

Informed Consent

The Wellness Program would like to learn more about the impact of the pandemic on your health, well-being, work, and coronavirus attitudes and behaviors. Results of the survey will aid the Wellness Program in providing wellness related opportunities and resources to support you and other members of campus. The survey will take approximately 15 minutes of your time, and is entirely confidential. At no time are you required to answer any questions that you don't feel comfortable answering. By indicating below you consent to participate in the study and agree that the purpose of this study has been satisfactorily explained to you. You also consent to allow your data to be used in future research. You understand you are free to discontinue participation at any time if you so choose and that the researchers will gladly answer any questions that may arise during the course of the research.

You may contact wellness@luther.edu if you have any questions or concerns about the survey.

Luther College has a Standing Committee, the HSRB, to which complaints or problems concerning any research project may, and should, be reported to The Dean's Office, Luther College, 563-387-1005 if they arise.

- ☐ Yes, I consent to participate in this survey.
- ☐ No, I do not consent to participate in this survey.

Demographics

What is your gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Non-binary
- ☐ Other

What is your age in years?

How would you describe your relationships status? Select all that apply.

- ☐ Married
- ☐ Partnered
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Single

☐ Other

How many children under the age of 18 and/or other dependents do you have?

What is your racial/ethnic identity?

Which of the following best describes your work at Luther?

- ☐ Faculty
- ☐ Staff
- ☐ Staff with teaching responsibilities
- ☐ Faculty with administrative assignment

Which of the following best describes your work appointment?

- ☐ Exempt staff (salaried pay)
- ☐ Non-exempt staff (hourly pay)
- ☐ Faculty

Are you a supervisor of staff or faculty?

- ☐ Yes
- ☐ No

Are you a supervisor of student staff?

- ☐ Yes
- ☐ No

What is your FTE (full time equivalency) if known. For example, 1.0 (40 hrs/week), .92, .83., .50 (20 hours/week), etc

	0	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
FTE											

How long is your typical commute time to campus in minutes?

	0	10	20	30	40	50	60	70	80	90	100
Commute time in minutes											

Work Schedule

Are you scheduled to work during July?

- ☐ Yes
- ☐ No

Are you scheduled to work during June?

- ☐ Yes
- ☐ No

What time are you typically scheduled to start and end work each day?

Start Time (ex. 8:00 a.m.)

End Time (ex. 5:00 p.m.)

Where did you work from during the Spring of 2020, Summer of 2020, and Fall of 2020 throughout the pandemic?

	On-Campus	Remote	A combination of on-campus and remote work
Spring 2020	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Summer 2020	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fall 2020	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you worked a combination of on-campus and remote work please estimate the number of hours on average each week worked on campus and remote.

	0	4	8	12	16	20	24	28	32	36	40
Average number of hours worked on-campus per week											
Average number of hours worked remote per week											

During times when much of the campus moved to remote work, have you flexed hours to times you aren't traditionally scheduled to work (i.e. early mornings, over lunch, evenings, weekends) to accommodate for changes in childcare or other circumstances?

- ☐ Yes
- ☐ No

During times when much of the campus moved to remote work have your traditional breaks (coffee break, lunch break, walk or workout break, etc.) changed? Select all that apply

- ☐ No, I don't take breaks
- ☐ No, my breaks have not changed
- ☐ Yes, I have taken less breaks
- ☐ Yes, I have taken more breaks
- ☐ Yes, the times at which I take breaks has changed

During times when much of the campus moved to remote work, have the activities you've engaged in during your breaks changed? Select all that apply

- ☐ Yes. Please describe how so:
- ☐ No

During times when much of the campus moved to remote work did you use PTO time you would not have typically used?

- ☐ Yes

☐ No

During times when much of the campus moved to remote work did you *not* use PTO time you would have typically used?

☐ Yes

☐ No

Work Life Balance

Since March of 2020, how would you describe the impact of the pandemic on your work life balance for the following areas?

[illegible]

Financial Health and Well-being

Since March of 2020, how would you describe the impact of the pandemic on your financial health and well-being in the following areas?

[illegible]

Physical Health and Well-being

Since March of 2020, how would you describe the impact of the pandemic on your physical health and well-being in the following areas?

