



**Detailed Outline of Topics in the  
Redesigned National Health Interview Survey (NHIS)  
Sample Adult Questionnaire**  
Version: March 2019

	2019	2020	2021	2022	2023	2024	2025	2026	2027
	<b>Household Roster - Selection of Sample Adult - Informed Consent</b>								
Annual core	<p style="text-align: center;"><b>Chronic Conditions:</b> Hypertension; High Cholesterol; Cardiovascular Conditions; Asthma; Cancer; Diabetes; Other Chronic Conditions; Height and Weight</p> <p style="text-align: center;"><b>Functioning and Disability:</b> Vision; Hearing; Mobility; Communication; Cognition; Self-Care and Upper Body Limitations; Anxiety; Depression; Social Functioning</p> <p style="text-align: center;"><b>Health Insurance:</b> Coverage Status; Sources of Coverage; Characteristics of Coverage; Continuity of Coverage; Reasons for No Health Insurance</p> <p style="text-align: center;"><b>Health Care Access and Use:</b> Primary and Urgent Care; Financial Barriers to Care; Prescription Medication; Flu and Pneumonia Immunization</p> <p style="text-align: center;"><b>Health-Related Behaviors:</b> Cigarettes and E-cigarettes</p> <p style="text-align: center;"><b>Demographics:</b> Marital Status; Sexual Orientation; Veterans Status; Nativity; Schooling; Employment; Family Income; Food-Related Program Participation; Housing; Telephone Use</p>								
Rotating core	<b>Service Utilization:</b> Dental Care; Mental Health Care; Other Services		<b>Allergies and Other Conditions</b>  Psychological Distress	<b>Service Utilization:</b> Dental Care; Mental Health Care; Other Services		<b>Allergies and Other Conditions</b>  Psychological Distress	<b>Service Utilization:</b> Dental Care; Mental Health Care; Other Services		<b>Allergies and Other Conditions</b>  Psychological Distress
	<b>Mental Health Assessment<sup>1</sup></b>	<b>Industry and Occupation</b>  Injuries		<b>Mental Health Assessment<sup>1</sup></b>	<b>Industry and Occupation</b>  Injuries		<b>Mental Health Assessment<sup>1</sup></b>	<b>Industry and Occupation</b>  Injuries	
	<b>Chronic Pain: Severity and Impact; Locations</b>	<b>Health-Related Behaviors:</b> Physical Activity; Walking; Sleep;	<b>Chronic Pain: Severity and Impact; Locations</b>	<b>Health-Related Behaviors:</b> Physical Activity; Walking; Sleep;	<b>Chronic Pain: Severity and Impact; Locations</b>	<b>Health-Related Behaviors:</b> Physical Activity; Walking; Sleep;	<b>Chronic Pain: Severity and Impact; Locations</b>	<b>Health-Related Behaviors:</b> Physical Activity; Walking; Sleep;	<b>Chronic Pain: Severity and Impact; Locations</b>
	<b>Preventive Services: Screening Tests; Aspirin Use</b>	Fatigue; Smoking History and Cessation; Alcohol Use	<b>Preventive Services: Screening Tests; Aspirin Use</b>	Fatigue; Smoking History and Cessation; Alcohol Use	<b>Preventive Services: Screening Tests; Aspirin Use</b>	Fatigue; Smoking History and Cessation; Alcohol Use	<b>Preventive Services: Screening Tests; Aspirin Use</b>	Fatigue; Smoking History and Cessation; Alcohol Use	<b>Preventive Services: Screening Tests; Aspirin Use</b>
Sponsored content	<p><b>Sustaining sponsors* add content every year.</b> Annual sponsored content will include cancer control and prevention (NCI and NCCDPHP), immunizations (NCIRD), non-cigarette tobacco product use (FDA), and food security (USDA).</p>								
	<p><b>Other sponsors* add content in selected years.</b> Anticipated sponsorships include expanded content on arthritis in 2019 (NCCDPHP and NIAMS), insulin use in 2019 (NIDDK and NCCDPHP), diabetes in 2020 (NCCDPHP), and complementary and integrative health in 2022 (NCCIH).</p>								
Emerging topics	<p><b>New topics of growing interest may be added by NCHS, generally for one year.</b> In 2019, the topics are prescription opioid use and pain management.</p>								

\* As of March 2019, sponsors include Food and Drug Administration (FDA), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), National Center for Complementary and Integrative Health (NCCIH), National Cancer Institute (NCI), National Center for Immunization and Respiratory Diseases (NCIRD), National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and United States Department of Agriculture (USDA). NCCDPHP and NCIRD are part of the U.S. Centers for Disease Control and Prevention (CDC). NCCIH, NCI, NIAMS, and NIDDK are part of the U.S. National Institutes of Health (NIH).

<sup>1</sup> Questions come from the Patient Health Questionnaire (PHQ-8) and the Generalized Anxiety Disorder scale (GAD-7).



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## Detailed Outline of Topics in the Redesigned National Health Interview Survey (NHIS) Sample Adult Questionnaire

Version: March 2019

This document presents the topics included in the redesigned NHIS sample adult interview, including content to be included annually and content that will rotate on and off the questionnaire with a pre-established periodicity. Additional topics sponsored by federal partners will also be included in the sample adult interview and are presented at the end of this document.

In 2019 and beyond, one “sample adult” aged 18 years or more and one “sample child” aged 17 years or less (if any children live in the household) will be randomly selected from each household following a brief household roster that identifies the age, sex, Hispanic ethnicity, and race of everyone who usually lives or stays in the household. The roster section will also ask questions about the highest educational attainment of all adults and whether any adults are currently active duty military. Only civilian adults are eligible to be the sample adult.

Questions will be asked to identify the parents of all children in the household and the members of the sample adult’s and sample child’s family. For NHIS, a family is defined as two or more persons residing 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) and any unmarried cohabiting partners and their children. Family members include adults who are temporarily away at school if they are living in on-campus housing. Adults living alone are considered single-person families.

