



# Health Information

## National Trends Survey





**Instructions:**

Please use a black or blue pen to complete this form.

Mark **X** to indicate your answer. To change an answer, darken the box **X** and mark the correct answer.

**A: Looking For Health Information**

A1. Have you ever looked for information about cancer from any source?

SeekCancerInfo

1 Yes

2 No → GO TO A3 below

A2. Based on the results of your most recent search for information about cancer, how much do you agree or disagree with each of the following statements?

Strongly agree   Somewhat agree   Somewhat disagree   Strongly disagree

a. It took a lot of effort to get the information you needed.....  1  2  3  4

CancerLotOfEffort

b. You felt frustrated during your search for the information.....  1  2  3  4

CancerFrustrated

A3. Overall, how confident are you that you could get advice or information about cancer if you needed it?

CancerConfidentGetHealthInf

1 Completely confident

2 Very confident

3 Somewhat confident

4 A little confident

5 Not confident at all

A4. In general, how much would you trust information about cancer from each of the following?

Not at all   A little   Some   A lot

a. A doctor.....  4  3  2  1

CancerTrustDoctor

b. Family or friends.....  4  3  2  1

CancerTrustFamily

c. Government health agencies...  4  3  2  1

CancerTrustGov

d. Charitable organizations.....  4  3  2  1

CancerTrustCharities

e. Religious organizations and leaders.....  4  3  2  1

CancerTrustReligiousOrgs

A5. If you had a strong need to get information about cancer. Where would you go first?

SEERStrongNeedCancerInfo

Mark only one.

1 Books

2 Brochures, pamphlets, etc.

3 Cancer organization

4 Family

5 Friend/Co-worker

6 Doctor or health care provider

7 Internet

8 Library

9 Magazines

10 Newspapers

11 Telephone information number

12 Complementary, alternative, or unconventional practitioner

91 Other - Specify → SEERStrongNeedCancerInfo\_OS



## B: Using the Internet to Find Information

B1. Do you ever go on-line to access the Internet or World Wide Web, or to send and receive e-mail?

UseInternet

- 1 Yes  
 2 No → GO TO B5 in the next column

B2. When you use the Internet, do you access it through...

Yes No

- |   | Yes                        | No                         |
|---|----------------------------|----------------------------|
| a. A regular dial-up telephone line.....<br>Internet_DialUp       | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| b. Broadband such as DSL, cable, or FiOS....<br>Internet_BroadBnd | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| c. A cellular network (i.e., phone, 3G/4G).....<br>Internet_Cell  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| d. A wireless network (Wi-Fi).....<br>Internet_WiFi               | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |

B3. How often do you access the Internet through each of the following?

Daily Sometimes Never Not applicable

- |   | Daily                      | Sometimes                  | Never                      | Not applicable             |
|---|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Computer at home.....<br>WhereUseInternet_Home   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| b. Computer at work.....<br>WhereUseInternet_Work   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| c. Computer in a public place (library, community center, other).....<br>WhereUseInternet_PublicPlace | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| d. On a mobile device (cell phone/smart phone/tablet).....<br>WhereUseInternet_MobileDevice           | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |

B4. To what extent are you satisfied with your Internet speed?

InternetSpeed

- 1 Not at all satisfied  
 2 Not very satisfied  
 3 Somewhat satisfied  
 4 Very satisfied  
 5 Extremely satisfied

B5. In the past 12 months, have you used a computer, smartphone, or other electronic means to do any of the following?

Yes No

- |  | Yes                        | No                         |
|--|----------------------------|----------------------------|
| a. Looked for health or medical information for yourself.....<br>Electronic_SelfHealthInfo                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| b. Used e-mail or the Internet to communicate with a doctor or a doctor's office.....<br>Electronic_TalkDoctor | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| c. Look up medical test results.....<br>Electronic_TestResults   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| d. Made appointments with a health care provider.....<br>Electronic_MadeApts                                   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |

B6. Please indicate if you have each of the following.

Mark all that apply.

- 1 Tablet computer (for example, an iPad, Samsung Galaxy, Motorola Xoom, or Kindle Fire)  
HaveDevice\_Tablet
- 1 Smartphone (for example, an iPhone, Android, Blackberry, or Windows phone)  
HaveDevice\_SmartPh
- 1 Basic cell phone only  
HaveDevice\_CellPh
- 1 I do not have any of the above  
HaveDevice\_None
- 1 I do not have any of the above  
HaveDevice\_Cat
- GO TO B10 on the next page

B7. On your tablet or smartphone, do you have any "apps" related to health and wellness?

TabletHealthWellnessApps

- 1 Yes  
 2 No → GO TO B9 on the next page  
 3 Don't know → GO TO B9 on the next page

B8. In the past 12 months, have you used any of these health or wellness apps?

UsedHealthWellnessApps

- 1 Yes  
 2 No  
 3 Don't know



B9. Has your tablet or smartphone...

	Yes ↓	No ↓
a. Helped you track progress on a health-related goal such as quitting smoking, losing weight, or increasing physical activity?.....	1	2
<i>Tablet_AchieveGoal</i>		
b. Helped you make a decision about how to treat an illness or condition?.....	1	2
<i>Tablet_MakeDecision</i>		
c. Helped you in discussions with your health care provider?.....	1	2
<i>Tablet_DiscussionsHCP</i>		

B10. In the past 12 months, have you used an electronic wearable device to monitor or track your health or activity? For example, a Fitbit, Apple Watch, or Garmin Vivofit.

	Yes ↓	No ↓
1 Yes		
2 No → GO TO B13 in the next column		

B11. In the past month, how often did you use a wearable device to track your health?

	Yes ↓	No ↓
1 Every day		
2 Almost every day		
3 1-2 times per week		
4 Less than once per week		
5 I did not use a wearable device in the past month		

B12. Would you be willing to share health data from your wearable device with...

	Yes ↓	No ↓
a. Your health care provider?.....	1	2
<i>WillingShareData_HCP</i>		
b. Your family?.....	1	2
<i>WillingShareData_YourFamily</i>		
c. Your friends?.....	1	2
<i>WillingShareData_YourFriends</i>		

B13. Have you shared health information from either an electronic monitoring device or smartphone with a health professional within the last 12 months?

	Yes ↓	No ↓
1 Yes		
2 No		
3 Not Applicable		

B14. Sometimes people use the Internet to connect with other people online through social networks like Facebook or Twitter. This is often called “social media”.

In the last 12 months, have you used the Internet for any of the following reasons?

