

# Boynton Health

## College Student Health Survey Questionnaires 2013

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**BOYNTON HEALTH**

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UNIVERSITY OF MINNESOTA

**SECTION: Health Care Coverage and Utilization****1****ANSWER REVIEW PAGE:**  
1 of 26 pages**You have completed 0 of 4 Items on this page**

Below are your saved responses for page 1. Please review before proceeding.

1 Other than health care services provided at your educational institution, do you have additional health insurance coverage?

- Yes, through my educational institution  
 Yes, through my parent's health insurance plan  
 Yes, through another health insurance plan  
 Yes, through a public program (Medicare, state program, etc.)  
 No, I do not have health insurance  
 Don't know

2 How many dependent children do you have?

(If you have no dependent children, mark 0)

- 0       1       2       3       4       5       6 or More

3 Are your dependent children covered by health insurance?

- Yes  
 No  
 Not applicable - I do not have dependent children  
 Don't know

4 Does your spouse/domestic partner have health insurance coverage?

- Yes  
 No  
 Not Applicable - I have no spouse/domestic partner  
 Don't know

**CONTINUE**

- CONTINUE Answering Survey - Page 2  
 EDIT Re-open Page 1 and edit your responses  
 COMPLETE SURVEY LATER Responses will be saved

**REVIEW**

- OVERALL Survey summary  
 PREV - summary for Page 0  
 NEXT - summary for Page 2

**SECTION: Health Care Coverage and Utilization**

<b>2</b>	<b>ANSWER REVIEW PAGE:</b> 2 of 26 pages	<b>You have completed 0 of 16 Items on this page</b>
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Below are your saved responses for page 2. Please review before proceeding.

5 Please indicate when you last had the following:

	Within the past 12 months	Within 13 months to 2 years	Within 3-5 years	6 or more years ago	Never
Routine medical exam (a physical)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental exam and cleaning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cholesterol checked	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood pressure checked	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Routine gynecological exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6 Where do you go for the following health care services while in school?  
 \*\* (Please mark all that apply) \*\*

	School health service	Student counseling service	Hospital	Community clinic	HMO	Private practice	None - I don't obtain this service
Routine doctor's visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing for sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment for sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing for HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7 Have you had any of the following immunizations?

	Yes	No	Don't Know
Hepatitis A	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meningitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flu vaccine within past 12 months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Human Papillomavirus (HPV) (all three doses)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CONTINUE	REVIEW
<input type="checkbox"/> CONTINUE Answering Survey - Page 3 <input type="checkbox"/> EDIT Re-open Page 2 and edit your responses <input type="checkbox"/> COMPLETE SURVEY LATER Responses will be saved	<input type="checkbox"/> OVERALL Survey summary <input type="checkbox"/> PREV - summary for Page 1 <input type="checkbox"/> NEXT - summary for Page 3

SECTION: **Health Status****3**

SURVEY PAGE: 3 of 26 pages

You have completed 0 of 74 Items on this page

**1**1.01 For each condition, indicate whether you have been diagnosed **in your lifetime**.1.02 For each condition, indicate whether you have been diagnosed **within the past 12 months**.

	Yes	No	Yes	No
Alcohol problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anorexia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attention deficit disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bipolar disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bulimia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chlamydia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes (Type I)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes (Type II)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug problems (other than alcohol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genital herpes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genital warts/Human papillomavirus (HPV)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gonorrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis A	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV/AIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lyme disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mononucleosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obsessive-compulsive disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Panic attacks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Post-traumatic stress disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pubic lice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repetitive stress injury (Carpal tunnel)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seasonal affective disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social phobia/Performance anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Strep throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Syphilis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urinary tract infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

SECTION: **Health Status****4****ANSWER REVIEW PAGE:**  
4 of 26 pages**You have completed 0 of 24 Items on this page**

Below are your saved responses for page 4. Please review before proceeding.

2 During the past 12 months, how have the following affected your academic performance?  
 \*\*(please select the most serious outcome for each issue)\*\*

	I do not have this issue/Not applicable	I have this issue, but my academics have not been affected	Received a lower grade on an exam or important project	Received a lower grade in the course	Received an incomplete in the course	Dropped the course	Dropped out of school/Took a leave of absence
Alcohol use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic conditions (diabetes, asthma, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concerns for troubled friend/family member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug use (other than alcohol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating disorder/problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive computer/internet use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Learning disability/Attention deficit disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health issues (depression, anxiety, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mononucleosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moved/Changed residence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnancy (yours or your partner's)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Serious injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual assault	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexually transmitted infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Upper respiratory infection (cold/flu, sinus, strep, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urinary tract infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

