

DRAFT

Topics under Consideration for Redesigned National Health Interview Survey (NHIS)

Sample Adult Questionnaire

Version: June 19, 2017

	2019	2020	2021	2022	2023	2024	2025	2026	2027
	Household Roster - Selection of Sample Adult - Informed Consent								
Annual core content	Health Status - Hypertension - High Cholesterol - Cardiovascular Conditions Asthma - Cancer - Diabetes - Other Chronic Conditions - Height and Weight Difficulties with Vision, Hearing, Mobility, Communication, Cognition, and Self-Care Anxiety - Depression - Social Functioning Health Insurance Status and Continuity Financial Burden of Medical Care - Health Care Utilization and Access Prescription Medication - Immunizations Cigarettes and E-cigarettes Marital Status - Veteran Status - Nativity Schooling - Employment Family Income - Food-Related Program Participation - Housing Telephone Use - Linkage Information								
Rotating core	Dental, Mental, Other Care Utilization		Rotating Conditions	Dental, Mental, Other Care Utilization		Rotating Conditions	Dental, Mental, Other Care Utilization		Rotating Conditions
	Mental Health Assessment	Employment Detail - Injuries		Mental Health Assessment	Employment Detail - Injuries		Mental Health Assessment	Employment Detail - Injuries	
	Chronic Pain - Preventive Services	Health Behaviors	Chronic Pain - Preventive Services	Health Behaviors	Chronic Pain - Preventive Services	Health Behaviors	Chronic Pain - Preventive Services	Health Behaviors	Chronic Pain - Preventive Services
Sponsored content	Sustaining Sponsors								
	Content from sponsors that commit to supplements every year								
	2-year supplements		1-year supplements	2-year supplements		1-year supplements	2-year supplements		1-year supplements
	1-year supplements	2-year supplements		1-year supplements	2-year supplements		1-year supplements	2-year supplements	
	1-year supplements	1-year supplements	1-year supplements	1-year supplements	1-year supplements	1-year supplements	1-year supplements	1-year supplements	1-year supplements

DRAFT**Topics under Consideration for Redesigned National Health Interview Survey (NHIS)
Sample Adult Questionnaire**

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This document presents the topics currently under consideration by the National Center for Health Statistics (NCHS) for inclusion in the redesigned NHIS sample adult interview, including content to be included annually and content that will rotate on and off the questionnaire with a pre-established periodicity. Additional topics sponsored by federal partners will also be included in the sample adult interview but are not presented here. See http://www.cdc.gov/nchs/data/nhis/nhis_supplements_and_sponsors.pdf for a list of sponsored content from previous years (e.g., food security, flu immunization among pregnant women).

NCHS proposes that the redesigned questionnaire content focus on one “sample adult” aged 18 years or more and one “sample child” aged 17 years or less (if any children live in the household). These individuals will be randomly selected from each household following a brief screener that identifies the age, sex, race, and ethnicity of everyone who usually lives or stays in the household, as well as the educational attainment of all adults. Information about the sample adult will be collected from the sample adult him/herself unless he/she is physically or mentally unable to do so, in which case a knowledgeable proxy will be allowed to answer for the sample adult. Information about the sample child will be collected from a parent or adult who is knowledgeable about and responsible for the health care of the child. The respondent for the child may or may not be the sample adult.

The order of the two interviews (sample adult and sample child) will vary by household depending on the availability of the respondents. The relationship between the sample adult and sample child will be obtained to determine whether they are in the same family. When they are, content areas that refer to the family will be captured only once, in whichever interview comes first.

ANNUAL CORE CONTENT UNDER CONSIDERATION FOR HOUSEHOLD**Household roster**

- First name or alias of all persons living in household
- Age, sex, race, and Hispanic ethnicity for all persons
- Educational attainment for all adults age 18+
- Identification of parents (biological/step/adoptive/foster) for all children under age 18
- Identification of adults who are currently serving on active duty in the military
- Confirmation that all persons living in household have been included on roster

Selection of sample adult and sample child

One civilian adult and one child (if any) are randomly selected from each household

- Identification of all persons in sample adult’s family
 - If sample child is not in sample adult’s family:*
 - Identification of all persons in sample child’s family
- Identification of possible respondents for sample child interview

For NHIS, a family is defined as two or more persons residing together who are related by birth, marriage, or adoption, as well as any unrelated children who are cared for by the family (such as foster children) and any unmarried cohabiting partners and their children.

