Study Number: | | | | | | | |
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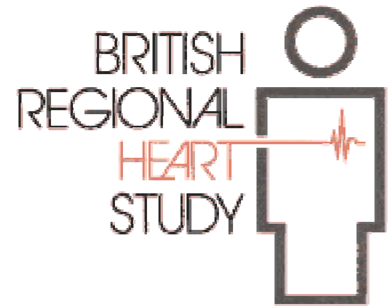


BRITISH REGIONAL HEART STUDY

2007 QUESTIONNAIRE

Thank you very much for taking the time to complete this questionnaire, which will bring us up to date with your present health and lifestyle. 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
University College London
Hampstead Campus
Rowland Hill Street
London NW3 2PF

DATES

1.0 Please enter today's date q07q1_0d ______ (day) q07q1_0m ______ (month) **2007**

1.1 Please give your Date of Birth q07q1_1d ______ (day) q07q1_1m ______ (month) 19 q07q1_1y ______ (year)

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

Conditions affecting the heart or circulation

2.0 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 this last happened.

		Yes	No		Year of last occurrence
a	Heart attack (coronary thrombosis or myocardial infarction)	☐	☐	q07q2_0a	q07q2_0ay
b	Heart failure	☐	☐	q07q2_0b	q07q2_0by
c	Angina	☐	☐	q07q2_0c	q07q2_0cy
d	Other heart trouble	☐	☐	q07q2_0d	q07q2_0dy
e	High blood pressure	☐	☐	q07q2_0e	q07q2_0ey
f	High blood cholesterol	☐	☐	q07q2_0f	q07q2_0fy
g	Aortic Aneurysm	☐	☐	q07q2_0g	q07q2_0gy
h	Narrowing or hardening of the leg arteries (including claudication)	☐	☐	q07q2_0h	q07q2_0hy
i	Deep Vein Thrombosis (clot in the deep leg vein)	☐	☐	q07q2_0i	q07q2_0iy
j	Pulmonary Embolism (clot on the lung)	☐	☐	q07q2_0j	q07q2_0jy

		Yes	No		Year
2.1	Do you have any other problems of the heart and circulation	☐	☐	q07q2_01	q07q2_01y

If Yes, please give details:

q07q2_01x

Office Use ☐

Stroke

		Yes	No		Year of last occurrence
3.0	Have you **ever** been told by a doctor that you have had a stroke?	☐	☐	q07q3_0	q07q3_0y
	If Yes,				
3.1	Did the symptoms last for more than 24 hours?	☐	☐	q07q3_1	
3.2	Have you made a complete recovery from your stroke?	☐	☐	q07q3_2	
3.3	Following your stroke, do you still need any help in carrying out everyday activities?	☐	☐	q07q3_3	

Investigations and special treatment for conditions affecting the heart and circulation

4.0 Have you **ever** had one of the following?

		Yes	No		Year of last occurrence
a	A referral to a heart specialist	☐	☐	q07q4_0a	q07q4_0ay
b	A referral to a chest pain clinic	☐	☐	q07q4_0b	q07q4_0by
c	An exercise ECG ("stress" or "treadmill") test	☐	☐	q07q4_0c	q07q4_0cy
d	Angiogram or X-ray of coronary arteries (using a dye)	☐	☐	q07q4_0d	q07q4_0dy
e	Angioplasty (balloon treatment of coronary artery for angina)	☐	☐	q07q4_0e	q07q4_0ey
f	Coronary artery bypass graft operation ("heart bypass" or "CABG")	☐	☐	q07q4_0f	q07q4_0fy
g	Other tests, investigations or operations on the heart, arteries or veins?	☐	☐	q07q4_0g	q07q4_0gy

If Yes, please give details: q07q4_0gx

Office Use ☐

Diabetes

		Yes	No		Year of diagnosis
5.0	Have you **ever** been told by a doctor that you have or have had diabetes?	☐	☐	q07q5_0	q07q5_0y

5.1 If Yes,
Do you have any complications of diabetes affecting your (Please tick whichever apply)

feet ☐ 1 q07q5_1f kidneys ☐ 1 q07q5_1k

nerves ☐ 1 q07q5_1n eyes ☐ 1 q07q5_1e

Cancer

		Yes	No		Year of diagnosis
6.0	Have you **ever** been told by a doctor that you have or have had cancer?	☐	☐	q07q6_0	q07q6_0y

6.1 If Yes, please give the Cancer Site (parts of the body affected)

Office Use

q07q6_1a
----

q07q6_1b

Liver Disease

		Yes	No	Year of diagnosis
7.0	Have you **ever** been told by a doctor that you have an illness or disease affecting the liver?	☐	☐ q07q7_0	q07q7_0y

If Yes, please give the name of the condition

Office Use

q07q7_0x ☐

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 this last happened.

