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

Serial q16qcoder

UCL

BRITISH REGIONAL HEART STUDY

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2016

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 q16q1_0Day (day) q16q1_0Month (month) 20 q16q1_0Year

1.1 Please give your Date of Birth q16q1_1Day (day) q16q1_1Month (month) 19 q16q1_1Year (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	☐	☐	q16q2_0a
b	Angina	☐	☐	q16q2_0b
c	Aortic Aneurysm	☐	☐	q16q2_0c
d	Atrial Fibrillation	☐	☐	q16q2_0d
e	Deep Vein Thrombosis (clot in the deep leg vein)	☐	☐	q16q2_0e
f	Heart attack (coronary thrombosis or myocardial infarction)	☐	☐	q16q2_0f
g	Heart failure	☐	☐	q16q2_0g
h	High blood pressure	☐	☐	q16q2_0h
i	High cholesterol	☐	☐	q16q2_0i
j	Narrowing or hardening of the leg arteries (including claudication)	☐	☐	q16q2_0j
k	Pulmonary Embolism (clot on the lung)	☐	☐	q16q2_0k
l	Other problems of the heart and circulation	☐	☐	q16q2_0l
m	**If yes** , please give details _____			

Stroke

		Yes	No	
3.0	Have you **ever** been told by a doctor that you have had a stroke?	☐	☐	q16q3_0
	If **yes**,			
a	Did the symptoms last for more than 24 hours?	☐	☐	q16q3_1
b	Have you made a complete recovery from your stroke?	☐	☐	q16q3_2

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)	☐	☐	q16q4_0a
b	Angioplasty (balloon treatment of coronary artery, PCI, stents)	☐	☐	q16q4.0b
c	Coronary artery bypass graft operation ("heart bypass" or "CABG")	☐	☐	q16q4.0c

		Yes	No	
4.1	Have you ever taken part in an exercise programme (cardiac rehabilitation) after experiencing a heart problem, cardiac surgery or procedure or a stroke?	☐	☐	q16q4_1
a	If yes, which year was this? _____			q16q4_1a

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?	☐	☐	_____	q16q5_0 / q16q5_0year

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

(Tick whichever apply)

a	feet	☐ 1	q16q5_1a
b	kidneys	☐ 1	q16q5_1b
c	eyes	☐ 1	q16q5_1c
d	nerves	☐ 1	q16q5_1d
e	none	☐ 1	q16q5_1e

Cancer

		Yes	No	Year of **first** diagnosis	
6.0	Have you **ever** been told by a doctor that you <u>have or have had</u> cancer?	☐	☐	_____	q16q6_0 / q16q6_0year

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

_____ _____ q16q6_1Canser_site1

q16q6_1Canser_site2

q16q6_1Canser_site3

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	☐	☐	q16q7_0a
b	Anaemia	☐	☐	q16q7_0b
c	Asthma	☐	☐	q16q7_0c
d	Bronchitis	☐	☐	q16q7_0d
e	Cataract	☐	☐	q16q7_0e
f	Chronic Kidney disease	☐	☐	q16q7_0f
g	Chronic obstructive pulmonary disease (COPD)	☐	☐	q16q7_0g
h	Dementia	☐	☐	q16q7_0h
i	Depression	☐	☐	q16q7_0i
j	Emphysema	☐	☐	q16q7_0j
k	Glaucoma	☐	☐	q16q7_0k
l	Macular degeneration	☐	☐	q16q7_0l
m	Osteoporosis	☐	☐	q16q7_0m
n	Parkinson's disease	☐	☐	q16q7_0n
o	Pneumonia	☐	☐	q16q7_0o

Arthritis

8.0 Have you **ever** been told by a doctor that you <u>have</u> arthritis? Yes ☐ No ☐ q16q8_0

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

q16q8_1knees	Knees	☐ 1	Wrists	☐ 1 q16q8_1wrist
q16q8_1hips	Hips	☐ 1	Back	☐ 1 q16q8_1back
q16q8_1feet	Feet	☐ 1	Neck	☐ 1 q16q8_1neck
q16q8_1Ankle	Ankle	☐ 1	Shoulders	☐ 1 q16q8_1shoulder
	Hands, fingers	☐ 1	Other, please specify	☐ 1 q16q8_1oth q16q8_1oth_BOX
q16q8_1Hands_fingers				

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 ☐ q16q9_0

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

q16q9_1knees
q16q9_1hips
q16q9_1feet
q16q9_1Ankle

Knees ☐1
Hips ☐1
Feet ☐1
Ankle ☐1
Hands, fingers ☐1 q16q9_1Hands_fingers

Wrists ☐1 q16q9_1wrist
Back ☐1 q16q9_1back
Neck ☐1 q16q9_1neck
Shoulders ☐1 q16q9_1shoulder
Other, please specify ☐1 q16q9_1oth q16q9_1oth_BOX

