



Participant ID

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***Six Month Follow-up  
Survey***

***CEASAR STUDY***

Thank you for your continued participation in the CEASAR study. This follow-up questionnaire is about your quality of life and other experiences related to your prostate cancer and its treatment. To help us get the most accurate information, it is important that you answer all questions honestly and completely about your own experience. You may skip any questions that you are uncomfortable answering. Your responses will help us in our efforts to learn more about how to best treat prostate cancer.

Information contained within this survey will remain strictly confidential.

Thank you very much for your assistance in answering these questions.



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## General Instructions

### PLEASE READ THESE INSTRUCTIONS CAREFULLY

- Answer each question as best you can. If you choose to skip a question, please write 'skip' next to it.
- Please fill in the oval next to your answer completely using blue or black ink.  
**Example:** Fill in ovals completely, like this: ●  
Not like this: ⊗ Or this: ◐
- Please follow any instructions that direct you to the next question.  
**Example:** ● No (***If no, go to the 'If no' section on the next page***)
- If you mark an answer with a line after it, please write the specific information on the line.  
**Example:**  
● Other, please specify: my friend who is a doctor
- Mark only one response for each question, unless other instructions are given.
- If you mark the wrong oval by mistake, put an X through it and fill in the correct answer, like this: ⊗
- As much as possible, please try to answer all of the questions in one sitting.



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1. Today's date:      /      / 2 0  
Month Day Year

**Prostate Cancer Treatment**

2. Have you received any of these treatments for your prostate cancer?  
(Choose all that apply).

	Yes	If Yes, Date Started:		Did <b>Not</b> Receive
		Month	Year	
a. Surgery (Robotic/Laparoscopic removal of prostate)	<input type="radio"/>	<u>    </u> /	<u>2</u> <u>0</u>	<input type="radio"/>
b. Surgery (Open removal of prostate/traditional approach with incision)	<input type="radio"/>	<u>    </u> /	<u>2</u> <u>0</u>	<input type="radio"/>
c. Seeds/Rods (Brachytherapy)	<input type="radio"/>	<u>    </u> /	<u>2</u> <u>0</u>	<input type="radio"/>
d. External Beam Radiation (IMRT/3-D CLRT)	<input type="radio"/>	<u>    </u> /	<u>2</u> <u>0</u>	<input type="radio"/>
e. Hormone Therapy as main/only therapy	<input type="radio"/>	<u>    </u> /	<u>2</u> <u>0</u>	<input type="radio"/>
f. Active Surveillance/Watchful Waiting	<input type="radio"/>	<u>    </u> /	<u>2</u> <u>0</u>	<input type="radio"/>
g. No therapy, have not decided yet	<input type="radio"/>	<u>    </u> /	<u>2</u> <u>0</u>	<input type="radio"/>
h. Other therapy (Please specify):	<input type="radio"/>	<u>    </u> /	<u>2</u> <u>0</u>	<input type="radio"/>

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### General Health Questions

3. Have you **ever** had any additional cancers diagnosed (see below)? Do **not** include prostate cancer or non-melanoma skin cancer.

- No (If No, please go to Question 4)
- Yes

If yes, please indicate which cancers you had: (Choose one response on each line)

	Yes	No
a. Colon or rectal cancer	<input type="radio"/>	<input type="radio"/>
b. Lung cancer	<input type="radio"/>	<input type="radio"/>
c. Kidney cancer	<input type="radio"/>	<input type="radio"/>
d. Bladder cancer	<input type="radio"/>	<input type="radio"/>
e. Lymphoma or leukemia	<input type="radio"/>	<input type="radio"/>
f. Stomach cancer	<input type="radio"/>	<input type="radio"/>
g. Pancreatic cancer	<input type="radio"/>	<input type="radio"/>
h. Mouth or oral cancer	<input type="radio"/>	<input type="radio"/>
i. Melanoma	<input type="radio"/>	<input type="radio"/>
j. Liver cancer	<input type="radio"/>	<input type="radio"/>
k. Other cancer, please specify:	<input type="radio"/>	<input type="radio"/>

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4. Have you **ever** been told by a physician that you have any of the following problems with your breathing? (*Choose one response on each line*)

	No	Yes
a. Emphysema or chronic bronchitis	<input type="radio"/>	<input type="radio"/>
b. Asthma	<input type="radio"/>	<input type="radio"/>