		Yes	No	Year
a	Asthma	☐	☐ q07q8_0a	q07q8_0ay
b	Bronchitis	☐	☐ q07q8_0b	q07q8_0by
c	Cataract	☐	☐ q07q8_0c	q07q8_0cy
d	Depression	☐	☐ q07q8_0d	q07q8_0dy
e	Emphysema	☐	☐ q07q8_0e	q07q8_0ey
f	Gall bladder disease	☐	☐ q07q8_0f	q07q8_0fy
g	Gastric, peptic or duodenal ulcer	☐	☐ q07q8_0g	q07q8_0gy
h	Glaucoma	☐	☐ q07q8_0h	q07q8_0hy
i	Gout	☐	☐ q07q8_0i	q07q8_0iy
j	Osteoporosis	☐	☐ q07q8_0j	q07q8_0jy
k	Parkinson's disease	☐	☐ q07q8_0k	q07q8_0ky
l	Pneumonia	☐	☐ q07q8_0l	q07q8_0ly
m	Prostate trouble	☐	☐ q07q8_0m	q07q8_0my
N	Chronic Kidney disease	☐	☐ q07q8_0n	q07q8_0ny

o Other conditions, please give details

q07q8_0o1y
q07q8_0o1x
q07q8_0o2x
q07q8_0o2y

Office Use

Arthritis

		Yes	No	Year of diagnosis
9.0	Have you **ever** been told by a doctor that you have or have had arthritis?	☐	☐ q07q9_0	q07q9_0y

9.1 If Yes, please give the type of arthritis if known,:

Osteoarthritis ☐1
Rheumatoid arthritis ☐2
Other (please give details) --

Office Use

q07q9_1o ☐

9.2 Which joints are affected: (Please tick whichever apply)

Knees	☐1 q07q9_2k	Back	☐1 q07q9_2b
Hips	☐1 q07q9_2h	Neck	☐1 q07q9_2n
Feet	☐1 q07q9_2f	Shoulders	☐1 q07q9_2s
Hands and / or wrists	☐1 q07q9_2hw	Other (please specify)	q07q9_2o --

Office Use ☐

Joint pain, swelling or stiffness

10.0 During **the past year** have you had pain, aching, stiffness or swelling on most days for at least one month, in your: (Please tick whichever apply)

Knees	☐1	q07q10_0k	Back	☐1	q07q10_0b
Hips	☐1	q07q10_0h	Neck	☐1	q07q10_0n
Feet	☐1	q07q10_0f	Shoulders	☐1	q07q10_0s
Hands and / or wrists	☐1	q07q10_0hw	Other (please specify)		q07q10_0o

Office Use ☐

Lower back pain

		Yes	No	
11.0	Have you **ever** had pain in your lower back on most days for at least one month?	☐	☐	q07q11_0
11.1	If Yes, have you had this in the **last year**?	☐	☐	q07q11_1

Fractures and falls

		Yes	No	Please give year
12.0	Have you **ever** fractured your hip?	☐	☐	q07q12_0 q07q12_0y ____
12.1	Have you **ever** fractured your wrist?	☐	☐	q07q12_1 q07q12_1y ____
12.2	Have you had a fall in the **last year**?	☐	☐	q07q12_2
12.3	If Yes, how many times ___ ___			q07q12_3

		Yes	No	
12.4	Did you receive medical attention for any of these falls?	☐	☐	q07q12_4

Operations

		Yes	No	
13.0	Have you had any major operations in the **last 2 years**?	☐	☐	q07q13_0

If Yes, please give details:

q07q13_0x

----

q07q13_0y

Office Use ☐☐☐ ☐☐☐

Chest Pain

		Yes	No	
14.0	Do you **ever** have any pain or discomfort in your chest?	☐	☐	q07q14_0

If Yes,

		Yes	No	Unable to walk on level	
14.1	When you walk at an ordinary pace on the level, does this produce the pain?	☐1	☐2	☐3	q07q14_1

