Date completed:

_____/_____/_____
(month) (day) (year)

BETTER
Health Survey™
Version 2

Name: _____

Thank you for completing the BETTER Health Survey™!

Your answers will help us provide better care for you.

During the visit, you and your healthcare provider will talk about how you can improve your health and the screening tests recommended for you. You will be able to set your own health goals and create a plan to help you achieve them.

Later, your healthcare provider will check with you to review your progress, help you change your plan, if needed, and set new goals.

INSTRUCTIONS: Please answer all questions as best you can.

For each question, please circle the number that matches your answer or fill in the blank as needed.

Your answers will help your healthcare provider get ready for your Prevention visit.

You are free to refuse to answer any question you wish.

If you wish to make a comment on any of the questions, please use the space at the end of the survey.

Please complete your survey and return it to your healthcare provider.

BETTER™

SAVE

v.31AUG2022

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SECTION A: GENERAL INFORMATION

Instructions: These questions are for both men and women.

For each of the following questions, please circle the number that matches your response or fill in the blank.

1. **What sex were you assigned at birth?** *Your sex at birth helps us to know what kinds of screening tests you may need.* (Circle one number)

    1. Male
    2. Female
    3. Decline to answer

2. **What pronouns do you prefer?** *For example, he, she, they, etc.* (Write your preferred pronouns in the space below)

    _____

3. **What is your date of birth?** (Write your month and year of birth in the space below)

	_____	_____
	(month)	(year)
e.g.	Feb	1959

4. **How tall are you without shoes on?** (Write your height in feet and inches or centimetres in the space below)

    ____ (feet) ____ (inches) **OR** _____ (cm)

5. **How much do you weigh?** (Write your weight in pounds or kilograms in the space below)

    _____ (pounds) **OR** _____ (kg)

BMI Calculator

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SECTION B: CHRONIC HEALTH CONDITIONS

Instructions: These questions are for both men and women.

The next questions ask about some health conditions that you may have that were diagnosed by a healthcare professional.

6. **Since your last medical visit with us, have you been told by a healthcare professional that you have any of the following health conditions related to cardiovascular (heart) disease or diabetes?** (Circle one number)

   Cardiovascular or heart disease refers to different conditions that affect the heart and blood vessels.

   Diabetes is a chronic disease, where the body either can't produce insulin or cannot properly use the insulin it produces. Insulin is a hormone that controls the amount of sugar in the blood.

   - **A stroke.** (*A stroke occurs when the blood supply to part of your brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients.)*
   - **Angina.** *(Angina refers to chest pain, including a squeezing, suffocating, or burning feeling.)*
   - **A genetic condition for cholesterol or Familial hypercholesterolemia.**
   - **Chronic Kidney Disease or chronic renal failure.** *(Chronic kidney disease or chronic renal failure describes a gradual loss of kidney function over time.)*
   - **Congestive Heart Failure (CHF).** *(Congestive heart failure is a condition that develops after the heart becomes damaged or weakened, limiting the movement of blood.)*
   - **Coronary Artery Disease (CAD).** *(Coronary artery disease is a type of heart disease that happens when arteries in the heart are blocked.)*
   - **Diabetes.** *(Diabetes is a chronic disease, where the body either can't produce insulin or cannot properly use the insulin it produces. Insulin is a hormone that controls the amount of sugar in the blood)*
   - **Heart Attack.** *(A heart attack is when blood flow is blocked from a section of the heart, not allowing oxygen to get in.)*
   - **Hyperlipidemia or high cholesterol, or high lipid (fat) levels, such as cholesterol.**

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- **Hypertension or high blood pressure.** (*High blood pressure, also called hypertension, means there is too much pressure in your blood vessels.)*
- **Peripheral Vascular Disease (PVD).** (*Peripheral vascular disease is a narrowing of the peripheral arteries serving the legs, stomach, arms, and head.)*

1. Yes
2. No → ***go to question 8***
3. Don't know → ***go to question 8***

7. Since your last medical visit with us, were you told by a healthcare professional that you have any of the following health conditions?

