

Welcome to the Oregon Adult Health Survey,

Your household was randomly selected for this important survey about the health of people and communities in Oregon. The results will help us to better understand the support and health services needed by people in each part of the state.

Please have the adult (age 18 or older) in your household **who had the most recent birthday** complete the questions in the enclosed paper form. **Mail it back as soon as possible** in the postage-free return envelope provided.

Some people may prefer to use the enclosed questionnaire to see what questions are being asked, and then give answers over the Internet. You can do that by going to www.Oregon.gov/HealthyAdults and entering your Access Code: [xxxxx]

Answering the questions either way is fine, but please do not respond to both the paper and internet questionnaires.

For more information about the survey, visit www.Oregon.gov/HealthyAdults or you may contact:

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Oregon Health Authority
Public Health Division
(503) 910-4992
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Thank you very much for your help!

1. **Would you say that in general your health is ...**

- Excellent
- Very Good
- Good
- Fair
- Poor

2. **Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?**

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Number of days

3. **Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?**

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Number of days

4. **Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?**

- Yes
- No
- Not sure

5. **About how tall are you without shoes?**

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Feet

--	--

Inches

6. **About how much do you weigh without shoes?**

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Pounds

7. **Which of the following is the primary source of your current health insurance?**

- Plan through an employer or union (yours or another person's)
- Medicare
- Medigap
- Oregon Health Plan (Medicaid)
- Children's Health Insurance Program (CHIP)
- Military related health care
- Indian Health Service
- Other (please specify)

- No health insurance of any type
- Not sure

8. **During the past 30 days, have you used any tobacco or vaping product with mint, fruit, coffee, or other flavors (do not include marijuana products)?**

- Yes
- No
- Not sure

9. Do you **currently** use the following nicotine or tobacco products (do not include marijuana products in your answer)?

	Every day	Some days	Not at all
Cigarettes (non-menthol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menthol cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E-cigarettes or vape pens (non-menthol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menthol e-cigarettes or vape pens	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Full-sized cigars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smaller-sized cigars or cigarillos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Has a doctor, nurse, or other health professional **ever** told you that you had the following:

	Yes	No	Not sure
Heart attack (myocardial infarction)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angina or coronary heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, do you still have asthma?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin cancer that is not melanoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Melanoma or other types of cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COPD, emphysema, or chronic bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A depressive disorder (e.g., major or minor depression)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney disease (not including kidney stones, bladder infection or incontinence)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes and you are female, was that only when you were pregnant?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pre-diabetes or borderline diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other chronic illness (please specify)	_____		

The next items ask about events that happened during your childhood. This information will allow us to better understand difficulties that may occur early in life and may help others in the future.

11. Did you live with anyone who was depressed, mentally ill, or suicidal?
- Yes
 No
 Not sure
12. Did you live with anyone who was a problem drinker or alcoholic?
- Yes
 No
 Not sure
13. Did you live with anyone who used illegal street drugs or who abused prescription medications?
- Yes
 No
 Not sure
14. Did you live with anyone who served time or was sentenced to serve time in prison, jail, or other correctional facility?
- Yes
 No
 Not sure
15. Were your parents separated or divorced?
- Yes
 No
 Not sure
16. How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?
- Never
 Once
 More than once
17. Not including spanking, (before age 18) how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?
- Never
 Once
 More than once
18. How often did a parent or adult in your home ever swear at you, insult you, or put you down?
- Never
 Once
 More than once
19. How often did anyone at least 5 years older than you or an adult, ever touch you sexually?
- Never
 Once
 More than once
20. How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually?
- Never
 Once
 More than once

21. How often did anyone at least 5 years older than you or an adult, force you to have sex?

- Never
- Once
- More than once

22. For how much of your childhood was there an adult in your household who made you feel safe and protected?

- Never
- A little of the time
- Some of the time
- Most of the time
- All of the time

23. For how much of your childhood was there an adult in your household who tried hard to make sure your basic needs were met?

- Never
- A little of the time
- Some of the time
- Most of the time
- All of the time

If you would like information or referral for the issues in the last few questions, please use the following toll-free numbers:

Oregon Statewide Crisis Number – 1 (888) 235-5333

National Domestic Violence Hotline – 1 (800) 799-SAFE (7233)

National Sexual Assault Hotline – 1 (800) 656-HOPE (4673)

National Hotline for Child Abuse – 1 (800) 4-A-CHILD (1-800-422-4453)

National Suicide and Crisis Hotline - 988

PLEASE CONTINUE TO NEXT PAGE

The next questions ask about gambling so we can better understand the relation between problem gambling and other public health concerns. Gambling involves betting or risking anything of value on a game or event so you can win money or something of value. Examples include buying lottery scratch-off tickets, playing cards for money, betting on sporting events, paying money to enter a raffle, playing slot machines or video lottery.

24. Have you done any of these things or other gambling activities in the past 12 months?

- Yes
- No → IF NO, SKIP TO Q. 30
- Not sure

25. During the past 12 months, have you become restless, irritable, or anxious when trying to stop or cut down on gambling?

- Yes
- No
- Not sure

26. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?

- Yes
- No
- Not sure

27. During the past 12 months, did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends, or welfare?

- Yes
- No
- Not sure

28. During the past 30 days, have you done any gambling or placed any bets online or using an app?

- Yes
- No → IF NO, SKIP TO Q. 30
- Not sure

29. We would like to understand if Oregonians are gambling on sites not required to have player protections. During the past 30 days, was the primary wagering site or app you gambled on unregulated in Oregon, for example, an offshore casino site or poker room?

- Yes
- No
- Not sure

The next questions are about you. Remember, your answers are completely confidential.

30. Which one of these categories best describes your current marital status?

- Married
- Divorced
- Widowed
- Separated
- Never married
- A member of an unmarried couple
- A member of a Registered Domestic Partnership

31. What is your current age?

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 Years of age

32. Do you own or rent your home?

- Own
- Rent
- Other arrangement

33. What is the highest grade or year of school you completed?

- Never attended school or only attended kindergarten
- Grades 1 through 8 (Elementary)
- Grades 9 through 11 (Some high school)
- Grade 12 (High school graduate)
- GED (did not graduate high school, instead obtained a GED)
- College 1 year to 3 years (Some college or technical school)
- College 4 years or more (College graduate)

34. Which one of the following best describes your current employment status?

- Employed for wages
- Self-employed
- Out of work for 1 year or more
- Out of work for less than 1 year
- A homemaker
- A student
- Retired
- Unable to work
- Not sure

35. Please fill in the last 3 digits of the ZIP Code where you currently live.

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ZIP Code

36. In which one of these Oregon counties do you now live?

- Baker
- Benton
- Clackamas
- Clatsop
- Columbia
- Coos
- Crook
- Curry
- Deschutes
- Douglas
- Gilliam
- Grant
- Harney
- Hood River
- Jackson
- Jefferson
- Josephine
- Klamath
- Lake
- Lane
- Lincoln
- Linn
- Malheur
- Marion
- Morrow
- Multnomah
- Polk
- Sherman
- Tillamook
- Umatilla
- Union
- Wallowa
- Wasco
- Washington
- Wheeler
- Yamhill

37. What language or languages do you use at home?

38. What language would you prefer to use to read important written information such as medical, legal, or health information?

39. (SKIP IF YOU DO NOT USE A LANGUAGE OTHER THAN ENGLISH OR SIGN LANGUAGE) How well do you speak English?

- Very Well
- Well
- Not Well
- Not at All
- Don't know
- Don't want to answer

40. What is your gender (select all that apply)?

- Woman
- Man
- Non-binary
- Agender / No gender
- Questioning
- Not listed (please describe) _____
- Don't know
- Don't know what this question is asking
- Don't want to answer

41. Are you transgender?

- Yes
- No
- Questioning
- Don't know
- Don't know what this question is asking
- Don't want to answer

42. Please describe your sexual orientation or sexual identity in any way you want:

43. How do you describe your sexual orientation or sexual identity (select all that apply)?

- Lesbian
- Gay
- Bisexual
- Straight
- Pansexual
- Asexual
- Queer
- Questioning
- Not listed (please describe) _____
- Don't know
- Don't know what this question is asking
- Don't want to answer

44. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?

45. Which of the following describes your racial or ethnic identity (select all that apply)?

Hispanic and Lantino/a/x

- Central American
- Mexican
- South American
- Other Hispanic or Latinx

Native Hawaiian and Pacific Islander

- CHamoru (Chamorro)
- Marshallese
- Communities of the Micronesian Region
- Native Hawaiian
- Samoan
- Other Pacific Islander

White

- Eastern European
- Slavic
- Western European
- Other White

American Indian and Alaska Native

- American Indian
- Alaska Native
- Canadian, Inuit, Metis, or First Nation
- Indigenous Mexican, Central American, or South American

Black and African American

- African American
- Afro-Caribbean
- Ethiopian
- Somali
- Other African (Black)
- Other Black

Middle Eastern/North African

- Middle Eastern
- North African

Asian

- Asian Indian
- Cambodian
- Chinese
- Communities of Myanmar
- Filipino/a
- Hmong
- Japanese
- Korean
- Laotian
- South Asian
- Vietnamese
- Other Asian

Other Categories

- Other (please list): _____
- Don't know
- Don't want to answer

46. If you checked more than one category above, is there ONE you think of as your primary racial or ethnic identity?

- Yes (Which one?) _____
- I do not have just one primary racial or ethnic identity
- No, I identify as Biracial or Multiracial
- N/A, I only checked one category above
- Don't know
- Don't want to answer

47. Your answers to the next items will help us find health and service differences among people with and without functional difficulties.

	Yes	If yes, at what age did this condition begin?	No	Don't know
Are you deaf or do you have serious difficulty hearing?	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Do you have serious difficulty walking or climbing stairs?	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Do you have difficulty dressing or bathing?	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Do you have serious difficulty learning how to do things most people your age can learn?	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Using your usual (customary) language, do you have serious difficulty communicating (for example understanding or being understood by others)?	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	Don't know what this question is asking		
Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	Don't know what this question is asking		

48. Please use the space below to tell us anything you'd like about sites, services and programs in your community that help support your health.

49. Please use the space to tell us anything you'd like about sites, services and programs in your community that ARE NEEDED to support your health.

Thank you very much for helping us improve health services throughout Oregon