

Study Number:

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serial

## **BRITISH REGIONAL HEART STUDY**

### **2003 QUESTIONNAIRE**

Thank you very much for taking the time to complete this questionnaire, which will bring us up to date with your present state of health. All the information will be treated as **strictly confidential** and will only be seen by the Research Team.

Most questions can be answered by ticking the correct box

Please check that you have answered as many questions as you can and return it to us in the envelope provided – you do not need to use a stamp.

If you have any trouble answering the questions, or would like a large-print copy, please phone us on 020 7830 2335 and give us your telephone number. We will then call you back to answer your query.

THANK YOU FOR YOUR HELP

**Department of Primary Care & Population Sciences  
Royal Free & University College Medical School,  
Rowland Hill Street, London NW3 2PF**





Cancer

q03q6\_0

6.0 Have you **ever** been told by a doctor that you have or have had cancer?

Yes No

If **Yes**, please give:

OFFICE USE

(a) Year first diagnosed q03q6\_0a

(b) Cancer Site q03q6\_0\_s  
q03q6\_0\_s2

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Arthritis

q03q7\_0

7.0 Have you **ever** been told by a doctor that you have or have had arthritis?

Yes No

If **Yes**,

7.1 Type of arthritis (if known), (eg. osteoarthritis, rheumatoid arthritis, other):

OFFICE USE

q03q7\_1

7.2 Year first diagnosed q03q7\_2

7.3 Joint(s) affected:

please tick the relevant box(es)

Knees

q03q7\_3\_k

Hips

q03q7\_3\_h

Feet

q03q7\_3\_f

Hands and/or wrists

q03q7\_3\_ha

Other (please specify) q03q7\_3\_o

OFFICE USE

Other Medical Conditions

8.0 Have you **ever** been told by a doctor that you have or have had any of the following conditions?

If **Yes**, please give the year when **first** diagnosed, if possible

(a) Asthma q03q8\_0a  Yes  No q03q8\_0a\_y Year

(b) Bronchitis q03q8\_0b  Yes  No q03q8\_0b\_y Year

(c) Cataract q03q8\_0c  Yes  No q03q8\_0c\_y Year

(d) Depression q03q8\_0d  Yes  No q03q8\_0d\_y Year

(e) Emphysema q03q8\_0e  Yes  No q03q8\_0e\_y Year

(f) Gall bladder q03q8\_0f  Yes  No q03q8\_0f\_y Year

(g) Gastric, peptic or q03q8\_0g  Yes  No q03q8\_0g\_y Year  
duodenal ulcer

(h) Glaucoma q03q8\_0h  Yes  No q03q8\_0h\_y Year

(i) Gout q03q8\_0i  Yes  No q03q8\_0i\_y Year

(j) Osteoporosis q03q8\_0j  Yes  No q03q8\_0j\_y Year

(k) Parkinson's disease q03q8\_0k  Yes  No q03q8\_0k\_y Year

(l) Pneumonia q03q8\_0l  Yes  No q03q8\_0l\_y Year

(m) Prostate trouble q03q8\_0m  Yes  No q03q8\_0m\_y Year

(n) Other conditions, please give details:

q03q8\_0n\_y (year)

q03q8\_0n

OFFICE USE

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q03q8\_0n2\_y (year)

q03q8\_0n2

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Joint pain, swelling or stiffness

9.0 During **the past year** have you had pain, aching, stiffness or swelling on most days for at least one month, in your...

- |                     | Yes                      | No                       |   |                                     |
|---------------------|--------------------------|--------------------------|---|-------------------------------------|
| (a) Hands or wrists | <input type="checkbox"/> | <input type="checkbox"/> | q03q9_0a                                    |                                     |
| (b) Knees           | <input type="checkbox"/> | <input type="checkbox"/> | q03q9_0b                                    |                                     |
| (c) Hips            | <input type="checkbox"/> | <input type="checkbox"/> | q03q9_0c                                    |                                     |
| (d) Feet            | <input type="checkbox"/> | <input type="checkbox"/> | q03q9_0d                                    |                                     |
| (e) Other joint     | <input type="checkbox"/> | <input type="checkbox"/> | (please specify) <u>q03q9_0e q03q9_0e_x</u> | <input type="checkbox"/> OFFICE USE |