	Yes ↓	No ↓
a. To visit a social networking site, such as Facebook or LinkedIn.....	1	2
<i>IntRsn_VisitedSocNet</i>		
b. To share health information on social networking sites, such as Facebook or Twitter.....	1	2
<i>IntRsn_SharedSocNet</i>		
c. To participate in an online forum or support group for people with a similar health or medical issue.....	1	2
<i>IntRsn_SupportGroup</i>		
d. To watch a health-related video on YouTube.....	1	2
<i>IntRsn_YouTube</i>		

## C: Your Health Care

C1. Not including psychiatrists and other mental health professionals, is there a particular doctor, nurse, or other health professional that you see most often?

	Yes ↓	No ↓
1 Yes		
2 No		





C2. In the past 12 months, not counting times you went to an emergency room, how many times did you go to a doctor, nurse, or other health professional to get care for yourself?

FreqGoProvider

0 None → GO TO C6 in the next column

- 1 1 time
- 2 2 times
- 3 3 times
- 4 4 times
- 5 5-9 times
- 6 10 or more times

C3. Overall, how would you rate the quality of health care you received in the past 12 months?

QualityCare

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

C4. The following questions are about your communication with all doctors, nurses, or other health professionals you saw during the past 12 months.

How often did they do each of the following?

Always Usually Sometimes Never

- a. Give you the chance to ask all the health-related questions you had..... 1 2 3 4  
ChanceAskQuestions
- b. Give the attention you needed to your feelings and emotions..... 1 2 3 4  
FeelingsAddressed
- c. Involve you in decisions about your health care as much as you wanted..... 1 2 3 4  
InvolvedDecisions
- d. Make sure you understood the things you needed to do to take care of your health..... 1 2 3 4  
UnderstoodNextSteps
- e. Explain things in a way you could understand..... 1 2 3 4  
ExplainedClearly
- f. Spend enough time with you..... 1 2 3 4  
SpentEnoughTime
- g. Help you deal with feelings of uncertainty about your health or health care..... 1 2 3 4  
HelpUncertainty

C5. In the past 12 months, when getting cancer care or care for other medical problems, was there a time when you...

Yes No

- a. Had to bring an X-ray, MRI, or other type of test result with you to the appointment?..... 1 2  
SEER\_ProbCare\_BringTest
- b. Had to wait for test results longer than you thought reasonable?..... 1 2  
SEER\_ProbCare\_WaitLong
- c. Had to redo a test or procedure because the earlier test results were not available?..... 1 2  
SEER\_ProbCare\_RedoTest
- d. Had to provide your medical history again because your chart could not be found?..... 1 2  
SEER\_ProbCare\_ProvideHist

C6. In the past 12 months, have you seen or talked to a mental health professional such as a psychologist, psychiatrist, psychiatric nurse or clinical social worker about your health?

TalkedMentalHealthProf

- 1 Yes
- 2 No

C7. Are you currently covered by any of the following types of health insurance or health coverage plans?

Yes No

- a. Insurance through a current or former employer or union..... 1 2  
HealthIns\_InsuranceEMP
- b. Insurance purchased directly from an insurance company..... 1 2  
HealthIns\_InsurancePriv
- c. Medicare, for people 65 and older, or people with certain disabilities..... 1 2  
HealthIns\_Medicare
- d. Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability..... 1 2  
HealthIns\_Medicaid
- e. TRICARE or other military health care..... 1 2  
HealthIns\_Tricare
- f. VA (including those who have ever used or enrolled for VA health care)..... 1 2  
HealthIns\_VA
- g. Indian Health Service..... 1 2  
HealthIns\_IHS
- h. Any other type of health insurance or health coverage plan (Specify)..... 1 2  
HealthIns\_Other

HealthIns\_Other\_OS



## D: Medical Records

Next, we are going to ask you some questions about your medical records. Medical records are defined as medical history, such as laboratory test results, clinical notes, and current list of medications.

D1. Do any of your doctors or other health care providers maintain your medical records in a computerized system?

ProviderMaintainEMR2

- 1 Yes
- 2 No
- 3 Don't know

D2. Have you ever been offered online access to your medical records by your...

	Yes ↓	No ↓	Don't know ↓
a. health care provider?..... <span style="color: red; font-size: small;">OfferedAccessHCP2</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. health insurer?..... <span style="color: red; font-size: small;">OfferedAccessInsurer2</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

D3. Have any of your health care providers, including doctors, nurses, or office staff ever encouraged you to use an online medical record?

HCPEncourageOnlineRec

- 1 Yes
- 2 No

D4. How many times did you access your online medical record in the last 12 months?

AccessOnlineRecord

- 0 0
  - 1 1 to 2 times
  - 2 3 to 5 times
  - 3 6 to 9 times
  - 4 10 or more times
- } **GO TO D6 on the next page**

D5. Why have you not accessed your medical records online? Is it because...

	Yes ↓	No ↓
a. You prefer to speak to your health care provider directly?..... <span style="color: red; font-size: small;">NotAccessed_SpeakDirectly</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. You do not have a way to access the website?..... <span style="color: red; font-size: small;">NotAccessed_NoInternet</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. You did not have a need to use your online medical record?..... <span style="color: red; font-size: small;">NotAccessed_NoNeed</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. You were concerned about the privacy or security of the website that had your medical records?..... <span style="color: red; font-size: small;">NotAccessed_ConcernedPrivacy</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
e. You don't have an online medical record..... <span style="color: red; font-size: small;">NotAccessed_NoRecord</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
f. You found it difficult to login (for example, you had trouble remembering your password)?..... <span style="color: red; font-size: small;">NotAccessed_LogInProb</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
g. You are not comfortable or experienced with computers?..... <span style="color: red; font-size: small;">NotAccessed_Uncomfortable</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
h. You have more than one online medical record?..... <span style="color: red; font-size: small;">NotAccessed_MultipleRec</span>	<input type="checkbox"/> 1	<input type="checkbox"/> 2



If you have not accessed any medical records in the last 12 months, go to E1 on the next page

Otherwise, go to D6 on the next page



## E: Cancer History

D6. In the past 12 months, have you used your online medical record to...

	Yes	No
a. Look up test results?..... <small>RecordsOnline_ViewResults</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Securely message health care provider and staff (for example, e-mail)?..... <small>RecordsOnline_MessageHCP</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Download your health information to your computer or mobile device, such as a cell phone or tablet?..... <small>RecordsOnline_DownloadHealth</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2

D7. How did you access your online medical record?

HowAccessOnlineRecord

1 App

2 Website

3 Both app and website

4 Don't know

D8. Do any of your online medical records include clinical notes (health provider's notes that describe a visit)?

OnlineRecClinNotes

1 Yes

2 No

3 Don't know

D9. Have you electronically sent your medical information to....

	Yes	No
a. Another health care provider?..... <small>ESent_AnotherHCP</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. A family member or another person involved with your care?..... <small>ESent_Family</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. A service or app that can help manage and store your health information?..... <small>ESent_HealthApp</small>	<input type="checkbox"/> 1	<input type="checkbox"/> 2

D10. How easy or difficult was it to understand the health information in your online medical record?

