Study Number: serial q17coder

UCL

BRITISH REGIONAL HEART STUDY

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2017

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 need any help 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

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on behalf of the British Regional Heart Study research team

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Dates

1.0 Please enter today's date q17q1_0Day q17q1_0Month 20 q17q1_0Year

day month

1.1 Please give your Date of Birth q17q1_1Day q17q1_1Mont 19 q17q1_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	☐	☐	q17q2_0a
b	Angina	☐	☐	q17q2_0b
c	Aortic Aneurysm	☐	☐	q17q2_0c
d	Atrial Fibrillation	☐	☐	q17q2_0d
e	Deep Vein Thrombosis (clot in the deep leg vein)	☐	☐	q17q2_0e
f	Heart attack (coronary thrombosis or myocardial infarction)	☐	☐	q17q2_0f
g	Heart failure	☐	☐	q17q2_0g
h	High blood cholesterol	☐	☐	q17q2_0h
i	High blood pressure	☐	☐	q17q2_0i
j	Narrowing or hardening of the leg arteries (including claudication)	☐	☐	q17q2_0j
k	Pulmonary Embolism (clot on the lung)	☐	☐	q17q2_0k
l	Other problems of the heart and circulation	☐	☐	q17q2_0l
m	**If yes** , please give details _____			q17q2_0m_Codingbox

Stroke

		Yes	No	
3.0	Have you **ever** been told by a doctor that you have had a stroke?	☐	☐	q17q3_0
	If **yes**,			
a	Did the symptoms last for more than 24 hours?	☐	☐	q17q3_0a
b	Have you made a complete recovery from your stroke?	☐	☐	q17q3_0b

Investigations and special treatment for conditions affecting your heart and circulation

		Yes	No	
4.0	Have you **ever** had one of the following?			
a	Angiogram or X-ray of coronary arteries (using a dye)	☐	☐	q17q4_0a
b	Angioplasty (balloon treatment of coronary artery for angina)	☐	☐	q17q4_0b
c	Coronary artery bypass graft operation ("heart bypass" or "CABG")	☐	☐	q17q4_0c

Diabetes

		Yes	No	Year of diagnosis
		q17q5_0		q17q5_0year
5.0	Have you **ever** been told by a doctor that you have or have had diabetes?	☐	☐	_____

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

(Tick whichever apply)

a	feet	☐ 1	q17q5_1a
b	kidneys	☐ 1	q17q5_1b
c	eyes	☐ 1	q17q5_1c
d	nerves	☐ 1	q17q5_1d
e	none	☐ 1	q17q5_1e

Cancer

		Yes	No	Year of diagnosis
		q17q6_0		q17q6_0year
6.0	Have you **ever** been told by a doctor that you have or have had cancer?	☐	☐	_____

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

_____ _____

q17q6_1Cancer_site1
q17q6_1Cancer_site2
q17q6_1Cancer_site3

Arthritis

		Yes	No	
7.0	Have you **ever** been told by a doctor that you have arthritis?	☐	☐	q17q7_0

Joint pain, swelling or stiffness

		Yes	No	
8.0	During **the past year,** have you had pain, aching, stiffness or swelling in your joints on most days for at least one month?	☐	☐	q17q8_0

Other medical conditions

9.0 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	☐	☐	q17q9_0a
b	Anaemia	☐	☐	q17q9_0b
c	Asthma	☐	☐	q17q9_0c
d	Bronchitis	☐	☐	q17q9_0d
e	Cataract	☐	☐	q17q9_0e
f	Chronic Kidney disease	☐	☐	q17q9_0f
g	Chronic obstructive pulmonary disease (COPD)	☐	☐	q17q9_0g
h	Dementia	☐	☐	q17q9_0h
i	Depression	☐	☐	q17q9_0i
j	Emphysema	☐	☐	q17q9_0j
k	Glaucoma	☐	☐	q17q9_0k
l	Gout	☐	☐	q17q9_0l
m	Macular degeneration	☐	☐	q17q9_0m
n	Osteoporosis	☐	☐	q17q9_0n
o	Parkinson's disease	☐	☐	q17q9_0o
p	Pneumonia	☐	☐	q17q9_0p

q Other medical conditions, please give details

_____ q17q9_0q_other_box1

_____ q17q9_0q_other_box2

Chest Pain

10.0 Do you **ever** have any pain or discomfort in your chest? Yes ☐ No ☐ q17q10_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 q17q10_1

10.2 When you walk uphill or hurry, does this produce the chest pain? Yes ☐ No ☐ Unable to walk uphill ☐3 q17q10_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 q17q11_0

