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HIP AND KNEE QUESTIONNAIRE

Dear Patient:

Since this is your first visit to our office, we would appreciate you filling out this questionnaire so that we can obtain the most accurate medical and orthopaedic history possible.

We thank you in advance for your patience in completing this document.

Sincerely,

Carlos J. Lavernia, M.D., F.A.A.O.S.

[Office Forms\Hip & Knee Questionnaire-Eng]

DEMOGRAPHIC INFORMATION

Please answer **ALL** questions as complete as possible. Thank you.

Last Name: _____ Maiden Name: _____

First Name, Middle Initial: _____ Sex: ☐ Male ☐ Female

Birthplace: _____ Date of Birth: _____

Marital Status: _____ Husband/Wife's Name: _____

☐ Single ☐ Widowed
☐ Married ☐ Divorced/Separated ☐ Significant Other

Local Address (City, State, Zip Code): _____

Permanent Address (if different from above): _____

Home Phone No.: _____ Work Phone No.: _____

Cellular Phone No.: _____

Social Security No.: _____ Driver's License No. and State issued in: _____

Email Address: _____

Occupation:

☐ Professional _____ ☐ Employed ☐ Self-employed ☐ Disabled
☐ Retired ☐ Unemployed ☐ Student ☐ Homemaker
☐ Other: _____

Level of Education:

☐ Elementary _____ (# of years)
☐ High School _____ (# of years)
☐ College _____ (# of years)
☐ Graduate Degree _____ (# of years) ☐ Masters ☐ PhD ☐ MD ☐ JD

Race:

☐ Black ☐ White ☐ Native-American ☐ Asian ☐ Other: _____

Ethnicity:

☐ African-American ☐ Caucasian ☐ Hispanic/Hispanic descent (specify): _____
☐ Asian/Pacific Islander ☐ Arabic ☐ Native American ☐ Other: _____

Religion (mark only one):

☐ Catholic ☐ Jewish ☐ Protestant ☐ Muslim ☐ Jehovah's Witness
☐ Christian (specify): _____ ☐ Other: _____

Nearest Relative *NOT LIVING WITH YOU*:

Relationship:

Address:_____

City:_____

State, Country:_____

Zip Code:_____

Home Phone No.:_____

Work Phone No.:_____

Closest Friend *NOT LIVING WITH YOU*:

Home Phone No.:_____

Work Phone No.:_____

Do you have an advance directive?: ☐ Yes ☐ No

If you are disabled, is the disability work-related?: ☐ Yes ☐ No

If you are unemployed, when was the last date you worked: ____/____/____

Is this is Worker's Compensation case?: ☐ Yes ☐ No

If YES, please provide the following information:

Name of Insurance Co.:_____

Adjuster's Name:_____

Phone No.:_____

Case No.:_____

Name of Employer:_____

Work Phone No.:_____

Employer's Address (City, State, Zip Code):_____

Is this a Litigation case?: ☐ Yes ☐ No

If YES, please provide the Attorney's Name:_____

Phone No.:_____

Case No.:_____

Referral Information:

☐ Primary physician ☐ Another physician

☐ Internet

☐ Newspaper

☐ Attorney

☐ **International Center**

☐ Insurance Carrier

☐ Yellow Pages

☐ Other _____

☐ Another patient (name): _____

Referring Physician:_____

Phone No.:_____

Primary Care Physician:_____

Phone No.:_____

Pharmacy Information: _____

Phone No.:_____

Patient Name: _____
Rev. 8.2018

Date: _____

CURRENT PROBLEM

Please check off the box on ALL that apply.