Information about the sample adult will be collected from the sample adult him/herself unless he/she is physically or mentally unable to do so, in which case a knowledgeable proxy will be allowed to answer for the sample adult. Information about the sample child will be collected from the sample child’s parent or a knowledgeable adult. The respondent for the sample child may or may not also be the sample adult.

The order of the sample adult and sample child interviews will vary by household depending on the availability of the respondents. When the sample adult and sample child are in the same family, content areas that refer to the family will be captured only once, in whichever interview comes first.

### ANNUAL CORE CONTENT FOR HOUSEHOLDS

#### Household roster

- Name or alias of all persons living in household
- Age, sex, Hispanic ethnicity, and race for all persons
- Educational attainment for all adults
- Identification of parents (biological/step/adoptive) for each child in household
  - For children without parents in the household:*
    - Whether child is in foster care
      - If any children are in foster care:*
        - Identification of foster parents
- Identification of adults who are currently serving on active duty in the military

### Selection of sample adult and sample child

*One civilian adult and one child (if any) are randomly selected from each household*

- Identification of all persons in sample adult's family  
*If sample child is not in sample adult's family:*
  - Identification of all persons in sample child's family
- Identification of possible knowledgeable respondents for sample child interview

## ANNUAL CORE CONTENT FOR SAMPLE ADULTS

### Demographic characteristics

- Verification of age, sex, Hispanic ethnicity, and race  
*If Hispanic, Asian, and/or Native Hawaiian or Pacific Islander:*
  - Specific ancestry (e.g., Mexican, Puerto Rican, Chinese, Filipino, Chamorro, Samoan)
- Date of birth

### Current health status (HIS)

- General health status: excellent, very good, good, fair, poor

### Hypertension (HYP)

- Ever told by doctor or other health professional that you had hypertension or high blood pressure  
*If yes:*
  - Told you have hypertension or high blood pressure on 2 or more different visits  
*If yes:*
    - (Past 12 months) Had hypertension or high blood pressure
  - (Currently) Taking prescription medication for high blood pressure

### High cholesterol (CHL)

- Ever told by doctor or other health professional that you had high cholesterol  
*If yes:*
  - (Past 12 months) Had high cholesterol
  - (Currently) Taking prescription medication for high cholesterol

### Cardiovascular chronic conditions (CVC)

- Ever told by doctor or other health professional that you had coronary heart disease
- Ever told by doctor or other health professional that you had angina
- Ever told by doctor or other health professional that you had a heart attack
- Ever told by doctor or other health professional that you had a stroke

### Asthma (AST)

- Ever told by doctor or other health professional that you had asthma  
*If yes:*
  - Still have asthma
  - (Past 12 months) Had an episode of asthma or an asthma attack
  - (Past 12 months) Had an ER or urgent care visit due to asthma

### Cancer (CAN)

- Ever told by doctor or other health professional that you had cancer

*If yes:*

- Type(s) of cancer/location(s) (up to 3 types/locations)
- Age(s) when each type of cancer first diagnosed (up to 3 types/locations)

### Diabetes (DIB)

*In 2019, additional questions on this topic are sponsored by NIDDK and NCCDPHP. See page 24.*

- Ever told by doctor or other health professional that you had prediabetes

*If female:*

- Ever told by doctor or other health professional that you had gestational diabetes
- (Other than prediabetes/gestational diabetes) Ever told by doctor or health professional you had diabetes

*If ever diagnosed with diabetes:*

- Age when first told you had diabetes (not including prediabetes or gestational diabetes)

*If ever diagnosed with diabetes or prediabetes:*

- (Currently) Taking diabetic pills
- (Currently) Taking insulin

*If ever diagnosed with diabetes:*

- Diabetes type according to doctor or other health professional: type 1, type 2, other, don't know

### Other chronic conditions (CON)

- Ever told by doctor or other health professional that you had...
  - COPD, emphysema, or chronic bronchitis
  - Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia
  - Dementia, including Alzheimer's
  - Any type of anxiety disorder
  - Any type of depression

*In 2019, additional questions on this topic are sponsored by NIAMS and NCCDPHP. See page 24.*

### Body measurements (BMI)

*If female and age 18-49, or female and age not given:*

- Are you currently pregnant?
- Self-reported height (without shoes)
- Self-reported weight (if currently pregnant, pre-pregnancy weight)

### Vision (VIS)

- Use of eyeglasses or contact lenses
- Level of difficulty seeing (even with glasses or contact lenses)

### Hearing (HEA)

- Use of hearing aid
  - If yes:*
    - Frequency of hearing aid use
- Level of difficulty hearing (even with hearing aid)

### **Mobility (MOB)**

- Level of difficulty walking or climbing steps
- Uses equipment or receives help for getting around
  - If does not use equipment or receive help for getting around:*
    - Level of difficulty walking 100 yards
      - If able to walk 100 yards:*
        - Level of difficulty walking one-third mile
    - Level of difficulty walking up or down 12 steps
  - If uses equipment or receives help for getting around:*
    - Use of cane or walker
    - Use of wheelchair or scooter
    - Use of someone's assistance
    - Without the use of your aid, level of difficulty walking 100 yards
      - If able to walk 100 yards without using aid(s):*
        - Without the use of your aid, level of difficulty walking one-third mile
    - Without the use of your aid, level of difficulty walking up or down 12 steps
  - If uses equipment or receives help getting around and does not use a wheelchair or scooter:*
    - When using your aid, level of difficulty walking 100 yards
      - If able to walk 100 yards when using aid(s):*
        - When using your aid, level of difficulty walking one-third mile
    - When using your aid, level of difficulty walking up or down 12 steps

### **Communication (COM)**

- Level of difficulty communicating in usual language (e.g., understanding or being understood)

### **Cognition (COG)**

- Level of difficulty remembering or concentrating
  - If any difficulty:*
    - Is that difficulty remembering or concentrating or both?
      - If difficulty includes remembering:*
        - How often do you have difficulty remembering?
        - Do you have difficulty remembering a few things, a lot of things, or almost everything?

