

Healthier Black Elders Center
Participant Research Pool Survey

_____/_____/20____
Date

Name: _____
Title First Name MI Last Name

Sex: Male Female **Date of Birth:** ____/____/____
Month Day Year

Phone #: Home (____) _____ - _____ Alternate (____) _____ - _____

Address Apt/Unit# City MI 48
ST Zip Code

- 1. Are you able to do heavy work around the house like shoveling snow, washing windows, walls or floors without help?**
 No Yes
- 2. Are you able to walk up and down stairs to the second floor without help?**
 No Yes
- 3. Are you able to walk half a mile without help? (That's about 8 ordinary blocks)**
 No Yes
- 4. How much difficulty, if any, do you have pulling or pushing large objects like a living room chair?**
 No Difficulty at All Some Difficulty Just Unable to Do It
 A Little Difficulty A lot of Difficulty
- 5. What about stooping, crouching, or kneeling?**
 No Difficulty at All Some Difficulty Just Unable to Do It
 A Little Difficulty A lot of Difficulty
- 6. How much difficulty, if any, do you have lifting or carrying weights over 10 pounds, like a heavy bag of groceries?**
 No Difficulty at All Some Difficulty Just Unable to Do It
 A Little Difficulty A lot of Difficulty
- 7. Reaching or extending your arms above shoulder level?**
 No Difficulty at All Some Difficulty Just Unable to Do It
 A Little Difficulty A lot of Difficulty
- 8. Either writing or handling or fingering small objects?**
 No Difficulty at All Some Difficulty Just Unable to Do It
 A Little Difficulty A lot of Difficulty

9. Please indicate which of following conditions you have now or have had in the past. Also check if your mother and/or father had/has each of the conditions listed.

Condition	You	Indicate year you learned about condition/unknown	Mother	Father
Diabetes (Type I or II)				
Arthritis: Rheumatoid				
Osteoarthritis				
Unknown Type				
Osteoporosis				
Cancer: Colon				
Lung				
Breast				
Prostate				
Skin				
Other Kind _____				
Bladder Control Prob.				
Kidney Problems Kind _____				
Liver Problems Kind _____				
Lung Problems Kind _____				
High Blood Pressure				
Heart Attack				
By-pass Surgery				
Other Heart Problems Kind _____				
Stroke				
Seizures				
Parkinson's Disease				
Memory Problems				
Psychiatric Disorders				
Balance Problems				
Difficulty Walking				
Alzheimer's Disease				
Nerve damage Where _____				
Other Neurological Prob. Kind _____				
Spine Prob. (back/neck) Kind _____				
Vision Prob. Kind _____				
Hearing Prob. Kind _____				
Other conditions Kind _____				

Thank you very much for taking the time to complete this survey.