34015164

OMB No.: 0920-0214 Expiration date: 12/31/2026

National Health Interview Survey

Start Here

Please use a blue or black pen to complete the paper questionnaire.

Place an X to mark your answers as shown below:

☒ Yes

☐ No

When entering numbers, please align the numbers to the right, as shown below:

	3	5

For help or questions about completing this form, please call 1-800-618-5888. The telephone call is free.

How many people, including yourself, live or stay at this address?

INCLUDE...

- ✓ people who are not related to you
- ✓ people who are away on travel
- ✓ babies and small children
- ✓ people staying here who have no other place where they usually live or stay
- ✓ college students living in on-campus housing

DO NOT INCLUDE anyone living somewhere else, such as...

- ✗ a college student living in off-campus housing
- ✗ someone in the Armed Forces on deployment

➔ **Number of people**

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NHIS-1R (2025)
(08/28/2025) Draft 4

A. You and Your Household

A1 **Fill out the following information for everyone, including yourself, who is living or staying at this address.**

If there are more than 6 people living or staying at this address, start with the OLDEST person, who we will call "Person 1" and continue with the next oldest until you have completed the section.

Person 1

Last Name *(Please print)* | First Name | MI

Sex ☐ Male ☐ Female

Date of birth *Print the numbers in the boxes.* Month | Year

Age in years *Enter '0' for babies under 1 year old.*

Person 2

Last Name *(Please print)* | First Name | MI

Sex ☐ Male ☐ Female

Date of birth *Print the numbers in the boxes.* Month | Year

Age in years *Enter '0' for babies under 1 year old.*

Person 3

Last Name *(Please print)* | First Name | MI

Sex ☐ Male ☐ Female

Date of birth *Print the numbers in the boxes.* Month | Year

Age in years *Enter '0' for babies under 1 year old.*

Person 4

Last Name *(Please print)* | First Name | MI

Sex ☐ Male ☐ Female

Date of birth *Print the numbers in the boxes.* Month | Year

Age in years *Enter '0' for babies under 1 year old.*

Person 5

Last Name *(Please print)* | First Name | MI

Sex ☐ Male ☐ Female

Date of birth *Print the numbers in the boxes.* Month | Year

Age in years *Enter '0' for babies under 1 year old.*

Person 6

Last Name *(Please print)* | First Name | MI

Sex ☐ Male ☐ Female

Date of birth *Print the numbers in the boxes.* Month | Year

Age in years *Enter '0' for babies under 1 year old.*

A2 **Of the people listed, which adult age 18 or older will have the next birthday?**

Write their name here:

A3 **Is this you?**

☐ Yes → Continue to **B. Your Health** below.

☐ No → Give this questionnaire to the person named in **A2** and ask them to continue to **B. Your Health** below.

B. Your Health

B1 **Would you say your health in general is...**

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

B2 **In general, how satisfied are you with your life?**

☐ Very satisfied
☐ Satisfied
☐ Dissatisfied
☐ Very dissatisfied

B3 **Have you EVER been told by a doctor or other health professional that you had hypertension, also called high blood pressure?** *If you take medication to control your high blood pressure, please answer yes.*

☐ Yes ☐ No

→ **During the past 12 months, have you had hypertension or high blood pressure?**

☐ Yes ☐ No

B4 **Have you EVER been told by a doctor or other health professional that you had high cholesterol?** *If you take medication to control your high cholesterol, please answer yes.*

☐ Yes ☐ No

→ **During the past 12 months, have you had high cholesterol?**

☐ Yes ☐ No

B5 **Have you EVER been told by a doctor or other health professional that you had asthma?**

☐ Yes ☐ No → **SKIP to question B6**

→ **a. Do you still have asthma?**

☐ Yes ☐ No

→ **b. During the past 12 months, have you had an episode of asthma or an asthma attack?**

☐ Yes ☐ No

→ **c. During the past 12 months, have you had to visit an emergency room or urgent care center because of asthma?**

☐ Yes ☐ No

B6 **Have you EVER been told by a doctor or other health professional that you had any of the following?**

Mark (X) yes or no for each item.

