

Thank you again for agreeing to participate in our study. The survey will take approximately 30-45 minutes to complete. The information you provide in the survey is completely confidential. If at any time, you are confused about a question, please let me know.

## Contact Information

Please provide the following information for our records (this page will be removed from the questionnaire and kept locked in a separate file):

Your Name: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

R00 CARE Participant ID \_\_\_\_\_ Date \_\_\_\_\_ Location \_\_\_\_\_ Interviewer Initials \_\_\_\_\_

<b>Date and Time of Interview</b>  <b>Date:</b> ____/____/____  <b>Time Started:</b> _____ AM/PM  <b>Time Ended:</b> _____ AM/PM  <b>Location:</b> _____	<b>Interviewer Name:</b> _____  <b>Height:</b> ____ feet ____ in or _____ cm  <b>Weight:</b> _____ lbs or _____ kg  <b>A1c Result:</b> _____ <b>Date of A1c Result:</b> ____/____/____  <b>Source of A1c:</b> 1) abstract medical record 2) self-report 3) A1cNOW test 4) other _____  <b>After this date (Date of A1c Result: ____/____/____), did you go to the doctor's office to check your blood sugar?</b> 1) Yes <i>[please remember to contact the doctor's office to update the A1c result and date]</i> 2) No 3) Don't remember/not sure
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### Background Information

This series of questions is a standard collection of background information that will be used for research purposes only. As with everything else in the study, all of the information you provide will be kept confidential.

**1. What is your gender?** ☐ Female ☐ Male

**2. What is your date of birth? (mm/dd/yyyy)** \_\_\_\_/\_\_\_\_/19\_\_\_\_  
mm dd year

**3. What country were you born in?**

- ☐ China  
☐ Hong Kong  
☐ Taiwan  
☐ United States  
☐ Other, please specify \_\_\_\_\_

**4. How many years have you lived in the United States?** \_\_\_\_\_ [WRITE IN YEAR]

**5. What is your marital status?**

- ☐ Currently married or living as married  
☐ Widowed  
☐ Divorced or Separated  
☐ Never married or Single  
☐ Other (please specify) \_\_\_\_\_

**6. What is your employment status?**

- ☐ Employed fulltime for wages  
☐ Part time (one job)  
☐ Part time (multiple jobs)  
☐ Self-employed  
☐ Not employed, not working  
☐ Other \_\_\_\_\_

**7. What is your primary occupation?** \_\_\_\_\_ [WRITE IN]

**8. How many hours a week do you work on average?** \_\_\_\_\_ [WRITE IN NUMBER OF HOURS]

**9. How well is your English?**

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all

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

- 1. Never attended school or only attended kindergarten → Question 11
- 2. Grades 1 through 8 (Elementary) → Question 11
- 3. Grades 9 through 11 (Some high school) → Question 11
- 4. Grade 12 or GED (High school graduate) → Question 11
- 5. College 1 year to 3 years (Some college or technical school) → Question 10a
- 6. College 4 years or more (College graduate or more) → Question 10a
- 98. Don't know/Not sure
- 99. Decline to state

**10a. Did you go to college in the United States?**

- 1. Yes
- 2. No
- 3. Don't know/Not sure
- 4. Refused

We are trying to understand how your income affects your ability to take care of your diabetes?

**11. What is your TOTAL household income from all sources per year?**

- 1. <\$25,000 → Question 12
- 2. \$25,000-\$55,000 → Question 12
- 3. >\$55,000 → Question 12
- 98. Don't know/Not sure → Question 11a
- 99. Decline to state

**11a. What is your weekly or monthly household income from all sources?**

Write-in: \_\_\_\_\_ (Choose Weekly or Monthly) 98. Don't know/Not sure 99. Decline to state

**12. Does your current household income meet your basic needs (including food, housing, utilities, medications, and other health care)?**

- ☐ Yes
- ☐ No
- ☐ Don't Know
- ☐ Refused
- ☐ SKIPPED

**13. What kind of health insurance do you have? Please check only one.**

- a) Medicaid ("White Card") [READ IF NEEDED: Medicaid is a health insurance program for persons whose income and resources cannot cover the costs of health care.]
- b) Medicare ("Blue and Red Card") [READ IF NEEDED: Medicare is a health insurance program for people 65 and older or persons with disabilities.]
- c) Private insurance
- d) Other type of public/government insurance (Family Health Plus, Child Health Plus)
- e) Work or company insurance
- f) No health insurance
- g) Other \_\_\_\_\_

## Eating Behaviors

**Now think about the foods you ate or drank during the past month, that is, the past 30 days, including meals and snacks. *Ask the participant use his/her fist as the equivalent of a cup.***

**1. In the past 30 days, on average, how many cups of fruits do you eat each day? INTERVIEWER**

**NOTE: INCLUDE FRESH, FROZEN OR CANNED FRUIT. DO NOT INCLUDE DRIED FRUITS. Ask the participant use his/her fist as the equivalent of a cup.**

\_\_\_\_\_ cups

☐ Don't Know

☐ Refused

**2. In the past 30 days, on average, how many cups of vegetables do you eat each day? INTERVIEWER**

**NOTE: DO NOT INCLUDE POTATO, SWEET POTATO. INCLUDE GREEN LEAFY VEGETABLES, TOMATOES, GREEN BEANS, CARROTS, CORN, CABBAGE, BEAN SPROUTS, COLLARD GREENS, AND BROCCOLI. INCLUDE RAW, COOKED, CANNED, OR FROZEN VEGETABLES. Ask the participant use his/her fist as the equivalent of a cup.**

\_\_\_\_\_ cups

☐ Don't Know

☐ Refused

**3. In the past 30 days, on average, how many cups of refined grains (which includes white rice, regular noodles, regular bread, regular dumplings, regular bun) do you eat each day? Ask the participant use his/her fist as the equivalent of a cup.**

\_\_\_\_\_ cups

☐ Don't Know

☐ Refused

**4. In the past 30 days, on average, how many cups of whole grains (which includes brown rice, millet, whole wheat, barley, whole wheat noodles, whole wheat bread, whole wheat-based dumplings or bun) do you eat each day? Ask the participant use his/her fist as the equivalent of a cup.**

\_\_\_\_\_ cups

☐ Don't Know

☐ Refused

**5. In the past 30 days, on average, how many cans of sugary drinks (e.g., regular or diet coke, fruit juice, bubble milk tea) do you drink each day? Ask the participant think the size of coke can.**

\_\_\_\_\_ cups

☐ Don't Know

☐ Refused

**6. In the past 30 days, on average, how many cups of potatoes do you eat each day?** *Ask the participant use his/her fist as the equivalent of a cup.*

\_\_\_\_\_ cups

☐ Don't Know

☐ Refused

**7. In general, how healthy is your overall diet?**

☐ Excellent

☐ Very Good

☐ Good

☐ Fair

☐ Poor

**8. How often did you read food nutrition label?**

☐ Almost Never or Never

☐ Sometimes

☐ Often

☐ Almost always or Always

**9. Who does most of the shopping and cooking of meals in your family?**

☐ Myself

☐ My spouse

☐ My adult children

☐ Senior center delivers food to my home

☐ We do not cook and have take-out/dine out most of the time.

☐ Other, please specify \_\_\_\_\_

## Physical Activity

**1. During the last 7 days, on how many days did you do large effort physical activities like heavy lifting, digging, aerobics, or fast bicycling that make your heart rate and breathing much faster? Activities can take place at home, at work, in the gym or elsewhere but think about only those physical activities that you do for at least 10 minutes at a time.**

\_\_\_\_\_ days per week

☐ No vigorous physical activities ➡ **Skip to question 3**

1a. What large effort physical activities did you perform?

☐ Running or jogging

☐ Lifting weights or heavy loads

☐ Aerobics

☐ Aerobic dance or jump rope

☐ Other \_\_\_\_\_

**2. How much time did you usually spend doing these large effort physical activities on one of those days? [If participant answers that the length of time varies, ask them to think about a normal day or the last day they did these types of physical activities]**

\_\_\_\_\_ minutes per day

☐ Don't know/Not sure

Now think about activities which take **moderate** physical effort that you did in the **last 7 days**. **Moderate** physical activities make you breathe somewhat harder than normal, but not so much that you are out of breath. Activities can take place at home, at work, in the gym or elsewhere but **think about only those physical activities that you do for at least 10 minutes at a time**.

3. During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying shopping bags or laundry, bicycling at a regular pace, or doubles tennis? Do not include walking.  
\_\_\_\_\_ **days per week**

☐ No moderate physical activities ➡ **Skip to question 5**

3a. What moderate physical activities did you perform?

- ☐ Carrying shopping bags or laundry
- ☐ Gardening
- ☐ Stretching
- ☐ Taichi
- ☐ Sit-ups
- ☐ Push-ups
- ☐ Raise milk bottles, water bottles, disinfectant bottles, laundry detergent bottles
- ☐ Other \_\_\_\_\_

4. How much time did you usually spend doing **moderate** physical activities on one of those days? *[If participant answers that the length of time varies, ask them to think about a normal day or the last day they did these types of physical activities]*

\_\_\_\_\_ **minutes per day**

☐ Don't know/Not sure

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

5. During the **last 7 days**, on how many days did you **walk for at least 10 minutes at a time**?

\_\_\_\_\_ **days per week**

☐ No walking ➡ **Skip to question 7**

6. How much time did you usually spend **walking** on one of those days?

\_\_\_\_\_ **minutes per day**

☐ Don't know/Not sure

The last question is about the time you spent **sitting** on weekdays during the **last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. During the **last 7 days**, how much time did you spend **sitting** on a **week day**?

\_\_\_\_\_ **minutes per day**

☐ Don't know/Not sure

8. During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles (such as lifting dumbbells, milk bottles, push-ups, sit-ups, squats, using elastic bands)?

☐ Never

\_\_\_\_\_ times per week

\_\_\_\_\_ times per month

☐ Don't know/Not sure

### The Summary of Diabetes Self-Care Activities

The questions below ask you about your diabetes self-care activities during the past 7 days. If you were sick during the past 7 days, please think about the last 7 days that you were not sick.

#### Diet

1. How many of the last SEVEN DAYS have you followed a healthful eating plan?

0      1      2      3      4      5      6      7

2. On average, over the past month, how many DAYS PER WEEK have you followed your eating plan?

0      1      2      3      4      5      6      7

3. On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables?

0      1      2      3      4      5      6      7

4. On how many of the last SEVEN DAYS did you eat high fat foods such as red meat or full-fat dairy products?

0      1      2      3      4      5      6      7

#### Exercise

5. On how many of the last SEVEN DAYS did you participate in at least 30 minutes of physical activity? (Total minutes of continuous activity, including walking)

0      1      2      3      4      5      6      7

6. On how many of the last SEVEN DAYS did you participate in a specific exercise session (such as swimming, walking, biking) other than what you do around the house or as part of your work?

0      1      2      3      4      5      6      7

#### Blood Sugar Testing

7a. Has your doctor recommended you check your blood sugar at home?

\_\_\_\_\_ NO (Go to Q9)

\_\_\_\_\_ YES (If Yes, how often did your doctor recommend? \_\_\_\_\_ Times per day or week)

7. On how many of the last SEVEN DAYS did you test your blood sugar?

0      1      2      3      4      5      6      7      N/A

8. On how many of the last SEVEN DAYS did you test your blood sugar the number of times recommended by your health care provider?

0      1      2      3      4      5      6      7      N/A



### **Foot Care**

**9. On how many of the last SEVEN DAYS did you check your feet?**

0      1      2      3      4      5      6      7      N/A

**10. On how many of the last SEVEN DAYS did you inspect the inside of your shoes?**

0      1      2      3      4      5      6      7      N/A

### **Medications**

**What medications has your doctor prescribed for your diabetes?**

\_\_\_\_ a) Oral diabetes medication

\_\_\_\_ b) Insulin

\_\_\_\_ c) Injectable that are not insulin

\_\_\_\_ d) My doctor did not prescribe any diabetes medication for me.

**11. On how many of the last SEVEN DAYS, did you take your recommended oral diabetes medication?**

0      1      2      3      4      5      6      7      N/A

**12. On how many of the last SEVEN DAYS, did you take your recommended number of diabetes pills?**

0      1      2      3      4      5      6      7      N/A

**13. On how many of the last SEVEN DAYS, did you take your recommended insulin injections?**

0      1      2      3      4      5      6      7      N/A

### **Self-Efficacy for Diabetes**

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

Not at all  
confident

Totally  
confident

1. How confident do you feel that you can eat your meals every 4 to 5 hours every day, including breakfast every day?

1      2      3      4      5      6      7      8      9      10

2. How confident do you feel that you can follow your diet when you have to prepare or share food with other people who do not have diabetes?

1      2      3      4      5      6      7      8      9      10

3. How confident do you feel that you can choose the appropriate foods to eat when you are hungry (for example, snacks)?

1      2      3      4      5      6      7      8      9      10

4. How confident do you feel that you can exercise 15 to 30 minutes, 4 to 5 times a week?

1      2      3      4      5      6      7      8      9      10

5. How confident do you feel that you can do something to prevent your blood sugar from dropping when you exercise?

1      2      3      4      5      6      7      8      9      10

Not at all  
confident

Totally  
confident

6. How confident do you feel that you know what to do when your blood sugar level goes higher or lower than it should be?

1 2 3 4 5 6 7 8 9 10

7. How confident do you feel that you can judge when the changes in your illness mean you should visit the doctor?

1 2 3 4 5 6 7 8 9 10

8. How confident do you feel that you can control your diabetes so that it does not interfere with things you want to do?

1 2 3 4 5 6 7 8 9 10

### Diabetes Knowledge

1. Have you ever taken a course or class in how to manage your diabetes in the United States?

- ☐ Yes  
☐ No  
☐ Don't know/ not sure  
☐ Refused

2. About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

[CHOOSE ONE; WRITE IN NUMBER OF TIMES]

- \_\_\_\_\_ times per day  
 \_\_\_\_\_ times per week  
 \_\_\_\_\_ times per month  
 \_\_\_\_\_ times per year
- ☐ Never  
☐ Don't know / Not sure  
☐ Refused

3. About how often do you check your feet for sores or irritations? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

[CHOOSE ONE; WRITE IN NUMBER OF TIMES]

- \_\_\_\_\_ times per day  
 \_\_\_\_\_ times per week  
 \_\_\_\_\_ times per month  
 \_\_\_\_\_ times per year
- ☐ No feet  
☐ Never  
☐ Don't know / Not sure  
☐ Refused

4. A test for "A1c" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for "A1c"?

\_\_\_\_\_ [WRITE IN NUMBER OF TIMES]

- ☐ None  
☐ Never heard of "A one C" test  
☐ Don't know / Not sure  
☐ Refused

**5. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?**

\_\_\_\_\_ [WRITE IN NUMBER OF TIMES]

- ☐ None  
☐ Don't know / Not sure

**6. About how many times in the past 12 months has a health professional checked your feet for any sores or irritations?**

\_\_\_\_\_ [WRITE IN NUMBER OF TIMES]

- ☐ None  
☐ Don't know / Not sure

**7. When was the last time you had an eye exam in which the pupils were dilated?**

NOTES: PUPIL DILATION INVOLVES GETTING EYE DROPS TO MAKE YOUR PUPILS LARGER.

- ☐ Within the past month  
☐ Within the past year  
☐ Within the past 2 years  
☐ 2 or more years ago  
☐ Don't know/Not sure  
☐ Never  
☐ Refuse

**8. Has a doctor ever told you that diabetes has affected your eyes or your kidney?**

- ☐ Yes  
☐ No  
☐ Don't Know/Not Sure  
☐ Refused

**Beliefs in Diabetes Self-Management**

How important is each of the following for controlling your diabetes?	Not important 1	2	3	4	Extremely important 5
1. Diabetic diet	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>
2. Exercise	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>
3. Self-monitoring blood glucose	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>
4. Medication	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>
5. Checking feet	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>

## Mental Health of Diabetes

### Social Support

	Never 1	Rarely 2	Sometimes 3	Usually 4	Always 5
1. I have someone who will listen to me when I need to talk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I have someone to confide in or talk to about myself or my problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I have someone who makes me feel appreciated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I have someone to talk with when I have a bad day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### Mental Health

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### Diabetes Distress

Living with Diabetes can sometimes be tough. There may be many problems and hassles concerning diabetes and they can vary greatly in severity. Problems may range from minor hassles to major life difficulties. Listed below are 17 potential problem areas that people with diabetes may experience. Consider the degree to which each of the 17 items may have distressed or bothered you DURING THE PAST MONTH.

	Not a problem	A slight problem	A moderate problem	Somewhat serious problem	A serious problem	A very serious problem
1. Feeling that diabetes is taking up too much of my mental and physical energy every day.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling that my doctor doesn't know enough about diabetes and diabetes care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	<b>Not a problem</b>	<b>A slight problem</b>	<b>A moderate problem</b>	<b>Somewhat serious problem</b>	<b>A serious problem</b>	<b>A very serious problem</b>
<b>3. Feeling angry, scared, and/or depressed when I think about living with diabetes.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>4. Feeling that my doctor doesn't give me clear enough directions on how to manage my diabetes.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>5. Feeling that I am not testing my blood sugars frequently enough.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>6. Feeling that I am often failing with my diabetes routine.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>7. Feeling that friends or family are not supportive enough of self-care efforts (e.g. planning activities that conflict with my schedule, encouraging me to eat the "wrong" foods).</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>8. Feeling that diabetes controls my life.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>9. Feeling that my doctor doesn't take my concerns seriously enough.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>10. Not feeling confident in my day-to-day ability to manage diabetes.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>11. Feeling that I will end up with serious long-term complications, no matter what I do.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>12. Feeling that I am not sticking closely enough to a good meal plan.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>13. Feeling that friends or family don't appreciate how difficult living with diabetes can be.</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Not a problem	A slight problem	A moderate problem	Somewhat serious problem	A serious problem	A very serious problem
14. Feeling overwhelmed by the demands of living with diabetes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Feeling that I don't have a doctor who I can see regularly enough about my diabetes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Not feeling motivated to keep up my diabetes self-management.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Feeling that friends or family don't give me the emotional support that I would like.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### General Health Information

**1. How would you describe your general health?**

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

**2. On average, how many hours of sleep do you get each night?** \_\_\_\_\_ Hours

**3. On average, how many hours of sleep do you get during the daytime nap?** \_\_\_\_\_ Hours

**4. How would you rate your fatigue on average?**

1. None
2. Mild
3. Moderate
4. Severe
5. Very severe

**5. Have you ever been told by your doctor that you have or have had any of the following conditions?**

- |                        | No                         | Yes                        |
|------------------------|----------------------------|----------------------------|
| a. Heart disease       | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| b. High blood pressure | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |

- |   |                            |                            |
|---|----------------------------|----------------------------|
| c. Lung disease   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| d. Diabetes or pre-diabetes                                       | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| e. High cholesterol   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| f. Stomach disease or Ulcer                                       | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| g. Kidney disease   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| h. Liver disease  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| i. Stroke   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| j. Cancer   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| k. Depression/Anxiety   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| l. Arthritis  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| m. Back pain  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| n. Memory loss, mild cognitive impairment, or Alzheimer's disease | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| o. Asthma   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| p. Obesity  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| q. Insomnia   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| r. Hepatitis (A, B, or C)   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| s. Other, please specify _____                                    | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |

6. Smoking history: Have you smoked at least 100 cigarettes (5 packs) in your entire life?

- a. Yes
- b. No
- c. Don't know/Not sure
- d. I've never smoked cigarettes/Not applicable →GO TO Q10

6a. What was the last time you smoked a cigarette, even a puff? \_\_\_\_\_(date)

7. Do you now smoke cigarettes every day, some days, or not at all?

- a. Every day
- b. Some days
- c. Not at all
- d. Don't know/Not sure

8. On the days that you smoke, how many cigarettes on average do you smoke per day?

\_\_\_\_\_ CIGARETTES PER DAY

9. In the past three months have you ever stopped smoking cigarettes for a day or more because you were trying to quit?

- a. Yes
- b. No
- c. Didn't smoke in the last 3 months

10. During **the last 12 months**, how often did you usually have any kind of drink containing alcohol? By a drink we mean half an ounce of absolute alcohol (e.g. a 12 ounce can or glass of beer or cooler, a 5 ounce glass of wine, or a drink containing 1 shot of liquor). Choose only one.

- a) Every day
- b) 5 to 6 times a week
- c) 3 to 4 times a week
- d) twice a week
- e) once a week
- f) 2 to 3 times a month
- g) once a month
- h) 3 to 11 times in the past year
- i) 1 or 2 times in the past year
- j) Not at all

### Memory Test Questions

**1. What is the year?**

1 = Correct  
0 = Error  
88 = DK  
99 = RF

**2. What is the season of the year?**

1 = Correct  
0 = Error  
88 = DK  
99 = RF

**3. What is the date?**

1 = Correct  
0 = Error  
88 = DK  
99 = RF

**4. What is the day of the week?**

1 = Correct  
0 = Error  
88 = DK  
99 = RF

**5. What is the month?**

1 = Correct  
0 = Error  
88 = DK  
99 = RF



**6. Which state are you in?** *[compare with information from phone screener]*

1 = Correct

0 = Error

88 = DK

99 = RF

**7. What county are you in?** *[compare with information from phone screener]*

1 = Correct

0 = Error

88 = DK

99 = RF

**8. What city are you in?** *[compare with information from phone screener]*

1 = Correct

0 = Error

88 = DK

99 = RF

**9. What is the address of your place?** *[compare with information from phone screener]*

1 = Correct

0 = Error

88 = DK

99 = RF

**10. I am going to name 3 objects. After I have said them, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. The objects are: [SAY 1 WORD/SECOND]  
Apple -- Newspapers -- Train. Now, please repeat the names for me.**

**1) [Apple]**

1 = Correct

0 = Error

88 = DK

99 = RF

**2) [Newspaper]**

1 = Correct

0 = Error

88 = DK

99 = RF

**3) [Train]**

1 = Correct

0 = Error

88 = DK

99 = RF

**11. Serial 7's. 1 point for each correct answer. Stop after 5 answers. (100 minus 7)**

**1) 93**

1 = Correct

0 = Error

88 = DK

99 = RF

**2) 86**

1 = Correct

0 = Error

88 = DK

99 = RF

**3) 79**

1 = Correct

0 = Error

88 = DK

99 = RF

**4) 72**

1 = Correct

0 = Error

88 = DK

99 = RF

**5) 65**

1 = Correct

0 = Error

88 = DK

99 = RF

**12. What are the three objects I asked you to remember?**

**1) [Apple]**

1 = Correct

0 = Error

88 = DK

99 = RF

**2) [Newspaper]**

1 = Correct

0 = Error

88 = DK

99 = RF

**3) [Train]**

1 = Correct

0 = Error

88 = DK

99 = RF

**13. Please identify the object you are speaking into right now? [my cell phone]**

1 = Correct

0 = Error

88 = DK

99 = RF

**14. I would like you to repeat a phrase after me. The phrase is: 'No if's, and's or but's.'" [Allow only one trial]**

1 = Correct

0 = Error

88 = DK

99 = RF

**15. Please say hello, tap the mouthpiece of the telephone three times, and say I am back.**

**1) [please say hello]**

1 = Correct

0 = Error

88 = DK

99 = RF

**2) [tap the mouthpiece of the telephone three times]**

1 = Correct

0 = Error

88 = DK

99 = RF

**3) [say I am back]**

1 = Correct

0 = Error

88 = DK

99 = RF

**16. Please tell me your cell phone number. [compare with information from phone screener]**

1 = Correct

0 = Error

88 = DK

99 = RF

## COVID-19 Related Questions

### COVID Information

1. Did you ever get tested for COVID-19? Yes\_\_\_\_; No\_\_\_\_  
If yes, what was the test result? Positive\_\_\_\_; Negative\_\_\_\_; DK/not sure\_\_\_\_; Refused\_\_\_\_  
If positive, did it require hospitalization? Yes\_\_\_\_; No\_\_\_\_
2. Do you know any one (family or friend) passed away from COVID-19 or related complications?  
Yes\_\_\_\_; No\_\_\_\_

3. Have you received the COVID-19 vaccine?

- ☐ Yes, I have received 2 doses.  
☐ Yes, I have received one dose.  
☐ No, please follow up with 3A

3A. If COVID-19 vaccine is available to you, are you planning to take the vaccine?

Yes \_\_\_\_\_;

No \_\_\_\_\_, if No, why? \_\_\_\_\_

- 1) I'm afraid to go to the doctor's office, afraid to catch COVID-19
- 2) Worried about the safety of vaccines (include not trusting the government)
- 3) I have infected the virus, I don't think I need to be vaccinated
- 4) I don't think I will be infected (It's just a flu, God has his own arrangements)
- 5) Worried about the side effects of the vaccine
- 6) I have allergic reaction
- 7) Religious reasons
- 8) Other \_\_\_\_\_

### Health Care Services

4. Has your health care been interrupted because of COVID-19?

- ☐ Yes, I didn't go to see my doctor (doctor's office closed, appointment was cancelled, I was afraid to go)  
☐ Yes, I was able to see my doctor, but I experienced delays in obtaining an appointment  
☐ Yes, I was able to see my doctor through telemedicine  
☐ No interruption

5. Did you lose your health insurance due to COVID-19?

- Yes  
No

### Financial

6. Has your Household income changed significantly since the beginning of COVID-19? (please EXCLUDE a stimulus payment from the federal government if you have received one)

- a. 1[ ] Yes, my household income is more
- b. 2[ ] Yes, my household income is less
- c. 3[ ] No, my household income is about the same

### Employment Status

7. How did COVID-19 affect your employment status? (check all that apply)

- a. Furlough (Temporarily laid off, leave of absence)
- b. Still employed but with decreased hours
- c. Still employed but with increased hours
- d. Still employed but have moved to online/remote work
- e. Laid off
- f. No change
- g. Unknown at this time
- h. Retired
- i. Other (please specify)

### **Diet**

8. Since the beginning of COVID-19, have you ever eaten less than you felt you should because there wasn't enough money to buy food?
- 1[ ] Yes  
2[ ] No  
[ ] Don't know  
[ ] Refused
9. Since the beginning of COVID-19, have you had any difficulty obtaining the food you need?
- ☐ Yes  
☐ No
10. Compared to before the COVID-19 outbreak, do you think there are changes in your fresh fruits and vegetables intake?
- ☐ Yes, I feel that I am eating fewer fresh fruits and vegetables  
☐ Yes, I feel that I am eating more fresh fruits and vegetables  
☐ No, I am eating the same

### **Physical Activity**

11. Compared to before the COVID-19 outbreak, do you think there are changes in your physical activities?
- ☐ Yes, I feel that I am exercising less  
☐ Yes, I feel that I am exercising more  
☐ No, it's the same

### **COVID-19 Discrimination**

12. Since the beginning of COVID-19, have you or someone you know experienced discrimination because of being Chinese?
- ☐ Yes  
☐ No
13. Were you worried that you would experience COVID-19 related discrimination (e.g. being bullied on public transportation, verbal harassment, lost your job, etc.)?
- ☐ Yes  
☐ No

### **Stress**

14. Compared to before the COVID-19 outbreak, do you think there are changes in your stress level?
- ☐ Yes, I feel that my stress level is lower  
☐ Yes, I feel that my stress level is higher  
☐ No change
15. Compared to before the COVID-19 outbreak, how isolated do you feel from others now?
- ☐ Much less isolated now than before the pandemic  
☐ About the same  
☐ Much more isolated now than before the pandemic  
☐ 99. Refused/missing