FOR PUBLIC COMMENT

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

Version: August 25, 2016

	2018	2019	2020	2021	2022	2023	2024	2025
	Eligibility Determination and Confirmation - Selection of Sample Adult - Informed Consent							
Annual core content	Family Composition - Health Status and Impact - Functioning and Disability Height and Weight - Hypertension - High Cholesterol Cardiovascular Conditions - Asthma - Cancer - Diabetes - Other Chronic Conditions Health Insurance Status and Continuity - Financial Burden of Medical Care Dental Care - Health Care Utilization - Mental Health Care - Other Care Prescription Medication - Immunizations Cigarettes and E-cigarettes - Physical Activity Demographics - Nativity Housing and Housing Security - Schooling - Employment Family Income - Food-Related Program Participation - Food Sufficiency Telephone Use - Linkage Information							
2-year core content	Anxiety and Depression			Anxiety and Depression			Anxiety and Depression	
		Injuries			Injuries			Injuries
	Alcohol - Sleep Smoking		Alcohol - Walking - Sleep - Smoking History			Alcohol - Walking - Sleep - Smoking History		
1-year core content	Preventive Services	Chronic Pain & Other Conditions	Preventive Services	Chronic Pain & Other Conditions	Preventive Services	Chronic Pain & Other Conditions	Preventive Services	Chronic Pain & Other Conditions
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	2-year supplements		1-year supplements	2-year supplements		1-year supplements	2-yr supplements
	1-year supplements	1-year supplements	2-year supplements		1-year supplements	2-year supplements		1-year supplements

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Topics under Consideration for Redesigned National Health Interview Survey (NHIS)
Sample Adult Questionnaire
Version: August 25, 2016

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).

For NHIS interviews in 2018 and beyond, NCHS proposes that one "sample adult" aged 18 years or more and one "sample child" aged 17 years or less (if any children live in the household) 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 knowledgeable adult who may or may not also 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 SAMPLE ADULTS

Family size and marital status (FAM)

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.

- Is everyone in household a member of your family?
  If no:
  - Determination of which household members are in the same family as the sample adult
- Marital status, including non-marital cohabitation
  If married or cohabiting:
  - Is your spouse/partner living in the same household?
    If yes:
    - Identification of spouse/partner (*age, sex, and race/ethnicity will be known from roster*)
    - Confirmation of sex of sample adult and spouse/partner

  If cohabiting:
  - Legal marital status

Current health status (HIS)

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

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)
  If able to hear at all:
    - 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)

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 walking stick
    - Use of walker or Zimmer frame
    - Use of crutches
    - Use of wheelchair or scooter
    - Use of artificial leg or foot
    - Use of someone's assistance
    - Use of other type of equipment or help

  If yes and does not use wheelchair or scooter:
    - Level of difficulty walking 100 yards when using aids
    - Level of difficulty walking one-third mile when using aids

  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)
- Use of sign language

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

Social functioning (SOC)

- Level of difficulty doing errands alone
- Level of difficulty participating in social activities
- Does a physical, mental, or emotional problem prevent working?
  If no:
    - Does a physical, mental, or emotional problem limit kind or amount of work?

Body measurements (BMI)

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

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)
    - Age(s) when each kind first diagnosed

Diabetes (DIB)

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

  If yes:
  - Age when first diagnosed with diabetes
  - (Currently) Taking diabetic pills
  - (Currently) Taking insulin
  - Type 1, type 2, other

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

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

- (Ever told) COPD, emphysema, or chronic bronchitis
- (Ever told) Weak or failing kidneys
- (Ever told) Hepatitis
- (Ever told) Cirrhosis or any other kind of long-term liver condition
- (Ever told) Arthritis, gout, lupus, or fibromyalgia
- (Ever told) Dementia, including Alzheimer's
- (Ever told) Anxiety disorder
- (Ever told) Depression

Current health insurance coverage (INS)

- Any health insurance coverage or health care plan?

  If yes:
  - Type of health insurance

  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 (INS)

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?

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. If so, 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:
  - Does the policyholder live in your household?
  - 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 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:

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

If military health care:

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

Health insurance continuity (HIC)

If currently uninsured:

- Length of time since last insured
  If less than 12 months:
  - (Past 12 months) Number of months without health insurance
- Reason(s) for not having health insurance

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 two questions 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

Dental care (DNC)

- Time since most recent dental exam or cleaning
  If more than 12 months:
  - Time since last saw a dentist 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

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
- Time since most recent preventive visit (excluding dental care)
  If not "never":
  - Location of most recent preventive visit
- (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

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

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

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

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

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)

Demographic characteristics (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?
- Sexual orientation
- Date of birth

Nativity and acculturation (NAT)

- Were you born in the United States?
  If yes:
    - State of birth

  If no:
    - What year did you come to the United States to stay?
    - US citizenship
- Level of proficiency with spoken English language
  If not "very well" and there is at least one other adult in family:
    - Does any adult in your family speak English very well?

Housing stability (HOU)

- Length of time you have lived in this house/apartment
  If less than 3 years:
    - (Past 3 years) Number of times you have moved

Housing (HOU)

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

- Owned, rented, or occupied by some other arrangement
  If rented:
    - Paying lower rent because a government program is paying part of the cost
- (Past 12 months) Level of difficulty affording housing costs (utilities/rent/mortgage/taxes)

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, 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.)
- Do/did you have paid sick leave?
- Is/was health insurance offered to you through workplace?
- (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, or tips?
- Income from self-employment, including business or farm income?
- Income from interest, dividends, rent, or royalties?
- Social Security or Railroad Retirement?
- Supplemental Security Income (SSI)?
- 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

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

- (Past 12 months) Any women or children in the family get 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

- (Past 12 months) Family has enough of the kinds of food they want to eat

Telephone use (TEL)

- What is your telephone number? *(if not already known from sample child interview because sample child respondent is the same as the sample adult)*
- 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)*

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

- Full name
- 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

ROTATING CORE CONTENT: ANXIETY AND DEPRESSION

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?

PHQ-8 diagnostic tool for depression (PHQ)

- (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)

- (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

ROTATING CORE CONTENT: CHRONIC PAIN AND OTHER CONDITIONS

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 (PAI)

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, migraine, or facial pain
- (Past 3 months) How much have you been bothered by…abdominal, pelvic, or genital pain

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
- *Additional conditions may be added by sponsors*

ROTATING CORE CONTENT: PREVENTIVE SERVICES

Preventive screening for adults (PRV)

- Time since blood pressure was last checked
- Time since blood cholesterol was last checked
- Time since last blood test for diabetes

If age 50+:

- (Ever) Colonoscopy
  If yes and within 10 years:
  - Time since most recent colonoscopy

  If no, or if time since most recent colonoscopy is more than 10 years:
  - (Ever) Any other kind of test for colorectal cancer
    If yes:
    - (Ever) Sigmoidoscopy
      If yes:
      - Time since most recent sigmoidoscopy
    - (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) test at doctor's office
      If yes:
      - Time since most recent office-based blood stool or FIT 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)

- (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

ROTATING CORE CONTENT: ALCOHOL USE, WALKING, SLEEP/FATIGUE, AND SMOKING HISTORY

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 on 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

Walking for transportation and leisure (WLK)

- (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

Sleep and fatigue (SLP)

- (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
- Average hours of sleep in 24-hour period on weekday or workday?
- Average hours 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

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

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

ROTATING CORE CONTENT: INJURIES

Injuries

- *Specific content to be determined*