Chest Pain

10.0 Do you **ever** have any pain or discomfort in your chest? Yes ☐ No ☐ q16q10_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 q16q10_1

10.2 When you walk uphill or hurry, does this produce the chest pain? Yes ☐ No ☐ Unable to walk uphill ☐3 q16q10_2

Cough and Wheeze

11.0 Do you usually bring up phlegm (or spit) from your chest first thing in the morning in the winter? Yes ☐ No ☐ q16q11_0

11.1 Do you bring up phlegm like this on **most days** for as much as three months in the winter each year? ☐ ☐ q16q11_1

Breathlessness

		Yes	No	Unable to walk	
12.0	Do you **ever** get short of breath walking with other people of your own age on level ground?	☐	☐	☐ 3	q16q12_0
12.1	On walking uphill or upstairs, do you get more breathless than people of your own age?	☐	☐	☐ 3	q16q12_1
12.2	Do you **ever** have to stop walking because of breathlessness?	☐	☐	☐ 3	q16q12_2
12.3	In the **past year** have you at any time been awoken at night by an attack of shortness of breath?	☐	☐		q16q12_3

Falls

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

Very fearful	☐ 1	q16q13_0
Somewhat fearful	☐ 2	
Not fearful	☐ 3	

		Yes	No	
13.1	Have you had a fall in the **last year**?	☐	☐	q16q13_1
13.2	**If yes**, how many times in the **past year**?	_____		q16q13_2
13.3	Did you receive medical attention for any of these falls?	☐	☐	q16q13_3

13.4 Did you suffer any of the following as a **result of a fall** in the **past year**?

(Tick **all** that apply)

a	cuts and bruises	☐ 1	q16q13_4a
b	damage to muscle or ligament	☐ 1	q16q13_4b
c	Broken or fractured **hip** bone	☐ 1	q16q13_4c
d	Broken or fractured **wrist** bone	☐ 1	q16q13_4d
e	Other broken or fractured bone	☐ 1	q16q13_4e

Dizziness

		Yes	No	
13.5	Have you had spells of dizziness, loss of balance or a sensation of spinning in the **last year**?	☐	☐	q16q13_5

Eyesight

		Yes	No	
14.0	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**)?	☐	☐	q16q14_0
14.1	**If no**, can you see well enough to recognise a friend at a distance of three feet/ one yard?	☐	☐	q16q14_1

Hearing

		Yes	No	
15.0	Have you **ever** had a hearing test?	☐	☐	q16q15_0
15.1	**If yes**, were you offered a hearing aid?	☐	☐	q16q15_1

		Yes	No	Occasionally	
15.2	Do you use a hearing aid?	☐	☐	☐	q16q15_2

		Yes	No	
15.3	Is your hearing good enough to follow a TV programme at a volume others find acceptable (using a hearing aid if needed)?	☐	☐	q16q15_3
15.4	**If no**, can you follow a TV programme with the volume turned up?	☐	☐	q16q15_4

Weight

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

q16q16_0st q16q16_0lb q16q16_0kg

___ ___ Stones ___ ___ Pounds **or** ___ ___ ___● ___ Kilograms

16.1 If you have no scales and have made an estimate please tick here ☐1 q16q16_1

		Yes	No	
16.2	Have you **lost** weight in the **last year**?	☐	☐	q16q16_2
16.3	**If yes,** was the weight loss intentional?	☐	☐	q16q16_3

		Yes	No	
16.4	Have you **gained** weight in the **last year**?	☐	☐	q16q16_4

Appetite

Which of the following statements best describes your appetite:

17.0 My appetite is

- very poor ☐ 1
- poor ☐ 2
- average ☐ 3
- good ☐ 4
- very good ☐ 5

q16q17_0

17.1 When I eat, I feel full after eating

- only a few mouthfuls ☐ 1
- about a third of a meal ☐ 2
- over half a meal ☐ 3
- most of the meal ☐ 4
- hardly ever ☐ 5

q16q17_1

17.2 Food generally tastes

- very bad ☐ 1
- bad ☐ 2
- average ☐ 3
- good ☐ 4
- very good ☐ 5

q16q17_2

17.3 Normally I eat

- less than one meal a day ☐ 1
- one meal a day ☐ 2
- two meals a day ☐ 3
- three meals a day ☐ 4
- more than three meals a day ☐ 5

q16q17_3

17.4 Have you noticed any change in your appetite over the **past three months**?

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

q16q17_4

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

17.5 _____

q16q17_5

Cigarette Smoking

		Yes	No	
18.0	Have you **ever** smoked cigarettes?	☐	☐	q16q18_0
18.1	Do you smoke cigarettes at present?	☐	☐	q16q18_1

