THE HEALTHY HOUSING OUTCOMES SURVEY

*As the [community name], we are interested in understanding your experience living here and how it relates to your health and well-being. Your responses will be kept private and used only to improve the building and our programming to better meet the needs of residents. They will be combined with the responses of other residents and no individual names will be used. Information you provide will not be shared with anyone. Participation in the survey is voluntary. We hope you will choose to complete all of the questions on the survey, but you may choose to skip any question you do not feel comfortable answering. Please let XX know if you have any questions. Thank you for your time and for sharing your thoughts with us.*

**We’d like to start out by asking you a few questions about your experiences and feelings about the property.**

1. How long have you lived in this property?

 Less than a year

 1-3 years

 4-5 years

 6-10 years

 10+ years

1. Overall, how satisfied are you with the following aspects of your property?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Very satisfied | Somewhat satisfied | Not at all satisfied | N/A |
| Your apartment |   |   |   |   |
| Common areas of your building |   |   |   |   |
| Outside spaces on the property |   |   |   |   |
| Services and events |   |   |   |   |
| Upkeep and maintenance |   |   |   |   |

1. Right now, how likely are you to recommend this property to someone else as a good place to live?

 Definitely would

 Probably would

 Probably would not

 Definitely would not

1. How safe would you say you feel walking in the community near the property during the day time?

 Very safe

 Somewhat safe

 Somewhat unsafe

 Very unsafe

1. How safe would you say you feel walking in the community near the property at night?

 Very safe

 Somewhat safe

 Somewhat unsafe

 Very unsafe

**The following questions are about your health and well-being. They include general questions about your overall health and more specific ones related to medical conditions you may be managing.**

1. Would you say that in general your health is …?

 Excellent

 Very good

 Good

 Fair

 Poor

1. During the past 30 days, for about how many days have you felt healthy enough to do your usual activities?

 All the time

 A little more than half the time

 Half the time

 Less than half the time

1. Has a doctor or nurse ever told you that you had any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | I don’t know |
| High cholesterol |  |  |  |
| Angina or coronary heart disease |  |  |  |
| Depression or anxiety |  |  |  |
| Arthritis |  |  |  |
| An autoimmune disease, such as fibromyalgia, lupus, or other autoimmune disease |  |  |  |
| Diabetes (Type 1 or 2) |  |  |  |
| High blood pressure/hypertension |  |  |  |

1. If you answered YES to any of the questions above, has your ability to manage any of these conditions improved in the last year?

 Yes

 No

**The following questions are about food and your eating preferences. There are no right or wrong answers.**

1. In general, would you say that your eating habits are…?

 Excellent

 Very good

 Good

 Fair

 Poor

1. On a typical day, how many times do you eat fruit (not including juice)?

 Three or more times a day

 About twice a day

 About once a day

 Less than once a day

 None

1. On a typical day, how often do you include vegetables of any type (either cooked or raw) in the meals you eat?

 Three or more times a day

 About twice a day

 About once a day

 Less than once a day

 None

1. If you wanted to eat fresh fruits and vegetables, how easy would it be for you to do so?

 Very easy **(skip to Question 15)**

 Somewhat easy **(skip to Question 15)**

 Somewhat difficult

 Very difficult

1. If it’s somewhat or very difficult, why is that?

*Check all that apply.*

[ ]  Too expensive

[ ]  Too far away

[ ]  Not able to prepare fresh fruits and vegetables

[ ]  Don’t know how to prepare fresh foods

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following questions are about how you get physical activity on the property and how easy it is to get around.**

1. Some people are able to get a lot of physical exercise while others have limitations on how physically active they can be. Do you have a diagnosed medical condition that limits your physical activity?

 Yes

 No

1. How often do you exercise in ways that are appropriate to your level of ability?

 Often

 Sometimes

 Rarely

 Never

1. Are you 65 or older?

 Yes

 No **(skip to Question 19)**

1. This question asks about recent falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level. In the past 12 months, how many times have you fallen in your apartment or around the building or property?