Lower back pain

- |  | Yes                      | No                       |          |
|--|--------------------------|--------------------------|----------|
| 10.0 Have you <b>ever</b> had pain in your lower back on most days for at least one month? | <input type="checkbox"/> | <input type="checkbox"/> | q03q10_0 |
| 10.1 If <b>Yes</b> , have you had this in the last year?                                   | <input type="checkbox"/> | <input type="checkbox"/> | q03q10_1 |

Fractures and falls

- |   | Yes                      | No                       | Please give year  |
|---|--------------------------|--------------------------|-------------------|
| 11.0 Have you <b>ever</b> fractured your hip?                       | <input type="checkbox"/> | <input type="checkbox"/> | <u>q03q11_0_y</u> |
| 11.1 Have you <b>ever</b> fractured your wrist?                     | <input type="checkbox"/> | <input type="checkbox"/> | <u>q03q11_1_y</u> |
| 11.2 Have you had a fall in the last 12 months?                     | <input type="checkbox"/> | <input type="checkbox"/> |                   |
| If <b>Yes</b> ,   |                          |                          |                   |
| (a) how many times? <input type="text"/> <input type="text"/> times |                          |                          | q03q11_2a         |
| (b) Did you receive medical attention for any of these falls?       | <input type="checkbox"/> | <input type="checkbox"/> | q03q11_2b         |

Chest pain

- |   | Yes                      | No                       |  |
|---|--------------------------|--------------------------|--|
| 12.0 Do you <b>ever</b> have any pain or discomfort in your chest?              | <input type="checkbox"/> | <input type="checkbox"/> | q03q12_0   |
| If <b>Yes</b> ,   |                          |                          |  |
| (a) When you walk at an ordinary pace on the level, does this produce the pain? | <input type="checkbox"/> | <input type="checkbox"/> | Unable to walk on level <input type="checkbox"/> q03q12_0a |
| (b) When you walk uphill or hurry, does this produce the pain?                  | <input type="checkbox"/> | <input type="checkbox"/> | Unable to walk uphill <input type="checkbox"/> q03q12_0b   |

Breathlessness

- |      |   | Yes                      | No                       |          |
|------|---|--------------------------|--------------------------|----------|
| 13.0 | Do you <b>ever</b> get short of breath walking with other people of your own age on level ground?               | <input type="checkbox"/> | <input type="checkbox"/> | q03q13_0 |
| 13.1 | On walking up hill or stairs do you get more breathless than people of your own age?                            | <input type="checkbox"/> | <input type="checkbox"/> | q03q13_1 |
| 13.2 | Do you <b>ever</b> have to stop walking because of breathlessness?  | <input type="checkbox"/> | <input type="checkbox"/> | q03q13_2 |
| 13.3 | In the <b>past twelve months</b> have you at any time been awoken at night by an attack of shortness of breath? | <input type="checkbox"/> | <input type="checkbox"/> | q03q13_3 |