	Yes	No
a. Coronary heart disease	☐	☐
b. Angina, also called angina pectoris	☐	☐
c. A heart attack, also called myocardial infarction	☐	☐
d. A stroke	☐	☐

B7 **Have you EVER been told by a doctor or other health professional that you had any of the following?**

Mark (X) yes or no for each item.

	Yes	No
a. COPD, emphysema, or chronic bronchitis	☐	☐
b. Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	☐	☐
c. Kidney problem, protein in the urine, or kidney disease	☐	☐
d. Hepatitis	☐	☐
e. Cirrhosis or any other kind of long-term liver condition	☐	☐

B8 **Have you EVER been told by a doctor or other health professional that you had cancer or a malignancy of any kind?**

☐ Yes ☐ No → **SKIP to question B9**

a. What kind of cancer was it?
Mark (X) for all that apply.

☐ Breast
☐ Lung
☐ Prostate
☐ Skin (melanoma)
☐ Colorectal
☐ Any other type of cancer – Please specify

b. How old were you when a doctor or other health professional first told you that you had cancer?

☐☐ years old

B9 **Has a doctor or other health professional EVER told you that you have diabetes?** *Do not include prediabetes, borderline diabetes, or gestational diabetes.*

☐ Yes ☐ No

How old were you when a doctor or health professional first told you that you had diabetes?

☐☐ years old

B10 **How tall are you without shoes?** *Answer in feet and inches OR meters and centimeters. Your best estimate is fine.*

☐ feet **AND** ☐☐ inches

OR

☐ meters **AND** ☐☐ centimeters

B11 **How much do you weigh?** *Answer in pounds OR kilograms. Your best estimate is fine.*

☐☐☐ pounds

OR

☐☐☐ kilograms

C. Your Life Right Now

C1 **How would you rate your quality of life, focusing on what matters most to you?**

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

C2 **How would you rate your social and family connections?**

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

C3 **In general, how healthy is your overall diet?**

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

C4 **How would you rate your physical activity, compared with people in your age group?**

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

C5 **How would you rate your ability to manage stress?**

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

C6 **How would you rate your sleep?**

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

C7 **How would you rate your ability to find meaning and purpose in your daily life?**

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

C8 **How would you rate your ability to manage your health, focusing on aspects of your health that matter most to you?**

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

C9 **Over the last 2 weeks, how often have you been bothered by little interest or pleasure in doing things?**

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

C10 **Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?**

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

C11 **Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?**

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

C12 **Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?**

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

D. Your Day-to-Day Experiences

D1 **Do you have difficulty seeing, even if wearing glasses or contact lenses?**

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all

D2 **Do you have difficulty hearing, even if using a hearing aid(s)?**

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all

D3 **Do you have difficulty walking or climbing steps?**

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all

D4 **Do you have difficulty remembering or concentrating?**

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all

D5 **Do you have difficulty with self-care, such as washing all over or dressing?**

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all

D6 **Using your usual language, do you have difficulty communicating, for example, understanding or being understood?**

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all

D7 **Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone, such as visiting a doctor's office or shopping?**

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all

D8 **Because of a physical, mental, or emotional condition, do you have difficulty participating in social activities, such as visiting friends, attending clubs and meetings, or going to parties?**

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all

D9 **Are you limited in the kind OR amount of work you can do because of a physical, mental, or emotional problem?** *Work includes paid work, volunteer work, schoolwork, and homework.*

- ☐ Yes
- ☐ No

D10 **During the past 12 months, about how many days of work did you miss because you had an illness, injury, or disability?** *Do not include family, maternity, or paternity leave.*

☐☐☐ days

D11 **In the past 3 months, how often did you have pain?**

- ☐ Never → **SKIP to E. Your Health Care Coverage**
- ☐ Some days
- ☐ Most days
- ☐ Every day

D12 **Thinking about the last time you had pain, how much pain did you have?**

- ☐ A little
- ☐ A lot
- ☐ Somewhere between a little and a lot

D13 **Over the past 3 months, how often did pain limit your life or work activities?**

- ☐ Never
- ☐ Some days
- ☐ Most days
- ☐ Every day

E. Your Health Care Coverage

The next questions are about health insurance.