Falls

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

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

q17q12_0

12.1 Have you had a fall in the **last year**? Yes ☐ No ☐ q17q12_1

12.2 **If yes**, how many times in the **past year**? q17q12_2 _____

Dizziness

13.0 Have you had spells of dizziness, loss of balance or a sensation of spinning in the **last year**? Yes ☐ No ☐ q17q13_0

Eyesight

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

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

q17q14_0

Hearing

15.0 Is your hearing (using a hearing aid if needed)

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

q17q15_0

Alcohol Intake

16.0 Would you describe your present alcohol intake as

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

q17q16_0

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

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

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

q17q16_1

Cigarette Smoking

		Yes	No	
17.0	Have you **ever** smoked cigarettes?	☐	☐	q17q17_0
17.1	Do you smoke cigarettes at present?	☐	☐	q17q17_1

Weight

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

q17q18_0st ___ ___ Stones q17q18_0lb ___ ___ Pounds **or** q17q18_0kg ___ ___ ___●___ Kilograms

18.1 If you have no scales and have made an estimate please tick here ☐ 1 q17q18_1

		Yes	No	
18.2	Have you **lost** weight in the last year?	☐	☐	q17q18_2
18.3	**If yes,** was the weight loss intentional?	☐	☐	q17q18_3

Appetite

Which of the following statements best describes your appetite:

19.0 My appetite is

- very poor ☐ 1
- poor ☐ 2 q17q19_0
- average ☐ 3
- good ☐ 4
- very good ☐ 5

19.1 When I eat, I feel full after eating

- only a few mouthfuls ☐ 1
- about a third of a meal ☐ 2 q17q19_1
- over half a meal ☐ 3
- most of the meal ☐ 4
- hardly ever ☐ 5

19.2 Food generally tastes

- very bad ☐ 1
- bad ☐ 2 q17q19_2
- average ☐ 3
- good ☐ 4
- very good ☐ 5

19.3 Normally I eat

- less than one meal a day ☐ 1
- one meal a day ☐ 2 q17q19_3
- two meals a day ☐ 3
- three meals a day ☐ 4
- more than three meals a day ☐ 5

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

- no change in my appetite ☐ 1 q17q19_4
- moderate loss of appetite ☐ 2
- severe loss of appetite ☐ 3
- improvement of appetite ☐ 4

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

q17q19_5

_____

Physical activity

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

No ☐ 1
Walk ☐ 2 q17q20_0
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**? q17q20_1 _____ Hours/ week

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

Slow ☐ 1
Steady average ☐ 2 q17q20_2
Fast ☐ 3

20.3 How long do you spend cycling in an **average week**? q17q20_3 _____ Hours/ week

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)? q17q20_4 _____ times /day

q17q20_4climb_stairs Do not climb stairs ☐ 0

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 q17q20_5
More active ☐ 2
Similar ☐ 3
Less active ☐ 4
Much less active ☐ 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 q17q20_6
Occasionally less than once a month ☐ 2
Frequently once a month or more ☐ 3

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

a _____ q17q20_6a

b _____ q17q20_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 q17q20_7a

b In summer _____ times/ month q17q20_7b

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

Yes ☐ No ☐ q17q20_8

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

q17q20_9hours _____ hours q17q20_9mins _____ minutes

Your overall health

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

21.0 **General health**

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

q17q21_0

21.1 **Pain/discomfort**

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

q17q21_1

21.2 **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

q17q21_2

21.3 **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

q17q21_3

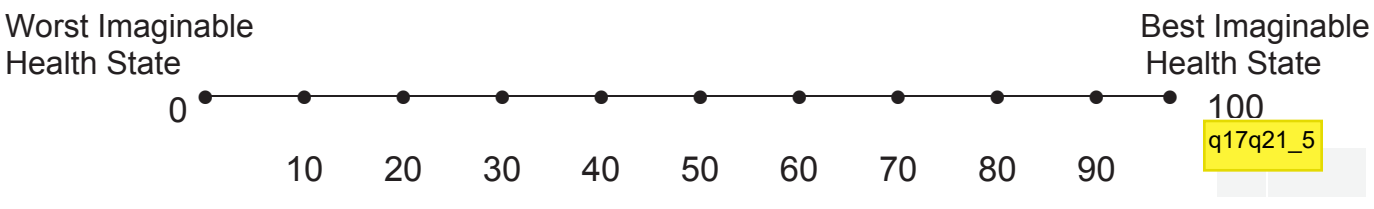
21.4 **Anxiety/depression**

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

q17q21_4

21.5 **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.



