Go to Question 45**
- 2  6 months or more → **Go to Question 46**
- 3  Don't know → **Go to Question 46**

45. In the last 6 months, on how many visits were you advised to quit smoking by a doctor or other health provider in your plan?

- 1  None
- 2  1 visit
- 3  2 to 4 visits
- 4  5 to 9 visits
- 5  10 or more visits
- 6  I had no visits in the last 6 months

46. In what **year** were you born? Please provide your **year of birth** only. For example, if your date of birth is January 1, 1935, please answer "1935."

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47. Are you male or female?

- 1  Male
- 2  Female

48. Are you of Hispanic or Spanish family background?

- 1  Yes
- 2  No

49. How would you describe your race?

- 1  American Indian or Alaskan Native
- 2  Asian or Pacific Islander
- 3  Black or African American
- 4  White
- 5  Another race or multiracial

50. What is your current marital status?

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

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

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

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

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

53. Is this house or apartment in a retirement community, building or complex?

- 1  Yes
- 2  No



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

- 1  Less than \$5,000
- 2  \$5,000 – \$9,999
- 3  \$10,000 – \$19,999
- 4  \$20,000 – \$29,999
- 5  \$30,000 – \$39,999
- 6  \$40,000 – \$49,999
- 7  \$50,000 – \$79,999
- 8  \$80,000 – \$99,999
- 9  \$100,000 or more
- 10  Don't know

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

"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0701. The time required to complete this information collection is estimated to average 20 minutes including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850."

Vendor Contact Info Here