UnderstandOnlineMedRec

1 Very easy

2 Somewhat easy

3 Somewhat difficult

4 Very difficult

E1. What type(s) of cancer have you been diagnosed with?

**Mark all that apply.**

1 I have never been diagnosed as having cancer → **GO TO E9 on the next page**

- 1 Bladder cancer  
SEER\_CaBladder
- 1 Bone cancer  
SEER\_CaBone
- 1 Breast cancer  
SEER\_CaBreast
- 1 Cervical cancer (cancer of the cervix)  
SEER\_CaCervical
- 1 Colon cancer  
SEER\_CaColon
- 1 Endometrial cancer (cancer of the uterus)  
SEER\_CaEndometrial
- 1 Head and neck cancer  
SEER\_CaHeadNeck
- 1 Leukemia/Blood cancer  
SEER\_CaLeukemia
- 1 Liver cancer  
SEER\_CaLiver
- 1 Lung cancer  
SEER\_CaLung
- 1 Lymphoma (Hodgkin's)  
SEER\_CaHodgkins
- 1 Lymphoma (Non-Hodgkin's)  
SEER\_CaNonHodgkin
- 1 Melanoma  
SEER\_CAMelanoma
- 1 Non-melanoma skin cancer (basal cell or squamous cell carcinoma)  
SEER\_CANonMelSkin
- 1 Oral cancer  
SEER\_CaOral
- 1 Ovarian cancer  
SEER\_CaOvarian
- 1 Pancreatic cancer  
SEER\_CaPancreatic
- 1 Pharyngeal (throat) cancer  
SEER\_CaPharyngeal
- 1 Prostate cancer  
SEER\_CaProstate
- 1 Rectal cancer  
SEER\_CaRectal
- 1 Renal (kidney) cancer  
SEER\_CaRenal
- 1 Stomach cancer  
SEER\_CaStomach
- 1 Other - Specify → SEER\_CaOther  
SEER\_CaOther\_OS  
SEER\_Cancer\_Cat

E2. At what age were you first told that you had cancer?

			<small>WhenDiagnosedCancer</small>
			Years old





E3. Did you ever receive any treatment for your cancer?

UndergoCancerTreatment

- 1 Yes
- 2 No → GO TO E6 below

E4. About how long ago did you receive your last cancer treatment?

HowLongFinishTreatment\_Cat

- 5 Still receiving treatment
- 1 Less than 1 year ago
- 2 1 year ago to less than 5 years ago
- 3 5 years ago to less than 10 years ago
- 4 10 or more years ago

E5. Overall, how would you rate the quality of the cancer care you received when you were treated for cancer?

QualityCancerCare

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

E6. Have you ever experienced any of the following conditions as a result of your cancer diagnosis or cancer treatment?

Yes No

- |   |                            |                            |
|---|----------------------------|----------------------------|
| a. Cognitive impairment (for example, having difficulty remembering things, or 'chemobrain')..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| <i>CancerCond_CogImpair</i>   |                            |                            |
| b. Neuropathy (numbness or tingling feelings).....  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| <i>CancerCond_Neuropathy</i>  |                            |                            |
| c. Severe fatigue (always tired or sleepy)....  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| <i>CancerCond_Fatigue</i>   |                            |                            |
| d. Nausea.....  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| <i>CancerCond_Nausea</i>  |                            |                            |
| e. Something else. Specify.....   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |

*CancerCond\_Other*  
*CancerCond\_Other\_OS*

E7. Looking back, since the time you were first diagnosed with cancer, how much, if at all, has cancer and its treatment hurt your financial situation?

CancerHurtFinances

- 1 Not at all
- 2 A little
- 3 Some
- 4 A lot

E8. At any time since you were first diagnosed with cancer, did any doctor or other health care provider ever discuss with you the impact of cancer or its treatment on your ability to work?

CancerAbilityToWork

- 1 Discussed it with me in detail
- 2 Briefly discussed it with me
- 3 Did not discuss it at all
- 4 I don't remember
- 5 I was not working at the time of my diagnosis

E9. The following questions ask about your knowledge about cancer in your family. By family we mean your first- and second-degree biological relatives: your parents, brothers and sisters, children, grandparents, aunts and uncles, nieces and nephews.

How well do you know your family's cancer history, including if you have no history of cancers in your family?

FamiliarFamilyCancer2

- 5 Not at all
- 4 A little
- 3 Somewhat
- 2 Well
- 1 Very well

E10. Have any of your first- or second-degree biological relatives (parents, brothers and sisters, children, grandparents, aunts and uncles, nieces and nephews) ever had cancer?

FamilyEverHadCancer2

- 1 Yes
- 2 No
- 3 Not sure

## F: Impact of COVID-19

F1. The following questions are related to the coronavirus/COVID-19 pandemic that impacted the United States in 2020.

Has the COVID-19 pandemic affected either your cancer treatment or any follow-up medical appointments related to your cancer? Do not include routine cancer screening or preventive care appointments.

**Mark all that apply.**

- I have not had any scheduled cancer treatment or any follow-up medical appointments related to my cancer during the pandemic  
`COVIDCa_NoAppts`
- Yes, some or all of my cancer treatment or follow-up medical appointments related to my cancer were cancelled or delayed  
`COVIDCa_ApptsCanceled`
- Yes, some or all of my cancer treatment or follow-up medical appointments related to my cancer were done by phone or video conference instead of in-person (telehealth)  
`COVIDCa_TelehealthAppts`
- No, my cancer treatment or follow-up medical appointments related to my cancer have not been affected by the COVID-19 pandemic  
`COVIDCa_ApptsUnaffected`  
`COVIDCa_Cat`

F2. Has the COVID-19 pandemic affected any of your appointments for routine cancer screening or preventive care (e.g., mammography, colonoscopy, etc.)?

**Mark all that apply.**

- I have not had any scheduled appointments for routine cancer screening or preventive care during the pandemic  
`COVIDRoutine_NoAppts`
- Yes, some or all of my appointments for routine cancer screening or preventive care were cancelled or delayed  
`COVIDRoutine_ApptsCanceled`
- Yes, some or all of my appointments for routine cancer screening or preventive care were done by phone or video conference instead of in-person (telehealth)  
`COVIDRoutine_TelehealthAppts`
- No, my appointments for routine cancer screening or preventive care have not been affected by the COVID-19 pandemic  
`COVIDRoutine_ApptsUnaffected`  
`COVIDRoutine_Cat`

F3. Has your cancer treatment plan changed as a result of the COVID-19 pandemic?

