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SECOND LONGITUDINAL STUDY OF AGING

WAVE 2

Survivor Questionnaire
(Self Administered)

Community Dweller - Self Respondent
Community Dweller - Proxy Respondent
Institutionalized - Self Respondent
Institutionalized - Proxy Respondent

Version SF 1.1

May 2002

Study conducted by the National Center for Health Statistics, with funding from the National Institute on Aging, the Department of Health and Human Services, and the Centers for Disease Control and Prevention.

NOTICE - Information collected on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m). Public reporting burden for this collection of information is estimated to vary from 20 to 30 minutes per response, with an average of 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer; ATTN: PRA; Humphrey Building, Room 721-H, 200 Independence Avenue, SW; Washington, DC 20201; and to the Office of Management and Budget, Paperwork Reduction Project (0920-0219) Washington DC 20503.

Instructions For Completing The Second Longitudinal Study of Aging

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by circling the appropriate number or by filling in the answer as requested. Instructions such as 'Go to' or arrows are sometimes used to direct you to the next question you should answer based on a particular response.

Example Questions

1. How long has it been since you last stayed overnight in a hospital?

(circle one)

Less than 3 months 1

Between 3 and 6 months 2

Between 6 and 12 months 3

Between 1 and 2 years 4

More than 2 years 5

Never 6

2. In what month and year were you born?

_____/_____
month year

If You Have Any Questions,
Please Call Study Coordinator, Gwen Merker,
Toll-Free At **1-800-981-3005**.

Thank You For Taking Part in This Study.

These first questions are about the place where you live.

1. Have you moved since September, 1995?

(circle one)

Yes . . . . 1 (Go to 2)

No . . . . 2 (Go to 4)

2. a. In what month and year did you move the last time?

_____/_____

month year

b. Why did you move at that time?

(This item was not on the original version of the Self Administered questionnaire. Responses were backcoded, and the item was created, based on the response given for question 3.)

Code (X) all that apply.

01 SP's health deteriorated
02 SP's health improved
03 Spouse's health deteriorated
04 Spouse's health improved
05 To move to different climate (better weather)
06 SP moved to a nursing home or other institution
07 Spouse moved to a nursing home or other institution
08 Spouse died
09 Divorced or separated from spouse or remarried
10 To live CLOSER to child/children
11 To live WITH child/children
12 To live with or closer to other relatives
13 Change in the people or availability of people who help or live with SP
14 To move to smaller house/apartment
15 Financial reasons; moved to a place that was less expensive to maintain
16 Because of structural limitations of the previous house
17 To move to a better or safer neighborhood
18 To move to a retirement home or retirement community
19 To move closer to a health facility
20 Other reasons

3. What is the main reason that you moved at that time?

____

4. Is the place where you live a...

(circle one)

Single family house or townhouse that is not part of a retirement community 1
Single family house, townhouse, or apartment that is part of a retirement community 2
Regular apartment 3
Nursing home . . . . 4 (Go to 6)
Convalescent or rest home 5
Retirement home 6
Supervised apartment 7
Personal care or board and care home 8
Assisted living facility 9
Some other type of group residence or facility 10
Something else 11

5. Since September, 1995, have you been a resident or patient in a nursing home?

(circle one)

Yes . . . . 1 (Go to 6)
No . . . . 2 (Go to 9)

6. How many **different times** have you been a resident or patient in a nursing home since September, 1995?

(write in number)

____________ Number of times

7. In what month and year were you admitted the **first** time?

_____/_______
month year

8. In what month and year were you discharged the **last** time? If currently residing in a nursing home, write in 00 for month and year.

_____/_______
month year

These next questions are about your family.

9. Are you now married, widowed, divorced, separated, or have you never been married?

	(circle one)
Married	1
Widowed	2
Divorced	3
Separated	4
Never married	5

10. **Not counting yourself**, how many people altogether live in your household? If you live alone, write in 0 and go to question 12.

(write in number)

____________ Number of people

11. Please complete the information below for each household member. **Year Began Living Together** refers to the year that you and the household member started living together. If you have lived together more than once, write in the year that you began living together the last time.

Household Chart

a. Name of each person (first/middle initial/last)	b. Relationship of each person to you	c. Sex of each person	d. Age of each person	e. Year Began Living Together
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

12. Including step and adopted children, how many **living sons** do you have?

(write in number)

____________ living sons

13. Including step and adopted children, how many **living daughters** do you have?

(write in number)

___________ living daughters

These next questions are about various activities.

14. During the **past 2 weeks**, did you...

(circle one number on each line)

	YES	NO
a. Get together socially with friends or neighbors?	1	2
b. Get together with **any** relatives not including those living with you?	1	2
c. Go to church, temple, or another place of worship for services or other activities?	1	2
d. Go to a show or movie, sports event, club meeting, class, or other group event?	1	2
e. Go out to eat at a restaurant?	1	2

15. How many days in the **past 2 weeks** did you leave your home for any reason?

(write in number)

___________ Number of days

16. Regarding your present social activities, do you feel that you are doing about enough, too much, or would you like to be doing more?