		Yes	No	Unable to walk uphill	
14.2	When you walk uphill or hurry, does this produce the pain?	☐1	☐2	☐3	q07q14_2

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?	☐1	☐2	☐3	q07q15_0
15.1	On walking uphill or upstairs, do you get more breathless than people of your own age?	☐1	☐2	☐3	q07q15_1
15.2	Do you **ever** have to stop walking because of breathlessness?	☐	☐		q07q15_2
15.3	In the **past year** have you at any time been awoken at night by an attack of shortness of breath?	☐	☐		q07q15_3

Cough and Wheeze

		Yes	No	
15.4	Do you usually bring up phlegm (or spit) from your chest first thing in the morning in the winter?	☐	☐	q07q15_4
15.5	Do you bring up phlegm like this on most days for as much as 3 months in the winter each year?	☐	☐	q07q15_5

15.6 In the **past two years** have you had a period of increased cough and phlegm lasting for 3 weeks or more?

Yes, once ☐1 q07q15_6
Yes, twice or more ☐2
Never ☐3

		Yes	No	
15.7	Does your chest ever sound wheezy or whistling?	☐	☐	q07q15_7
15.8	If Yes, does this happen on most days or nights?	☐	☐	q07q15_8

15.9 How many times in the past year have you had a chest infection requiring antibiotic treatment from your doctor?

None ☐1 q07q15_9
Once ☐2
More than once ☐3

Eyesight

		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**)?	☐	☐	q07q16_0
16.1	If No, can you see well enough to recognise a friend at a distance of one yard?	☐	☐	q07q16_1

16.2 In the **past two years** has your sight:

deteriorated ☐1 q07q16_2
improved ☐2
stayed the same ☐3

Hearing

		Yes	No	
16.3	Is your hearing good enough to follow a TV programme at a volume others find acceptable (using a hearing aid if needed)?	☐	☐	q07q16_3
16.4	If No, can you follow a TV programme with the volume turned up?	☐	☐	q07q16_4

16.5 In the **past two years** has your hearing:

deteriorated	☐1	q07q16_5
improved	☐2	
stayed the same	☐3	

		Yes	No	Occasionally	
16.6	Do you use a hearing aid?	☐1	☐2	☐3	q07q16_6

Leg Pain

		Yes	No	
17.0	Do you get pain or discomfort in your leg or legs when you walk?	☐	☐	q07q17_0
	If Yes,			
17.1	Do you know the cause of the pain?	☐	☐	q07q17_1

Office Use

If Yes, please state cause -- ☐

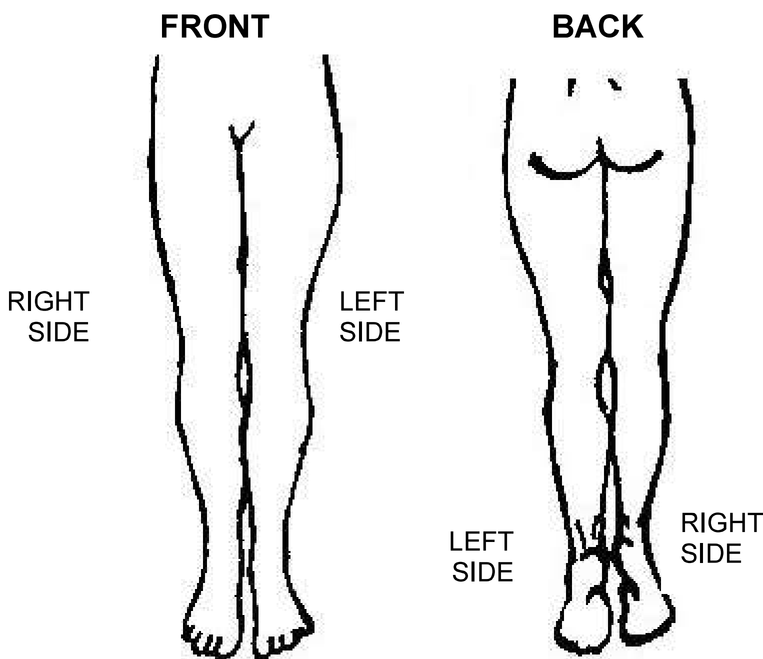
		Yes	No	
17.2	Does this pain ever begin when you are standing still or sitting?	☐	☐	q07q17_2