- Yes, my cancer treatment plan changed because of the COVID-19 pandemic  
`COVIDChangeCaTreatment`
- No, my cancer treatment plan has not changed because of the COVID-19 pandemic
- I have not been undergoing cancer treatment during the COVID-19 pandemic

F4. Have any of your healthcare providers discussed, or provided you with information about your risk for COVID-19 complications due to your cancer history?

- Yes  
`COVIDRiskCancerHistory`
- No
- Don't know



F5. During the COVID-19 pandemic, have you done any of the following things more, less, or about the same as you normally do?

	I've done this MORE	I've done this the SAME	I've done this LESS	I don't do this at all
a. Slept..... <i>COVIDLife_Slept</i>	1	2	3	
b. Ate food in general..... <i>COVIDLife_GenFood</i>	1	2	3	
c. Ate high fat or sugary foods..... <i>COVIDLife_FatSugFood</i>	1	2	3	4
d. Ate healthy food..... <i>COVIDLife_HealthFood</i>	1	2	3	4
e. Exercised..... <i>COVIDLife_Exercise</i>	1	2	3	4
f. Drank alcohol..... <i>COVIDLife_Alcohol</i>	1	2	3	4
g. Smoked cigarettes or vaped..... <i>COVIDLife_CigVape</i>	1	2	3	4
h. Used cannabis, marijuana, or CBD..... <i>COVIDLife_Cannabis</i>	1	2	3	4
i. Used prescription drugs.... <i>COVIDLife_RxDrugs</i>	1	2	3	4
j. Used non-prescription drugs..... <i>COVIDLife_NonRxDrugs</i>	1	2	3	4
k. Connected with others, including talking with people you trust about your concerns and how you are feeling..... <i>COVIDLife_ConnectPeople</i>	1	2	3	4
l. Contacted a healthcare provider..... <i>COVIDLife_ContactedHCP</i>	1	2	3	4
m. Looked for health information..... <i>COVIDLife_LookedHealth</i>	1	2	3	4
n. Took breaks from watching, reading, or listening to news stories, including social media..... <i>COVIDLife_NewsBreaks</i>	1	2	3	4

F6. How much would you trust each of the following for reliable information about COVID-19?

	Not at all	A little	Some	A lot
a. CDC – Centers for Disease Control and Prevention..... <i>COVIDTrust_CDC</i>	4	3	2	1
b. NIH – National Institutes of Health..... <i>COVIDTrust_NIH</i>	4	3	2	1
c. Your state government..... <i>COVIDTrust_StateGov</i>	4	3	2	1
d. Your local government..... <i>COVIDTrust_LocalGov</i>	4	3	2	1
e. News media..... <i>COVIDTrust_NewsMedia</i>	4	3	2	1
f. Your healthcare provider..... <i>COVIDTrust_HCP</i>	4	3	2	1
g. Your family and friends..... <i>COVIDTrust_FamFr</i>	4	3	2	1
h. Social media..... <i>COVIDTrust_SocMed</i>	4	3	2	1
i. WHO – The World Health Organization..... <i>COVIDTrust_WHO</i>	4	3	2	1

F7. How much do you agree or disagree with each of the following statements about your feelings towards COVID-19?

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
a. There's not much people can do to lower their chances of getting COVID-19..... <i>COVID_PreventNotPossible</i>	1	2	3	4
b. There are so many different recommendations about preventing COVID-19, it's hard for people to know which ones to follow..... <i>COVID_TooManyRecommendations</i>	1	2	3	4



## G: Genetic Testing

G1. Genes are inherited from your parents and are passed down from one generation to the next. Genetic tests can determine your genetic makeup.

Which of the following types of genetic tests have you heard of?

Mark all that apply.

- Ancestry testing:**  
To determine the background or geographic/ethnic origin of an individual's ancestors (for example, Ancestry.com and 23andMe)  
`HeardGenTest_Ancestry`
- Genetic health risk testing:**  
To determine health risk for a variety of health conditions (for example, 23andMe)  
`HeardGenTest_HealthRisk`
- Cancer genetic testing**  
(for example, testing for inherited cancer syndromes like BRCA1/2 or Lynch Syndrome)  
`HeardGenTest_CancerRisk`
- Other - Specify → `HeardGenTest_Other`  
`HeardGenTest_Other_OS`
- Not sure  
`HeardGenTest_NotSure`
- I have not heard of any of these types of genetic tests → **GO TO G8 on the next page**  
`HeardGenTest_None`  
`HeardGenTest_Cat`

G2. From which of the following sources did you read or hear anything about genetic tests?

Mark all that apply.

- Newspaper  
`TestSource_Ppr`
- Magazine  
`TestSource_Mag`
- Radio  
`TestSource_Radio`
- Your primary health care provider  
`TestSource_HCP`
- Oncologist/cancer surgeon  
`TestSource_Oncol`
- Genetic counselor  
`TestSource_Counselor`
- Family member  
`TestSource_Family`
- Friend  
`TestSource_Friend`
- Social media  
`TestSource_SocMed`
- Television  
`TestSource_TV`
- Internet  
`TestSource_WWW`
- Other - Specify → `TestSource_Other`  
`TestSource_Other_OS`
- Have not heard of such tests → **GO TO G8 on the next page**  
`TestSource_NotHeard`
- Not sure  
`TestSource_NotSure`  
`TestSource_Cat`

G3. Have you ever had any of the following types of genetic tests?

Mark all that apply.

- Ancestry testing:**  
To determine the background or geographic/ethnic origin of an individual's ancestors (for example, Ancestry.com and 23andMe)  
`HadTest2_Ancestry`
- Genetic health risk testing:**  
To determine health risk for a variety of health conditions (for example, 23andMe)  
`HadTest2_HealthRisk`
- Cancer genetic testing**  
(for example, testing for inherited cancer syndromes like BRCA1/2 or Lynch Syndrome)  
`HadTest2_CancerRisk`
- Other - Specify → `HadTest2_Other_OS`  
`HadTest2_Other`
- Not sure  
`HadTest2_NotSure`
- None of the above → **GO TO G8 on the next page**  
`HadTest2_None`  
`HadTest2_Cat`

G4. If you had a **cancer genetic test for inherited cancer syndromes**, where did you get information about this type of testing?

Mark all that apply.

- I did not have cancer genetic testing → **GO TO G6 on the next page**  
`CaTest_NotHad`
- Your primary health care provider  
`CaTest_HCP`
- Oncologist/cancer surgeon  
`CaTest_Oncol`
- Genetic counselor  
`CaTest_Counselor`
- Genetic testing companies  
`CaTest_TestCo`
- Somewhere else. Specify → `CaTest_Other`  
`CaTest_Cat`  
`CaTest_Other_OS`

G5. Who ordered your cancer genetic test for inherited cancer syndromes?

Mark only one.

- Your primary health care provider
- Oncologist/cancer surgeon
- Genetic counselor
- I ordered it directly from a genetic testing company
- I don't know



G6. If you had any genetic test, who helped you understand the results?