### **Self-care and upper body (UPP)**

- Level of difficulty with self-care such as washing or dressing
- Level of difficulty raising a 2-liter bottle
- Level of difficulty using hands and fingers

### **Social functioning (SOC)**

- Level of difficulty doing errands alone due to a physical, mental, or emotional condition
- Level of difficulty participating in social activities due to a physical, mental, or emotional condition
- Does a physical, mental, or emotional problem limit kind or amount of work?

## Health insurance coverage (INS)

- Any health insurance coverage or health care plan?  
*If yes:*
  - Type of health insurance
- If 65 or older and does not report Medicare:*
  - Confirm no Medicare
- If under 65 and no insurance coverage reported:*
  - Confirm no Medicaid
- Do you have separate plan for dental services?
- Do you have separate plan for vision services?
- Do you have separate plan for prescriptions?
- Confirm no insurance or confirm all types of insurance coverage recorded

## Specifics about current insurance coverage

*If enrolled in Medicare:*

- Enrollment in Part A, Part B, or both
- Medicare Advantage enrollment
- Medicare managed care arrangement
- If enrolled in Advantage or managed care:*
  - Name of Advantage or Medicare HMO plan (*open-ended*)
- Part D enrollment

*If enrolled in Medicaid:*

- Name of plan (*open-ended*)
- Was the plan obtained through healthcare.gov or Marketplace?
- Are you required to pay a premium?
- Is there a deductible?  
*If yes:*
  - Is it a high deductible health plan?

*If enrolled in a private plan:*

*(Repeated for each private plan in which sample adult is enrolled)*

*(If sample child questionnaire is complete, adult and child are in same family, and sample child was enrolled in a private plan, ask if adult has same plan as child. If so, skip this section.)*

- Name of plan (*open-ended*)
- Any additional private plans?  
*If yes:*
  - Name of second plan (*open-ended*)  
*The private plan questions will be repeated for second plan*
- Are you the policyholder?  
*If yes:*
  - Does the plan cover self-only or family?
- If no:*
  - Relationship to policyholder
- How plan was obtained (employer, union, association, direct purchase, etc.)  
*If plan was purchased directly or obtained through state/local government or community program:*
  - Was plan obtained through healthcare.gov or Marketplace?

- Who pays for plan? (self/family, employer, person outside household, government program, etc.)

*If self/family in household pays for the plan:*

- Out-of-pocket premium amount
- Is there a deductible?
  - If yes:*
    - Is it a high deductible health plan?
      - If yes:*
        - Does it include a health savings account?
  - Does it include prescription drug coverage?
  - Does it include dental coverage?
  - Does it include vision coverage?

*If enrolled in CHIP, state-sponsored, and/or other government plan:*

*(Repeated for each type of CHIP, state-sponsored, and/or other government plan in which sample adult is enrolled)*

- Name of plan (*open-ended*)
- Was the plan obtained through healthcare.gov or Marketplace?
- Are you required to pay a premium?
- Is there a deductible?
  - If yes:*
    - Is it a high deductible health plan?

*If military health care:*

- Type of plan (TRICARE, VA, CHAMP-VA, other)

### **Health insurance continuity**

*If currently uninsured:*

- Length of time since last insured
  - If less than 12 months:*
    - (Past 12 months) Number of months without health insurance
  - If uninsured less than 3 years:*
    - What were the reason(s) you are no longer enrolled? Was it because...
      - You retired, lost a job, or changed employers
      - Missed a deadline to sign up
      - Ineligible for coverage because of age or leaving school
      - Cost increases
      - No longer eligible for Medicaid, CHIP, or other public coverage
- What are the reason(s) for not having health insurance? Was it because...
  - Coverage is unaffordable
  - Do not need or want coverage
  - Ineligible for coverage
  - Signing up is too difficult or confusing
  - Cannot find a plan that meets needs
  - Applied for coverage that has not started yet
  - Other reason (*open-ended*)

*If currently insured:*

- (Past 12 months) Any time without health insurance
  - If yes:*
    - (Past 12 months) Number of months without health insurance

### Financial burden of medical care (PAY)

*Skip first question and follow-up if sample child questionnaire is complete and if adult and child are in same family.*

- (Past 12 months) Anyone in family have problems paying or unable to pay medical bills
  - If yes:*
    - (Currently) Anyone in family have medical bills unable to pay at all
- Level of worry about ability to pay medical bills if sick or injured

### Health care utilization and access (UTZ)

- Time since last seen doctor or health professional
  - If not never:*
    - Was most recent visit a wellness visit, physical, or general purpose check-up
      - If no:*
        - Time since last wellness visit, physical, or general purpose check-up
- Has a usual place for care when sick
  - If yes or more than one place:*
    - Type of place (or type of place visited most often)
- (Past 12 months) Number of walk-in clinic, retail clinic, and urgent care center visits
- (Past 12 months) Number of hospital ER visits
- (Past 12 months) Any overnight hospital stay
- (Past 12 months) Delayed getting medical care because of cost
- (Past 12 months) Did not get medical care because of cost

### Prescription medications (PMD)

*In 2019, additional questions are included as emerging topics. See page 25.*

- (Past 12 months) Took any prescribed medication
  - If yes:*
    - (Past 12 months) Skipped medication doses to save money
    - (Past 12 months) Took less medicine to save money
    - (Past 12 months) Delayed filling a prescription to save money
- (Past 12 months) Any medication needed that you didn't get due to cost

### Immunizations (IMS)

*In 2019, additional questions on this topic are sponsored by NCIRD. See page 22.*

- (Past 12 months) Flu vaccination
  - If yes:*
    - Month and year of most recent flu vaccination
- (Ever) Pneumonia shot

### Anxiety (ANX)

- Frequency of feeling worried, nervous, or anxious
- (Currently) Taking prescription medication for these feelings
  - If worried at least a few times per year and/or taking medication for anxiety:*
    - (Last time felt anxious) How anxious did you feel?