Weight

- 14.0 What is your present weight (indoor clothes, without shoes)?  
q03q14\_0st \_\_\_\_\_Stones q03q14\_0lb \_\_\_\_\_Pounds / or q03q14\_0kg \_\_\_\_\_Kilograms  
(If you have no scales and have made an estimate please tick here  ) q03q14\_0e
- |      |   |                               |                          |                          |                                     |           |
|------|---|-------------------------------|--------------------------|--------------------------|-------------------------------------|-----------|
| 14.1 | Have you tried to lose weight in the last four years?   | q03q14_1                      | Yes                      | No                       |                                     |           |
|      | If <b>Yes</b> , did you:  |                               | <input type="checkbox"/> | <input type="checkbox"/> |                                     |           |
|      | Change your diet?   | q03q14_1c                     | <input type="checkbox"/> | <input type="checkbox"/> |                                     |           |
|      | Take more exercise?   | q03q14_1t                     | <input type="checkbox"/> | <input type="checkbox"/> |                                     |           |
|      | Other (please give details) _____   | q03q14_o                      |                          |                          | OFFICE USE <input type="checkbox"/> |           |
| 14.2 | Have you been advised by a doctor or other health professional to lose weight in the last four years? |                               | Yes                      | No                       | q03q14_2                            |           |
|      |   |                               | <input type="checkbox"/> | <input type="checkbox"/> |                                     |           |
| 14.3 | Has your weight changed in the last four years?   | Not changed                   | <input type="checkbox"/> |                          | q03q14_3                            |           |
|      |   | Increased                     | <input type="checkbox"/> |                          |                                     |           |
|      |   | Decreased                     | <input type="checkbox"/> |                          |                                     |           |
|      |   | Both increased and decreased) | <input type="checkbox"/> |                          |                                     |           |
|      |   | Don't know                    | <input type="checkbox"/> |                          |                                     |           |
| 14.4 | <b>If your weight has changed</b>   |                               | Yes                      | No                       | q03q14_4                            |           |
|      | -was this change intentional?   |                               | <input type="checkbox"/> | <input type="checkbox"/> |                                     |           |
|      | -was it the result of:-   | Personal choice               | <input type="checkbox"/> |                          |                                     | q03q14_4p |
|      |   | Medical advice                | <input type="checkbox"/> |                          |                                     | q03q14_4m |
|      |   | Illness or ill health         | <input type="checkbox"/> |                          | q03q14_4i                           |           |
| 14.5 | Do you consider your present weight to be:-   | about right                   | <input type="checkbox"/> |                          | q03q14_5                            |           |
|      |   | too high                      | <input type="checkbox"/> |                          |                                     |           |
|      |   | too low                       | <input type="checkbox"/> |                          |                                     |           |

<u>Disability</u>		Yes	No	
15.0	Do you have any long-standing illness, disability or infirmity?	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_0
<b>("long-standing" means anything which has troubled you over a period of time or is likely to do so)</b>				
If Yes,		Yes	No	
(a)	Does this illness or disability limit your activities in any way?	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_0a
(b)	Do you receive a disability allowance?	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_0b
15.1	Do you currently have difficulty carrying out any of the following activities on your own as a result of a <b>long term</b> health problem?	Yes	No	
(a)	Going up or down stairs	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_1a
(b)	Bending down	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_1b
(c)	Straightening up	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_1c
(d)	Keeping your balance	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_1d
(e)	Going out of the house?	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_1e
(f)	Walking 400 yards	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_1f
15.2	Is your present state of health causing problems with any of the following:-	Yes	No	
(a)	Job at work (paid employment)	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_2a
(b)	Household chores	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_2b
(c)	Social life	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_2c
(d)	Sex life	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_2d
(e)	Interests and hobbies	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_2e
(f)	Holidays and outings	<input type="checkbox"/>	<input type="checkbox"/>	q03q15_2f

<u>Eyesight</u>		Yes	No	
16.0	Using glasses or corrective lenses if needed, can you see well enough to recognise a friend at a distance of 12 feet/ four yards (across a road)?	<input type="checkbox"/>	<input type="checkbox"/>	q03q16_0
	If No, can you see well enough to recognise a friend at a distance of one yard?	<input type="checkbox"/>	<input type="checkbox"/>	q03q16_0_no

<u>Hearing</u>		Yes	No	
17.0	Do you use a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	q03q17_0
17.1	Using a hearing aid if needed, is your hearing good enough to follow a TV programme at a volume others find acceptable?	<input type="checkbox"/>	<input type="checkbox"/>	q03q17_1
	If No, can you follow a TV programme with the volume turned up?	<input type="checkbox"/>	<input type="checkbox"/>	q03q17_1_no





Physical activity

- 19.0 Do you make regular journeys every day or most days either walking or cycling?
- |       |                          |   |          |
|-------|--------------------------|---|----------|
| No    | <input type="checkbox"/> | 1 |          |
| Walk  | <input type="checkbox"/> | 2 | q03q19_0 |
| Cycle | <input type="checkbox"/> | 3 |          |
| Both  | <input type="checkbox"/> | 4 |          |

(a) How many hours do you normally spend walking (e.g. on errands or for leisure) in an average week?   hours q03q19\_0a