Mark **all that apply**.

- Your primary health care provider  
UndGenTest2\_HCP
- Oncologist/cancer surgeon  
UndGenTest2\_Oncol
- Genetic counselor  
UndGenTest2\_Counselor
- Spouse/partner  
UndGenTest2\_Spouse
- Parents  
UndGenTest2\_Parent
- Siblings  
UndGenTest2\_Sibling
- Children  
UndGenTest2\_Child
- Friend  
UndGenTest2\_Friend
- Other  
UndGenTest2\_Other
- No one helped me understand the results  
UndGenTest2\_NoOne  
UndGenTest2\_Cat

G7. If you had any genetic test, who did you share the results with?

Mark **all that apply**.

- Your primary health care provider  
SharedRes3\_HCP
- Oncologist/cancer surgeon  
SharedRes3\_Oncol
- Genetic counselor  
SharedRes3\_Counselor
- Spouse/partner  
SharedRes3\_Spouse
- Parents  
SharedRes3\_Parent
- Siblings  
SharedRes3\_Sibling
- Children  
SharedRes3\_Child
- Friend  
SharedRes3\_Friend
- Other  
SharedRes3\_Other
- Did not share the results  
SharedRes3\_NotShared  
SharedRes3\_Cat

G8. How much do you think genes that are inherited determine whether or not a person will develop each of the following conditions?

	Not at all	A little	Somewhat	A lot
a. Obesity.....	4	3	2	1
Genetics2_Obesity				
b. Cancer.....	4	3	2	1
Genetics2_Cancer				
c. Cardiovascular disease.....	4	3	2	1
Genetics2_Cardio				
d. Diabetes.....	4	3	2	1
Genetics2_Diabetes				

G9. How important is knowing a person's genetic information for...

	Not at all	A little	Somewhat	Very
a. Preventing cancer?.....	4	3	2	1
KnowGenes_PreventCa				
b. Detecting cancer early?.....	4	3	2	1
KnowGenes_DetectCa				
c. Treating cancer?.....	4	3	2	1
KnowGenes_TreatCa				

G10. "Precision medicine" is an approach for disease treatment and prevention that takes into account individual differences in genes, environment, and lifestyle.

Before completing this survey, had you ever heard of approaches like precision medicine?

- Yes  
HeardPrecisionMedicine
- No

G11. Precision medicine in the cancer treatment setting may involve doing genetic testing on the cancer tumor or tissue. This is different from genetic testing to look at genes that are inherited from your parents.

Was this type of genetic testing on your cancer tumor or tissue ever discussed with you?

- Yes  
DiscussedCaPrecisionMedicine
- No
- I don't know

G12. Was this type of testing done as part of your cancer diagnosis and/or treatment?

- Yes  
TreatedCaPrecisionMedicine
- No
- I don't know





## H: Clinical Trials

H1. Clinical trials are research studies that involve people. They are designed to compare new kinds of health care with the standard health care people currently get. For example, a new drug or a new way for patients to track their diets.

How would you describe your level of knowledge about clinical trials?

*ClinicalTrialKnowledge*

- 1 I don't know anything about clinical trials
- 2 I know a little bit about clinical trials
- 3 I know a lot about clinical trials

H2. Has a doctor or other member of your medical team discussed clinical trials as a possible treatment option for your cancer?

*DiscussedClinicalTrial*

- 1 Yes
- 2 No

H3. If you had a need to get information about clinical trials. Which of the following would you go to first to get information about clinical trials?

*FirstInfoClinTrials2*

**Mark only one.**

- 1 My health care provider
- 2 My family and friends
- 3 Government health agencies
- 4 Health organizations or groups (for example, the American Cancer Society, American Lung Association)
- 5 Disease-specific patient support groups
- 6 Drug companies
- 7 Internet search

H4. If you had a need to get information about clinical trials. Which of the following would you most trust as a source of information about clinical trials?

*TrustInfoClinTrials2*

**Mark only one.**

- 1 My health care provider
- 2 My family and friends
- 3 Government health agencies
- 4 Health organizations or groups (for example, the American Cancer Society, American Lung Association)
- 5 Disease-specific patient support groups
- 6 Drug companies

H5. Have you ever heard of the website [clinicaltrials.gov](http://clinicaltrials.gov)?

*HeardClinTrialsWebsite*

- 1 Yes
- 2 No

H6. Have you ever participated in a clinical trial for treatment of your cancer?

*ClinicalTrialCancerTx2*

- 1 Yes
- 2 No → **GO TO J1 on the next page**
- 3 Don't know → **GO TO J1 on the next page**



H7. If you participated in a clinical trial, how much did each of the following influence your decision to participate?

	Not at all	A little	Somewhat	A lot	Not Applicable
a. My participation will help other people..... <i>SEER_ClinTrial_HelpingPeople</i>	4	3	2	1	5
b. I was paid to participate..... <i>SEER_ClinTrial_GetPaid</i>	4	3	2	1	5
c. I was given support to participate such as transportation, childcare, or paid time off from work... <i>SEER_ClinTrial_GetSupport</i>	4	3	2	1	5
d. My doctor encouraged me to participate..... <i>SEER_ClinTrial_DocEncouraged</i>	4	3	2	1	5
e. My family and friends encouraged me to participate..... <i>SEER_ClinTrial_FamEncouraged</i>	4	3	2	1	5
f. I thought that participating would help me get better.... <i>SEER_ClinTrial_GetBetter</i>	4	3	2	1	5
g. I wanted the chance to try a new kind of care..... <i>SEER_ClinTrial_NewCare</i>	4	3	2	1	5
h. The standard care was not covered by my insurance..... <i>SEER_ClinTrial_StdNotCovered</i>	4	3	2	1	5

## J: Your Overall Health

J1. In general, would you say your health is...

- GeneralHealth*
- 1 Excellent,
  - 2 Very good,
  - 3 Good,
  - 4 Fair, or
  - 5 Poor?

J2. Overall, how confident are you about your ability to take good care of your health?

- OwnAbilityTakeCareHealth*
- 1 Completely confident
  - 2 Very confident
  - 3 Somewhat confident
  - 4 A little confident
  - 5 Not confident at all

J3. Are you deaf or do you have serious difficulty hearing?

- Deaf*
- 1 Yes
  - 2 No

J4. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- Blind*
- 1 Yes
  - 2 No

J5. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

- DecisionMaking*
- 1 Yes
  - 2 No

J6. Do you have serious difficulty walking or climbing stairs?

- DifficultyWalking*
- 1 Yes
  - 2 No

J7. Do you have difficulty dressing or bathing?

