65. What is the natural color of your eyes?

- ○ Blue
- ○ Green
- ○ Hazel
- ○ Light brown
- ○ Dark brown
- ○ Other

66. Did anyone help you complete this survey?

- ○ Yes
- ○ No

DATA MATRIX BARCODE

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Thank you for completing this survey.

Please enclose the following four documents in the postage-paid self-addressed envelope and put them in the mail.

- The Research Consent Form
- The HIPAA Authorization Form
- The Authorization for Use and/or Disclosure of Patient Health Information Form
- This Gulf War Era Veterans' Survey of Men and Women Who Served our Country between 1990-1991

We will call you soon to talk about what happens next.

Use the postage-paid envelope we provided to mail your completed study documents to:

Department of Veterans Affairs
CSP #585 Gulf War Era Cohort and Biorepository
1009 Slater Rd., Suite 120
Durham, NC 27703

1-855-493-8387 or 1-855-GWE-VETS

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Gulf War Era Veterans' Survey

A Survey of Men and Women Who Served our Country between 1990-1991

Please Note:

1. Your responses will not affect your eligibility for benefits or the care that you receive at the VA.
2. Do not complete the survey until you have spoken with the Enrollment Coordinating Center and have gone through the Informed Consent process.

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58. Including yourself, how many people currently live in your household?

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9+

59. Which of the following best describes your current work status? *(Mark any that apply)*

- ○ Working full-time
- ○ Working part-time
- ○ Unemployed, searching for work
- ○ Unemployed, not searching for work
- ○ Retired
- ○ Disabled
- ○ Student

60. Which income category represents the total income of your household from all sources (before taxes and deductions) during the last 12 months?

- ○ Less than $10,000
- ○ $10,000 – $19,999
- ○ $20,000 – $29,999
- ○ $30,000 – $39,999
- ○ $40,000 – $49,999
- ○ $50,000 – $59,999
- ○ $60,000 – $74,999
- ○ $75,000 – $99,999
- ○ $100,000 – $149,999
- ○ $150,000 or more
- ○ Prefer not to answer

61. Are you right or left handed?

- ○ Right
- ○ Left
- ○ Both right and left (ambidextrous)

62. What is your...?

Round to the nearest inch

Height: ☐ Feet ☐☐ Inches

Round to the nearest pound

Weight: ☐☐☐ Pounds

63. What best describes the color of your skin without tanning?

- ○ Very fair
- ○ Fair
- ○ Light olive
- ○ Dark olive
- ○ Brown
- ○ Black

64. What best describes your natural hair color? *(If grey, please indicate color before going grey.)*

- ○ Black
- ○ Dark brown
- ○ Light brown
- ○ Blonde
- ○ Red

Continue to next page. ➔

Finally, we have a few questions to help us describe the Veterans who completed this survey.

51. What is your date of birth?

MONTH / DAY / YEAR

52. What is your gender?

- ○ Male
- ○ Female

53. Are you Spanish, Hispanic, or Latino? *(Mark any that apply)*

- ○ No, not Spanish, Hispanic, Latino
- ○ Yes, Mexican, Mexican American, Chicano
- ○ Yes, Puerto Rican
- ○ Yes, Cuban
- ○ Yes, other Spanish, Hispanic, Latino

54. What is your race? *(Mark any that apply)*

- ○ White
- ○ Black / African-American
- ○ American Indian / Alaska Native
- ○ Chinese
- ○ Japanese
- ○ Asian Indian
- ○ Other Asian
- ○ Filipino
- ○ Pacific Islander
- ○ Other

55. Where are your ancestors originally from? *(Mark any that apply)*

- ○ Africa
- ○ East Asia / Pacific Ocean region
- ○ Middle East
- ○ North America
- ○ Northern Europe
- ○ Southern Europe
- ○ South America
- ○ Southwest Asia

56. What is the highest degree or level of school you have completed?

- ○ Less than high school
- ○ High school diploma / GED
- ○ Some college credit, but no degree
- ○ Associate's degree (e.g., AA, AS)
- ○ Bachelor's degree (e.g., BA, BS)
- ○ Master's degree (e.g., MA, MS, MBA)
- ○ Professional or Doctorate degree

57. What is your current marital status? *(Mark one response)*

- ○ Married
- ○ Civil commitment
- ○ Cohabitating
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Never married

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Please read the following instructions:

- Please use dark blue or black ballpoint pen to mark an answer.
- Please answer as many questions as possible on the following pages. You do not have to answer any question that makes you feel uncomfortable, but we appreciate you providing as much information as you can.
- If you are unsure about how to answer a question, please give the best answer you can.
- Based on your answers, you may be able to skip some questions. If there is an arrow next to the answer you choose, please follow it for skip instructions.
- When we ask for dates or ages, if you cannot remember the exact year or how old you were when something happened, please give us your best estimate.
- Do not make any stray marks on the survey.
- Do not draw a line through any sections that are left blank or not applicable.
- Print numbers as shown and avoid contact with the edge of the box.