(circle one)

About enough 1
Too much 2
Would like to be doing more 3

17. During a typical week, are you able to leave your home as often as you would like, or does something prevent you from getting out?

(circle one)

Able to leave as often as would like .... 1 (Go to 19a)

Able to leave as often as would like, but dependent on others for transportation .... 2 (Go to 19a)

Something prevents you from getting out as often as you would like .... 3 (Go to 18)

18. What prevents you from leaving your home as often as you would like?

(circle all that apply)

Transportation problem (none available, too expensive, no regular or dependable source) 1

Your own health or physical impairment 2

Your own mental/cognitive impairment 3

Spouse's health or physical impairment 4

Spouse's mental/cognitive impairment 5

Other household member's health or physical impairment 6

Other household member's mental/cognitive impairment 7

Concerned about safety 8

Bad weather (e.g., snow/ice, too cold, too hot, etc.) 9

No place to go/nothing to see or do 10

No one to go with 11

No time, too much to do at home 12

Specify other reason 13

____

Providing child care 14

Financial reasons 15

The next questions are about how well you are able to do certain activities.

19. a. By yourself and not using aids, do you have **any** difficulty walking for a quarter of a mile, that is, about 2 or 3 blocks?

(circle one)

Yes 1
No 2

b. If yes, how much difficulty do you have walking for a quarter of a mile?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

c. By yourself and not using aids, do you have **any** difficulty walking up 10 steps without resting?

(circle one)

Yes 1
No 2

d. If yes, how much difficulty do you have walking up 10 steps without resting?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

e. By yourself and not using aids, do you have **any** difficulty stooping, crouching or kneeling?

(circle one)

Yes 1
No 2

f. If yes, how much difficulty do you have stooping, crouching or kneeling?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

g. By yourself and not using aids, do you have **any** difficulty reaching up over your head?

(circle one)

Yes 1
No 2

h. If yes, how much difficulty do you have reaching up over your head?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

i. By yourself and not using aids, do you have **any** difficulty reaching out as if to shake someone's hand?

(circle one)

Yes 1
No 2

j. If yes, how much difficulty do you have reaching out?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

k. By yourself and not using aids, do you have **any** difficulty using your fingers to grasp or handle?

(circle one)

Yes 1
No 2

l. If yes, how much difficulty do you have using your fingers to grasp or handle?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

m. By yourself and not using aids, do you have **any** difficulty lifting or carrying something as heavy as 10 pounds?

(circle one)

Yes 1
No 2

n. If yes, how much difficulty do you have lifting or carrying something as heavy as 10 pounds?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

These questions are about some other activities and how well you are able to do them by yourself and without using special equipment.

20. a. Because of a health or physical problem, do you have **any** difficulty bathing or showering?

(circle one)

Yes 1
No 2

b. If yes, by yourself and without using special equipment, how much difficulty do you have bathing or showering?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

c. Because of a health or physical problem, do you have **any** difficulty dressing?

(circle one)

Yes 1
No 2

d. If yes, by yourself and without using special equipment, how much difficulty do you have dressing?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

e. Because of a health or physical problem, do you have **any** difficulty eating?

(circle one)

Yes 1
No 2

f. If yes, by yourself and without using special equipment, how much difficulty do you have eating?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

g. Because of a health or physical problem, do you have **any** difficulty getting in and out of bed or chairs?

(circle one)

Yes 1
No 2

h. If yes, by yourself and without using special equipment, how much difficulty do you have getting in and out of bed or chairs?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

i. Because of a health or physical problem, do you have **any** difficulty walking?

(circle one)

Yes 1
No 2

j. If yes, by yourself and without using special equipment, how much difficulty do you have walking?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

k. Because of a health or physical problem, do you have **any** difficulty using the toilet, including getting to the toilet?

(circle one)

Yes 1
No 2

l. If yes, by yourself and without using special equipment, how much difficulty do you have using the toilet, including getting to the toilet?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

These questions are about some other activities. Please tell us about doing them by yourself.

23. a. Because of a health or physical problem, do you have **any** difficulty preparing your own meals?

(circle one)

Yes 1
No 2

b. If yes, by yourself, how much difficulty do you have preparing your own meals?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

c. Because of a health or physical problem, do you have **any** difficulty shopping for groceries and personal items, such as toilet items or medicines?

(circle one)

Yes 1
No 2

d. If yes, by yourself, how much difficulty do you have shopping for groceries and personal items?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

e. Because of a health or physical problem, do you have **any** difficulty managing your money, such as keeping track of expenses or paying bills?

