



## Spring 2016 Canadian National College Health Assessment

The following questions ask about various aspects of your health. This survey is completely voluntary. You may choose not to participate or not to answer any specific questions. You may skip any question you are not comfortable answering. The survey is confidential. E-mail contact information is destroyed before data are compiled to protect confidentiality. Composite data will then be shared with your campus for use in health promotion activities.

**NAVIGATE WITH THE MOUSE OR PRESS THE TAB KEY AFTER EACH ENTRY  
DO NOT USE THE ENTER KEY**

### Health, Health Education, and Safety

#### 1) How would you describe your general health?

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know

#### 2A) Have you received information on the following topics from your college or university? (Please mark the appropriate column for each row)

	No	Yes
Alcohol and other drug use	<input type="radio"/>	<input type="radio"/>
Cold/Flu/Sore throat	<input type="radio"/>	<input type="radio"/>
Depression/Anxiety	<input type="radio"/>	<input type="radio"/>
Eating disorders	<input type="radio"/>	<input type="radio"/>
Grief and loss	<input type="radio"/>	<input type="radio"/>
How to help others in distress	<input type="radio"/>	<input type="radio"/>
Injury prevention	<input type="radio"/>	<input type="radio"/>
Nutrition	<input type="radio"/>	<input type="radio"/>
Physical activity	<input type="radio"/>	<input type="radio"/>
Pregnancy prevention	<input type="radio"/>	<input type="radio"/>

**2B) Have you received information on the following topics from your college or university? (Please mark the appropriate column for each row)**

	No	Yes
Problem use of Internet/computer games	<input type="radio"/>	<input type="radio"/>
Relationship difficulties	<input type="radio"/>	<input type="radio"/>
Sexual assault/Relationship violence prevention	<input type="radio"/>	<input type="radio"/>
Sexually transmitted disease/infection (STD/I) prevention	<input type="radio"/>	<input type="radio"/>
Sleep difficulties	<input type="radio"/>	<input type="radio"/>
Stress reduction	<input type="radio"/>	<input type="radio"/>
Suicide prevention	<input type="radio"/>	<input type="radio"/>
Tobacco use	<input type="radio"/>	<input type="radio"/>
Violence prevention	<input type="radio"/>	<input type="radio"/>

**3A) Are you interested in receiving information on the following topics from your college or university? (Please mark the appropriate column for each row)**

	No	Yes
Alcohol and other drug use	<input type="radio"/>	<input type="radio"/>
Cold/Flu/Sore throat	<input type="radio"/>	<input type="radio"/>
Depression/Anxiety	<input type="radio"/>	<input type="radio"/>
Eating disorders	<input type="radio"/>	<input type="radio"/>
Grief and loss	<input type="radio"/>	<input type="radio"/>
How to help others in distress	<input type="radio"/>	<input type="radio"/>
Injury prevention	<input type="radio"/>	<input type="radio"/>
Nutrition	<input type="radio"/>	<input type="radio"/>
Physical activity	<input type="radio"/>	<input type="radio"/>
Pregnancy prevention	<input type="radio"/>	<input type="radio"/>

**3B) Are you interested in receiving information on the following topics from your college or university? (Please mark the appropriate column for each row)**

	No	Yes
Problem use of Internet/computer games	<input type="radio"/>	<input type="radio"/>
Relationship difficulties	<input type="radio"/>	<input type="radio"/>
Sexual assault/Relationship violence prevention	<input type="radio"/>	<input type="radio"/>
Sexually transmitted disease/infection (STD/I) prevention	<input type="radio"/>	<input type="radio"/>
Sleep difficulties	<input type="radio"/>	<input type="radio"/>
Stress reduction	<input type="radio"/>	<input type="radio"/>
Suicide prevention	<input type="radio"/>	<input type="radio"/>
Tobacco use	<input type="radio"/>	<input type="radio"/>
Violence prevention	<input type="radio"/>	<input type="radio"/>

**4) Within the last 12 months, how often did you: (Please mark the appropriate column for each row)**

	N/A, did not do this activity within the <b>last 12 months</b>	Never	Rarely	Sometimes	Most of the time	Always
Wear a seatbelt when you rode in a car?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wear a helmet when you rode a bicycle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wear a helmet when you rode a motorcycle?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wear a helmet when you were inline skating?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**5) Within the last 12 months: (Please mark the appropriate column for each row)**