  Example: 0 1 2 3 4 5 6 7 8 9

- Fill in the bubbles completely for each of the questions in this form.

  Like this: ● Not like this: ⊘ ✓

If you have any questions about completing this survey, please call us toll-free at: 1-855-493-8387 or 1-855-GWE-VETS

Thanks again for your participation!

The following questions ask for general information about you. Any information you provide us about you or your family members will be kept **confidential** and **secure** according to VA policy. The survey has a study identification ("ID") number instead of your name to maintain confidentiality. We will not attempt to contact your family members.

1. What is today's date?

MONTH / DAY / 2 0 YEAR

The following questions are about your military service.

2. In which branch of the service did you serve? *(Mark any that apply)*

- ○ Army
- ○ Navy
- ○ Air Force
- ○ Marine Corps
- ○ Coast Guard
- ○ National Guard
- ○ Merchant Marines
- ○ NOAA
- ○ Public Health Service
- ○ None → **Skip to question 15 on page 7**

3. Please indicate whether your service was: *(Mark any that apply)*

- ○ Active duty
- ○ Reserves
- ○ Not applicable (not in the military)

4. When did you serve? *(Mark any that apply)*

- ○ September 2001 or later
- ○ August 1990 to August 2001 (includes Gulf War)
- ○ May 1975 to July 1990
- ○ August 1964 to April 1975 (Vietnam era)
- ○ February 1955 to July 1964
- ○ July 1950 to January 1955 (Korean War)
- ○ January 1947 to June 1950
- ○ December 1941 to December 1946 (WWII)
- ○ November 1941 or earlier

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5. Did you serve outside the United States?

- ○ Yes
- ○ No

6. Where were you stationed, whether on land or in water? *(Mark any that apply)*

- ○ USA / Canada
- ○ Africa
- ○ Asia / South Pacific
- ○ Caribbean
- ○ Eastern Europe
- ○ Mexico
- ○ Middle East / Southwest Asia
- ○ Northern / Central Europe
- ○ Southern Europe / Mediterranean Basin
- ○ South / Central America
- ○ Other