		Yes	No	Unable to walk	
17.3	Do you get the pain if you walk uphill or hurry?	☐1	☐2	☐3	q07q17_3
17.4	Do you get the pain walking at an ordinary pace on the level?	☐1	☐2	☐3	q07q17_4

17.5 What happens to the pain if you stand still?

Usually continues more than 10 minutes	☐1	q07q17_5
Usually disappears in 10 minutes or less	☐2	

17.6 Please mark on the diagram below where you get the pain.



Office Use

q07q17_6l L ☐

q07q17_6r R ☐

Weight

18.0 What is your present weight (indoor clothes, without shoes)?

q07q18_0st ___ ___ Stones q07q18_0lb ___ ___ Pounds **or** q07q18_0kg ___ ___ ___ Kilograms

18.1 If you have no scales and have made an estimate please tick here ☐ q07q18_1

		Yes	No	
18.2	Have you tried to lose weight in the **last two years**?	☐	☐	q07q18_2

If Yes, did you: (Please tick whichever apply)

- Change your diet? ☐1 q07q18_2di
- Take more exercise? ☐1 q07q18_2ex

		Yes	No	
18.3	Have you been advised by a doctor or other health professional to lose weight in the **last two years**?	☐	☐	q07q18_3

18.4 Has your weight changed in the **last two years**? q07q18_4

- Not changed ☐1
- Increased ☐2
- Decreased ☐3
- Both increased and decreased ☐4
- Don't know ☐5

If your weight has changed in the last two years…

18.5 By what amount has your weight changed? q07q18_5st _____ Stones q07q18_5lb _____ Pounds **or** q07q18_5kg _____ Kilograms

		Yes	No	
18.6	Was this change intentional?	☐	☐	q07q18_6

18.7 Was it the result of

- Personal choice ☐1 q07q18_7pc
- Medical advice ☐1 q07q18_7ma
- Illness or ill health ☐1 q07q18_7il

18.8 Do you consider your present weight to be q07q18_8

- about right ☐1
- too high ☐2
- too low ☐3

Cigarette smoking

		Yes	No	
19.0	Do you smoke cigarettes at present?	☐	☐	q07q19_0

If yes,

19.1 How many cigarettes a day do you smoke at present? ___ ___ q07q19_1

Pipe and cigar smoking

		Yes	No	
20.0	Do you currently smoke a pipe?	☐	☐	q07q20_0
20.1	Do you currently smoke cigars?	☐	☐	q07q20_1

Alcohol Intake

21.0 Would you describe your present alcohol intake as q07q21_0

- Daily/most days ☐1
- Weekends only ☐2
- Occasionally once or twice a month ☐3
- Special occasions only ☐4
- None ☐5

Alcohol Intake, continued

One drink is **HALF A PINT** of beer/lager/cider, a **SINGLE** whisky, gin, etc. or **ONE GLASS (small, 125ml)** of wine or sherry

21.1 How much do you usually drink on the days when you drink alcohol? q07q21_1

- More than 6 drinks ☐1
- 5-6 drinks ☐2
- 3-4 drinks ☐3
- 1-2 drinks ☐4

21.2 How many alcoholic drinks do you have during an average week? __ __ q07q21_2

21.3 What type of drink do you usually take?

- Beers, Lagers ☐1 q07q21_3bl
- Wines, Sherry ☐1 q07q21_3ws
- Spirits ☐1 q07q21_3s
- Combination of Beers, Wines or Spirits ☐1 q07q21_3com
- Low alcohol drinks ☐1 q07q21_3lo

21.4 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	q07q21_4bl	☐	☐	☐	☐	☐	☐
Red Wine single glass	q07q21_4rw	☐	☐	☐	☐	☐	☐
White Wine single glass	q07q21_4ww	☐	☐	☐	☐	☐	☐
Spirits 1 drink / shot	q07q21_4sp	☐	☐	☐	☐	☐	☐

21.5 Is the alcohol which you drink usually taken…… (Please tick whichever apply)

- before meals ☐1 q07q21_5bm
- with meals ☐1 q07q21_5wm
- after meals ☐1 q07q21_5am
- separate from meals ☐1 q07q21_5sm

21.6 Have you reduced your alcohol intake in the last two years? Yes ☐ No ☐ q07q21_6

21.7 Was this due to: (please tick whichever apply)

- Personal choice ☐1 q07q21_7pc
- Doctor's advice ☐1 q07q21_7da
- Illness or ill-health ☐1 q07q21_7il
- Health precaution ☐1 q07q21_7hp
- Being on medication ☐1 q07q21_7bm
- Financial reasons ☐1 q07q21_7fr
- Other ☐1 q07q21_7ot

