



Patient Follow-up Survey

Version 3.0, 07/29/2020

INSTRUCTION:

We are interested in learning how you have been doing since we were last in touch with you. As you complete this form, answer the questions as best as you can. If you don't know the answer or do not want to answer a question, you may leave it blank.

What is today's date? |__|__| - |__|__| - |__|__|__|__|
 Month Day Year

A. YOUR RECENT PAIN

- 1. Do you take pain medicine every day for your sickle cell disease? Yes No

- 2. What pain medicines do you currently take for your sickle cell disease? On the list below, check the box next to the name of the **pain medicines** you take (even if not everyday). Check here if you don't take pain medicines →

PAIN MEDICATIONS	
<input type="checkbox"/> acetaminophen & codeine (Tylenol-Codeine #3 or #4)	<input type="checkbox"/> magnesium salicylic acid (Durasal)
<input type="checkbox"/> acetaminophen & oxycodone (Percocet, Endocet)	<input type="checkbox"/> meperidine (Demerol)
<input type="checkbox"/> acetaminophen & hydrocodone (Vicodin, Norco, Lortab)	<input type="checkbox"/> methadone (Dolophine)
<input type="checkbox"/> acetaminophen (Tylenol)	<input type="checkbox"/> morphine sulfate (MS Contin, Kadian)
<input type="checkbox"/> amitriptyline/Elavil	<input type="checkbox"/> morphine and naltrexone (Embeda, MS IR)
<input type="checkbox"/> aspirin (any brand)	<input type="checkbox"/> naproxen (Aleve, Naprosyn)
<input type="checkbox"/> buprenorphine/Belbuca/Butrans	<input type="checkbox"/> oxycodone (Oxycontin, Roxicodone)
<input type="checkbox"/> butalbital, acetaminophen, and caffeine (Fioricet)	<input type="checkbox"/> oxymorphone (Opana)
<input type="checkbox"/> butalbital, aspirin, caffeine, & codeine (Ascomp-Codeine)	<input type="checkbox"/> pentazocine/Talwin
<input type="checkbox"/> celecoxib (Celebrex)	<input type="checkbox"/> pregabalin (Lyrica)
<input type="checkbox"/> diclofenac/Voltaren/Cambia/Solaraze	<input type="checkbox"/> promethazine/Phenergan with codeine
<input type="checkbox"/> esomeprazole (Nexium)	<input type="checkbox"/> tapentadol/Nucynta
<input type="checkbox"/> Excedrin	<input type="checkbox"/> tramadol
<input type="checkbox"/> fentanyl (Duragesic)	<input type="checkbox"/> venlafaxine/Effexor
<input type="checkbox"/> gabapentin (Neurontin)	<input type="checkbox"/> medical marijuana/cannabis
<input type="checkbox"/> hydromorphone (Exalgo ER, Dilaudid)	<input type="checkbox"/> topical/skin cream for pain (all types)
<input type="checkbox"/> ibuprofen (Motrin, Advil)	<input type="checkbox"/> Other pain medication (specify below)
<input type="checkbox"/> ketorolac/Toradol	

- 3. In the past 12 months, how many sickle cell pain attacks (crises) did you have?
 - I did not have a pain attack in the past 12 months
 - 1
 - 2
 - 3
 - 4 or more

- 4. When was your last pain attack (crisis)?
 - I've never had a pain attack (crisis) → **skip to Question 8**
 - More than a year ago → **skip to Question 8**
 - 7-11 months ago
 - 1-6 months ago
 - 1-3 weeks ago
 - Less than a week ago
 - I have one right now

5. How severe was your pain during your last pain attack (crisis)? **Circle a number from 0 to 10 below**, where 0 is no pain and 10 is the worst pain imaginable.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable
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6. How much did your last pain attack (crisis) interfere with your life?