4 Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

5 During the past 30 days, on how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

CONTINUE	REVIEW
<ul style="list-style-type: none"><li><input type="radio"/> CONTINUE Answering Survey - Page 5</li><li><input type="radio"/> EDIT Re-open Page 4 and edit your responses</li><li><input type="radio"/> COMPLETE SURVEY LATER Responses will be saved</li></ul>	<ul style="list-style-type: none"><li><input type="radio"/> OVERALL Survey summary</li><li><input type="radio"/> PREV - summary for Page 3</li><li><input type="radio"/> NEXT - summary for Page 5</li></ul>

**SECTION: Emotional and Mental Health****5****SURVEY PAGE: 5** of 26 pages**You have completed 0 of 7 Items on this page****1 Have you experienced any of the following in the past 12 months?****\*\* (Mark all that apply) \*\***

- Getting married
- Failing a class
- Serious physical illness of someone close to you
- Death of someone close to you
- Being diagnosed as having a serious physical illness
- Being diagnosed as having a mental illness
- Spouse/Partner conflict (including divorce or separation)
- Termination of a personal relationship (not including marriage)
- Attempted suicide
- Being put on academic probation
- Excessive credit card debt
- Excessive debt other than credit card
- Being arrested
- Being fired or laid off from a job
- Roommate/Housemate conflict
- Parental conflict
- Lack of health care coverage
- Issues related to sexual orientation
- Bankruptcy
- Not applicable-None of the above happened to me

**2 Are you currently taking medication for depression?**

- Yes
- No

**3 Are you currently taking medication for a mental health problem other than depression?**

- Yes
- No

**4 Are you currently seeing a mental health counselor/therapist?**

- Yes
- No



**5 On a scale from one to ten, with one being not stressed at all and ten being very stressed, how would you rate your average level of stress in the past 30 days?**

\*\* (Please mark appropriate number corresponding with your average level of stress)\*\*

Not stressed at all										Very stressed
1	2	3	4	5	6	7	8	9	10	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**6 On a scale from one to ten, with one being ineffective and ten being effective, how would you rate your ability to manage your stress in the past 30 days?**

\*\* (Please mark appropriate number corresponding with your effectiveness in managing stress)\*\*

Ineffective										Very effective
1	2	3	4	5	6	7	8	9	10	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**7 On how many of the past seven days did you get enough sleep so that you felt rested when you woke up in the morning?**

0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

SECTION: **Personal Safety****6****ANSWER REVIEW PAGE:**  
6 of 26 pages**You have completed 0 of 17 Items on this page**

Below are your saved responses for page 6. Please review before proceeding.

1	1.01 Within <b>your lifetime</b> have you:		1.02 Within the <b>past 12 months</b> have you:	
	Yes	No	Yes	No
Had sexual intercourse with someone without that person's consent or against his/her will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Touched someone sexually without that person's consent or against his/her will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Slapped, kicked, or pushed your significant other or spouse/partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Threatened or "put-down" your significant other or spouse/partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Experienced actual or attempted sexual intercourse without your consent or against your will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Experienced actual or attempted sexual touching without your consent or against your will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been slapped, kicked, or pushed by your significant other or spouse/partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been hurt by threats, "put-downs", or yelling from your significant other or spouse/partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2 If you experienced sexual intercourse/sexual touching against your will, did you report the incident to any of the following?

\*\* (Mark all that apply) \*\*

- Not applicable - I was not involved in any incident
- Health care provider (e.g. Physician, Nurse, or Therapist)
- Hall director or community advisor
- Campus sexual violence office
- Police
- Other
- I did not report the incident

**CONTINUE**

- CONTINUE Answering Survey - Page 7
- EDIT Re-open Page 6 and edit your responses
- COMPLETE SURVEY LATER Responses will be saved

**REVIEW**

- OVERALL Survey summary
- PREV - summary for Page 5
- NEXT - summary for Page 7

SECTION: **Personal Safety****7****SURVEY PAGE: 7** of 26 pages**You have completed 0 of 4 Items on this page**

The following questions pertain to issues related to personal safety. When answering the questions please use the following definitions: sexual intercourse - oral, vaginal, or anal penetration; sexual touching - touching of breasts, buttocks, or genitals.