		Yes	No	
21.8	Have you ever felt you ought to cut down on your drinking?	☐	☐	q07q21_8
21.9	Have people annoyed you by criticizing your drinking?	☐	☐	q07q21_9
21.10	Have you ever felt bad or guilty about your drinking?	☐	☐	q07q21_10
21.11	Have you ever had a drink first thing in the morning (eye-opener) to steady your nerves or get rid of a hangover?	☐	☐	q07q21_11

Your overall health

Please indicate which statements best describe your health **TODAY.**

Please tick **only one box**

22.0 **General Health**

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

q07q22_0

22.1 **Pain/Discomfort**

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

q07q22_1

22.2 **Mobility**

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

q07q22_2

22.3 **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

q07q22_3

Sleeping patterns

22.4 On average, how many hours of sleep do you have in a **24 hour period**?

Please include day-time and night-time sleep

q07q22_4 ___ ___ hours

22.5 During **the last month**, did you have difficulties falling asleep?

- almost never ☐1
- sometimes ☐2
- often ☐3

q07q22_5

22.6 During **the last month**, how often did you wake up during the night?

- almost never ☐1
- sometimes ☐2
- often ☐3

q07q22_6

Your Memory

22.7 In the past year, how often did you have trouble remembering things?

- never ☐1
- rarely ☐2
- sometimes ☐3
- often ☐4

q07q22_7

22.8 **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

0 — 10 — 20 — 30 — 40 — 50 — 60 — 70 — 80 — 90 — 100

Office Use

q07q22_8 ☐☐☐

Physical activity

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

- No ☐1
- Walk ☐2
- Cycle ☐3
- Both ☐4

q07q23_0

23.1 How many hours do you normally spend walking e.g. on errands or for leisure in an average week?

___ ___ hours q07q23_1

23.2 Which of the following best describes your usual walking pace?

- Slow ☐1
- Steady average ☐2
- Fast ☐3

q07q23_2

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

___ ___ hours q07q22_3

23.4 Compared with a man who spends two hours on most days 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

q07q23_4

23.5 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

q07q23_5

23.6 If you ticked **frequently** please state type of activities:

q07q23_6

Office Use ☐☐

- -

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

(please give overall total)

In winter ___ ___ times q07q23_7w

In summer ___ ___ times q07q23_7s

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

Yes ☐ No ☐ q07q23_8

23.9 If Yes, on average how many **hours per week** do you engage in these exercises?

___ ___ Hours q07q23_9

Disability

24.0 Do you have any **long-standing** illness, disability or infirmity? Yes ☐ No ☐ q07q24_0

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

If Yes,

		Yes	No	
a	Does this illness or disability limit your activities in any way?	☐	☐	q07q24_0a
b	Do you receive a disability allowance?	☐	☐	q07q24_0b

24.1 Do you currently have difficulty carrying out any of the following activities on your own as a result of a **long term** health problem?

		Yes	No	
a	Going up or down stairs	☐	☐	q07q24_1a
b	Bending down	☐	☐	q07q24_1b
c	Straightening up	☐	☐	q07q24_1c
d	Keeping your balance	☐	☐	q07q24_1d
e	Going out of the house	☐	☐	q07q24_1e
f	Walking 400 yards	☐	☐	q07q24_1f

24.2 Is your present state of health causing problems with any of the following:-

		Yes	No	Does not apply	
a	Job at work paid employment	☐1	☐2	☐3	q07q24_2a
b	Household chores	☐	☐		q07q24_2b
c	Social life	☐	☐		q07q24_2c
d	Sex life	☐	☐		q07q24_2d
e	Interests and hobbies	☐	☐		q07q24_2e
f	Holidays and outings	☐	☐		q07q24_2f

Present circumstances

25.0 Are you at present:-

single ☐1
married ☐2
widowed ☐3
divorced or separated ☐4
other ☐5

q07q25_0

25.1 If you are widowed or divorced/separated, please give the year when this occurred:- q07q25_1 ______

25.2 Are you at present:-

living alone ☐1
living with a partner or spouse ☐2
living with other family members ☐3
living with other people ☐4

q07q25_2

Your accommodation

25.3 Are you:- q07q25_3

an owner occupier ☐1
renting from the local authority ☐2
renting privately ☐3
living in a residential home ☐4
living in a nursing home ☐5
living in sheltered accommodation ☐6
other please give details ☐7 q07q25_3x ______

