Study Number: | | | | | | | | | | q15coder

UCL

BRITISH REGIONAL HEART STUDY

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2015

Thank you very much for taking the time to complete this questionnaire, which will bring us up to date with your present health and circumstances. 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

Professor Peter Whincup & Ms Lucy Lennon
on behalf of the British Regional Heart Study research team

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Dates

1.0 Please enter today's date q15q1_0Day q15q1_0Month **20** q15q1_0Year

day month

1.1 Please give your Date of Birth q15q1_1Day q15q1_1Month 19 q15q1_1Year

day month 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?

		Yes	No	
a	Acute coronary syndrome	☐	☐	q15q2_0a
b	Angina	☐	☐	q15q2_0b
c	Aortic Aneurysm	☐	☐	q15q2_0c
d	Atrial Fibrillation	☐	☐	q15q2_0d
e	Deep Vein Thrombosis (clot in the deep leg vein)	☐	☐	q15q2_0e
f	Heart attack (coronary thrombosis or myocardial infarction)	☐	☐	q15q2_0f
g	Heart failure	☐	☐	q15q2_0g
h	High blood cholesterol	☐	☐	q15q2_0h
i	High blood pressure	☐	☐	q15q2_0i
j	Narrowing or hardening of the leg arteries (including claudication)	☐	☐	q15q2_0j
k	Pulmonary Embolism (clot on the lung)	☐	☐	q15q2_0k
l	Other problems of the heart and circulation	☐	☐	q15q2_0l
m	**If yes** , please give details _____			q15q2_0m_box

Stroke

		Yes	No	
3.0	Have you **ever** been told by a doctor that you have had a stroke?	☐	☐	q15q3_0
	If **yes**,			
a	Did the symptoms last for more than 24 hours?	☐	☐	q15q3_0a
b	Have you made a complete recovery from your stroke?	☐	☐	q15q3_0b

Investigations and special treatment for conditions affecting your heart and circulation

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

		Yes	No	
a	Angiogram or X-ray of coronary arteries (using a dye)	☐	☐	q15q4_0a
b	Angioplasty (balloon treatment of coronary artery, PCI, stents)	☐	☐	q15q4_0b
c	Coronary artery bypass graft operation ("heart bypass" or "CABG")	☐	☐	q15q4_0c

Diabetes

		Yes	No	Year of diagnosis
5.0	Have you **ever** been told by a doctor that you <u>have or have had</u> diabetes?	☐ q15q5_0	☐	q15q5_0y _____

5.1 **If yes**, do you have any complications of diabetes affecting your:

(Tick whichever apply)

a	feet	☐ 1	q15q5_1a
b	kidneys	☐ 1	q15q5_1b
c	eyes	☐ 1	q15q5_1c
d	nerves	☐ 1	q15q5_1d
e	none	☐ 1	q15q5_1e

Cancer

		Yes	No	Year of diagnosis
6.0	Have you **ever** been told by a doctor that you <u>have or have had</u> cancer?	q15q6_0 ☐	☐	q15q6_0y _____

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

q15q6_1Cancer_site1 _____

q15q6_1Cancer_site2 _____

Other medical conditions

7.0 Have you **ever** been told by a doctor that you <u>have or have had</u> any of the following conditions?

		Yes	No	
a	Alzheimer's disease	☐	☐	q15q7_0a
b	Anaemia	☐	☐	q15q7_0b
c	Asthma	☐	☐	q15q7_0c
d	Bronchitis	☐	☐	q15q7_0d
e	Cataract	☐	☐	q15q7_0e
f	Chronic Kidney disease	☐	☐	q15q7_0f
g	Chronic obstructive pulmonary disease (COPD)	☐	☐	q15q7_0g
h	Dementia	☐	☐	q15q7_0h
i	Depression	☐	☐	q15q7_0i
j	Emphysema	☐	☐	q15q7_0j
k	Glaucoma	☐	☐	q15q7_0k
l	Gout	☐	☐	q15q7_0l
m	Macular degeneration	☐	☐	q15q7_0m
n	Osteoporosis	☐	☐	q15q7_0n
o	Parkinson's disease	☐	☐	q15q7_0o
p	Pneumonia	☐	☐	q15q7_0p

q Other medical conditions, please give details q15q7_0q_other1

_____ q15q7_0q_other2

_____

Arthritis

		Yes	No	
8.0	Have you **ever** been told by a doctor that you <u>have</u> arthritis?	☐	☐	q15q8_0

