

2019 Delaware Youth Risk Behavior Survey

Middle School Questionnaire

This survey is about health behavior. It has been developed so you can tell us what you do that may affect your health. The information you give will be used to develop better health education for young people like yourself.

DO NOT write your name on this survey. The answers you give will be kept private. No one will know what you write. Answer the questions based on what you really do.

Completing the survey is voluntary. Whether or not you answer the questions will not affect your grade in this class. If you are not comfortable answering a question, just leave it blank.

The questions that ask about your background will be used only to describe the types of students completing this survey. The information will not be used to find out your name. No names will ever be reported.

Make sure to read every question. Fill in the circles completely. When you are finished, follow the instructions of the person giving you the survey.

Thank you very much for your help.

DIRECTIONS

Use a #2 pencil only.

Make dark marks.

Fill in a response like this: A B C D

To change your answer, erase completely.

PLEASE DO NOT WRITE IN THIS AREA



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1. What is your zip code?
Please fill in the boxes at the top, then fill in the circles in each column.

Zip Code				
0	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9

2. How old are you?
- 10 years old or younger
 - 11 years old
 - 12 years old
 - 13 years old
 - 14 years old
 - 15 years old
 - 16 years old or older

3. What is your sex?
- Female
 - Male

4. In what grade are you?
- 6th grade
 - 7th grade
 - 8th grade
 - Ungraded or other grade

5. Are you Hispanic or Latino?
- Yes
 - No

6. What is your race? **(Select one or more responses.)**
- American Indian or Alaska Native
 - Asian
 - Black or African American
 - Native Hawaiian or Other Pacific Islander
 - White

7. How tall are you without your shoes on?
Directions:
Write your height in the shaded blank boxes. Fill in the matching oval below each number.

Example

Height	
Feet	Inches
5	7
<input type="radio"/> 3	<input type="radio"/> 0
<input type="radio"/> 4	<input type="radio"/> 1
<input checked="" type="radio"/> 5	<input type="radio"/> 2
<input type="radio"/> 6	<input type="radio"/> 3
<input type="radio"/> 7	<input type="radio"/> 4
	<input type="radio"/> 5
	<input type="radio"/> 6
	<input checked="" type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 11

Height	
Feet	Inches
<input type="radio"/> 3	<input type="radio"/> 0
<input type="radio"/> 4	<input type="radio"/> 1
<input type="radio"/> 5	<input type="radio"/> 2
<input type="radio"/> 6	<input type="radio"/> 3
<input type="radio"/> 7	<input type="radio"/> 4
	<input type="radio"/> 5
	<input type="radio"/> 6
	<input type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 11

8. How much do you weigh without your shoes on?
Directions:
Write your weight in the shaded blank boxes. Fill in the matching oval below each number.

Example

Weight		
Pounds		
1	5	2
<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0
<input checked="" type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2	<input checked="" type="radio"/> 2
	<input type="radio"/> 3	<input type="radio"/> 3
	<input type="radio"/> 4	<input type="radio"/> 4
	<input checked="" type="radio"/> 5	<input type="radio"/> 5
	<input type="radio"/> 6	<input type="radio"/> 6
	<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8	<input type="radio"/> 8
	<input type="radio"/> 9	<input type="radio"/> 9

Weight		
Pounds		
<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3	<input type="radio"/> 3
	<input type="radio"/> 4	<input type="radio"/> 4
	<input type="radio"/> 5	<input type="radio"/> 5
	<input type="radio"/> 6	<input type="radio"/> 6
	<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8	<input type="radio"/> 8
	<input type="radio"/> 9	<input type="radio"/> 9

9. During the past 12 months, how would you describe your grades in school?
- Mostly A's
 - Mostly B's
 - Mostly C's
 - Mostly D's
 - Mostly F's
 - None of these grades
 - Not sure

The next 2 questions ask about safety.

- 10. How often do you wear a seat belt when **riding** in a car?
 - Never
 - Rarely
 - Sometimes
 - Most of the time
 - Always
- 11. Have you ever ridden in a car driven by someone who had been drinking alcohol?
 - Yes
 - No
 - Not sure

The next 4 questions ask about violence-related behaviors.