**3 What type of injuries have you sustained during the past 12 months?**

\*\* (Mark all that apply) \*\*

- Not applicable - I was not injured
- Assaulted by another person (nonsexual)
- Burned by fire or a hot substance
- Motor vehicle related
- Team sports
- Individual sports
- Bicycle related
- Falls
- Other

**4 While attending school, do you have immediate access to firearms?**

- Yes
- No

**5 What type of firearms do you have immediate access to?**

\*\* (Mark all that apply) \*\*

- Not Applicable - I do not have access to a firearm
- Handgun
- Rifle
- Shotgun
- Other

**6 Have you ever carried a weapon (gun, knife, etc.) within the past 12 months?**

\*\* (Does not include carrying a weapon while hunting) \*\*

- Yes
- No

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

<b>SECTION: Personal Safety</b>		
<b>8</b>	<b>ANSWER REVIEW PAGE:</b> 8 of 26 pages	<b>You have completed 0 of 5 Items on this page</b>

Below are your saved responses for page 8. Please review before proceeding.

7 Within the past 12 months, how often did you:  
 \*\* (Mark the appropriate column for each of the three questions) \*\*

	N/A (Didn't do this activity within the last 12 months)	Never	Sometimes	Most of the time	Always
Wear a helmet when you rode a bicycle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wear a helmet when you rode a motorized two-wheeled vehicle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Text while driving?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9 Within the past 12 months have you ridden in a car with a driver who has been impaired due to alcohol consumption?

Yes  
 No  
 Don't know

10 Within the past 12 months were you in a physical fight?

Yes  
 No

CONTINUE	REVIEW
<input type="checkbox"/> CONTINUE Answering Survey - Page 9 <input type="checkbox"/> EDIT Re-open Page 8 and edit your responses <input type="checkbox"/> COMPLETE SURVEY LATER Responses will be saved	<input type="checkbox"/> OVERALL Survey summary <input type="checkbox"/> PREV - summary for Page 7 <input type="checkbox"/> NEXT - summary for Page 9

<b>SECTION: Nutrition and Physical Activity</b>		
<b>9</b>	<b>SURVEY PAGE: 9</b> of 26 pages	<b>You have completed 0 of 5 Items on this page</b>

**1 Your height in feet and inches**

**1.01 Feet**

3                      4                      5                      6                      7

**1.02 Inches**

0      1      2      3      4      5      6      7      8      9      10      11

**2 Approximate your current weight in pounds.**  
 \*\* (If less than 100 pounds, mark answers 096, 085, etc.)  
 (1 kilogram = 2.2 pounds)\*\*

		3							
		digits							

**3 How do you describe your weight?**

- Very underweight
- Slightly underweight
- About the right weight
- Slightly overweight
- Very overweight

**4 During the past 30 days, I felt satisfied with my body image/size:**  
 \*\* (Mark the most appropriate response)\*\*

Never                      Sometimes                      Most of the time                      Always

	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

<b>SECTION: Nutrition and Physical Activity</b>		
<b>10</b>	<b>ANSWER REVIEW PAGE:</b> 10 of 26 pages	<b>You have completed 0 of 6 Items on this page</b>

Below are your saved responses for page 10. Please review before proceeding.

5 In the past 7 days, how many hours did you spend doing the following activities?

	None	Less than 1/2 hour	1/2 - 2 hours	2 1/2 - 4 hours	4 1/2 - 6 hours	6 1/2+ hours
Strenuous exercise (heart beats rapidly). Examples: biking fast, aerobics, dancing, running, basketball, swimming laps, rollerblading, tennis, soccer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moderate exercise (not exhausting). Examples: walking quickly, baseball, easy biking, volleyball, skateboarding, snowboarding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercises to strengthen or tone your muscles. Examples: push-ups, sit-ups, weight lifting/training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6 On an average day, how many hours do you spend doing the following activities?

	None	Less than 1 hour	1 hour	2 hours	3 hours	4 hours	5+ hours
Watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer for something that is not for work or school work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a handheld device for something that is not for work or school work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CONTINUE	REVIEW
<input type="checkbox"/> CONTINUE Answering Survey - Page 11 <input type="checkbox"/> EDIT Re-open Page 10 and edit your responses <input type="checkbox"/> COMPLETE SURVEY LATER Responses will be saved	<input type="checkbox"/> OVERALL Survey summary <input type="checkbox"/> PREV - summary for Page 9 <input type="checkbox"/> NEXT - summary for Page 11

**SECTION: Nutrition and Physical Activity**

**11**      **SURVEY PAGE: 11** of 26 pages      **You have completed 0 of 20** Items on this page

**7 During the past 7 days, how many times did you eat/drink the following?**

\*\* (Think about all the meals and snacks you had from the time you got up until you went to bed. Be sure to include food you ate at home, school, restaurants, or anywhere else.)\*\*

	I did not eat or drink this	1 to 3 times during the past 7 days	4 to 6 times during the past 7 days	1 time per day	2 times per day	3 times per day	4 or more times per day
100% fruit juice (Do not include punch, Kool-Aid, sports drinks, or other fruit-flavored drinks.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fruit (Do not include juice.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Green salad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Potatoes (Do not include French fries, fried potatoes, or potato chips.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carrots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other vegetables (Do not include green salad, potatoes, or carrots.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**8 During the past 7 days, how many times did you drink the following?**