- DifficultyDressing*
- 1 Yes
  - 2 No

J8. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- DifficultyErrands*
- 1 Yes
  - 2 No

J9. Is there anyone you can count on to provide you with emotional support when you need it - such as talking over problems or helping you make difficult decisions?

- EmotionalSupport*
- 1 Yes
  - 2 No



J10. Do you have friends or family members that you talk to about your health?

TalkHealthFriends

- 1 Yes
- 2 No

J11. If you needed help with your daily chores, is there someone who can help you?

HelpDailyChores

- 1 Yes
- 2 No

J12. How often do you feel that you lack companionship?

LackCompanionship

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always

J13. How often do you feel that you have a lot in common with the people around you?

LotInCommonPeople

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always

J14. How often do you feel close to people?

FeelClosePeople

- 1 Never
- 2 Rarely
- 3 Sometimes
- 4 Always

J15. Please respond to each item by marking one box per row.

Never      Rarely      Sometimes      Usually      Always  
 ↓            ↓            ↓            ↓            ↓

- |  |                            |                            |                            |                            |                            |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. I feel left out.....                                  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| <i>FeelLeftOut</i>                                       |                            |                            |                            |                            |                            |
| b. I feel that people barely know me.....                | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| <i>FeelPeopleBarelyKnow</i>                              |                            |                            |                            |                            |                            |
| c. I feel isolated from others... with me.....           | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| <i>FeelIsolated</i>                                      |                            |                            |                            |                            |                            |
| d. I feel that people are around me but not with me..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| <i>FeelPeopleNotWithMe</i>                               |                            |                            |                            |                            |                            |

J16. Has a doctor or other health professional ever told you that you had any of the following medical conditions:

Yes      No  
 ↓        ↓

- |  |                            |                            |
|--|----------------------------|----------------------------|
| a. Diabetes or high blood sugar?.....  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| <i>MedConditions_Diabetes</i>  |                            |                            |
| b. High blood pressure or hypertension?.....   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| <i>MedConditions_HighBP</i>  |                            |                            |
| c. A heart condition such as heart attack, angina, or congestive heart failure?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| <i>MedConditions_HeartCondition</i>  |                            |                            |
| d. Chronic lung disease, asthma, emphysema, or chronic bronchitis?.....              | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| <i>MedConditions_LungDisease</i>   |                            |                            |
| e. Depression or anxiety disorder?.....  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| <i>MedConditions_Depression</i>  |                            |                            |

J17. About how tall are you without shoes?

Height\_Feet, Height\_Inches

Feet **and**   Inches

J18. About how much do you weigh, in pounds, without shoes?

Weight

Pounds



J19. Over the past 2 weeks, how often have you been bothered by any of the following problems?

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

- |   |   |   |   |   |
|---|---|---|---|---|
| a. Little interest or pleasure in doing things..... | 1 | 2 | 3 | 4 |
| <i>LittleInterest</i>                               |   |   |   |   |
| b. Feeling down, depressed, or hopeless.....        | 1 | 2 | 3 | 4 |
| <i>Hopeless</i>                                     |   |   |   |   |
| c. Feeling nervous, anxious, or on edge.....        | 1 | 2 | 3 | 4 |
| <i>Nervous</i>                                      |   |   |   |   |
| d. Not being able to stop or control worrying.....  | 1 | 2 | 3 | 4 |
| <i>Worrying</i>                                     |   |   |   |   |

J20. How much do you agree or disagree with the following statements?

Strongly agree  
 Somewhat agree  
 Somewhat disagree  
 Strongly disagree

- |   |   |   |   |   |
|---|---|---|---|---|
| a. When I feel threatened or anxious I find myself thinking about my values.....    | 1 | 2 | 3 | 4 |
| <i>Threatened_Values</i>  |   |   |   |   |
| b. When I feel threatened or anxious I find myself thinking about my strengths..... | 1 | 2 | 3 | 4 |
| <i>Threatened_Strengths</i>   |   |   |   |   |

J21. How much do you agree or disagree with the following statement?

*ExpectWorst*

I go to medical appointments expecting the worst.

- 1 Strongly agree
- 2 Agree
- 3 Neither agree nor disagree
- 4 Disagree
- 5 Strongly disagree

J22. From the set of values below, which ONE is most important to you in your day-to-day life?

*MostImportantValues*

**Mark only one.**

- 1 Making my own decisions
- 2 Being happy
- 3 Helping people
- 4 Being loyal to family and friends
- 5 Having a deep connection to my religion
- 6 Keeping myself in good health
- 7 Assuring my family is safe and secure

## K: Health and Nutrition

K1. Thinking about the last time you ordered food in a fast food or sit down restaurant, did you notice calorie information listed next to the food on the menu or menu board?

*NoticeCalorieInfoOnMenu*

- 1 Yes
- 2 No

K2. To what extent would you support or oppose the following?

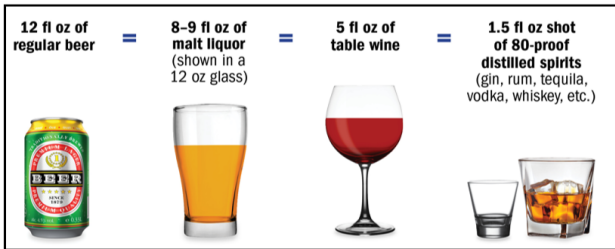
Junk food products, including candy, chips, soda, and flavored sports drinks, should not be advertised to children on social media.

*JunkFoodAdRestrictions*

- 1 Strongly oppose
- 2 Oppose
- 3 Neither support nor oppose
- 4 Support
- 5 Strongly support



K3. These are examples of one drink of alcohol:



During the past 30 days, how many days per week did you have at least one drink of any alcoholic beverage?

DrinkDaysPerWeek  
 Days per week

(IF 0 THEN GO TO K6 in the next column)

K4. During the past 30 days, on the days when you drank, about how many drinks did you drink on average?

DrinksPerDay  
 Average drinks per day

K5. **For males:** During the past 30 days, how many times did you have 5 or more alcoholic drinks on one occasion?

**For females:** During the past 30 days, how many times did you have 4 or more alcoholic drinks on one occasion?

DrinksOneOccasion

- 1 Never
- 2 1 or 2 times
- 3 3 to 5 times
- 4 6 to 10 times
- 5 11 or more times

K6. In your opinion, how much does drinking the following types of alcohol affect the risk of getting cancer?

	Decreases risk a lot	Decreases risk a little	No effect	Increases risk a little	Increases risk a lot	Don't know
a. Beer.....	1	2	3	4	5	6
Beer_CancerRisk						
b. Wine.....	1	2	3	4	5	6
Wine_CancerRisk						
c. Liquor.....	1	2	3	4	5	6
Liquor_CancerRisk						

K7. In your opinion, how much does drinking the following types of alcohol affect the risk of getting heart disease?