- 12. Have you ever carried a **weapon**, such as a gun, knife, or club?
 - Yes
 - No
- 13. Have you ever been in a physical fight?
 - Yes
 - No
- 14. During the past 12 months, did **someone you were dating or going out with purposely** try to control you or emotionally hurt you? (Count such things as being told who you could or could not spend time with, being humiliated in front of others, or being threatened if you did not do what they wanted.)
 - I did not date or go out with anyone during the past 12 months
 - Yes
 - No
- 15. During the past 12 months, did **someone you were dating or going out with** physically hurt you on purpose? (Count such things as being hit, slammed into something, or injured with an object or weapon.)
 - I did not date or go out with anyone during the past 12 months
 - Yes
 - No

The next 2 questions ask about bullying. **Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.**

- 16. Have you ever been bullied **on school property**?
 - Yes
 - No
- 17. Have you ever been **electronically** bullied? (Count being bullied through texting, Instagram, Facebook, or other social media.)
 - Yes
 - No

The next 3 questions ask about your emotions and feelings.

- 18. During the past 12 months, did you ever feel so sad or hopeless almost every day **for two weeks or more** in a row that you stopped doing some usual activities?
 - Yes
 - No
- 19. Do you ever feel sad, empty, hopeless, angry, or anxious?
 - Yes
 - No
- 20. When you feel sad, empty, hopeless, angry, or anxious, how often do you get the kind of help you need?
 - I do not feel sad, empty, hopeless, angry, or anxious
 - Never
 - Rarely
 - Sometimes
 - Most of the time
 - Always

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The next question asks about intentionally hurting yourself.

21. During the past 12 months, did you do something to purposely hurt yourself without wanting to die, such as cutting or burning yourself on purpose?

- Yes
- No

The next 3 questions ask about attempted suicide. Sometimes people feel so sad and depressed that they may consider attempting suicide or killing themselves.

22. Have you ever **seriously** thought about killing yourself?

- Yes
- No

23. Have you ever made a **plan** about how you would kill yourself?

- Yes
- No

24. Have you ever tried to kill yourself?

- Yes
- No

The next 4 questions ask about cigarette smoking.

25. Have you ever tried cigarette smoking, even one or two puffs?

- Yes
- No

26. How old were you when you smoked a whole cigarette for the first time?

- I have never smoked a whole cigarette
- 8 years old or younger
- 9 years old
- 10 years old
- 11 years old
- 12 years old
- 13 years old or older

27. During the past 30 days, on how many days did you smoke cigarettes?

- 0 days
- 1 or 2 days
- 3 to 5 days
- 6 to 9 days
- 10 to 19 days
- 20 to 29 days
- All 30 days

28. During the past 30 days, on the days you smoked, how many cigarettes did you smoke **per day**?

- I did not smoke cigarettes during the past 30 days
- Less than 1 cigarette per day
- 1 cigarette per day
- 2 to 5 cigarettes per day
- 6 to 10 cigarettes per day
- 11 to 20 cigarettes per day
- More than 20 cigarettes per day

The next 4 questions ask about electronic vapor products, such as JUUL, Vuse, MarkTen, and blu. Electronic vapor products include e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods.

29. Have you ever used an electronic vapor product?

- Yes
- No

30. During the past 30 days, on how many days did you use an electronic vapor product?

- 0 days
- 1 or 2 days
- 3 to 5 days
- 6 to 9 days
- 10 to 19 days
- 20 to 29 days
- All 30 days

31. During the past 30 days, how did you usually get your own electronic vapor products? (Select only **one** response.)

- I did not use any electronic vapor products during the past 30 days
- I bought them in a store such as a convenience store, supermarket, discount store, gas station, or vape store
- I got them on the Internet
- I gave someone else money to buy them for me
- I borrowed them from someone else
- A person who can legally buy these products gave them to me
- I took them from a store or another person
- I got them some other way

32. When you have used an electronic vapor device, what did you put in it? (Mark all that apply.)

- I have never used an electronic vapor device
- E-liquids that smell or taste good but have no nicotine or other drug
- Tobacco or nicotine products
- Marijuana or marijuana products
- Synthetic marijuana
- Other illegal drugs
- Nothing, I use the device without anything in it

The next 2 questions ask about other tobacco products.