\*\* (Think about all the beverages you had from the time you got up until you went to bed. Be sure to include beverages you drank at home, school, restaurants, or anywhere else.)\*\*

	I did not drink this	1 to 3 times during the past 7 days	4 to 6 times during the past 7 days	1 time per day	2 times per day	3 times per day	4 or more times per day
Can, bottle, or glass of soda or pop (Coke, Pepsi, or Sprite, etc.). (Do not include diet soda or diet pop.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Can, bottle, or glass of diet soda or diet pop (Diet Coke, Diet Pepsi, or Diet Sprite, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fruit-flavored drinks with sugar (Kool-aid, Hi-C, lemonade, cranberry cocktail, vitamin water, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sports drinks (Gatorade, Powerade, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee drinks with added sugar (lattes, mochas, Frappuccinos, Macchiatos, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other sweetened beverages (energy drinks, sweetened teas, rice drinks, sugar can beverages, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**9 In the past 7 days, on how many days did you eat breakfast**

0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**10 Indicate how often you did the following in the past 12 months:**

Never	Once a year or less	A few times a year	Once or twice per month	Once per week	Several times per week	Daily	Several times a day
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Eat fast food meals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat at any restaurant (do not include fast food establishments)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use laxatives to control weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Take diet pills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Binge eat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Induce vomiting to control weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**11 Do you regularly take a multivitamin?**

- Yes
- No

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.



<b>SECTION: Chemical Health</b>		
<b>12</b>	<b>ANSWER REVIEW PAGE:</b> 12 of 26 pages	<b>You have completed 0 of 20 Items on this page</b>

Below are your saved responses for page 12. Please review before proceeding.

1 During the past 12 months, how often have you used:  
 \*\*(Mark one for each line)\*\*

	Did not use	Once/year	6 times/year	Once/month	More than once/month
Smoking tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smokeless tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol (beer, wine, liquor)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Marijuana (pot, hash, hash oil)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cocaine (crack, rock, freebase)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amphetamines (meth, speed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sedatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hallucinogens (LSD, PCP)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opiates (heroin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inhalants (glue, solvents, gas)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ecstasy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Performance enhancing steroids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GHB, Rohypnol (or other club drugs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescription drug not prescribed for you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco from a water pipe (hookah)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2 During the past 30 days, on how many days did you use:  
 \*\*(Mark one for each line)\*\*

	0 days	1-2 days	3-5 days	6-9 days	10-19 days	20-29 days	All 30 days
Smoking tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smokeless tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol (beer, wine, liquor)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Marijuana (pot, hash, hash oil)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco from a water pipe (hookah)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>CONTINUE</b>	<b>REVIEW</b>
<input type="radio"/> CONTINUE Answering Survey - Page 13 <input type="radio"/> EDIT Re-open Page 12 and edit your responses <input type="radio"/> COMPLETE SURVEY LATER Responses will be saved	<input type="radio"/> OVERALL Survey summary <input type="radio"/> PREV - summary for Page 11 <input type="radio"/> NEXT - summary for Page 13

SECTION: <b>Chemical Health</b>		
<b>13</b>	SURVEY PAGE: 13 of 26 pages	You have completed 0 of 4 Items on this page

**3 For questions 3 - 6 a drink is defined as: a bottle of beer, a glass of wine, a wine cooler, a shot glass of liquor, or a mixed drink**

**3.01 Average # of drinks you consume in a week:**

\*\*Enter a number between 00 and 99 (If less than 10, mark as 09, 08, etc.)\*\*

2		
digits		

**4 Think back over the last two weeks. How many times have you had five or more drinks in a sitting?**

- I do not drink alcohol
- None
- Once
- Twice
- 3-5 times
- 6-9 times
- 10 or more times

**5 The last time you "partied"/socialized, how many hours did you drink alcohol? State your best estimate.**

\*\*Enter a number between 00 and 99.

If you do not drink alcohol, please enter 00

If less than 10, mark as 09, 08, etc.\*\*

2		
digits		

**6 The last time you "partied"/socialized, how many alcoholic drinks did you have? State your best estimate.**

\*\*Enter a number between 00 and 99.

If you do not drink alcohol, please enter 00

If less than 10, mark as 09, 08, etc.\*\*

2		
digits		

<input type="button" value="Submit"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="button" value="Skip"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

<b>SECTION: Chemical Health</b>		
<b>14</b>	<b>ANSWER REVIEW PAGE:</b> 14 of 26 pages	<b>You have completed 0 of 19 Items on this page</b>

Below are your saved responses for page 14. Please review before proceeding.