Hip: ☐ Left ☐ Right ☐ Both ☐ Other **Age:** _____
Knee: ☐ Left ☐ Right ☐ Both

When did your pain begin?:

_____ days _____ weeks _____ months _____ years

When did your current pain start getting worse?:

_____ days _____ weeks _____ months _____ years

Did your pain start because of (check off the box on ALL that apply):

☐ Twisting injury ☐ Fracture ☐ Contusion
☐ Spontaneously ☐ Fall ☐ Car accident ☐ Other: _____

Do you feel any (check off all that apply):

☐ Pain ☐ Locking ☐ Other
☐ Swelling ☐ Loss of motion
☐ Weakness ☐ Aching
☐ Numbness ☐ Giving out

How is your pain (most of the time)? (ANSWER ONLY ONE):

☐ None ☐ Other _____
☐ Mild or occasional
☐ Only when standing
☐ Only when walking or climbing stairs
☐ Moderate-severe when weight bearing; unable to do any activity
☐ Severe, even at night
☐ Intense and permanent

How is your pain at night? (ANSWER ONLY ONE):

☐ None ☐ Continuous ☐ Intermittent

How is the pain with no activity (at rest)? (ANSWER ONLY ONE):

☐ None ☐ Mild ☐ Moderate ☐ Moderate-Severe ☐ Severe

What is the character of your pain? (ANSWER ONLY ONE):

☐ Sharp ☐ Dull ☐ Other _____

Where is your *knee* pain? (Mark ALL that apply):

☐ All over the knee ☐ Inside of the knee
☐ In front of the knee ☐ Back of the knee
☐ Outside the knee ☐ No knee pain
☐ Along the prior scar ☐ Other _____

Where is your *hip* pain? (Mark *ALL* that apply):

- ☐ Groin ☐ Front of thigh ☐ Other _____
☐ Buttock ☐ Outside of thigh
☐ Inside of thigh ☐ No hip pain

Symptoms are worsened by? (Mark *ALL* that apply):

- ☐ Walking ☐ Stairs ☐ Other _____
☐ Standing ☐ Lifting
☐ Sitting ☐ Carrying

Symptoms are improved by? (Mark *ALL* that apply):

- ☐ With nothing (no improvement) ☐ Other _____
☐ Walking
☐ Physical therapy
☐ Ice
☐ Rest
☐ Exercise
☐ Medications/Pills (specify which brand): _____

Please choose the sentence that best describes your activity level:

- ☐ Wholly inactive; dependent on others; cannot leave the resident.
☐ Mostly inactive; very restricted to minimum activities of daily living.
☐ Sometimes participates in mild activities as walking, limited housework & limited shopping.
☐ Regularly participates in mild activities.
☐ Sometimes participates in moderate activities such as swimming; can do unlimited housework or shopping.
☐ Regularly participates in moderate activities.
☐ Regularly participates in very active events, such as bicycling; and can lift up to 50 pounds.
☐ Regularly participates in very active events, such as bowling or golf.
☐ Sometimes participates in impact sports such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, or backpacking; can lift more than 50 pounds.
☐ Regularly participates in impact sports.

Walking tolerance (ANSWER ONLY ONE):

- ☐ Unlimited
☐ 6 to 20 blocks
☐ 2 to 5 blocks
☐ Less than 2 blocks
☐ Indoors only
☐ Unable

How long can you walk at one time *WITHOUT* support? (*WITHOUT* a cane, crutch, or walker?) (ANSWER ONLY ONE):

- ☐ Over an hour
- ☐ 31 to 60 minutes
- ☐ 11 to 30 minutes
- ☐ 2 to 10 minutes
- ☐ Less than 2 minutes, or indoors only.
- ☐ I am unable to walk *WITHOUT* support.

How do you climb stairs? (ANSWER ONLY ONE):

- ☐ Normally, without using the rail, one foot over the other, one foot on each step.
- ☐ Normally, but using the rail, one foot over the other, one foot on each step.
- ☐ Both feet on each step, taking only one step at a time.
- ☐ I am unable to climb stairs.

What level of support do you use? (ANSWER ONLY ONE):

- ☐ 1. None
- ☐ 2. A cane occasionally
- ☐ 3. A cane most of the time
- ☐ 4. A cane all the time
- ☐ 5. One crutch all the time
- ☐ 6. Two canes or two crutches
- ☐ 7. A walker
- ☐ 8. Unable to walk

If you answered 3, please specify:

- ☐ A long time with a cane, short time without a cane.
- ☐ I use one cane for less than one (1) hour, but it is difficult without a cane.

