



Identifying Our Needs: A Survey of Elders VIII



Funding for this project is provided by Cooperative Agreement 900IRC0003 from the Administration For Community Living, AOA - Older Indians National Resource Centers (an agency within the US Department of Health and Human Services).

- Use black or blue pen or a number 2 pencil.
- Make dark marks that fill the oval completely.
- Do not use pens with ink that soaks through the paper.
- Make no stray marks and do not bend survey.



GENERAL HEALTH STATUS

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?

NUMBER OF OVERNIGHT STAYS

HOW LONG WAS EACH STAY?

DAYS

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
- High Blood Pressure
- Osteoporosis
- Depression
- Diabetes (If so, please mark all that apply)
 - Do you take oral medication?
 - Do you take insulin?
 - Are you on dialysis?
 - Was this only during a pregnancy? (For women only)
 - Are you a diabetic amputee?
- Prostate Cancer (For men only)
- Colon/Rectal Cancer
- Lung Cancer
- Breast Cancer
- Cervical Cancer (For women only)
- Other: _____
- None

4. If you have diabetes, how old were you when you were diagnosed?

AGE IN YEARS

5. In the last month, did you worry about falling down?

- Yes
- No

6. How many falls, if any, have you had in the past year? (If 0, please skip to question 8)

NUMBER OF FALLS

7. In any of these falls, did you injure yourself seriously enough to need medical treatment?

- Yes
- No

ACTIVITIES OF DAILY LIVING

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

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

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

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

SCREENING

10. About how long ago has it been since you last visited a doctor/health care provider for a routine check-up?

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

11. (FOR WOMEN ONLY) How long has it been since you had your last mammogram?

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

DO NOT WRITE IN THIS AREA



057140

12. (FOR WOMEN ONLY) How long has it been since you had your last pap smear?
- 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
13. (FOR MEN ONLY) How long has it been since you had your last PSA, prostate-specific antigen test, a blood test used to check for prostate cancer?
- 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

VISION, HEARING & DENTAL

14. Do you have total blindness in one or both eyes?
 Yes No
15. Do you use glasses or contact lenses?
 Yes No
16. Do you have trouble seeing (even when wearing corrective lenses)?
 Yes No
17. Have you seen an optometrist (eye doctor) in the past year?
 Yes No
18. Has a doctor ever treated you for glaucoma?
 Yes No
19. Do you now have total deafness?
 Yes No
20. Do you use a hearing aid?
 Yes No
21. Do you have trouble hearing (even when wearing your hearing aid)?
 Yes No
22. Have you had a hearing test in the past year?
 Yes No
23. Have you seen a dentist or dental hygienist in the past year?
 Yes No
24. 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 (new dentures)
 Relief of pain
 Work to improve appearance (for example, braces or bonding)
 Other: _____
 None
25. During the past 12 months, was there a time when you needed dental care but could not get it at that time?
 Yes No

26. What were the reasons that you could not get the dental care you needed? (Please mark all that apply)
- Could not afford the cost
 Did not want to spend the money
 Insurance did not cover recommended procedures
 Dental office is too far away
 Dental office is not open at convenient times
 Another dentist recommended not doing it
 Afraid or do not like dentists
 Unable to take time off from work
 Too busy
 Did not think anything serious was wrong/expected dental problems to go away
 Did not have transportation
 Other: _____

MEMORY & DISABILITY

27. Please indicate if you have been diagnosed with any of the following? (Please mark all that apply)
- Alzheimer's Disease
 Dementia
 Other Problems with Memory or Thinking
 None of the above
28. During the past 12 months, have you experienced any of the following? (Please mark all that apply):
- Memory loss
 Difficulty performing familiar tasks
 Problems with language
 Disorientation to time and place
 Poor or decreased judgement
 Problems with abstract thinking (ability to think about objects, principles, and ideas not physically present)
 Misplacing things
 Changes in mood or behavior
 Changes in personality
 Loss of initiative (the power or opportunity to act or take charge before others do)
 None
29. Have you been diagnosed with a disability? (If NO, skip question 31)
 Yes No
30. How were you disabled? (Please mark all that apply)
- Congenital (born with)
 In military service
 Due to chronic disease
 Due to accident/injury
 Other (please specify) _____
31. Do you now have any health problems that require you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone? (Include occasional use or use in certain circumstances).
 Yes No
32. Have you ever had a brain injury that limited you in any way for more than a week in any activities?
 Yes No

HEALTH CARE ACCESS

33. What type of health care coverage do you have? (Please mark all that apply)

- Medicare
- Medicaid
- Private Insurance: Health/Medical
- Private Insurance: Long-term care
- Veteran's Administration
- Indian Health Services
- Alaska Native Health Organization
- Indian Health/Tribal Insurance
- Native Hawaiian Health Care System
- Other: _____
- None

34. When you are sick or need professional advice about your health, to which of the following places do you usually go? (Please mark all that apply)

- A doctor's office
- A clinic
- A hospital outpatient department
- A hospital emergency room
- Urgent care center
- Community health Aide/(CHA/CHR)
- Traditional healer
- Other: _____
- None

35. Have any of the following kept you from medical care in the past 12 months? (Please mark all that apply)

- Cost
- Distance
- Office wasn't open when I could get there
- Too long a wait for an appointment
- No one spoke my language
- No childcare
- No transportation
- No access for people with disabilities
- Too long a wait in waiting room
- None
- Other: _____

36. Not including over-the-counter (OTC) medications, was there a time in the past 12 months when you did not take your medication as prescribed because of cost?