	Decreases risk a lot	Decreases risk a little	No effect	Increases risk a little	Increases risk a lot	Don't know
a. Beer.....	1	2	3	4	5	6
Beer_HeartRisk						
b. Wine.....	1	2	3	4	5	6
Wine_HeartRisk						
c. Liquor.....	1	2	3	4	5	6
Liquor_HeartRisk						

K8. To reduce the problems associated with excessive alcohol use, to what extent would you support or oppose...

	Strongly oppose	Oppose	Neither support nor oppose	Support	Strongly support
a. Banning outdoor advertising of alcohol such as on billboards and bus stops?.....	1	2	3	4	5
ExcessiveAlcohol_BanAds					
b. Requiring specific health warnings on alcohol containers?.....	1	2	3	4	5
ExcessiveAlcohol_RegWarn					
c. Requiring alcohol containers to show the recommended drinking guidelines for keeping health risks low?.....	1	2	3	4	5
ExcessiveAlcohol_Guidelines					





## L: Physical Activity and Exercise

L1. In a typical week, how many days do you do any physical activity or exercise of at least moderate intensity, such as brisk walking, bicycling at a regular pace, and swimming at a regular pace (do not include weightlifting)?

*TimesModerateExercise*

0 None → **GO TO L3 below**

1 1 day per week

2 2 days per week

3 3 days per week

4 4 days per week

5 5 days per week

6 6 days per week

7 7 days per week

L2. On the days that you do any physical activity or exercise of at least moderate intensity, how long do you typically do these activities?

*HowLongModerateExerciseMinutes*

**Minutes per day**

L3. In a typical week, outside of your job or work around the house, how many days do you do leisure-time physical activities specifically designed to strengthen your muscles such as lifting weights or circuit training (do not include cardio exercise such as walking, biking, or swimming)?

*TimesStrengthTraining*

0 None

1 1 day per week

2 2 days per week

3 3 days per week

4 4 days per week

5 5 days per week

6 6 days per week

7 7 days per week

L4. During the past 7 days, how much time did you spend sitting on a typical day at home or at work? This may include time spent sitting at a desk, visiting friends, reading, driving or riding in a car, or sitting or lying down to watch television.

*AverageTimeSitting*

**Hours per day**

## M: Tobacco Products

M1. Have you smoked at least 100 cigarettes in your entire life?

*Smoke100*

1 Yes

2 No → **GO TO M3 below**

M2. How often do you now smoke cigarettes?

*SmokeNow*

1 Every day

2 Some days

3 Not at all

M3. New types of cigarettes are now available called electronic cigarettes or e-cigarettes (also known as vapes, vape-pens, tanks, mods or pod-mods). These products deliver nicotine through a vapor. Compared to smoking cigarettes, would you say that electronic cigarettes are...

*ElectCigLessHarm*

1 Much less harmful,

2 Less harmful,

3 Just as harmful,

4 More harmful,

5 Much more harmful, or

7 I don't know



M4. Have you ever used an e-cigarette, even one or two times?

UsedECigEver

- 1 Yes
- 2 No → GO TO M6 below

M5. Do you now use an e-cigarette every day, some days, or not at all?

UseECigNow

- 1 Every day
- 2 Some days
- 3 Not at all

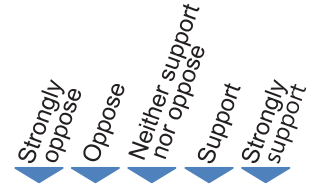
M6. Heated tobacco products, also known as heat-not-burn tobacco products, use a technology that heats tobacco instead of burning it. These are NOT the same as e-cigarettes. Some brands of heated tobacco products include IQOS and Eclipse.

Thinking about heated tobacco products, which of the following statements BEST applies to you?

HeardHeatedTobacco

- 1 I have never heard of heated tobacco products
- 2 I have heard of heated tobacco products but have never tried them
- 3 I have tried heated tobacco products but do not use them anymore
- 4 I currently use heated tobacco products
- 5 Don't know

M7. To what extent would you support or oppose the following measures related to cigarettes?



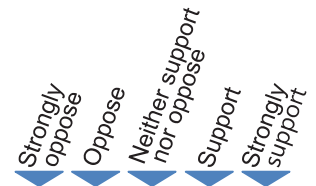
a. Just like with violence and sex, movies with cigarette smoking should be rated "R" to protect children and youth from seeing cigarette smoking in movies..... 1 2 3 4 5

CigMeasures\_MovieRatings

b. Cigarette packs should be required to have warning labels that use both images and words to show the negative health effects of smoking..... 1 2 3 4 5

CigMeasures\_WarningLabels

M8. To what extent would you support or oppose the following measures related to all tobacco products, including cigarettes, e-cigarettes, smokeless tobacco, hookah, and cigars?



a. Stores should be required to keep tobacco products out of customers' view at the checkout counter..... 1 2 3 4 5

TobaccoMeasures\_HideProducts

b. Stores should be required to keep advertisements for tobacco products away from cash registers and out of windows..... 1 2 3 4 5

TobaccoMeasures\_HideAds

c. Tobacco products should not be advertised on social media..... 1 2 3 4 5

TobaccoMeasures\_NoSocMed



## N: Cancer Screening and Awareness

N1. **For males:** GO TO N3 below

**For females:** How long ago did you have your most recent Pap test to check for cervical cancer?

WhenPapTest

- 1 A year ago or less
- 2 More than 1, up to 2 years ago
- 3 More than 2, up to 3 years ago
- 4 More than 3, up to 5 years ago
- 5 More than 5 years ago
- 6 I have never had a Pap test

N2. When did you have your most recent mammogram to check for breast cancer, if ever?

WhenMammogram

- 1 A year ago or less
- 2 More than 1, up to 2 years ago
- 3 More than 2, up to 3 years ago
- 4 More than 3, up to 5 years ago
- 5 More than 5 years ago
- 6 I have never had a mammogram

N3. There are a few different tests to check for colon cancer. These tests include:

A **colonoscopy** - For this test, a tube is inserted into your rectum and you are given medication that may make you feel sleepy. After the procedure, you need someone to drive you home.

A **sigmoidoscopy** - For this test, you are awake when the tube is inserted into your rectum. After the test you can drive yourself home.

A **stool blood test** - For this test, you collect a stool sample at home, and then provide it to a doctor or lab for testing.

Have you ever had one of these tests to check for colon cancer?

EverTestedColonCa

- 1 Yes
- 2 No

N4. Have you ever heard of **HPV**? HPV stands for Human Papillomavirus. It is not HCV, HIV, HSV, or herpes.

HeardHPV

- 1 Yes
- 2 No → GO TO N6 below

N5. Do you think **HPV** can cause...