- Not at all, I did everything I usually do
- I had to cut down on some things I usually do
- I could not do most things I usually do
- I could not take care of myself and needed some help from family or friends
- I could not take care of myself and needed constant care from family, friends, doctors, or nurses

7. About how long did your most recent pain attack (crisis) last?

- Less than 1 hour
- 1-12 hours
- 13-23 hours
- 1-3 days
- 4-6 days
- 1-2 weeks
- More than 2 weeks

8. Think about your pain in the **past 7 days**, and answer the following questions.

		Never	Rarely	Sometimes	Often	Always
a.	How often did you have very severe pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	How often did you have pain so bad that it was hard to finish what you were doing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Now think about your pain in the **past 6 months**, and answer the following questions.

		Never	Rarely	Sometimes	Often	Always
a.	How often did you have very severe pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	How often did you have pain so bad that it was hard to finish what you were doing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Think about how your pain felt in the **past 7 days**, and answer the following questions.

		Not at all	A little bit	Somewhat	Quite a bit	Very much
a.	Did your pain feel like pins and needles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Did your pain feel sore?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Would you say that your pain management plan is.....

- Effective for managing your pain
- Somewhat effective for managing your pain
- Ineffective at managing your pain
- You don't have a pain management plan

B. YOUR MEDICAL CONDITIONS

12. Do you get regular blood transfusions for your sickle cell disease?

- Yes
- No

13. In the past 12 months, how many units (pints) of blood have you received?

- None
- 1 – 2
- 3 – 5
- 6 – 10
- 11 – 15
- >15
- Don't Know

14. Are you **currently** on iron chelation treatment (e.g., Desferal, Exjade, Jadenu, deferasirox, Ferriprox, deferiprone, phlebotomy)?

- Yes
- No
- Don't Know

15. In the past 12 months, has your spleen been removed?

- Yes
- No

16. In the past 12 months, have you been **newly diagnosed** with any of the following conditions?

	Condition	YES	NO
a.	Lung problems such as pneumonia or acute chest syndrome	<input type="checkbox"/>	<input type="checkbox"/>
b.	Kidney damage	<input type="checkbox"/>	<input type="checkbox"/>
c.	Eye damage called retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
d.	Damage to your hip or shoulder due to sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>
e.	High blood pressure in your lungs (also called pulmonary hypertension)	<input type="checkbox"/>	<input type="checkbox"/>
f.	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
g.	Blood clots in your legs or arms or that went to your lung	<input type="checkbox"/>	<input type="checkbox"/>
h.	A stroke	<input type="checkbox"/>	<input type="checkbox"/>
i.	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
j.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
k.	Liver problems such as hepatitis, iron overload, or cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
l.	Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>

C. HYDROXYUREA USE

17. In the past 12 months, have you taken hydroxyurea?

- Yes
- No → **skip to Section D**

18. Are you **currently** taking hydroxyurea?

- Yes → **skip to Question 20**
- No

19. In the past 12 months, what is the reason you discontinued or stopped taking hydroxyurea? Please select one from the list below.

- Side effects
- Personal preference
- Provider decision
- Didn't work
- Pregnancy concerns
- Other reason not listed above, specify _____

20. How many days did you take hydroxyurea in the PAST WEEK?

- 0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

21. In the last 12 months, which of the following side effects did you experience while you were taking hydroxyurea? Select one or more from the list below.

- Hair loss/thinning
- Nail blackening or discoloration
- Lowered blood counts (e.g., platelets, white count, hemoglobin)
- Low sperm count or other fertility problems
- Nausea/vomiting
- Skin ulcers
- Weight gain
- Headaches or dizziness
- Fatigue/drowsiness
- No side effects

22. In the last 12 months, what makes it difficult for you to take hydroxyurea, or is there a reason why you do not take hydroxyurea? Select one or more from the list below, whether or not you have ever taken hydroxyurea.