Alcohol Intake

19.0 Would you describe your present alcohol intake as

Daily/most days	☐ 1	q16q19_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

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

More than 6 drinks	☐ 1	q16q19_1
5-6 drinks	☐ 2	
3-4 drinks	☐ 3	
1-2 drinks	☐ 4	

19.2 How many alcoholic drinks do you have during an **average week**? q16q19_2 ___ ___

Physical activity

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

No	☐ 1	q16q20_0
Walk	☐ 2	
Cycle	☐ 3	
Both	☐ 4	

20.1 How many hours do you normally spend walking e.g. on errands or for leisure in an **average week**? q16q20_1 _____ Hours/ week

20.2 Which of the following best describes your **usual walking pace**?

Slow ☐ 1
Steady average ☐ 2
Fast ☐ 3

q16q20_2

20.3 How long do you spend cycling in an **average week**? _____ Hours/ week

q16q20_3

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

_____ times /day

q16q20_4

Do not climb stairs ☐ 0

q16q20_4climb_stairs

20.5 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

q16q20_5

20.6 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

q16q20_6

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

a _____
b _____

q16q20_6a
q16q20_6b

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

(please give overall total)

a In winter _____ times/ month

q16q20_7a

b In summer _____ times/ month

q16q20_7b

		Yes	No	
20.8	Do you engage in exercises to increase muscle strength and endurance such as lifting weights, doing push-ups, using exercise machines?	☐	☐	q16q20_8

20.9 **If yes,** on average, how much time each **week** do you engage in these exercises?

q16q20_9h _____ hours q16q20_9m _____ minutes

21.0 Strengthening and Balance Exercises

We are interested to know about activities that you do, either through exercise or part of your everyday living, that use your muscles. Please circle the number of times you do the activity.

		Number of days each week							Monthly 0	Rarely/ Never 8	
a	Carrying or moving heavy loads –e.g. carrying shopping or grandchildren, pushing a wheelchair or lawnmower.	7	6	5	4	3	2	1	M	R	q16q21_0a
b	Doing exercises – e.g. push ups, sit ups, chair aerobics, an exercise routine.	7	6	5	4	3	2	1	M	R	q16q21_0b
c	Balance and co-ordination - e.g. dancing, standing on one leg, or Tai Chi style exercises.	7	6	5	4	3	2	1	M	R	q16q21_0c

General Fitness

Can you do any of the following activities:

		Yes	No	
22.0	run a short distance?	☐	☐	q16q22_0
22.1	do heavy work around the house (e.g. lifting & moving heavy furniture)	☐	☐	q16q22_1
22.2	do gardening (e.g. raking leaves, weeding & pushing the lawn mower)	☐	☐	q16q22_2
22.3	participate in moderate activities like golf, bowling, dancing or doubles tennis?	☐	☐	q16q22_3
22.4	participate in strenuous sports like swimming or singles tennis?	☐	☐	q16q22_4
22.5	have sexual relations?	☐	☐	q16q22_5

Grip Strength

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

Very good ☐ 1
Good ☐ 2 q16q23_0
Fair ☐ 3
Poor ☐ 4

Your overall health

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

24.0 **General health**

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

q16q24_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

q16q24_1

24.2 **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

q16q24_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

q16q24_3

24.4 **Anxiety/depression**

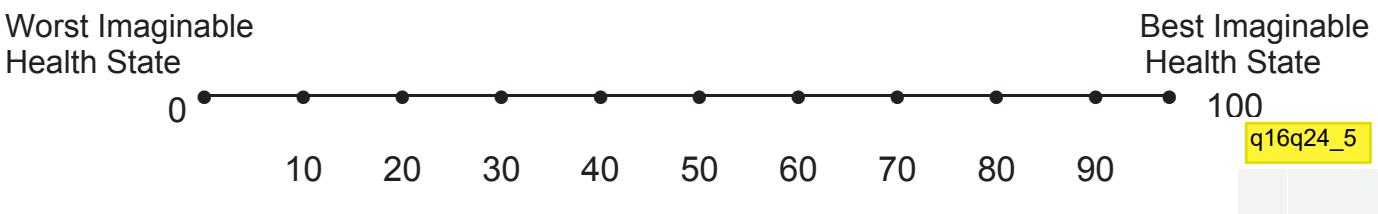
- I am not anxious or depressed ☐ 1
- I am moderately anxious and/or depressed ☐ 2
- I am extremely anxious and/or depressed ☐ 3

q16q24_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**.