	Yes	No	Not sure
a. Cervical Cancer?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HPVCauseCancer_Cervical			
b. Penile Cancer?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HPVCauseCancer_Penile			
c. Anal Cancer?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HPVCauseCancer_Anal			
d. Oral Cancer?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
HPVCauseCancer_Oral			

N6. A vaccine to prevent **HPV** infection is available and is called the HPV shot, cervical cancer vaccine, GARDASIL®.

Before today, have you ever heard of the cervical cancer vaccine or HPV shot?

HeardHPVVaccine2

- 1 Yes
- 2 No

## O: Beliefs About Cancer

O1. How worried are you about getting cancer again?

FreqWorryCancerAgain

- 1 Not at all
- 2 Slightly
- 3 Somewhat
- 4 Moderately
- 5 Extremely

O2. How much do you agree or disagree with each of the following statements?

		Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
a. It seems like everything causes cancer.....	1	2	3	4	
<i>EverythingCauseCancer</i>					
b. There's not much people can do to lower their chances of getting cancer .....	1	2	3	4	
<i>SEER_PreventNotPossible</i>					
c. There are so many different recommendations about preventing cancer, it's hard to know which ones to follow.....	1	2	3	4	
<i>TooManyRecommendations</i>					

O3. How much do you think that each of the following can influence whether or not a person will develop cancer?

		A lot	A little	Not at all	Don't know
a. Being overweight or obese.....	1	2	3	4	
<i>InfluenceCancer_Obesity</i>					
b. Gaining weight in adult life.....	1	2	3	4	
<i>InfluenceCancer_AdultWeight</i>					
c. Eating too much red meat.....	1	2	3	4	
<i>InfluenceCancer_RedMeat</i>					

## P: You and Your Household

P1. What is your age?

--	--	--

*Age*  
Years old

P2. On your original birth certificate, were you listed as male or female?

*BirthGender*

1 Male

2 Female

P3. What is your current gender identity?

*GenderIdentity*

1 Male

2 Female

3 Transgender

4 Gender non-conforming

5 Other-Specify → *GenderIdentity\_OS*

P4. In the past 30 days, did you usually work 35 hours or more per week in total at all jobs or businesses?

*WorkFullTime*

1 Yes

2 No

P5. Which of the following best describe your current occupational status?

**Mark all that apply.**

1 Employed  
*Occupation\_Employed*

1 Unemployed for 1 year or more  
*Occupation\_1YUnEmployed*

1 Unemployed for less than 1 year  
*Occupation\_Less1YUnEmployed*

1 Homemaker  
*Occupation\_Homemaker*

1 Student  
*Occupation\_Student*

1 Retired  
*Occupation\_Retired*

1 Disabled  
*Occupation\_Disabled*

1 Other-Specify → *Occupation\_Other*  
*Occupation\_Other\_OS*

*Occupation\_Cat*  
*FullTimeOcc\_Cat*

P6. What is your marital status?

*MaritalStatus*

1 Married

2 Living as married or living with a romantic partner

3 Divorced

4 Widowed

5 Separated

6 Single, never been married



P7. What is the highest grade or level of schooling you completed?

Education

- 1 Less than 8 years
- 2 8 through 11 years
- 3 12 years or completed high school
- 4 Post high school training other than college (vocational or technical)
- 5 Some college
- 6 College graduate
- 7 Postgraduate

P8. Are you of Hispanic, Latino/a, or Spanish origin? One or more categories may be selected.

Mark **all that apply**.

- 1 No, not of Hispanic, Latino/a, or Spanish origin
- 1 Yes, Mexican, Mexican American, Chicano/a  
NotHisp  
Mexican
- 1 Yes, Puerto Rican  
PuertoRican
- 1 Yes, Cuban  
Cuban
- 1 Yes, another Hispanic, Latino/a, or Spanish origin  
OthHisp  
Hisp\_Cat

P9. What is your race? One or more categories may be selected.

Mark **all that apply**.

- 1 White  
White
- 1 Black or African American  
Black
- 1 American Indian or Alaska Native  
AmerInd
- 1 Asian Indian  
AsInd
- 1 Chinese  
Chinese
- 1 Filipino  
Filipino
- 1 Japanese  
Japanese
- 1 Korean  
Korean
- 1 Vietnamese  
Vietnamese
- 1 Other Asian  
OthAsian
- 1 Native Hawaiian  
Hawaiian
- 1 Guamanian or Chamorro  
Guamanian
- 1 Samoan  
Samoa
- 1 Other Pacific Islander  
OthPacIsl  
Race\_Cat2

P10. How much do you agree or disagree with the following statement?

I have a strong sense of belonging to my own ethnic group.

EthnicGroupBelonging

- 1 Strongly agree
- 2 Agree
- 3 Neither agree nor disagree
- 4 Disagree
- 5 Strongly disagree

P11. Do you think of yourself as...

SexualOrientation

- 1 Heterosexual, or straight
- 2 Homosexual, or gay or lesbian
- 3 Bisexual
- 91 Something else – Specify ↴

SexualOrientation\_OS

P12. Including yourself, how many people live in your household?

--	--

TotalHousehold  
Number of people

P13. How many children under the age of 18 live in your household?

--	--

ChildrenInHH  
Number of children under 18

P14. Thinking about politics these days, how would you describe your own political viewpoint?

PoliticalViewpoint

- 1 Very Liberal
- 2 Liberal
- 3 Somewhat Liberal
- 4 Moderate
- 5 Somewhat Conservative
- 6 Conservative
- 7 Very Conservative





P15. Thinking about members of your family living in this household, what is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?

*IncomeRanges*

- 1 \$0 to \$9,999
- 2 \$10,000 to \$14,999
- 3 \$15,000 to \$19,999
- 4 \$20,000 to \$34,999
- 5 \$35,000 to \$49,999
- 6 \$50,000 to \$74,999
- 7 \$75,000 to \$99,999
- 8 \$100,000 to \$199,999
- 9 \$200,000 or more

P16. Which one of these comes closest to your own feelings about your household's income?

*IncomeFeelings*

- 1 Living comfortably on present income
- 2 Getting by on present income
- 3 Finding it difficult on present income
- 4 Finding it very difficult on present income

P17. We invite you to participate in future research studies. These studies are voluntary and will involve answering surveys similar to this one a few times a year.

Can we send you a request to participate in additional studies?

*FutureStudies*

- 1 Yes
- 2 No → **GO TO END**

P18. To make it easier to contact you, could you provide your e-mail address in the box below? This is voluntary and we will follow-up by mail if you do not provide an e-mail address.

*ContactEmail*

E-mail:

## Thank you!

Please return this survey in the postage-paid envelope within 2 weeks.

If you have lost the envelope, mail the completed survey to:

HINTS Study, TC 1046F  
Westat  
1600 Research Boulevard  
Rockville, MD 20850