7. Did you deploy in support of the 1990-1991 Gulf War? *(Mark any that apply)*

- ○ Yes, deployed to the Gulf
- ○ Yes, deployed elsewhere
- ○ No

→ **Skip to question 12 on page 7**

8. In what month and year did you first arrive in the Gulf region?

MONTH / YEAR

9. In what month and year did you last leave the Gulf region?

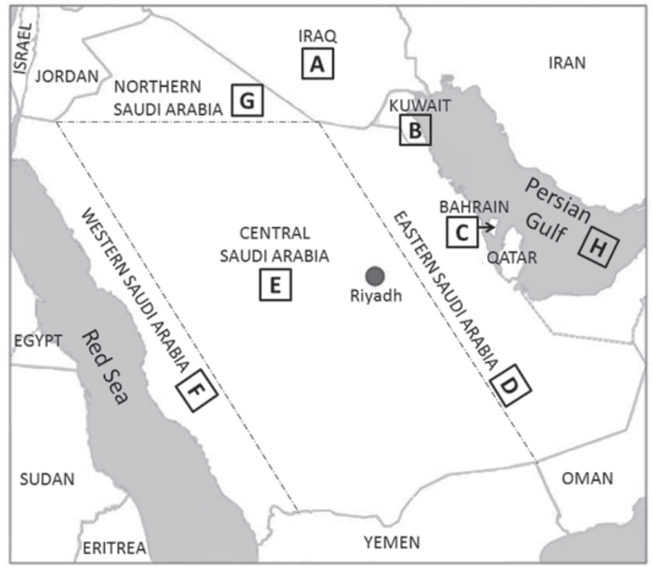
MONTH / YEAR

50. Please tell us if any of your biological family members have been diagnosed with the following conditions.

	Mother			Father			Any Sibling			Any Grandparent on Mother's Side			Any Grandparent on Father's Side		
	Unknown	No	Yes	Unknown	No	Yes	Unknown	No	Yes	Unknown	No	Yes	Unknown	No	Yes
a. Alzheimer's / Other dementia	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
b. Asthma	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
c. Bipolar disorder	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
d. Cancer, breast	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
e. Cancer, colon	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
f. Cancer, lung	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
g. Cancer, prostate				○	○	○	○	○	○	○	○	○	○	○	○
h. Cancer, skin	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
i. Cancer, all others	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Mother			Father			Any Sibling			Any Grandparent on Mother's Side			Any Grandparent on Father's Side		
	Unknown	No	Yes	Unknown	No	Yes	Unknown	No	Yes	Unknown	No	Yes	Unknown	No	Yes
j. Chronic lung disease (COPD, Emphysema, or Bronchitis)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
k. Coronary artery / Coronary heart disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
l. Depression	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
m. Diabetes / "Sugar"	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
n. High blood pressure	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
o. High cholesterol	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
p. Kidney disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
q. Liver condition	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
r. Schizophrenia	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
s. Stroke / Transient ischemic attack (TIA)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

49. Please answer some questions about your biological siblings, beginning with the eldest. If you are not sure, take your best guess.

	Biological Siblings?		Year of Birth		Living?			IF NO: Year of Death	
	Brother	Sister	Unknown	Year	Unknown	Yes	No ➔	Unknown	Year
a.	○	○	○		○	○	○	○	
b.	○	○	○		○	○	○	○	
c.	○	○	○		○	○	○	○	
d.	○	○	○		○	○	○	○	
e.	○	○	○		○	○	○	○	
f.	○	○	○		○	○	○	○	
g.	○	○	○		○	○	○	○	
h.	○	○	○		○	○	○	○	
i.	○	○	○		○	○	○	○	
j.	○	○	○		○	○	○	○	
k.	○	○	○		○	○	○	○	
l.	○	○	○		○	○	○	○	
m.	○	○	○		○	○	○	○	
n.	○	○	○		○	○	○	○	



10. While you were in the Persian Gulf region, were you ever located in…? *(Mark No or Yes for each)*			IF YES: About how many days?		
	No	Yes ➔	1-6 days	7-30 days	31 days or more
a. Iraq (area A on map)	○ No	○ Yes	○	○	○
b. Kuwait (area B on map)	○ No	○ Yes	○	○	○
c. Bahrain (area C on map)	○ No	○ Yes	○	○	○
d. Saudi Arabia: Eastern area (area D on map)	○ No	○ Yes	○	○	○
e. Saudi Arabia: Central area (area E on map)	○ No	○ Yes	○	○	○
f. Saudi Arabia: Western area (area F on map)	○ No	○ Yes	○	○	○
g. Saudi Arabia: Northern area (area G on map)	○ No	○ Yes	○	○	○
h. At sea: in the Persian Gulf (area H on map)	○ No	○ Yes	○	○	○
i. At sea: other location - specify:	○ No	○ Yes	○	○	○
j. Other location - specify:	○ No	○ Yes	○	○	○

11. While you were in the Gulf region, did you experience any of the following?	Not Sure	No	Yes ➔	IF YES: About how many days? 1-6 days	7-30 days	31 days or more
a. Entered Iraq	○ Not Sure	○ No	○ Yes	○	○	○
b. Entered Kuwait	○ Not Sure	○ No	○ Yes	○	○	○
c. Served on board a ship	○ Not Sure	○ No	○ Yes	○	○	○
d. Close proximity to smoke from oil well fires	○ Not Sure	○ No	○ Yes	○	○	○
e. Directly involved in ground combat	○ Not Sure	○ No	○ Yes	○	○	○
f. Took pyridostigmine bromide (anti-nerve agent pills)	○ Not Sure	○ No	○ Yes	○	○	○
g. Exposed to chemical or biological warfare agents	○ Not Sure	○ No	○ Yes	○	○	○
h. Worked with prisoners of war	○ Not Sure	○ No	○ Yes	○	○	○
i. Used pesticide cream or liquid on your skin	○ Not Sure	○ No	○ Yes	○	○	○
j. Wore a uniform treated with pesticides	○ Not Sure	○ No	○ Yes	○	○	○
k. Used insect baits / no-pest strips in your living area	○ Not Sure	○ No	○ Yes	○	○	○

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The following questions are about your family, including your family's health history.