	No	Yes
Were you in a physical fight?	<input type="radio"/>	<input type="radio"/>
Were you physically assaulted (do not include sexual assault)?	<input type="radio"/>	<input type="radio"/>
Were you verbally threatened?	<input type="radio"/>	<input type="radio"/>
Were you sexually touched without your consent?	<input type="radio"/>	<input type="radio"/>
Was sexual penetration attempted (vaginal, anal, oral) without your consent?	<input type="radio"/>	<input type="radio"/>
Were you sexually penetrated (vaginal, anal, oral) without your consent?	<input type="radio"/>	<input type="radio"/>
Were you a victim of stalking (e.g., waiting for you outside your classroom, residence, or office; repeated emails/phone calls)?	<input type="radio"/>	<input type="radio"/>

**6) Within the last 12 months, have you been in an intimate (coupled/partnered) relationship that was: (Please mark the appropriate column for each row)**

	No	Yes
Emotionally abusive? (e.g., called derogatory names, yelled at, ridiculed)	<input type="radio"/>	<input type="radio"/>
Physically abusive? (e.g., kicked, slapped, punched)	<input type="radio"/>	<input type="radio"/>
Sexually abusive? (e.g., forced to have sex when you didn't want it, forced to perform or have an unwanted sexual act performed on you)	<input type="radio"/>	<input type="radio"/>

**7) How safe do you feel: (Please mark the appropriate column for each row)**

	Not safe at all	Somewhat unsafe	Somewhat safe	Very safe
On this campus (daytime)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
On this campus (nighttime)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the community surrounding this school (daytime)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the community surrounding this school (nighttime)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





**One drink of alcohol is defined as a 12 oz. can or bottle of beer or wine cooler, a 4 oz. glass of wine, or a shot of liquor straight or in a mixed drink.**

**10) The last time you "partied"/socialized how many drinks of alcohol did you have? (If you did not drink alcohol, please enter 0)**

\_\_\_\_\_ Drinks

**11) The last time you "partied"/socialized, over how many hours did you drink alcohol? (If you did not drink alcohol, please enter 0)**

\_\_\_\_\_ Hours

**12) How many drinks of alcohol do you think the typical student at your school had the last time he/she "partied"/socialized? (If you think the typical student at your school does not drink alcohol, please enter 0)**

\_\_\_\_\_ Drinks

**13) Over the last two weeks, how many times have you had five or more drinks of alcohol at a sitting?**

- N/A, don't drink
- None
- 1 time
- 2 times
- 3 times
- 4 times
- 5 times
- 6 times
- 7 times
- 8 times
- 9 times
- 10 or more times

**14) Within the last 30 days, did you: (Please mark the appropriate column for each row)**

	N/A, don't drive	N/A, don't drink	No	Yes
Drive after drinking any alcohol at all	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drive after drinking five or more drinks of alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**15) During the last 12 months, when you "partied"/socialized, how often did you:  
(Please mark the appropriate column for each row)**

	N/A, don't drink	Never	Rarely	Sometimes	Most of the time	Always
Alternate non-alcoholic with alcoholic beverages	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoid drinking games	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Choose not to drink alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Determine, in advance, not to exceed a set number of drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat before and/or during drinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have a friend let you know when you have had enough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keep track of how many drinks you were having	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pace your drinks to 1 or fewer per hour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stay with the same group of friends the entire time you were drinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stick with only one kind of alcohol when drinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use a designated driver	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**16) Within the last 12 months, have you experienced any of the following when drinking alcohol? (Please mark the appropriate column for each row)**

	N/A, don't drink	No	Yes
Did something you later regretted	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forgot where you were or what you did	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Got in trouble with the police	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Someone had sex with me <b>without my</b> consent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Had sex with someone <b>without their</b> consent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Had unprotected sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physically injured yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physically injured another person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seriously considered suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**17A) Within the last 30 days, what percent of students at your school used cigarettes? State your best estimate.**

\_\_\_\_\_ Percent

**17B) Within the last 30 days, what percent of students at your school used alcohol? State your best estimate.**

\_\_\_\_\_ Percent

**17C) Within the last 30 days, what percent of students at your school used marijuana? State your best estimate.**

\_\_\_\_\_ Percent

**18) In the last 12 months, have you taken any of the following prescriptions drugs that were not prescribed to you? (Please mark the appropriate column for each row)**