5. During the **past 6 months**, how many times did you have each of the following? (*Choose one response on each line*)

	Never	Once	Twice	Three or More Times
a. Pneumonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Bronchitis for which you took antibiotics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Flu, with coughing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. During the **past 6 months**, how often did you feel short of breath? (*Choose one response on each line*)

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. When lying down flat	<input type="radio"/>				
b. When sitting or resting	<input type="radio"/>				
c. When walking less than one block	<input type="radio"/>				
d. When climbing one flight of stairs	<input type="radio"/>				
e. When climbing several flights of stairs	<input type="radio"/>				

7. Have you **ever** been told by a physician that you have any of the following problems related to your heart or circulation? (*Choose one response on each line*)

	No	Yes
a. Heart attack	<input type="radio"/>	<input type="radio"/>
b. Congestive heart failure	<input type="radio"/>	<input type="radio"/>
c. Angina	<input type="radio"/>	<input type="radio"/>



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8. Have you **ever** been told by a physician that you have high blood pressure?

- No (If No, please go to Question 9)
- Yes
- Don't know

**If yes, please answer the following:**

a. How many years have you had high blood pressure?

- Less than 5 years
- 5-9 years
- 10 years or more
- Don't know

b. During the **past 6 months**, did you take medication for your high blood pressure?

- Yes, and the medication controlled my high blood pressure
- Yes, but my blood pressure is still high
- No, I did not take any medication for high blood pressure

9. Have you **ever** had any of the following operations or procedures related to your heart? (Choose one response on each line)

	No	Yes
a. Coronary artery bypass surgery (open heart surgery)	<input type="radio"/>	<input type="radio"/>
b. Coronary angioplasty (balloon or stent)	<input type="radio"/>	<input type="radio"/>
c. Heart catheterization (angiogram)	<input type="radio"/>	<input type="radio"/>
d. Exercise test (stress test)	<input type="radio"/>	<input type="radio"/>
e. Pacemaker/defibrillator insertion	<input type="radio"/>	<input type="radio"/>



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10. During the **past 6 months**, how many times have you had any of the following problems related to your heart or circulation? (Choose one response on each line)

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Chest pain or pressure when you exercise	<input type="radio"/>				
b. Chest pain or pressure when resting	<input type="radio"/>				
c. Ankles or legs that swell as the day goes on	<input type="radio"/>				
d. Fainting or dizziness when you stand up	<input type="radio"/>				

11. During the **past 6 months**, how often have you had pain in your back or joints? (Choose one response on each line)

	Never	Once or twice only	About once a month	Almost every week	More than once a week
a. That lasted at least half a day	<input type="radio"/>				
b. That kept you from sleeping	<input type="radio"/>				
c. That kept you from exercising or doing vigorous activities	<input type="radio"/>				

12. Have you **ever** been told by a physician that you have any of the following problems with your feet or legs? (Choose one response on each line)

	No	Yes
a. Peripheral vascular disease (poor circulation in the legs)	<input type="radio"/>	<input type="radio"/>
b. Claudication (cramping in the calf during exercise)	<input type="radio"/>	<input type="radio"/>
c. Peripheral neuropathy (numbness, tingling, or burning in the feet)	<input type="radio"/>	<input type="radio"/>
d. Foot ulcers	<input type="radio"/>	<input type="radio"/>



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13. Have you **ever** been told by a physician that you have any of the following problems? (Choose one response on each line)

	No	Yes
a. Stroke	<input type="radio"/>	<input type="radio"/>
b. Transient ischemic attack (TIA)	<input type="radio"/>	<input type="radio"/>
c. Epilepsy or seizure disorder	<input type="radio"/>	<input type="radio"/>
d. Parkinson's Disease	<input type="radio"/>	<input type="radio"/>
e. Migraines	<input type="radio"/>	<input type="radio"/>

14. Have you **ever** had any of the following problems? (Choose one response on each line)

	No	Yes
a. Paralysis or weakness on one side of the body	<input type="radio"/>	<input type="radio"/>
b. Lost the ability to talk	<input type="radio"/>	<input type="radio"/>

15. Have you **ever** been told by a physician that you have any of the following problems with your eyes? (Choose one response on each line)

	No	Yes
a. Cataracts (clouding of the lens of the eye)	<input type="radio"/>	<input type="radio"/>
b. Glaucoma	<input type="radio"/>	<input type="radio"/>
c. Blurred vision (not correctable with eye glasses)	<input type="radio"/>	<input type="radio"/>
d. Retinopathy or macular degeneration	<input type="radio"/>	<input type="radio"/>

16. Have you **ever** had any of the following operations on your eyes? (Choose one response on each line)

	No	Yes, on ONE eye only	Yes, on BOTH eyes
a. Cataract surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Laser treatment for diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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17. Have you **ever** been told by a physician that you have diabetes?