q16q24_5

Long standing illness, disability or infirmity

		Yes	No	
25.0	Do you have any **long-standing** illness, disability or infirmity?	☐	☐	q16q25_0

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

		Yes	No	
a	**If yes**, does this illness or disability limit your activities in any way?	☐	☐	q16q25_0a
b	do you receive a disability allowance?	☐	☐	q16q25_0b

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	☐	☐	q16q26_0a
b	Bending down	☐	☐	q16q26_0b
c	Straightening up	☐	☐	q16q26_0c
d	Keeping your balance	☐	☐	q16q26_0d
e	Going out of the house	☐	☐	q16q26_0e
f	Walking 400 yards	☐	☐	q16q26_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	q16q26_1a
b	Household chores	☐	☐		q16q26_1b
c	Social life	☐	☐		q16q26_1c
d	Interests and hobbies	☐	☐		q16q26_1d
e	Holidays and outings	☐	☐		q16q26_1e

26.2 Do you have any difficulties getting about outdoors?

No difficulty	☐ 1	q16q26_2
Slight	☐ 2	
Moderate	☐ 3	
Severe	☐ 4	
Unable to do	☐ 5	

Mobility Aids

27.0 Do you use any mobility aids? Yes ☐ No ☐ q16q27_0

27.1 **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 q16q27_1a

b Walking frame ☐1 q16q27_1b

c Wheelchair/ mobility scooter ☐1 q16q27_1c

d Other ☐1 q16q27_1d

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?

q16q28_0

200 yards or more ☐1

More than a few steps but less than 200 yards ☐2

Only a few steps ☐3

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

q16q28_1

Yes ☐1

Yes, only if I hold on and take a rest ☐2

Not at all ☐3

28.2 When standing, can you bend down and pick up a shoe from the floor? q16q28_2 Yes ☐ No ☐

28.3 When sitting, can you rise from a chair of knee height, without using your hands? q16q28_3 ☐☐

28.4 Would you say there has been any change in your ability to do practical things in the past two years?

No change ☐1

Better ☐2 q16q28_4

Worse ☐3

Much Worse ☐4

29.0 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	q16q29_0a	Reaching or extending your arms above shoulder level	☐	☐	☐
b	q16q29_0b	Pulling or pushing large objects like a living room chair	☐	☐	☐
c	q16q29_0c	Walking across a room	☐	☐	☐
d	q16q29_0d	Getting in and out of bed on your own	☐	☐	☐
e	q16q29_0e	Getting in and out of a chair on your own	☐	☐	☐
f	q16q29_0f	Dressing and undressing yourself on your own	☐	☐	☐
g	q16q29_0g	Bathing or showering	☐	☐	☐
h	q16q29_0h	Feeding yourself, including cutting food	☐	☐	☐
i	q16q29_0i	Getting to and using the toilet on your own	☐	☐	☐
j	q16q29_0j	Lifting and carrying something as heavy as 10 lbs, (e.g. a bag of groceries)	☐	☐	☐
k	q16q29_0k	Shopping for personal items such as toilet items or medicine by yourself	☐	☐	☐
l	q16q29_0l	Doing light housework (e.g. washing up)	☐	☐	☐
m	q16q29_0m	Preparing your own meals by yourself	☐	☐	☐
n	q16q29_0n	Using the telephone by yourself	☐	☐	☐
o	q16q29_0o	Taking medications by yourself	☐	☐	☐
p	q16q29_0p	Managing money (e.g. paying bills etc)	☐	☐	☐
q	q16q29_0q	Using public transport on your own	☐	☐	☐
r	q16q29_0r	Driving a car on your own	☐	☐	☐
s	q16q29_0s	Gripping with hands (e.g. opening a jam jar)	☐	☐	☐