Include health insurance obtained through employment or purchased directly, as well as government programs like Medicare, Medicaid, and Children's Health Insurance Program, that provide medical care or help pay medical bills.

E1 **Are you now covered by any kind of health insurance or some other kind of health care plan?**

- ☐ Yes
- ☐ No → **SKIP to question E4 on page 8.**

E2 **What kind of health insurance or health care coverage do you have?**

Mark (X) yes or no for each item.

	Yes	No
a. Private health insurance	☐	☐
b. Medicare (including Medicare Advantage)	☐	☐
c. Medicare supplement (Medigap)	☐	☐
d. Medicaid	☐	☐
e. Children's Health Insurance Program (CHIP)	☐	☐
f. TRICARE or other military health care (CHAMPUS)	☐	☐
g. VA health care or CHAMPVA	☐	☐
h. Indian Health Service	☐	☐
i. State-sponsored health plan	☐	☐
j. Other government program	☐	☐

E3 **Was any of the health insurance you marked on E2 obtained through Healthcare.gov, the Health Insurance Marketplace, or a state-based health insurance exchange?** *Healthcare.gov is a website for the Affordable Care Act, also known as Obamacare.*

- ☐ Yes ☐ No

↳ **What is the name of this plan?**

These next few questions are about types of health insurance you may have had in the past 12 months.

E4 **At any time in the past 12 months, did you have health insurance through a current or former employer or union?**

- ☐ Yes
- ☐ No

E5 **At any time in the past 12 months, did you have health insurance purchased through Healthcare.gov, the Health Insurance Marketplace, or a state-based health insurance exchange?**

Healthcare.gov is a website for the Affordable Care Act, also known as Obamacare.

- ☐ Yes
- ☐ No

E6 **At any time in the past 12 months, did you have Medicaid, Medical Assistance, or the Children's Health Insurance Program?**

- ☐ Yes
- ☐ No

E7 **During the past 12 months, were you covered by health insurance for...**

- ☐ All of the year
- ☐ Some of the year → **How many months did you have coverage?** months ☐☐
- ☐ None of the year

F. Your Health Care

F1 **About how long has it been since you last saw a doctor or other health professional about your health?** *Do not include appointments by video or phone. Do not include dental care. Include doctors seen while a patient in a hospital.*

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 2 years ago
- ☐ 2 years ago or more
- ☐ Never

F2 **About how long has it been since you last saw a doctor or other health professional for a wellness visit, physical, or general-purpose check-up?** *If a wellness exam was combined with a visit for some other reason, include this visit. An obstetrician/gynecologist (OB/GYN) may perform this visit.*

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 2 years ago
- ☐ 2 years ago or more
- ☐ Never

F3 **When was the last time you had your blood pressure checked by a doctor, nurse, or other health professional?**

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 2 years ago
- ☐ 2 years ago or more
- ☐ Never

F4 **When was the last time you had a blood test for high blood sugar or diabetes by a doctor, nurse, or other health professional?**

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 3 years ago
- ☐ 3 years ago or more
- ☐ Never

F5 **During the past 12 months, how many times have you gone to a retail health clinic about your health?** *Retail health clinics are located in a pharmacy, grocery store, or supercenter. These clinics can provide common services, such as certain vaccinations, as well as testing for or treatment of minor uncomplicated illnesses.*

- ☐ None
- ☐ 1 time
- ☐ 2 or 3 times
- ☐ 4 or more times

F6 **During the past 12 months, how many times have you gone to an urgent care center about your health?** *An urgent care center is located in its own building or space. These centers can provide services such as x-rays and stitches.*

- ☐ None
- ☐ 1 time
- ☐ 2 or 3 times
- ☐ 4 or more times

F7 **During the past 12 months, how many times have you gone to a hospital emergency room about your health?** *This includes emergency room visits that resulted in a hospital admission.*

- ☐ None
- ☐ 1 time
- ☐ 2 or 3 times
- ☐ 4 or more times

F8 **During the past 12 months, how many nights have you been hospitalized?** *Do not include an overnight stay in the emergency room.*

- ☐ None
- ☐ 1 night
- ☐ 2 or 3 nights
- ☐ 4 or more nights

F9 **During the past 12 months, have you had an appointment with a doctor, nurse, or other health professional by video or by phone?**

- ☐ Yes
- ☐ No

F10 **During the past 12 months, have you had a dental examination or cleaning?** *Include examinations or cleanings from all types of dental care providers, such as dentists, orthodontists, oral surgeons, dental hygienists, and all other dental specialists.*

- ☐ Yes
- ☐ No

F11 **During the past 12 months, have you had an eye exam from an eye specialist, such as an optometrist, ophthalmologist, or eye doctor?**

- ☐ Yes
- ☐ No

F12 **During the past 12 months, did you receive counseling or therapy from a mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker?**

- ☐ Yes
- ☐ No

F13 **During the past 12 months, have you had a flu vaccination?** *There are 2 types of flu vaccinations. One is a shot and the other is a spray, mist, or drop in the nose.*

- ☐ Yes
- ☐ No

These next questions are about different types of colorectal cancer screening.

F14 **Have you ever had a colonoscopy or sigmoidoscopy exam?** *These are exams in which a doctor inserts a tube into the rectum to look for polyps or cancer.*

☐ Yes ☐ No

→ **About how long has it been since your MOST RECENT colonoscopy or sigmoidoscopy?**

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 2 years ago
- ☐ At least 2 years ago but less than 3 years ago
- ☐ At least 3 years ago but less than 5 years ago
- ☐ At least 5 years ago but less than 10 years ago
- ☐ 10 years ago or more

F15 **Have you ever had a CT colonography or virtual colonoscopy?** *CT colonography, sometimes called virtual colonoscopy, is a test that looks for cancer in the colon. Unlike regular colonoscopies, you do not need medication to make you sleepy during the test. In this test, your colon is filled with air, and you are moved through a donut-shaped X-ray machine as you lie on your back and then your stomach.*

☐ Yes ☐ No

→ **When was your most recent CT colonography or virtual colonoscopy?**

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 2 years ago
- ☐ At least 2 years ago but less than 3 years ago
- ☐ At least 3 years ago but less than 5 years ago
- ☐ At least 5 years ago but less than 10 years ago
- ☐ 10 years ago or more

F16 **Have you ever had a blood stool or FIT test, using a HOME kit?** *These are tests to determine whether you have blood in your stool or bowel movement and can be done at home using a kit. You use a stick or brush to obtain a small amount of stool at home and send it back to the doctor or lab. This may also be called a fecal occult blood test or fecal immunochemical test.*

☐ Yes ☐ No

→ **When was your most recent blood stool or FIT test, using a home test kit?**

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 2 years ago
- ☐ At least 2 years ago but less than 3 years ago
- ☐ At least 3 years ago but less than 5 years ago
- ☐ At least 5 years ago but less than 10 years ago
- ☐ 10 years ago or more

F17 **Have you ever had a Cologuard test?** *The Cologuard test is another type of stool test for colon cancer. It tests for blood in your stool and DNA changes. With this test, you mail a whole bowel movement back in a container to be tested.*

☐ Yes ☐ No

→ **When was your most recent Cologuard test?**

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 2 years ago
- ☐ At least 2 years ago but less than 3 years ago
- ☐ At least 3 years ago but less than 5 years ago
- ☐ At least 5 years ago but less than 10 years ago
- ☐ 10 years ago or more