- No *(If No, please go to Question 18)*
- Yes
- Don't know

**If yes, please answer the following:**

**a.** How many years have you had diabetes?

- Less than 5 years
- 5-9 years
- 10 years or more
- Don't know

**b.** Do you take insulin shots?

- No
- Yes
- Don't know

18. Have you **ever** been told by a physician that you have inflammatory bowel disease (Crohn's Disease, ulcerative colitis)?

- No
- Yes
- Don't know



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## General Health

19. The following items are activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (*Choose one response on each line*)

	Yes, I am LIMITED a lot	Yes, I am LIMITED a little	No, I am NOT LIMITED at all
a. <u>Vigorous activities</u> , such as running, lifting heavy objects, participating in strenuous sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Lifting or carrying groceries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Climbing <u>several</u> flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Climbing <u>one</u> flight of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Bending, kneeling, or stooping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Walking <u>more than a mile</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Walking <u>several hundred yards</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Walking <u>one hundred yards</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Bathing or dressing yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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20. These questions are about how you feel and how things have been going 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 **past 4 weeks** ...  
(Choose one response on each line)

	<u>None</u> of the time	A <u>little</u> of the time	<u>Some</u> of the time	A <u>good</u> <u>bit</u> of the time	<u>Most</u> of the time	<u>All</u> of the time
a. Did you feel full of life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you been very nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Have you felt so down in the dumps that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Have you felt down-hearted and depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Did you feel worn out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Have you been happy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Did you feel tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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21. During the **past 4 weeks** how often were the following statements true?  
(Choose one response on each line)

	<u>None of</u> the time	<u>Some or</u> a <u>little</u> of the time	<u>Occasionally</u>	<u>Most or all</u> of the time
a. I was bothered by things that usually don't bother me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I felt that I could not shake off the blues even with help from my family or friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I had trouble keeping my mind on what I was doing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I felt depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I felt that everything I did was an effort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. My sleep was restless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I was happy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I enjoyed life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I felt sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Specific Health Issues

### Urinary Issues

22. Over the **past 4 weeks**, how often have you leaked urine? (*Choose one*)
- More than once a day
  - About once a day
  - More than once a week
  - About once a week
  - Rarely or never
23. Which of the following best describes your urinary control during the **last 4 weeks**? (*Choose one*)
- No urinary control whatsoever
  - Frequent dribbling
  - Occasional dribbling
  - Total control
24. How many pads or adult diapers per day did you usually use to control leakage during the **last 4 weeks**? (*Choose one*)
- None
  - 1 pad per day
  - 2 pads per day
  - 3 or more pads per day



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25. How big a problem, if any, has each of the following been for you during the **last 4 weeks**? (Choose one response on each line)

	No problem	Very small problem	Small problem	Moderate problem	Big problem
a. Dripping or leaking urine	<input type="radio"/>				
b. Pain or burning on urination	<input type="radio"/>				
c. Bleeding with urination	<input type="radio"/>				
d. Weak urine stream or incomplete emptying	<input type="radio"/>				
e. Need to urinate frequently during the day	<input type="radio"/>				

26. Overall, how big a problem has your urinary function been for you during the **last 4 weeks**? (Choose one)

- No problem
- Very small problem
- Small problem
- Moderate problem
- Big problem

### Bowel Issues

27. How big a problem, if any, has each of the following been for you during the **last 4 weeks**? (Choose one response on each line)

	No problem	Very small problem	Small problem	Moderate problem	Big problem
a. Urgency to have a bowel movement	<input type="radio"/>				
b. Increased frequency of bowel movements	<input type="radio"/>				
c. Losing control of your stools	<input type="radio"/>				
d. Bloody stools	<input type="radio"/>				
e. Abdominal/Pelvic/Rectal pain	<input type="radio"/>				



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28. Overall, how big a problem have your bowel habits been for you during the **last 4 weeks**? (Choose one)

- No problem
- Very small problem
- Small problem
- Moderate problem
- Big problem