For each health condition in the table below, please circle the number that best indicates if you have been told that you have the condition.

- For "Yes", circle the number 1
- For "No", circle the number 2

If you need help remembering what each health condition is, please refer to the previous question for the description and definition.

	I have been told that I have this health condition since my last medical visit	
Health Condition	**Yes**	**No**
Angina	1	2
Congestive Heart Failure (CHF)	1	2
Coronary Artery Disease (CAD)	1	2
Diabetes	1	2
Chronic Kidney Disease or chronic renal failure	1	2
Familial hypercholesterolemia or a genetic condition for cholesterol	1	2
Heart Attack	1	2

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	I have been told that I have this health condition since my last medical visit	
Health Condition	**Yes**	**No**
Hyperlipidemia or high cholesterol, or high lipid (fat) levels, such as cholesterol	1 ◯	2 ◯
Hypertension or high blood pressure	1 ◯	2 ◯
Peripheral Vascular Disease (PVD)	1 ◯	2 ◯
Stroke	1 ◯	2 ◯

8. **Are you currently being treated for osteoporosis?** *Osteoporosis causes bones to become weak and brittle, putting you at greater risk for sudden and unexpected bone fractures. Treatment for osteoporosis can include medication or focusing on changing risk factors for bone loss and falls.* (Circle one number)

◯ 1. Yes **→ *go to Section C (next page)***
◯ 2. No
◯ 3. Don't know

9. **Since your last medical visit with us, have you been told by a healthcare provider that you have had a fragility fracture?** *A fragility fracture is a fracture that results from a minor injury that would not normally result in a fracture, such as a fall from standing height or less.* (Circle one number)

◯ 1. Yes
◯ 2. No
◯ 3. Don't know

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SECTION C: CANCER SCREENING FOR MEN AND WOMEN

Instructions: These questions are for both men and women.

For each of the following questions, please circle the number that matches your response or fill in the blank.

10. Since your last medical visit with us, have you been told by a healthcare professional that you have any of the following health conditions related to your lungs, bowels, or colon? (Circle one number)

Lungs are a pair of organs in the chest that supply the body with oxygen and remove carbon dioxide from the body.

Bowels are long, tube-shaped organs – the small intestine and the large intestine.

The colon is the longest part of the large intestine.

- **Colorectal Cancer.** (*Colorectal cancer is a type of cancer that develops in the colon and/or the rectum.)*
- **Crohn's Disease.** (*Crohn's disease is a condition in which the gastrointestinal tract is inflamed over a long period of time.)*
- **Familial Adenomatous Polyposis (FAP).** *(FAP is an inherited condition in which many polyps form on the inside walls of the colon and rectum.)*
- **Hereditary Nonpolyposis Colon Cancer (HNPCC) or Lynch Syndrome.** (*HNPCC or Lynch Syndrome is an inherited disorder.)*
- **Lung cancer** *(Lung cancer is a type of cancer that begins in the lungs, usually in the cells that line the air passages)*
- **Ulcerative Colitis.** *(Ulcerative colitis is a chronic inflammation of the colon that produces ulcers in its lining.)*

1. Yes
2. No → ***go to question 12***
3. Don't know → ***go to question 12***

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11. Since your last medical visit with us, were you told by a healthcare professional that you have any of the following health conditions?

For each health condition in the table below, please circle the number that best indicates if you have been told that you have the condition.

- For "Yes", circle the number 1
- For "No", circle the number 2

If you need help remembering what each health condition is, please refer to the previous question for the description and definition.