 None

 2 or less

 3-4

 5 or more

**Now we’d like to ask you some questions about the respiratory and general health of yourself and your family members.**

1. Does your building have a no-smoking policy?

 Yes

 No

 I don’t know

1. Do you or anyone living in your home experience the following? *Check all that apply.*

[ ]  Breathlessness or shortness of breath

[ ]  Coughing

[ ]  Chest tightness

[ ]  Wheezing

[ ]  Other allergic reactions

[ ]  None **(Skip to Question 22)**

1. Do those symptoms go away when you leave your apartment?

 Yes, within a few hours

 Yes, if gone a few days

 No, they stay the same

1. Has a doctor, nurse, or other health professional ever told you that you had any of the following? *Check all that apply*

[ ]  Asthma

[ ]  COPD

[ ]  Emphysema

[ ]  Other respiratory disease

[ ]  None **(skip to Question 25)**

1. During the past 12 months, have your respiratory symptoms become more intense or occurred more frequently?

 Yes

 No

 Don’t know

1. During the past 12 months, how many times did you visit the emergency room because you had trouble breathing?

 None

 1-2

 3-4

 5-6

 7 or more

1. Has a doctor, nurse, or other health professional ever told you that your child or any of your children have asthma?

 Yes

 No **(skip to Question 28)**

 Don’t know **(skip to Question 28)**

 I don’t have children **(skip to Question 29)**

25b. If yes, how many of your children have asthma? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. During the past 12 months, have their asthma symptoms become more intense or occurred more frequently?

 Yes

 No

 Don’t know

1. During the past 12 months, how many times did they visit the emergency room because of their asthma?

 None

 1-2

 3-4

 5-6

 7 or more

 Don’t know

1. Has a doctor or nurse ever told you that your child (or children) have any of the following?

*Check all that apply*

[ ]  Diabetes (Type 1 or 2)

[ ]  Allergies

 [ ]  High blood pressure/hypertension

 [ ]  I don’t have children living in my household

28b. If yes, how many of your children have diabetes (Type 1 or 2), allergies or high blood pressure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The next two questions ask about your reactions to strong odors related to building maintenance.**

1. Have you or anyone in your household noticed strong odors from the use of pesticides or cleaning products in your home or common areas of your property?

 Yes

 No

 Don’t know

Have you or anyone in your household experienced symptoms such as headaches from the use of pesticides or cleaning products in your home or common areas of your property?

 Yes

 No

 Don’t know

**The following questions ask about health issues related to lead.**

1. Has a doctor or nurse ever told you that someone in your home has a problem with lead in their blood?

 Yes

 No **(skip to Question 34)**

1. Are they being treated?

 Yes

 No

1. What has happened to this person’s lead level over the past 12 months?

 Increased

 Decreased

 Remained the same

 Don’t know

**Now we’d like to ask you about the social aspects of living in the property.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Thinking about your relationships with people in your property, please indicate the degree to which you feel each of the following statements describes you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Very much like me  | Somewhat like me  | Not like me  |  |
| If I need support, I know who I can call on.  |   |   |   |  |
| I have people I feel close to.  |   |   |   |  |
| I know there are people who really understand me.  |   |   |   |  |
| I feel a part of a group of friends. |   |   |   |  |

 |

1. The following is a list of ways in which neighbors sometimes interact with each other. Please indicate how often neighbors in this property do each of them.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Often  | Sometimes  | Rarely  | Never  |
| Stop to talk when they see each other  |   |   |   |   |
| Watch sports or other entertainment together  |   |   |   |   |
| Prepare or share a meal  |   |   |   |   |
| Watch their children together  |   |   |   |   |
| Have a neighbor over to talk |  |  |  |  |
| Call or text a neighbor |  |  |  |  |

**Now, we’d like to ask a few questions about you and your household.**

1. Including yourself, how many adults 18 years of age or older live in your household?

 1

 2

 3

 4 or more

1. How many children under 18 years of age live in your household?

 1

 2

 3

 4 or more

 None

1. Do you smoke tobacco or use tobacco products?

 Yes

 No

1. What language is most often spoken in your household?

 English

 Spanish

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your age?

 18-24

 25-34

 35-44

 45-54

 55-64

 65-74

 75 and older

1. How do you define your gender? *Check all that apply.*

 Male

 Female

 Trans\*

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you consider yourself as Hispanic, Latino, Latina, or of Spanish origin?

 Yes, Hispanic/Latino/Latina/Spanish origin

 No, not Hispanic/Latino/Latina/Spanish origin

1. What is your race?

 Black/African American

 Caucasian/White

 American Indian/Aleut/Eskimo/Alaska Native

 Asian

 Native Hawaiian/Pacific Islander

 Mixed race

1. What is the highest degree or level of school you have completed?  *If currently enrolled, highest degree received.*

 No schooling completed

 Elementary (1st grade to 8th grade)

 Some high school, no diploma

 High school graduate, diploma or the equivalent (for example: GED)

 Some college credit, no degree

 Trade/ technical/ vocational training

 Associate degree

 Bachelor's degree

 Master's degree

 Professional degree

 Doctoral degree

**Thank you for completing this survey! We appreciate your time.**