Sexual Issues

29. Do you have a sexual partner at this time?

- Yes
  - No
- Regardless of your answer to this question, please try to answer the questions below**

30. Do you currently use any of the following to help with problems with sexual function? (Choose one response on each line)

	Yes	No
a. Vacuum suction device?	<input type="radio"/>	<input type="radio"/>
b. Penile injections (shots)?	<input type="radio"/>	<input type="radio"/>
c. Pills, such as Viagra, Cialis, Levitra?	<input type="radio"/>	<input type="radio"/>
d. Urethral pellets or suppositories (Muse)?	<input type="radio"/>	<input type="radio"/>
e. Penile prosthesis?	<input type="radio"/>	<input type="radio"/>

31. How would you rate each of the following during the **last 4 weeks**? (Choose one response on each line)

	Very poor to none	Poor	Fair	Good	Very good
a. Your ability to have an erection?	<input type="radio"/>				
b. Your ability to reach orgasm (climax)?	<input type="radio"/>				



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32. How would you describe the usual QUALITY of your erections during the **last 4 weeks**? (*Choose one*)
- None at all
  - Not firm enough for any sexual activity
  - Firm enough for masturbation and foreplay only
  - Firm enough for intercourse
33. How would you describe the FREQUENCY of your erections during the **last 4 weeks**? (*Choose one*)
- I NEVER had an erection when I wanted one
  - I had an erection LESS THAN HALF the time I wanted one
  - I had an erection ABOUT HALF the time I wanted one
  - I had an erection MORE THAN HALF the time I wanted one
  - I had an erection WHENEVER I wanted one
34. Overall, how would you rate your ability to function sexually during the **last 4 weeks**? (*Choose one*)
- Very poor
  - Poor
  - Fair
  - Good
  - Very good
35. Overall, how big a problem has your sexual function or lack of sexual function been for you during the **last 4 weeks**? (*Choose one*)
- No problem
  - Very small problem
  - Small problem
  - Moderate problem
  - Big problem



Hormonal Issues

36. How big a problem during the **last 4 weeks**, if any, has each of the following been for you? (Choose one response on each line)

	No problem	Very small problem	Small problem	Moderate problem	Big problem
a. Hot flashes	<input type="radio"/>				
b. Breast tenderness/enlargement	<input type="radio"/>				
c. Feeling depressed	<input type="radio"/>				
d. Lack of energy	<input type="radio"/>				
e. Change in body weight	<input type="radio"/>				

**Concerns Surrounding Impact of Prostate Cancer**

37. Overall, how much of a burden is your having prostate cancer on you and your family in each of the following areas? (Choose one response on each line)

	<u>Very large</u> burden	<u>Large</u> burden	Feel <u>neutral</u>	<u>Small</u> burden	<u>Very small</u> burden	<u>Not a</u> burden at all
a. Our overall health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Our social activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Our lifestyle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Our finances in general	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Our finances due to the cost of my treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Our finances due to the other costs of health care for prostate cancer (such as visits to the doctor, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Our finances due to the cost of my health insurance because I have prostate cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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38. How true has each of the following statements been for you during the **past 4 weeks**? (Choose one response on each line)

	Not at all	A little bit	Somewhat	Quite a bit	Very much
a. I am confident that my cancer is under control	<input type="radio"/>				
b. I worry that my cancer might come back	<input type="radio"/>				
c. I worry about my cancer spreading	<input type="radio"/>				
d. I wonder whether the treatment I got for prostate cancer really worked	<input type="radio"/>				
e. It worries me that I can't tell what is going on with my prostate cancer	<input type="radio"/>				

**Satisfaction with Care**

39. What is your overall feeling about the ... (Choose one response on each line)

	Completely Satisfied	Very Satisfied	Somewhat Satisfied	Mixed	Somewhat Unsatisfied	Very Unsatisfied	Completely Unsatisfied
a. Effect of health care services in helping you deal with your cancer and maintain your well-being?	<input type="radio"/>						
b. Effect of cancer treatment in preventing cancer progression or recurrence?	<input type="radio"/>						
c. Quality of cancer care you have received?	<input type="radio"/>						
d. Effect of services in helping relieve symptoms or reduce problems?	<input type="radio"/>						
e. In an overall general sense, how satisfied are you with the cancer treatment you have received?	<input type="radio"/>						