7 Please indicate how often you have experienced the following due to your drinking or drug use during the past 12 months ** (Mark one for each line)**	Never	Once	Twice	3 - 5 times	6 - 9 times	10 or more times
Had a hangover	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Performed poorly on a test or important project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been in trouble with police, residence hall, or other college authorities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Damaged property, pulled fire alarm, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Got into an argument or fight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Got nauseated or vomited	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driven a car while under the influence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Missed a class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been criticized by someone I know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thought I might have a drinking or other drug problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Had a memory loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Done something I later regretted	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been arrested for DWI/DUI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have been taken advantage of sexually	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have taken advantage of another sexually	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tried unsuccessfully to stop using	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seriously thought about suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seriously tried to commit suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Been hurt or injured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<b>CONTINUE</b>	<b>REVIEW</b>
<input type="radio"/> CONTINUE Answering Survey - Page 15 <input type="radio"/> EDIT Re-open Page 14 and edit your responses <input type="radio"/> COMPLETE SURVEY LATER Responses will be saved	<input type="radio"/> OVERALL Survey summary <input type="radio"/> PREV - summary for Page 13 <input type="radio"/> NEXT - summary for Page 15

SECTION: **Chemical Health****15**

SURVEY PAGE: 15 of 26 pages

You have completed 0 of 6 Items on this page

**8 Do you consider yourself a smoker?**

- Yes
- No

**9.02 Average number of cigarettes you smoke per weekday (Monday through Thursday)**2  
digits**(enter a number between 00 and 99)**

\*\*(Non-smokers please enter 00. If less than 10, mark as 09, 08, etc. 1 pack=20 cigarettes)\*\*

**9.03 Average number of cigarettes you smoke per weekend day (Friday through Sunday)**2  
digits**(enter a number between 00 and 99)**

\*\*(Non-smokers please enter 00. If less than 10, mark as 09, 08, etc. 1 pack=20 cigarettes)\*\*

**10 Where have you used tobacco**

\*\*(Mark all that apply)\*\*

- Not applicable - I do not use tobacco
- On campus (inside)
- On campus (outside)
- Residence hall (outside)
- Fraternity/Sorority (inside)
- Fraternity/Sorority (outside)
- Bar/Restaurant (outside)
- In a car
- Where I live (inside)
- Where I live (outside)
- Private parties (inside)
- Private parties (outside)
- Worksite (outside)
- Parking ramp/Garage
- Other (inside)
- Other (outside)

**11 During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?**

- Yes
- No
- Not applicable - I do not smoke

**12 How many times in the past 12 months did you try to quit smoking?**

\*\* (Enter a number between 00 and 99 - Non-smokers and smokers who have not attempted to quit please enter 00. If less than 10, mark as 09, 08, etc.)\*\*

				2 digits

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

SECTION: **Chemical Health****16****ANSWER REVIEW PAGE:**  
16 of 26 pages**You have completed 0 of 4 Items on this page**

Below are your saved responses for page 16. Please review before proceeding.

13 In an average week, how many hours are you in the same room with someone who is smoking tobacco?

- 0 hours     
  Less than 30 minutes     
  31 minutes - 1 hour     
  2 - 3 hours     
  4 - 6 hours     
  7 or more hours

14 In an average week, where have you been exposed to secondhand smoke?

\*\*(Mark all that apply)\*\*

- Not applicable - I am never exposed to secondhand smoke  
 On campus (inside)  
 On campus (outside)  
 Residence hall (outside)  
 Fraternity/Sorority (inside)  
 Fraternity/Sorority (outside)  
 Bar/Restaurant (outside)  
 In a car  
 Where I live (inside)  
 Where I live (outside)  
 Private parties (inside)  
 Private parties (outside)  
 Worksite (outside)  
 Parking ramp/Garage  
 Other (inside)  
 Other (outside)

15 In the past two weeks, what percentage of students attending your institution do you think had 5 or more drinks at a sitting?







(One drink equals one shot of alcohol, a 12-ounce can of beer, a mixed drink containing 1 or 1 1/2 ounces of alcohol, a 12-ounce wine cooler, or a 5-ounce glass of wine) [Enter numerical percentage of 00 - 99] (If less than 10, mark as 09, 08, etc.)

[ *not yet answered* ]

16 If a person has "passed out" from alcohol/drug use and you cannot wake them up, how likely is it you would call "911"?