8.1 **If yes**, which joints are affected: (Tick whichever apply)

Knees	☐ 1 q15q8_1knees	Back	☐ 1 q15q8_1back
Hips	☐ 1 q15q8_1hips	Neck	☐ 1 q15q8_1neck
Feet	☐ 1 q15q8_1feet	Shoulders	☐ 1 q15q8_1shoulder
Hands and / or wrists	☐ 1 q15q8_1wrist	Other, please specify	☐ 1 q15q8_1oth q15q8_1oth_box

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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? Yes No q15q9_0

9.1 **If yes**, which joints are affected: (Tick whichever apply)

Knees	q15q9_1knees 1	Back	q15q9_1back 1
Hips	q15q9_1hips 1	Neck	q15q9_1neck 1
Feet	q15q9_1feet 1	Shoulders	q15q9_1shoulder 1
Hands and / or wrists	q15q9_1wrist 1	Other, please specify	q15q9_1other 1 q15q9_1other_box

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Chest Pain

10.0 Do you **ever** have any pain or discomfort in your chest? Yes No q15q10_0

10.1 When you walk at an ordinary pace on the level, does this produce the chest pain? Yes No Unable to walk on level 3 q15q10_1

10.2 When you walk uphill or hurry, does this produce the chest pain? Yes No Unable to walk uphill 3 q15q10_2

Breathlessness

11.0 Do you **ever** get short of breath walking with other people of your own age on level ground? Yes No Unable to walk 3 q15q11_0

11.1 On walking uphill or upstairs, do you get more breathless than people of your own age? 3 q15q11_1

11.2 Do you **ever** have to stop walking because of breathlessness? 3 q15q11_2

11.3 In the **past year** have you at any time been awoken at night by an attack of shortness of breath? q15q11_3

Fractures

		Yes	No	
12.0	Have you **ever** fractured your hip (as an adult)?	☐	☐	q15q12_0
12.1	Have you **ever** fractured your wrist (as an adult)?	☐	☐	q15q12_1

Falls

13.0 At the present time, are you afraid that you may fall over? q15q13_0

- Very fearful ☐ 1
- Somewhat fearful ☐ 2
- Not fearful ☐ 3

		Yes	No	
13.1	Have you had a fall in the **last year**?	☐	☐	q15q13_1
13.2	**If yes**, how many times in the **past year**?	_____		q15q13_2
13.3	Did you receive medical attention for any of these falls?	☐	☐	q15q13_3

Dizziness

		Yes	No	
14.0	Have you had spells of dizziness, loss of balance or a sensation of spinning in the **last year**?	☐	☐	q15q14_0

Eyesight

15.0 Is your eyesight (with your glasses or lenses, if you wear them) q15q15_0

- Excellent/ good ☐ 1
- Fair ☐ 2
- Poor ☐ 3
- Very poor ☐ 4

		Yes	No	
15.1	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**)?	☐	☐	q15q15_1
15.2	**If no**, can you see well enough to recognise a friend at a distance of one yard?	☐	☐	q15q15_2

Hearing

16.0 Is your hearing (using a hearing aid if needed) q15q16_0

- Excellent/ good ☐ 1
- Fair ☐ 2
- Poor ☐ 3
- Very poor ☐ 4

		Yes	No	
16.1	Have you **ever** had a hearing test?	☐	☐	q15q16_1
16.2	**If yes**, were you offered a hearing aid?	☐	☐	q15q16_2

		Yes	No	Occasionally	
16.3	Do you use a hearing aid?	☐	☐	☐	q15q16_3

		Yes	No	
16.4	Is your hearing good enough to follow a TV programme at a volume others find acceptable (using a hearing aid if needed)?	☐	☐	q15q16_4
16.5	**If no**, can you follow a TV programme with the volume turned up?	☐	☐	q15q16_5

Weight

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

q15q17_0st ___ ___ Stones q15q17_0lb ___ ___ Pounds **or** q15q17_0kg ___ ___ ● ___ Kilograms

17.1 If you have no scales and have made an estimate please tick here ☐ 1 q15q17_1

		Yes	No	
17.2	Have you lost weight in the last year?	☐	☐	q15q17_2
17.3	**If yes,** was the weight loss intentional?	☐	☐	q15q17_3