44. Were you adopted as a child?

○ Yes
○ No

45. Are you a twin, triplet, or other multiple birth?

○ Yes
○ No
○ Unknown

46. Do you have any of the following, living or dead?	Unknown	No	Yes ➔	How Many?
a. Daughters	○ Unknown	○ No	○ Yes	
b. Sons	○ Unknown	○ No	○ Yes	
c. Brothers	○ Unknown	○ No	○ Yes	
d. Sisters	○ Unknown	○ No	○ Yes	

47. Do you know any family health information about your biological family members? Biological family members include full-blood and half-blood relatives (e.g., half-sister). Do not include people who are not blood relatives. These include people who married into your family, step-parents, step-brothers and step-sisters, and adopted relatives.

○ No ➔ **Skip to question 51 on page 30**

○ Yes ➔ **Continue to question 48**

48. Please answer the following questions about your biological family, if known. If you are not sure, take your best guess.

	Year of Birth: Unknown	Year of Birth: Year	Living? Unknown	Living? Yes	Living? No ➔	IF NO: Year of Death: Unknown	IF NO: Year of Death: Year
a. Mother	○		○	○	○	○	
b. Father	○		○	○	○	○	

43. Please list the names of all medications that you take on a regular basis. This should include pills, injections, and inhalers, as well as any over-the-counter medications, vitamins, or herbal supplements.

○ I am not taking any medications

List the medications you are currently taking below (one per row):

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.

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12. Did you deploy in support of Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) (September 2001 or later)?

○ Yes
○ No

13. Were you ever exposed to Agent Orange?

○ Yes
○ No
○ Not Sure

14. Were you ever given the Anthrax vaccine?

○ Yes
○ No
○ Not Sure

The following questions are about your lifestyle and activities.

15. How would you rate your current physical fitness status?

○ Very good
○ Fairly good
○ Satisfactory
○ Fairly poor
○ Very poor

16. How physically strenuous is your current work / job (paid and unpaid)?

○ Very light (mainly sitting)
○ Light (mainly walking)
○ Medium (lifting, carrying light loads)
○ Heavy manual work (climbing, carrying heavy loads)
○ Not applicable

17. How often do you exercise vigorously enough to work up a sweat?

○ Rarely / Never
○ 1 – 3 times a month
○ Once a week
○ 2 – 4 times a week
○ 5 – 6 times a week
○ Daily

18. On how many days did you engage in <u>moderate</u> physical activity (like a brisk walk) in the last 7 days?

☐ number of days ➔ **If zero days, skip to question 20 on page 8**

19. On those days that you engaged in <u>moderate</u> physical activity, how many minutes, on average, did you exercise at this level?

☐☐☐ number of minutes

20. On how many days did you engage in vigorous physical activity (like running/jogging) in the last 7 days?

☐ number of days ➔ **If zero days, skip to question 22**

21. On those days that you engaged in vigorous physical activity, how many minutes, on average, did you exercise at this level?

☐☐☐ number of minutes

22. In your lifetime, have you smoked a total of at least 100 cigarettes, cigars, or pipes?

○ Yes
○ No ➔ **Skip to question 23**

22a. Have you ever smoked daily or almost every day for at least 1 year?

○ Yes
○ No

22b. Do you smoke now?

○ Yes, daily
○ Yes, occasionally
○ Not at all

23. How often do you have a drink containing alcohol?

○ Never ➔ **Skip to question 24 on page 9**
○ 1 – 3 days per month
○ 1 day per week
○ 2 – 3 days per week
○ 4 – 5 days per week
○ 6+ days per week

23a. How many drinks containing alcohol do you have on a typical day when you are drinking?

○ 1 or 2
○ 3 or 4
○ 5 or 6
○ 7 to 9
○ 10 or more

23b. How often do you have six or more drinks on one occasion?

○ Never
○ Less than monthly
○ Monthly
○ 2 – 3 times per week
○ 4+ times a week

39. In the PAST YEAR, about how much of your health care did you get at a VA facility (e.g., doctor's visits, hospitalizations, urgent care visits or counseling)?

○ None
○ 1 – 25%
○ 26 – 50%
○ 51 – 75%
○ 76 – 99%
○ 100%

40a. In the PAST YEAR, how many times were you a patient in a VA Healthcare Facility overnight or longer?