G. Your Health Care Costs

G1 **During the past 12 months, have you DELAYED getting dental care because of the cost?**

- ☐ Yes
- ☐ No

G2 **During the past 12 months, was there any time when you needed dental care, but did NOT get it because of the cost?**

- ☐ Yes
- ☐ No

G3 **During the past 12 months, have you DELAYED getting medical care because of the cost?** *Do not include dental care.*

- ☐ Yes
- ☐ No

G4 **During the past 12 months, was there any time when you needed medical care, but did NOT get it because of the cost?** *Do not include dental care.*

- ☐ Yes
- ☐ No

G5 **During the past 12 months, were any of the following true for you?**

Mark (X) yes or no for each item.

	Yes	No
a. You skipped medication doses to save money.	☐	☐
b. You took less medication to save money.	☐	☐
c. You delayed filling a prescription to save money.	☐	☐

G6 **During the past 12 months, was there any time when you needed prescription medication, but did NOT get it because of the cost?**

- ☐ Yes
- ☐ No

G7 **If you get sick or have an accident, how worried are you that you will be able to pay your medical bills?**

- ☐ Very worried
- ☐ Somewhat worried
- ☐ Not at all worried

H. Your Prescription Medication

H1 **At any time in the past 12 months, did you take prescription medication?**

- ☐ Yes
- ☐ No → **SKIP to I. Women's Health on page 12.**

H2 **Are you now taking any medication prescribed by a doctor for high blood pressure?**

- ☐ Yes
- ☐ No

H3 **Are you now taking any medication prescribed by a doctor to help lower cholesterol?**

- ☐ Yes
- ☐ No

H4 **Are you now taking diabetic pills to lower blood sugar?** *These are sometimes called oral agents or oral hypoglycemic agents.*

- ☐ Yes
- ☐ No

H5 **Are you now taking insulin?** *Insulin can be taken by shot or pump.*

- ☐ Yes
- ☐ No

H6 **Other than insulin, are you now taking any injectable medication to lower blood sugar or lose weight?** *These medications include GLP-1 injectables, such as Ozempic, Wegovy, Saxenda, Victoza, Trulicity, Mounjaro, and Byetta.*

- ☐ Yes
- ☐ No

H7 **At any time in the past 12 months, did you take prescription medication to help you with your emotions or with your concentration, behavior, or mental health?**

- ☐ Yes
- ☐ No → **SKIP to question I1 on page 12.**

→ **a. Are you now taking prescription medication for depression?**

- ☐ Yes
- ☐ No

→ **b. Are you now taking prescription medication for anxiety?** *Anxiety can include feeling worried, nervous, or anxious.*

- ☐ Yes
- ☐ No

I. Women's Health

I1 **What is your sex?**

- ☐ Male → **SKIP to J. Your Physical Activity**
- ☐ Female

I2 **Have you EVER HAD a mammogram?** *A mammogram is an x-ray taken only of the breast by a machine that presses against the breast.*

- ☐ Yes
- ☐ No

→ **About how long has it been since your MOST RECENT mammogram?**

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 2 years ago
- ☐ At least 2 years ago but less than 3 years ago
- ☐ At least 3 years ago but less than 5 years ago
- ☐ At least 5 years ago but less than 10 years ago
- ☐ 10 years ago or more

I3 **There are 2 different kinds of tests to check for cervical cancer. One is a Pap smear or Pap test and the other is the HPV or Human Papillomavirus test. Have you EVER HAD a test or tests to check for cervical cancer?** *These are routine tests for women in which a doctor or other health professional takes a sample from the cervix through the vagina with a swab or brush and sends it to the lab.*