q17q21_5

Long standing illness, disability or infirmity

22.0 Do you have any **long-standing** illness, disability or infirmity? Yes ☐ No ☐ q17q22_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?	☐	☐	q17q22_0a
b	do you receive a disability allowance?	☐	☐	q17q22_0b

Disability

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

		No difficulty 1	Yes, a little difficulty 2	Yes, a lot of difficulty 3	
a	Going up or down stairs	☐	☐	☐	q17q23_0a
b	Bending down	☐	☐	☐	q17q23_0b
c	Straightening up	☐	☐	☐	q17q23_0c
d	Keeping your balance	☐	☐	☐	q17q23_0d
e	Going out of the house	☐	☐	☐	q17q23_0e
f	Walking 400 yards	☐	☐	☐	q17q23_0f

23.1 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	q17q23_1a
b	Household chores	☐	☐		q17q23_1b
c	Social life	☐	☐		q17q23_1c
d	Interests and hobbies	☐	☐		q17q23_1d
e	Holidays and outings	☐	☐		q17q23_1e

23.2 Do you have any difficulties getting about outdoors?

No difficulty	☐ 1	q17q23_2
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

24.0 What is the furthest you can walk on your own without stopping and without discomfort? q17q24_0

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

24.1 Can you walk up and down a flight of 12 stairs without resting? q17q24_1

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

		Yes	No
24.2	When standing, can you bend down and pick up a shoe from the floor? q17q24_2	☐	☐
24.3	When sitting, can you rise from a chair of knee height, without using your hands? q17q24_3	☐	☐

Grip Strength

25.0 How would you rate your hand grip strength compared to other people your age? q17q25_0

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

Mobility Aids

		Yes	No	
26.0	Do you use any mobility aids?	☐	☐	q17q26_0

26.1 **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	q17q26_1a
b	Walking frame	☐ 1	q17q26_1b
c	Push wheelchair	☐ 1	q17q26_1c
d	Electric wheelchair or mobility scooter	☐ 1	q17q26_1d
e	Other	☐ 1	q17q26_1e

Sleeping Patterns

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

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

q17q27_0

On average how many hours of sleep do you have at

27.1 Night time? _____ hours _____ minutes

q17q27_1Night_hours q17q27_1Night_mins

27.2 Day time? _____ hours _____ minutes

q17q27_2Day_hours q17q27_2Day_mins

Tiredness / Exhaustion

		Rarely or never (less than 1 day) 1	Sometimes (1-2 days) 2	Often (more than 3 days) 3	
28.0	During the **past week**, how often did you feel that everything you did was an effort?	☐	☐	☐	q17q28_0
28.1	During the **past week**, how often did you feel that you could not get "going"?	☐	☐	☐	q17q28_1

Snacks

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

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

q17q29_0

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

q17q29_1

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	Reaching or extending your arms above shoulder level	☐	☐	☐	q17q30_0a
b	Pulling or pushing large objects like a living room chair	☐	☐	☐	q17q30_0b
c	Walking across a room	☐	☐	☐	q17q30_0c
d	Getting in and out of bed on your own	☐	☐	☐	q17q30_0d
e	Getting in and out of a chair on your own	☐	☐	☐	q17q30_0e
f	Dressing and undressing yourself on your own	☐	☐	☐	q17q30_0f
g	Bathing or showering	☐	☐	☐	q17q30_0g
h	Feeding yourself, including cutting food	☐	☐	☐	q17q30_0h
i	Getting to and using the toilet on your own	☐	☐	☐	q17q30_0i
j	Lifting and carrying something as heavy as 10 lbs, (eg a bag of groceries)	☐	☐	☐	q17q30_0j
k	Shopping for personal items such as toilet items or medicine by yourself	☐	☐	☐	q17q30_0k
l	Doing light housework (eg washing up)	☐	☐	☐	q17q30_0l
m	Preparing your own meals by yourself	☐	☐	☐	q17q30_0m
n	Using the telephone by yourself	☐	☐	☐	q17q30_0n
o	Taking medications by yourself	☐	☐	☐	q17q30_0o
p	Managing money (e.g. paying bills etc)	☐	☐	☐	q17q30_0p
q	Using public transport on your own	☐	☐	☐	q17q30_0q
r	Driving a car on your own	☐	☐	☐	q17q30_0r
s	Gripping with hands (eg. opening a jam jar)	☐	☐	☐	q17q30_0s

Dental Health (mouth, teeth and or dentures)