	No	Yes
Antidepressants (e.g., Celexa, Lexapro, Prozac, Wellbutrin, Zoloft)	<input type="radio"/>	<input type="radio"/>
Erectile dysfunction drugs (e.g., Viagra, Cialis, Levitra)	<input type="radio"/>	<input type="radio"/>
Pain killers (e.g., OxyContin, Vicodin, Codeine)	<input type="radio"/>	<input type="radio"/>
Sedatives (e.g., Xanax, Valium)	<input type="radio"/>	<input type="radio"/>
Stimulants (e.g., Ritalin, Adderall)	<input type="radio"/>	<input type="radio"/>

## Sex Behavior and Contraception

**19) Within the last 12 months, with how many partners have you had oral sex, vaginal intercourse, or anal intercourse? (If you did not have a sex partner within the last 12 months, please enter 0)**

\_\_\_\_\_ Number of Partners

**20) Within last 12 months, did you have sexual partner(s) who were: (Please mark the appropriate column for each row)**

	No	Yes
Women	<input type="radio"/>	<input type="radio"/>
Men	<input type="radio"/>	<input type="radio"/>
Trans women	<input type="radio"/>	<input type="radio"/>
Trans men	<input type="radio"/>	<input type="radio"/>
Genderqueer	<input type="radio"/>	<input type="radio"/>
Person(s) with another identity	<input type="radio"/>	<input type="radio"/>

**21) Within the last 30 days, did you have: (Please mark the appropriate column for each row)**

	No, have never done this sexual activity	No, have done this sexual activity in the past but not in the <b>last 30 days</b>	Yes
Oral sex?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal intercourse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal intercourse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**22) Within the last 30 days, how often did you or your partner(s) use a condom or other protective barrier (e.g., male condom, female condom, dam, glove) during: (Please mark the appropriate column for each row)**

	N/A, never did this sexual activity	Have not done this sexual activity during the <b>last 30 days</b>	Never	Rarely	Sometimes	Most of the time	Always
Oral sex?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anal intercourse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**23A) Did you or your partner use a method of birth control to prevent pregnancy the last time you had vaginal intercourse?**

- Yes
- N/A, have not had vaginal intercourse
- No, have not had vaginal intercourse that could result in a pregnancy
- No, did not want to prevent pregnancy
- No, did not use any birth control method
- Don't know

**23B) Please indicate whether or not you or your partner used each of the following methods of birth control to prevent pregnancy the last time you had vaginal intercourse. (Please mark the appropriate column for each row)**

	No	Yes
Birth control pills (monthly or extended cycle)	<input type="radio"/>	<input type="radio"/>
Birth control shots	<input type="radio"/>	<input type="radio"/>
Birth control implants	<input type="radio"/>	<input type="radio"/>
Birth control patch	<input type="radio"/>	<input type="radio"/>
Vaginal ring	<input type="radio"/>	<input type="radio"/>
Intrauterine device (IUD)	<input type="radio"/>	<input type="radio"/>
Male condom	<input type="radio"/>	<input type="radio"/>
Female condom	<input type="radio"/>	<input type="radio"/>
Diaphragm or cervical cap	<input type="radio"/>	<input type="radio"/>
Contraceptive sponge	<input type="radio"/>	<input type="radio"/>
Spermicide (e.g., foam, jelly, cream)	<input type="radio"/>	<input type="radio"/>
Fertility awareness (e.g., calendar, mucous, basal body temperature)	<input type="radio"/>	<input type="radio"/>
Withdrawal	<input type="radio"/>	<input type="radio"/>
Sterilization (e.g., hysterectomy, tubes tied, or vasectomy)	<input type="radio"/>	<input type="radio"/>
Other method	<input type="radio"/>	<input type="radio"/>

**24) Within the last 12 months, have you or your partner(s) used emergency contraception (“morning after pill”)?**

- N/A, have not had vaginal intercourse in the **last 12 months**
- No
- Yes
- Don't know

**25) Within the last 12 months, have you or your partner(s) become pregnant?**

- N/A, have not had vaginal intercourse in the **last 12 months**
- No
- Yes, unintentionally
- Yes, intentionally
- Don't know