[illegible]

Since March of 2020 and the pandemic, have any of the following occurred related to your medical care?

	Yes	No
Did you delay seeking medical treatment?	<input type="radio"/>	<input type="radio"/>
Were you unable to get an appointment for medical care?	<input type="radio"/>	<input type="radio"/>
Did you have an appointment, procedure, or surgery postponed.	<input type="radio"/>	<input type="radio"/>

Have you been, or do you plan to be, vaccinated for influenza with either a flu shot or nasal spray this fall?

- ☐ Yes, I have received my flu vaccine
- ☐ No, I have not received my flu vaccine but plan to receive it soon
- ☐ No, I do not plan to receive a flu vaccine

Emotional Health and Well-being

Since March of 2020, how would you describe the impact of the pandemic on your emotional health and well-being in the following areas?

[illegible]

	Extremely positive	Somewhat positive	Neither positive nor negative	Somewhat negative	Extremely negative	Does not apply
Difficulty concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self Care (eg. personal hygiene, engaging in hobbies and activities you enjoy, seeking out social support)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Management of diagnosed mental health conditions (eg. depressive disorders, anxiety disorders, substance use disorders)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Social Health (Relationships) and Well-being

Since March of 2020, how would you describe the impact of the pandemic on the health and well-being of the following relationships?

	Extremely positive	Somewhat positive	Neither positive nor negative	Somewhat negative	Extremely negative	Does not apply
Significant Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Children/Dependents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coworkers in your department	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colleagues in other departments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supervisor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employees reporting to you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Students	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Block 10

Please use the space provided to share any more information you'd like about the impacts of the pandemic on your physical, emotional, social, and financial health and well-being since March of 2020.

Work Impacts

Since March of 2020, how would you describe the impact of the pandemic on your work compared to the past?

	Much higher	Moderately higher	Slightly higher	About the same	Slightly lower	Moderately lower	Much lower

	Much higher	Moderately higher	Slightly higher	About the same	Slightly lower	Moderately lower	Much lower
Productivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Engagement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
New skills learned	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Process improvements (eg. new efficiencies, cost savings, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strategically discontinued tasks/programs no longer relevant or meaningful to objectives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Completed or started new tasks/programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Since the majority of campus moved to remote work what did you learn that you will take with you into your future work as campus operations return to normal? (eg. new skills, new perspective)

Since the majority of campus moved to remote work is there anything you would do differently in hindsight?

If campus needed to move to primarily remote work again what might you need to complete your work? (eg. technology, secure internet, software, etc)

Resources Utilized

Since March of 2020, did you access any of the following resources for health and well-being?

	Yes	No
Teledoc	<input type="radio"/>	<input type="radio"/>
Employee Assistance Program (EAP)	<input type="radio"/>	<input type="radio"/>
Health and Wellness Coaching	<input type="radio"/>	<input type="radio"/>
Therapy Assistance Online (TAO)	<input type="radio"/>	<input type="radio"/>

	Yes	No
Telemedicine Appointment	<input type="radio"/>	<input type="radio"/>
Real Appeal	<input type="radio"/>	<input type="radio"/>
Wellness Outlet	<input type="radio"/>	<input type="radio"/>
Linkedin Learning	<input type="radio"/>	<input type="radio"/>
CELT Workshops	<input type="radio"/>	<input type="radio"/>
TIAA CREF	<input type="radio"/>	<input type="radio"/>
Professional Listserves	<input type="radio"/>	<input type="radio"/>
Other, please specify if yes <input type="text"/>	<input type="radio"/>	<input type="radio"/>

COVID-19 Preventative Practices

There are currently several recommendations on how to prevent the spread of coronavirus. How often do you:

	Never	Sometimes	About half the time	Most of the time	Always
Use a hand sanitizer that contains at least 60% alcohol, if soap and water are not readily available.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoid touching your eyes, nose, and mouth with unwashed hands.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoid close contact with people who are sick.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Put distance between yourself and other people if COVID-19 is spreading in your community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cover your mouth and nose with a tissue when you cough or sneeze or use the inside of your elbow.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Throw used tissues in the trash.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
After coughing or sneezing, immediately wash your hands with soap and water for at least 20 seconds.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
After coughing or sneezing, if soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clean AND disinfect frequently touched surfaces (tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

As you may know, many people have recently died from a new disease known as the coronavirus. How worried are you that you or someone in your family will be exposed to coronavirus?