Sleeping Patterns

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

Excellent ☐ 1
Good ☐ 2 q16q30_0
Fair ☐ 3
Poor ☐ 4

30.1 On average how many hours of sleep do you have at: Night time? q16q30_1Night _____ hours

30.2 Day time? q16q30_1Day _____ hours

30.3 How often do you feel excessively sleepy during the day

Never/rarely ☐ 1
sometimes ☐ 2 q16q30_3
Frequently ☐ 3
Always ☐ 4

During **the last month**,

30.4 Did you have difficulties falling asleep at night?

rarely ☐ 1
sometimes ☐ 2 q16q30_4
often ☐ 3

30.5 Do you often wake up during the early hours and are unable to get back to sleep? Yes ☐ No ☐ q16q30_5

30.6 Do you have trouble maintaining sleep at night?

rarely ☐ 1
sometimes ☐ 2 q16q30_6
often ☐ 3

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

rarely ☐ 1
sometimes ☐ 2 q16q30_7
often (at least 3times/week) ☐ 3

30.8 Do you snore **loudly** while asleep?

no ☐ 1
sometimes ☐ 2 q16q30_8
Often ☐ 3
don't know ☐ 4

Tiredness / Exhaustion

		Rarely or never (less than 1 day) 1	Sometimes (1-2 days) 2	Often (more than 3 days) 3	
31.0	During the **past week**, how often did you feel that everything you did was an effort?	☐	☐	☐	q16q31_0
31.1	During the **past week**, how often did you feel that you could not get "going"?	☐	☐	☐	q16q31_1

Dental Health (mouth, teeth and or dentures)

General Dental Health

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

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

q16q32_0

32.1 Do you have any of your own teeth? Yes ☐ No ☐ q16q32_1

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

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

q16q32_2

32.3 Do you **avoid eating some foods** because of problems with your teeth, mouth or dentures? Yes ☐ No ☐ q16q32_3

32.4 Does it take you **longer to finish a meal** than other people of your own age? ☐ ☐ q16q32_4

Dentures

32.5 Do you wear dentures (plate or false teeth that are removable)? Yes ☐ No ☐ q16q32_5

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

		Yes	No	
a	Loose dentures	☐	☐	q16q32_6a
b	Difficulty eating with dentures	☐	☐	q16q32_6b

32.7 Have you seen your dentist in the last year? Yes ☐ No ☐ q16q32_7

Other dental problems

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

		Yes	No	
a	Pain related to teeth or mouth	☐	☐	q16q32_8a
b	Loose tooth	☐	☐	q16q32_8b
c	Sensitivity to hot/ cold food or drink	☐	☐	q16q32_8c
d	Bleeding gums	☐	☐	q16q32_8d
e	Other gum problems	☐	☐	q16q32_8e

33.0 **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	q16q33_0a	☐	☐	☐	☐	☐
b	My mouth feels dry when eating a meal	q16q33_0b	☐	☐	☐	☐	☐
c	I have difficulty in eating dry foods	q16q33_0c	☐	☐	☐	☐	☐
d	I have difficulties swallowing certain foods	q16q33_0d	☐	☐	☐	☐	☐
e	I sip liquids to aid in swallowing food	q16q33_0e	☐	☐	☐	☐	☐
f	I suck sweets to relieve dry mouth	q16q33_0f	☐	☐	☐	☐	☐
g	I get up at night to drink	q16q33_0g	☐	☐	☐	☐	☐
h	My lips feel dry	q16q33_0h	☐	☐	☐	☐	☐
i	My eyes feel dry	q16q33_0i	☐	☐	☐	☐	☐
j	The skin of my face feels dry	q16q33_0j	☐	☐	☐	☐	☐
k	The inside of my nose feels dry	q16q33_0k	☐	☐	☐	☐	☐

Present circumstances

34.0 Are you at present:-

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

q16q34_0

34.1 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

q16q34_1

.

Your accommodation

35.0 Are you:-

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

q16q35_0

Recent major life events

36.0 Have you experienced any of the following **major** life events in the **last two years**?

(Tick **all** that apply)

a	death of a spouse	☐ 1	q16q36_0a
b	death of a close relative/friend	☐ 1	q16q36_0b
c	illness/accident to a family member	☐ 1	q16q36_0c
d	financial difficulties	☐ 1	q16q36_0d
e	personal illness, accident or injury	☐ 1	q16q36_0e
f	moving house	☐ 1	q16q36_0f
g	divorce	☐ 1	q16q36_0g
h	addition to family circle e.g. grandchild	☐ 1	q16q36_0h
i	other please give details	☐ 1	q16q36_0i
j	none	☐ 1	q16q36_0j

q16q36_0i_codeBOX

Social contact

		Hardly ever /Never 1	Sometimes 2	Often 3	
37.0	How often do you feel you lack companionship?	☐	☐	☐	q16q37_0
37.1	How often do you feel isolated from others?	☐	☐	☐	q16q37_1
37.2	How often do you feel left out?	☐	☐	☐	q16q37_2
37.3	How often do you feel in tune with the people around you?	☐	☐	☐	q16q37_3