Office Use ☐

25.4 During the winter, is your accommodation usually:

Very warm	☐1	q07q25_4
Warm	☐2	
Medium	☐3	
Cold	☐4	
Very cold	☐5	

	Yes	No	
25.5 Do you have a car available for your own use?	☐	☐	q07q25_5
25.6 Do you have private medical insurance?	☐	☐	q07q25_6

25.7 Which of the following phrases best describes how you are managing financially these days?

manage very well	☐1	q07q25_7
manage quite well	☐2	
get by alright	☐3	
don't manage very well	☐4	
have some financial difficulties	☐5	
have severe financial difficulties	☐6	

25.8 What type of financial support do you currently have? (Please tick whichever apply)

q07q25_8sp	State pension	☐1	q07q25_8ep	Employer provided occupational pension scheme	☐1
q07q25_8pp	Private Personal Pension	☐1	q07q25_8ra	Retirement Annuity pensions pre 86 PPPs	☐1
q07q25_8st	Stakeholder pension	☐1	q07q25_8s2	S226 plan self-employed personal pension	☐1
q07q25_8gp	Group Personal Pension	☐1	q07q25_8or	Other retirement saving scheme	☐1
q07q25_8pe	Earnings from paid employment	☐1			

Your family - grandparents

We would like to know a bit more about your family history.
When were your grandparents born? And where? And at what age did they die? If you do not know precisely please give as much detail as possible

Place of birth:

		a) Year of birth	b) City or town or village	c) County	d) Country	e) Age at death	Office use
26.0	Your grandmother (father's side)	q07q26_0yr		q07q26_0wh		q07q26_0age	
26.1	Your grandfather (father's side)	q07q26_1yr		q07q26_1wh		q07q26_1age	
26.2	Your grandmother (mother's side)	q07q26_2yr		q07q26_2wh		q07q26_2age	
26.3	Your grandfather (mother's side)	q07q26_3yr		q07q26_3wh		q07q26_3age	

Time spent on various activities

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

		Hours per week	
a	Looking after wife/partner	____ ____	q07q27_0a
b	Looking after other adult family member or friend	____ ____	q07q27_0b
c	Looking after grandchildren	____ ____	q07q27_0c
d	Spending time with family, friends and neighbours	____ ____	q07q27_0d
e	Talking with friends/relatives on the telephone	____ ____	q07q27_0e
f	In paid work	____ ____	q07q27_0f
g	In voluntary work	____ ____	q07q27_0g
h	On housework	____ ____	q07q27_0h
i	On gardening	____ ____	q07q27_0i
j	In a pub or club	____ ____	q07q27_0j
k	Attending religious services	____ ____	q07q27_0k
l	Playing cards, games, or bingo	____ ____	q07q27_0l
m	Visiting the cinema/restaurants/sporting events	____ ____	q07q27_0m
n	Watching television/videos/DVD's	____ ____	q07q27_0n
o	Reading	____ ____	q07q27_0o
p	Attending class or course of study	____ ____	q07q27_0p
q	Using a computer	____ ____	q07q27_0q

28.0 Do you go on day or overnight trips? q07q28_0

- Never ☐1
- Sometimes ☐2
- Often ☐3

	Yes	No	
28.1 Have you been on holiday in the last year?	☐	☐	q07q28_1
28.2 Do you use the internet and or email?	☐	☐	q07q28_2

Activities of daily living

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

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

- 200 yards or more ☐1
- More than a few steps but less than 200 yards ☐2
- Only a few steps ☐3

