

Section 14 - MEDICAL CONDITIONS AND PRACTICES

Statement Z

Now I'd like to ask some questions about your health and health practices.

N14STZ

<p>1. (Not counting hospitalization for delivery of a healthy live born infant,) How many separate times did you stay in a hospital overnight or longer in the last 12 months?</p>	<p>0 <input type="checkbox"/> No times - <i>SKIP to 3</i> OR _____ Number of times</p> <p align="right">N14Q1</p>
<p>2. (Again not counting hospitalization for delivery of a healthy live born infant,) How many days altogether did you spend in the hospital in the last 12 months?</p>	<p>_____ Number of days</p> <p align="right">N14Q2</p>
<p>3. During the last 12 months, how many times did you receive medical care or treatment in a hospital emergency room?</p>	<p>0 <input type="checkbox"/> No times OR _____ Number of times</p> <p align="right">N14Q3</p>
<p>4. During the last 12 months, how many injuries have you had that caused you to seek medical help or to cut down your usual activities for more than half a day?</p>	<p>0 <input type="checkbox"/> No injuries OR _____ Number of injuries</p> <p align="right">N14Q4</p>
<p>5. And now some questions about your health and sexual practices. <i>(SHOW FLASHCARD 49)</i> People are different in their sexual attraction to other people. Which category on the card best describes your feelings?</p>	<p>1 <input type="checkbox"/> Only attracted to females N14Q5 2 <input type="checkbox"/> Mostly attracted to females 3 <input type="checkbox"/> Equally attracted to females and males 4 <input type="checkbox"/> Mostly attracted to males 5 <input type="checkbox"/> Only attracted to males</p>
<p>6. <i>(SHOW FLASHCARD 49A)</i> In your entire life, have you had sex with only males, only females, both males and females, or have you never had sex?</p>	<p>1 <input type="checkbox"/> Only males N14Q6 2 <input type="checkbox"/> Only females 3 <input type="checkbox"/> Both males and females 4 <input type="checkbox"/> Never had sex</p>
<p><i>(SHOW FLASHCARD 50)</i> 7. Which of the categories on the card best describes you?</p>	<p>1 <input type="checkbox"/> Heterosexual (straight) N14Q7 2 <input type="checkbox"/> Gay or lesbian 3 <input type="checkbox"/> Bisexual 4 <input type="checkbox"/> Not sure</p>
<p>CHECK ITEM 14.1 Is "4" marked in 6? Has respondent never had sex?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to Check Item 14.4</i> N14CK141 2 <input type="checkbox"/> No</p>
<p>8a. Have you had sex in the last 12 months?</p>	<p>1 <input type="checkbox"/> Yes N14Q8A 2 <input type="checkbox"/> No - <i>SKIP to 11</i></p>
<p>CHECK ITEM 14.1A Is "1" or "2" marked in 6? Has respondent had sex with only males or only females?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 8c</i> N14CK141A 2 <input type="checkbox"/> No</p>
<p>8b. During the last 12 months, did you have sex with only males, only females, or both males and females?</p>	<p>1 <input type="checkbox"/> Only males N14Q8B 2 <input type="checkbox"/> Only females 3 <input type="checkbox"/> Both males and females</p>
<p>c. During the last 12 months, did you have sex with someone who you knew or suspected was an injection drug user?</p>	<p>1 <input type="checkbox"/> Yes N14Q8C 2 <input type="checkbox"/> No</p>
<p><i>(SHOW FLASHCARD 51)</i> d. When you had sex in the last 12 months, about how often did you use a condom?</p>	<p>1 <input type="checkbox"/> Never N14Q8D 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often</p>
<p>CHECK ITEM 14.2 Is respondent a Female AND is 1 or 3 marked in 8b?</p>	<p>1 <input type="checkbox"/> Yes N14CK142 2 <input type="checkbox"/> No - <i>SKIP to 11</i></p>
<p>8e. During the last 12 months, did you have sex with a male partner who you knew or suspected had sex with other male partners?</p>	<p>1 <input type="checkbox"/> Yes N14Q8E 2 <input type="checkbox"/> No</p>