### Depression (DEP)

- Frequency of feeling depressed
- (Currently) Taking prescription medication for depression
  - If depressed at least a few times per year and/or taking medication for depression:*
    - (Last time felt depressed) How depressed did you feel?

### Cigarette smoking and e-cigarettes (CIG)

*In 2019, additional questions on this topic are sponsored by FDA. See page 21.*

- (Lifetime) Smoked 100 or more cigarettes
  - If yes:*
    - (Currently) Smoke every day, some days, or not at all
      - If smoking everyday:*
        - Average number of cigarettes smoked per day
      - If smoking some days:*
        - (Past 30 days) Number of days smoked cigarettes
        - (Past 30 days) Average number of cigarettes on days smoked any cigarettes
- (Ever) Used e-cigarette, even one time
  - If yes:*
    - (Currently) Use e-cigarette every day, some days, or not at all

### Sexual orientation (ORN)

- Sexual orientation

### Marital status (MAR)

*Skip section if marital status of sample adult was already collected from sample adult during sample child interview.*

- Married, living with partner as unmarried couple, or neither
  - If married:*
    - Is your spouse living in the same household?
      - If yes:*
        - Identification of spouse
        - Confirmation of sex of spouse
      - If no:*
        - Are you and spouse legally separated?
  - If living with a partner:*
    - Identification of partner
    - Confirmation of sex of partner
    - Ever been married
      - If yes:*
        - Legal marital status (married, widowed, divorced, separated)
  - If neither:*
    - Ever been married
      - If yes:*
        - Legal marital status (widowed, divorced, or separated)

### **Veteran status (VET)**

- Ever serve on active duty in US Armed Forces, military reserves, or National Guard
  - If yes:*
    - Was this only for training in Reserves or National Guard?
      - If no:*
        - Ever served in a foreign country during armed conflict or on humanitarian mission?
    - Do you have a VA service-connected disability rating?
    - (Past 12 months) Received any care at Veteran's Health Administration facility or received any other health care paid for by the VA
      - If no and did not specify VA health care in INS section:*
        - Ever enrolled in or used VA health care

### **Nativity and acculturation (NAT)**

- Were you born in the United States or a US territory?
  - If yes:*
    - State or US territory of birth
  - If no:*
    - What year did you come to the United States to stay?
    - Are you a citizen of the United States?
      - If yes:*
        - Born abroad to an American parent, born abroad and adopted by an American parent, or naturalized

### **Schooling (SCH)**

- (Currently) attending or enrolled in school
  - If yes:*
    - (Past 12 months) Number of school days missed due to illness/injury/disability

### **Employment (EMP)**

- (Last week) Work for pay at a job or business
  - If no:*
    - (Last week) Have a job or business, but temporarily absent due to illness, vacation, family or maternity leave, or some other reason
      - If yes:*
        - Usually work 35 hours or more per week in total in all jobs/businesses?
      - If no:*
        - (Last week) Main reason not working
          - If not working for any reason besides working in a family business not for pay or does seasonal/contract work.*
            - Length of time since last held a job or worked at a business
- If yes:*
  - (Last week) Number of hours worked in total at all jobs/businesses
    - If worked less than 35 hours in past week or don't know or refused to say how many hours worked:*
      - Usually work 35 hours or more per week in total in all jobs/businesses?

*If working at or had a paid job or business last week, if working in a family business not for pay, or if not working because does seasonal/contract work:*

- Is paid sick leave available if you need it?
- Was health insurance offered to you through workplace?

*If working at or had a paid job or business last week, if working in a family business not for pay, if not working because does seasonal/contract work, or if not currently working but had a paid job or business in past 12 months:*

- (Past 12 months) Number of work days missed due to illness/injury/disability

### **Employment of all adult family members (FEM)**

*Skip section if sample child questionnaire is complete and if adult and child are in same family, or if there is only one adult in the family.*

*Ask for each adult family member other than sample adult:*

- (Currently) Work for pay at a job or business

*If yes:*

- Usually work 35 hours or more per week in total in all jobs/businesses?

### **Family income and source(s) of income (INC)**

*Skip section if sample child questionnaire is complete and if adult and child are in same family. If family size is one (sample adult is living alone or with unrelated roommates), then questions are asked only about the sample adult's income and sources.*

*(Last calendar year) Did you or any adult family members living here receive:*

- Income from wages, salaries, commissions, bonuses, tips, or self-employment?
- Income from interest, dividends, rent, royalties, or income from estates or trusts?
- Social Security or Railroad Retirement?
- Supplemental Security Income (SSI) or Social Security Disability?

*If yes:*

- Was it SSI, SSDI or both?
- Was this a disability benefit?

*If more than one person in the family:*

- Who in the family received SSI and/or SSDI?
- Any public assistance or welfare payments?
- Retirement, survivor, or disability pensions?
- Other income, such as VA payments, unemployment, child support, or alimony?
- (Last calendar year) Total family income

*If unknown or refused:*

- Cascading questions to categorize income relative to federal poverty thresholds

### **Family participation in food-related programs (FOO)**

*Skip section if sample child questionnaire is complete and if adult and child are in same family.*

*In 2019, additional questions on this topic are sponsored by USDA. See page 23.*

- (Past 12 months) Anyone in family receive SNAP/food stamp benefits

*If family includes females 12-55 or children 0-5:*

- (Past 12 months) Anyone in family receive food through the WIC program

*If family includes children 5-17:*

- (Past 12 months) Any children in the family receive free or reduced-cost lunches at school

### **Housing (HOU)**

*Skip second question and follow-up if sample child questionnaire is complete and if adult and child are in same family.*

- Length of time you have lived in this house/apartment
- Owned, rented, or occupied by some other arrangement

*If rented:*

- Paying lower rent because a government program is paying part of the cost

### **Recontact information (REC)**

- Full name

### **Telephone use (TEL)**

- Is there a working telephone in your home that is not a cell phone? *(if not already known from sample child interview)*

- Do you have a working cell phone (wireless/mobile telephone)?

