Study Number: serial q40coder

UCL

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1978-2018

BRITISH REGIONAL HEART STUDY

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2018

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

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 q40q1_0Day q40q1_0Month **20** q40q1_0Year

day month year

1.1 Please give your Date of Birth q40q1_1Day q40q1_1Month **19** q40q1_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	☐	☐	q40q2_0a
b	Angina	☐	☐	q40q2_0b
c	Aortic Aneurysm	☐	☐	q40q2_0c
d	Atrial Fibrillation	☐	☐	q40q2_0d
e	Deep Vein Thrombosis (clot in the deep leg vein)	☐	☐	q40q2_0e
f	Heart attack (coronary thrombosis or myocardial infarction)	☐	☐	q40q2_0f
g	Heart failure	☐	☐	q40q2_0g
h	High blood pressure	☐	☐	q40q2_0h
i	High cholesterol	☐	☐	q40q2_0i
j	Narrowing or hardening of the leg arteries (including claudication)	☐	☐	q40q2_0j
k	Pulmonary Embolism (clot on the lung)	☐	☐	q40q2_0k
l	Other problems of the heart and circulation	☐	☐	q40q2_0l

Office Use

m **If yes**, please give details q40q2_0m_box

Stroke

		Yes	No	Year of last occurrence
3.0	Have you **ever** been told by a doctor that you have had a stroke?	☐	☐	q40q3_0_year
	If yes,	q40q3_0		
a	Did the symptoms last for more than 24 hours?	☐	☐	q40q3_0a
b	Have you made a complete recovery from your stroke?	☐	☐	q40q3_0b
c	Following your stroke, do you still need any help in carrying out everyday activities?	☐	☐	q40q3_0c

Investigations and special treatment for conditions affecting your heart and circulation

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

			Yes	No	Year of last occurrence
a	q40q4_0a	A referral for an echocardiogram ("echo")	☐	☐	q40q4_0a_year
b	q40q4_0b	An exercise ECG ("stress" or "treadmill") test	☐	☐	q40q4_0b_year
c	q40q4_0c	Angiogram or X-ray of coronary arteries (using a dye)	☐	☐	q40q4_0c_year
d	q40q4_0d	Angioplasty (balloon treatment of coronary artery, PCI, stents)	☐	☐	q40q4_0d_year
e	q40q4_0e	Coronary artery bypass graft operation ("heart bypass" or "CABG")	☐	☐	q40q4_0e_year
f	q40q4_0f	Other tests, investigations or operations on your heart, arteries or veins?	☐	☐	q40q4_0f_year

g q40q4_0g If **yes**, please give details:

_____

Office Use q40q4_0g_box

Cardiac rehabilitation

		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?	☐ q40q4_1	☐
4.2	If yes, which year was this?	q40q4_2	

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?	☐ q40q5_0	☐	q40q5_0year

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

(Tick **all** that apply)

a	feet	☐ 1 q40q5_1afeet
b	kidneys	☐ 1 q40q5_1bkidney
c	eyes	☐ 1 q40q5_1ceyes
d	nerves	☐ 1 q40q5_1dnerves
e	none	☐ 1 q40q5_1enone

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?	☐ q40q6_0	☐	q40q6_0year

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

_____ q40q6_1Canser_site1_boxes1

q40q6_1Canser_site2_boxes2

_____ q40q6_1Canser_site3_boxes3

Office Use

Other medical conditions

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

		Yes	No	
a	Alzheimer's disease	☐	☐	q40q7_0a
b	Anaemia	☐	☐	q40q7_0b
c	Asthma	☐	☐	q40q7_0c
d	Bronchitis	☐	☐	q40q7_0d
e	Cataract	☐	☐	q40q7_0e
f	Chronic Kidney disease	☐	☐	q40q7_0f
g	Chronic obstructive pulmonary disease (COPD)	☐	☐	q40q7_0g
h	Crohn's disease	☐	☐	q40q7_0h
i	Dementia	☐	☐	q40q7_0i
j	Depression	☐	☐	q40q7_0j
k	Emphysema	☐	☐	q40q7_0k
l	Gall bladder disease	☐	☐	q40q7_0l
m	Gastric, peptic or duodenal ulcer	☐	☐	q40q7_0m
n	Glaucoma	☐	☐	q40q7_0n
o	Gout	☐	☐	q40q7_0o
p	Liver disease, cirrhosis or hepatitis	☐	☐	q40q7_0p
q	Macular degeneration	☐	☐	q40q7_0q
r	Osteoporosis	☐	☐	q40q7_0r
s	Parkinson's disease	☐	☐	q40q7_0s
t	Pneumonia	☐	☐	q40q7_0t
u	Prostate trouble	☐	☐	q40q7_0u
v	Shingles	☐	☐	q40q7_0v
w	Ulcerative colitis	☐	☐	q40q7_0w