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11. How old were you when you first had sex?		_____ Age	N14Q11
CHECK ITEM 14.4	If sex = 1, Is Q5 coded as 2,3,4,5,D,R OR Q6 coded as 1,3,D,R OR Q7 coded as 2,3,4, D,R?	If sex = 2, Is Q5 coded as 1,2,3,4,D,R, OR Q6 coded as 2,3,D,R, OR Q7 coded as 2,3,4,D,R?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 15a</i> N14CK144
(SHOW FLASHCARD 51)			
12a. Now I'd like to know about how often you have experienced discrimination, been prevented from doing something, or been hassled or made to feel inferior in any of the following situations because you were assumed to be gay, lesbian or bisexual.		b. About how often did this happen BEFORE 12 months ago?	
(1)	During the last 12 months, about how often did you experience discrimination in your ability to obtain health care or health insurance coverage because you were assumed to be gay, lesbian or bisexual?	1 <input type="checkbox"/> Never N14Q12A1 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often	1 <input type="checkbox"/> Never N14Q12B1 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often
(2)	During the last 12 months, how often did you experience discrimination in how you were treated when you got care because you were assumed to be gay, lesbian or bisexual?	1 <input type="checkbox"/> Never N14Q12A2 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often	1 <input type="checkbox"/> Never N14Q12B2 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often
(3)	During the last 12 months, how often did you experience discrimination in public, like on the street, in stores or in restaurants, because you were assumed to be gay, lesbian or bisexual?	1 <input type="checkbox"/> Never N14Q12A3 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often	1 <input type="checkbox"/> Never N14Q12B3 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often
(4)	During the last 12 months, about how often did you experience discrimination because you were assumed to be gay, lesbian or bisexual in ANY other situation, like obtaining a job or on the job, getting admitted to a school or training program, in the courts or by the police?	1 <input type="checkbox"/> Never N14Q12A4 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often	1 <input type="checkbox"/> Never N14Q12B4 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often
(5)	During the last 12 months, about how often were you called names because you were assumed to be gay, lesbian or bisexual?	1 <input type="checkbox"/> Never N14Q12A5 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often	1 <input type="checkbox"/> Never N14Q12B5 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often
(6)	During the last 12 months, about how often were you made fun of, picked on, pushed, shoved, hit, or threatened with harm because you were assumed to be gay, lesbian or bisexual?	1 <input type="checkbox"/> Never N14Q12A6 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often	1 <input type="checkbox"/> Never N14Q12B6 2 <input type="checkbox"/> Almost never 3 <input type="checkbox"/> Sometimes 4 <input type="checkbox"/> Fairly often 5 <input type="checkbox"/> Very often
CHECK ITEM 14.5	Are all items (1) - (6) in 12a AND 12b marked "1" OR "Never" OR D OR R?	1 <input type="checkbox"/> Yes - <i>SKIP to 15a</i> 2 <input type="checkbox"/> No	N14CK145
13.	When you are treated unfairly because you were assumed to be gay, lesbian or bisexual, do you USUALLY accept it as a fact of life, or do you try to do something about it?	1 <input type="checkbox"/> Accept it 2 <input type="checkbox"/> Try to do something about it	N14Q13
14.	When you are treated unfairly because you were assumed to be gay, lesbian or bisexual, do you USUALLY talk to other people about it, or do you keep it to yourself?	1 <input type="checkbox"/> Talk to other people 2 <input type="checkbox"/> Keep it to yourself	N14Q14
15a.	Have you EVER been tested for HIV, the virus that causes AIDS, or tested for AIDS?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16a</i>	N14Q15A
b.	Did you EVER test positive for HIV or AIDS?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	N14Q15B

