



Identifying Our Needs: A Survey of Elders II

Funding for this project is provided by a grant, No. 90-AM-0756, from the Administration on Aging, Department of Health and Human Services.



**MARKING
EXAMPLE**

| NUMBER OF TIMES | |
|-----------------|---------------------|
| 2 | 0 1 ● 3 4 5 6 7 8 9 |
| 5 | 0 1 2 3 4 ● 6 7 8 9 |

GENERAL HEALTH STATUS

(The following questions are related to your general health status, any Chronic diseases you might have, and your ability to get around.)

1. Would you say your health in general is excellent, very good, good, fair, or poor?

- Excellent Very Good Good Fair Poor

2. During the past 12 months, how many different times did you stay in the hospital overnight or longer?

- None **NUMBER OF TIMES**
- | | | | | | | | | | | |
|--|---|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

3. Has a doctor ever told you that you had any of the following diseases. (Please mark all that apply)

- Arthritis?
- Congestive Heart Failure?
- Stroke?
- Asthma?
- Cataracts?
- Diabetes?
 - Do you take oral medication?
 - Do you take insulin?
 - Are you on dialysis?
 - (For women) Was this only during a pregnancy?
- Prostate Cancer?
- Colon/Rectal Cancer?
- Lung Cancer?
- Breast Cancer?
- Other Cancer?
- High Blood Pressure?
- Osteoporosis?
- Depression?

4. How long has it been since you had your blood stool test using a home kit?

- Never Within the past 3 years
 Within the past year Within the past 5 years
 Within the past 2 years 5 or more years ago

5. How long has it been since you had your last mammogram? (For women only)

- Never Within the past 3 years
 Within the past year Within the past 5 years
 Within the past 2 years 5 or more years ago

6. How long has it been since you had your last Pap smear? (For women only)

- Never Within the past 3 years
 Within the past year Within the past 5 years
 Within the past 2 years 5 or more years ago

7. How long has it been since you had your last PSA, prostate-specific antigen test, a blood test used to check MEN for prostate cancer? (For men only)

- Never Within the past 3 years
 Within the past year Within the past 5 years
 Within the past 2 years 5 or more years ago

ACTIVITIES OF DAILY LIVING (ADL'S)

8. Because of a health or physical problem that lasted more than 3 months, did you have any difficulty... (Please mark all that apply)

Yes Needs Assistance

- Bathing or showering?
 Dressing?
 Eating?
 Getting in or out of bed?
 Walking?
 Using the toilet, including getting to the toilet?

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL'S)

9. Because of a health or physical problem that lasted longer than 3 months, did you have any difficulty...(Please mark all that apply)

Yes Needs Assistance

- Preparing your own meals?
 Shopping for personal items (such as toilet items or medicines)?
 Managing your money, (such as keeping track of expenses or paying bills)?
 Using the telephone?
 Doing heavy housework, (like scrubbing floors, or washing windows)?
 Doing light housework, (like doing dishes, straightening up, or light clean up)?
 Getting outside?

VISION, HEARING, & DENTAL

10. Do you have total blindness in one or both eyes?

- Yes, one eye Yes, both eyes No

11. Do you use eyeglasses or contact lenses?

- Yes No

12. Do you have trouble seeing with one or both eyes (even when wearing glasses or contact lenses)?

- Yes, one eye Yes, both eyes No

13. How long ago was your last visit to the optometrist or eye doctor?

- 6 months or less
 More than 6 months, but not more than 1 year ago
 More than 1 year, but not more than 2 years ago
 More than 2 years, but not more than 3 years ago
 More than 3 years, but not more than 5 years ago
 More than 5 years ago
 Never have been

PLEASE DO NOT WRITE IN THIS AREA



VISION, HEARING, & DENTAL

14. Do you now have total deafness in one or both ears?

- Yes, one ear Yes, both ears No

15. Do you use a hearing aid? Yes No

16. Do you have trouble hearing (even when wearing your hearing aid)? Yes No

17. How long has it been since your last hearing test?

- 6 months or less
 More than 6 months, but not more than 1 year ago
 More than 1 year, but not more than 2 years ago
 More than 2 years, but not more than 3 years ago
 More than 3 years, but not more than 5 years ago
 More than 5 years ago
 Never have been

18. What type of dental care do you need now?
(Please mark all that apply)

- Teeth filled or replaced (for example, fillings, crowns, and/or bridges)
 Teeth pulled
 Gum treatment
 Denture work
 Relief of pain
 Work to improve appearance (for example, braces or bonding)
 Other
 None

19. How long ago was your last visit to a dentist or dental hygienist?

- 6 months or less
 More than 6 months, but not more than 1 year ago
 More than 1 year, but not more than 2 years ago
 More than 2 years, but not more than 3 years ago
 More than 3 years, but not more than 5 years ago
 More than 5 years ago
 Never have been

HEALTH CARE ACCESS

20. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?