Time spent on various activities

38.0 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	q16q38_0a	Looking after wife/partner	☐	☐	_____	q16q38_0ah
b	q16q38_0b	Looking after other adult family member or friend	☐	☐	_____	q16q38_0bh
c	q16q38_0c	Looking after grandchildren	☐	☐	_____	q16q38_0ch
d	q16q38_0d	Watching television/videos/DVDs	☐	☐	_____	q16q38_0dh
e	q16q38_0e	Reading	☐	☐	_____	q16q38_0eh
f	q16q38_0f	Using a computer	☐	☐	_____	q16q38_0fh
g	q16q38_0g	Driving or sitting in a car	☐	☐	_____	q16q38_0gh

		Yes	No	
38.1	Have you been on any day or overnight trips in the last year?	☐	☐	q16q38_1
38.2	Have you been on holiday in the last year?	☐	☐	q16q38_2
38.3	Are you planning to go on holiday next year?	☐	☐	q16q38_3
38.4	Do you use the internet and or email?	☐	☐	q16q38_4
38.5	Have you written a personal letter / email in the last week?	☐	☐	q16q38_5
38.6	Do you take a weekly or monthly magazine or journal?	☐	☐	q16q38_6
38.7	Did you vote in the last general or local elections?	☐	☐	q16q38_7

Memory

In the past year,

39.0 How often did you have trouble remembering things? q16q39_0

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

		Yes	No	
39.1	Did you have more trouble than usual remembering recent events?	☐	☐	q16q39_1
39.2	Did you have more trouble than usual remembering a short list of items such as a shopping list?	☐	☐	q16q39_2
39.3	Did you have trouble remembering things from one second to the next?	☐	☐	q16q39_3
39.4	Did you have any difficulty in understanding or following spoken instruction?	☐	☐	q16q39_4
39.5	Did you have more trouble than usual following a group conversation or a plot on TV due to your memory?	☐	☐	q16q39_5
39.6	Did you have trouble finding your way around familiar streets?	☐	☐	q16q39_6
39.7	Did you have trouble getting things organised/ organising your day?	☐	☐	q16q39_7
39.8	Did you have trouble concentrating on things e.g. reading a book?	☐	☐	q16q39_8

		Yes	No	
39.9	**In past 12 months,** have you been forgetful to the extent that it has affected your daily life?	☐	☐	q16q39_9

Your Feelings

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

		Yes	No	
a	Were you basically satisfied with your life?	☐	☐	q16q40_0a
b	Did you feel that your life is empty?	☐	☐	q16q40_0b
c	Were you afraid that something bad is going to happen to you?	☐	☐	q16q40_0c
d	Did you feel happy most of the time?	☐	☐	q16q40_0d
e	Did you drop many of your activities and interests?	☐	☐	q16q40_0e
f	Did you prefer to stay at home, rather than going out to do new things?	☐	☐	q16q40_0f
g	Did you feel full of energy?	☐	☐	q16q40_0g

40.1 Please indicate how much you agree with the following statements:

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

		Strongly agree 1	Agree 2	Neither agree nor disagree 3	Disagree 4	Strongly disagree 5	
a	I enjoy my life overall	☐	☐	☐	☐	☐	q16q40_1a
b	I look forward to things	☐	☐	☐	☐	☐	q16q40_1b
c	I am healthy enough to get out and about	☐	☐	☐	☐	☐	q16q40_1c
d	My family, friends or neighbours would help me if needed	☐	☐	☐	☐	☐	q16q40_1d
e	I have social or leisure activities/hobbies that I enjoy doing	☐	☐	☐	☐	☐	q16q40_1e
f	I try to stay involved with things	☐	☐	☐	☐	☐	q16q40_1f
g	I am healthy enough to have my independence	☐	☐	☐	☐	☐	q16q40_1g
h	I can please myself in what I do	☐	☐	☐	☐	☐	q16q40_1h
i	I feel safe where I live	☐	☐	☐	☐	☐	q16q40_1i
j	I get pleasure from my home	☐	☐	☐	☐	☐	q16q40_1j
k	I take life as it comes and make the best of things	☐	☐	☐	☐	☐	q16q40_1k
l	I feel lucky compared to most people	☐	☐	☐	☐	☐	q16q40_1l
m	I have enough money to pay for household bills	☐	☐	☐	☐	☐	q16q40_1m

Use of Health services, Local Authority services (including private care or help)

41.0 We'd like to ask you whether you have had contact with any of the following services, either in your own home or by visiting them yourself.

In the last 4 weeks, have you had contact with any of the following Services?