- ☐ Yes
- ☐ No

→ **When did you have your MOST RECENT test to check for cervical cancer?**

- ☐ Within the past 12 months
- ☐ At least 1 year ago but less than 2 years ago
- ☐ At least 2 years ago but less than 3 years ago
- ☐ At least 3 years ago but less than 5 years ago
- ☐ At least 5 years ago but less than 10 years ago
- ☐ 10 years ago or more

I4 **Have you had a hysterectomy?** *A hysterectomy is when the uterus or womb is removed. This is different from having your tubes tied.*

- ☐ Yes
- ☐ No

J. Your Physical Activity

The next questions are about physical activities such as exercise, sports, or physically active hobbies that you may do in your LEISURE time. These questions are about 2 different types of physical activity — moderate-intensity and vigorous-intensity.

J1 **How often do you do MODERATE-INTENSITY leisure-time physical activities?** *Moderate-intensity activities cause moderate increases in breathing or heart rate.*

☐☐ times per day

OR

☐☐ times per week

OR

☐☐ times per month

OR

☐ Never → **SKIP to J3**

OR

☐ I am unable to do this type of activity → **SKIP to J3**

J2 **About how long do you do these moderate leisure-time physical activities each time?**

☐☐☐ minutes each time

OR

☐☐ hours each time

J3 **How often do you do VIGOROUS-INTENSITY leisure-time physical activities?** *Vigorous-intensity activities cause large increases in breathing or heart rate.*

☐☐ times per day

OR

☐☐ times per week

OR

☐☐ times per month

OR

☐ Never → **SKIP to J5 on page 13.**

OR

☐ I am unable to do this type of activity → **SKIP to J5 on page 13.**

J4 **About how long do you do these vigorous leisure-time physical activities each time?**

☐☐☐ minutes each time

OR

☐☐ hours each time

J5 **How often do you do leisure-time physical activities specifically designed to STRENGTHEN your muscles such as sit-ups, push-ups, or lifting weights?** *Include any muscle-strengthening activities you may have reported earlier as moderate-intensity or vigorous-intensity leisure-time physical activities.*

☐☐ times per day

OR

☐☐ times per week

OR

☐☐ times per month

OR

☐ Never

OR

☐ I am unable to do this type of activity

J6 **In the past 7 days, did you walk for transportation?** *This is walking you might have done to travel to and from work, to do errands, or to go from place to place.*

☐ Yes ☐ No

↳ **Did you generally walk for at least 10 minutes at a time?**

☐ Yes ☐ No

J7 **Sometimes you may walk for fun, relaxation, exercise, or to walk the dog. In the past 7 days, did you walk for any of these reasons?** *Do not include walking for transportation.*

☐ Yes ☐ No

↳ **Did you generally walk for at least 10 minutes at a time?**

☐ Yes ☐ No

J8 **On average, how many hours of sleep do you get in a 24-hour period?** *Enter whole numbers only.*

☐☐ hours

K. Nicotine and Alcohol Use

K1 **Have you smoked at least 100 cigarettes in your ENTIRE LIFE?**

☐ Yes ☐ No

↳ **Do you now smoke cigarettes every day, some days, or not at all?**

☐ Every day

☐ Some days

☐ Not at all

K2 **Have you ever used an e-cigarette or other electronic vaping product, even just one time, in your entire life?** *Include e-cigarettes used for nicotine. Do not include marijuana use.*

☐ Yes ☐ No

↳ **Do you now use e-cigarettes or other electronic vaping products every day, some days, or not at all?**

☐ Every day

☐ Some days

☐ Not at all

K3 **In your ENTIRE LIFE, have you had at least 1 drink of any kind of alcohol, not counting small tastes or sips?** *Alcohol includes beer, wine, wine coolers, liquors such as vodka, whiskey or rum, mixed drinks or cocktails with alcohol, and any other type of alcoholic drink.*

☐ Yes ☐ No

↳ **During the past 12 months, did you ever have 4 or more drinks in a day?**

☐ Yes ☐ No

L. You and Your Family

L1 Do you consider yourself to be Hispanic or Latino?