33. During the past 30 days, on how many days did you use chewing tobacco, snuff, dip, snus, or dissolvable tobacco products, such as Copenhagen, Grizzly, Skoal, or Camel Snus? (Do not count any electronic vapor products.)

- 0 days
- 1 or 2 days
- 3 to 5 days
- 6 to 9 days
- 10 to 19 days
- 20 to 29 days
- All 30 days

34. During the past 30 days, on how many days did you smoke cigars, cigarillos, or little cigars?

- 0 days
- 1 or 2 days
- 3 to 5 days
- 6 to 9 days
- 10 to 19 days
- 20 to 29 days
- All 30 days

The next 3 questions ask about drinking alcohol. This includes drinking beer, wine, wine coolers, and liquor such as rum, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of wine for religious purposes.

35. Have you ever had a drink of alcohol, other than a few sips?

- Yes
- No

36. How old were you when you had your first drink of alcohol other than a few sips?

- I have never had a drink of alcohol other than a few sips
- 8 years old or younger
- 9 years old
- 10 years old
- 11 years old
- 12 years old
- 13 years old or older

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37. During the past 30 days, did you have a drink of alcohol, other than a few sips?

- Yes
- No

The next 3 questions ask about marijuana use. Marijuana also is called pot, weed, or cannabis.

38. Have you ever used marijuana?

- Yes
- No

39. How old were you when you tried marijuana for the first time?

- I have never tried marijuana
- 8 years old or younger
- 9 years old
- 10 years old
- 11 years old
- 12 years old
- 13 years old or older

40. During the past 30 days, did you use marijuana?

- Yes
- No

The next 2 questions ask about the use of prescription pain medicine without a doctor's prescription or differently than how a doctor told you to use it. For these questions, count drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet.

41. Have you ever taken **prescription pain medicine** without a doctor's prescription or differently than how a doctor told you to use it?

- Yes
- No

42. During the past 30 days, have you taken **prescription pain medicine** without a doctor's prescription or differently than how a doctor told you to use it?

- Yes
- No

The next 3 questions ask about other drugs.

43. Have you ever used **any** form of cocaine, including powder, crack, or freebase?

- Yes
- No

44. Have you ever sniffed glue, breathed the contents of spray cans, or inhaled any paints or sprays to get high?

- Yes
- No

45. Have you ever taken **steroid pills or shots** without a doctor's prescription?

- Yes
- No

The next 4 questions ask about sexual intercourse.

46. Have you ever had sexual intercourse?

- Yes
- No

47. How old were you when you had sexual intercourse for the first time?

- I have never had sexual intercourse
- 8 years old or younger
- 9 years old
- 10 years old
- 11 years old
- 12 years old
- 13 years old or older

48. During your life, with how many people have you had sexual intercourse?

- I have never had sexual intercourse
- 1 person
- 2 people
- 3 people
- 4 people
- 5 people
- 6 or more people

49. The **last time** you had sexual intercourse, did you or your partner use a condom?

- I have never had sexual intercourse
- Yes
- No

The next 2 questions ask about body weight.

50. How do **you** describe your weight?

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

51. Which of the following are you trying to do about your weight?

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

The next 5 questions ask about food you ate or drank yesterday. Think about all the meals and snacks you had from the time you got up until you went to bed. Be sure to include food you ate at home, at school, at restaurants, or anywhere else.

52. Yesterday, how many times did you eat **fruit**?
(Do **not** count fruit juice.)

- 0 times
- 1 time
- 2 times
- 3 or more times

53. Yesterday, how many times did you eat **green salad or other vegetables**? (Do **not** count potatoes.)

- 0 times
- 1 time
- 2 times
- 3 or more times

54. Yesterday, how many times did you drink a **can, bottle, or glass of soda or pop**, such as Coke, Pepsi, or Sprite? (Do **not** include diet soda or diet pop.)