			Yes	No
a	q16q41_0a	Home help or home care assistant	☐	☐
b	q16q41_0b	Any nursing Services	☐	☐
c	q16q41_0c	Chiropodist	☐	☐
d	q16q41_0d	Meals on wheels	☐	☐
e	q16q41_0e	Physiotherapist	☐	☐
f	q16q41_0f	Occupational therapist	☐	☐
g	q16q41_0g	Speech Therapist	☐	☐
h	q16q41_0h	Social Worker	☐	☐
i	q16q41_0i	Day Centre	☐	☐
j	q16q41_0j	Day Hospital	☐	☐
k	q16q41_0k	GP (family doctor)	☐	☐

41.1 During the **last three months,** did you attend the Casualty or outpatient department of a hospital as a patient? Yes ☐ No ☐ q16q41_1

If yes, what was the problem? _____ q16q41_1_codeBOX

41.2 In the **last year,**

		Yes	No	
a	Have you had your sight tested by an optician?	☐	☐	q16q41_2a
b	Have you had a hearing test?	☐	☐	q16q41_2b

Medicines

42.0 Do you take any regular medication? Yes ☐ No ☐ q16q42_0

Details of ALL medicines

43.0 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	q16q43_0bnf12_1 q16q43_0bnf34_1 q16q43_0bnf5_1 q16q43_0bnf6_1	q16q43_0icd1	q16q43_0medpr1
2	q16q43_0bnf12_2 q16q43_0bnf34_2 q16q43_0bnf5_2 q16q43_0bnf6_2	q16q43_0icd2	q16q43_0medpr2
3	q16q43_0bnf12_3 q16q43_0bnf34_3 q16q43_0bnf5_3 q16q43_0bnf6_3	q16q43_0icd3	q16q43_0medpr3
4	q16q43_0bnf12_4 q16q43_0bnf34_4 q16q43_0bnf5_4 q16q43_0bnf6_4	q16q43_0icd4	q16q43_0medpr4
5	q16q43_0bnf12_5 q16q43_0bnf34_5 q16q43_0bnf5_5 q16q43_0bnf6_5	q16q43_0icd5	q16q43_0medpr5
6	q16q43_0bnf12_6 q16q43_0bnf34_6 q16q43_0bnf5_6 q16q43_0bnf6_6	q16q43_0icd6	q16q43_0medpr6
7	q16q43_0bnf12_7 q16q43_0bnf34_7 q16q43_0bnf5_7 q16q43_0bnf6_7	q16q43_0icd7	q16q43_0medpr7
8	q16q43_0bnf12_8 q16q43_0bnf34_8 q16q43_0bnf5_8 q16q43_0bnf6_8	q16q43_0icd8	q16q43_0medpr8
9	q16q43_0bnf12_9 q16q43_0bnf34_9 q16q43_0bnf5_9 q16q43_0bnf6_9	q16q43_0icd9	q16q43_0medpr9
10	q16q43_0bnf12_10 q16q43_0bnf34_10 q16q43_0bnf5_10 q16q43_0bnf6_10	q16q43_0icd10	q16q43_0medpr10
11	q16q43_0bnf12_11 q16q43_0bnf34_11 q16q43_0bnf5_11 q16q43_0bnf6_11	q16q43_0icd11	q16q43_0medpr11
12	q16q43_0bnf12_12 q16q43_0bnf34_12 q16q43_0bnf5_12 q16q43_0bnf6_12	q16q43_0icd12	q16q43_0medpr12
13	q16q43_0bnf12_13 q16q43_0bnf34_13 q16q43_0bnf5_13 q16q43_0bnf6_13	q16q43_0icd13	q16q43_0medpr13

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

YOUR DIET

How to fill in the diet questionnaire

The following questions are mostly about how often you **USUALLY** eat different sorts of food each week.

Please ring **one** answer for each of the foods listed. Remember to circle **R** if you never eat a food.