## **Weight, Nutrition, and Exercise**

**26) How do you describe your weight?**

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

**27) Are you trying to do any of the following about your weight?**

- I am not trying to do anything about my weight
- Stay the same weight
- Lose weight
- Gain weight

**28) How many servings of fruits and vegetables do you usually have per day? (1 serving = 1 medium piece of fruit; 1/2 cup fresh, frozen, or canned fruits/vegetables; 3/4 cup fruit/vegetable juice; 1 cup salad greens; or 1/4 cup dried fruit)**

- 0 servings per day
- 1-2 servings per day
- 3-4 servings per day
- 5 or more servings per day

**29) On how many of the past 7 days did you: (Please mark the appropriate column for each row)**

	0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
Do <b>moderate-intensity</b> cardio or aerobic exercise (caused a noticeable increase in heart rate, such as a brisk walk) for at least <b>30 minutes</b> ?	<input type="radio"/>							
Do <b>vigorous-intensity</b> cardio or aerobic exercise (caused large increases in breathing or heart rate, such as jogging) for at least <b>20 minutes</b> ?	<input type="radio"/>							
Do 8-10 strength training exercises (such as resistance weight machines) for 8-12 repetitions each?	<input type="radio"/>							

## Mental Health

**30) Have you ever: (Please mark the appropriate column for each row)**

	No, never	No, not in the <b>last 12 months</b>	Yes. in the <b>last 2 weeks</b>	Yes, in the <b>last 30 days</b>	Yes, in the <b>last 12 months</b>
Felt things were hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt overwhelmed by all you had to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt exhausted (not from physical activity)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt very lonely	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt very sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt so depressed that it was difficult to function	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt overwhelming anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt overwhelming anger	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intentionally cut, burned, bruised, or otherwise injured yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seriously considered suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attempted suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



**32) Have you ever been diagnosed with depression?**

- No
- Yes

**33) Within the last 12 months, have any of the following been traumatic or very difficult for you to handle? (Please mark the appropriate column for each row)**

	No	Yes
Academics	<input type="radio"/>	<input type="radio"/>
Career-related issue	<input type="radio"/>	<input type="radio"/>
Death of a family member or friend	<input type="radio"/>	<input type="radio"/>
Family problems	<input type="radio"/>	<input type="radio"/>
Intimate relationships	<input type="radio"/>	<input type="radio"/>
Other social relationships	<input type="radio"/>	<input type="radio"/>
Finances	<input type="radio"/>	<input type="radio"/>
Health problem of a family member or partner	<input type="radio"/>	<input type="radio"/>
Personal appearance	<input type="radio"/>	<input type="radio"/>
Personal health issue	<input type="radio"/>	<input type="radio"/>
Sleep difficulties	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

**34) Have you ever received psychological or mental health services from any of the following? (Please mark the appropriate column for each row)**

	No	Yes
Counselor/Therapist/Psychologist	<input type="radio"/>	<input type="radio"/>
Psychiatrist	<input type="radio"/>	<input type="radio"/>
Other medical provider (e.g., physician, nurse practitioner)	<input type="radio"/>	<input type="radio"/>
Minister/Priest/Rabbi/Other clergy	<input type="radio"/>	<input type="radio"/>

**35) Have you ever received psychological or mental health services from your current college/university's Counseling or Health Service?**

- No
- Yes

**36) If in the future you were having a personal problem that was really bothering you, would you consider seeking help from a mental health professional?**

- No
- Yes

**37) Within the last 12 months, how would you rate the overall level of stress you have experienced?**

- No stress
- Less than average stress
- Average stress
- More than average stress
- Tremendous stress

## Physical Health

**38) Within the last 30 days, did you do any of the following? (Please mark the appropriate column for each row)**

	No	Yes
Exercise to lose weight	<input type="radio"/>	<input type="radio"/>
Diet to lose weight	<input type="radio"/>	<input type="radio"/>
Vomit or take laxatives to lose weight	<input type="radio"/>	<input type="radio"/>
Take diet pills to lose weight	<input type="radio"/>	<input type="radio"/>