	I have been told that I have this health condition since my last medical visit	
Health Condition	**Yes**	**No**
Colorectal (bowel) cancer	1 ◯ ***→ go to Section D (next page)***	2 ◯
Crohn's Disease	1 ◯	2 ◯
Familial Adenomatous Polyposis (FAP)	1 ◯	2 ◯
Hereditary Nonpolyposis Colon Cancer (HNPCC) or Lynch Syndrome	1 ◯	2 ◯
Lung cancer	1 ◯	2 ◯
Ulcerative Colitis	1 ◯	2 ◯

12. Since your last medical visit with us, have you or any of your relatives had genetic testing for a mutation related to Lynch syndrome? *Lynch Syndrome is an inherited disorder.* (Circle one number)

◯ 1. Yes
◯ 2. No → ***go to Section D (next page)***
◯ 3. Don't know → ***go to Section D (next page)***

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13. **Did any of your close relatives (parents, siblings, children) test positive for a genetic mutation related to Lynch syndrome since your last medical visit with us?** *Lynch Syndrome is an inherited disorder.* (Circle one number)

1. Yes
2. No
3. Don't know

14. **Have you had genetic testing for a mutation related to Lynch syndrome since your last medical visit with us?** (Circle one number)

1. Yes
2. No → ***go to Section D***
3. Don't know → ***go to Section D***

15. **Did you test positive for a genetic mutation related to Lynch syndrome?** (Circle one number)

1. Yes
2. No
3. Don't know

SECTION D: SCREENING TESTS AND CHRONIC HEALTH CONDITIONS FOR WOMEN

Instructions: These questions are for women. If you are male, please go to Section E (page 15).

For each of the following questions, please circle the number that corresponds to your response or fill in the blank as appropriate.

16. **Are you post-menopausal? That is, have you not had your period for at least 1 year?** (Circle one number)

1. Yes
2. No
3. Don't know

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17. **Since your last medical visit with us, have you been told by a healthcare professional that you have any of the following health conditions related to diabetes and cervical cancer?** (Circle one number)

Diabetes is a chronic disease, where the body either can't produce insulin or cannot properly use the insulin it produces. Insulin is a hormone that controls the amount of sugar in the blood.

Cervical cancer is a type of cancer that forms in tissues of the cervix (the organ connecting the uterus and vagina).

- **Gestational diabetes. (***Diabetes during pregnancy.)*
- **Immunocompromised or having a weakened immune system because of one of the following reasons:**
  - You are an organ transplant recipient; or
  - You have chronic use of corticosteroids (*Corticosteroids are used to provide relief for inflamed areas of the body. Chronic use means that you have used the medication for at least a month.); or*
  - You have been prescribed an alkylating agent, antimetabolite, and/or tumour necrosis factor (TNF) blocker. (*An alkylating agent is a type of medication that is used in the treatment of cancer. Antimetabolites are medications used to treat certain diseases associated with abnormally rapid cell growth. A TNF blocker is a medication that helps stop inflammation from conditions such as arthritis.)*
- **Cervical intraepithelial neoplasia (CIN) 2 or 3.** *(Cervical intraepithelial neoplasia (CIN) is a condition in which abnormal cells grow on the surface of your cervix. With early detection and treatment, you can prevent these abnormal cells from becoming cancerous. CIN is classified on a scale from one to three.)*

1. Yes
2. No → ***go to question 19***
3. Don't know → ***go to question 19***

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18. Since your last medical visit with us, were you told by a healthcare professional that you have any of the following health conditions?

For each health condition in the table below, please circle the number that best indicates if you have been told that you have the condition.

- For "Yes", circle the number 1
- For "No", circle the number 2

If you need help remembering what each health condition is, please refer to the previous question for the description and definition.