- 19.1 Which of the following best describes your usual walking pace?
- |                |                          |   |          |
|----------------|--------------------------|---|----------|
| Slow           | <input type="checkbox"/> | 1 | q03q19_1 |
| Steady average | <input type="checkbox"/> | 2 |          |
| Fast           | <input type="checkbox"/> | 3 |          |

19.2 How long do you spend cycling in an average week?   hours q03q19\_2

19.3 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 | <input type="checkbox"/> | 1 |          |
| More active      | <input type="checkbox"/> | 2 | q03q19_3 |
| Similar          | <input type="checkbox"/> | 3 |          |
| Less active      | <input type="checkbox"/> | 4 |          |
| Much less active | <input type="checkbox"/> | 5 |          |

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

- |                                       |                          |   |          |
|---------------------------------------|--------------------------|---|----------|
| No                                    | <input type="checkbox"/> | 1 | q03q19_4 |
| Occasionally (less than once a month) | <input type="checkbox"/> | 2 |          |
| Frequently (once a month or more)     | <input type="checkbox"/> | 3 |          |

(a) If you ticked **frequently** please state type of activities:

q03q19\_4a OFFICE USE

(b) How many times a **month** (on average) do you take part in these activities? (give overall total)

In winter   times q03q19\_4b\_w

In summer   times q03q19\_4b\_s

19.5 Do you engage in exercises to increase muscle strength and endurance such as lifting weights, doing push-ups, using exercise machines?

- |     |                          |          |
|-----|--------------------------|----------|
| Yes | <input type="checkbox"/> |          |
| No  | <input type="checkbox"/> | q03q19_5 |

If Yes, on average how many hours per week do you engage in these exercises?   hours per week q03q19\_5\_h

Cigarette smoking

		Yes	No	
20.0	Do you smoke cigarettes at present?	<input type="checkbox"/>	<input type="checkbox"/>	q03q20_0
	If <b>Yes</b> , please answer the following questions:			
20.1	How many cigarettes do you smoke a day at present?	<input type="text"/>	<input type="text"/>	q03q20_1
20.2	If hand-rolled, how much tobacco do you use a week?	<input type="text"/>	<input type="text"/>	oz / <input type="text"/>
		<input type="text"/>	<input type="text"/>	grams
		q03q20_2oz	q03q20_2gr	
20.3	Do you want to give up smoking?	<input type="checkbox"/>	<input type="checkbox"/>	q03q20_3
20.4	Have you tried to stop smoking?	<input type="checkbox"/>	<input type="checkbox"/>	q03q20_4
20.5	Have you been offered any of the following to help you stop smoking?			
		Yes	No	
(a)	Advice from a health professional (e.g. doctor or nurse)	<input type="checkbox"/>	<input type="checkbox"/>	q03q20_5a
(b)	Referral to a stop-smoking clinic	<input type="checkbox"/>	<input type="checkbox"/>	q03q20_5b
(c)	Nicotine replacement treatment (including sprays, patches etc)	<input type="checkbox"/>	<input type="checkbox"/>	q03q20_5c
(d)	Zyban tablets	<input type="checkbox"/>	<input type="checkbox"/>	q03q20_5d
(e)	Other treatment (please specify) _____			q03q20_5e
				OFFICE USE <input type="checkbox"/>

21.0	Have you changed your cigarette smoking habits during the past four years?			
	No	<input type="checkbox"/>	1	
	Yes, increased	<input type="checkbox"/>	2	q03q21_0
	Yes, cut down	<input type="checkbox"/>	3	
	Yes, given up	<input type="checkbox"/>	4	

21.1	<b>If you have given up smoking</b> in the last four years, were any of these factors important?			
		Yes	No	
(a)	Advice from a health professional (e.g. doctor or nurse)	<input type="checkbox"/>	<input type="checkbox"/>	q03q21_1a
(b)	Referral to a stop-smoking clinic	<input type="checkbox"/>	<input type="checkbox"/>	q03q21_1b
(c)	Nicotine replacement treatment (including sprays, patches etc)	<input type="checkbox"/>	<input type="checkbox"/>	q03q21_1c
(d)	Zyban tablets	<input type="checkbox"/>	<input type="checkbox"/>	q03q21_1d
(e)	Illness or ill-health	<input type="checkbox"/>	<input type="checkbox"/>	q03q21_1e
(f)	Cost of cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	q03q21_1f
(g)	Other factors (please specify) _____			q03q21_1g
				OFFICE USE <input type="checkbox"/>

<u>Pipe and cigar smoking</u>				
		Yes	No	
22.0	Do you currently smoke a pipe?	<input type="checkbox"/>	<input type="checkbox"/>	q03q22_0
22.1	Do you currently smoke cigars?	<input type="checkbox"/>	<input type="checkbox"/>	q03q22_1

Alcohol intake

23.0 Would you describe your present alcohol intake as

- Daily/most days  <sub>1</sub>
- Weekends only  <sub>2</sub> q03q23\_0
- Occasionally (once or twice a month)  <sub>3</sub>
- Special occasions only  <sub>4</sub>
- None  <sub>5</sub>

One drink is **HALF** a pint of beer/lager/cider, a **SINGLE** whisky, gin, etc. or **ONE GLASS** of wine or sherry

23.1 How much do you usually drink on the days when you drink alcohol?

- More than 6 drinks  <sub>1</sub>
- 5-6 drinks  <sub>2</sub>
- 3-4 drinks  <sub>3</sub> q03q23\_1
- 1-2 drinks  <sub>4</sub>

23.2 How many alcoholic drinks do you have during an average week?

  q03q23\_2

23.3 What type of drink do you usually take?

- Beers, Lagers  <sub>1</sub>
- Wines, Sherry  <sub>2</sub> q03q23\_3
- Spirits  <sub>3</sub>
- Combination of Beers, Wines or Spirits  <sub>4</sub>
- Low alcohol drinks  <sub>5</sub>

23.4 What is your usual consumption of these alcoholic beverages? Please tick boxes

Type of drink	PER WEEK					
	Never/ hardly ever	Less than 1	1-6	7-13	14-20	21+
Beer or lager (pints)	<input type="checkbox"/> q03q23_4be <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red wine (single glass)	<input type="checkbox"/> q03q23_4rw <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White wine (single glass)	<input type="checkbox"/> <input type="checkbox"/> q03q23_4ww	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirits (1 drink/shot)	<input type="checkbox"/> q03q23_4sp <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23.5 Is the alcohol which you drink usually taken (tick whichever applies):-

- before meals  <sub>1</sub> q03q23\_5b
- with meals  <sub>1</sub> q03q23\_5w
- after meals  <sub>1</sub> q03q23\_5a
- separate from meals  <sub>1</sub> q03q23\_5s

Alcohol Intake continued

23.6 Have you changed your alcohol intake in the last four years?

- No \_1 q03q23\_6
- Yes, increased \_2
- Yes, cut down \_3
- Yes, given up \_4

23.7 If you have **CUT DOWN** or **GIVEN UP**, was this due to (tick whichever applies):-

- |                       |                             |                     |                             |            |
|-----------------------|-----------------------------|---------------------|-----------------------------|------------|
| Personal choice       | <input type="checkbox"/> _1 | Being on medication | <input type="checkbox"/> _1 | q03q23_7_1 |
| Doctor's advice       | <input type="checkbox"/> _1 | Financial reasons   | <input type="checkbox"/> _1 | q03q23_7_2 |
| Illness or ill health | <input type="checkbox"/> _1 | Other               | <input type="checkbox"/> _1 | q03q23_7_3 |
| Health precaution     | <input type="checkbox"/> _1 |                     |                             | q03q23_7_4 |
|                       |                             |                     |                             | q03q23_7_5 |
|                       |                             |                     |                             | q03q23_7_6 |
|                       |                             |                     |                             | q03q23_7_7 |