(circle one)

Yes 1
No 2

f. If yes, by yourself, how much difficulty do you have managing your money?

(circle one)

Some difficulty	1
A lot of difficulty	2
Unable to do it	3

g. Because of a health or physical problem, do you have **any** difficulty doing heavy housework, like scrubbing floors or washing windows?

(circle one)

Yes	1
No	2

h. If yes, by yourself, how much difficulty do you have doing heavy housework?

(circle one)

Some difficulty	1
A lot of difficulty	2
Unable to do it	3

i. Because of a health or physical problem, do you have **any** difficulty doing light housework, like doing dishes, straightening up, or light cleaning?

(circle one)

Yes	1
No	2

j. If yes, by yourself, how much difficulty do you have doing light housework?

(circle one)

Some difficulty	1
A lot of difficulty	2
Unable to do it	3

k. Because of a health or physical problem, do you have **any** difficulty managing your medication?

(circle one)

Yes	1
No	2

l. If yes, by yourself, how much difficulty do you have managing your medication?

(circle one)

Some difficulty 1
A lot of difficulty 2
Unable to do it 3

24. a. Do you receive help from another person in preparing your own meals?

(circle one)

Yes 1
No 2

b. Do you receive help from another person in shopping for groceries and personal items?

(circle one)

Yes 1
No 2

c. Do you receive help from another person in managing your money?

(circle one)

Yes 1
No 2

d. Do you receive help from another person in doing heavy housework?

(circle one)

Yes 1
No 2

e. Do you receive help from another person in doing light housework?

(circle one)

Yes 1
No 2

f. Do you receive help from another person in managing your medication?

(circle one)

Yes 1
No 2

The following questions are about vision, hearing, and dental problems, and other health conditions.

25. Do you **now** have any of the following conditions?

(circle one number on each line)

		YES	NO
a. Cataracts in one eye		1	2
b. Cataracts in both eyes		1	2
c. Glaucoma		1	2
d. Blindness in one eye		1	2
e. Blindness in both eyes		1 (Go to g)	2
f. Other trouble seeing with one or both eyes, **even** when wearing glasses or contact lenses		1	2

Do you **now** have any of the following conditions?

(circle one number on each line)

		YES	NO
g. Deafness in one ear		1	2
h. Deafness in both ears		1 (Go to j)	2
i. Other trouble hearing with one or both ears		1	2
j. Tooth or mouth problems that make it hard for you to eat (even when wearing dentures or partial plates)		1	2

		YES	NO
k. Osteoporosis		1	2
l. Diabetes		1	2
m. Arthritis		1	2
n. Chronic bronchitis or emphysema		1	2
o. Asthma		1	2
p. Hypertension, sometimes called high blood pressure		1	2
q. Any type of heart disease including coronary heart disease, angina, or congestive heart failure		1	2

26. Do you use a hearing aid?

(circle one)

Yes 1
No 2

27. Since September, 1995 have you had a ...

(circle one number on each line)

		YES	NO
a. Broken hip?		1	2
b. Heart attack?		1	2
c. Stroke or cerebrovascular accident?		1	2

28. Do you **now** have cancer of any kind?

(circle one)

Yes ....1 (Go to 29)
No ....2 (Go to 30)

29. What kind of cancer is this?

(circle all that apply)

Colon/rectal/bowel 1
Skin - melanoma 2
Skin - nonmelanoma 3
Skin - unknown type 4
Uterine/ovarian 5
Prostate 6
Stomach 7
Leukemia 8
Breast 9
Cervical 10
Lung 11
Liver 12
Pancreatic 13
Kidney 14
Lymphoma 15
Other 16

The next questions ask for your personal opinion about health related matters.

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

(circle one)

Excellent 1
Very good 2
Good 3
Fair 4
Poor 5

31. Compared to September, 1995, would you say that your health is better now, about the same, or worse?

(circle one)

Better 1

About same 2

Worse 3

32. In the past 12 months, how often did you feel sad or depressed?

(circle one)

All of the time 1

Some of the time 2

A little of the time 3

None of the time 4

These next questions are about your sources of medical care.

33. Do you have a general practitioner, internist, or family doctor whom you see regularly?

(circle one)

Yes .... 1 (Go to 34)

No .... 2 (Go to 35)

34. In the past 3 months, how many times have you seen this doctor?

(write in number)

___________ Number of times

35. Since September, 1995, have you been a patient in a hospital overnight?

(circle one)

Yes .... 1 (Go to 36)

No .... 2 (Go to 38)

36. How many **different times** were you a patient in a hospital overnight since September, 1995?

(write in number)

___________ Number of times

37. Altogether, how many nights were you a patient in a hospital since September, 1995?

(write in number)

___________ Number of nights

38. In general, how satisfied are you with the health care services you receive?

(circle one)

Very satisfied 1
Somewhat satisfied 2
Somewhat dissatisfied 3
Very dissatisfied 4

These next questions are about health insurance.