	I have been told that I have this health condition since my last medical visit	
Health Condition	**Yes**	**No**
Gestational diabetes	1 ◯	2 ◯
Immunocompromised	1 ◯	2 ◯
Cervical intraepithelial neoplasia (CIN) 2 or 3	1 ◯	2 ◯

19. Have you had a hysterectomy since your last medical visit with us? That is, your womb/uterus removed? (Circle one number)

◯ 1. Yes
◯ 2. No → ***go to question 21***
◯ 3. Don't know → ***go to question 21***

20. Did they remove your cervix ("total hysterectomy") at the time of the hysterectomy? (Circle one number)

◯ 1. Yes
◯ 2. No
◯ 3. Don't know

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21. **Since your last medical visit with us, have you been told by a healthcare professional that you had cervical cancer?** *Cervical cancer is a type of cancer that forms in tissues of the cervix (the organ connecting the uterus and vagina).* (Circle one number)

1. Yes → ***go to question 24***
2. No
3. Don't know

22. **Have you had a Pap test since your last medical visit with us?** *A Pap test is done to test for cervical cancer or other conditions, like infections of inflammation. It involves putting a speculum into the vagina and using a small brush or spatula to gently remove cells from the cervix to be checked under a microscope.* (Circle one number)

1. Yes
2. No → ***go to question 24***
3. Don't know → ***go to question 24***

23. **Were any of the Pap test results abnormal since your last medical visit with us?** (Circle one number)

1. Yes
2. No
3. Don't know

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24. Since your last medical visit with us, have you been told by a healthcare professional that you have any of the following health conditions related to breast cancer or diabetes? (Circle one number)

Breast cancer is a type of cancer that forms in tissues of the breast.

Diabetes is a chronic disease, where the body either can't produce insulin or cannot properly use the insulin it produces. Insulin is a hormone that controls the amount of sugar in the blood.

- **Breast cancer.** (*Breast cancer is a type of cancer that forms in tissues of the breast.)*
- **Ovarian cancer.** (*Ovarian cancer is a type of cancer that forms in tissues of the ovary.)*
- **Polycystic ovarian disease or polycystic ovary syndrome.** (*Polycystic ovarian disease is a hormonal disorder in which a woman's hormones are out of balance*.)

1. Yes
2. No → ***go to question 26***
3. Don't know → ***go to question 26***

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25. Since your last medical visit with us, were you told by a healthcare professional that you have any of the following health conditions?

For each health condition in the table below, please circle the number that best indicates if you have been told that you have the condition.

- For "Yes", circle the number 1
- For "No", circle the number 2

If you need help remembering what each health condition is, please refer to the previous question for the description and definition.

	I have been told that I have this health condition since my last medical visit	
Health Condition	**Yes**	**No**
Polycystic ovarian disease or polycystic ovary syndrome	1 ◯	2 ◯
Breast cancer	1 ◯ ***→ go to Section F (page 15)***	2 ◯
Ovarian cancer	1 ◯	2 ◯

26. Have you ever had a bilateral mastectomy? That is, have you had both of your breasts surgically removed? (Circle one number)

◯ 1. Yes ***→ go to Section F (page 15)***
◯ 2. No
◯ 3. Don't know

27. Since your last medical visit with us, have you or any of your relatives had genetic testing for a mutation in the BRCA1 or BRCA2 genes? *BRCA1 and BRCA2 are genes that normally help to stop cell growth.* (Circle one number)

◯ 1. Yes
◯ 2. No → ***go to question 30***
◯ 3. Don't know → ***go to question 30***

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28. Did any of your close relatives (parents, siblings, children) test positive for a BRCA1 or BRCA2 gene mutation since your last visit with us? (Circle one number)

1. Yes
2. No
3. Don't know

29. Did any of your other relatives (aunts, uncles, cousins, grandparents) test positive for a BRCA1 or BRCA2 gene mutation since your last visit with us? (Circle one number)

1. Yes
2. No
3. Don't know

30. Have you had genetic testing for a mutation in the BRCA1 or BRCA2 genes since your last visit with us? (Circle one number)

1. Yes
2. No → ***go to Section F (page 15)***
3. Don't know → ***go to Section F (page 15)***

31. Did you test positive for a BRCA1 or BRCA2 gene mutation? (Circle one number)

1. Yes
2. No
3. Don't know

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SECTION E: CANCER SCREENING FOR MEN

Instructions: These questions are for men. If you are female, please go to Section F.