- ☐ Not worried at all
- ☐ Not too worried
- ☐ Somewhat worried
- ☐ Very worried

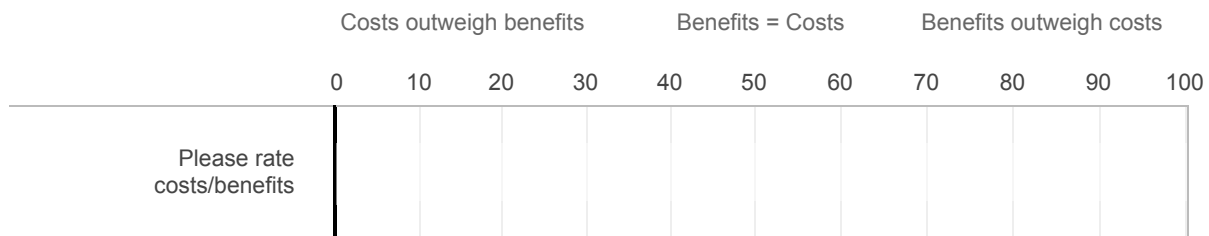
If you were to get sick from contracting the coronavirus, how severe would the sickness be?

- ☐ Not at all severe
- ☐ Not too severe
- ☐ Somewhat severe
- ☐ Very severe

How susceptible do you feel you are to getting sick from the coronavirus?

- ☐ Not at all susceptible
- ☐ Not too susceptible
- ☐ Somewhat susceptible
- ☐ Very susceptible

To what extent do the benefits of things like social distancing, quarantining, and lock downs outweigh the costs?



GENERAL INFORMATION (continued)

8. How would you rate your health, compared to other people your age?

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

9. How many days were you out sick last year?

- ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7 or more

10. How many times have you been seen in a doctor's office, clinic, emergency room, or hospital for your health in the past 12 months (other than for pregnancy visits)?

- ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7 or more

11. How many different prescription medications are you currently taking?

- ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7 or more

EATING HABITS

12. How often do you eat foods high in unhealthy fats, such as red meats, oils, fried foods, bakery goods, or high-fat dairy products?

- ☐ Less than once a week
☐ Once a week
☐ Several times a week
☐ Once a day
☐ Several times a day

13. How often do you eat foods that are high in fiber, such as whole-grain breads, cereals, pasta; beans; fresh fruits; or leafy vegetables?

- ☐ Less than once a week
☐ Once a week
☐ Several times a week
☐ Once a day
☐ Several times a day

14. Are you satisfied with your eating habits? If not, how do you feel about making changes to your eating habits?

- ☐ I am satisfied with my eating habits.
☐ I am already making changes to my eating habits.
☐ I intend to start making changes to my eating habits within the next 30 days.
☐ I intend to start making changes to my eating habits within the next 6 months.
☐ I have no plans to change my eating habits.

PHYSICAL ACTIVITY

15. On average, how often do you engage in *moderate* physical activity for 30 minutes or more? *Examples of moderate physical activity are brisk walking, cycling, vacuuming, and gardening. They cause some increase in breathing or heart rate.*

- ☐ Never ☐ 3 days per week ☐ 6 days per week
☐ 1 day per week ☐ 4 days per week
☐ 2 days per week ☐ 5 days per week ☐ Every day

16. On average, how often do you engage in *vigorous* physical activity for 20 minutes or more? *Examples of vigorous physical activity are heavy lifting, running, aerobics, and fast cycling. They cause a large increase in breathing or heart rate.*

- ☐ Never ☐ 3 days per week ☐ 6 days per week
☐ 1 day per week ☐ 4 days per week
☐ 2 days per week ☐ 5 days per week ☐ Every day

17. To what degree do your daily activities include repetitive bending or lifting, extensive vibration exposure, or long periods of sitting, standing, or driving?