- I have no difficulties or concerns using hydroxyurea
- I don't know enough about the medicine
- Sometimes I forget to take the medicine
- I am worried about side effects
- I don't like the frequent blood tests or clinic visits
- I'm feeling well and I don't think I need it
- The cost is more than I can afford
- I have heard that hydroxyurea may cause cancer
- I have heard that hydroxyurea may cause problems with having healthy children
- Other difficulty, specify _____

D. OTHER MEDICATIONS YOU ARE TAKING

23. In the past 12 months, have you taken the drug called Endari (l-glutamine)?

- Yes
 No → **skip to Question 28**

24. Are you **currently** taking Endari?

- Yes → **skip to Question 26**
 No

25. In the past 12 months, what is the reason you discontinued or stopped taking Endari? Please select one from the list below.

- Side effects
- Personal preference
- Provider decision
- Didn't work
- Other reason not listed above, specify _____

26. How many days did you take Endari in the PAST WEEK?

- 0 days 1 day 2 days 3 days 4 days 5 days 6 days 7 days

27. In the last 12 months, what side effects have you experienced while you were taking Endari? Select one or more from the list below.

- No side effects
- Nausea/vomiting
- Stomach pain
- Cough
- Headaches or dizziness
- Other not listed above _____

28. We would like to know what other types of medications you are **currently** taking, *excluding pain medications, iron chelators, hydroxyurea, and Endari* which we already asked about.

Review the list in the table below and check the box next to the type of medications you are **currently** taking.

CATEGORIES OR TYPES OF DRUGS YOU MAY BE TAKING	
<input type="checkbox"/> Allergy drugs	<input type="checkbox"/> High cholesterol drugs
<input type="checkbox"/> Asthma or COPD inhalers (bronchodilators)	<input type="checkbox"/> Hypothyroid drugs
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Insomnia drugs & sleep aides
<input type="checkbox"/> ADD/ADHD drugs	<input type="checkbox"/> Nausea drugs
<input type="checkbox"/> Anti-seizure drugs	<input type="checkbox"/> Muscle relaxers
<input type="checkbox"/> Anti-anxiety drugs	<input type="checkbox"/> Stool softeners and laxatives
<input type="checkbox"/> Antidepressants	TYPES OF VITAMINS
<input type="checkbox"/> Birth control	<input type="checkbox"/> Iron supplements
<input type="checkbox"/> Blood thinning drugs (anticoagulants)	<input type="checkbox"/> Folic acid
<input type="checkbox"/> Diabetes drugs	<input type="checkbox"/> Vitamin D, all types
<input type="checkbox"/> Diuretics, fluid/water retention pills	<input type="checkbox"/> Multi-vitamins
<input type="checkbox"/> Heartburn, indigestion, acid reflux drugs	<input type="checkbox"/> Any other vitamins and supplements

29. Are you taking any medications for **high blood pressure** (hypertension) or for your **heart**? Yes No
 If yes, what is the name of the high blood pressure or heart medication? _____

30. Are you taking any other type of medication that we did not already ask about? Yes No
 If yes, what is the name of the other medication(s)? _____

31. Are you currently participating in a study where you are taking a medicine for sickle cell? Yes No

E. YOUR SLEEP

32. Think about your sleep in the **past 7 days**, and answer the following questions.

		Never	Rarely	Sometimes	Often	Always
a.	How often did you stay up most of the night because you could not fall asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	How often did you have a lot of trouble falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F. YOUR SOCIAL AND MENTAL HEALTH

33. Please respond to each statement by marking one box per row.

		Never	Rarely	Sometimes	Usually	Always
a.	I have someone who will listen to me when I need to talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I have someone to confide in or talk to about myself or my problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	I have someone who makes me feel appreciated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I have someone to talk with when I have a bad day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. Think about how you felt in the **past 7 days**, and respond to each question or statement.

		Never	Rarely	Sometimes	Often	Always
a.	I felt worthless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I felt helpless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	I felt depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I felt hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	How often did you feel completely hopeless because of your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	How often were you very worried about needing to go to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Not at all	A little bit	Somewhat	Quite a bit	Very much
g.	I felt tired.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. Please respond to each statement by marking one box per row.

	In the past 7 days.....	Never	Rarely	Sometimes	Usually	Always
a.	I felt fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I found it hard to focus on anything other than my anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	My worries overwhelmed me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I felt uneasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. In the **past 7 days**, how often did the following happen?