*If no:*

- Do you live with anyone who has a working cell phone? *(if not already known from sample child interview)*

*If adult has cell phone and home has a landline telephone:*

- Frequency of your landline/wireless use (landline mostly, wireless mostly, equal use)

### **Linkage with vital statistics and health-related records of other government agencies (LNK)**

- Linkage intro, providing explanation for why SSN and Medicare number are being sought
- Last 4 digits of social security number

*If Medicare was reported in INS section:*

- Last 4 digits and any letters of Medicare number

*If no SSN or SSN refused or unknown and/or Medicare number refused or unknown:*

- Consent to link without SSN and/or Medicare number

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**ROTATING CORE CONTENT: UTILIZATION OF SERVICES**  
**Years: 2019, 2020, 2022, 2023, 2025, 2026**

**Dental care (DNC)**

- Time since most recent dental exam or cleaning
- (Past 12 months) Any dental care delayed because of cost
- (Past 12 months) Any dental care needed that you didn't get due to cost

**Other care received (PTC)**

- (Past 12 months) Received an eye exam from an eye specialist
- (Past 12 months) Received physical, speech, rehabilitative, or occupational therapy
- (Past 12 months) Received care at home from nurse or other health professional

**Mental health care (MHC)**

*If does not take medication for anxiety or depression:*

- (Past 12 months) Any prescription medication taken to help with other emotions, concentration, behavior, or mental health
- (Past 12 months) Received counseling or therapy from a mental health professional

*If yes:*

- (Currently) Receiving counseling or therapy
- (Past 12 months) Any counseling or therapy delayed due to cost
- (Past 12 months) Any counseling or therapy needed that you didn't get due to cost

**ROTATING CORE CONTENT: CHRONIC PAIN**  
**Years: 2019, 2021, 2023, 2025, 2027**

**Frequency, severity, and impact of pain (PAI)**

*In 2019, additional questions are included as emerging topics. See page 25.*

- (Past 3 months) Frequency of pain

*If at least some days:*

- (Last time had pain) Severity of pain: a lot, a little, somewhere in between
- (Past 3 months) Frequency of interference with life or work activities
- (Past 3 months) Frequency that your pain affected your family and significant others

**Pain locations**

*If experienced pain at least some days in past 3 months:*

- (Past 3 months) How much have you been bothered by...back pain
- (Past 3 months) How much have you been bothered by...pain in hands, arms, or shoulders
- (Past 3 months) How much have you been bothered by...pain in hips, knees, or feet
- (Past 3 months) How much have you been bothered by...headaches or migraines
- (Past 3 months) How much have you been bothered by...abdominal, pelvic, or genital pain
- (Past 3 months) How much have you been bothered by...toothache or jaw pain

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**ROTATING CORE CONTENT: PREVENTIVE SERVICES**  
**Years: 2019, 2021, 2023, 2025, 2027**

**Aspirin use for prevention (ASP)**

*If age 40+:*

- (Ever) Doctor or other health professional advised taking low-dose aspirin every day

*If yes:*

- (Currently) Following this advice?

*If no:*

- Did doctor advise you to stop taking low-dose aspirin?

*If no:*

- (Currently) Taking low-dose aspirin every day on your own

**Preventive screening for adults (PRV)**

*In 2019, additional questions on this topic are sponsored by NCI and NCCDPHP. See page 20.*

- Time since blood pressure was last checked
- Time since cholesterol was last checked
- Time since blood sugar test for diabetes

*If age 40+:*

- (Ever) Colonoscopy or sigmoidoscopy

*If yes:*

- Have had colonoscopy, sigmoidoscopy, or both?

*If colonoscopy or both:*

- Time since most recent colonoscopy

*If sigmoidoscopy or both:*

- Time since most recent sigmoidoscopy

*If don't know which:*

- Time since most recent colonoscopy or sigmoidoscopy

- (Ever) Any other kind of test for colorectal cancer

*If yes:*

- Ever had CT colonography or virtual colonoscopy

*If yes:*

- Time since most recent CT colonography or virtual colonoscopy

- (Ever) had blood stool or FIT test using at home kit

*If yes:*

- Time since most recent home-based blood stool or FIT test

*If female:*

- (Ever) have Pap or HPV test to check for cervical cancer

*If yes:*

- Time since most recent test for cervical cancer

- (Ever) Hysterectomy

*If female and age 30+:*

- (Ever) Mammogram

*If yes:*

- Time since most recent mammogram

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**ROTATING CORE CONTENT: MENTAL HEALTH ASSESSMENT**  
**Years: 2019, 2022, 2025**

**PHQ-8 diagnostic tool for depression (PHQ)**

See <http://www.phqscreeners.com> for more information on the Patient Health Questionnaire.

- (Past 2 weeks) Frequency of...little interest or pleasure in doing things
- (Past 2 weeks) Frequency of...feeling down, depressed, hopeless
- (Past 2 weeks) Frequency of...trouble falling or staying asleep, or sleeping too much
- (Past 2 weeks) Frequency of...feeling tired or having little energy
- (Past 2 weeks) Frequency of...poor appetite or overeating
- (Past 2 weeks) Frequency of...feeling bad about self, or that you are a failure, or have let yourself or family down
- (Past 2 weeks) Frequency of...trouble concentrating
- (Past 2 weeks) Frequency of...moving/speaking slowly or fidgety/restless

**GAD-7 diagnostic tool for anxiety (GAD)**

See <http://www.phqscreeners.com> for more information on the GAD-7.