- ☐ None ☐ Low ☐ Moderate ☐ High

18. To what degree does your health limit your ability to perform your usual daily activities?

- ☐ None ☐ Low ☐ Moderate ☐ High

19. Are you satisfied with your level of physical activity? If not, how do you feel about increasing your level of physical activity?

- ☐ I am satisfied with my level of physical activity.
☐ I am already increasing my level of physical activity.
☐ I intend to start increasing my level of physical activity within the next 30 days.
☐ I intend to start increasing my level of physical activity within the next 6 months.
☐ I have no plans to increase my level of physical activity.

20. Have you ever had a back or joint injury?

- ☐ No ☐ Yes

21. Do you suffer from recurring back pain?

- ☐ No
☐ Yes, but not at present.
☐ Yes, the current episode has lasted less than 6 weeks.
☐ Yes, the current episode has lasted 6-12 weeks.
☐ Yes, the current episode has lasted more than 12 weeks.

ALCOHOL USE

22. Do you ever drink alcoholic beverages?

- ☐ No → If no, skip this section and continue with question 26. ☐ Yes → If yes, continue with question 23.

23. How many alcoholic beverages do you drink in a typical week?

- ☐ None ☐ 1-7 ☐ 8-14 ☐ 15-21 ☐ More than 21

24. How many times in the past month did you have five or more drinks (men) or four or more drinks (women) in 2 hours or less?

- ☐ None ☐ Once ☐ More than once

25. Are you satisfied with your use of alcohol? If not, how do you feel about making changes to your alcohol consumption?

- ☐ I am satisfied with my use of alcohol.
☐ I am already making changes to my alcohol consumption.
☐ I intend to start making changes to my alcohol consumption within the next 30 days.
☐ I intend to start making changes to my alcohol consumption within the next 6 months.
☐ I have no plans to change my alcohol consumption.

SUBSTANCE ABUSE

26. How often do you use drugs or medications that affect your mood or help you relax? **Do NOT count medications you use according to your healthcare providers' instructions.**

- ☐ Almost every day ☐ Weekly ☐ Sometimes ☐ Rarely or never

TOBACCO USE

27. Do you smoke cigarettes?

- ☐ Yes, every day
☐ Yes, some days
 If Yes, go to question 28.
☐ No, I used to smoke but don't now. → Skip to question 31.
☐ No, I have never smoked. → Skip to question 34.

28. How many years have you smoked?

Years	
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

29. How many packs of cigarettes do you smoke per day?

- ☐ 0.5 packs or less
☐ 1.0 packs
☐ 1.5 packs
☐ 2.0 packs
☐ 2.5 packs
☐ 3.0 packs
☐ 3.5 packs
☐ 4.0 packs
☐ 4.5 packs
☐ 5.0 packs or more

31. How long has it been since you quit?

Years	
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

32. How many years did you smoke?

Years	
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

33. Before you quit, how many packs of cigarettes did you smoke per day?

- ☐ 0.5 packs or less
☐ 1.0 packs
☐ 1.5 packs
☐ 2.0 packs
☐ 2.5 packs
☐ 3.0 packs
☐ 3.5 packs
☐ 4.0 packs
☐ 4.5 packs
☐ 5.0 packs or more

30. How do you feel about quitting smoking?

- ☐ I intend to quit within the next 30 days.
☐ I intend to quit within the next 6 months.
☐ I have no plans to quit. → Skip to question 34.

34. Do you use any kind of smokeless tobacco, such as chewing tobacco, snuff, or pouches?

- ☐ Yes, every day
☐ Yes, some days → Go to question 35.
☐ No → Skip to question 36.

35. How do you feel about quitting your use of smokeless tobacco?

- ☐ I intend to quit within the next 30 days.
☐ I intend to quit within the next 6 months.
☐ I have no plans to quit.