Preventive Health Care

24.0 In what **year** did you last consult a GP about a health problem? q03q24\_0

- 24.1 Have you ever had any of the following
- |  | Yes                      | No                       | If <b>Yes</b> , year of most recent |
|--|--------------------------|--------------------------|-------------------------------------|
| (a) Blood pressure check q03q24_1a         | <input type="checkbox"/> | <input type="checkbox"/> | q03q24_1a_y                         |
| (b) Blood cholesterol check q03q24_1b      | <input type="checkbox"/> | <input type="checkbox"/> | q03q24_1b_y                         |
| (c) Flu vaccination q03q24_1c              | <input type="checkbox"/> | <input type="checkbox"/> | q03q24_1c_y                         |
| (d) Dental check q03q24_1d                 | <input type="checkbox"/> | <input type="checkbox"/> | q03q24_1d_y                         |
| (e) Foot care from a chiropodist q03q24_1e | <input type="checkbox"/> | <input type="checkbox"/> | q03q24_1e_y                         |

24.2 Approximately, how many times in the **last twelve months** have you consulted your GP about a health problem?  times q03q24\_2

Questions about medicines

25.0 Do you take any regular medication? Yes  No  q03q25\_0

If **Yes**, do you take any of the following medicines regularly? Year started

- |   |           |                          |                          |             |
|---|-----------|--------------------------|--------------------------|-------------|
| (a) Aspirin tablets                         | q03q25_0a | <input type="checkbox"/> | <input type="checkbox"/> | q03q25_0a_y |
| (b) Treatment for any form of heart disease | q03q25_0b | <input type="checkbox"/> | <input type="checkbox"/> | q03q25_0b_y |
| (c) Treatment to lower blood pressure       | q03q25_0c | <input type="checkbox"/> | <input type="checkbox"/> | q03q25_0c_y |
| (d) Treatment to lower blood cholesterol    | q03q25_0d | <input type="checkbox"/> | <input type="checkbox"/> | q03q25_0d_y |

25.1 If you are on treatment to lower your blood cholesterol:-

- (a) Please give the name of this medicine: q03q25\_1a  OFFICE USE
- (b) Please give the amount you take each day: q03q25\_1b  (details of the amount in each tablet should be on the bottle)

Details of ALL medicines

26.0 Please write down details of all medicines – including tablets, injections, inhalers, eye-drops etc – which you take regularly. Please also include any medications which you buy for yourself.

	Name of medicine	Reason for taking (if you know)	Date started	Is this prescribed?		
				Yes	No	OFFICE USE
1	q03q26_0_bnf12_1 q03q26_0_bnf34_1 q03q26_0_bnf5_1 q03q26_0_bnf6_1	q03q26_0_icd1 q03q26_0_icd_x4d1	q03q26_0_med_year1	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr1
2	q03q26_0_bnf12_2 q03q26_0_bnf34_2 q03q26_0_bnf5_2 q03q26_0_bnf6_2	q03q26_0_icd2 q03q26_0_icd_x4d2	q03q26_0_med_year2	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr2
3	q03q26_0_bnf12_3 q03q26_0_bnf34_3 q03q26_0_bnf5_3 q03q26_0_bnf6_3	q03q26_0_icd3 q03q26_0_icd_x4d3	q03q26_0_med_year3	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr3
4	q03q26_0_bnf12_4 q03q26_0_bnf34_4 q03q26_0_bnf5_4 q03q26_0_bnf6_4	q03q26_0_icd4 q03q26_0_icd_x4d4	q03q26_0_med_year4	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr4
5	q03q26_0_bnf12_5 q03q26_0_bnf34_5 q03q26_0_bnf5_5 q03q26_0_bnf6_5	q03q26_0_icd5 q03q26_0_icd_x4d5	q03q26_0_med_year5	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr5
6	q03q26_0_bnf12_6 q03q26_0_bnf34_6 q03q26_0_bnf5_6 q03q26_0_bnf6_6	q03q26_0_icd6 q03q26_0_icd_x4d6	q03q26_0_med_year6	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr6
7	q03q26_0_bnf12_7 q03q26_0_bnf34_7 q03q26_0_bnf5_7 q03q26_0_bnf6_7	q03q26_0_icd7 q03q26_0_icd_x4d7	q03q26_0_med_year7	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr7
8	q03q26_0_bnf12_8 q03q26_0_bnf34_8 q03q26_0_bnf5_8 q03q26_0_bnf6_8	q03q26_0_icd8 q03q26_0_icd_x4d8	q03q26_0_med_year8	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr8
9	q03q26_0_bnf12_9 q03q26_0_bnf34_9 q03q26_0_bnf5_9 q03q26_0_bnf6_9	q03q26_0_icd9 q03q26_0_icd_x4d9	q03q26_0_med_year9	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr9
10	q03q26_0_bnf12_10 q03q26_0_bnf34_10 q03q26_0_bnf5_10 q03q26_0_bnf6_10	q03q26_0_icd10 q03q26_0_icd_x4d10	q03q26_0_med_year10	<input type="checkbox"/>	<input type="checkbox"/>	q03q26_0_medpr10