○ None
○ 1 – 3
○ 4 – 6
○ 7 – 9
○ 10 or more

40b. In the PAST YEAR, how many times were you a patient in a Non-VA Healthcare Facility overnight or longer?

○ None
○ 1 – 3
○ 4 – 6
○ 7 – 9
○ 10 or more

41a. How many prescription medications do you currently receive from a VA Pharmacy?

○ None
○ 1 – 3
○ 4 – 6
○ 7 – 9
○ 10 or more

41b. How many prescription medications do you currently receive from a Non-VA Pharmacy?

○ None
○ 1 – 3
○ 4 – 6
○ 7 – 9
○ 10 or more

42a. How many non-prescription medications do you currently receive from a VA Pharmacy?

○ None
○ 1 – 3
○ 4 – 6
○ 7 – 9
○ 10 or more

42b. How many non-prescription medications do you currently receive from a Non-VA Pharmacy?

○ None
○ 1 – 3
○ 4 – 6
○ 7 – 9
○ 10 or more

Have you ever been told that you have…?

38j. Other Conditions	No	Yes ➔	Year Told	Currently Taking Meds	
12. Skin condition (e.g., Eczema, Psoriasis) If yes, specify type:	○ No	○ Yes		○ No	○ Yes
13. Other disease / disorder If yes, specify type(s): **1.**	○ No	○ Yes	**1.**	○ No	○ Yes
2.			**2.**	○ No	○ Yes
3.			**3.**	○ No	○ Yes

24. For each of the following, other than what was prescribed to you, have you ever used…?	No	Yes ➔	IF YES: When did you use the substance? (Mark any that apply) Last 12 months	Prior to last 12 months
a. Sedatives	○ No	○ Yes	○	○
b. Tranquilizers	○ No	○ Yes	○	○
c. Painkillers (other than over-the-counter medications)	○ No	○ Yes	○	○
d. Stimulants	○ No	○ Yes	○	○
e. Marijuana	○ No	○ Yes	○	○
f. Cocaine or Crack	○ No	○ Yes	○	○
g. Hallucinogens	○ No	○ Yes	○	○
h. Inhalants / Solvents	○ No	○ Yes	○	○
i. Heroin	○ No	○ Yes	○	○
j. Something else? Specify:	○ No	○ Yes	○	○

The following questions are about your physical and mental health.

25. In general, would you say your health is:

○ Excellent
○ Very good
○ Good
○ Fair
○ Poor

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26. COMPARED TO ONE YEAR AGO, how would you rate your:	Much better	Slightly better	About the same	Slightly worse	Much worse
a. Physical health in general now?	○	○	○	○	○
b. Emotional health (such as feeling anxious, depressed, or irritable) now?	○	○	○	○	○
c. Cognitive (memory and thinking) health in general now?	○	○	○	○	○

27. On a scale of 0-10, where 0 means no pain and 10 means pain as bad as you can imagine, please rate your overall amount of pain in the PAST WEEK:

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
No pain										Pain as bad as you can imagine

28. Does your health now limit you in these activities? If so, how much?	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	○	○	○
b. Climbing several flights of stairs?	○	○	○

29. During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
a. Accomplished less than you would like?	○	○	○	○	○
b. Were limited in the kind of work or other activities?	○	○	○	○	○

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Have you ever been told that you have…?

38j. Other Conditions	No	Yes ➔	Year Told	Currently Taking Meds
1. Asthma	○ No	○ Yes		○ No ○ Yes
2. Chronic lung disease (COPD, Emphysema or Bronchitis)	○ No	○ Yes		○ No ○ Yes
3. Diabetes / "Sugar"	○ No	○ Yes		○ No ○ Yes
4. Enlarged prostate (Benign prostatic hyperplasia)	○ No	○ Yes		○ No ○ Yes
5. Liver condition (e.g., Cirrhosis)	○ No	○ Yes		○ No ○ Yes
6. Sleep apnea	○ No	○ Yes		○ No ○ Yes
7. Lupus	○ No	○ Yes		○ No ○ Yes
8. Other cancer If yes, specify type:	○ No	○ Yes		○ No ○ Yes
9. Other digestive system disorder If yes, specify type:	○ No	○ Yes		○ No ○ Yes
10. Thyroid problems If yes, specify type:	○ No	○ Yes		○ No ○ Yes
11. Other infectious disease If yes, specify type:	○ No	○ Yes		○ No ○ Yes

Have you ever been told that you have…?

