Adult Questions by Age Group

	Responses In the Left Column **Do Not Require Follow-Up**	Responses in the Middle Column **Require Follow-Up**	Adult Question Number on Questionnaire	Senior Question Number on Questionnaire
Nutrition				
Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	1	1
Do you eat fruits and vegetables every day?	Yes	No	2	2
Do you limit the amount of fried food or fast food that you eat?	Yes	No	3	3
Are you easily able to get enough healthy food?	Yes	No	4	4
Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	5	5
Do you often eat too much or too little food?	No	Yes	6	6
Do you have difficulty chewing or swallowing?	No	Yes	—	7
Are you concerned about your weight?	No	Yes	7	8
Physical Activity				
Do you exercise or spend time doing activities, such as walking, gardening or swimming for at least ½ hour per day?	Yes	No	8	9
Safety				
Do you feel safe where you live?	Yes	No	9	10
Do you often have trouble keeping track of your medicines?	No	Yes	—	11
Are family members or friends worried about your driving?	No	Yes	—	12
Have you had any car accidents lately?	No	Yes	10	13
Do you sometimes fall and hurt yourself, or is it hard for you to get up?	No	Yes	—	14

Adult Questions by Age Group

	Responses In the Left Column **Do Not Require Follow-Up**	Responses in the Middle Column **Require Follow-Up**	Adult Question Number on Questionnaire	Senior Question Number on Questionnaire
Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	11	15
Do you always wear a seat belt when driving or riding in a car?	Yes	No	12	—
Do you keep a gun in your house or place where you live?	No	Yes	13	16
Dental				
Do you brush and floss your teeth daily?	Yes	No	14	17
Mental Health				
Do you often feel sad, hopeless, angry, or worried?	No	Yes	15	18
Do you often have trouble sleeping?	No	Yes	16	19
Do you or others think that you are having trouble remembering things?	No	Yes	—	20
Alcohol, Tobacco, Drug Use (Tobacco Smoke Exposure)				
Do you smoke or chew tobacco?	No	Yes	17	21
Do friends or family members smoke in your house or place where you live?	No	Yes	18	22
In the past year, have you had: ☐ (**men**) 5 or more alcohol drinks in one day? ☐ (**women**) 4 or more alcohol drinks in one day?	No	Yes	19	—
In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	—	23
Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	20	24
Sexual Issues				
Do you think you or your partner could be pregnant?	No	Yes	21	—

Adult Questions by Age Group

	Responses In the Left Column **Do Not Require Follow-Up**	Responses in the Middle Column **Require Follow-Up**	**Adult** Question Number on Questionnaire	**Senior** Question Number on Questionnaire
Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	22	25
Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	23	—
Have you or your partner(s) had sex with other people in the past year?	No	Yes	24	26
Have you or your partner(s) had sex without a condom in the past year?	No	Yes	25	27
Have you ever been forced or pressured to have sex?	No	Yes	26	28
Independent Living				
Do you have someone to help you make decisions about your health and medical care?	Yes	No	—	29
Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	—	30
Do you have someone to call when you need help in an emergency?	Yes	No	—	31
Last Question (Open Ended)				
Do you have any other questions or concerns about your health? If yes, please describe:	No	Yes	27	32
		Total Number of Questions on Each Questionnaire	**27**	**32**