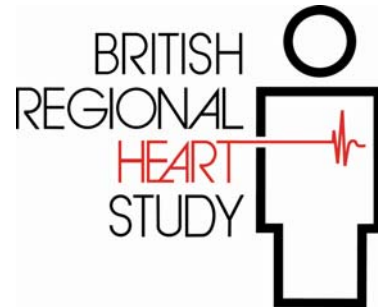
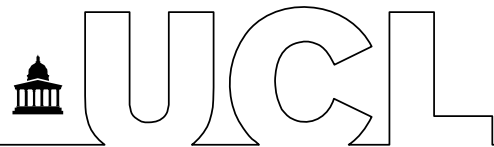


Study Number:

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Activity Survey: Questionnaire

This questionnaire asks about your health, activity and things which may affect the amount of activity you do.

Please complete this questionnaire as soon as is convenient and return it along with the red monitor and green activity diary at the end of the week. A pre-paid envelope is provided.

It is important that we receive this package as soon as possible after you have had the monitor for seven days.

All the information that you provide will be treated as strictly confidential and will only be seen by the Research Team. If you have any questions about this survey please phone us on 020 7830 2335.

Thank you very much for your help.

British Regional Heart Study
Department of Primary Care & Population Health
UCL Medical School
Royal Free Campus
Rowland Hill Street.
London NW3 2PF

<http://www.ucl.ac.uk/pcph/research/brhs>

DATES

1.0 Please enter today's date:// 20.....
Day / Month / Year

1.1 Please enter your date of birth// 19.....
Day / Month / Year

(This information is necessary for us to ensure that you are the correct recipient).

YOUR CURRENT HEALTH

2.0 Have you **ever** been told by a doctor that you have or have had any of the following conditions? If you tick **Yes**, please give the year of **last occurrence**

		Yes	No	Year of last occurrence
a	Heart attack (coronary thrombosis or myocardial infarction)	<input type="checkbox"/>	<input type="checkbox"/>	_____
b	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	_____
c	Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
d	Other heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
e	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
f	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
g	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
h	Arthritis affecting knees, hips or feet	<input type="checkbox"/>	<input type="checkbox"/>	_____
i	Narrowing or hardening of the leg arteries (including claudication)	<input type="checkbox"/>	<input type="checkbox"/>	_____
j	Chest trouble (eg bronchitis or emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
k	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
l	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____

Smoking & Drinking

	Yes	No
3.0 Do you currently smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
3.1 Do you currently smoke cigars or a pipe?	<input type="checkbox"/>	<input type="checkbox"/>
3.2 In the past week, how many units of alcohol have you drunk? (1 unit is half a pint of beer, a glass of wine or sherry, or a measure of spirits)	_____	units/week

Weight

4.0 What is your present weight(indoor clothes, without shoes)?
_____ Stones _____ Pounds or _____ Kilograms
If you have no scales and have made an estimate please tick here

5.0 Please indicate which statements best describe your health in the **past week**

(tick **one** answer for each question)

5.1 **General Health**

- Excellent ₁
- Good ₂
- Fair ₃
- Poor ₄

5.2 **Pain / discomfort**

- I have no pain or discomfort ₁
- I have moderate pain or discomfort ₂
- I have extreme pain or discomfort ₃

5.3 **Usual Activities** (e.g. work, study, housework, family or leisure activities):

- I have no problems with performing my usual activities ₁
- I have some problems with performing my usual activities ₂
- I am unable to perform my usual activities ₃

5.4 **Self Care**

- I have no problems with washing and dressing ₁
- I have some problems with washing and dressing myself ₂
- I am unable to wash or dress myself ₃

5.5 **Mobility**

- I have no problems walking about ₁
- I have some problems walking about ₂
- I am confined to a chair /wheelchair ₃

5.6 **Anxiety/Depression:-**

- I am not anxious or depressed ₁
- I am moderately anxious and /or depressed ₂
- I am extremely anxious and /or depressed ₃

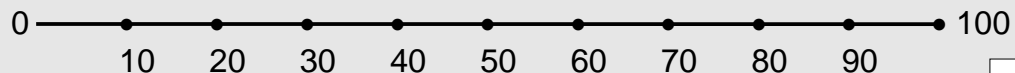
5.7 **Health Scale**

We have drawn a health scale (rather like a thermometer) on which perfect health is 100 and very poor health is 0.

Please put a cross (X) on the scale to reflect how good or bad your health is today.

Worst Imaginable
Health State

Best Imaginable
Health State



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OFFICE USE

LONGSTANDING ILLNESS OR DISABILITY**Yes No**6.0 Do you have any long-standing illness, disability or infirmity?

"long-standing" means anything which has troubled you over a period of time or is likely to do so

6.1 If **YES**, does this illness or disability limit your activities in any way? 6.2 do you receive a disability allowance? 7.0 Do you currently have difficulty carrying out any of the following activities on your own as a result of a **long term** health problem? (tick **one** box for each statement)

	No difficulty	Yes, a little difficulty	Yes, a lot of difficulty
a Going up or down stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b Bending down	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c Straightening up	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d Keeping your balance	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e Going out of the house	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f Walking 400 yards	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

8.0 Please indicate if you have difficulty doing any of the following activities: (tick **one** box)

	No Difficulty	Some Difficulty	Unable to do or need help
a Getting in and out of a chair on your own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b Dressing and undressing yourself on your own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c Bathing or showering	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d Feeding yourself, including cutting food	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e Shopping for personal items such as toilet items or medicine by yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f Doing light housework such as washing up	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g Preparing your own meals by yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h Using the telephone by yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
i Taking medications by yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
j Managing money (e.g. paying bills etc)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
k Using public transport on your own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
l Driving a car on your own.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

YOUR MOBILITY

9.0 Do you have any difficulties getting about outdoors? (tick **one** box only)

No difficulty ₁ Slight ₂ Moderate ₃ Severe ₄ Unable to do ₅

GOING OUT OF THE HOUSE

9.1 Thinking about the last seven days, on which days (if any) did you go out of your house? (tick **all** that apply, it doesn't matter if you were wearing the monitor or not)

Monday ₁ Tuesday ₁ Wednesday ₁ Thursday ₁

Friday ₁ Saturday ₁ Sunday ₁

I did not go out of the house in the last seven days ₁

MOBILITY AIDS

Yes No

9.2 Do you use any mobility aids?

9.3 If **YES**, which aids or appliances do you use to help with day to day activities?:

Walking stick ₁ Toilet raised seat ₁

Walking frame ₁ Bath board/shower ₁

Push wheelchair ₁ Extra rails in bathroom ₁

Electric wheelchair or mobility scooter ₁ Stair lift ₁

FALLS

Yes No

10.0 Have you had a fall in the past 12 months?

10.1 If **YES**, How many falls have you had in past 12 months?

_____ falls

Yes No

10.2 Did you receive medical attention for any of these falls?

10.3 Did you suffer any of the following:

a Cuts and bruises ₁

b Damage to muscle or ligament ₁

c Broken or fractured **hip** bone ₁

d Broken or fractured **wrist** bone ₁

e **Other** Broken or fractured bone(s) ₁

10.4 At the present time, are you afraid that you may fall over? (tick one box)

Very fearful

Somewhat fearful

Not fearful

₁

₂

₃

PHYSICAL ACTIVITY

11.0 Do you make regular journeys every day or most days either walking or cycling?

(tick one box)

a No ₁

b Walking ₂

c Cycling ₃

d Both ₄

11.1 How many hours do you normally spend walking (eg. on errands or for leisure) in an average week?

_____ Hours/week in winter _____ Hours/week in summer

11.2 Which of the following best describes your usual walking pace? Slow ₁

Steady average ₂

Fast ₃

11.3 How long do you spend cycling in an average week?

_____ Hours/week in Winter _____ Hours/week in Summer

11.4 On a normal day, how many times do you climb a flight of stairs _____
(assuming that 1 flight of stairs has 10 steps)?