Do you limp when walking *WITHOUT* support? (*WITHOUT* a cane, crutch, or walker?) (ANSWER ONLY ONE):

- ☐ No limp
- ☐ Slight limp
- ☐ Moderate limp
- ☐ Severe limp
- ☐ I am unable to walk without support.

Car access (mark only the one that best describes you):

- ☐ I can get in and out of a car easily.
- ☐ It is difficult for me to get in and out of a car.
- ☐ I am unable to get in and out of a car.

Which of the following statements best describes your work situation during the past month? (ANSWER ONLY ONE):

- | | |
|---|--|
| ☐ Working full-time | ☐ Student, full-time |
| ☐ Working part-time | ☐ Disabled, why _____ |
| ☐ Unemployed because of my health | ☐ Other _____ |
| ☐ Unemployed, looking for work | |
| ☐ Retired or quit work because of hip or knee problems | |
| ☐ Retired for reasons unrelated to my hip or knee | |
| ☐ Homemaker, full-time | |

How much does your hip or knee limit your work or usual activities?

(ANSWER ONLY ONE):

- ☐ No limitations
- ☐ Slightly limits me
- ☐ Moderately limits me
- ☐ Greatly limits me
- ☐ Totally limits me

How much does your hip or knee limit or interfere with your sexual activity?

(ANSWER ONLY ONE):

- ☐ No limitations
- ☐ Slightly limits me
- ☐ Moderately limits me
- ☐ Greatly limits me
- ☐ Totally limits me
- ☐ I am not sexually active for reasons unrelated to my hip or knee.

Do you have difficulty putting your shoes and socks on the *SPECIFIED FOOT*?

(ANSWER ONLY ONE IN EACH COLUMN):

Left **Right**

- | | | |
|--------------------------|--------------------------|--------------------|
| ☐ | ☐ | No difficulty |
| ☐ | ☐ | Slight difficulty |
| ☐ | ☐ | Extreme difficulty |
| ☐ | ☐ | Unable to do so |

How do you arise from a chair to a standing position? (ANSWER ONLY ONE):

- ☐ I can stand up from a chair without using my arms to push off.
- ☐ I have to use my arms to push off when standing up from a chair.
- ☐ I am unable to stand up from a chair without someone's help.

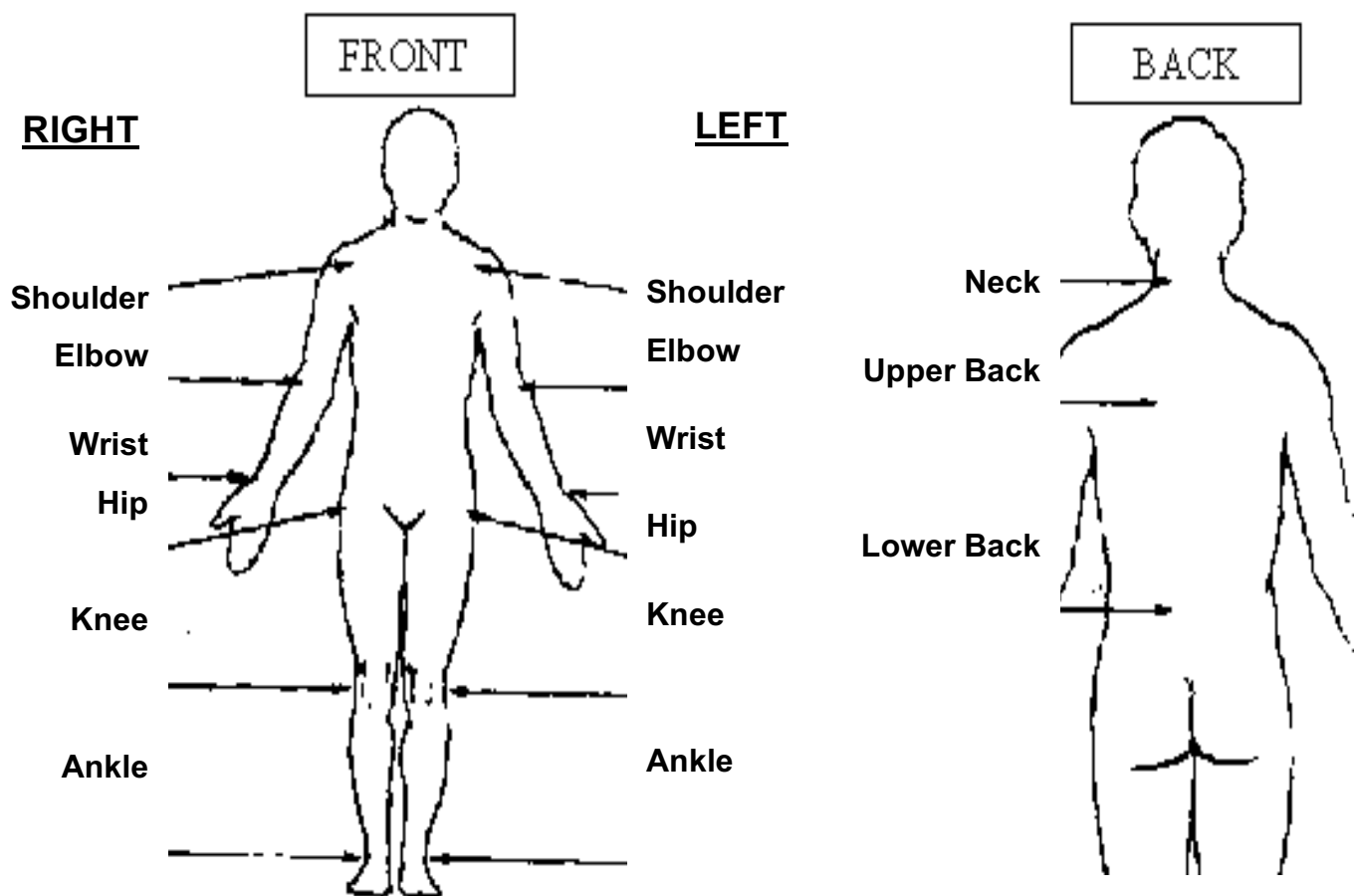
Do you feel any difference in leg length: ☐ Yes ☐ No ☐ I don't know

If you answered YES, which one feels shorter? ☐ Right ☐ Left

Please specify *how much shorter does your leg feel?*

- | | |
|---|---|
| ☐ Less than half-inch | ☐ Between 2 and 3 inches |
| ☐ Between half-inch and 1 inch | ☐ Three (3) inches |
| ☐ One (1) inch | ☐ More than 3 inches |
| ☐ Between 1 and 2 inches | ☐ I don't know |
| ☐ Two (2) inches | |

Circle additional areas where you feel significant pain:



Have you had previous **JOINT INJECTIONS**?: ☐ Yes ☐ No

If **YES**, please indicate the number of injections: _____

What type of injection? _____

Where was the injection? _____

Was the injection: ☐ Helpful ☐ Not helpful

If **HELPFUL**, for how long?: ____ days ____ weeks ____ months ____ years

When was your **LAST INJECTION**?: ____ days ____ weeks ____ months ____ years

Do you wear a brace on your hip or knee?: ☐ Yes ☐ No

If **YES**, what type?: _____

Was the brace: ☐ Helpful ☐ Not helpful

Have you ever had **PHYSICAL THERAPY**?: ☐ Yes ☐ No

If **YES**, was the physical therapy: ☐ Helpful ☐ Not helpful

Prior **HIP** surgeries:

☐ Hip replacement ☐ Core decompression ☐ Fusion ☐ Fracture
☐ Other: _____

Surgeon's Name: _____

Date of Surgery: _____ Hospital: _____

In any of the above surgeries, did you ever have complications with?:

☐ Anesthesia ☐ Blood clots/Bleeding ☐ Infection
☐ Other _____ ☐ None

Prior **KNEE** surgeries:

☐ Arthroscopy ☐ Replacement ☐ Osteotomy ☐ Fracture
☐ Fusion ☐ Core decompression ☐ Other: _____

Surgeon's Name: _____

Date of Surgery: _____ Hospital: _____

In any of the above surgeries, did you ever have complications with?:

☐ Anesthesia ☐ Blood clots/Bleeding ☐ Infection
☐ Other _____ ☐ None

Please mark with "C" ALL medications that you are currently taking for this pain and mark with a "P" the ones you have taken in the past for this pain:

___ NSAID	___ DILAUDID	___ PREDNISONE
___ ARTHROTEC	___ FELDENE	___ RELAFEN
___ ASPIRIN	___ GOLD	___ INDOCIN
___ LYRICA	___ CELEBREX	___ MORPHINE
___ NEURONTIN	___ CLINORIL	___ DAYPRO
___ MOTRIN	___ TYLENOL	___ CODEINE
___ NARCOTICS	___ TYLENOL #3	___ DARVON
___ NAPROSYN	___ OTC	___ NATURAL REMEDIES
___ PERCODAN	___ VOLTAREN	___ OTHERS
___ DEMEROL	___ PLAQUENIL	

Other anti-inflammatory or analgesic drugs not mentioned above:

Have you taken *OPIOIDS* in the past? ☐ Yes ☐ No

If *YES*, name of steroid(s) used: _____

Reason or medical condition for using steroids: _____

Dosage used: _____ mg. . . . for . . . ____ days ____ weeks ____ months ____ years

Last time it was used: _____

Are you taking *OPIOIDS* at this time? ☐ Yes ☐ No

If *YES*, name of steroid(s) used: _____

Reason or medical condition for using steroids: _____

Dosage used: _____ mg. . . . for . . . ____ days ____ weeks ____ months ____ years

Last time it was used: _____

Have you taken **STEROIDS** in the past? ☐ Yes ☐ No

If **YES**, name of steroid(s) used: _____

Reason or medical condition for using steroids: _____

Dosage used: _____ mg. . . . for . . . ____ days ____ weeks ____ months ____ years

Last time it was used: _____

TESTS that you have had done (for your *CURRENT PROBLEM*):

- | | |
|---|---|
| ☐ Plain x-rays | ☐ Blood tests |
| ☐ Nerve tests | ☐ C.A.T. scan |
| ☐ Diagnostic arthroscopy | ☐ Bone scan |
| ☐ M.R.I. | ☐ Fluid analysis |
| ☐ Other: _____ | |

Please list other **ORTHOPAEDIC SURGEONS** that you have seen:

First and Last Name: _____

Phone No.: _____ City & State: _____

First and Last Name: _____

Phone No.: _____ City & State: _____

Did they recommend surgery?: ☐ Yes ☐ No

What type of surgery was recommended?: _____

SOCIAL HISTORY/HOUSING:

You live with: ☐ Wife/Husband ☐ Friends
☐ Girlfriend/Boyfriend ☐ Relatives
☐ Other: _____

You live in a: ☐ House ☐ Nursing Home
☐ Apartment: ☐ Assisted Living Facility
(What floor? ____) ☐ Other: _____

Are there any stairs in your house, apartment, etc.?: ☐ Yes ☐ No

Is there an elevator in your house, apartment, etc.?: ☐ Yes ☐ No

In case you need surgery, who will take care of you where you live?

- | | |
|--|--|
| ☐ My relatives | ☐ My son/daughter |
| ☐ My husband/wife | ☐ Significant other ☐ Other: _____ |

FAMILY HISTORY: Has anyone in your family had history of any of the following?:

Condition/Disease:

Relationship:

Avascular Necrosis (AVN)	☐ Yes ☐ No ☐ Do not know	_____
Cancer (CA)	☐ Yes ☐ No ☐ Do not know	_____
Diabetes (DM)	☐ Yes ☐ No ☐ Do not know	_____
Heart Disease (CAD)	☐ Yes ☐ No ☐ Do not know	_____
High Cholesterol	☐ Yes ☐ No ☐ Do not know	_____
Blood Clotting Disorders	☐ Yes ☐ No ☐ Do not know	_____
Hypertension/High Blood Pressure (HTN)	☐ Yes ☐ No ☐ Do not know	_____
Osteoarthritis (OA)	☐ Yes ☐ No ☐ Do not know	_____
Rheumatoid Arthritis (RA)	☐ Yes ☐ No ☐ Do not know	_____
Systemic Lupus Erythematosus (SLE)	☐ Yes ☐ No ☐ Do not know	_____
Stroke	☐ Yes ☐ No ☐ Do not know	_____