Appetite

18.0 Have you noticed any change in your appetite over the past three months? q15q18_0

- no change in my appetite ☐ 1
- moderate loss of appetite ☐ 2
- severe loss of appetite ☐ 3
- improvement of appetite ☐ 4

18.1 If you have had a loss of appetite, what was the reason for this? _____ q15q18_1

Cigarette Smoking

		Yes	No	
19.0	Have you **ever** smoked cigarettes?	☐	☐	q15q19_0
19.1	Do you smoke cigarettes at present?	☐	☐	q15q19_1
19.2	If yes, how many cigarettes do you smoke per day?	_____		q15q19_2

Alcohol Intake

20.0 Would you describe your present alcohol intake as

Daily/most days	☐ 1	q15q20_0
Weekends only	☐ 2	
Occasionally once or twice a month	☐ 3	
Special occasions only	☐ 4	
None	☐ 5	

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

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

More than 6 drinks	☐ 1	q15q20_1
5-6 drinks	☐ 2	
3-4 drinks	☐ 3	
1-2 drinks	☐ 4	

20.2 How many alcoholic drinks do you have during an **average week**? q15q20_2 ____ ____

Grip Strength

21.0 How would you rate your hand grip strength compared to other people your age?

Very good	☐ 1	q15q21_0
Good	☐ 2	
Fair	☐ 3	
Poor	☐ 4	

Physical activity

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

Yes ☐ No ☐ q15q22_0

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

q15q22_1 _____ Hours/ week

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

q15q22_2

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

22.3 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?

q15q22_3

- Much more active ☐ 1
- More active ☐ 2
- Similar ☐ 3
- Less active ☐ 4
- Much less active ☐ 5

Mobility Aids

23.0 Do you use any mobility aids?

Yes ☐ No ☐ q15q23_0

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

Please tick all that apply

a Walking stick ☐ 1 q15q23_1a

b Walking frame ☐ 1 q15q23_1b

c Wheelchair/ mobility scooter ☐ 1 q15q23_1c

d Other ☐ 1 q15q23_1d

Your overall health

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

24.0 **General health**

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

q15q24_0

24.1 **Pain/discomfort**

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

q15q24_1

24.2 **Usual activities** (eg 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

q15q24_2

24.3 **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

q15q24_3

24.4 **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

q15q24_4

24.5 **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

q15q24_5

Long standing illness, disability or infirmity

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

q15q25_0

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

a **If yes**, does this illness or disability limit your activities in any way? Yes ☐ No ☐

q15q25_a

b do you receive a disability allowance? Yes ☐ No ☐

q15q25_b

Disability

26.0 Do you currently have difficulty carrying out any of the following activities on your own?

		Yes	No	
a	Going up or down stairs	☐	☐	q15q26_0a
b	Bending down	☐	☐	q15q26_0b
c	Straightening up	☐	☐	q15q26_0c
d	Keeping your balance	☐	☐	q15q26_0d
e	Going out of the house	☐	☐	q15q26_0e
f	Walking 400 yards	☐	☐	q15q26_0f

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

		Yes	No	Does not apply	
a	Job at work paid employment	☐	☐	☐ 3	q15q26_1a
b	Household chores	☐	☐		q15q26_1b
c	Social life	☐	☐		q15q26_1c
d	Interests and hobbies	☐	☐		q15q26_1d
e	Holidays and outings	☐	☐		q15q26_1e

26.2 Do you have any difficulties getting about outdoors?

q15q26_2

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

Activities of daily living

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

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

q15q27_0

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

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

q15q27_1

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

		Yes	No	
27.2	When standing, can you bend down and pick up a shoe from the floor?	☐	☐	q15q27_2
27.3	When sitting, can you rise from a chair of knee height, without using your hands?	☐	☐	q15q27_3

