West Valley Human Services Alliance
Medical Work Group Survey

The following survey is intended for residents of the West Valley. The purpose of the survey is to assess the need for additional mobile health vans for that area. Mobile health vans travel throughout Maricopa County and provide basic preventive and routine health care services. If you have any questions, please contact Amy St. Peter at astpeter@mag.maricopa.gov or 602.452.5049. Thank you!

What is the name of the city/town and zip code where you live? _____

Does a mobile health unit come to your area/town? Y N Don't Know

Have you ever used a mobile health unit? Y N If no, why _____

Would you use a mobile health unit if it were available?

At no cost to you	Y	N	Maybe
At a cost to you	Y	N	Maybe

Where are you currently receiving your health care?

__Physician's Office __Community Clinic __Hospital __Other

Does anyone in your family have any of the following medical problems? (Circle all that apply)

High Blood Pressure Heart Conditions Respiratory Illness Diabetes Cancer Other

In the last year have you had any….

Dental problems	Y	N
Vision problems	Y	N
Mental Health problems	Y	N

How long has it been since your last visit to?

Physician	__Less than 1 year	__1-3 years	__3-5 years	__Over 5 years
Dentist	__Less than 1 year	__1-3 years	__3-5 years	__Over 5 years
Eye Doctor	__Less than 1 year	__1-3 years	__3-5 years	__Over 5 years

Do you have insurance for…

Medical	Y	N	Vision	Y	N
Dental	Y	N	Mental Health Care	Y	N

In the last year have you missed an appointment or avoided getting health care? Y N

What is the main reason for not getting (please circle all that apply):

Medical Care	Transportation	Cost	Distance	Other_____
Dental Care	Transportation	Cost	Distance	Other_____
Vision Care	Transportation	Cost	Distance	Other_____
Mental Health Care	Transportation	Cost	Distance	Other_____

For Women Only:

When was your last Pap smear?

__Within the last year __Within the last two-three years __Don't remember

Were you or anyone else in your household pregnant in the last six months?

Y N If yes, did you receive prenatal care?_____

Was prenatal care received within the first three months of pregnancy? Y N

If no, why_____

Demographics

What is your gender? ___ Male ___ Female

What is your age? __18-24 __25-39 __40-59 __60+

What is your race/ethnicity?

___ White Non-Hispanic
___ Hispanic/Latino
___ Black/African American
___ Don't know/Unsure
___ Native American
___ Asian
___ Hawaiian/Pacific Islander

How many children under 18 years of age live in your household? _____

How many people live in your household? __ one-two __three-four __more than 5

What is your annual family income?

__Less than $15,000 __$15,001-$30,000
__$30,001-$50,000 __More than $50,000

Does anyone in your household smoke? Y N

Do you have any additional comments or concerns regarding access to health care services in your community?