For each of the following questions, please circle the number that corresponds to your response.

32. Since your last medical visit with us, were you told by a healthcare professional that you had prostate cancer? *Prostate cancer is a type of cancer that forms in tissues of the prostate.* (Circle one number)

1. Yes → ***go to next section***
2. No

33. Have you had a prostate-specific antigen (PSA) test since your last visit with us? *Prostate-specific antigen, or PSA, is a protein produced by cells of the prostate gland. The PSA test measures the level of PSA in a man's blood.* (Circle one number)

1. Yes
2. No

SECTION F: LIFESTYLE AND NUTRITION

Instructions: These questions are for both men and women.

The next group of questions ask about some of your lifestyle behaviours such as smoking, physical activity, eating habits and alcohol intake.

For each question, please circle the number that matches your response or fill in the blank as appropriate.

34. Do you currently smoke cigarettes every day, some days, or not at all? (Circle one number)

1. Every day
2. Some days
3. Not at all → ***go to question 39***

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35. **On average, how many cigarettes do you currently smoke <u>each day</u>?** (Write the number in the space below)

Number of cigarettes smoked daily: _____

36. **How long have you smoked cigarettes?** (Write the length of time in the space below)

Pack Years Calculator

_____ years + _____ months.

37. **Please indicate how prepared you are to decrease the number of cigarettes you currently smoke.** Where 0 = not prepared to decrease and 10 = already decreasing. (Circle one number)

<u>How prepared</u>

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ **10** ○

Not prepared to decrease — **Already decreasing**

38. **How confident are you that you can decrease the number of cigarettes you currently smoke?** Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

<u>How confident</u>

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ **10** ○

Not at all confident — **Extremely confident**

→ go to question 43

39. **Have you ever smoked cigarettes regularly, that is, at least one cigarette per day?** (Circle one number)

○ 1. Yes
○ 2. No ***→ go to question 43***

40. **On average, how many cigarettes did you smoke <u>each day</u> when you were smoking?** (Write the number in the space below)

Number of cigarettes smoked daily: _____

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41. **How long did you smoke cigarettes?** (Write the length of time in the space below)

_____ years + _____ months

42. **How long ago did you stop smoking cigarettes completely?** (Write the length of time in the space below)

_____ years + _____ months

43. **In the past 12 months, how often have you used tobacco by way of vaporizers (or vape) or e-cigarettes?** (Circle one number)

1. Every day or almost every day
2. Weekly
3. Monthly
4. Every few months
5. Not at all

44. **In the past 12 months, how often have you used other tobacco products by way of snuff or chewing?** (Circle one number)

1. Every day or almost every day
2. Weekly
3. Monthly
4. Every few months
5. Not at all

45. **In the past 12 months, how often have you used non-medical or recreational marijuana or cannabis products by way of vaporized cannabis, cannabis oil, edible cannabis, or smoked cannabis?** *Vaporized cannabis is cannabis oil or plant material that is heated using a vaporizer or vape to create vapor that is inhaled. Cannabis oil is an oil extract taken by mouth and includes THC and/or CBD capsules, sprays, or solutions. Edible cannabis is a product, substance or mixture that has cannabis in it and is meant to be consumed like food. Smoked cannabis is dried cannabis that is inhaled like a cigarette.* (Circle one number)

1. Every day or almost every day
2. Weekly
3. Monthly
4. Every few months
5. Not at all

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46. Please tell us the type and amount of physical activity involved in your work.[1] (Circle one number)

- ◯ 1. I am not employed (for example: retired, retired for health reasons, unemployed, full-time carer, etc.).
- ◯ 2. I spend most of my time at work sitting (such as in an office).
- ◯ 3. I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (for example: shop assistant, hairdresser, security guard, child care provider, etc.).
- ◯ 4. My work involves definite physical effort including handling of heavy objects and use of tools (for example: plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers, etc.).
- ◯ 5. My work involves vigorous physical activity including handling of very heavy objects (for example: scaffolder, construction worker, refuse collector, etc.).