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16a. And now a few questions about your health. During the last 12 months, did you have. . .		b. Did a doctor or other health professional tell you that you had (Name of condition)?
(1) Cirrhosis of the liver?	1 <input type="checkbox"/> Yes — N14Q16A1 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B1 2 <input type="checkbox"/> No
(2) Any other form of liver disease?	1 <input type="checkbox"/> Yes — N14Q16A2 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B2 2 <input type="checkbox"/> No
(3) Hardening of the arteries or arteriosclerosis?	1 <input type="checkbox"/> Yes — N14Q16A3 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B3 2 <input type="checkbox"/> No
(4) Diabetes or sugar diabetes?	1 <input type="checkbox"/> Yes — N14Q16A4 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B4 2 <input type="checkbox"/> No
(5) High blood pressure or hypertension?	1 <input type="checkbox"/> Yes — N14Q16A5 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B5 2 <input type="checkbox"/> No
(6) High cholesterol?	1 <input type="checkbox"/> Yes — N14Q16A6 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B6 2 <input type="checkbox"/> No
(7) High triglycerides?	1 <input type="checkbox"/> Yes — N14Q16A7 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B7 2 <input type="checkbox"/> No
(8) Chest pain or angina?	1 <input type="checkbox"/> Yes — N14Q16A8 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B8 2 <input type="checkbox"/> No
(9) Rapid heart beat or tachycardia?	1 <input type="checkbox"/> Yes — N14Q16A9 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B9 2 <input type="checkbox"/> No
(10) A heart attack or myocardial infarction?	1 <input type="checkbox"/> Yes — N14Q16A10 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B10 2 <input type="checkbox"/> No
(11) Any other form of heart condition or heart disease?	1 <input type="checkbox"/> Yes — N14Q16A11 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B11 2 <input type="checkbox"/> No
(12) A stomach ulcer?	1 <input type="checkbox"/> Yes — N14Q16A12 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B12 2 <input type="checkbox"/> No
(13) Any sexually transmitted diseases or venereal diseases like gonorea, sifalis, clamidia or herpez?	1 <input type="checkbox"/> Yes — N14Q16A13 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B13 2 <input type="checkbox"/> No
(14) Epilepsy or seizure disorder?	1 <input type="checkbox"/> Yes — N14Q16A14 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B14 2 <input type="checkbox"/> No
(15) Arthritis?	1 <input type="checkbox"/> Yes — N14Q16A15 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B15 2 <input type="checkbox"/> No
(16) A stroke?	1 <input type="checkbox"/> Yes — N14Q16A16 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B16 2 <input type="checkbox"/> No
(17) Problems falling asleep or staying asleep?	1 <input type="checkbox"/> Yes — N14Q16A17 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B17 2 <input type="checkbox"/> No
(18) Liver cancer?	1 <input type="checkbox"/> Yes — N14Q16A18 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B18 2 <input type="checkbox"/> No
(19) Breast cancer?	1 <input type="checkbox"/> Yes — N14Q16A19 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B19 2 <input type="checkbox"/> No
(20) Cancer of the mouth, tongue, throat or esophagus?	1 <input type="checkbox"/> Yes — N14Q16A20 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B20 2 <input type="checkbox"/> No