ALLERGIES:

Please write the medication(s) or food(s) you are allergic to in the appropriate spaces:

- ☐ Pollen
☐ Medicines: _____
☐ Food: _____
☐ Other: _____
☐ No known allergies

Please list *ALL* the medications you are currently taking, the dosage, and for how long you have been taking them:

- EXAMPLE:** 1. Coumadin, 5 mg., every day, for 2 weeks
2. Percocet, 1 tab, every 6 hours, for 7 days

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

HABITS: Do you drink any **CAFFEINATED BEVERAGES?** (This includes **COFFEE, CHOCOLATE, TEA, SODAS**, etc):

NOW: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

PAST: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

Approximately how many number of cups of coffee/tea do you drink daily?
_____ cups of coffee _____ cups of tea

How often did you have a drink containing alcohol in the last year?

- ☐ Never
- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ None, I do not drink
- ☐ 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 or more

How often did you have six or more drinks on one occasion in the past year?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Do you smoke or use *TOBACCO* in any form? (*INHALED, CHEWED*, etc):

NOW: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

PAST: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

Approximately how many packs do you smoke daily?

_____ (# of packs) For how long? _____

GENERAL MEDICAL CONDITION:

Please mark **ALL THE BLANKS** that apply and explain, if necessary:

Height: ____ FEET ____ INCHES Weight: ____ LBS.

A. General health:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

B. Head:

- ☐ Headaches
- ☐ Past injury
- ☐ Other: _____

C. Neck:

- ☐ Stiffness
- ☐ Pain
- ☐ Arthritis
- ☐ Other: _____

D. Skin:

- ☐ Infections
- ☐ Boils
- ☐ Psoriasis/Rashes
- ☐ Other: _____

E. Eyes:

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| ☐ Blindness: | ☐ Right | ☐ Left | ☐ Both |
| ☐ Glasses or Contact Lenses | ☐ Right | ☐ Left | ☐ Both |
| ☐ Glaucoma | ☐ Right | ☐ Left | ☐ Both |
| ☐ Blurred Vision: | ☐ Right | ☐ Left | ☐ Both |
| ☐ Cataracts: | ☐ Right | ☐ Left | ☐ Both |
| ☐ Other: _____ | | | |

F. Constitution:

- ☐ Fever
- ☐ Chills
- ☐ Malaise
- ☐ Weight Loss
- ☐ Other: _____

- G. Ears:**
- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| ☐ Hearing Loss: | ☐ Right | ☐ Left | ☐ Both |
| ☐ Hearing aid | ☐ Right | ☐ Left | ☐ Both |
| ☐ Ringing/Buzzing | ☐ Right | ☐ Left | ☐ Both |
| ☐ Infection | ☐ Right | ☐ Left | ☐ Both |
| ☐ Other:_____ | ☐ Right | ☐ Left | ☐ Both |

- H. Nose and Throat:**
- ☐ Bleeding
 - ☐ Hoarseness
 - ☐ Polyps
 - ☐ Sinus trouble
 - ☐ Trouble swallowing
 - ☐ Other:_____

- I. Respiratory System Throat:**
- ☐ Asthma
 - ☐ Wheezing
 - ☐ Chronic Cough
 - ☐ Shortness of breath
 - ☐ Coughing up blood
 - ☐ Pain on breathing
 - ☐ Sleep Apnea/CPAP
 - ☐ Tuberculosis
 - ☐ Other:_____

- J. Cardiovascular System:**
- ☐ Chest pain
 - ☐ Heart disease (INFARCTS, ARRHYTHMIAS, DEFECTS, etc.) **Date:**_____
 - ☐ Leg cramps: ☐ at night ☐ while walking
 - ☐ Heartbeat: ☐ irregular ☐ fast
 - ☐ Blood pressure: ☐ high ☐ low
 - ☐ Cold fingers/toes
 - ☐ Sweating fingers/toes
 - ☐ Other:_____