EMOTIONAL HEALTH

36. How would you describe the stress in your daily life?

- ☐ None ☐ Low ☐ Moderate ☐ High

37. To what degree have you experienced major life changes in the last 12 months? **Changes would include someone close dying, a relationship ending, a job change, or money problems.**

- ☐ None ☐ Low ☐ Moderate ☐ High

38. In the past 2 weeks, how would you rate your overall mood on a scale from 1 (bad) to 10 (good)?

Bad ← → Good									
1	2	3	4	5	6	7	8	9	10

39. In the past year, have you received treatment or counseling because you felt low or depressed?

- ☐ Yes ☐ No

40. Do any of the following apply to the way you have felt in the past 2 weeks? **Please mark all that apply or select "None of the above."**

- ☐ I have felt downhearted, low, or sad.
☐ I haven't enjoyed the things I used to.
☐ I have been gaining or losing a significant amount of weight.
☐ I have been sleeping too much or too little.
☐ I have experienced a change in activity level.
☐ I have been feeling tired and lacking in energy.
☐ I have felt worthless or guilty.
☐ I have had trouble concentrating and making decisions.
☐ I have thought about death or suicide.
☐ None of the above.

41. To what degree, in the past 2 weeks, have your emotional problems interfered with your regular daily activities?

- ☐ None ☐ Low ☐ Moderate ☐ High

MOTOR VEHICLE SAFETY

42. How much of the time do you buckle your safety belt when driving or riding?

- ☐ Always ☐ Sometimes
☐ Usually ☐ Rarely or never

43. On average, how close to the speed limit do you usually drive?

- ☐ Within 5 mph of the limit
☐ 6-10 mph over the limit
☐ More than 10 mph over the limit
☐ I don't drive

44. How often do you drive or ride when the driver has perhaps had too much alcohol to drink or is under the influence of drugs?

- ☐ Almost every day ☐ Sometimes
☐ Weekly ☐ Rarely or never

45. If you ride a motorcycle, bicycle, horse, or all-terrain vehicle, how much of the time do you wear a helmet?

- ☐ Always ☐ Sometimes ☐ This doesn't apply to me
☐ Usually ☐ Rarely or never

46. If you travel in a motor vehicle with children, do they use an appropriate child seat?

- ☐ Always ☐ Sometimes ☐ This doesn't apply to me
☐ Usually ☐ Rarely or never

PERSONAL HEALTH HISTORY

47. Have you ever been exposed to asbestos?

- ☐ No ☐ Yes

48. Have you ever suffered from colorectal polyps or chronic inflammatory bowel disease (for example, ulcerative colitis, Crohn's disease)?

- ☐ No ☐ Yes ☐ Don't know

49. To what degree are you regularly exposed to smoke, chemicals, or other air pollutants?

- ☐ None ☐ Low ☐ Moderate ☐ High

50. Do you have fair (light-colored) skin that freckles or burns easily?

- ☐ No ☐ Yes

51. Do you have a vision impairment that requires special reading materials?

- ☐ No ☐ Yes

52. Do you have a hearing impairment that requires special equipment?

- ☐ No ☐ Yes

PERSONAL HEALTH MANAGEMENT

53. When did you last have a routine physical check?

- ☐ Don't know/Haven't had one ☐ 1-3 years ago
☐ In the last year ☐ More than 3 years ago

54. Have you had a flu shot in the past year?

- ☐ No ☐ Yes

55. When did you last have a blood pressure check?

- ☐ Don't know/Haven't had one ☐ 1-3 years ago
☐ In the last year ☐ More than 3 years ago

56. If you have had a blood pressure check, what was the result?

- ☐ Good ☐ Too high
☐ Borderline high ☐ Don't know

56a. What is your top number (Systolic)?

- ☐ Don't know

56b. What is your bottom number (Diastolic)?

- ☐ Don't know

57. When did you last have a cholesterol test?

- ☐ Don't know/Haven't had one ☐ 1-5 years ago
☐ In the last year ☐ More than 5 years ago

58. If you have had your cholesterol checked, what were the results?

- LDL ☐ Good ☐ Too high
☐ Borderline high ☐ Don't know

- HDL ☐ Good ☐ Too low
☐ Borderline low ☐ Don't know

- Total Cholesterol ☐ Good ☐ Too high
☐ Borderline high ☐ Don't know

- Triglycerides ☐ Good ☐ Too high
☐ Borderline high ☐ Don't know

59. When did you last have a fasting blood sugar test?

- ☐ Don't know/Haven't had one ☐ 1-3 years ago
☐ In the last year ☐ More than 3 years ago