ANNUAL CORE CONTENT UNDER CONSIDERATION FOR SAMPLE ADULTS

Demographic characteristics

- Verification of age
- Date of birth
- Verification of sex, race, and ethnicity
 - If Hispanic, Asian, and/or Native Hawaiian or Pacific Islander:*
 - Specific ancestry (e.g., Mexican, Puerto Rican, Chinese, Filipino, Chamorro, Samoan)

Current health status (HIS)

- General health status: excellent, very good, good, fair, poor

Hypertension (HYP)

- Ever told by doctor or other health professional that you had hypertension
 - If yes:*
 - Told you have hypertension on 2 or more different visits
 - If yes:*
 - (Past 12 months) Had hypertension
 - (Currently) Taking prescription medication for hypertension

High cholesterol (CHL)

- Ever told by doctor or other health professional that you had high cholesterol
 - If yes:*
 - (Past 12 months) Had high cholesterol
 - (Currently) Taking prescription medication for high cholesterol

Cardiovascular chronic conditions (CVC)

- Ever told by doctor or other health professional that you had coronary heart disease
- Ever told by doctor or other health professional that you had angina
- Ever told by doctor or other health professional that you had heart attack
- Ever told by doctor or other health professional that you had stroke

Asthma (AST)

- Ever told by doctor or other health professional that you had asthma
 - If yes:*
 - Still have asthma
 - (Past 12 months) Had an episode of asthma or an asthma attack
 - (Past 12 months) Had an ER or urgent care visit due to asthma

Cancer (CAN)

- Ever told by doctor or other health professional that you had cancer
 - If yes:*
 - Kind(s) of cancer/location(s) (up to 3 types/locations)
 - Age(s) when each kind first diagnosed (up to 3 types/locations)

Diabetes (DIB)

- Ever told by doctor or other health professional that you had prediabetes

If female:

- Ever told by doctor or other health professional that you had gestational diabetes
- Ever told by doctor or other health professional that you had diabetes

If yes (diagnosed with diabetes other than prediabetes or when pregnant):

- Age when first diagnosed with (non-gestational, non-prediabetes) diabetes
- (Currently) Taking diabetic pills
- (Currently) Taking insulin
- Diabetes type: type 1, type 2, other

Other chronic conditions ever diagnosed by doctor or other health professional (CON)

- (Ever told) COPD, emphysema, or chronic bronchitis
- (Ever told) Arthritis, gout, lupus, or fibromyalgia
- (Ever told) Dementia, including Alzheimer's
- (Ever told) Anxiety disorder
- (Ever told) Depression

Body measurements (BMI)

If female and age 18-49:

- Are you currently pregnant?
- Self-reported weight (if currently pregnant, pre-pregnancy weight)
- Self-reported height

Vision (VIS)

- Use of eyeglasses or contact lenses
- Level of difficulty seeing (even with glasses or contact lenses)

Hearing (HEA)

- Use of hearing aid
- If yes:*
 - Frequency of hearing aid use
- Level of difficulty hearing (even with hearing aid)

Mobility (MOB)

- Level of difficulty walking or climbing steps
- Use of equipment or receipt of help for getting around
- If yes:*
 - Use of cane or walker
 - Use of wheelchair or scooter
 - Use of someone's assistance
- If yes and does not use wheelchair or scooter:*
 - Level of difficulty walking 100 yards when not using aids
 - Level of difficulty walking one-third mile when not using aids
 - Level of difficulty walking up or down 12 steps when not using aids
 - Level of difficulty walking 100 yards when using aids
 - Level of difficulty walking one-third mile when using aids
 - Level of difficulty walking up or down 12 steps

If no:

- Level of difficulty walking 100 yards
- Level of difficulty walking one-third mile
- Level of difficulty walking up or down 12 steps

Communication (COM)

- Level of difficulty communicating in usual language (e.g., understanding or being understood)

Cognition (COG)

- Level of difficulty remembering or concentrating

If any difficulty:

- Do you have difficulty remembering or concentrating or both?

If difficulty includes remembering:

- How often do you have difficulty remembering?
- Do you have difficulty remembering a few things, a lot of things, or almost everything?