Present circumstances

27.0 Are you at present:-

- |                       |                          |   |          |
|-----------------------|--------------------------|---|----------|
| single                | <input type="checkbox"/> | 1 |          |
| married               | <input type="checkbox"/> | 2 | q03q27_0 |
| widowed               | <input type="checkbox"/> | 3 |          |
| divorced or separated | <input type="checkbox"/> | 4 |          |
| other                 | <input type="checkbox"/> | 5 |          |

(a) If you are widowed or divorced/separated, please give the year when this occurred:- q03q27\_0a

27.1 Are you at present:-

- |                                    |                          |   |          |
|------------------------------------|--------------------------|---|----------|
| living alone                       | <input type="checkbox"/> | 1 |          |
| living with a partner or spouse    | <input type="checkbox"/> | 2 | q03q27_1 |
| living with other family member(s) | <input type="checkbox"/> | 3 |          |
| living with other people           | <input type="checkbox"/> | 4 |          |

27.2 Your accommodation

Are you:-

- |                                  |                          |   |          |
|----------------------------------|--------------------------|---|----------|
| an owner occupier                | <input type="checkbox"/> | 1 |          |
| renting from the local authority | <input type="checkbox"/> | 2 | q03q27_2 |
| renting privately                | <input type="checkbox"/> | 3 |          |
| living in a residential home     | <input type="checkbox"/> | 4 |          |
| living in a nursing home         | <input type="checkbox"/> | 5 |          |
| other (please give details)      | <input type="checkbox"/> | 6 |          |
- 

27.3 During the winter, is your accommodation usually:

- |           |                          |   |          |
|-----------|--------------------------|---|----------|
| Very warm | <input type="checkbox"/> | 1 |          |
| Warm      | <input type="checkbox"/> | 2 | q03q27_3 |
| Medium    | <input type="checkbox"/> | 3 |          |
| Cold      | <input type="checkbox"/> | 4 |          |
| Very cold | <input type="checkbox"/> | 5 |          |

27.4 Do you have a car available for your own use?

- |     |                          |    |                          |          |
|-----|--------------------------|----|--------------------------|----------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | q03q27_4 |
|-----|--------------------------|----|--------------------------|----------|

27.5 Are you currently in full-time paid employment?

- |                          |                          |          |
|--------------------------|--------------------------|----------|
| <input type="checkbox"/> | <input type="checkbox"/> | q03q27_5 |
|--------------------------|--------------------------|----------|

27.6 Do you have private medical insurance?

- |                          |                          |          |
|--------------------------|--------------------------|----------|
| <input type="checkbox"/> | <input type="checkbox"/> | q03q27_6 |
|--------------------------|--------------------------|----------|

27.7 Have you ever had private medical treatment?

- |                          |                          |          |
|--------------------------|--------------------------|----------|
| <input type="checkbox"/> | <input type="checkbox"/> | q03q27_7 |
|--------------------------|--------------------------|----------|

Activities of daily living

The following questions will help us to understand difficulties people may have with various everyday activities

28.0 What is the furthest you can walk on your own without stopping and without discomfort?

- 200 metres or more <sub>1</sub> q03q28\_0  
 More than a few steps but less than 200 metres <sub>2</sub>  
 Only a few steps <sub>3</sub>

28.1 Can you walk up and down a flight of 12 stairs without resting?

- Yes <sub>1</sub>  
 Only if I hold on and take a rest <sub>2</sub> q03q28\_1  
 Not at all <sub>3</sub>

