

Appendix. Mobile Technology and Health Survey Instrument

The survey was printed on both sides and folded in half to distribute it as a “booklet”.

PART 4: Your use of other health technologies

19. Doctors often give patients papers with information. With cell phones, doctors or nurses could give you a video to watch or an app to use instead of papers to read. How helpful would it be for your doctor to give you information through your phone?

Very helpful
 Helpful
 A little bit helpful
 Not helpful at all

20. Some people communicate with their doctor or clinic through a “patient portal” on the internet (like MyChart or E-care). Does your clinic have a patient portal?

Yes
 No (Go to 21)
 I don't know (Go to 21)

20a. Do you use the patient portal?

Yes
 No

21. If you were using a patient portal or health app on your phone, how comfortable would you feel entering private information if:

a. Your doctor could see your information?

Very comfortable
 Comfortable
 Uncomfortable
 Very uncomfortable

b. The information is stored by a third party (like a website or company that is not part of your doctor's office)?

Very comfortable
 Comfortable
 Uncomfortable
 Very uncomfortable

Comments: _____

Mobile Technology and Health

This clinic is doing a research study with the University of Washington.

This survey will ask you about how you may use a cell phone to manage your health. Your answers, taken with other responses, will help your clinic provide better care to patients.

- The survey should take less than 5 minutes to fill out.
- Your answers are anonymous, which means that they cannot be traced back to you in any way.
- Your doctors and nurses will not see your answers.
- Taking part in this survey is up to you. It is voluntary. You do not have to answer any questions you do not want to answer.

DO NOT FILL OUT THE FORM IF:
(1) You are 17 years old or younger
(2) You have already filled out this form

PART 1: You and your phone

1. Do you have a cell phone... or a Blackberry, iPhone or other device that is also a cell phone?

Yes
 No (Go to PART 3)

2. Some cell phones are called “smartphones” because of certain features they have. Is your cell phone a smartphone, such as an iPhone, Android, Blackberry or Windows phone?

Yes
 No (Go to PART 3)

3. Have you ever used your phone to:

Find health or medical information
 Download or use a health “app”

Check all that apply. Track or manage a health issue (your diet or weight, activity, mood, blood pressure, etc.)
 None of these (Go to PART 3)

3a. How often do you use your phone for these health reasons?

Once a month or less
 2 or 3 times a month
 1 to 6 times a week
 Once a day or more



Site ID: _____

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**When you finish the survey,
please put it in the yellow drop box
by the front desk.**

Thank you!

If you have questions about this research study, please contact _____, (XXX) XXX-XXXX, _____, XXXXXX@XXX.XXX

PART 2: How you use your phone

4. How did you learn about the mobile health apps you have used?

My doctor or clinic
 Friend or family
 Website or internet
 Flier, mail or other ad
 Other: _____

5. What is the name of the most useful health “app” you have used?

5a. What does the app do that is useful for you?

6. Have you tried any health apps that you stopped using after just a short time?

Yes
 No (Go to 7)

6a. If yes, why did you stop using it?

Problem with login / password
 Didn't do what you wanted
 Took too much time to use
 Other: _____

7. How important is it for your primary care provider to know about the health app(s) you use?

Very important
 Important
 A little bit important
 Not at all important

8. Has your doctor ever recommended a health app for you?

Yes
 No (Go to 9)

8a. What is the name of the app? _____

8b. Was it helpful for you?

Yes
 No

9. How useful would the following features be for you to have on your phone?

	Least Useful	0	1	2	3	4	5	Most Useful
a. General health information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Appointment reminders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medication reminders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Get feedback on how I'm doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Tell my doctor how I'm doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Track progress (mood, weight, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Help with stress management or coping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Help me change a habit (diet, smoking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Tell my friends/family how I'm doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Support group / social network	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Other feature (describe: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 3: You and your health

10. How old are you? _____ years

11. Are you:

Male
 Female

12. What is your race and ethnicity? *Check all that apply.*

American Indian / Alaska Native
 Black or African American
 White (not Hispanic or Latino)
 Other: _____

Asian
 Pacific Islander
 Hispanic or Latino

13. Do you have any of these health conditions? *Check all that apply.*

High blood pressure
 Heart disease
 None of these
 Diabetes
 Depression
 Other: _____

Asthma
 Chronic pain

14. Over the last 2 weeks, how often have you been bothered by little interest or pleasure in doing things?

Not at all
 Several days
 More than half the days
 Nearly every day

15. Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

Not at all
 Several days
 More than half the days
 Nearly every day

If you are experiencing these symptoms, please tell your doctor.

16. How confident are you filling out medical forms by yourself?

Extremely confident
 Quite a bit confident
 Somewhat confident
 A little bit confident
 Not at all confident

17. How often do you have problems learning about your medical problems because of difficulty understanding written information?

Always
 Often
 Sometimes
 Occasionally
 Never

18. How often do you have someone like a family member, friend, caregiver, or a hospital or clinic worker help you read clinic or hospital materials?

Always
 Often
 Sometimes
 Occasionally
 Never

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