28.0 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	q15q28_0a	Reaching or extending your arms above shoulder level	☐	☐	☐
b	q15q28_0b	Pulling or pushing large objects like a living room chair	☐	☐	☐
c	q15q28_0c	Walking across a room	☐	☐	☐
d	q15q28_0d	Getting in and out of bed on your own	☐	☐	☐
e	q15q28_0e	Getting in and out of a chair on your own	☐	☐	☐
f	q15q28_0f	Dressing and undressing yourself on your own	☐	☐	☐
g	q15q28_0g	Bathing or showering	☐	☐	☐
h	q15q28_0h	Feeding yourself, including cutting food	☐	☐	☐
i	q15q28_0i	Getting to and using the toilet on your own	☐	☐	☐
j	q15q28_0j	Lifting and carrying something as heavy as 10 lbs, (eg a bag of groceries)	☐	☐	☐
k	q15q28_0k	Shopping for personal items such as toilet items or medicine by yourself	☐	☐	☐
l	q15q28_0l	Doing light housework (eg washing up)	☐	☐	☐
m	q15q28_0m	Preparing your own meals by yourself	☐	☐	☐
n	q15q28_0n	Using the telephone by yourself	☐	☐	☐
o	q15q28_00	Taking medications by yourself	☐	☐	☐
p	q15q28_0p	Managing money (e.g. paying bills etc)	☐	☐	☐
q	q15q28_0q	Using public transport on your own	☐	☐	☐
r	q15q28_0r	Driving a car on your own	☐	☐	☐
s	q15q28_0s	Gripping with hands (eg. opening a jam jar)	☐	☐	☐

Sleeping Patterns

29.0 On most nights, how would you rate the quality of your sleep?

Excellent ☐ 1
Good ☐ 2 q15q29_0
Fair ☐ 3
Poor ☐ 4

29.1 On average how many hours of sleep do you have at: Night time? q15q29_1Night _____ hours

29.2 Day time? q15q29_2Day _____ hours

During **the last month**,

29.3 Did you have difficulties falling asleep at night?

rarely ☐ 1
sometimes ☐ 2 q15q29_3
often ☐ 3

		Yes	No	
29.4	Do you often wake up during the early hours and are unable to get back to sleep?	☐	☐	q15q29_4

29.5 Do you have trouble maintaining sleep at night?

rarely ☐ 1
sometimes ☐ 2 q15q29_5
often ☐ 3

29.6 How often do you wake up feeling tired and worn out after the usual amount of sleep?

rarely ☐ 1
sometimes ☐ 2 q15q29_6
Often (at least 3times/week) ☐ 3

Tiredness / Exhaustion

		Rarely or never (less than 1 day) 1	Sometimes (1-2 days) 2	Often (more than 3 days) 3
30.0	During the **past week**, how often did you feel that everything you did was an effort? q15q30_0	☐	☐	☐
30.1	During the **past week**, how often did you feel that you could not get "going"? q15q30_1	☐	☐	☐

Dental Health (mouth, teeth and or dentures)

General Dental Health

31.0 Would you say that your **dental health** is:

- Excellent ☐ 1
- Good ☐ 2 q15q31_0
- Fair ☐ 3
- Poor ☐ 4

31.1 Do you have any of your own teeth? Yes ☐ No ☐ q15q31_1

31.2 Do you have **difficulty chewing any foods** because of problems with your teeth, mouth or dentures?

- No ☐ 1
- Yes, some difficulty ☐ 2 q15q31_2
- Yes, great difficulty ☐ 3

31.3 Do you **avoid eating some foods** because of problems with your teeth, mouth or dentures? Yes ☐ No ☐ q15q31_3

31.4 Does it take you **longer to finish a meal** than other people of your own age? ☐ ☐ q15q31_4

Dentures

31.5 Do you wear dentures (plate or false teeth that are removable)? Yes ☐ No ☐ q15q31_5

31.6 If you wear dentures, do you have any of the following problems?

		Yes	No	
a	Loose dentures	☐	☐	q15q31_6a
b	Difficulty eating with dentures	☐	☐	q15q31_6b

c Do you take out your dentures (false teeth) while eating? Yes ☐ No ☐ q15q31_6c

d Do you take out your dentures (false teeth) before going to bed? ☐ ☐ q15q31_6d

Dentures continued

Upper Teeth

31.7 Do you wear a denture (plate or false teeth) for **upper teeth**? Yes ☐ No ☐ q15q31_7

If **yes**,

a I wear a full set of dentures ☐1
I wear a partial set of dentures ☐2
(to replace some but not all missing teeth) q15q31_7a

b How long have you had this denture?
q15q31_7b_y _____Years q15q31_7b_m _____Months

c Do you use this denture every day? Yes ☐ No ☐ q15q31_7c

Lower Teeth

31.8 Do you wear a denture (plate or false teeth) for **lower teeth**? Yes ☐ No ☐ q15q31_8

If **yes**,

a I wear a full set of dentures ☐1
I wear a partial set of dentures ☐2
(to replace some but not all missing teeth) q15q31_8a