General Dental Health

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

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

q17q31_0

31.1 Do you have any of your own teeth? Yes ☐ No ☐ q17q31_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
- Yes, great difficulty ☐ 3

q17q31_2

31.3 Do you **avoid eating some foods** because of problems with your teeth, mouth or dentures? Yes ☐ No ☐ q17q31_3

31.4 Does it take you **longer to finish a meal** than other people of your own age? Yes ☐ No ☐ q17q31_4

31.5 How frequently do you brush your teeth?

- More than once a day ☐ 1
- Once a day ☐ 2
- Less than once a day ☐ 3

q17q31_5

Dentures

32.0 Do you wear full or partial dentures (plate or false teeth that are removable)? Yes ☐ No ☐ q17q32_0

a If yes, are these dentures for the: upper teeth ☐ q17q32_0a

b lower teeth ☐ q17q32_0b

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

		Yes	No	
a	Loose dentures	☐	☐	q17q32_1a
b	Difficulty eating with dentures	☐	☐	q17q32_1b

Dentures continued

		Yes	No	
c	Do you take out your dentures (false teeth) while eating?	☐	☐	q17q32_1c
d	Do you take out your dentures (false teeth) before going to bed?	☐	☐	q17q32_1d

		Yes	No	
32.2	Do you clean your dentures everyday?	☐	☐	q17q32_2

Other dental problems

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

		Yes	No	
a	Pain related to teeth or mouth	☐	☐	q17q33_0a
b	Loose tooth	☐	☐	q17q33_0b
c	Sensitivity to hot/ cold food or drink	☐	☐	q17q33_0c
d	Bleeding gums	☐	☐	q17q33_0d
e	Other gum problems	☐	☐	q17q33_0e

34.0 **Dry Mouth**

The following statement will help assess the extent to which you have dryness of mouth

(Tick **one** box) q17q34_0

	Never	Hardly ever	Occasionally	Fairly often	Very often
	1	2	3	4	5
Over the last 4 weeks my mouth has felt dry	☐	☐	☐	☐	☐

Present circumstances

35.0 Are you at present:-

single	☐ 1	q17q35_0
married	☐ 2	
widowed	☐ 3	
divorced or separated	☐ 4	
other	☐ 5	

35.1 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

q17q35_1

Your accommodation

36.0 Are you:-

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

q17q36_0

Social contact

		Hardly ever /Never 1	Sometimes 2	Often 3	
37.0	How often do you feel you lack companionship?	☐	☐	☐	q17q37_0
37.1	How often do you feel isolated from others?	☐	☐	☐	q17q37_1
37.2	How often do you feel left out?	☐	☐	☐	q17q37_2
37.3	How often do you feel in tune with the people around you?	☐	☐	☐	q17q37_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	q17q38_0a	Looking after wife/partner	☐	☐	_____	q17q38_0ahours
b	q17q38_0b	Looking after other adult family member or friend	☐	☐	_____	q17q38_0bhours
c	q17q38_0c	Looking after grandchildren	☐	☐	_____	q17q38_0chours
d	q17q38_0d	Watching television/videos/DVDs	☐	☐	_____	q17q38_0dhours
e	q17q38_0e	Reading	☐	☐	_____	q17q38_0ehours
f	q17q38_0f	Using a computer	☐	☐	_____	q17q38_0fhours
g	q17q38_0g	Driving or sitting in a car	☐	☐	_____	q17q38_0ghours

Memory

In the past year,

39.0 How often did you have trouble remembering things?

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

q17q39_0

		Yes	No	
39.1	Did you have more trouble than usual remembering a short list of items such as a shopping list?	☐	☐	q17q39_1
39.2	Did you have trouble remembering things from one second to the next?	☐	☐	q17q39_2
39.3	Did you have any difficulty in understanding or following spoken instruction?	☐	☐	q17q39_3
39.4	Did you have more trouble than usual following a group conversation or a plot on TV due to your memory?	☐	☐	q17q39_4
39.5	Did you have trouble finding your way around familiar streets?	☐	☐	q17q39_5
39.6	Did you have trouble getting things organised/ organising your day?	☐	☐	q17q39_6
39.7	Did you have trouble concentrating on things eg reading a book?	☐	☐	q17q39_7

		Yes	No	
39.8	**In past 12 months,** have you been forgetful to the extent that it has affected your daily life?	☐	☐	q17q39_8

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?	☐	☐	q17q40_0a
b	Did you feel that your life is empty?	☐	☐	q17q40_0b
c	Were you afraid that something bad is going to happen to you?	☐	☐	q17q40_0c
d	Did you feel happy most of the time?	☐	☐	q17q40_0d
e	Did you drop many of your activities and interests?	☐	☐	q17q40_0e
f	Did you prefer to stay at home, rather than going out to do new things?	☐	☐	q17q40_0f
g	Did you feel full of energy most of the time?	☐	☐	q17q40_0g