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16a. During the last 12 months, did you have . . .		b. Did a doctor or other health professional tell you that you had (Name of condition)?
(21) Any other cancer?	1 <input type="checkbox"/> Yes — N14Q16A21 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B21 2 <input type="checkbox"/> No
(22) Anemia?	1 <input type="checkbox"/> Yes — N14Q16A22 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B22 2 <input type="checkbox"/> No
(23) Fibromyalgia?	1 <input type="checkbox"/> Yes — N14Q16A23 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B23 2 <input type="checkbox"/> No
(24) Reflex sympathetic dystrophy (RSD) or Complex Regional Pain Syndrome (CRPS)?	1 <input type="checkbox"/> Yes — N14Q16A24 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B24 2 <input type="checkbox"/> No
(25) Any other nerve problem in your legs, arms or back?	1 <input type="checkbox"/> Yes — N14Q16A25 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B25 2 <input type="checkbox"/> No
(26) Bowel problems, like inflammatory bowel disease (IBD) or irritable bowel syndrome (IBS)?	1 <input type="checkbox"/> Yes — N14Q16A26 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B26 2 <input type="checkbox"/> No
(27) Osteoporosis?	1 <input type="checkbox"/> Yes — N14Q16A27 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B27 2 <input type="checkbox"/> No
(28) Lung problems like chronic bronchitis, emphysema, pneumonia, or influenza?	1 <input type="checkbox"/> Yes — N14Q16A28 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B28 2 <input type="checkbox"/> No
(29) Pancreatitis?	1 <input type="checkbox"/> Yes — N14Q16A29 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B29 2 <input type="checkbox"/> No
(30) Tuberculosis?	1 <input type="checkbox"/> Yes — N14Q16A30 → 2 <input type="checkbox"/> No - <i>SKIP to next condition</i>	1 <input type="checkbox"/> Yes N14Q16B30 2 <input type="checkbox"/> No
(31) A serious or traumatic brain injury?	1 <input type="checkbox"/> Yes — N14Q16A31 → 2 <input type="checkbox"/> No - <i>SKIP to 16c</i>	1 <input type="checkbox"/> Yes N14Q16B31 2 <input type="checkbox"/> No
16c. Have you ever been prescribed or used medical marijuana?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16f</i>	N14Q16C
d. Did you use medical marijuana in the last 12 months?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 16f</i>	N14Q16D
e. Did you use medical marijuana BEFORE 12 months ago, that is before last (Month one year ago)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	N14Q16E
f. In the past 30 days, about how many hours did you sleep during a typical day?	_____ Number of hours	N14Q16F
g. In the last 12 months, did a doctor or other health professional tell you that you had schizophrenia or a psychotic illness or episode?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	N14Q16G
h. Did this happen BEFORE 12 months ago, that is before last (Month one year ago)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	N14Q16H
17a. During the last 12 months, have you provided personal care or help with daily activities to another person because of a health condition or limitation? If you provided this assistance to more than one person, please answer the questions for the person you assisted the MOST. (Do not include care for others that is related to your job.)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - <i>SKIP to 18a</i>	N14Q17A
b. Was the person to whom you provided care living in your home, in another home or in a health care institution?	1 <input type="checkbox"/> Own home 2 <input type="checkbox"/> Another home 3 <input type="checkbox"/> Health care institution	N14Q17B
<i>(SHOW FLASHCARD 52)</i>	<input type="text"/> <input type="text"/> Code	N14Q17C
c. What is this person's relationship to you?		