**39) Have you: (Please mark the appropriate column for each row)**

	No	Yes	Don't know
Had a dental exam and cleaning in the <b>last 12 months</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(Males) Performed a testicular self exam in the <b>last 30 days</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(Females) Performed a breast self exam in the <b>last 30 days</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(Females) Had a routine gynecological exam in the <b>last 12 months</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Used sunscreen regularly with sun exposure?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ever been tested for Human Immunodeficiency Virus (HIV) infection?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**40) Have you received the following vaccinations (shots)? (Please mark the appropriate column for each row)**

	No	Yes	Don't know
Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Human Papillomavirus/HPV (cervical cancer vaccine)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Influenza (the flu) in the <b>last 12 months</b> (shot or nasal mist)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Measles, Mumps, Rubella	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meningococcal disease (meningococcal meningitis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Varicella (chicken pox)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**41A) Within the last 12 months, have you been diagnosed or treated by a professional for any of the following? (Please mark the appropriate column for each row)**

	No	Yes
Allergies	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>
Back pain	<input type="radio"/>	<input type="radio"/>
Broken bone/Fracture/Sprain	<input type="radio"/>	<input type="radio"/>
Bronchitis	<input type="radio"/>	<input type="radio"/>
Chlamydia	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Ear infection	<input type="radio"/>	<input type="radio"/>
Endometriosis	<input type="radio"/>	<input type="radio"/>
Genital herpes	<input type="radio"/>	<input type="radio"/>
Genital warts/Human Papillomavirus (HPV)	<input type="radio"/>	<input type="radio"/>
Gonorrhea	<input type="radio"/>	<input type="radio"/>
Hepatitis B or C	<input type="radio"/>	<input type="radio"/>

**41B) Within the last 12 months, have you been diagnosed or treated by a professional for any of the following? (Please mark the appropriate column for each row)**

	No	Yes
High blood pressure	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>
Human Immunodeficiency Virus (HIV)	<input type="radio"/>	<input type="radio"/>
Irritable Bowel Syndrome (IBS)	<input type="radio"/>	<input type="radio"/>
Migraine headache	<input type="radio"/>	<input type="radio"/>
Mononucleosis	<input type="radio"/>	<input type="radio"/>
Pelvic Inflammatory Disease (PID)	<input type="radio"/>	<input type="radio"/>
Repetitive stress injury (e.g., carpal tunnel syndrome)	<input type="radio"/>	<input type="radio"/>
Sinus infection	<input type="radio"/>	<input type="radio"/>
Strep throat	<input type="radio"/>	<input type="radio"/>
Tuberculosis	<input type="radio"/>	<input type="radio"/>
Urinary tract infection	<input type="radio"/>	<input type="radio"/>

**42) On how many of the past 7 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







**45D) Within the last 12 months, have any of the following affected your academic performance? (Please select the most serious outcome for each item below)**

	This did not happen to me/not applicable	I have experienced 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 or dropped the course	Significant disruption in thesis, dissertation, research, or practicum work
Roommate difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexually transmitted disease/infection (STD/I)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sinus infection/Ear infection/Bronchitis/Strep throat	<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"/>
Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please specify in "Additional Comments" box below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Demographic Characteristics

**46) How old are you?**

\_\_\_\_\_ Years

**47A) What sex were you assigned at birth, such as on an original birth certificate?**

- Female
- Male

**47B) Do you identify as transgender?**

- No
- Yes

**48) What term best describes your sexual orientation?**

- Asexual
- Bisexual
- Gay
- Lesbian
- Pansexual
- Queer
- Questioning
- Same Gender Loving
- Straight/Heterosexual
- Another identity (please specify) \_\_\_\_\_

**49) What is your height in feet (') and inches (")?**

- Under 3' 6"
- 3' 6"
- 3' 7"
- 3' 8"
- 3' 9"
- 3' 10"
- 3' 11"
- 4' 0"
- 4' 1"
- 4' 2"
- 4' 3"
- 4' 4"
- 4' 5"
- 4' 6"
- 4' 7"
- 4' 8"
- 4' 9"
- 4' 10"
- 4' 11"
- 5' 0"
- 5' 1"
- 5' 2"
- 5' 3"
- 5' 4"
- 5' 5"
- 5' 6"
- 5' 7"
- 5' 8"
- 5' 9"
- 5' 10"
- 5' 11"
- 6' 0"
- 6' 1"
- 6' 2"
- 6' 3"
- 6' 4"
- 6' 5"
- 6' 6"
- 6' 7"
- 6' 8"
- 6' 9"
- 6' 10"
- 6' 11"
- 7' 0"
- Over 7' 0"