Office Use

x Other conditions, please give details _____ q40q7_0x_other_box1

q40q7_0x_other_box2 _____

Chest Pain

		Yes	No	Unable to walk on level	
8.0	Do you **ever** have any pain or discomfort in your chest?	☐	☐		q40q8
8.1	When you walk at an ordinary pace on the level, does this produce the chest pain?	☐	☐	☐ 3	q40q8_1
8.2	When you walk uphill or hurry, does this produce the chest pain?	☐	☐	☐ 3	q40q8_2

Breathlessness

		Yes	No	Unable to walk	
9.0	Do you **ever** get short of breath walking with other people of your own age on level ground?	☐	☐	☐ 3	q40q9_0
9.1	On walking uphill or upstairs, do you get more breathless than people of your own age?	☐	☐	☐ 3	q40q9_1
9.2	Do you **ever** have to stop walking because of breathlessness?	☐	☐	☐ 3	q40q9_2
9.3	In the **past year** have you at any time been awoken at night by an attack of shortness of breath?	☐	☐		q40q9_3

Cough and Wheeze

		Yes	No	
10.0	Do you usually bring up phlegm (or spit) from your chest first thing in the morning in the winter?	☐	☐	q40q10_0
10.1	Do you bring up phlegm like this on most days for as much as three months in the winter each year?	☐	☐	q40q10_1

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

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

q40q10_2

		Yes	No	
10.3	Does your chest ever sound wheezy or whistling?	☐	☐	q40q10_3
10.4	**If yes**, does this happen on most days or nights?	☐	☐	q40q10_4

Chest infections and antibiotics

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

None ☐ 1
Once ☐ 2
More than once ☐ 3

q40q10_5

Operations

		Yes	No	
11.0	Have you had any major operations in the **last 10 years**?	☐	☐	q40q11_0

11.1 **If yes,** please give details:

_____ Office Use

q40q11_1

Bladder control

		Yes	No	
11.2	Many people complain that they leak urine unintentionally. In the **past 12 months**, have you leaked even a small amount of urine?	☐	☐	q40q11_2

Leg Pain

		Yes	No	Unable to walk	
12.0	Do you get pain or discomfort in your leg or legs when you walk?	☐	☐	☐ 3	q40q12_0
12.1	Does this pain ever begin when you are standing still or sitting?	☐	☐		q40q12_1
		Yes	No	Unable to walk	
12.2	Do you get the pain if you walk uphill or hurry?	☐	☐	☐ 3	q40q12_2
12.3	Do you get the pain walking at an ordinary pace on the level?	☐	☐	☐ 3	q40q12_3

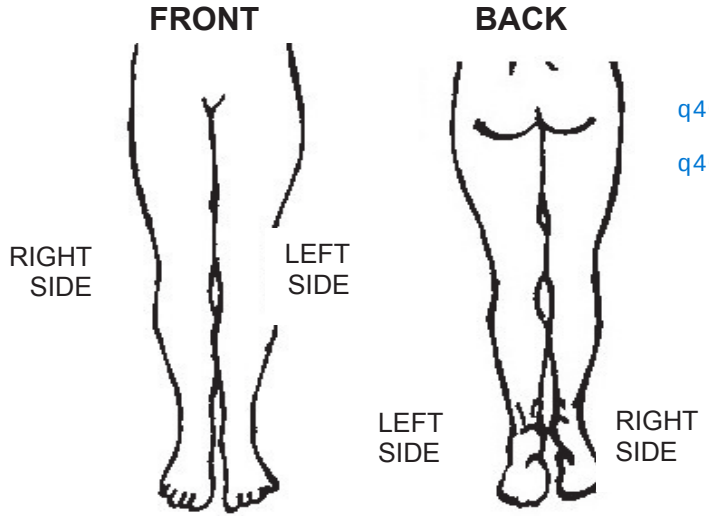
12.4 What happens to the pain if you stand still?

Usually continues more than 10 minutes ☐ 1

Usually disappears in 10 minutes or less ☐ 2

q40q12_4

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



Office Use

q40q12_5_L_box L ☐

q40q12_5_R_box R ☐

Arthritis

		Yes	No	Year of diagnosis
13.0	Have you **ever** been told by a doctor that you <u>have or have had</u> arthritis?	☐	☐	_____
		q40q13		q40q13_0_year

13.1 **If yes**, please give the type of arthritis if known:

Osteoarthritis ☐ 1

Rheumatoid arthritis ☐ 2 q40q13_1

Other (please give details) ☐ 3 _____ q40q13_1_box

Don't know ