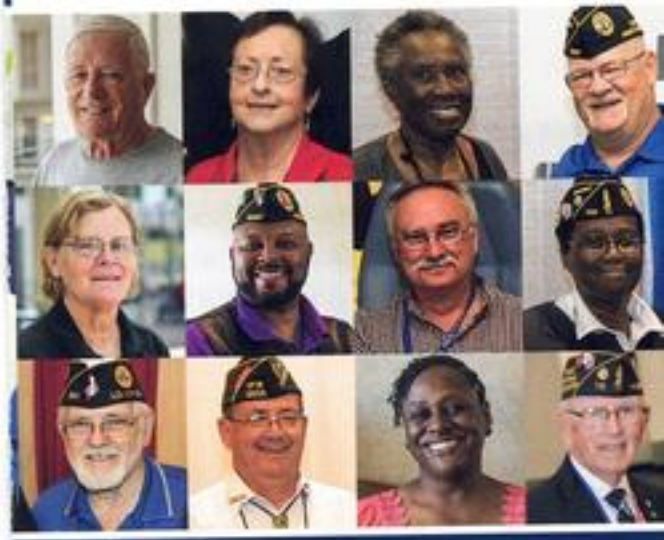
Call toll-free **866-441-6075**

MILLION VETERAN PROGRAM

10 YEARS

A Partnership with Veterans



VA | U.S. Department of Veterans Affairs

DISCOVERY • INNOVATION • ADVANCEMENT

What is the Million Veteran Program?

The Department of Veterans Affairs' Million Veteran Program (MVP) is a national, voluntary research program. MVP is designed to help researchers better understand how genes affect health and illness, with the goal of improving healthcare for Veterans.

What will MVP study?

MVP is one of the largest research programs on genes and health in the United States. With an expected enrollment of at least one million individuals, MVP provides an important opportunity to understand genes and health. An increasingly common way to gain knowledge in this area is to collect genetic samples and health information from large groups of people. Researchers use this information to learn how genes, lifestyle, and military experiences affect health and disease.

MVP

Participation in MVP is entirely voluntary and will not in any way affect Veterans' access to health care or benefits.

What is involved in MVP participation?

Participation includes:

1. Filling out surveys to help us understand more about you that we cannot learn from your health record or DNA.
2. Completing a **one-time** visit to provide a blood sample for genetic and other analysis at participating MVP locations.
3. Permitting authorized MVP staff and researchers to have access to information from your health records on an ongoing basis.
4. Agreeing to future contact by MVP for additional research opportunities.

The MVP visit takes about 20 minutes. For your convenience, **MVP visits may be scheduled on the same day as other healthcare appointments at participating MVP locations.**

What are the potential benefits of MVP?

Research findings based on MVP may lead to new ways of preventing and treating illnesses in Veterans and all Americans. This research may help answer questions like:

- Why does a treatment work well for some Veterans but not for others?
- Why are some Veterans at a greater risk for developing an illness?
- How can we prevent certain illnesses in the first place?

While your participation may not directly benefit you, over time what we learn from MVP will benefit all Veterans and the population at large.

Are there any risks in participating?

- The risks of a blood draw include pain, bleeding, bruising, or infection.
- Filling out the survey may result in distress if you discover family health conditions of which you were not aware.
- There is a slight risk of a breach of confidentiality. The section below describes how VA will minimize this risk.

What confidentiality and privacy protections are in place?

Patient safety and information security are the top priorities in MVP and all VA research. If you participate in MVP, your privacy and confidentiality are protected in the following ways:

- All samples will be stored in secure VA biorepositories.
- All samples and health information will be coded. Only select authorized MVP staff will have the ability to link the coded information to your identity.
- Researchers who are approved access to analyze samples and data will not receive name, date of birth, contact information, or social security number of participating Veterans.

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Million Veteran Program Baseline Survey

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

Please complete and return this survey in the postage-paid envelope. By answering all or some of these questions, you are 1) voluntarily consenting to complete this survey and 2) agreeing to have a **one-time MVP visit** scheduled.

During this visit, MVP staff will review how to join MVP and ask you to **provide a blood sample**. This sample will be stored and used for future research on health, disease, illness, or condition.

How to Schedule an MVP Visit

To schedule your MVP visit, please **"X"** ALL day(s) and time(s) you are available. Every effort will be made to provide you with a convenient appointment. **If possible, we will schedule a visit on the same day as another VA appointment.** Please provide your best phone number so that we may reach you if needed. After you return your MVP Baseline Survey, we will send you a letter with the date, time, and location of your MVP visit.

You can also visit **mvp.va.gov** to schedule your visit, complete this survey, and even join MVP!

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐

☐ I am available all these days and times

Best Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Comments:

If you have any questions, please call the MVP Info Center toll-free at **866-441-6075**

Thank you for your help!

Section A: Demographics

1. **What is today's date?**

mm / dd / yyyy

2. **What is your date of birth?**

mm / dd / yyyy

3. **What is your gender?**

- ☐ Male
- ☐ Female

4. **Are you Spanish, Hispanic, or Latino?**

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

5. **What is your race?** *(Mark all that apply)*

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

6. **Where are your ancestors originally from?** *(Mark all that apply)*

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

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

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

8. **What is your current marital status?**

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

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

1	2	3	4	5	6	7	8	9+
☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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

Section B: Physical Features

11. Are you right or left handed?

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

12. What is your:

Height ☐ feet ☐☐ inches

Weight ☐☐☐ pounds

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

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

14. What best describes your natural hair color (if grey, please indicate color before going grey)?

- ☐ Black
- ☐ Dark brown
- ☐ Light brown
- ☐ Blonde
- ☐ Red

15. What is the natural color of your eyes?

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

Section C: Uniformed Services Experience

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

- ☐ Army
- ☐ Navy
- ☐ Air Force
- ☐ Marine Corps
- ☐ Coast Guard
- ☐ National Guard
- ☐ Merchant Marines
- ☐ NOAA
- ☐ Public Health Service
- ☐ None → ***Skip to Q27 on Page 3***

17. Please indicate whether your service was:

- ☐ Active Duty
- ☐ Reserves only
- ☐ Not applicable (not in the military)

18. When did you serve? *(Mark all that apply)*

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

19. Did you serve outside the United States?

- ☐ Yes
- ☐ No

20. Where were you stationed? *(Mark all that apply)*

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

21. **Did you deploy in support of the 1990-91 Gulf War?**

- ☐ Yes
- ☐ No

22. **Did you deploy in support of Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF)?**

- ☐ Yes
- ☐ No

23. **Were you ever exposed to Agent Orange?**

- ☐ Yes
- ☐ No
- ☐ Not sure

24. **Were you ever exposed to chemical or biological warfare agents?**

- ☐ Yes
- ☐ No
- ☐ Not sure

25. **Were you ever given the Anthrax vaccine?**

- ☐ Yes
- ☐ No
- ☐ Not sure

26. **Have you ever taken pyridostigmine bromide (anti-nerve agent pills)?**

- ☐ Yes
- ☐ No
- ☐ Not sure

Section D: Activities and Habits

27. **How would you rate your current physical fitness status?**

- ☐ Very good
- ☐ Fairly good
- ☐ Satisfactory
- ☐ Fairly poor
- ☐ Very poor

28. **How physically strenuous is your work / job (paid and unpaid)?**

- ☐ Very light (mainly sitting)
- ☐ Light (mainly walking)
- ☐ Medium (lifting, carrying light loads)
- ☐ Heavy manual work (climbing, carrying heavy loads)

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

- ☐ Daily
- ☐ 5 - 6 times a week
- ☐ 2 - 4 times a week
- ☐ Once a week
- ☐ 1 - 3 times a month
- ☐ Rarely / Never

30. **How often do you have a drink containing alcohol?**

- ☐ Never → ***Skip to Q33 on Page 4***
- ☐ 1 - 3 days per month
- ☐ 1 day per week
- ☐ 2 - 3 days per week
- ☐ 4 - 5 days per week
- ☐ 6+ days per week

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

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

32. **How often do you have six or more drinks on one occasion?**

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ 2 - 3 times per week
- ☐ 4+ times a week

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

- ☐ No
- ☐ Yes

  33a. **Have you ever smoked daily or almost every day for at least 1 year?**
  - ☐ Yes
  - ☐ No

  33b. **Do you smoke now?**
  - ☐ Yes, daily
  - ☐ Yes, occasionally
  - ☐ Not at all

Section E: Health Status

34. **In general, would you say your health is:**

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

The following question is about activities you might do during a typical day.

35. **Does your health now limit you in these activities? If so, how much?**

a. **Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:**
- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

b. **Climbing several flights of stairs:**
- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

36. **During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular activities as a result of your physical health?**

a. **Accomplished less than you would like:**
- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

b. **Were limited in the kind of work or other activities:**
- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

37. **During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)?**

a. **Accomplished less than you would like:**
- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

b. **Did not do work or other activities as carefully as usual:**
- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

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

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

The following 3 questions are about how you feel and how things have been with you. For each question, please give the one answer that comes closest to the way you have been feeling.

39. **How much of the time during the PAST 4 WEEKS...**

a. **Have you felt calm and peaceful?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

b. **Did you have a lot of energy?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

c. **Have you felt downhearted and blue?**

- ☐ All of the time
- ☐ Most of the time
- ☐ Good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

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

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

41. **COMPARED TO ONE YEAR AGO, how would you rate your:**

a. **Physical health in general now?**

- ☐ Much better
- ☐ Somewhat better
- ☐ About the same
- ☐ Somewhat worse
- ☐ Much worse

b. **Emotional health in general now?**

- ☐ Much better
- ☐ Somewhat better
- ☐ About the same
- ☐ Somewhat worse
- ☐ Much worse

c. **Cognitive (memory and thinking) health in general now?**

- ☐ Much better
- ☐ Somewhat better
- ☐ About the same
- ☐ Somewhat worse
- ☐ Much worse

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

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

Section F: Medical History and Health Care Usage

43. Please tell us if you have been diagnosed with the following conditions. Check the appropriate box and indicate the year of diagnosis and whether you currently take any medication(s) ("TAKE MEDS") for that condition. *(Mark all that apply)*

Circulatory System Problems

	YES	YEAR DIAGNOSED	TAKE MEDS
High blood pressure (Hypertension)	☐	☐☐☐☐	☐
Stroke	☐	☐☐☐☐	☐
Transient ischemic attack (TIA)	☐	☐☐☐☐	☐
Heart attack	☐	☐☐☐☐	☐
Coronary artery / Coronary heart disease (includes angina)	☐	☐☐☐☐	☐
Peripheral vascular disease	☐	☐☐☐☐	☐
High cholesterol	☐	☐☐☐☐	☐
Pulmonary embolism or deep vein thrombosis (DVT)	☐	☐☐☐☐	☐
Congestive heart failure	☐	☐☐☐☐	☐
Other circulatory system problem	☐	☐☐☐☐	☐

Mental Health Disorders

	YES	YEAR DIAGNOSED	TAKE MEDS
Anxiety reaction / Panic disorder	☐	☐☐☐☐	☐
Attention deficit hyper-activity disorder (ADHD)	☐	☐☐☐☐	☐
Bipolar disorder	☐	☐☐☐☐	☐
Post traumatic stress disorder (PTSD)	☐	☐☐☐☐	☐
Depression	☐	☐☐☐☐	☐
Eating disorder	☐	☐☐☐☐	☐
Personality disorder	☐	☐☐☐☐	☐
Schizophrenia	☐	☐☐☐☐	☐
Social phobia	☐	☐☐☐☐	☐
Other mental health disorder	☐	☐☐☐☐	☐

Skeletal / Muscular Problems

	YES	YEAR DIAGNOSED	TAKE MEDS
Osteoarthritis	☐	☐☐☐☐	☐
Rheumatoid arthritis	☐	☐☐☐☐	☐
Other arthritis	☐	☐☐☐☐	☐
Gout	☐	☐☐☐☐	☐
Osteoporosis	☐	☐☐☐☐	☐
Other skeletal / muscular problem	☐	☐☐☐☐	☐

Hearing / Vision

	YES	YEAR DIAGNOSED	TAKE MEDS
Cataracts	☐	☐☐☐☐	☐
Glaucoma	☐	☐☐☐☐	☐
Macular degeneration	☐	☐☐☐☐	☐
Blindness, all causes	☐	☐☐☐☐	☐
Tinnitus or ringing in the ears	☐	☐☐☐☐	☐
Severe hearing loss or partial deafness in one or both ears	☐	☐☐☐☐	☐

Infectious Diseases

	YES	YEAR DIAGNOSED	TAKE MEDS
Tuberculosis	☐	☐☐☐☐	☐
Hepatitis C	☐	☐☐☐☐	☐
HIV / AIDS	☐	☐☐☐☐	☐
Other infectious disease	☐	☐☐☐☐	☐

Kidney Disease

	YES	YEAR DIAGNOSED	TAKE MEDS
Kidney disease without dialysis	☐	☐☐☐☐	☐
Kidney disease with dialysis	☐	☐☐☐☐	☐
Acute kidney disease with no current dialysis	☐	☐☐☐☐	☐

Digestive System Problems

	YES	YEAR DIAGNOSED	TAKE MEDS
Acid reflux / GERD	☐	☐☐☐☐	☐
Peptic ulcers	☐	☐☐☐☐	☐
Bowel obstruction	☐	☐☐☐☐	☐
Colon polyps	☐	☐☐☐☐	☐
Irritable bowel syndrome (IBS)	☐	☐☐☐☐	☐
Ulcerative colitis	☐	☐☐☐☐	☐
Crohn's disease	☐	☐☐☐☐	☐
Celiac disease / Sprue	☐	☐☐☐☐	☐
Other digestive system disorder	☐	☐☐☐☐	☐

Cancer

	YES	YEAR DIAGNOSED	TAKE MEDS
Breast cancer	☐	☐☐☐☐	☐
Colon cancer / Rectal cancer	☐	☐☐☐☐	☐
Lung cancer	☐	☐☐☐☐	☐
Prostate cancer	☐	☐☐☐☐	☐
Skin cancer	☐	☐☐☐☐	☐
Other cancer	☐	☐☐☐☐	☐

Nervous System Problems

	YES	YEAR DIAGNOSED	TAKE MEDS
Migraine headaches	☐	☐☐☐☐	☐
Other headaches	☐	☐☐☐☐	☐
Memory loss or impairment	☐	☐☐☐☐	☐
Dementia (includes Alzheimer's, vascular, etc.)	☐	☐☐☐☐	☐
Concussion or loss of consciousness	☐	☐☐☐☐	☐
Traumatic brain injury	☐	☐☐☐☐	☐
Spinal cord injury or impairment	☐	☐☐☐☐	☐
Epilepsy / Seizure	☐	☐☐☐☐	☐
Parkinson's disease	☐	☐☐☐☐	☐
Amyotrophic lateral sclerosis (Lou Gehrig's disease)	☐	☐☐☐☐	☐
Multiple sclerosis	☐	☐☐☐☐	☐
Other nervous system problem	☐	☐☐☐☐	☐

Other Conditions

	YES	YEAR DIAGNOSED	TAKE MEDS
Asthma	☐	☐☐☐☐	☐
Chronic lung disease (COPD, Emphysema or Bronchitis)	☐	☐☐☐☐	☐
Diabetes / "sugar"	☐	☐☐☐☐	☐
Enlarged prostate (Benign prostatic hyperplasia)	☐	☐☐☐☐	☐
Liver condition (e.g., Cirrhosis)	☐	☐☐☐☐	☐
Skin condition (e.g., Eczema, Psoriasis)	☐	☐☐☐☐	☐
Sleep apnea	☐	☐☐☐☐	☐
Thyroid problems	☐	☐☐☐☐	☐
Other disease / disorder	☐	☐☐☐☐	☐

Section G: Healthcare Utilization

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

- ☐ None
- ☐ 1 - 25%
- ☐ 26 - 50%
- ☐ 51 - 75%
- ☐ 76 - 99%
- ☐ 100%

45. In the PAST YEAR, how many times were you a patient in a hospital overnight or longer?

	VA Healthcare Facility	Non-VA Healthcare Facility
None	☐	☐
1 - 3	☐	☐
4 - 6	☐	☐
7 - 9	☐	☐
10 or more	☐	☐

46. How many prescription medications do you currently receive from:

	VA Pharmacy	Non-VA Pharmacy
None	☐	☐
1 - 3	☐	☐
4 - 6	☐	☐
7 - 9	☐	☐
10 or more	☐	☐

47. How many non-prescription medications do you currently receive from:

	VA Pharmacy	Non-VA Pharmacy
None	☐	☐
1 - 3	☐	☐
4 - 6	☐	☐
7 - 9	☐	☐
10 or more	☐	☐

Section H: Family History

48. Were you adopted as a child?

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

50. Please answer the following questions about your biological family, if known.

	YEAR OF BIRTH	LIVING? YES	LIVING? NO	YEAR OF DEATH
Mother	☐☐☐☐	☐	☐ →	☐☐☐☐
Father	☐☐☐☐	☐	☐ →	☐☐☐☐

51. Do you have any of the following?

	NO	YES	HOW MANY?
Daughters	☐	☐ →	☐☐
Sons	☐	☐ →	☐☐
Brothers	☐	☐ →	☐☐
Sisters	☐	☐ →	☐☐

52. Please answer some questions about your biological siblings, beginning with the eldest.

	BROTHER OR SISTER?	YEAR OF BIRTH	LIVING?		YEAR OF DEATH
1	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
2	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
3	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
4	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
5	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
6	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
7	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
8	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
9	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
10	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
11	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐
12	☐ Brother ☐ Sister	☐☐☐☐	☐ Yes	☐ No →	☐☐☐☐

53. Please tell us if any of YOUR BIOLOGICAL FAMILY MEMBERS have been diagnosed with the following conditions. If you do not have information regarding any of your family members listed, please leave those sections blank.

	MOTHER	FATHER	SIBLING	GRANDPARENTS ON MOTHER'S SIDE	GRANDPARENTS ON FATHER'S SIDE
Alzheimer's / Other dementia	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Bipolar disorder	☐	☐	☐	☐	☐
Cancer, breast	☐	☐	☐	☐	☐
Cancer, colon	☐	☐	☐	☐	☐
Cancer, lung	☐	☐	☐	☐	☐
Cancer, prostate	N/A	☐	☐	☐	☐
Cancer, skin	☐	☐	☐	☐	☐
Cancer, all others	☐	☐	☐	☐	☐
Chronic lung disease (COPD, Emphysema or Bronchitis)	☐	☐	☐	☐	☐
Coronary artery / Coronary heart disease	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes / "sugar"	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Liver condition	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Stroke / Transient ischemic attack (TIA)	☐	☐	☐	☐	☐

54. Did anyone help you complete this survey?

☐ Yes
☐ No

Thank you for completing this survey.