38i. Nervous System Problems	No	Yes →	Year Told	Currently Taking Meds	
1. Migraine headaches	○ No	○ Yes		○ No	○ Yes
2. Other headaches	○ No	○ Yes		○ No	○ Yes
3. Memory loss or impairment	○ No	○ Yes		○ No	○ Yes
4. Dementia (includes Alzheimer's, vascular, etc.)	○ No	○ Yes		○ No	○ Yes
5. Concussion or loss of consciousness	○ No	○ Yes		○ No	○ Yes
6. Traumatic brain injury (TBI)	○ No	○ Yes		○ No	○ Yes
7. Spinal cord injury or impairment	○ No	○ Yes		○ No	○ Yes
8. Epilepsy / Seizure	○ No	○ Yes		○ No	○ Yes
9. Parkinson's disease	○ No	○ Yes		○ No	○ Yes
10. Amyotrophic lateral sclerosis (ALS) (Lou Gehrig's disease)	○ No	○ Yes		○ No	○ Yes
11. Multiple sclerosis (MS)	○ No	○ Yes		○ No	○ Yes
12. Other nervous system problem	○ No	○ Yes		○ No	○ Yes

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30. During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
a. Accomplished less than you would like?	○	○	○	○	○
b. Didn't do work or other activities as carefully as usual?	○	○	○	○	○

31. During the PAST 4 WEEKS, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ○ Not at all
- ○ A little bit
- ○ Moderately
- ○ Quite a bit
- ○ Extremely

32. How much of the time during the PAST 4 WEEKS...	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
a. Have you felt calm and peaceful?	○	○	○	○	○	○
b. Did you have a lot of energy?	○	○	○	○	○	○
c. Have you felt downhearted and blue?	○	○	○	○	○	○

33. During the PAST 4 WEEKS, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ○ None of the time
- ○ A little of the time
- ○ Some of the time
- ○ Most of the time
- ○ All of the time

34. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○
c. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
d. Feeling tired or having little energy	○	○	○	○
e. Poor appetite or overeating	○	○	○	○
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	○	○	○	○
g. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
h. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○

i. **If you marked *Several days, More than half the days, or Nearly every day* for any problems in the table above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

35a. In the past 7 days, my sleep quality was...

- ○ Very Poor
- ○ Poor
- ○ Fair
- ○ Good
- ○ Very Good

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Have you ever been told that you have…?

38g. Digestive System Problems	No	Yes ➔	Year Told	Currently Taking Meds
6. Ulcerative colitis	○ No	○ Yes		○ No ○ Yes
7. Crohn's disease	○ No	○ Yes		○ No ○ Yes
8. Celiac disease / Sprue	○ No	○ Yes		○ No ○ Yes

38h. Cancer	No	Yes ➔	Year Told	Currently Taking Meds
1. Brain cancer	○ No	○ Yes		○ No ○ Yes
2. Breast cancer	○ No	○ Yes		○ No ○ Yes
3. Colon cancer / Rectal cancer	○ No	○ Yes		○ No ○ Yes
4. Lung cancer	○ No	○ Yes		○ No ○ Yes
5. Prostate cancer	○ No	○ Yes		○ No ○ Yes
6. Skin cancer	○ No	○ Yes		○ No ○ Yes

Have you ever been told that you have…?

38e. Infectious Diseases	No	Yes →	Year Told	Currently Taking Meds	
1. Tuberculosis	○ No	○ Yes		○ No	○ Yes
2. Hepatitis C	○ No	○ Yes		○ No	○ Yes
3. HIV / AIDS	○ No	○ Yes		○ No	○ Yes

38f. Kidney Disease	No	Yes →	Year Told	Currently Taking Meds	
1. Kidney disease without dialysis	○ No	○ Yes		○ No	○ Yes
2. Kidney disease with dialysis	○ No	○ Yes		○ No	○ Yes
3. Acute kidney disease with no current dialysis	○ No	○ Yes		○ No	○ Yes

38g. Digestive System Problems	No	Yes →	Year Told	Currently Taking Meds	
1. Acid reflux / GERD	○ No	○ Yes		○ No	○ Yes
2. Peptic ulcers	○ No	○ Yes		○ No	○ Yes
3. Bowel obstruction	○ No	○ Yes		○ No	○ Yes
4. Colon polyps	○ No	○ Yes		○ No	○ Yes
5. Irritable bowel syndrome (IBS)	○ No	○ Yes		○ No	○ Yes

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Please respond to each statement by marking one bubble per row.