11.5 Compared with a man who spends four hours on most weekends on activities such as walking, gardening, household chores, DIY projects, how physically active would you consider yourself?

Much more active ₁

More active ₂

Similar ₃

Less active ₄

Much less active ₅

11.6 Do you take active sporting physical exercise such as running, swimming, dancing, golf, tennis, squash, jogging, bowls, cycling, hiking, etc.?

No ₁

Occasionally (less than once a month) ₂

Frequently (once a month or more) ₃

11.7 If you ticked **frequently**, please list the types of activities:

11.8 How many times a **month** (on average) do you take part in these activities?

_____times /month in Winter _____times /month in Summer

11.9 Do you engage in exercises to increase muscle strength and endurance such as lifting weights, doing push-ups, using exercise machines? Yes No

11.10 If **YES**, on average, how many hours per week do you engage in these exercises?
_____ hours/week

Yes No

12.0 Do you own a dog at the moment?

12.1 Do you regularly walk a dog at the moment?

13.0 On a normal day, how many hours do you spend sitting (eg to eat, read, watch TV) or lying down, excluding your night time sleep?
_____ hours/day None

14.0 On a normal day, how much time do you spend watching television (including videos and DVDs)?
_____ hours _____ minutes/day None

BREATHLESSNESS

Yes No Unable to walk

15.0 Do you ever get short of breath walking with other people of your own age on level ground?

15.1 On walking uphill or upstairs, do you get more breathless than people of your own age?

15.2 Do you ever have to stop walking because of breathlessness?

YOUR FEELINGS ABOUT EXERCISE (eg. going for a walk, doing particular sports, gardening or DIY)

16.0 How much do you agree with the following statements about the exercise you do?
(tick one box for each statement)

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a	Makes me feel better physically	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
b	Makes my mood better in general	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
c	Helps me feel less tired	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
d	Makes my muscles stronger	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
e	Is an activity I enjoy doing	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
f	Gives me a sense of personal accomplishment	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
g	Makes me more alert mentally	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
h	Improves my endurance in performing daily activities	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
i	Helps to strengthen my bones	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
j	Helps to improve my balance and prevent me falling over	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

HOW YOU FEEL ABOUT EXERCISE

17.0 Please indicate how confident you are that you could exercise (or walk) if you had to, for 20 minutes three times a week in each of the following cases:

(tick **one** box for each statement)

		Not confident					Very confident				
		1	2	3	4	5	6	7	8	9	10
a	If the weather was bothering you	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
b	If you were bored by the activity	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
c	If you felt pain when exercising	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
d	If you had to exercise alone	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
e	If you did not enjoy it	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
f	If you were too busy with other activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
g	If you felt tired	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
h	If you felt stressed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
i	If you felt depressed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10

YOUR FEELINGS

18.0 Please tell us about how you have been feeling in the past week:

Yes **No**

a	Are you basically satisfied with your life?	<input type="checkbox"/>	<input type="checkbox"/>
b	Do you feel that your life is empty?	<input type="checkbox"/>	<input type="checkbox"/>
c	Are you afraid that something bad is going to happen to you?	<input type="checkbox"/>	<input type="checkbox"/>
d	Do you feel happy most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
e	Have you dropped many of your activities and interests?	<input type="checkbox"/>	<input type="checkbox"/>
f	Do you prefer to stay at home, rather than going out to do new things?	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY AND FRIENDS

19.0 **FAMILY:** Considering the people to whom you are related either by birth or marriage:

	None	1	2	3 or 4	5 to 8	9 or more	
a	How many relatives do you see or hear from at least once a month?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
b	How many relatives do you feel emotionally close to, such that you could call on them for help?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
c	How many relatives do you feel at ease with that you can talk about private matters?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

20.0 **FRIENDS:** Considering all of your friends including those who live in your neighbourhood:

	None	1	2	3 or 4	5 to 8	9 or more	
a	How many friends do you see or hear from at least once a month?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
b	How many friends do you feel emotionally close to, such that you could call on them for help?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
c	How many friends do you feel at ease with that you can talk about private matters?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

PRESENT CIRCUMSTANCES

21.0	Are you at present:	Single	<input type="checkbox"/> ₁
		Married	<input type="checkbox"/> ₂
		Widowed	<input type="checkbox"/> ₃
		Divorced or separated	<input type="checkbox"/> ₄
		Other	<input type="checkbox"/> ₅

22.0	At present are you living:	At home, with family	<input type="checkbox"/> ₁
		At home, alone	<input type="checkbox"/> ₂
		In a residential home	<input type="checkbox"/> ₃
		In a nursing home	<input type="checkbox"/> ₄

The next questions ask about *your* local area. We want to know how you feel about the place that you live, and what it is like to live there.

YOUR LOCAL AREA		Yes	No
23.0	Would you say that this is an area in which you enjoy living?	<input type="checkbox"/>	<input type="checkbox"/>
23.1	Please rate the following things in your local area and neighbourhood: (tick one box on each line)		
		Very Good	Good
		Average	Poor
			Very Poor
a	Social and leisure activities for people like yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
		<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
		<input type="checkbox"/> ₅	
b	Facilities for people of your age	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
		<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
		<input type="checkbox"/> ₅	
c	The quality & frequency of rubbish collection	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
		<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
		<input type="checkbox"/> ₅	
d	Your local health service (e.g. your GP or the local hospital)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
		<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
		<input type="checkbox"/> ₅	
e	Local transport to where you want to go	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
		<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
		<input type="checkbox"/> ₅	
f	Your area for having somewhere nice to go for a walk	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
		<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
		<input type="checkbox"/> ₅	

23.2	In the area you live in, how safe (from crime) do you feel when:					
		Very Safe	Fairly Safe	A bit unsafe	Very unsafe	Never go out alone
a	Walking alone in the daytime	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
b	Walking alone after dark	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
23.3	How much do you agree with the following statement about your neighbourhood?					
		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
	Your neighbourhood has lots of green space.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

23.4 In your neighbourhood, how much of a problem are the following?		Serious problem	Minor problem	Not a problem
a	The speed of traffic?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b	The volume of traffic?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c	Noise (eg. neighbours, traffic)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d	The amount of crime?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e	The quality of air you breathe?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
f	Rubbish or litter lying around?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g	Graffiti and vandalism?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h	Uneven or dangerous pavements?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

		Yes	No	Someone else shops for me
24.0	Do you do most of your shopping (food, household necessities etc) at shops within easy walking distance (less than 15 minutes) of your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.0	How do you mostly go shopping?(tick one box only)			
	Walking <input type="checkbox"/> ₁ By bus <input type="checkbox"/> ₂ Other public transport <input type="checkbox"/> ₃ Dial a ride <input type="checkbox"/> ₄			
	By taxi <input type="checkbox"/> ₅ Drive myself <input type="checkbox"/> ₆ A friend/relative drives me <input type="checkbox"/> ₇ Internet delivery <input type="checkbox"/> ₈			
	I don't go shopping <input type="checkbox"/> ₉			

TRANSPORT		Yes	No
26.0	Do you own a car?	<input type="checkbox"/>	<input type="checkbox"/>
26.1	Do you drive a car?	<input type="checkbox"/>	<input type="checkbox"/>
26.2	Which of the following means of transport do you use regularly? (tick all that apply)		
	Car <input type="checkbox"/> ₁ Public transport <input type="checkbox"/> ₁ Cycle <input type="checkbox"/> ₁ Walk <input type="checkbox"/> ₁ Dial a ride <input type="checkbox"/> ₁		
	Not applicable <input type="checkbox"/> ₁		

Thank you very much for completing the questionnaire.
Please return it to us, along with the green activity diary and red monitor,
in the pre-paid envelope provided.