		Number of days each week							Monthly	Rarely/ Never
D1	**Meat**								0	8
	Red meat (including beef, minced beef, beef burgers, lamb, pork, bacon, ham, salami) q16D1_Read_meat	7	6	5	4	3	2	1	M	R
	Chicken, turkey, other poultry q16D1_Chicken	7	6	5	4	3	2	1	M	R
	Tinned meat (all types, corned beef, etc) q16D1_Tinned_meat	7	6	5	4	3	2	1	M	R
	Pork sausages, beef sausages, pies, pasties q16D1_Pork_sausages	7	6	5	4	3	2	1	M	R
	Liver, kidney, heart q16D1_Liver	7	6	5	4	3	2	1	M	R
D2	**Fish**									
	White fish (cod, haddock, hake, plaice, fish fingers, etc) q16D2_Fish_white	7	6	5	4	3	2	1	M	R
	Kippers, herrings, pilchards, tuna, sardines, salmon, mackerel (including tinned) q16D2_Fish_Kipper	7	6	5	4	3	2	1	M	R
	Shellfish q16D2_Fish_Shellfish	7	6	5	4	3	2	1	M	R
D3	**Fruit and vegetables**									
	Fresh fruit in the **summer** q16D3_Fresh_Fruit_SUMMER	7	6	5	4	3	2	1	M	R
	Fresh fruit in the **winter** q16D3_Fresh_Fruit_WINTER	7	6	5	4	3	2	1	M	R
	Fresh vegetables in the **summer** q16D3_Fresh_Vegetables_SUMMER	7	6	5	4	3	2	1	M	R
	Fresh vegetables in the **winter** q16D3_Fresh_Vegetables_WINTER	7	6	5	4	3	2	1	M	R
	Legumes (e.g. baked or butter beans, lentils, peas, chickpeas) q16D3_legumes	7	6	5	4	3	2	1	M	R
D4	**Bread**									
	White bread / bread rolls q16D4_Bread_WHITE	7	6	5	4	3	2	1	M	R
	Brown or wholemeal bread / bread rolls q16D4_Bread_BROWN	7	6	5	4	3	2	1	M	R
D5	**Dairy**									
	Full-fat cheese (e.g. Cheddar, Leicester, Stilton, Brie, soft cheese) q16D5_Dairy_FULL_FAT	7	6	5	4	3	2	1	M	R
	Low-fat cheese (e.g. Edam, Cottage cheese, reduced fat cheese) q16D5_Dairy_LOW_FAT	7	6	5	4	3	2	1	M	R

Please ring the correct number or letter for every food item (one circle only per line)

Please ring the correct number or letter for every food item (one circle only per line)

D6 **Cereals**

Spaghetti and other pasta q16D6_Cereals_SPAGHETTI	7	6	5	4	3	2	1	M	R
Rice (all types exc. pudding rice) q16D6_Cereals_RICE	7	6	5	4	3	2	1	M	R
Crispbread (Ryvita, cream crackers etc) q16D6_Cereals_CRISPBREAD	7	6	5	4	3	2	1	M	R
Breakfast cereal (all types inc. porridge) q16D6_Cereals_BREAKFAST_CEREAL	7	6	5	4	3	2	1	M	R

D7 **Olive oil** (for cooking, salads etc) q16D7_OLIVE_OIL — 7 6 5 4 3 2 1 M R

D8 **Snacks**

Savoury snacks (e.g. crisps/ salted nuts) q16D8_Snacks_SAVOURY	7	6	5	4	3	2	1	M	R
Sweet snacks (e.g. biscuits/cakes/ chocolate/sweets) q16D8_Snacks_SWEET	7	6	5	4	3	2	1	M	R

D9 **Milk**

Roughly how much milk do you drink a day in tea, coffee, milky drinks or cereals?

(Tick only **one** box)

- none at all ☐ 1
- half pint or less ☐ 2 q16D9
- between half and one pint ☐ 3
- more than one pint ☐ 4

D9.1 What kind of milk do you usually use? (Tick only **one** box)

- full fat milk, fresh or dried ☐ 1
- semi-skimmed milk, fresh or dried ☐ 2 q16D91
- fully skimmed milk, fresh or dried ☐ 3
- other kinds of milk, e.g. condensed, evaporated ☐ 4

Snacks

D10 How many times **a day** do you snack on q16D10_TIMES_SNACKS_SAVOURY

Savoury snacks (e.g. crisps/ salted nuts)? _____ times per day

Sweet snacks (e.g. biscuits/cakes/ chocolate/sweets)? _____ times per day q16D10_TIMES_SWEET_SAVOURY

Alcoholic drinks

D11 How much did you drink in the **last seven days?** Number of drinks

- Number of half pints of beers or lagers _____ q16D11_Pints_BEERS
- Number of glasses of wine or sherry _____ q16D11_Glasses_WINE
- Number of singles glasses of spirits _____ q16D11_sglasses_SPIRITS

General comments:

q16General_comments

Date received stamp
q16DateStamp_d
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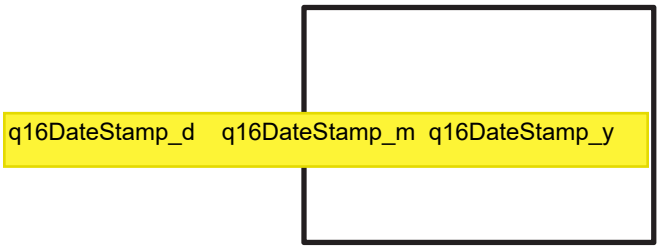
Office use:



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

Professor P H Whincup
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Web: http://www.ucl.ac.uk/pcph/research-groups-themes/brhs-pub