b How long have you had this denture?
q15q31_8b_y _____Years q15q31_8b_m _____Months

c Do you use this denture every day? Yes ☐ No ☐ q15q31_8c

Other dental problems

31.9 In the **past 6 months,** have you had any of following **dental problems**?

		Yes	No	
a	Pain related to teeth or mouth	☐	☐	q15q31_9a
b	Loose tooth	☐	☐	q15q31_9b
c	Sensitivity to hot/ cold food or drink	☐	☐	q15q31_9c
d	Bleeding gums	☐	☐	q15q31_9d
e	Other gum problems	☐	☐	q15q31_9e

32.0 **Dry Mouth**

The following statements will help assess the extent to which you have dryness of mouth Please tick which of the statements that apply to you over the **last 4 weeks.**

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

			Never 1	Hardly ever 2	Occasionally 3	Fairly often 4	Very often 5
a	My mouth feels dry	q15q32_0a	☐	☐	☐	☐	☐
b	My mouth feels dry when eating a meal	q15q32_0b	☐	☐	☐	☐	☐
c	I have difficulty in eating dry foods	q15q32_0c	☐	☐	☐	☐	☐
d	I have difficulties swallowing certain foods	q15q32_0d	☐	☐	☐	☐	☐
e	I sip liquids to aid in swallowing food	q15q32_0e	☐	☐	☐	☐	☐
f	I suck sweets to relieve dry mouth	q15q32_0f	☐	☐	☐	☐	☐
g	I get up at night to drink	q15q32_0g	☐	☐	☐	☐	☐
h	My lips feel dry	q15q32_0h	☐	☐	☐	☐	☐
i	My eyes feel dry	q15q32_0i	☐	☐	☐	☐	☐
j	The skin of my face feels dry	q15q32_0j	☐	☐	☐	☐	☐
k	The inside of my nose feels dry	q15q32_0k	☐	☐	☐	☐	☐

Present circumstances

33.0 Are you at present:-

single	☐ 1	q15q33_0
married	☐ 2	
widowed	☐ 3	
divorced or separated	☐ 4	
other	☐ 5	

33.1 Are you at present:-

living alone	☐ 1	q15q33_1
living with a partner or spouse	☐ 2	
living with other family members	☐ 3	
living with other people	☐ 4	

.

Your accommodation

34.0 Are you:-

living in your own home	☐ 1	
living in a residential or nursing home	☐ 2	q15q34_0
living in sheltered accommodation	☐ 3	
other	☐ 4	

Social contact

			Hardly ever /Never 1	Sometimes 2	Often 3
35.0	How often do you feel you lack companionship?	q15q35_0	☐	☐	☐
35.1	How often do you feel isolated from others?	q15q35_1	☐	☐	☐
35.2	How often do you feel left out?	q15q35_2	☐	☐	☐
35.3	How often do you feel in tune with the people around you?	q15q35_3	☐	☐	☐

Time spent on various activities

36.0 Do you spend any time on these activities? **If yes**, please tell us how many **hours/week** you spend on these.

			Yes	No	Hours per week
a	q15q36_0a	Looking after wife/partner	☐	☐	q15q36_0ah
b	q15q36_0b	Looking after other adult family member or friend	☐	☐	q15q36_0bh
c	q15q36_0c	Looking after grandchildren	☐	☐	q15q36_0ch
d	q15q36_0d	Watching television/videos/DVDs	☐	☐	q15q36_0dh
e	q15q36_0e	Reading	☐	☐	q15q36_0eh
f	q15q36_0f	Using a computer	☐	☐	q15q36_0fh
g	q15q36_0g	Driving or sitting in a car	☐	☐	q15q36_0gh