Medicines

41.0 Do you take any regular medication? Yes ☐ No ☐ q17q41_0

Details of ALL medicines

42.0 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	q17q 42_0_bnf12_1 q17q 42_0_bnf34_1 q17q 42_0_bnf5_1 q17q 42_0_bnf6_1	q17q 42_0_icd1	q17q 42_0_medpr1
2	q17q 42_0_bnf12_2 q17q 42_0_bnf34_2 q17q 42_0_bnf5_2 q17q 42_0_bnf6_2	q17q 42_0_icd2	q17q 42_0_medpr2
3	q17q 42_0_bnf12_3 q17q 42_0_bnf34_3 q17q 42_0_bnf5_3 q17q 42_0_bnf6_3	q17q 42_0_icd3	q17q 42_0_medpr3
4	q17q 42_0_bnf12_4 q17q 42_0_bnf34_4 q17q 42_0_bnf5_4 q17q 42_0_bnf6_4	q17q 42_0_icd4	q17q 42_0_medpr4
5	q17q 42_0_bnf12_5 q17q 42_0_bnf34_5 q17q 42_0_bnf5_5 q17q 42_0_bnf6_5	q17q 42_0_icd5	q17q 42_0_medpr5
6	q17q 42_0_bnf12_6 q17q 42_0_bnf34_6 q17q 42_0_bnf5_6 q17q 42_0_bnf6_6	q17q 42_0_icd6	q17q 42_0_medpr6
7	q17q 42_0_bnf12_7 q17q 42_0_bnf34_7 q17q 42_0_bnf5_7 q17q 42_0_bnf6_7	q17q 42_0_icd7	q17q 42_0_medpr7
8	q17q 42_0_bnf12_8 q17q 42_0_bnf34_8 q17q 42_0_bnf5_8 q17q 42_0_bnf6_8	q17q 42_0_icd8	q17q 42_0_medpr8
9	q17q 42_0_bnf12_9 q17q 42_0_bnf34_9 q17q 42_0_bnf5_9 q17q 42_0_bnf6_9	q17q 42_0_icd9	q17q 42_0_medpr9
10	q17q 42_0_bnf12_10 q17q 42_0_bnf34_10 q17q 42_0_bnf5_10 q17q 42_0_bnf6_10	q17q 42_0_icd10	q17q 42_0_medpr10
11	q17q 42_0_bnf12_11 q17q 42_0_bnf34_11 q17q 42_0_bnf5_11 q17q 42_0_bnf6_11	q17q 42_0_icd11	q17q 42_0_medpr11
12	q17q 42_0_bnf12_12 q17q 42_0_bnf34_12 q17q 42_0_bnf5_12 q17q 42_0_bnf6_12	q17q 42_0_icd12	q17q 42_0_medpr12
13	q17q 42_0_bnf12_13 q17q 42_0_bnf34_13 q17q 42_0_bnf5_13 q17q 42_0_bnf6_13	q17q 42_0_icd13	q17q 42_0_medpr13

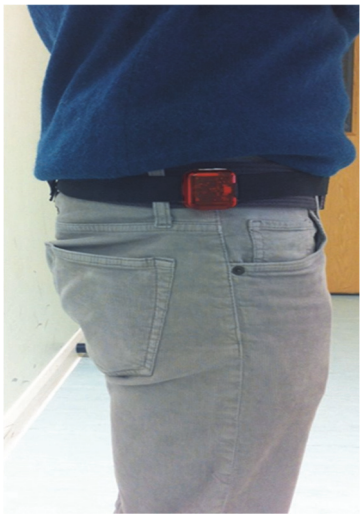
Please use the back of the questionnaire if more space is needed to record this information.

BRHS Activity Survey

We are planning a further phase of the BRHS Activity Survey in the very near future. We hope you will consider helping with this.

You would be asked to wear a small activity monitor and keep a simple log of your activities for seven days.

The activity monitor is worn around the waist, with the monitor positioned on the right hip as illustrated.



The monitor is pre-programmed. You do not need to switch it on or off.

If you agree to take part the monitor will be **sent within the next six weeks.**

PLEASE TICK THE APPROPRIATE BOX

☐ YES, I would like to participate in the BRHS activity survey in the next six weeks

☐ YES, I would like to participate in the BRHS activity survey but on another occasion

Please suggest an alternative date _____

☐ NO, I do not wish to participate in the BRHS activity survey.

General comments:

q17General_comments

Office use:

q17DateStamp_d
q17DateStamp_m
q17DateStamp_y

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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