		Never	Rarely (Once)	Sometimes (2-3 times)	Often (once a day)	Very often (several times a day)
a.	I had to read something several times to understand it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	My thinking was slow.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	I had to work really hard to pay attention or I would make a mistake.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I had trouble concentrating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

37. How much DIFFICULTY do you **currently** have doing the following things?

		None	A little	Somewhat	A lot	Cannot do
a.	Reading and following complex instructions (e.g., directions for a new medication)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Planning for and keeping appointments that are not part of your weekly routine (e.g., therapy or doctor appointment, social gathering with friends/family)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Managing your time to do most of your daily activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Learning new tasks or instructions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

38. In the **past 30 days**, how much did the following happen?

		Not at all	A little bit	Somewhat	Quite a bit	Very much
a.	How much did you rely on others to take care of you because of your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	How much did your health make it hard for you to do things with your friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

39. Please respond to each statement by marking one box per row.

In the past month, please describe how often...		Never	Rarely	Sometimes	Usually	Always
a.	I feel alone and apart from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I feel left out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	I feel that I am no longer close to anyone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I feel alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	I feel lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	I feel isolated from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. Please respond to each statement by marking one box per row.

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a.	I tend to bounce back quickly after hard times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I have a hard time making it through stressful events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	It does not take me long to recover from a stressful event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	It is hard for me to snap back when something bad happens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	I usually come through difficult times with little trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	I tend to take a long time to get over setbacks in my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. YOUR PHYSICAL HEALTH

41. Please respond to each question or statement by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
a.	In general, how would you rate your physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Completely	Mostly	Moderately	A little	Not at all
b.	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H. YOUR ABILITY TO MANAGE YOUR SICKLE CELL DISEASE

42. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

- Never
- Rarely
- Sometimes
- Often
- Always

43. Please respond to each statement below by marking one box per row.

CURRENT Level of Confidence (confidence is how sure you are about each statement)		I am not at all confident	I am a little confident	I am somewhat confident	I am quite confident	I am very confident
a.	I can follow directions when my doctor changes my medications.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I can take my medication when there is a change in my usual day (unexpected things happen).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	I can manage my medication without help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I can list my medications, including the doses and schedule.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I. BARRIERS

44. During the past 12 months, was there any time when you didn't get the medical care you needed or had delays in getting the care you needed?

- Yes
 No → **skip to Question 46**

45. In the past 12 months, did you not get the medical care you needed or have delays getting medical care you needed for any of the following reasons? Select one or more from the list below.

- Worry about the cost
 The doctor or hospital wouldn't accept your health insurance
 Your health plan wouldn't pay for the treatment
 You couldn't get an appointment soon enough
 You couldn't get there when the doctor's office or clinic was open
 It takes too long to get to the doctor's office or clinic from your house or work
 You couldn't get through on the telephone
 You were too busy with work or other commitments to take the time
 You didn't think the problem was serious enough
 You had previous bad experiences with the health care system
 People at the doctor's office or clinic don't speak the same language I do
 The Coronavirus/COVID-19 pandemic
 Some other reason not listed above, please specify _____

46. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- 1 = Not hard at all
 2 = Not very hard
 3 = Somewhat hard
 4 = Hard
 5 = Very hard

47. Did you lose your health insurance in the past year?

- 1 = Yes
 2 = No

48. Have you ever experienced discrimination, been prevented from doing something, or been hassled or made to feel inferior in any of the following situations because of your race, ethnicity, or color? If yes, please indicate whether it happened 1-2 times or 3 or more times in your entire life.

		No	Yes →	How many times did this ever happen?
a.	At school?	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more
b.	Getting hired or getting a job?	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more
c.	At work?	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more
d.	Getting housing?	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more
e.	Getting medical care?	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more
f.	Getting service in a store or restaurant?	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more
g.	Getting credit, bank loans, or a mortgage?	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more
h.	On the street or in a public setting?	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more
i.	From the police or in the courts?	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more

This is the END of the survey. Please return it to the study coordinator. Thank you!