- Very likely  
 Somewhat likely  
 Somewhat unlikely  
 Very unlikely

**CONTINUE****REVIEW**

 CONTINUE Answering Survey - Page 17	 OVERALL Survey summary
 EDIT Re-open Page 16 and edit your responses	 PREV - summary for Page 15
 COMPLETE SURVEY LATER Responses will be saved	 NEXT - summary for Page 17

<b>SECTION: Chemical Health</b>		
<b>17</b>	SURVEY PAGE: 17 of 26 pages	You have completed 0 of 2 Items on this page

**17 On a scale from one to ten, with one being strongly disagree and ten being strongly agree, please indicate your opinion regarding a smoke-free or tobacco-free policy for your campus.**

**17.01 In my opinion, my campus should have a smoke-free policy prohibiting smoking both indoors and outdoors.**

Not applicable-My campus currently has a smoke-free policy.

1	2	3	4	5	6	7	8	9	10
(Strongly Disagree)									(Strongly Agree)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**17.02 In my opinion, my campus should have a tobacco-free policy prohibiting any type of tobacco use both indoors and outdoors.**

Not applicable-My campus currently has a tobacco-free policy.

1	2	3	4	5	6	7	8	9	10
(Strongly Disagree)									(Strongly Agree)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.



SECTION: **Sexual Health****18****ANSWER REVIEW PAGE:**  
18 of 26 pages**You have completed 0 of 5 Items on this page**

Below are your saved responses for page 18. Please review before proceeding.

1 Have you ever been sexually active? **\*\***(Sexually active is defined as having engaged in vaginal or anal intercourse or oral sex)**\*\***

- Yes  
 No

2 Was your reason for not being sexually active because you were intentionally choosing to be abstinent?

- Not Applicable - I have been sexually active  
 Yes  
 No

3 Have you been sexually active in the past 12 months?

- Yes  
 No

4 Describe your most recent sexual partner **\*\***(Select One)**\*\***

- Not applicable - I am not sexually active  
 A stranger  
 A casual acquaintance  
 A close but not exclusive dating partner  
 An exclusive dating partner  
 Fiance(e), spouse, or spousal equivalent  
 Other

5 Within the past 12 months, with how many partners, if any, have you had vaginal or anal intercourse or oral sex?

(Enter a number between 00 and 99. If less than 10, mark as 09, 08, etc.)

[ *not yet answered* ]

**CONTINUE**

- CONTINUE Answering Survey - Page 19  
 EDIT Re-open Page 18 and edit your responses  
 COMPLETE SURVEY LATER Responses will be saved

**REVIEW**

- OVERALL Survey summary  
 PREV - summary for Page 17  
 NEXT - summary for Page 19

<b>SECTION: Sexual Health</b>		
<b>19</b>	SURVEY PAGE: 19 of 26 pages	You have completed 0 of 6 Items on this page

**6 Within the past 12 months, were your sexual partner(s), if any,**

- Not applicable - I was not sexually active
- Male
- Female
- Both male and female

**7 Did you use a condom or dental dam the last time you had...**

	I have never had this type of encounter	Yes	No	Don't know/Can't remember
Oral sex?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal intercourse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal intercourse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**8 Were you intoxicated the last time you had vaginal or anal intercourse or oral sex?**

- Not applicable - I have not been sexually active
- Yes
- No
- Not sure

**9 The last time you had vaginal intercourse, what did you or your partner use as your method of pregnancy prevention?**

\*\* (Mark all that apply) \*\*

- Not applicable - I have not engaged in vaginal intercourse
- Not applicable - I/we are attempting to get pregnant
- I did not use any method of pregnancy prevention
- Birth control pills
- Depo-Provera (shots)
- Intrauterine device (IUD)
- Condoms (male, female)
- Diaphragm and spermicide
- Fertility awareness (calendar, basal body temperature, mucous, rhythm method)
- Withdrawal
- Ortho Evra (patch)
- NuvaRing
- Emergency contraception (Plan B, "morning after pill", etc.)
- Other

Don't know/Can't remember

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

SECTION: **Sexual Health****20****ANSWER REVIEW PAGE:**  
20 of 26 pages**You have completed 0 of 6 Items on this page**

Below are your saved responses for page 20. Please review before proceeding.

10 Within the past 12 months, have you become pregnant or impregnated someone else?

- Not applicable-Not sexually active  
 Yes  
 No  
 Don't know

11 Was this pregnancy:

- Not Applicable-Not involved in a pregnancy  
 Intentional  
 Unintentional

12 What was the outcome of that pregnancy?

- Not applicable - I have not been involved in a pregnancy  
 Birth and parenting  
 Birth and adoption  
 Abortion  
 Miscarriage  
 Still pregnant  
 Don't know

13 Within the past 12 months, have you or your partner used emergency contraception (Plan B, "morning after pill", etc.)?

- Not applicable-Not sexually active  
 Yes  
 No  
 Don't know

14.01 Within the past 12 months, how many times have you or your partner used emergency contraception (Plan B, "morning after pill", etc.)?