- ☐ Yes
- ☐ No

L2 What race or races do you consider yourself to be?
Mark (X) for all that apply.

- ☐ White
- ☐ Black or African American
- ☐ American Indian
- ☐ Alaska Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Asian
- ☐ Some other race

L3 What is the HIGHEST level of school you have completed or the highest degree you have received?

- ☐ Less than a high school diploma
- ☐ Regular high school diploma
- ☐ GED or equivalent
- ☐ Some college, no degree
- ☐ Occupational, technical, or vocational program
- ☐ Two year or Associate's degree
- ☐ Bachelor's degree (Example: BA, AB, BS, BBA)
- ☐ Master's degree (Example: MA, MS, MEng, MEd, MBA)
- ☐ Professional school degree (Example: MD, DDS, DVM, JD)
- ☐ Doctoral degree (Example: PhD, EdD)

L4 Did you ever serve on active duty in the U.S. Armed Forces, military Reserves, or National Guard?

- ☐ Never served in the military
- ☐ Only on active duty for training in the Reserves or National Guard
- ☐ Now on active duty
- ☐ On active duty in the past, but not now

L5 Is the place where you usually live owned or rented by you or someone in your family?

- ☐ Owned or being bought
- ☐ Rented
- ☐ Other arrangement

L6 Are you now living with a spouse or partner?

- ☐ Yes
- ☐ No

L7 What is your current legal marital status?

- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Never married

L8 Do you think of yourself as...

- ☐ Lesbian or gay
- ☐ Straight, that is, not lesbian or gay
- ☐ Bisexual
- ☐ Something else
- ☐ I don't know the answer

L9 Were you born in the United States or a U.S. territory?

- ☐ Yes, born in a state or the District of Columbia
- ☐ Yes, born in a U.S. territory
- ☐ No

L10 **Which of the following best describes your current employment status?** *Mark 1 box.*

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Working WITHOUT pay at a family-owned business
- ☐ Not employed but looking for work
- ☐ Not employed and not looking for work
- ☐ Retired

L11 **Not including yourself, how many of the people in your household are members of your family?** *For this survey, family refers to everybody living 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. Family also includes any people living together as a couple and their children.*

If you live alone or live only with unrelated roommates, please answer zero (00).

☐☐ Number of family members in household

The next questions are about your total family income in 2024.

L12 **In 2024, did you or any family member 18 or older receive income from any of the following sources?**

Mark (X) yes or no for each item.

	Yes	No
a. Wages, salaries, commissions, bonuses, tips, or self-employment	☐	☐
b. Interest-bearing accounts or investments	☐	☐
c. Dividends from stocks or mutual funds	☐	☐
d. Net rental income, royalty income, or income from estates and trusts	☐	☐
e. Social Security or Railroad Retirement	☐	☐
f. Supplemental Security Income (SSI)	☐	☐
g. Any public assistance or welfare payments from the state or local welfare office	☐	☐
h. Retirement income, pensions, survivors or disability income	☐	☐
i. Any other sources of income received regularly such as Veterans' VA payments, unemployment compensation, child support, or alimony	☐	☐

L13 **What is your best estimate of the total income of all family members from all sources in 2024?** *Report amount before taxes. Report net income after business expenses if self-employed.*

$ ☐☐☐,☐☐☐,☐☐☐.00

L14 **What is your age today?**

Age in years

☐☐☐

Mailing Instructions

Please print today's date. *This should be the date this form was completed.*

Month Day Year

On behalf of the U.S. Department of Health and Human Services, we would like to thank you for the time and effort you have spent sharing information about you and your family.

Your answers to this survey will provide better information for health policies and decisions that affect millions of people across the United States.

Place the completed questionnaire in the postage-paid return envelope. If the envelope has been misplaced, please mail the questionnaire to:

DIRECTOR
U.S. Census Bureau
P.O. Box 5000
Jeffersonville, IN 47199-5000