35. In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
b. My sleep was refreshing.	○	○	○	○	○
c. I had a problem with my sleep.	○	○	○	○	○
d. I had difficulty falling asleep.	○	○	○	○	○

36. Below is a list of problems and complaints that Veterans sometimes have in response to stressful life experiences. Please read each one carefully and mark one bubble per row to indicate how much you have been bothered by that problem IN THE LAST MONTH.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Repeated, disturbing *memories*, *thoughts*, or *images* of a stressful experience from the past?	○	○	○	○	○
b. Repeated, disturbing *dreams* of a stressful experience from the past?	○	○	○	○	○
c. Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?	○	○	○	○	○
d. Feeling *very upset* when *something reminded* you of a stressful experience from the past?	○	○	○	○	○
e. Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?	○	○	○	○	○
f. Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?	○	○	○	○	○
g. Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?	○	○	○	○	○
h. Trouble *remembering important parts* of a stressful experience from the past?	○	○	○	○	○

36. Below is a list of problems and complaints that Veterans sometimes have in response to stressful life experiences. Please read each one carefully and mark one bubble per row to indicate how much you have been bothered by that problem IN THE LAST MONTH.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
i. Loss of *interest in things that you used to enjoy*?	○	○	○	○	○
j. Feeling *distant* or *cut off* from other people?	○	○	○	○	○
k. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	○	○	○	○	○
l. Feeling as if your *future* will somehow be *cut short*?	○	○	○	○	○
m. Trouble *falling* or *staying asleep*?	○	○	○	○	○
n. Feeling *irritable* or having *angry outbursts*?	○	○	○	○	○
o. Having *difficulty concentrating*?	○	○	○	○	○
p. Being *"super alert"* or watchful on guard?	○	○	○	○	○
q. Feeling *jumpy* or easily startled?	○	○	○	○	○

37. Indicate No or Yes for each. Over the PAST 6 MONTHS, have you had a persistent or recurring problem with…?	No	Yes ➔	IF YES: How would you rate this problem? Mild	Moderate	Severe
a. Fatigue	○ No	○ Yes	○	○	○
b. Feeling unwell after physical exercise or exertion	○ No	○ Yes	○	○	○
c. Problems getting to sleep or staying asleep	○ No	○ Yes	○	○	○
d. Not feeling rested after you sleep	○ No	○ Yes	○	○	○
e. Pain in your joints	○ No	○ Yes	○	○	○

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Have you ever been told that you have…?

38c. Mental Health Disorders	No	Yes ➔	Year Told	Currently Taking Meds
7. Personality disorder	○ No	○ Yes		○ No ○ Yes
8. Schizophrenia	○ No	○ Yes		○ No ○ Yes
9. Social phobia	○ No	○ Yes		○ No ○ Yes
10. Other mental health disorder	○ No	○ Yes		○ No ○ Yes

38d. Vision / Hearing Problems	No	Yes ➔	Year Told	Currently Taking Meds
1. Cataracts	○ No	○ Yes		○ No ○ Yes
2. Glaucoma	○ No	○ Yes		○ No ○ Yes
3. Macular degeneration	○ No	○ Yes		○ No ○ Yes
4. Blindness, all causes	○ No	○ Yes		○ No ○ Yes
5. Tinnitus, or ringing in the ears	○ No	○ Yes		○ No ○ Yes
6. Severe hearing loss or partial deafness in one or both ears	○ No	○ Yes		○ No ○ Yes

Have you ever been told that you have…?