Self-care and upper body (UPP)

- Level of difficulty with self-care such as washing or dressing
- Level of difficulty raising a 2-liter bottle
- Level of difficulty using hands and fingers

Anxiety (ANX)

- Frequency of feeling worried, nervous, or anxious
- (Currently) Taking medication for anxiety

If worried at least a few times per year or if taking medication:

- (Last time felt anxious) How anxious did you feel?

Depression (DEP)

- Frequency of feeling depressed
- (Currently) Taking medication for depression

If depressed at least a few times per year or if taking medication:

- (Last time felt depressed) How depressed did you feel?
-

Social functioning (SOC)

- Level of difficulty doing errands alone
- Level of difficulty participating in social activities
- Does a physical, mental, or emotional problem keep you from working?

If no:

- Does a physical, mental, or emotional problem limit kind or amount of work?

Health insurance coverage (INS)

- Any health insurance coverage or health care plan?
If yes:
 - Type of health insurance or health care coverage
- If 65 or older and does not report Medicare:*
 - Confirm no Medicare
- If under 65 and no insurance coverage reported:*
 - Confirm no Medicaid
- Do you have separate plan for dental services?
- Do you have separate plan for vision services?
- Do you have separate plan for prescriptions?
- Confirm no insurance or confirm all types of insurance coverage recorded

Specifics about current insurance coverage

If enrolled in Medicare:

- Enrollment in Part A, Part B, or both
- Medicare Advantage enrollment
- Medicare managed care arrangement
- If enrolled in Advantage or managed care:*
 - Name of Advantage or Medicare HMO plan (*open-ended*)
- Part D enrollment

If enrolled in Medicaid:

- Name of plan (*open-ended*)
- Was the plan obtained through healthcare.gov or Marketplace?
- Are you required to pay a premium?
- Is there a deductible?

If yes:

- Is it a high-deductible health plan?

If enrolled in a private plan:

(If sample child questionnaire is complete, adult and child are in same family, and sample child was enrolled in a private plan, ask if adult has same plan as child and adult's relationship to policyholder. If private plan is the same, skip this section.)

- Name of plan (*open-ended*)
- Any additional private plans?
- If yes:*
 - Name of second plan (*open-ended*)

The private plan questions will be repeated for second plan

- Are you the policyholder?
- If yes:*
 - Does the plan cover self-only or family?

If no:

- Relationship to policyholder
- How plan was obtained (employer, union, association, direct purchase, etc.)
- If plan was purchased directly or obtained through state/local government or community program:*
 - Was plan obtained through healthcare.gov or Marketplace?

- Who pays for plan? (self/family, employer, person outside household, government program, etc.)

If self/family pays for the plan:

- Out-of-pocket premium amount
- Is there a deductible?
 - If yes:*
 - Is it a high-deductible health plan?
 - If yes:*
 - Does it include a health savings account?
- Does it include prescription drug coverage?
- Does it include dental coverage?
- Does it include vision coverage?

If enrolled in CHIP, state-sponsored, and/or other government plan:

(Repeated for each type of CHIP, state-sponsored, and/or other government plan in which sample child is enrolled)

- Name of plan (*open-ended*)
- Was the plan obtained through healthcare.gov or Marketplace?
- Are you required to pay a premium?
- Is there a deductible?
 - If yes:*
 - Is it a high-deductible health plan?

If military health care:

- Type of plan (TRICARE, VA, CHAMP-VA)

Health insurance continuity

If currently uninsured:

- Length of time since last insured
 - If less than 12 months:*
 - (Past 12 months) Number of months without health insurance
 - If less than 3 years:*
 - What were the reason(s) you are no longer enrolled? Was it because...
 - You retired, lost a job, or changed employers
 - Missed a deadline to sign up
 - Ineligible for coverage because of age or leaving school
 - Cost increases
 - No longer eligible for Medicaid
- What are the reason(s) for not having health insurance? Was it because...
 - Coverage is unaffordable
 - Do not need or want coverage
 - Ineligible for coverage
 - Signing up is difficult
 - Cannot find a plan that meets needs
 - Applied for coverage that has not started yet
 - Other reason (*open-ended*)

If currently insured:

- (Past 12 months) Any time without health insurance

If yes:

- (Past 12 months) Number of months without health insurance

Financial burden of medical care (PAY)

Skip first question and follow-up if sample child questionnaire is complete and if adult and child are in same family

- (Past 12 months) Anyone in family have problems paying medical bills

If yes:

- (Currently) Anyone in family have medical bills unable to pay at all
- Level of worry about ability to pay medical bills if sick or injured

Health care utilization and access (UTZ)

- Time since last seen health professional
- Has a usual place for care when sick

If yes:

- Type of place / location
- (Past 12 months) Number of walk-in clinic, retail clinic, and urgent care center visits
- (Past 12 months) Number of ER visits
- (Past 12 months) Any overnight hospital stay
- (Past 12 months) Delayed getting medical care because of cost
- (Past 12 months) Did not get medical care because of cost

Prescription medications (PMD)

- (Past 12 months) Any medication prescribed

If yes:

- (Past 12 months) Skipped medication doses to save money
- (Past 12 months) Took less medicine to save money
- (Past 12 months) Delayed filling a prescription to save money
- (Past 12 months) Any medication needed that you didn't get due to cost

Immunizations (IMM)

- (Past 12 months) Flu shot

If yes:

- Month and year of most recent flu shot
- (Ever) Pneumonia shot

If yes:

- Number of pneumonia shots

Cigarette smoking and e-cigarettes (CIG)

- (Lifetime) Smoked 100 or more cigarettes

If yes:

- (Currently) Smoke every day, some days, or not at all

If current smoker and smoking everyday:

- (Typical day) Average number of cigarettes

If current smoker and smoking some days:

- (Past 30 days) Number of days smoked cigarettes
- (Past 30 days) Average number of cigarettes on days smoked any cigarettes

- (Lifetime) Used e-cigarette, even one time
If yes:
 - (Currently) Use e-cigarette every day, some days, or not at all

Marital status (FAM)

- Sexual orientation
- Married, living with partner as unmarried couple, or neither
If married:
 - Is your spouse living in the same household?
If yes:
 - Identification of spouse (*age, sex, and race/ethnicity will be known from roster*)
 - Confirmation of sex of sample adult and spouse
 - If no:*
 - Are you and spouse legally separated?
- If cohabiting:*
 - Identification of partner (*age, sex, and race/ethnicity will be known from roster*)
 - Confirmation of sex of sample adult and partner
 - Legal marital status
- If neither:*
 - Legal marital status

Veteran status (DEM)

- Veteran status
If ever served on active duty:
 - Ever served in a foreign country during armed conflict or on humanitarian mission?
 - Do you have a VA service-connected disability rating?
 - (Past 12 months) Received any care at Veteran's Health Administration facility or received any other health care paid for by the VA?

Nativity (NAT)

- Were you born in the United States or a US territory?
If yes:
 - State or territory of birth
- If no:*
 - What year did you come to the United States to stay?
 - US citizenship
If yes:
 - Naturalized, born to an American parent, or adopted by an American parent

Schooling (SCH)

- (Currently) Student status
If yes:
 - (Past 12 months) Number of school days missed due to your own illness/injury/disability

Employment (EMP)

- (Last week) Work for pay at a job or business

If yes:

- (Last week) Number of hours worked in total at all jobs/businesses

If worked less than 35 hours in past week:

- Usually work 35 hours or more per week in total in all jobs/businesses?

If no:

- (Last week) Have a job or business, but temporarily absent for some reason

If yes:

- Usually work 35 hours or more per week in total in all jobs/businesses?

If no:

- (Last week) Main reason not working

If not working for any reason besides working in a family business not for pay or does seasonal/contract work:

- Length of time since last held a job or worked at a business

If working at or had a paid job or business last week, if working in a family business not for pay, or if doing seasonal/contract work:

- Do/did you have paid sick leave?
- Is/was health insurance offered to you through workplace?

If working at or had a paid job or business last week, if working in a family business not for pay, if doing seasonal/contract work, or if not currently working but had a paid job or business in past 12 months:

- (Past 12 months) Number of work days missed due to your own illness/injury/disability

Employment of all adult family members (FEM)

Skip section if sample child questionnaire is complete and if adult and child are in same family, or if family size is one (sample adult is living alone or with unrelated roommates), or if family size is greater than one but there are no other adults in family.

Ask for each adult family member:

- (Currently) Work for pay at a job or business
- Usually work 35 hours or more per week in total in all jobs/businesses?

Family income and source(s) of income (INC)

Skip section if sample child questionnaire is complete and if adult and child are in same family. If family size is one (sample adult is living alone or with unrelated roommates), then questions are asked only about the sample adult's income and sources.