28.2 Can you, when standing, bend down and pick up a shoe from the floor?

- Yes  q03q28\_2  
 No

29.0 Please indicate if you have difficulty doing any of the following activities:

No difficulty      Some difficulty      Unable to do or need help

- |   |                          |  |                                      |                          |
|---|--------------------------|--|--------------------------------------|--------------------------|
| Reaching or extending your arms above shoulder level                              | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_1  | <input type="checkbox"/> |
| Pulling or pushing large objects like a living room chair                         | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_2  | <input type="checkbox"/> |
| Walking across a room   | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_3  | <input type="checkbox"/> |
| Getting in and out of bed on your own?  | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_4  | <input type="checkbox"/> |
| Getting in and out of a chair on your own?  | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_5  | <input type="checkbox"/> |
| Dressing and undressing yourself on your own?                                     | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_6  | <input type="checkbox"/> |
| Bathing or showering?   | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_7  | <input type="checkbox"/> |
| Feeding yourself, including cutting food?   | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_8  | <input type="checkbox"/> |
| Getting to and using the toilet on your own?                                      | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_9  | <input type="checkbox"/> |
| Lifting and carrying something as heavy as 10 lbs, for example a bag of groceries | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_10 | <input type="checkbox"/> |
| Shopping for personal items such as toilet items or medicine by yourself          | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_11 | <input type="checkbox"/> |
| Doing light housework such as washing up  | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_12 | <input type="checkbox"/> |
| Preparing your own meals by yourself  | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_13 | <input type="checkbox"/> |
| Using the telephone by yourself   | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_14 | <input type="checkbox"/> |
| Taking medications by yourself  | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_15 | <input type="checkbox"/> |
| Managing money (e.g. paying bills etc)  | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_16 | <input type="checkbox"/> |
| Using public transport on your own  | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_17 | <input type="checkbox"/> |
| Driving a car on your own   | <input type="checkbox"/> |  | <input type="checkbox"/> q03q29_0_18 | <input type="checkbox"/> |

Time spent on various activities

30.0 Approximately how many **hours each week** (if any) do you spend:

Tick box if you never do

q03q30_0_1	Looking after wife/partner?	<input type="text"/>	<input type="text"/>	hours per week	<input type="checkbox"/>
q03q30_0_2	Looking after other adult family member or friend?	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>
q03q30_0_3	Looking after grandchildren?	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>
q03q30_0_4					
q03q30_0_5					
q03q30_0_6					
q03q30_0_7	In paid work?	<input type="text"/>	<input type="text"/>	hours per week	<input type="checkbox"/>
q03q30_0_8					
q03q30_0_9	In voluntary work?	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>
q03q30_0_10					
q03q30_0_11	On housework?	<input type="text"/>	<input type="text"/>	hours per week	<input type="checkbox"/>
q03q30_0_12	On gardening?	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>
q03q30_0_13					
q03q30_0_14					
q03q30_0_15	In a pub or club?	<input type="text"/>	<input type="text"/>	hours per week	<input type="checkbox"/>
q03q30_0_16	Attending religious services?	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>
q03q30_0_17					
q03q30_0_18					
q03q30_0_19	Playing cards, games, or bingo?	<input type="text"/>	<input type="text"/>	hours per week	<input type="checkbox"/>
q03q30_0_20	Visiting the cinema/restaurants/sporting events?	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>
q03q30_0_21					
q03q30_0_22					
q03q30_0_23	Watching television/videos?	<input type="text"/>	<input type="text"/>	hours per week	<input type="checkbox"/>
q03q30_0_24	Reading?	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>
q03q30_0_25	Attending class or course of study?	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>
q03q30_0_26					
q03q30_0_27					
q03q30_0_28					

31.0	Do you go on day or overnight trips...	Never	<input type="checkbox"/>	1	
		Sometimes	<input type="checkbox"/>	2	q03q31_0
		Often	<input type="checkbox"/>	3	
		Yes	<input type="checkbox"/>		
		No	<input type="checkbox"/>		q03q31_1
31.1	Have you been on holiday in the last year?				

**Thank you very much for completing the questionnaire.**

**Please return it to us, along with the blue consent form, in the envelope provided.**

**No stamp is needed.**