- 0 times
- 1 time
- 2 times
- 3 or more times

55. Yesterday, how many **caffeinated drinks** did you have? (Please include coffee, tea, sodas, power drinks, energy drinks or other drinks with caffeine added.)

- 0 caffeinated drinks
- 1 caffeinated drink
- 2 caffeinated drinks
- 3 or more caffeinated drinks

56. Yesterday, how many **sugar-sweetened** beverages did you drink from a can, bottle, or glass? (Please include sports drinks, such as Gatorade or PowerAde, energy drinks, such as Red Bull or Jolt, lemonade, sweetened tea or coffee drinks, flavored milk, Snapple, or Sunny Delight. Do **not** count soda or pop.)

- 0 sugar-sweetened beverages
- 1 sugar-sweetened beverage
- 2 sugar-sweetened beverages
- 3 or more sugar-sweetened beverages

The following 3 questions ask about meals you have eaten recently.

57. During the past 7 days, on how many days did you eat **breakfast**?

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

58. During the past 7 days, on how many days did you eat dinner **at home with at least one of your parents**?

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

The next question asks about gambling.

67. In the past year, which of the following have you done? **(Mark all that apply.)**
- Played the lottery or scratch off tickets
 - Bet on fantasy sports
 - Bet on individual sports teams
 - Played Bingo for money
 - Bet on dice games such as craps
 - Bet money on a challenge (dare, fight, street race, etc.)
 - Played online gambling games for money
 - Bet on video games
 - Bet on games of personal skill such as pool, darts, or basketball

The next 9 questions ask about other health-related topics.

68. During the last 12 months, have you been to: **(Mark all that apply.)**
- A dentist for a check up, exam, or teeth cleaning
 - A doctor or other healthcare provider for a routine check-up
 - A mental health professional or counselor for any reason
 - An emergency room for healthcare
69. Has a doctor or nurse ever told you that you have asthma?
- Yes
 - No
 - Not Sure
70. Have you ever been taught about AIDS or HIV infection in school?
- Yes
 - No
 - Not sure
71. On an average school night, how many hours of sleep do you get?
- 4 or less hours
 - 5 hours
 - 6 hours
 - 7 hours
 - 8 hours
 - 9 hours
 - 10 or more hours

72. Are you deaf or do you have serious difficulty hearing?
- Yes
 - No
73. Do you have serious difficulty seeing, even when wearing glasses?
- Yes
 - No
74. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
- Yes
 - No
75. Do you have serious difficulty walking or climbing stairs?
- Yes
 - No
76. Have you been identified by a doctor or other health care professional as having difficulty concentrating, remembering, making decisions, or doing things because of a physical, learning, or emotional disability? **(Mark all that apply.)**
- No
 - Physical Disability
 - Learning Disability
 - Emotional Disability

The next question asks about where you live.

77. During the past 30 days, where did you usually sleep?
- In my parent's or guardian's home
 - In the home of a friend, family member, or other person because I had to leave my home or my parent or guardian cannot afford housing
 - In a shelter or emergency housing
 - In a motel or hotel
 - In a car, park, campground, or other public place
 - I do not have a usual place to sleep
 - Somewhere else

The next 5 questions ask about your feelings in the past four weeks.	1 NEVER	2	3	4	5 ALWAYS
78. How often did you feel <u>really</u> sad?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
79. How often did you feel <u>really</u> worried?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
80. How often did you feel afraid?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
81. How often did you have trouble relaxing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82. How often did you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next 8 questions ask about your relationship with your parent(s).