- K. Bleeding:**
- ☐ Anemia
 - ☐ Bleeding problems
 - ☐ Blood clots
 - ☐ Bruise easily
 - ☐ Rectal bleeding
 - ☐ Bleeding by mouth
 - ☐ Prolonged bleeding after shaving or small cuts
 - ☐ Other:_____

L. Stomach and Bowel:

- ☐ Ulcer
- ☐ Loss of appetite
- ☐ Swelling
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ Nausea/Vomiting
- ☐ Pain
- ☐ Change in bowel habits
- ☐ Gallbladder problems
- ☐ Pancreatitis
- ☐ Bleeding
- ☐ IBS
- ☐ Diverticular Disease
- ☐ Other: _____

M. Urinary System

- ☐ Leakage
- ☐ Back pain
- ☐ Sores on genitalia
- ☐ Discharge/drainage
- ☐ Strong urine
- ☐ Bloody urine
- ☐ Frequent urination
- ☐ Nighttime urination
- ☐ Trouble urinating (starting, stopping)
- ☐ Urinary infections
- ☐ Other: _____

N. Metabolic:

- ☐ Diabetes
- ☐ Hypoglycemia (low blood sugar)
- ☐ Thyroid trouble
- ☐ High Cholesterol
- ☐ Other: _____

O. Neurological System/Headaches:

- ☐ Seizures (epilepsy)
- ☐ Paralysis
- ☐ Fainting
- ☐ Stroke
- ☐ Numbness
- ☐ Balance problems
- ☐ Other: _____

P. Rheumatoid:

- ☐ Lupus
- ☐ RA
- ☐ Osteoporosis
- ☐ Other: _____

Q. Psychological:

- ☐ Nervous breakdown
- ☐ Crying frequently
- ☐ Tension
- ☐ Feeling BLUE
- ☐ Anxious
- ☐ Stress-prone
- ☐ Insomnia
- ☐ Psychosis
- ☐ Exhausted
- ☐ Other: _____

R. Prior diseases or infections:

- ☐ Hepatitis
- ☐ Sexually transmitted: (Syphilis, AIDS, herpes, others...)
- ☐ Cancer: (what type): _____
- ☐ Infections: (what type): _____
- ☐ Other: _____

S. Female History:

- ☐ Menopause
- ☐ Menstruating: (If yes, please indicate date of last menstruation: _____)
- ☐ Birth control pills

T. Number of pregnancies: _____

U. Number of live births: _____

V. Prior surgeries: (Please specify the procedure and date the surgery was done.)

- ☐ Back fusion _____
- ☐ Brain surgery _____
- ☐ Thyroid surgery _____
- ☐ Heart bypass surgery _____
- ☐ Bowel removal _____
- ☐ Kidney removal _____
- ☐ Hysterectomy _____
- ☐ Kidney stones _____
- ☐ Lumbar disc removal _____
- ☐ Chest surgery _____
- ☐ Cataract removal: _____
- ☐ Stomach removal _____
- ☐ Colostomy _____
- ☐ Gallbladder removal _____
- ☐ Caesarian section _____
- ☐ Appendectomy _____
- ☐ Prostate removal _____
- ☐ Balloon angioplasty _____
- ☐ Bladder repair _____
- ☐ Hemorrhoidectomy _____
- ☐ Tubal ligation _____
- ☐ Vascular surgery _____
- ☐ Vein ligation/stripping _____
- ☐ Inguinal hernia repair: _____
- ☐ Other: _____

In any of the above surgeries, did you ever have complications with?:

- ☐ Anesthesia ☐ Blood clots/Bleeding ☐ Infection
- ☐ Other: _____

The following information is *VOLUNTARY, STRICTLY CONFIDENTIAL*, and used for *RESEARCH PURPOSES ONLY*:

Your annual income is:

- ☐ Less than \$13,000
- ☐ From \$13,001 to \$19,999
- ☐ From \$20,000 to \$39,999
- ☐ From \$40,000 to \$59,999
- ☐ From \$60,000 to \$79,999
- ☐ From \$80,000 to \$99,999
- ☐ More than \$100,000
- ☐ Prefer not to answer