(Last calendar year) Did you or any family members living here receive:

- Income from wages, salaries, commissions, bonuses, tips, or self-employment?
- Income from interest, dividends, rent, royalties, or income from estates or trusts?
- Social Security or Railroad Retirement?
- Supplemental Security Income (SSI) or Social Security Disability Income (SSDI)?

If yes:

- Did you receive these benefits?

If yes:

- Was this because of your own disability?

- Any public assistance or welfare payments?
- Retirement, survivor, or disability pensions?
- Other income, such as VA payments, unemployment, child support, or alimony?

- (Last calendar year) Family income
If unknown or refused:
 - Cascading questions to categorize income relative to federal poverty thresholds based on family size

Family participation in food-related programs (FOO)

Skip section if sample child questionnaire is complete and if adult and child are in same family

- (Past 12 months) Anyone in family receive SNAP/food stamp benefits
If yes:
 - (Past 30 days) Anyone in family receive SNAP/food stamp benefits

If female 18-55, or if family includes females 12-55 or children 0-5:

- (Past 12 months) Anyone in family receive food through the WIC program
If family includes children 5-17:
 - (Past 12 months) Any children in the family receive free or reduced-cost lunches at school

Housing (HOU)

Skip second question and follow-up if sample child questionnaire is complete and if adult and child are in same family

- Length of time you have lived in this house/apartment
- Owned, rented, or occupied by some other arrangement
If rented:
 - Paying lower rent because a government program is paying part of the cost

Telephone use (TEL)

- Full name
- Is there a working telephone in your home that is not a cell phone? *(if not already known from sample child interview)*
- Do you have a working cell phone (wireless/mobile telephone)?
If adult has cell phone and home has a landline telephone:
 - Frequency of your landline/wireless use (landline mostly, wireless mostly, equal use)*If no:*
 - Do you live with anyone who has a working cell phone? *(if not already known from sample child interview)*
- What is your telephone number? *(if not already known from sample child interview because sample child respondent is the same as the sample adult)*

Linkage with vital statistics and health-related records of other government agencies (LNK)

- Linkage intro, providing explanation for why SSN and Medicare number are being sought
- Last 4 digits of social security number
If Medicare was reported in INS section:
 - Last 4 digits and any letters of Medicare number*If SSN or Medicare number refused or unknown:*
 - Consent to link without SSN and/or Medicare number

2019-2020 ROTATING CORE CONTENT: UTILIZATION OF SERVICES

Dental care (DNC)

- Time since most recent dental exam or cleaning
 - If more than 12 months:*
 - Time since last saw a dentist or other dental care provider for any reason
- (Past 12 months) Any dental care delayed because of cost
- (Past 12 months) Any dental care needed that you didn't get due to cost

Other care received (PTC)

- (Past 12 months) Received an eye exam from an optometrist, ophthalmologist, or eye doctor
- (Past 12 months) Received special therapy, such as physical, speech, rehabilitative, occupational, or respiratory therapy
- (Past 12 months) Received care at home from nurse or other health professional

Mental health care (MHC)

- (Past 12 months) Any medication taken to help with emotions, concentration, behavior, or mental health
- (Past 12 months) Received counseling, therapy, or other non-medication treatment from a mental health professional
 - If yes:*
 - (Currently) Receiving counseling or therapy
- (Past 12 months) Any counseling or therapy delayed due to cost
- (Past 12 months) Any counseling or therapy needed that you didn't get due to cost

2019 ROTATING CORE CONTENT: MENTAL HEALTH ASSESSMENT

PHQ-8 diagnostic tool for depression (PHQ)

See <http://www.phqscreeners.com> for more information on the Patient Health Questionnaire.

- (Past 2 weeks) Frequency of...little interest in doing things
- (Past 2 weeks) Frequency of...feeling down, depressed, hopeless
- (Past 2 weeks) Frequency of...trouble sleeping or sleeping too much
- (Past 2 weeks) Frequency of...feeling tired or having little energy
- (Past 2 weeks) Frequency of...poor appetite or overeating
- (Past 2 weeks) Frequency of...feeling bad about self or a failure
- (Past 2 weeks) Frequency of...trouble concentrating
- (Past 2 weeks) Frequency of...moving/speaking slowly or fidgety/restless

GAD-7 diagnostic tool for anxiety (GAD)

See <http://www.phqscreeners.com> for more information on the GAD-7.

- (Past 2 weeks) Frequency of...feeling nervous, anxious, on edge
- (Past 2 weeks) Frequency of...not being able to stop or control worrying
- (Past 2 weeks) Frequency of...worrying too much about different things
- (Past 2 weeks) Frequency of...trouble relaxing
- (Past 2 weeks) Frequency of...being so restless that it is hard to sit still
- (Past 2 weeks) Frequency of...becoming easily annoyed or irritable
- (Past 2 weeks) Frequency of...feeling afraid that something awful might happen

2019 ROTATING CORE CONTENT: CHRONIC PAIN

Frequency, severity, and impact of pain (PAI)

- (Past 3 months) Frequency of pain
If at least some days:
 - (Last time had pain) Severity of pain: a lot, a little, somewhere in between
If work limitation was reported in SOC section:
 - (Currently) Pain limits kind or amount of work / unable to work due to pain
 - (Past 3 months) Frequency of interference with life or work activities
 - (Past 3 months) Frequency that your pain affected your family and significant others
 - (Past 3 months) Extent to which pain could be managed

Pain locations

If at least some days:

- (Past 3 months) How much have you been bothered by...back pain
- (Past 3 months) How much have you been bothered by...pain in hands, arms, or shoulders
- (Past 3 months) How much have you been bothered by...pain in hips, knees, or feet
- (Past 3 months) How much have you been bothered by...headache or migraine
- (Past 3 months) How much have you been bothered by...abdominal, pelvic, or genital pain
- (Past 3 months) How much have you been bothered by...toothache or jaw pain

2019 ROTATING CORE CONTENT: PREVENTIVE SERVICES

Preventive screening for adults (PRV)

- Time since most recent preventive visit (excluding dental care)
If not "never":
 - Location of most recent preventive visit
 - Time since blood pressure was last checked
 - Time since blood cholesterol was last checked
 - Time since last blood test for diabetes
- If age 40+:*
- (Ever) Colonoscopy or sigmoidoscopy
If yes:
 - Have had colonoscopy, sigmoidoscopy, or both?
If colonoscopy or both:
 - Time since most recent colonoscopy*If sigmoidoscopy, or if both and time since colonoscopy is > 10 years:*
 - Time since most recent sigmoidoscopy
 - (Ever) Any other kind of test for colorectal cancer
If yes:
 - (Ever) CT colonography or virtual colonoscopy
If yes:
 - Time since most recent CT colonography or virtual colonoscopy
 - (Ever) Blood stool or fecal immunochemical (FIT) test using at home kit
If yes:
 - Time since most recent home-based blood stool or FIT test
 - (Ever) Blood stool or fecal immunochemical (FIT) DNA test using at home kit
If yes:
 - Time since most recent home-based blood stool or FIT DNA test
- If female:*
- (Ever) Pap smear / Pap test
If yes:
 - Time since most recent Pap smear / Pap test
 - (Ever) Hysterectomy
- If female and age 30+:*
- (Ever) Mammogram
If yes:
 - Time since most recent mammogram

Aspirin use for prevention (ASP)

- If age 40+:*
- (Ever) Doctor or other health professional advised taking aspirin every day
If yes:
 - (Currently) Following this advice?
If no:
 - Did doctor advise you to stop taking aspirin?
 - If no:*
 - (Currently) Taking aspirin every day on your own

2020-2021 ROTATING CORE CONTENT: EMPLOYMENT AND INJURIES

Detailed adult employment (EMD)

If working at or had a paid job or business last week, if working in a family business not for pay, if doing seasonal/contract work, or if not currently working but had a paid job or business in past 12 months:

- For whom do/did you work at your main job/business? (name of company, employer, etc.)
- Industry (kind of business) (*open-ended*)
- Occupation (kind of work) (*open-ended*)
- Most important activities on the job (*open-ended*)
- Supervisory status
- Work category (private sector, government employee, self-employed, etc.)

Injuries (INJ)

- *Specific content to be determined*

2020 ROTATING CORE CONTENT: HEALTH BEHAVIORS

Fatigue (FGE)

- (Past 30 days) Frequency of feeling very tired or exhausted
If at least some days:
 - (Last time) Duration of feeling very tired or exhausted (some/most/all of the day)
 - (Last time) Level of tiredness: a lot, a little, somewhere in between

Smoking history and cessation (CIH)

If current or former smoker:

- Age when first started smoking regularly

If former smoker:

- Length of time since quit smoking cigarettes

If current smoker:

- (Past 12 months) Stopped smoking for at least 1 day because trying to quit

If yes, and if ever used e-cigarettes:

- (Past 12 months) Used e-cigarettes to try to quit cigarette smoking

If former smoker, and if ever used e-cigarettes:

- (Past 12 months) Used e-cigarettes to successfully quit cigarette smoking

Physical activity (PHY)

- Frequency of moderate-intensity leisure-time activities (# times per day/week/month/year)
If at least once per year:
 - Number of hours/minutes each time
- Frequency of vigorous-intensity leisure-time activities (# times per day/week/month/year)
If at least once per year:
 - Number of hours/minutes each time
- Frequency of leisure-time muscle-strengthening activities (# times per day/week/month/year)

Walking for transportation and leisure (WLK)

Skip section if sample adult reported being unable to walk or climb steps in MOB section

- (Past 7 days) Walked at least 10 minutes to get some place
If yes:
 - (Past 7 days) Number of times walked at least 10 minutes
 - Average length of walk(s), in minutes/hours
- (Past 7 days) Walked at least 10 minutes for fun, relaxation, exercise, or to walk the dog
If yes:
 - (Past 7 days) Number of times walked at least 10 minutes
 - Average length of walk(s), in minutes/hours

Alcohol use (ALC)

- (Lifetime) Had one or more drinks of any alcoholic beverage
If yes:
 - (Past 12 months) Number of days per week/month/year that alcohol was consumed
If none:
 - (In any one year) Had 12 or more drinks of any alcoholic beverage
 - If any:*
 - (Past 12 months) Average number of drinks on days consumed any alcohol
If average is less than 5 (if male) or 4 (if female):
 - (Past 12 months) Did you have 5/4 or more drinks in a day?
If average is greater than or equal to 5 (if male) or 4 (if female), or if yes, had 5/4 or more drinks in one day in past 12 months:
 - (Past 30 days) Had one or more drinks of any alcoholic beverage
If yes:
 - (Past 30 days) Number of times had 5/4 or more drinks on an occasion

Content of care (COC)

If current smoker or recent former smoker and seen doctor in past 12 months:

- (Past 12 months) Doctor advised you about ways to quit smoking or prescribed medicine

If current drinker and seen doctor in past 12 months:

- (Past 12 months) Doctor advised you to stop or cut down on your drinking

If seen doctor in past 12 months:

- (Past 12 months) Doctor advised you to exercise more

Sleep (SLP)

- Average hours / minutes of sleep in 24-hour period on weekday or workday
- Average hours / minutes of sleep in 24-hour period on a weekend or non-workday
- (Past 30 days) Frequency waking up well-rested
- (Past 30 days) Frequency having trouble falling asleep
- (Past 30 days) Frequency having trouble staying asleep
- (Past 30 days) Frequency taking sleep medication

2021 ROTATING CORE CONTENT: ROTATING CONDITIONS SECTION

Rotating hearing detail

- Level of difficulty hearing a conversation in a quiet room (even with hearing aid)
If able to hear at all in a quiet room:
 - Level of difficulty hearing a conversation in a noisier room (even with hearing aid)
- Use of sign language

Rotating conditions list (RCN)

- (Past 12 months) Hay fever or seasonal allergy
- (Past 12 months) Any other kind of respiratory allergy
- (Past 12 months) Any kind of food or digestive allergy
- (Past 12 months) Eczema or any kind of skin allergy
- (Ever told) Weak or failing kidneys
- (Ever told) Hepatitis
- (Ever told) Cirrhosis or any other kind of long-term liver condition

Serious psychological distress (AMH)

See https://www.hcp.med.harvard.edu/ncs/k6_scales.php for more information on the K6 scale.

- (Past 30 days) Frequency of feeling ... so sad that nothing could cheer you up
- (Past 30 days) Frequency of feeling ... nervous
- (Past 30 days) Frequency of feeling ... restless or fidgety
- (Past 30 days) Frequency of feeling ... hopeless
- (Past 30 days) Frequency of feeling ... that everything was an effort
- (Past 30 days) Frequency of feeling ... worthless