- Yes No

TOBACCO & ALCOHOL USE

37. Do you smoke tobacco now?

- Yes, every day (If so, please mark all that apply)
 - Ceremonial
 - Social/Recreational
- Yes, some days (If so, please mark all that apply)
 - Ceremonial
 - Social/Recreational
- No (If NO, skip to question 39)

38. How many cigarettes do you smoke per day?

NUMBER OF CIGARETTES

--	--

39. Do you use chewing tobacco or snuff? (If NO, please skip to question 41)

- Yes No

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

NUMBER OF CONTAINERS

--	--

41. 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 (If you have never had an alcoholic drink, skip to question 43)

42. 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
- 1 or 2 days
- 3 to 5 days
- 6 or more days

WEIGHT & NUTRITION

43. How tall are you without shoes?

FEET INCHES

--	--	--	--

44. How much do you weigh today?

POUNDS

--	--	--	--

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

- Aerobics
- Bicycling or bicycling on a stationary bike
- Gardening
- Jogging
- Running
- Walking
- Swimming
- Weightlifting
- Yard Work
- Traditional Dancing (Pow-wow, Hula)
- Other: _____
- None (If none, skip to question 47)

46. How many times per week do you typically engage in these vigorous exercises?

- 1-2 times per week
- 3-4 times per week
- 5 or more times per week

47. Do you have access to traditional foods? (If no, skip to question 51)

- Yes
- No

48. Do you consume traditional foods regularly? (If no, skip to question 51)

- Yes
- No

49. How often do you consume traditional foods?

- 1-2 times per week
- 3-4 times per week
- 5 or more times per week

50. What traditional foods do you consume regularly?

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

- I have an illness or condition that made me change the kind and/or amount of food that 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.

52. "The food I bought just didn't last, and I didn't have money to get more." How true was this for you in the last 12 months?

- Often true
- Sometimes true
- Never true

53. "I couldn't afford to eat balanced meals." How true was this for you in the last 12 months?

- Often true
- Sometimes true
- Never true

54. In the last 12 months, did you ever cut the size of your meals or skip meals because there wasn't enough money for food?

- Yes
- No

55. In the last 12 months, how often did you cut the size of your meals or skip them?

- Almost every month
- Some months but not every month
- Only 1 or 2 months
- No

56. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

- Yes
- No

57. In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?

- Yes
- No

58. Do you participate in cultural practices that include traditional food, music, and customs?

- All of the time
- Most of the time
- Some of the time
- None of the time (If none of the time, skip to question 60)

59. Do you participate in the following cultural practices/traditions? (Please mark all that apply)

- Powwows
- Smudging
- Cultural/Traditional Storytelling
- Talking Circles
- Drum Group
- Cultural/Traditional music/songs
- Cultural/Traditional Dance
- Prepare cultural/traditional foods
- Consume cultural/traditional foods
- Speak my cultural/traditional language
- Sweat Lodge Ceremony
- Sundance Ceremony
- Other: _____

60. How often do you get out and socialize (attend church/religious meetings, clubs/organizations you belong to or cultural activities/traditional ceremonies)?

TIMES PER MONTH

--	--

61. Do you have a family member who provides care for you?

- Yes
- No

62. Do you take care of grandchildren?

- Yes No

63. Are you the primary caregiver of grandchildren?

- Yes No

64. Do you have someone (family friend, or neighbor) you feel like you can depend on to provide physical support to you (for example, shopping or running errands, fixing things around the house, or providing transportation to you)?

- Yes No

65. Do you have someone you feel like you can depend on to provide social support to you (for example, listening to problems, giving advice, or providing companionship)?

- Yes No

HOUSING/PHYSICAL ENVIRONMENT

66. 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)
- Homeless
- Other

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

- Less than 5 years
- 6-10 years
- Over 10 years

68. 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

69. How many (INCLUDING YOURSELF) live in your household?

NUMBER IN HOUSEHOLD

70. How many children less than 18 years of age live in your household?

CHILDREN IN HOUSEHOLD

SOCIAL FUNCTIONING

71. During the past month, how much of the time were you a happy person?

- All of the time
- Most of the time
- Some of the time
- None of the time

72. During the past month, how much of the time have you felt calm and peaceful?

- All of the time
- Most of the time
- Some of the time
- None of the time

73. During the past month, how much of the time have you been a very nervous person?

- All of the time
- Most of the time
- Some of the time
- None of the time

74. During the past month, how much of the time have you felt downhearted and blue?

- All of the time
- Most of the time
- Some of the time
- None of the time

75. During the past month, how much of the time have you felt so down in the dumps that nothing could cheer you up?

- All of the time
- Most of the time
- Some of the time
- None of the time

76. During the past 12 months, how would you rate your quality of life?

- Excellent
- Very Good
- Good
- Fair
- Poor

77. Are you now using the following nutrition services? (Please mark all that apply)

- Home Delivered Meals
- Congregate Meals
- Dietary Management
- Nutrition Counseling
- Nutrition Education

78. Are you now using the following support services? (Please mark all that apply)

- Case Management
- Elder Abuse Prevention Programs
- Employment Services
- Home Health Services
- Information and Referral Assistance
- Legal Service
- Telephone Reassurance
- Transportation
- Volunteer Services
- Health Prevention and Disease Prevention
- Senior Center Programs
- Home Repair/Modification
- Home Safety Assessments
- Occupational Therapy
- Speech Therapy
- Physical Therapy