- (Past 2 weeks) Frequency of...feeling nervous, anxious, or on edge
- (Past 2 weeks) Frequency of...not being able to stop or control worrying
- (Past 2 weeks) Frequency of...worrying too much about different things
- (Past 2 weeks) Frequency of...trouble relaxing
- (Past 2 weeks) Frequency of...being so restless that it is hard to sit still
- (Past 2 weeks) Frequency of...becoming easily annoyed or irritable
- (Past 2 weeks) Frequency of...feeling afraid that something awful might happen

**ROTATING CORE CONTENT: EMPLOYMENT**  
**Years: 2020, 2021, 2023, 2024, 2026, 2027**

**Detailed adult employment (EMD)**

*If working at or had a paid job or business last week, if working in a family business not for pay, if doing seasonal/contract work, or if not currently working but had a paid job or business in past 12 months:*

- For whom do/did you work at your main job/business? (name of company, employer, etc.)
- Industry (kind of business) (*open-ended*)
- Occupation (kind of work) (*open-ended*)
- Most important activities on the job (*open-ended*)
- Supervisory status
- Work category of main job (private sector, government employee, self-employed, etc.)

**ROTATING CORE CONTENT: INJURIES**  
**Years: 2020, 2021, 2023, 2024, 2026, 2027**  
**UNDER DEVELOPMENT**

**Repetitive strain injuries**

- (Past 3 months) Any injuries due to repetitive strain
  - If yes:*
    - Any repetitive strain injuries serious enough to limit activities for 24 hours
    - (Past 3 months) Any school or work days missed due to repetitive strain injuries
  - If yes to either of these two seriousness questions:*
    - Talk to doctor or health professional about these repetitive strain injuries
    - Any repetitive strain activities caused by something you did while working at a job

**Accidents and injuries (not including repetitive strain injuries)**

- (Past 3 months) Any accident or injury where any part of your body was hurt
  - If yes:*
    - Any injuries serious enough to limit activities for 24 hours
    - Any injuries serious enough that you missed at least one school or work day
  - If yes to either of these two seriousness questions:*
    - (Past 3 months) Number of times injured
    - (Past 3 months) Talk to doctor or health professional about any of these injuries
      - If yes:*
        - (Past 3 months) Number of medically consulted injuries
        - (Past 3 months) Any ER visit because of an injury
        - (Past 3 months) Any overnight hospitalization because of an injury
    - Any injury while you were working at a job or business
    - Any injury while you were at school, taking classes, or doing schoolwork
    - Any injury while you were playing sports or exercising
    - Any injury while you were doing household activities
    - Any injury while you were doing leisure activities
    - Any injury while you were walking to get some place outside your home
    - Any injury a result of a fall or falling
      - If yes:*
        - Any falls occurred while you were working at a job or business
    - Any injury a result of a collision involving a motor vehicle
      - If yes:*
        - Were you a driver, passenger, bicyclist, or pedestrian when this occurred?

**Impact of injuries (including repetitive strain injuries)**

*Skip entire section if no repetitive strain or other type of injury in past 3 months.*

*If employed in past year and missed work days:*

- (Past 3 months) Number of days of work missed because of injuries
- Do you expect to miss any more days of work because of injuries that occurred during past 3 months?

*If employed in past year:*

- (Past 3 months) Stopped working or changed jobs because of an injury
- (Past 3 months) Made a major change in work activities because of an injury

*If currently in school and missed school days:*

- (Past 3 months) Number of days of school missed because of injuries
- Do you expect to miss any more days of school because of injuries that occurred during past 3 months?

## ROTATING CORE CONTENT: HEALTH BEHAVIORS

Years: 2020, 2022, 2024, 2026

**UNDER DEVELOPMENT**

### Physical activity (PHY)

- Frequency of moderate-intensity leisure-time activities (# times per day/week/month/year)  
*If at least once per year:*
  - Number of hours/minutes each time
- Frequency of vigorous-intensity leisure-time activities (# times per day/week/month/year)  
*If at least once per year:*
  - Number of hours/minutes each time
- Frequency of leisure-time muscle-strengthening activities (# times per day/week/month/year)

### Walking for transportation and leisure (WLK)

*Skip to last question if sample adult reported being unable to walk or climb steps in MOB section*

- (Past 7 days) Walked at least 10 minutes to get some place  
*If yes:*
    - (Past 7 days) Number of times walked at least 10 minutes
    - Average length of walk(s), in minutes/hours
  - (Past 7 days) Walked at least 10 minutes for fun, relaxation, exercise, or to walk the dog  
*If yes:*
    - (Past 7 days) Number of times walked at least 10 minutes
    - Average length of walk(s), in minutes/hours
- If seen doctor in past 12 months:*
- (Past 12 months) Doctor advised you to exercise more

### Fatigue (FGE)

- (Past 30 days) Frequency of feeling very tired or exhausted  
*If at least some days:*
  - (Last time) Duration of feeling very tired or exhausted (some/most/all of the day)
  - (Last time) Level of tiredness: a lot, a little, somewhere in between

### Sleep (SLP)

- Average hours of sleep in 24-hour period on weekday or workday
- Average hours of sleep in 24-hour period on a weekend or non-workday
- (Past 30 days) Frequency waking up well-rested
- (Past 30 days) Frequency having trouble falling asleep
- (Past 30 days) Frequency having trouble staying asleep
- (Past 30 days) Frequency taking sleep medication (prescribed or over-the-counter)