39. Are you currently covered by Medicare? (Medicare is the Social Security health insurance program for people 65 years of age or older and for certain persons with disabilities.)

(circle one)

Yes .... 1 (Go to 40)
No .... 2 (Go to 41)

40. What is your Health Insurance Claim Number on your Medicare card?

(This number is needed to allow Medicare records of the Health Care Financing Administration to be easily and accurately located and identified for statistical or research purposes. We may also need to link it with other records in order to re-contact you. Except for these purposes, NCHS will not release your Health Insurance Claim Number to anyone including any other government agency. Providing the Health Insurance Claim Number is voluntary and collected under the authority of the Public Health Service Act.)

Whether the number is given or not, there will be no effect on your benefits. This number will be held in strict confidence.

The Public Health Service Act is Title 42, United States Code, Section 242k.

(write in numbers)

|___|___|___|-|___|___|___|-|___|___|___|___|

41. Are you currently covered by any of the following programs?

(circle one number on each line)

	YES	NO
a. Medicaid	1	2
b. Military health care, including VA, CHAMPUS, or CHAMP-VA	1	2
c. Other public assistance program	1	2

42. a. Do you have any private health insurance? (This could include insurance for dental care, but does not include long-term care insurance).

(circle one)

Yes 1
No 2

b. If yes, what are the complete names of each plan that you currently have? Please write in the **complete** names of each plan.

Plan #1 ____

Plan #2 ____

Plan #3 ____

Plan #4 ____

Plan #5 ____

Plan #6 ____

43. a. Are you signed up with an HMO (Health Maintenance Organization), or other type of managed care plan?

(circle one)

Yes 1
No 2

b. If yes, what is the name of the HMO or managed care plan?

Name ____

These next questions are about income you and/or your spouse receive.

44. Do you or your spouse currently receive any income from the following sources?

(circle one number on each line)

	YES	NO
a. A job or business	1	2
b. Social Security or Railroad Retirement	1	2
c. Supplemental Security Income or SSI	1	2
d. Veteran's benefits	1	2
e. Any other retirement or survivor pension	1	2

		YES	NO
f.	Any disability pension	1	2
g.	Any public assistance or welfare payments	1	2
h.	Interest from savings, bank accounts, money market funds, treasury notes, bonds, or interest from any other investments	1	2
i.	Payments or withdrawals from IRA's or Keogh accounts	1	2
j.	Dividend income from stocks or mutual funds, income from rental property, royalties, estates or trusts	1	2
k.	Any other source	1	2

45. Altogether, about how much income in total before taxes and other deductions did you and/or your spouse receive from all sources listed above, in 1996?

(write in numbers)

$ |___|___|___|,|___|___|___|,|___|___|___|.00

46. In general, how do your finances usually work out at the end of the month? Do you find that you usually end up with some money left over, just enough to make ends meet, or not enough money to make ends meet?

(circle one)

Some money left over 1

Just enough to make ends meet 2

Not enough to make ends meet 3

To conclude this section, we need your Social Security Number. Providing this number is voluntary and there will be no effect on your benefits if you do not provide it. The National Center for Health Statistics will use your Social Security Number to conduct health-related research by combining your survey data with vital statistics and data supplied by selected government agencies such as the Health Care Financing Administration (Medicare). We may also use it if we need to recontact you or your family. Except for these purposes, the National Center for Health Statistics will not release your Social Security Number to anyone. This number is collected under the authority of the Public Health Service Act.

The Public Health Service Act is title 42, United States Code, section 242k.

47. What is your Social Security Number?

(write in numbers)

|___|___|___|-|___|___|-|___|___|___|___|

The National Center for Health Statistics may wish to contact you again to obtain additional health related information. Please fill out **your** name, address and telephone number so we can keep our files up to date.

Name: ____

Address: ____

____

City: ____________________ State: |___||___| Zip: |___||___||___||___||___|

Telephone: (|___||___||___|)|___||___||___|-|___||___||___||___|

9 Check box if you do not have a telephone

The National Center for Health Statistics would also like the name, address, and telephone number of a relative or friend who would know where you could be reached in case we need additional health information in the future but cannot reach you. Please provide the name of someone who is **not** currently living in your household.

Name: ____

Address: ____

____

City: ____________________ State: |___||___| Zip: |___||___||___||___||___|

Telephone: (|___||___||___|)|___||___||___|-|___||___||___||___|

Thank You For Completing This Questionnaire.
Please return your completed questionnaire in the enclosed prepaid envelope addressed to:

NORC
University of Chicago
1525 E. 55th Street
Chicago, IL 60615