(Enter a number between 00 and 99)







(If not sexually active, please enter 00) (If less than 10, mark as 09, 08, etc.)

[ *not yet answered* ]

15 Are you (or your partner) planning on getting pregnant within the next two years?

- Yes  
 No  
 Unsure

**CONTINUE****REVIEW**

 CONTINUE Answering Survey - Page 21	 OVERALL Survey summary
 EDIT Re-open Page 20 and edit your responses	 PREV - summary for Page 19
 COMPLETE SURVEY LATER Responses will be saved	 NEXT - summary for Page 21

SECTION: **Demographic Information****21**

SURVEY PAGE: 21 of 26 pages

You have completed 0 of 5 Items on this page

**1 What is your gender?**

- Male
- Female
- Transgender
- Other

**2 How old are you?**

\*\*(Enter your age to the nearest year)\*\*

2  
digits**3 What is your race/ethnicity?**

\*\*(Mark all that apply)\*\*

- American Indian/Alaskan Native
- Asian/Pacific Islander
- Black-Not Hispanic
- Latino/Hispanic
- White-Not Hispanic (Includes Middle Eastern)
- Other

**4 Are you an international student?**

- Yes
- No

**5 How many years have you been enrolled at a postsecondary institution (college/university)?**

\*\*(Enter a number between 00 and 99. If less than 10, mark as 09, 08, etc.)\*\*

2  
digits

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

**SECTION: Demographic Information****22****ANSWER REVIEW PAGE:**  
22 of 26 pages**You have completed 0 of 4 Items on this page**

Below are your saved responses for page 22. Please review before proceeding.

6 What is your relationship status?

- Single
- Married/Domestic partner
- Separated
- Widowed
- Divorced
- Engaged/Committed dating relationship

7 Which of the following terms best describes you?

- Heterosexual
- Gay/Lesbian
- Bisexual
- Unsure

8 What is your grade point average? (A=4.00, B=3.00, etc.)





Enter your GPA as 3 numbers (4.00, 3.25, 2.50, 2.96, etc.)

[ *not yet answered* ]

9 Do you have any of the following:

\*\*(Select all that apply)\*\*

- I have no disability or impairment
- Attention deficit/hyperactivity disorder
- Deaf, hard-of-hearing, or deaf blind
- Learning disability (formally assessed)
- Mobility impairment
- Psychiatric disorder
- Systemic disability (diabetes mellitus, multiple sclerosis, etc.)
- Traumatic brain injury
- Visual impairment (not corrected by contacts or eyeglasses)
- Other

**CONTINUE** CONTINUE Answering Survey - Page 23 EDIT Re-open Page 22 and edit your responses COMPLETE SURVEY LATER Responses will be saved**REVIEW** OVERALL Survey summary PREV - summary for Page 21 NEXT - summary for Page 23

<b>SECTION: Demographic Information</b>		
<b>23</b>	SURVEY PAGE: 23 of 26 pages	You have completed 0 of 7 Items on this page

**10 How many hours do you spend in a typical 7-day week doing each of the following?**

0 hours	1 - 5 hours	6 - 10 hours	11 - 15 hours	16 - 20 hours	21 - 25 hours	26 - 30 hours	31 - 40 hours	More than 40 hours
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Preparing for class

\*\* (studying, reading, writing, doing homework, rehearsing, and other academic activities)\*\*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Working for pay on campus

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Working for pay off campus

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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**11 Over the past 12 months, how often have you engaged in any form of gambling (on-line, casino, poker, slot machine, lottery, etc.)?**

Never	Once a year	2 - 6 times/year	Once/month	More than once per month
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**12 In an average month how much do you spend on all forms of gambling?**

- Not applicable - I do not gamble
- \$1 - \$24
- \$25 - \$49
- \$50 - \$99
- \$100 - \$249
- \$250 - \$499
- \$500 - \$749
- \$750 - \$999
- \$1,000 or more

**13 How many credits are you taking this term? (00-99)**

\*\*If no credits this term please enter 00. If less than 10, mark as 01, 02, etc.\*\*

2			
digits			

**14 Last month, how much total credit card debt did you carry? That is, what was the total unpaid balance on all your credit cards?**

- Not applicable - I do not have a credit card
- None, I pay the full amount each month
- \$1 - \$99
- \$100 - \$249
- \$250 - \$499
- \$500 - \$999
- \$1,000 - \$1,999
- \$2,000 - \$2,999



- \$3,000 - \$3,999
- \$4,000 - \$4,999
- \$5,000 - \$5,999
- \$6,000 or more

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

<b>SECTION: Demographic Information</b>		
<b>24</b>	<b>ANSWER REVIEW PAGE:</b> 24 of 26 pages	<b>You have completed 0 of 6 Items on this page</b>

Below are your saved responses for page 24. Please review before proceeding.