### Alcohol use (ALC)

- (Lifetime) Had at least one drink of any alcoholic beverage
  - If yes:*
    - (Past 12 months) Number of days per week/month/year that alcohol was consumed
      - If none:*
        - (In any one year) Had at least 12 drinks of any alcoholic beverage
      - If any:*
        - (Past 12 months) Average number of drinks on days consumed any alcohol
          - If average is less than 5 (if male) or 4 (if female):*
            - (Past 12 months) Did you ever have 5/4 or more drinks in a day?
              - If average is greater than or equal to 5 (if male) or 4 (if female), or if yes, had 5/4 or more drinks in one day in past 12 months:*
                - (Past 30 days) Had at least one drink
                  - If yes:*
                    - (Past 30 days) Number of times had 5/4 or more drinks on an occasion
  - If any and seen doctor in past 12 months:*
    - (Past 12 months) Doctor advised you to stop or cut down on your drinking

### Smoking history and cessation (CIH)

- If ever smoked 100 cigarettes:*
  - Age when first started smoking regularly
- If currently an everyday smoker or someday smoker:*
  - (Past 12 months) Stopped smoking for at least 1 day because trying to quit
- If former smoker:*
  - Length of time since quit smoking cigarettes
- If everyday smoker, someday smoker, or quit smoking in the past 12 months, and if seen doctor in past 12 months:*
  - (Past 12 months) Doctor advised you about ways to quit smoking or prescribed medicine to help you quit smoking

**ROTATING CORE CONTENT: ROTATING CONDITIONS SECTION**  
**Years: 2021, 2024, 2027**

**Rotating hearing detail (HEA)**

- Level of difficulty hearing a conversation in a quiet room (even with hearing aid)  
*If able to hear at all in a quiet room:*
  - Level of difficulty hearing a conversation in a noisier room (even with hearing aid)

**Rotating communication detail (COM)**

- Use of sign language

**Rotating conditions list (RCN)**

- Ever told by doctor or other health professional that you had weak or failing kidneys
- Ever told by doctor or other health professional that you had hepatitis
- Ever told by doctor or other health professional that you had cirrhosis or any other kind of long-term liver condition
- (Past 12 months) Hay fever or seasonal allergy
- (Past 12 months) Any other kind of respiratory allergy
- (Past 12 months) Any kind of food or digestive allergy
- (Past 12 months) Eczema or any kind of skin allergy

**Serious psychological distress (AMH)**

See [https://www.hcp.med.harvard.edu/ncs/k6\\_scales.php](https://www.hcp.med.harvard.edu/ncs/k6_scales.php) for more information on the K6 scale.

- (Past 30 days) Frequency of feeling ... so sad that nothing could cheer you up
- (Past 30 days) Frequency of feeling ... nervous
- (Past 30 days) Frequency of feeling ... restless or fidgety
- (Past 30 days) Frequency of feeling ... hopeless
- (Past 30 days) Frequency of feeling ... that everything was an effort
- (Past 30 days) Frequency of feeling ... worthless

**SPONSORED CONTENT: NCI and NCCDPHP**  
**Year: 2019**

**Sustaining Sponsors:** National Cancer Institute (NCI) and National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

**Preventive screening for adults (PRV)**

*If age 40+ and ever had a colonoscopy:*

- Main reason for most recent colonoscopy (routine exam, because of a problem, follow-up test of earlier test/screening, some other reason)
- Did you pay for none, part, or all of the cost of most recent colonoscopy?

*If age 40+ and ever had a blood stool or FIT test using home test kit:*

- (Ever) Cologuard test

*If yes:*

- Was the blood stool/FIT test you reported earlier part of a Cologuard test?

*If yes:*

- Time since most recent Cologuard test

*If over 40 and haven't had colorectal test within recommend time frame or never had colorectal test:*

- (Past 12 months) Doctor or other health professional recommended you be tested for problems in colon/rectum

*If yes:*

- Which test(s) to check for colon cancer were recommended (FIT test, Cologuard or FIT DNA test, sigmoidoscopy, colonoscopy, CT virtual colonoscopy, other)

*If male and age 40+:*

- (Ever) PSA test

*If yes:*

- Time since most recent PSA test
- Main reason for PSA (routine exam, because of a problem, some other reason)
- Who first suggested PSA test (you, your doctor, someone else)
- (Past 5 years) Number of PSA tests

- (Ever) Doctor discussed advantages of the PSA test

- (Ever) Doctor discussed disadvantages of the PSA test

*If female and ever had cervical cancer screening:*

- Main reason for most recent cervical cancer screening (routine exam, because of a problem, follow-up test, other reason)
- (At most recent screening) Pap test
- (At most recent screening) HPV test

*If female and had cervical cancer screening in past 5 years:*

- (Past 5 years) Any cervical cancer screening test require follow-up to check for cancer or precancerous cells

*If female and haven't had cervical cancer screening in past 5 years:*

- Main reason haven't had cervical cancer screening

*If female, 30+ years, and ever had a mammogram:*

- Main reason for most recent mammogram (routine exam, because of a problem, other reason)
- Age when had first mammogram

*If first mammogram was under age 50:*

- Main reason for first mammogram (because of a problem, told was high risk, family history of breast cancer, routine exam, requested it, other reason)

*If female and age 30+:*

- (Ever) Breast exam by doctor or other health professional to check for lumps or signs of breast cancer

*If yes:*

- Time since most recent breast exam
- Main reason for most recent breast exam (routine exam, because of problem, other reason)

#### **SPONSORED CONTENT: FDA**

**Sustaining Sponsor:** Food and Drug Administration (FDA)

#### **Other tobacco products (OTB)**

- (Ever) Smoked a regular cigar, cigarillo, or little filtered cigar, even one time

*If yes:*

- (Currently) Smoke cigars, cigarillos, or little filtered cigars every day, some days, not at all

*If some days or not at all:*

- (Past 30 days) Number of days smoked cigar, cigarillo, or little filtered cigar

- (Ever) Smoked tobacco pipe either regular pipe, water pipe, or hookah, even one time

*If yes:*

- (Currently) Smoke tobacco pipes (regular, water, or hookah) every day, some days, not at all

- (Ever) Used smokeless tobacco products, even one time

*If yes:*

- (Currently) Use smokeless tobacco products every day, some days, not at all

**SPONSORED CONTENT: NCIRD**  
**Year: 2019**

**Sustaining Sponsor:** National Center for Immunization and Respiratory Diseases (NCIRD)

**Immunizations (IMS)**

*If female age 18-49, if being interviewed between August and March, and if currently pregnant and received a flu vaccination in the past 12 months:*

- Did you get a flu vaccination before or during current pregnancy?