47. During the last week, please indicate with an "x" how many hours you spent on each of the following activities. Please answer the questions even if you are not employed.

	None	Some, but less than 1 hour	1 hour, but less than 3 hours	3 hours or more
a) Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout, etc.	◯	◯	◯	◯
b) Cycling, including to work and during leisure time	◯	◯	◯	◯
c) Walking, including walking to work, shopping, for pleasure, etc.	◯	◯	◯	◯
d) Housework/Childcare	◯	◯	◯	◯
e) Gardening/Do-it-yourself projects	◯	◯	◯	◯

[1] Physical activity questions are the General Practice Physical Activity Questionnaire (GPPAQ).
Heron N, Tully MA, McKinley MC, Cupples ME. Physical activity assessment in practice: a mixed methods study of GPPAQ use in primary care. BMC Family Practice. 2014; 15:11.

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48. How would you describe your usual walking pace? (Circle one number)

1. Slow pace
2. Steady average pace
3. Brisk pace
4. Fast pace

49. Do you do muscle strengthening, body weight or resistive exercises 2 or more days per week? *Muscle strengthening, body weight and resistive exercises include using weight machines (typically at a gym, fitness, or community centre), push-ups, squats, sit ups, and using resistance bands or free weights, like dumbbells.* (Circle one number)

1. Yes
2. No

50. Please indicate how prepared you are to increase the amount of physical activity you currently do. Where 0 = not prepared to increase and 10 = already increasing. (Circle one number)

How prepared

0 1 2 3 4 5 6 7 8 9 **10**

Not prepared to increase — **Already increasing**

51. How confident are you that you can increase the amount of physical activity you currently do? Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

How confident

0 1 2 3 4 5 6 7 8 9 **10**

Not at all confident — **Extremely confident**

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52. Please tell us about your eating habits[2]:

52a. Is olive oil the main source of fat for cooking? (Circle one number)

1. Yes
2. No

52b. Do you have 4 tablespoons (60 ml) or more of olive oil each day? (Circle one number)

1. Yes
2. No

52c. Do you eat 4 servings of vegetables each day? *1 serving is ½ cup raw or cooked vegetables or 1 cup of raw, leafy greens.* (Circle one number)

1. Yes
2. No

52d. Do you have 3 or more servings fruit each day? *1 serving is a whole fruit or ½ cup of fruit.* (Circle one number)

1. Yes
2. No

52e. Do you eat less than 2 servings of red meat or processed meats each day, including red meat, hamburger, or other meat products (for example ham, sausage ,etc.)? *1 serving is 75 grams or 3 ounces.* (Circle one number)

1. Yes
2. No

52f. Do you eat 1 tablespoon (15 ml) or less of butter, margarine or cream each day? (Circle one number)

1. Yes
2. No

[2] Adapted from the Mediterranean Diet Score Tool + Adherence Screener.
Dietitians of Canada. Mediterranean Diet Toolkit: Supporting Patients to Reduce CVD Risk and Improve Mental Health. March 2020.

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52g. Do you drink less than 1 can (355 ml or 12 oz) of sugar sweetened beverages each day? (Circle one number)

1. Yes
2. No

52h. Do you have 3 or more servings of legumes (peas, beans, or lentils) each week? *1 serving is half a cup to two-thirds of a cup.* (Circle one number)

1. Yes
2. No

52i. Do you have 4 or more servings of fish or seafood [or 6 or more servings of shellfish] each week? *Shellfish are animals with a shell-like exterior such as shrimp, crayfish, crab, clams, lobster, scallops, oysters, and mussels. 1 fish or shellfish serving is 3.5-5 oz or 100-150 g. One seafood serving 4-5 pieces.* (Circle one number)

1. Yes
2. No

52j. Do you eat commercial baked goods such as cookies, doughnuts or cake less than 2 times each week? (Circle one number)

1. Yes
2. No

52k. Do you eat nuts 3 or more times each week? 1 serving is 30 g or 1 ounce. (Circle one number)