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<p><i>(SHOW FLASHCARD 24)</i></p> <p>17d. During the last 12 months, about how often did you provide care or assistance to this person?</p>	<p>1 <input type="checkbox"/> Every day N14Q17D 2 <input type="checkbox"/> Nearly every day 3 <input type="checkbox"/> 3 to 4 times a week 4 <input type="checkbox"/> 2 times a week 5 <input type="checkbox"/> Once a week 6 <input type="checkbox"/> 2 to 3 times a month 7 <input type="checkbox"/> Once a month 8 <input type="checkbox"/> 7 to 11 times in the last year 9 <input type="checkbox"/> 3 to 6 times in the last year 10 <input type="checkbox"/> 1 or 2 times in the last year</p>
<p>e. About how long have you been providing care or assistance to this person?</p>	<p>_____ Weeks N14Q17EUNIT, N14Q17ECONT or _____ Months or _____ Years</p>
<p>18a. In your ENTIRE life did you EVER attempt suicide?</p>	<p>1 <input type="checkbox"/> Yes N14Q18A 2 <input type="checkbox"/> No - <i>SKIP to Check Item 14.6</i></p>
<p>b. How old were you the FIRST time that happened?</p>	<p>_____ Age N14Q18B</p>
<p>c. How old were you the MOST RECENT time that happened?</p>	<p>_____ Age N14Q18C 0 <input type="checkbox"/> Only happened once - <i>SKIP to Check Item 14.6</i></p>
<p>d. How many times have you attempted suicide?</p>	<p><input type="text"/> <input type="text"/> Times N14Q18D</p>
<p>CHECK ITEM 14.6 Is respondent a female aged 18 - 55?</p>	<p>1 <input type="checkbox"/> Yes N14CK146 2 <input type="checkbox"/> No - <i>SKIP to 20a</i></p>
<p>19a. Are you pregnant at this time?</p>	<p>1 <input type="checkbox"/> Yes - <i>SKIP to 19c</i> N14Q19A 2 <input type="checkbox"/> No</p>
<p>b. Were you pregnant at any time during the last year?</p>	<p>1 <input type="checkbox"/> Yes N14Q19B 2 <input type="checkbox"/> No - <i>SKIP to 20a</i></p>
<p>c. (Did you experience/Have you experienced) any complications with this most recent pregnancy (or during delivery)?</p>	<p>1 <input type="checkbox"/> Yes N14Q19C 2 <input type="checkbox"/> No</p>
<p><i>(SHOW FLASHCARD 53)</i></p> <p>20a. Please look at the categories on the card and let me know how much each of the following statements describes you...</p> <p>When doing several things in a row, I mix up the sequence.</p>	<p>1 <input type="checkbox"/> Not at all N14Q20A 2 <input type="checkbox"/> A little 3 <input type="checkbox"/> Somewhat 4 <input type="checkbox"/> A lot 5 <input type="checkbox"/> Very much</p>
<p>b. I try to plan for the future.</p>	<p>1 <input type="checkbox"/> Not at all N14Q20B 2 <input type="checkbox"/> A little 3 <input type="checkbox"/> Somewhat 4 <input type="checkbox"/> A lot 5 <input type="checkbox"/> Very much</p>
<p>c. I have trouble doing two things at once, multi-tasking.</p>	<p>1 <input type="checkbox"/> Not at all N14Q20C 2 <input type="checkbox"/> A little 3 <input type="checkbox"/> Somewhat 4 <input type="checkbox"/> A lot 5 <input type="checkbox"/> Very much</p>
<p>d. I'm an organized person.</p>	<p>1 <input type="checkbox"/> Not at all N14Q20D 2 <input type="checkbox"/> A little 3 <input type="checkbox"/> Somewhat 4 <input type="checkbox"/> A lot 5 <input type="checkbox"/> Very much</p>

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(SHOW FLASHCARD 53)

20e. I save money on a regular basis.

- 1 Not at all
- 2 A little
- 3 Somewhat
- 4 A lot
- 5 Very much

N14Q20E

f. I only have to make a mistake once in order to learn from it.

- 1 Not at all
- 2 A little
- 3 Somewhat
- 4 A lot
- 5 Very much

N14Q20F

g. I sometimes lose track of what I'm doing.

- 1 Not at all
- 2 A little
- 3 Somewhat
- 4 A lot
- 5 Very much

N14Q20G

h. I think about the consequences of an action before I do it.

- 1 Not at all
- 2 A little
- 3 Somewhat
- 4 A lot
- 5 Very much

N14Q20H

i. I have trouble summing up information in order to make a decision with it.

- 1 Not at all
- 2 A little
- 3 Somewhat
- 4 A lot
- 5 Very much

N14Q20I

j. I start things, but then lose interest and do something else.

- 1 Not at all
- 2 A little
- 3 Somewhat
- 4 A lot
- 5 Very much

N14Q20J

k. I use strategies to remember things.

- 1 Not at all
- 2 A little
- 3 Somewhat
- 4 A lot
- 5 Very much

N14Q20K

l. I monitor myself so that I can catch any mistakes.

- 1 Not at all
- 2 A little
- 3 Somewhat
- 4 A lot
- 5 Very much

N14Q20L