**50) What is your weight in pounds?**

\_\_\_\_\_Pounds

**51) What is your year in school?**

- 1st year undergraduate
- 2nd year undergraduate
- 3rd year undergraduate
- 4th year undergraduate
- 5th year or more undergraduate
- Graduate or professional
- Not seeking a degree
- Other

**52) What is your enrollment status?**

- Full-time
- Part-time
- Other

**53) Have you transferred to this college or university within the last 12 months?**

- No
- Yes

**54) What is your racial or ethnic identification? (select all that apply)**

- Aboriginal (Inuit, Metis, North American Indian, etc.; status or non-status)
- Arab
- Black
- Chinese
- Filipino
- Japanese
- Korean
- Latin American
- South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.)
- West Asian (e.g., Iranian, Afghan, etc.)
- White
- Multiracial
- Other

**55) Are you an international student?**

- No
- Yes

**56) What is your relationship status?**

- Not in a relationship
- In a relationship but not living together
- In a relationship and living together

**57) What is your marital status?**

- Single
- Married/Partnered
- Separated
- Divorced
- Other

**58) Where do you currently live?**

- Campus residence hall
- Fraternity or sorority house
- Other college/university housing
- Parent/guardian's home
- Other off-campus housing
- Other

**59) Are you a member of a social fraternity or sorority? (e.g., National Interfraternity Conference, National Panhellenic Conference, National Pan-Hellenic Council, National Association of Latino Fraternal Organizations)**

- No
- Yes

**60) How many hours a week do you work for pay?**

- 0 hours
- 1-9 hours
- 10-19 hours
- 20-29 hours
- 30-39 hours
- 40 hours
- More than 40 hours

**61) How many hours a week do you volunteer?**

- 0 hours
- 1-9 hours
- 10-19 hours
- 20-29 hours
- 30-39 hours
- 40 hours
- More than 40 hours

**62) What is your approximate cumulative grade average?**

- A
- B
- C
- D/F
- N/A

**63) Within the last 12 months, have you participated in organized college athletics at any of the following levels? (Please mark the appropriate column for each row)**

	No	Yes
Varsity	<input type="radio"/>	<input type="radio"/>
Club sports	<input type="radio"/>	<input type="radio"/>
Intramurals	<input type="radio"/>	<input type="radio"/>

**64) Do you have any of the following? (Please mark the appropriate column for each row)**

	No	Yes
Attention Deficit and Hyperactivity Disorder (ADHD)	<input type="radio"/>	<input type="radio"/>
Chronic illness (e.g., cancer, diabetes, auto-immune disorders)	<input type="radio"/>	<input type="radio"/>
Deafness/Hearing loss	<input type="radio"/>	<input type="radio"/>
Learning disability	<input type="radio"/>	<input type="radio"/>
Mobility/Dexterity disability	<input type="radio"/>	<input type="radio"/>
Partial sightedness/Blindness	<input type="radio"/>	<input type="radio"/>
Psychiatric condition	<input type="radio"/>	<input type="radio"/>
Speech or language disorder	<input type="radio"/>	<input type="radio"/>
Other disability	<input type="radio"/>	<input type="radio"/>

**65) Are you currently or have you been a member of the Canadian Forces (Regular Force or Reserve)?**

- No
- Yes and I **have** deployed to an area of hazardous duty
- Yes and I **have not** deployed to an area of hazardous duty



**68B) Please answer the following questions about how you have been feeling during the past month. Please mark the answer that best represents how often you have experienced or felt the following: During the past month, how often do you feel...**

	Never	Once or Twice	About Once a Week	About 2 or 3 times a week	Almost Every Day	Every Day
That the way our society works makes sense to you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That you liked most parts of your personality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Good at managing the responsibilities of your daily life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That you had warm and trusting relationships with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That you had experiences that challenged you to grow and become a better person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confident to think or express your own ideas and opinions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That your life has a sense of direction or meaning to it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you for taking the time and thought to complete this survey. We appreciate your participation!