15.01 Do you currently hold a bachelor's degree?

- Yes
- No

16 What degree program are you currently enrolled in?

- Associate's degree/Certificate program (A.A., A.S., etc.)
- Bachelor's degree (B.A., B.S., etc.)
- Master's degree (M.A., M.S., M.P.H., M.B.A., etc.)
- Doctoral or professional degree (J.D., M.D., Ph.D., etc.)
- Not enrolled in a degree program

17 On a scale from one to ten, with one being very unsupportive to ten being very supportive, how would you rate your relationship with the following:

	Very unsupportive										Very supportive
	1	2	3	4	5	6	7	8	9	10	
Friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Institution Faculty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Institution Staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CONTINUE	REVIEW
<ul style="list-style-type: none"> <li> CONTINUE Answering Survey - Page 25</li> <li> EDIT Re-open Page 24 and edit your responses</li> <li> COMPLETE SURVEY LATER Responses will be saved</li> </ul>	<ul style="list-style-type: none"> <li> OVERALL Survey summary</li> <li> PREV - summary for Page 23</li> <li> NEXT - summary for Page 25</li> </ul>

SECTION: **Residence/Special Demographics****25**

SURVEY PAGE: 25 of 26 pages

You have completed 0 of 5 Items on this page

**1 What are your living arrangements?**

- Parent's home
- Rent or share rent
- Residence hall
- Fraternity/Sorority
- Public/Subsidized housing
- Own a house
- Other

**2 Please enter the 5-digit Zip Code number for the address where you are currently living.**

5					
digits					

**3 Are you currently or have you ever served in the United States Armed Forces?**

- Yes
- No

**4 Are you an Operation Iraqi Freedom and/or Operation Enduring Freedom Veteran?**

- Yes
- No
- Not applicable-I have never served in the United States Armed Forces

**5 While serving in the United States Armed Forces how many deployments to Iraq or Afghanistan have you had?**

- Not applicable-I have not served in the United States Armed Forces
- I did not deploy to Iraq or Afghanistan while serving in the Armed Forces
- 1 deployment
- 2 deployments
- 3 deployments
- 4 deployments
- 5 or more deployments

<input type="checkbox"/>	<b>SUBMIT RESPONSES</b> - Updates will be saved. You will be taken to the ANSWER REVIEW PAGE.
<input type="checkbox"/>	<b>SKIP THIS PAGE</b> - No updates will be saved. You will be taken to the OVERALL SURVEY SUMMARY PAGE.

## SECTION: Residence/Special Demographics

26

ANSWER REVIEW PAGE:  
26 of 26 pages

You have completed 0 of 7 Items on this page

Below are your saved responses for page 26. Please review before proceeding.

6 What is the highest level of education your parents, step-parents or guardians completed?	Did not finish high school	Finished high school (or got a GED)	Attended college but did not complete degree	Completed an associate's degree/certificate program (A.A., A.S., etc.)	Completed a bachelor's degree (B.A., B.S., etc.)	Completed a master's degree (M.A., M.S., M.P.H., M.B.A., etc.)	Completed a doctoral or professional degree (J.D., M.D., Ph.D., etc.)	I prefer not to answer or I do not know
---	----------------------------	-------------------------------------	--	--	--	--	---	---

MALE Parent,  
Step-Parent or  
Guardian
        
FEMALE Parent,  
Step-Parent or  
Guardian
        

7 Would you describe your parents'/guardians' yearly income as:

- \$0 - \$21,999  
 \$22,000 - \$39,999  
 \$40,000 - \$64,999  
 \$65,000 - \$83,999  
 \$84,000 - \$99,999  
 \$100,000 or more  
 I prefer not to answer

8 What would you estimate is the combined outstanding balance on all your student loans today?

- \$0  
 \$1 - \$5,000  
 \$5,001 - \$10,000  
 \$10,001 - \$15,000  
 \$15,001 - \$20,000  
 \$20,001 - \$30,000  
 \$30,001 - \$50,000  
 \$50,001 or more

9 Who is primarily responsible for repayment of your student loans?






- Not applicable-I do not have a student loan  
 Self  
 Parent or guardian  
 Other  
 Don't know

10 Are you dependent on your parents/guardians for financial support?

- Yes  
 No

11 How many online courses are you taking this term?

- None  
 Some  
 All

CONTINUE	REVIEW
 EDIT Re-open Page 26 and edit your responses  COMPLETE SURVEY LATER Responses will be saved	 OVERALL Survey summary  PREV - summary for Page 25  NEXT - Overall summary