Memory

In the past year,

37.0 How often did you have trouble remembering things?

never ☐ 1
rarely ☐ 2 q15q37_0
sometimes ☐ 3
often ☐ 4

		Yes	No	
37.1	Did you have more trouble than usual remembering recent events?	☐	☐	q15q37_1
37.2	Did you have more trouble than usual remembering a short list of items such as a shopping list?	☐	☐	q15q37_2
37.3	Did you have trouble remembering things from one second to the next?	☐	☐	q15q37_3
37.4	Did you have any difficulty in understanding or following spoken instruction?	☐	☐	q15q37_4
37.5	Did you have more trouble than usual following a group conversation or a plot on TV due to your memory?	☐	☐	q15q37_5
37.6	Did you have trouble finding your way around familiar streets?	☐	☐	q15q37_6
37.7	Did you have trouble getting things organised/ organising your day?	☐	☐	q15q37_7
37.8	Did you have trouble concentrating on things eg reading a book?	☐	☐	q15q37_8

		Yes	No	
37.9	**In past 12 months,** have you been forgetful to the extent that it has effected your daily life?	☐	☐	q15q37_9

Your Feelings

38.0 In the **past week,** please tell us about how you have been feeling

		Yes	No	
a	Were you basically satisfied with your life?	☐	☐	q15q38_0a
b	Did you feel that your life is empty?	☐	☐	q15q38_0b
c	Were you afraid that something bad is going to happen to you?	☐	☐	q15q38_0c
d	Did you feel happy most of the time?	☐	☐	q15q38_0d
e	Did you drop many of your activities and interests?	☐	☐	q15q38_0e
f	Did you prefer to stay at home, rather than going out to do new things?	☐	☐	q15q38_0f
g	Did you feel full of energy?	☐	☐	q15q38_0g

Medicines

39.0 Do you take any regular medication? Yes ☐ No ☐ q15q39_0

Details of ALL medicines

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

	Name of medicine	Reason for taking (if known)	Is this prescribed? Yes ☐ No ☐
1	q15q40_0_bnf12_1 q15q40_0_bnf34_1 q15q40_0_bnf5_1 q15q40_0_bnf6_1	q15q40_0_icd1	q15q40_0_medpr1
2	q15q40_0_bnf12_2 q15q40_0_bnf34_2 q15q40_0_bnf5_2 q15q40_0_bnf6_2	q15q40_0_icd2	q15q40_0_medpr2
3	q15q40_0_bnf12_3 q15q40_0_bnf34_3 q15q40_0_bnf5_3 q15q40_0_bnf6_3	q15q40_0_icd3	q15q40_0_medpr3
4	q15q40_0_bnf12_4 q15q40_0_bnf34_4 q15q40_0_bnf5_4 q15q40_0_bnf6_4	q15q40_0_icd4	q15q40_0_medpr4
5	q15q40_0_bnf12_5 q15q40_0_bnf34_5 q15q40_0_bnf5_5 q15q40_0_bnf6_5	q15q40_0_icd5	q15q40_0_medpr5
6	q15q40_0_bnf12_6 q15q40_0_bnf34_6 q15q40_0_bnf5_6 q15q40_0_bnf6_6	q15q40_0_icd6	q15q40_0_medpr6
7	q15q40_0_bnf12_7 q15q40_0_bnf34_7 q15q40_0_bnf5_7 q15q40_0_bnf6_7	q15q40_0_icd7	q15q40_0_medpr7
8	q15q40_0_bnf12_8 q15q40_0_bnf34_8 q15q40_0_bnf5_8 q15q40_0_bnf6_8	q15q40_0_icd8	q15q40_0_medpr8
9	q15q40_0_bnf12_9 q15q40_0_bnf34_9 q15q40_0_bnf5_9 q15q40_0_bnf6_9	q15q40_0_icd9	q15q40_0_medpr9
10	q15q40_0_bnf12_10 q15q40_0_bnf34_10 q15q40_0_bnf5_10 q15q40_0_bnf6_10	q15q40_0_icd10	q15q40_0_medpr10
11	q15q40_0_bnf12_11 q15q40_0_bnf34_11 q15q40_0_bnf5_11 q15q40_0_bnf6_11	q15q40_0_icd11	q15q40_0_medpr11
12	q15q40_0_bnf12_12 q15q40_0_bnf34_12 q15q40_0_bnf5_12 q15q40_0_bnf6_12	q15q40_0_icd12	q15q40_0_medpr12
13	q15q40_0_bnf12_13 q15q40_0_bnf34_13 q15q40_0_bnf5_13 q15q40_0_bnf6_13	q15q40_0_icd13	q15q40_0_medpr13

Please use the back of the questionnaire if more space is needed to record this information.

General comments:

q15General_comment

Office use:

q15DateStamp_d q15DateStamp_m q15DateStamp_y

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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