**Problems/Complications**

**40.** Did you have any problems from your prostate cancer treatment?

Yes *(If Yes, choose all that apply below)*

No *(If No, please go to Question 41)*

	Yes	No
<b>a.</b> Urethral scarring/stricture	<input type="radio"/>	<input type="radio"/>
<b>b.</b> Infections	<input type="radio"/>	<input type="radio"/>
<b>c.</b> Pneumonia	<input type="radio"/>	<input type="radio"/>
<b>d.</b> Deep venous thrombosis/pulmonary embolism/blood clots	<input type="radio"/>	<input type="radio"/>
<b>e.</b> Hernia	<input type="radio"/>	<input type="radio"/>
<b>f.</b> Other, please specify:	<input type="radio"/>	<input type="radio"/>

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**41.** Since receiving treatment for your prostate cancer, have you been admitted to the hospital for any prostate cancer-related issues?

Yes

No



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42. Which of the following health professionals have you seen in the **last 6 months**? Please do not include any visits while you were in the hospital or for receiving a medication injection only. (Choose one response on each line)

	Yes	No
a. Primary Physician, Internist or General Practitioner	<input type="radio"/>	<input type="radio"/>
b. Urologist	<input type="radio"/>	<input type="radio"/>
c. Medical Oncologist (cancer specialist)	<input type="radio"/>	<input type="radio"/>
d. Radiation Oncologist/Radiologist, Radiation Technician/Therapist for treatment	<input type="radio"/>	<input type="radio"/>
e. Mental Health Professional (psychiatrist, psychologist, etc.)	<input type="radio"/>	<input type="radio"/>
f. Nurse Practitioner or Physician's Assistant	<input type="radio"/>	<input type="radio"/>
g. Gastroenterologist, Proctologist (digestive tract specialist)	<input type="radio"/>	<input type="radio"/>
h. Cardiologist (heart disease specialist)	<input type="radio"/>	<input type="radio"/>
i. Optometrist, Ophthalmologist (eye specialist)	<input type="radio"/>	<input type="radio"/>
j. Dermatologist (skin specialist)	<input type="radio"/>	<input type="radio"/>
k. Allergist	<input type="radio"/>	<input type="radio"/>
l. Ear, Nose and Throat physician	<input type="radio"/>	<input type="radio"/>
m. Orthopedist (bone specialist)	<input type="radio"/>	<input type="radio"/>
n. Podiatrist (foot specialist)	<input type="radio"/>	<input type="radio"/>
o. Neurologist (nervous system specialist)	<input type="radio"/>	<input type="radio"/>
p. Other Physicians (please specify, for example: pain clinic, pulmonologist): _____	<input type="radio"/>	<input type="radio"/>
q. Chiropractor	<input type="radio"/>	<input type="radio"/>
r. Other Health Workers (please specify, e.g: dietician, physical therapist, social worker): _____	<input type="radio"/>	<input type="radio"/>



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43. What is your current employment status? (*Choose all that apply*)
- Working full time
  - Working part time
  - Retired
  - Unemployed (or looking for work)
44. How do you describe yourself? (*Choose one*)
- White/Caucasian (not Latino/Hispanic)
  - Black/African-American (not Latino/Hispanic)
  - Latino/Hispanic/Mexican-American
  - Asian/Oriental/Pacific Islander
  - American Indian/Native Alaskan
  - Other, please specify: \_\_\_\_\_
45. What is your approximate annual combined household income? (*Choose one*)
- Less than \$10,000
  - \$10,000 – \$30,000
  - \$30,001 - \$50,000
  - \$50,001 – \$100,000
  - More than \$100,000
46. How much school did you complete? (*Choose one*)
- Grade school or less
  - Some high school or technical school
  - High school or technical school graduate
  - Some college
  - College graduate
  - Graduate or professional school after college



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47. What is your current marital status? *(Choose one)*

- Never married
- Married
- Separated
- Divorced
- Widowed

48. What type of health insurance or health care coverage do you currently have?  
*(Choose all that apply)*

- No insurance
- Private health insurance or HMO
- Medicare
- Veteran's Administration (VA) Health Care
- Military health care (including CHAMPUS/TriCARE, CHAMP-VA)
- Medicaid
- Indian Health Service, Tribal Health Program, or Urban Indian Clinic
- Don't know
- Other, please specify: \_\_\_\_\_

**Thank you very much for your participation. Please mail the survey back in the enclosed postage paid envelope. If you have any questions, please contact:**