*If female age 18-49, if being interviewed between April and July, and if currently pregnant; or if female age 18-49 and not currently pregnant:*

- Were you pregnant at any time between August and March?

*If yes and received flu vaccination in the past 12 months:*

- Did you get a flu vaccination before, during, or after pregnancy?

*If ever had pneumonia shot:*

- (Lifetime) Number of pneumonia shots

*If age 50+:*

- (Ever) Vaccine for shingles

*If yes:*

- (Ever) Zostavax vaccine

*If yes:*

- Year of most recent Zostavax shot

*If don't know/refused:*

- Before 2018?

- (Ever) Shingrix vaccine

*If yes:*

- (Lifetime) Number of Shingrix shots

- Year of most recent Shingrix shot

*If don't know/refused:*

- Before 2018?

*If female age 18-49:*

- (Past 12 months) Had a pregnancy that ended in a live birth

*If yes:*

- (During pregnancy that resulted in live birth) Tdap vaccination

*If male, or if female and did not have live birth in past 12 months, or if female and did not receive Tdap vaccination during recent pregnancy:*

- (Past 10 years) Tetanus shot

*If yes:*

- Did most recent tetanus shot include pertussis or whooping cough vaccine?

*If age 18-64:*

- (Ever) HPV shot or vaccine

*If yes:*

- Age at first HPV shot

- (Currently) Provide direct medical care to patients in your work or volunteer activities

*If no:*

- (Currently) Work or volunteer in a health care facility

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## SPONSORED CONTENT: USDA

**Sustaining Sponsor:** United States Department of Agriculture (USDA)

### Family participation in food-related programs (FOO)

*Skip section if sample child questionnaire is complete and if adult and child are in same family.*

*If anyone in the family received SNAP/food stamp benefits in past 12 months:*

- (Last 30 days) Anyone in family receive SNAP/food stamp benefits

### Food security (FDS)

*Skip section if sample child questionnaire is complete and if adult and child are in same family.*

- (Past 30 days) “You or your family worry food would run out before got money to buy more” – often true, sometimes true, or never true
- (Past 30 days) “You or your family have that food didn’t last and didn’t have money to get more” – often true, sometimes true, or never true
- (Past 30 days) “You or your family couldn’t afford to eat balanced meals” – often true, sometimes true, or never true

*If any of statements about worrying food would run out, food didn’t last, or couldn’t afford to eat balance meals were often or sometimes true:*

- (Past 30 days) Any adult in family cut size of meals or skip meals because there wasn’t enough money for food

*If yes:*

- (Past 30 days) Number of days this happened

- (Past 30 days) Any adult in family ate less because there wasn’t enough money for food
- (Past 30 days) Any adult in family was hungry but didn’t eat because there wasn’t enough money for food
- (Past 30 days) Any adult in family lost weight because there wasn’t enough money for food *If cut or skipped meal, ate less than should, felt hungry, or lost weight because there wasn’t enough money for food:*

- (Past 30 days) Any adult in family not eat a whole day because there wasn’t enough money for food

*If yes:*

- (Past 30 days) Number of days this happened

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**SPONSORED CONTENT: NIDDK and NCCDPHP**

**Year: 2019**

**Sponsors:** National Institute of Diabetes and Digestive and Kidney Disease (NIDDK) and National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

**Diabetes (DIB)**

*If ever had diabetes and now taking insulin:*

- Length of time between diabetes diagnosis and first started taking insulin
- (Since starting insulin) Ever stopped taking it for more than 6 months?

*If yes and started insulin less than a year after first diagnosed with diabetes:*

- Was this only during first year after diagnosed with diabetes?

**SPONSORED CONTENT: NIAMS and NCCDPHP**

**Year: 2019**

**Sponsors:** National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) and National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

**Arthritis (ART)**

*If ever had arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia:*

- (Past 3 months) Had symptoms of pain, aching, or stiffness in/around a joint

*If yes:*

- (Past 30 days) How bad was joint pain (0-10 scale)
- Now limited in any usual activities because of arthritis or joint symptoms
- Does arthritis or joint symptoms affect your ability to work, type of work, or amount of work?
- Has a doctor or other health professional ever suggested losing weight to help arthritis or joint symptoms?
- Has a doctor or other health professional ever suggested physical activity or exercise to help arthritis or joint symptoms?

## EMERGING TOPICS

Year: 2019

### Prescription opioid use (OPD)

*If prescribed any medication by doctor or other health professional:*

- (Past 12 months) Taken any opioid pain relievers prescribed by doctor or dentist

*If yes:*

- (Past 3 months) Taken any opioid pain relievers prescribed by doctor or dentist

*If yes:*

- (Past 3 months) Taken opioid for short-term/acute pain
- (Past 3 months) Taken opioid for long-term/chronic pain

*If yes:*

- (Past 3 months) Used opioids some days, most days, everyday

### Pain management (PAI)

*If experienced pain at least some days in past 3 months:*

- (Past 3 months) Used physical/rehabilitative/occupational therapy
- (Past 3 months) Used spinal manipulation or other chiropractic care
- (Past 3 months) Used talk therapy to
- (Past 3 months) Used chronic pain self-management program or workshop
- (Past 3 months) Used chronic pain peer support groups
- (Past 3 months) Used yoga or tai chi
- (Past 3 months) Used massage
- (Past 3 months) Used meditation, guided imagery, or other relaxation techniques
- (Past 3 months) Used other approach

*If used any pain management technique or prescription opioids in past 3 months:*

- (Past 3 months) Effectiveness in managing pain