60. If you have had your blood sugar checked, what was the result?

- ☐ Good ☐ Too high
☐ Borderline high ☐ Don't know

PERSONAL HEALTH MANAGEMENT (continued)

61. When did you last have a colonoscopy or sigmoidoscopy?

- ☐ Don't know/Haven't had one ☐ More than 10 years ago
☐ In the last 10 years

62. Do you wear sunscreen when you are in the sun?

- ☐ Rarely or never ☐ Usually
☐ Sometimes ☐ I am rarely in the sun

63. Do you wear protective clothing when you are in the sun?

- ☐ Rarely or never ☐ Usually
☐ Sometimes ☐ I am rarely in the sun

WOMEN ONLY

64. Are you pregnant or do you plan on becoming pregnant in the next 12 months?

- ☐ No ☐ Yes, currently pregnant
☐ Yes, planning on becoming pregnant

65. Have you ever suffered from gestational diabetes or delivered a baby weighing more than 9 lbs?

- ☐ No ☐ Yes

66. Have you ever been treated with radiation to the chest or neck?

- ☐ No ☐ Yes

67. When did you last have a Pap smear test and pelvic examination?

- ☐ Don't know/Haven't had one ☐ 1-2 years ago
☐ In the last year ☐ More than 2 years ago

68. Do you examine your breasts for lumps?

- ☐ Never ☐ Sometimes ☐ At least once a month

69. When did you last have a breast exam by a trained healthcare professional?

- ☐ Don't know/Haven't had one ☐ 1-3 years ago
☐ In the last year ☐ More than 3 years ago

70. When did you last have a mammogram (breast x-ray)?

- ☐ Don't know/Haven't had one ☐ 1-2 years ago
☐ In the last year ☐ More than 2 years ago

71. Have you ever had a breast biopsy?

- ☐ No ☐ Yes, benign tumor
☐ Yes, negative ☐ Yes, malignant tumor
☐ Yes, atypical hyperplasia ☐ Yes, result unknown

MEN ONLY

72. Have you ever had an undescended testicle?

- ☐ No ☐ Yes

73. Do you examine your testicles for lumps?

- ☐ Never ☐ Sometimes ☐ At least once a month

74. When did you last have a prostate-specific antigen (PSA) test?

- ☐ Don't know/Haven't had one ☐ 1-3 years ago
☐ In the last year ☐ More than 3 years ago

74a. If so, what was the result? ng/mL ☐ Don't know

WORKPLACE PRODUCTIVITY

If you are employed either part-time or full-time, please answer questions 75-85.

75. About how many hours altogether did you work in the past 7 days?

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Hours

76. How many hours does your employer expect you to work in a typical 7-day week? If it varies, estimate the average.

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Hours

In the past 4 weeks:

77. How often did you miss an entire work day because of problems with your physical or mental health?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

Days

78. How often did you miss an entire work day for any other reason? Do not include approved time off.

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

Days

WORKPLACE PRODUCTIVITY (continued)

In the past 4 weeks:

79. How often did you miss *part* of a work day because of problems with your physical or mental health?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

Days

80. How often did you miss *part* of a work day for any other reason? **Do not include approved time off.**

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

Days

81. How often did you come in early, go home late, or work on your day off?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

Days

82. About how many hours altogether did you work in the past 4 weeks? **Include approved time off as work hours.** (40 hours per week = 160 hours; 35 hours per week = 140 hours)

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Hours

On a scale from 0 to 10 where 0 is the worst job performance anyone could have at your job and 10 is the performance of a top worker:

83. How would you rate the usual performance of *most* workers in a job similar to yours?

Worst job performance ← → Top Worker
0 1 2 3 4 5 6 7 8 9 10

84. How would you rate your *usual* job performance over the past year or two?

0 1 2 3 4 5 6 7 8 9 10

85. How would you rate your *overall* job performance on the days you worked during the *past 4 weeks*?

0 1 2 3 4 5 6 7 8 9 10

EXISTING MEDICAL CONDITIONS

86. Has a doctor ever told you that you have any of the following conditions? **Please mark all that apply or select "None of the above."**

- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain
- ☐ Cancer
- ☐ Chronic kidney disease
- ☐ Chronic obstructive pulmonary disease (COPD, emphysema, or chronic bronchitis)
- ☐ Depression
- ☐ Diabetes (other than during pregnancy)
- ☐ Digestive problems
- ☐ Heart disease (CAD, angina, heart attack)
- ☐ Heart failure (CHF)
- ☐ High blood pressure (hypertension, other than during pregnancy)
- ☐ High cholesterol
- ☐ Osteoporosis (bone loss)
- ☐ Sleep problems
- ☐ Stroke
- ☐ None of the above

87. Are you currently taking prescription medications for any of the following conditions? **Please mark all that apply or select "None of the above."**

- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain
- ☐ Cancer
- ☐ Chronic kidney disease
- ☐ Chronic obstructive pulmonary disease (COPD, emphysema, or chronic bronchitis)
- ☐ Depression
- ☐ Diabetes (other than during pregnancy)
- ☐ Digestive problems
- ☐ Heart disease (CAD, angina, heart attack)
- ☐ Heart failure (CHF)
- ☐ High blood pressure (hypertension, other than during pregnancy)
- ☐ High cholesterol
- ☐ Osteoporosis (bone loss)
- ☐ Sleep problems
- ☐ Stroke
- ☐ None of the above

→ If "None of the above," you do not need to answer any more questions; your assessment is now complete.

ARTHRITIS - If you filled in the oval for Arthritis in question 86 on the previous page, please complete this section.

88. To what degree does joint pain/swelling limit your ability to perform such daily activities as walking, bathing, and dressing?

- ☐ None ☐ Moderate
☐ Low ☐ High

89. How long does your morning stiffness last from the time you wake up?

- ☐ Less than 30 minutes ☐ More than 60 minutes
☐ 30-60 minutes

90. Is your arthritis in good control? If not, how do you feel about making changes to the way your arthritis is managed?

- ☐ My arthritis is in good control.
☐ I am already making changes to the way my arthritis is managed.
☐ I would like to make changes to the way my arthritis is managed within the next 30 days.
☐ I would like to make changes to the way my arthritis is managed within the next 6 months.
☐ I have no plans to change the way my arthritis is managed.

ASTHMA - If you filled in the oval for Asthma in question 86 on the previous page, please complete this section.

91. In the past 4 weeks, how often did your asthma symptoms affect you during the day?

- ☐ Never ☐ Every day
☐ Twice a week or less ☐ Continuously
☐ 3-6 days per week ☐ Only when I exercise

92. In the past 4 weeks, how many times did your asthma wake you at night?

- ☐ Never ☐ More than 4 times
☐ Once ☐ Frequently
☐ 2-4 times

93. How many times have you refilled your short-acting inhaler in the past month?

- ☐ None ☐ More than once
☐ Once ☐ I don't have a short-acting inhaler

94. In the past 6 months, have you been to the emergency room for your asthma?

- ☐ No ☐ Yes

95. In the past 6 months, have you been hospitalized for your asthma?

- ☐ No ☐ Yes

96. Is your asthma in good control? If not, how do you feel about making changes to the way your asthma is managed?

- ☐ My asthma is in good control.
☐ I am already making changes to the way my asthma is managed.
☐ I would like to make changes to the way my asthma is managed within the next 30 days.
☐ I would like to make changes to the way my asthma is managed within the next 6 months.
☐ I have no plans to change the way my asthma is managed.

CANCER - If you filled in the oval for Cancer in question 86 on the previous page, please complete this section.

97. Which of the following types of cancer have you had? Please mark all that apply.

- ☐ Breast ☐ Colorectal (colon or rectum) ☐ Lung ☐ Skin ☐ Other

COPD - If you filled in the oval for COPD in question 86 on the previous page, please complete this section.