q07q29_0

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

- Yes ☐1
- Only if I hold on and take a rest ☐2
- Not at all ☐3

q07q29_1

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

- Yes ☐1
- No ☐2

q07q29_2

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

			No difficulty 1	Some difficulty 2	Unable to do or need help 3
a	q07q30_0a	Reaching or extending your arms above shoulder level	☐	☐	☐
b	q07q30_0b	Pulling or pushing large objects like a living room chair	☐	☐	☐
c	q07q30_0c	Walking across a room	☐	☐	☐
d	q07q30_0d	Getting in and out of bed on your own	☐	☐	☐
e	q07q30_0e	Getting in and out of a chair on your own	☐	☐	☐
f	q07q30_0f	Dressing and undressing yourself on your own	☐	☐	☐
g	q07q30_0g	Bathing or showering	☐	☐	☐
h	q07q30_0h	Feeding yourself, including cutting food	☐	☐	☐
i	q07q30_0i	Getting to and using the toilet on your own	☐	☐	☐
j	q07q30_0j	Lifting and carrying something as heavy as 10 lbs, for example a bag of groceries	☐	☐	☐
k	q07q30_0k	Shopping for personal items such as toilet items or medicine by yourself	☐	☐	☐
l	q07q30_0l	Doing light housework such as washing up	☐	☐	☐
m	q07q30_0m	Preparing your own meals by yourself	☐	☐	☐
n	q07q30_0n	Using the telephone by yourself	☐	☐	☐
o	q07q30_0o	Taking medications by yourself	☐	☐	☐
p	q07q30_0p	Managing money (e.g. paying bills etc)	☐	☐	☐
q	q07q30_0q	Using public transport on your own	☐	☐	☐
r	q07q30_0r	Driving a car on your own	☐	☐	☐
s	q07q30_0s	Gripping with hands (eg. opening a jam jar)	☐	☐	☐

During the past week

31.0

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way **during the past week** (please tick one box on each line)

			Rarely or none of the time (less than 1 day)	Some or a little of the Time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)	All of the time (5-7 days)
a	I was bothered by things that usually don't bother me	q07q31_0a	☐1	☐2	☐3	☐4
b	I had trouble keeping my mind on what I was doing	q07q31_0b	☐1	☐2	☐3	☐4
c	I felt depressed	q07q31_0c	☐1	☐2	☐3	☐4
d	I felt that everything I did was an effort	q07q31_0d	☐1	☐2	☐3	☐4
e	I felt hopeful about the future	q07q31_0e	☐1	☐2	☐3	☐4
f	I felt fearful	q07q31_0f	☐1	☐2	☐3	☐4
g	My sleep was restless	q07q31_0g	☐1	☐2	☐3	☐4
h	I was happy	q07q31_0h	☐1	☐2	☐3	☐4
j	I felt lonely	q07q31_0j	☐1	☐2	☐3	☐4
m	I could not "get going"	q07q31_0m	☐1	☐2	☐3	☐4
				Office use ☐	Office use ☐	Office use ☐

31.1 If you ticked that you have experienced any of the problems mentioned in the above question **at least 1 day this week**, please can you tell us how difficult these problems made it for you to do your work, take care of things at home, or get along with other people?

q07q31_1

- Not difficult at all ☐1
- Somewhat difficult ☐2
- Very difficult ☐3
- Extremely difficult ☐4

Preventive Health Care

32.0 Approximately how many times in the **last year** have you consulted your GP about a health problem?

q07q32_0 ___ ___ times

32.1 If none, in what **year** did you last consult a GP about a health problem? q07q32_1 ______

32.2 Have you had any of the following in the **last two years**:

		Yes	No	
a	Blood pressure check	☐	☐	q07q32_2a
b	Blood cholesterol check	☐	☐	q07q32_2b
c	Flu vaccination	☐	☐	q07q32_2c

Medicines

		Yes	No		Year started
33.0	Do you take any regular medication?	☐	☐	q07q33_0	
	If Yes, do you take any of the following medicines regularly?	Yes	No		Year started
a	Treatment for any form of heart disease	☐	☐	q07q33_0a	q07q33_0ay
b	Treatment to lower blood pressure	☐	☐	q07q33_0b	q07q33_0by
c	Treatment to lower blood cholesterol	☐	☐	q07q33_0c	q07q33_0cy
d	Treatment to lower triglycerides	☐	☐	q07q33_0d	

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

Office Use

a Please give the name of this medicine: q07q33_1a ------------------------------

b Please give the amount you take each day: q07q33_1b ___ ___ ___ mg
(details of the amount in each tablet should be on the bottle)