83. How wrong do your parents feel it would be for you to play violent video games, such as games that are rated M?
- Not at all wrong
 - A little bit wrong
 - Wrong
 - Very wrong

The following 8 questions ask about your relationship with your parent(s).	1 NEVER	2	3	4	5 ALWAYS
84. How often do you get along <u>well</u> with your parent(s)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
85. How often do your parent(s) spend time with you doing something fun?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
86. How often do your parent(s) show you they are proud of you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
87. How often do your parent(s) take an interest in your activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
88. How often do your parent(s) listen to you when you talk to them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
89. How often can you count on your parent(s) to be there when you need them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
90. How often do you and your parent(s) talk about the things that really matter?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
91. How often are you comfortable sharing your thoughts and feelings with your parent(s)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

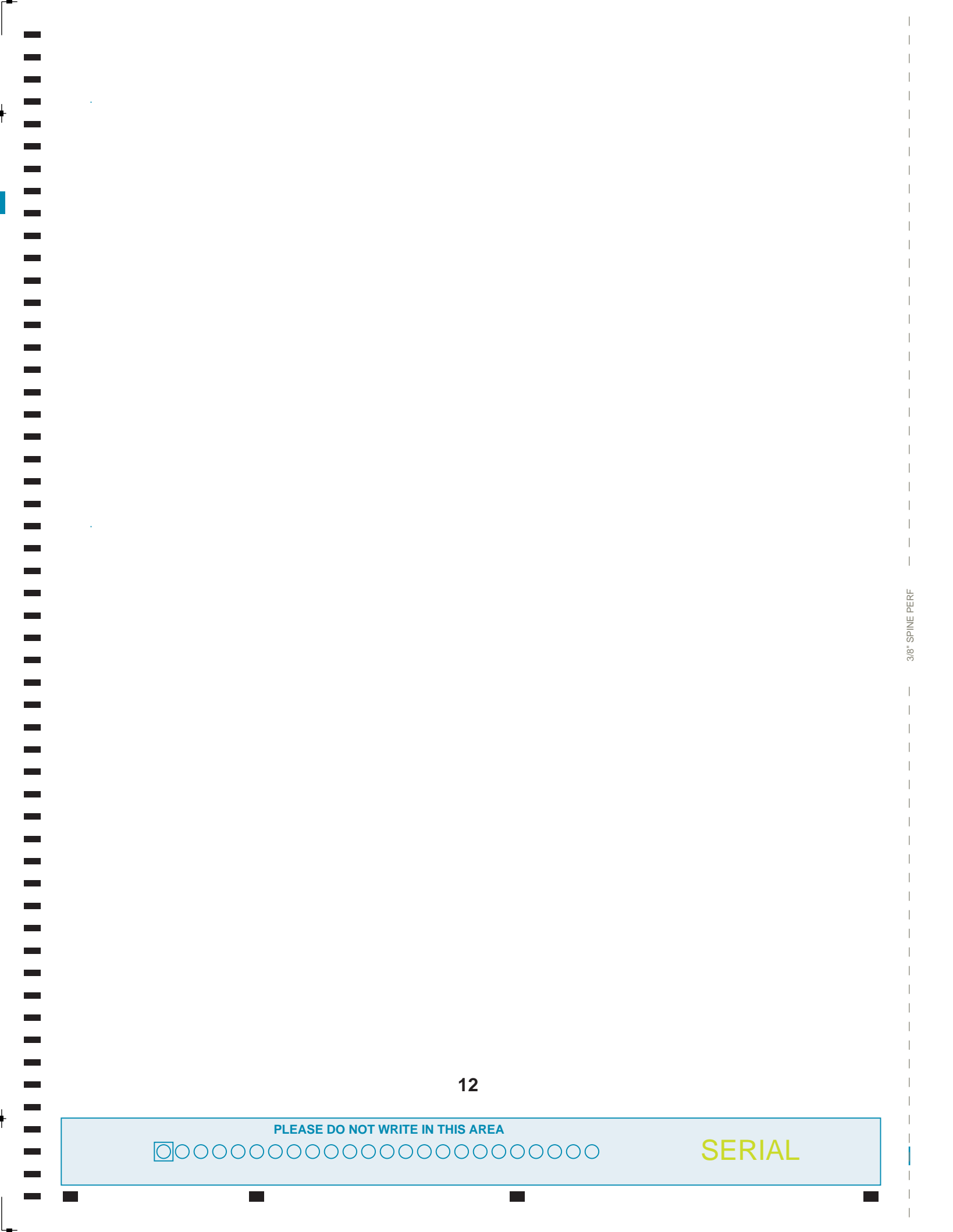
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This is the end of the survey.

Thank you very much for your help.



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