98. To what degree does your COPD impact your daily activities?

- ☐ None ☐ Moderate
☐ Low ☐ High

101. In the past 12 months, have you been hospitalized for your COPD?

- ☐ No ☐ Yes, in the last 6 months
☐ Yes, 6-12 months ago

99. Describe the severity of your COPD symptoms during your usual daily activities.

- ☐ None ☐ Moderate
☐ Mild ☐ Severe – symptoms at rest

102. Is your COPD in good control? If not, how do you feel about making changes to the way your COPD is managed?

- ☐ My COPD is in good control.
☐ I am already making changes to the way my COPD is managed.
☐ I would like to make changes to the way my COPD is managed within the next 30 days.
☐ I would like to make changes to the way my COPD is managed within the next 6 months.
☐ I have no plans to change the way my COPD is managed.

100. In the past 12 months, have you been to the emergency room for your COPD?

- ☐ No ☐ Yes, in the last 6 months
☐ Yes, 6-12 months ago

DIABETES - If you filled in the oval for Diabetes in question 86 on the previous page, please complete this section.

103. What type of diabetes do you have?

- ☐ Type 1 ☐ Type 2 ☐ Don't know

104. Have you had a hemoglobin A1c (HbA1c) test in the last year?

- ☐ No ☐ Yes ☐ Don't know

DIABETES (continued) - If you filled in the oval for Diabetes in question 86 on page 6, please complete this section.

105. If you have had a hemoglobin A1c test, what was the result?

- ☐ Good ☐ Too high
☐ Borderline ☐ Don't know

105a. Actual results, if known.

(range 0.0 to 20.0%)

%

106. Has your urine been tested for protein levels (microalbuminuria) in the past year?

- ☐ No ☐ Yes, result positive
☐ Yes, result negative ☐ Don't know
☐ Yes, result unknown

107. Is your diabetes in good control? If not, how do you feel about making changes to the way your diabetes is managed?

- ☐ My diabetes is in good control.
☐ I am already making changes to the way my diabetes is managed.
☐ I would like to make changes to the way my diabetes is managed within the next 30 days.
☐ I would like to make changes to the way my diabetes is managed within the next 6 months.
☐ I have no plans to change the way my diabetes is managed.

HEART DISEASE - If you filled in the oval for Heart Disease in question 86 on page 6, please complete this section.

108. Have you ever had any of the following cardiovascular procedures?

	No	Yes, in the last 6 months	Yes, 6-24 months ago	Yes, more than 24 months ago
a. Coronary artery bypass graft (CABG)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Coronary angioplasty or PTCA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Stent placement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Rotoblator	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Balloon procedure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

109. Is your heart disease in good control? If not, how do you feel about making changes to the way your heart disease is managed?

- ☐ My heart disease is in good control.
☐ I am already making changes to the way my heart disease is managed.
☐ I would like to make changes to the way my heart disease is managed within the next 30 days.
☐ I would like to make changes to the way my heart disease is managed within the next 6 months.
☐ I have no plans to change the way my heart disease is managed.

HEART FAILURE - If you filled in the oval for Heart Failure in question 86 on page 6, please complete this section.

110. To what degree does your heart failure impact your usual daily activities?

- ☐ None ☐ Moderate
☐ Low ☐ High

111. Describe the severity of your heart failure symptoms during your usual daily activities.

- ☐ None ☐ Moderate
☐ Mild ☐ Severe

112. In the past 6 months have you been to the emergency room for your heart failure?

- ☐ Yes ☐ No

113. In the past 6 months have you been hospitalized for your heart failure?

- ☐ Yes ☐ No

114. Is your heart failure in good control? If not, how do you feel about making changes to the way your heart failure is managed?

- ☐ My heart failure is in good control.
☐ I am already making changes to the way my heart failure is managed.
☐ I would like to make changes to the way my heart failure is managed within the next 30 days.
☐ I would like to make changes to the way my heart failure is managed within the next 6 months.
☐ I have no plans to change the way my heart failure is managed.

HIGH BLOOD PRESSURE - If you filled in the oval for High Blood Pressure in question 86 on page 6, please complete this section.

115. Is your blood pressure in good control? If not, how do you feel about making changes to the way your blood pressure is managed?

- ☐ My blood pressure is in good control.
☐ I am already making changes to the way my blood pressure is managed.
☐ I would like to make changes to the way my blood pressure is managed within the next 30 days.
☐ I would like to make changes to the way my blood pressure is managed within the next 6 months.
☐ I have no plans to change the way my blood pressure is managed.

Thank you for completing this assessment!