Aspirin

		Yes	No		Year started
33.2	Do you take aspirin regularly?	☐	☐	q07q33_2	q07q33_2y
	If Yes,				
a	Is this prescribed by your doctor?	☐	☐	q07q33_2a	

b What dose do you take? q07q33_2a_mg ___ ___ ___. mg
(details of the amount in each tablet should be on the bottle)

c How often do you take it?
Daily ☐1
Every other day ☐2
Weekly ☐3
q07q33_2c

Office Use

d Why do you take it? q07q33_2d --

Details of ALL medicines

34.0 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 known)	Year started	Is this prescribed? Yes	No	Office Use
1	q07q34_0_bnf12_1 q07q34_0_bnf34_1 q07q34_0_bnf5_1 q07q34_0_bnf6_1	q07q34_0_icd1 q07q34_0_x4d1	q07q34_0_med_year1	☐ q07q34_0_medpr1 Yes	☐ No	
2	q07q34_0_bnf12_2 q07q34_0_bnf34_2 q07q34_0_bnf5_2 q07q34_0_bnf6_2	q07q34_0_icd2 q07q34_0_x4d2	q07q34_0_med_year2	☐ q07q34_0_medpr2 Yes	☐ No	
3	q07q34_0_bnf12_3 q07q34_0_bnf34_3 q07q34_0_bnf5_3 q07q34_0_bnf6_3	q07q34_0_icd3 q07q34_0_x4d3	q07q34_0_med_year3	☐ q07q34_0_medpr3 Yes	☐ No	
4	q07q34_0_bnf12_4 q07q34_0_bnf34_4 q07q34_0_bnf5_4 q07q34_0_bnf6_4	q07q34_0_icd4 q07q34_0_x4d4	q07q34_0_med_year4	☐ q07q34_0_medpr4 Yes	☐ No	
5	q07q34_0_bnf12_5 q07q34_0_bnf34_5 q07q34_0_bnf5_5 q07q34_0_bnf6_5	q07q34_0_icd5 q07q34_0_x4d5	q07q34_0_med_year5	☐ q07q34_0_medpr5 Yes	☐ No	
6	q07q34_0_bnf12_6 q07q34_0_bnf34_6 q07q34_0_bnf5_6 q07q34_0_bnf6_6	q07q34_0_icd6 q07q34_0_x4d6	q07q34_0_med_year6	☐ q07q34_0_medpr6 Yes	☐ No	
7	q07q34_0_bnf12_7 q07q34_0_bnf34_7 q07q34_0_bnf5_7 q07q34_0_bnf6_7	q07q34_0_icd7 q07q34_0_x4d7	q07q34_0_med_year7	☐ q07q34_0_medpr7 Yes	☐ No	
8	q07q34_0_bnf12_8 q07q34_0_bnf34_8 q07q34_0_bnf5_8 q07q34_0_bnf6_8	q07q34_0_icd8 q07q34_0_x4d8	q07q34_0_med_year8	☐ q07q34_0_medpr8 Yes	☐ No	
9	q07q34_0_bnf12_9 q07q34_0_bnf34_9 q07q34_0_bnf5_9 q07q34_0_bnf6_9	q07q34_0_icd9 q07q34_0_x4d9	q07q34_0_med_year9	☐ q07q34_0_medpr9 Yes	☐ No	
10	q07q34_0_bnf12_10 q07q34_0_bnf34_10 q07q34_0_bnf5_10 q07q34_0_bnf6_10	q07q34_0_icd10 q07q34_0_x4d10	q07q34_0_med_year10	☐ q07q34_0_medpr10	☐	

Vitamins, minerals and complementary therapies

		Yes	No
35.0	Do you regularly take any **vitamins**, **minerals** and **complementary therapies**?	☐	☐
		q07q35_0	

If Yes, please give details: please include homeopathic and herbal treatments

	Name of medicine	Reason for taking (if known)	Year started	Office Use
1	q07q35_0_2 q07q35_0_3 q07q35_0_4 q07q35_0_5	q07q35_0_6 q07q35_0_7	q07q35_0_vit_year	
2	q07q35_0_9 q07q35_0_10 q07q35_0_11 q07q35_0_12	q07q35_0_13 q07q35_0_14	q07q35_0_8_vit_year	
3	q07q35_0_16 q07q35_0_17 q07q35_0_18 q07q35_0_19	q07q35_0_20 q07q35_0_21	q07q35_0_15_vit_year	
4	q07q35_0_23 q07q35_0_24 q07q35_0_25 q07q35_0_26	q07q35_0_27 q07q35_0_28	q07q35_0_22_vit_year	
5	q07q35_0_30 q07q35_0_31 q07q35_0_32 q07q35_0_33	q07q35_0_34 q07q35_0_35	q07q35_0_29_vit_year	
6				

Thank you very much for completing the questionnaire.
Please return it to us in the envelope provided. No stamp is needed.

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