



Cholesterol (Other prescription)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know/ Not Sure	<input type="checkbox"/> Not Applicable						
Blood Sugar	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know/ Not Sure	<input type="checkbox"/> Not Applicable						
Are you taking aspirin daily to help prevent a heart attack or stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know/ Not Sure	<input type="checkbox"/> Not Applicable						
During the past 7 days, how many days did you take prescribed medication for the following conditions:										
High blood pressure	0	1	2	3	4	5	6	7	<input type="checkbox"/> Don't Know/ Not Sure	<input type="checkbox"/> Not Applicable
High cholesterol	0	1	2	3	4	5	6	7	<input type="checkbox"/> Don't Know/ Not Sure	<input type="checkbox"/> Not Applicable
High blood sugar	0	1	2	3	4	5	6	7	<input type="checkbox"/> Don't Know/ Not Sure	<input type="checkbox"/> Not Applicable

SECTION 3: HEALTH BEHAVIORS

Do you measure your blood pressure at home or using or using other calibrated sources in the community?
 Multiple times per day Weekly Don't Know/Not Sure
 Daily Monthly
 A few times a week None

Do you regularly share blood pressure readings with a health care provider for feedback?
 Yes No Don't Know/ Not Sure

How many cups of fruits and vegetables do you eat in an average day? _____ Cups None

Do you eat fish at least 2 times a week? Yes No

Think about all the servings of grain products you eat in a typical day. How many are whole grains?
 Less than half Half More than Half

Do you drink less than 36 ounces (450 calories) of sugar sweetened beverages weekly? Yes No

Are you currently watching or reducing your sodium or salt intake Yes No

In the past 7 days, how often have you had a drink containing alcohol? _____ Number of Days None

How many alcoholic drinks, on average, do you consume when you drink? _____ Number of Drinks None

How many minutes of physical activity (exercise) do you get in a week? _____ Number of Minutes None

Do you smoke (includes cigarettes, pipes, cigars, e-cigarettes, vaping)?
 Current Smoker Quit (1 – 2 months ago) Quit (more than 12 months ago) Never smoked

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several Days	<input type="checkbox"/> More than Half	<input type="checkbox"/> Nearly Every Day
Feeling down, depressed, or hopeless	<input type="checkbox"/> Not at all	<input type="checkbox"/> Several Days	<input type="checkbox"/> More than Half	<input type="checkbox"/> Nearly Every Day

SECTION 4: SOCIAL QUESTIONS

Do you use any of the following types of computers: desktop/laptop, smartphone, tablet or another portable wireless computer? Yes No Don't know Don't want to answer

Do you or ant member of your household have access to the internet?
 Yes, by paying a cell phone company or internet service provider
 Yes, **without** paying a cell phone company or internet provider
 No access to the internet at home (house, apartment, or mobile home)
 Don't know
 Don't want to answer

During the past 12 months, was there at time when you were worried you would run out of food because of lack of money or other resources?
 Yes
 No
 Don't know
 Don't want to answer



Have you ever missed a doctor's appointment because of a transportation problem?

- Yes
- No
- Don't know
- Don't want to answer

If you are currently using childcare services, please identify the type of services. If none, select Not applicable. Select all that apply.

- Infant (birth to 11 months)
- Toddler (11 to 36 months)
- Preschool (3 to 5 years)
- Afterschool Care (K – 9th Grade)
- Don't know
- Don't want to answer
- Not applicable

Have you ever had any of these childcare related problems during the past year? Select all that apply.

- Cost
- Hours of operation
- Not applicable
- Availability
- Other: _____
- Location
- Don't know
- Transportation
- Don't want to answer

What is your housing situation today?

- I have housing.
- I have housing, but I am worried about losing my housing.
- I don't have housing.
- Don't know
- Don't want to answer

How often does your partner physically hurt you?

- Never
- Fairly often
- Rarely
- Frequently
- Sometimes
- Don't want to answer

How often does your partner insult or talk down to you?

- Never
- Fairly often
- Rarely
- Frequently
- Sometimes
- Don't want to answer

Do you ever forget to take your medicine?

- Yes
- No
- Don't want to answer

Are you careless at times about taking your medicine?

- Yes
- No
- Don't want to answer

When you feel better, do you sometimes stop taking your medicine?

- Yes
- No
- Don't want to answer