38b. Skeletal / Muscular Problems	No	Yes →	Year Told	Currently Taking Meds	
1. Osteoarthritis	○ No	○ Yes		○ No	○ Yes
2. Rheumatoid arthritis	○ No	○ Yes		○ No	○ Yes
3. Other arthritis	○ No	○ Yes		○ No	○ Yes
4. Gout	○ No	○ Yes		○ No	○ Yes
5. Osteoporosis	○ No	○ Yes		○ No	○ Yes
6. Other skeletal / muscular problem	○ No	○ Yes		○ No	○ Yes

38c. Mental Health Disorders	No	Yes →	Year Told	Currently Taking Meds	
1. Anxiety reaction / Panic disorder	○ No	○ Yes		○ No	○ Yes
2. Attention deficit hyperactivity disorder (ADHD)	○ No	○ Yes		○ No	○ Yes
3. Bipolar disorder	○ No	○ Yes		○ No	○ Yes
4. Post-traumatic stress disorder (PTSD)	○ No	○ Yes		○ No	○ Yes
5. Depression	○ No	○ Yes		○ No	○ Yes
6. Eating disorder	○ No	○ Yes		○ No	○ Yes

37. Indicate No or Yes for each. Over the PAST 6 MONTHS, have you had a persistent or recurring problem with…?	No	Yes →	IF YES: How would you rate this problem? Mild	Moderate	Severe
f. Stiffness in your joints	○ No	○ Yes	○	○	○
g. Pain in your muscles	○ No	○ Yes	○	○	○
h. Body pain, where you hurt all over	○ No	○ Yes	○	○	○
i. Headaches	○ No	○ Yes	○	○	○
j. Feeling dizzy, lightheaded, or faint	○ No	○ Yes	○	○	○
k. Eyes very sensitive to light	○ No	○ Yes	○	○	○
l. Blurred or double vision	○ No	○ Yes	○	○	○
m. Numbness or tingling in your extremities	○ No	○ Yes	○	○	○
n. Tremors or shaking	○ No	○ Yes	○	○	○
o. Low tolerance for heat or cold	○ No	○ Yes	○	○	○
p. Night sweats	○ No	○ Yes	○	○	○
q. Having physical or mental symptoms in response to certain smells or chemicals	○ No	○ Yes	○	○	○
r. Skin rashes	○ No	○ Yes	○	○	○
s. Other skin problems	○ No	○ Yes	○	○	○
t. Diarrhea	○ No	○ Yes	○	○	○

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37. Indicate No or Yes for each. Over the PAST 6 MONTHS, have you had a persistent or recurring problem with…?	No	Yes →	IF YES: How would you rate this problem? Mild	Moderate	Severe
u. Nausea or upset stomach	○ No	○ Yes	○	○	○
v. Abdominal pain or cramping	○ No	○ Yes	○	○	○
w. Difficulty breathing or shortness of breath	○ No	○ Yes	○	○	○
x. Frequent coughing when you don't have a cold	○ No	○ Yes	○	○	○
y. Wheezing in your chest	○ No	○ Yes	○	○	○
z. Sore throat	○ No	○ Yes	○	○	○
aa. Tender lymph nodes in your neck or armpits	○ No	○ Yes	○	○	○
bb. Difficulty concentrating	○ No	○ Yes	○	○	○
cc. Difficulty remembering recent information	○ No	○ Yes	○	○	○
dd. Trouble finding words when speaking	○ No	○ Yes	○	○	○
ee. Feeling down or depressed	○ No	○ Yes	○	○	○
ff. Feeling irritable or having angry outbursts	○ No	○ Yes	○	○	○
gg. Feeling moody	○ No	○ Yes	○	○	○
hh. Feeling anxious	○ No	○ Yes	○	○	○

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The following questions are about your Health History and Medications.

38. Please tell us if a doctor or other healthcare provider has ever told you that you have any of the following conditions. Mark No or Yes for each. If Yes, write the year you were told, and whether you currently take any medication(s) ("Currently Taking Meds") for that condition.

Have you ever been told that you have…?

38a. Circulatory System Problems	No	Yes →	Year Told	Currently Taking Meds
1. High blood pressure (Hypertension)	○ No	○ Yes		○ No ○ Yes
2. Stroke	○ No	○ Yes		○ No ○ Yes
3. Transient ischemic attack (TIA)	○ No	○ Yes		○ No ○ Yes
4. Heart attack	○ No	○ Yes		○ No ○ Yes
5. Coronary artery / Coronary heart disease (includes angina)	○ No	○ Yes		○ No ○ Yes
6. Peripheral vascular disease	○ No	○ Yes		○ No ○ Yes
7. High cholesterol	○ No	○ Yes		○ No ○ Yes
8. Pulmonary embolism or deep vein thrombosis (DVT)	○ No	○ Yes		○ No ○ Yes
9. Congestive heart failure	○ No	○ Yes		○ No ○ Yes
10. Other circulatory system problem	○ No	○ Yes		○ No ○ Yes