1. Yes
2. No

52l. Do you choose chicken or turkey more often than beef, pork, Hamburger, or sausage? (Circle one number)

1. Yes
2. No

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52m. Do you consume vegetables, pasta, or rice dishes with a homemade sauce of sautéed garlic, onions, olive oil and tomatoes 2 or more times a week? (Circle one number)

Mediterranean Diet Score

◯ 1. Yes
◯ 2. No — 0

53. Please circle the number that shows how prepared you are to improve your current diet. Where 0 = not prepared to improve and 10 = already improving. (Circle one number)

How prepared

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ **10** ◯

Not prepared to improve — **Already improving**

54. How confident are you that you could improve your current diet? Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

How confident

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ **10** ◯

Not at all confident — **Extremely confident**

55. During the past 12 months, have you had any drinks containing alcohol? (Circle one number)

◯ 1. Yes
◯ 2. No → ***go to Section G (page 24)***

56. On average, how many drinks containing alcohol do you currently have <u>each week</u>? *A drink is defined as a 341 ml (12 oz.) glass containing 5% alcohol (beer, cider or cooler), a 142 ml (5 oz.) glass of wine with 12% alcohol content, or a 43 ml (1.5 oz.) shot/serving of 40% distilled alcohol content (rye, gin, rum, etc.).* (Write the number in the space below)

Number of drinks containing alcohol you have weekly: _____

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57. **MEN: How often do you have 4 or more drinks containing alcohol on one occasion?** (Circle one number)

WOMEN: How often do you have 3 or more drinks containing alcohol on one occasion? (Circle one number)

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily

58. **Please indicate how prepared you are to reduce the amount of alcohol you currently drink.** Where 0 = not prepared to reduce and 10 = already reducing. (Circle one number)

How prepared

0 1 2 3 4 5 6 7 8 9 **10**

Not prepared to reduce — **Already reducing**

59. **How confident are you that you could reduce the amount of alcohol you currently drink?** Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

How confident

0 1 2 3 4 5 6 7 8 9 **10**

Not at all confident — **Extremely confident**

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SECTION G: GENERAL HEALTH

Instructions: These questions are for both men and women.

These next questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please circle the number that you think best describes how you feel. If you are unsure about how to answer a question, please give the best answer you can.

60. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?[3]

60a. Little interest or pleasure in doing things (Circle one number)

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

60b. Feeling down, depressed, or hopeless (Circle one number)

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

PHQ-2 Score

0

[3] The Patient Health Questionnaire – 2 (PHQ-2).
Kroenke K, Spitzer L, Williams JBW. The Patient Health Questionnaire – 2: Validity of a two-item depression screener. Medical Care. 2003; 41:11.

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SECTION H: FAMILY MEDICAL HISTORY

Instructions: These questions are for both men and women.

Knowing your family history can help your health care practitioners provide better care for you.

61. Since your last medical visit with us, have any members of your family been told by a healthcare professional that they have any of the following health conditions? (Circle one number)

- **Breast cancer.** (*Breast cancer is a type of cancer that forms in tissues of the breast.)*
- **Colorectal (bowel) cancer.** (*Colorectal cancer is a type of cancer that develops in the colon and/or the rectum.)*
- **Diabetes** *(Diabetes is a chronic disease, where the body either can't produce insulin or cannot properly use the insulin it produces. Insulin is a hormone that controls the amount of sugar in the blood.)*
- **Osteoporosis.** *(Osteoporosis causes bones to become weak and brittle, putting you at greater risk for sudden and unexpected bone fractures.)*
- **Ovarian cancer.** (*Ovarian cancer is a type of cancer that forms in tissues of the ovary.)*
- **Pancreatic cancer.** *(Pancreatic cancer is a type of cancer that forms in the tissues of your pancreas.)*
- **Prostate cancer.** (*Prostate cancer is a type of cancer that forms in tissues of the prostate.)*

1. Yes
2. No → ***go to Section I (page 28)***
3. Don't know → ***go to Section I (page 28)***

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62. The 2 tables below list some chronic diseases. Please complete the 2 tables to the best of your knowledge.