- Yes Don't know/Not sure
 No Refused

21. If yes, which type of health care coverage do you have (Please mark all that apply)?

- Medicare Indian Health Service
 Medicaid Tribal Insurance
 Private Insurance Other
 Veteran's Administration

22. Do you have one person you think of as your personal doctor or health care provider?

- Yes, only one Don't know/not sure
 More than one Refused
 No

23. When you are sick or need advice about your health, to which one of the following places do you usually go?

- A doctor's office
 A public health clinic (I.H.S. or tribal) or community health center
 A hospital outpatient department
 A hospital emergency room
 Urgent care center
 Some other kind of place
 No usual place

24. Was there a time in the past 12 months when you needed medical care, but could not get it?

- Yes (go to question 25)
 No (go to question 26)

25. What is the main reason you did not get medical care?

- Cost
 Distance
 Office wasn't open when I could get there
 Too long a wait for an appointment
 Too long a wait in waiting room
 No child care
 No transportation
 No access for people with disabilities
 The medical provider didn't speak my language.
 Other

TOBACCO & ALCOHOL USAGE

26. Do you smoke cigarettes now?

- Yes, everyday
 Yes, some days (e.g. ceremonial or social)
 No (Skip to question #28)

27. How many cigarettes do you smoke a day? (Please enter the number of cigarettes.)

NUMBER OF CIGARETTES

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

28. Do you use chewing tobacco or snuff?

- Yes
 No (If no, skip to question #30)

29. How many containers of snuff or chewing tobacco per week do you use?

Number of Containers

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

30. The next few questions are about drinks of alcoholic beverages. By a "drink," we mean a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. How long has it been since you last drank an alcoholic beverage?

- Within the past 30 days
 More than 30 days ago but within the past 12 months
 More than 12 months ago but within the past 3 years
 More than 3 years ago
 I have never had an alcoholic drink in my life (skip to question #32)

31. During the past 30 days, on how many days did you have five or more drinks on the same occasion? (By "occasion," we mean at the same time or within a couple hours of each other).

- None 3 to 5 days
 1 or 2 days 6 or more

WEIGHT & NUTRITION

32. How tall are you without shoes?

FEET

INCHES

33. How much do you weigh today?

POUNDS

34. In the past 12 months, has a doctor, nurse or other health professional given you advice about your weight?

- Yes, to lose weight
 Yes, to gain weight
 No

35. Are you presently trying to lose or gain weight?

- Yes, trying to lose weight
 Yes, trying to gain weight
 No, my weight is OK

36. Please mark all that apply to your nutritional health.

Yes

- I have an illness or condition that made me change the kind and/or amount of food I eat.
 I eat fewer than 2 meals per day.
 I eat few fruits or vegetables or milk products.
 I have 3 or more drinks of beer, liquor or wine almost every day.
 I have tooth or mouth problems that make it hard for me to eat.
 I don't always have enough money to buy the food I need.
 I eat alone most of the time.
 I take 3 or more different prescribed or over-the-counter drugs a day.
 Without wanting to, I have lost or gained 10 pounds in the last 6 months.
 I am not always physically able to shop, cook and/or feed myself.

ADD FOR TOTAL SCORE 0-2 = good,
 3-5 = moderate nutritional risk,
 6 or more = high nutritional risk

EXERCISE

37. Over the past 30 days, what vigorous exercises did you do? (Please mark all that apply)

- Aerobics Walking on a treadmill?
 Bicycling Swimming
 Bicycling on a stationary bike? Weight Lifting
 Gardening Yard Work
 Jogging Traditional Pow-wow Dancing
 Jogging on a treadmill?
 Running
 Running on a treadmill?
 Walking

SOCIAL SUPPORT/HOUSING

38. How often do you attend church, sweats, ceremonies, or religious services?

TIMES PER WEEK

39. How many clubs or organizations such as church groups, community boards, or school groups do you belong to?

NUMBER OF GROUPS

40. Altogether, how often do you attend meetings of the clubs or organizations that you belong to?

TIMES PER WEEK

41. How long have you lived at your present address?

- Whole life 3 - 4 years
 21 years & over 1 - 2 years
 11 - 20 years Less than 1 year
 5 - 10 years

42. What type of housing do you presently have?

- Single family residence
 An apartment
 Sleeping room, boarding house
 *Retirement home
 *A health facility (available medical personnel)
 Other

(* If retirement home/health facility is checked skip to question #49)

43. Are you living with family members, non-family members, or alone?

- With family members
 With non-family members
 With both family and non-family members
 Alone

44. How many (including yourself) live in your household?

NUMBER IN HOUSEHOLD

45. Do you have a family member who cares for you?

- Yes No

46. Do you take care of grandchildren?

- Yes No

Please continue
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