*For each of the following, please only include relatives that are related to you by **blood or birth** and do not include relatives related to you by marriage.*

If one or more of your blood relatives has been diagnosed with the disease, please indicate the age of the relative who was diagnosed the youngest. For example, if your sister was diagnosed with diabetes at age 20 and your brother was also diagnosed with diabetes at age 35, you would write "20" under youngest age at diagnosis.

If you are not sure at what age someone was diagnosed, please use your best guess for the age.

	First Degree Relatives					
Chronic Diseases	**Your Parents**		**Your Brothers or Sisters**		**Your Children**	
	Number of parents with disease	Youngest age at diagnosis	Total number of brothers or sisters with disease	Youngest age at diagnosis	Total number of children with disease	Youngest age at diagnosis
Breast Cancer						
Colorectal (Bowel) Cancer						
Diabetes						
Osteoporosis						
Ovarian Cancer						
Pancreatic Cancer						
Prostate Cancer						

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	Second Degree Relatives *Uncles, Aunts, Nieces, Nephews, and Grandparents*			
Chronic Diseases	**On Your Mother's Side**		**On Your Father's Side**	
	Total number of relatives with disease	Youngest age at diagnosis	Total number of relatives with disease	Youngest age at diagnosis
Breast Cancer				
Colorectal (Bowel) Cancer				
Ovarian Cancer				
Pancreatic Cancer				
Prostate Cancer				

63. If you indicated that one or more of your first or second-degree relatives have breast cancer, were any of those relatives male? (Circle one number)

1. Yes
2. No
3. Don't know
4. Not Applicable

SAVE

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SECTION I: ABOUT YOU

Instructions: These questions are for both men and women.

For each of the following questions, please circle the number that corresponds to your response or fill in the blank as appropriate.

64. **Is this your first time completing the BETTER Health Survey™?** (Circle one number)

1. Yes
2. No → ***go to question 66***
3. Don't know → ***go to question 66***

65. Your ethnic and cultural background helps determine your risk for cancer and other chronic diseases. Some groups are known to be at higher risk. The list below will help us determine if YOU are at higher risk for chronic diseases.

Please tell us if any of the following describe your ethnic or cultural background. (Circle all that apply)

1. Indigenous → ***go to question 65a***
2. African-Caribbean (e.g., African, African Canadian, Afro-Caribbean, etc.)
3. Ashkenazi Jewish
4. East Asian (e.g., Chinese, Japanese, Korean, Taiwanese, etc.)
5. European (e.g., British, French, German, Spanish, Swedish, etc., but not including Icelandic)
6. Icelandic
7. Latin American (e.g., Mexico, Central and South American countries)
8. Middle Eastern (e.g., Arab, Persian, etc.)
9. North American (e.g., American, Canadian)
10. Southeast Asian (e.g., Cambodia, Filipino, Indonesian, Malaysian, Thai, Vietnamese, etc.)
11. South Asian (e.g., Bangladeshi, East Indian, Pakistani, Sri Lankan, etc.)
12. West Asian (e.g., Afghan, Egyptian, Iranian, Kurdish, Lebanese, Turkish, etc.)
13. Don't know
14. Prefer not to answer

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65a. **If you are an Indigenous person, do you identify as First Nations, Inuk/Inuit and/or Métis?** (Circle all that apply)

- ◯ 1. First Nations
- ◯ 2. Inuk or Inuit
- ◯ 3. Métis
- ◯ 4. Don't know
- ◯ 5. Prefer not to answer

66. **If there is anything else that you would like to comment on, or feel is important to include, please feel free to write in the space below**.

_____

_____

_____

_____

_____

THANK YOU for completing the BETTER Health Survey™!

Please return your survey to your healthcare provider.

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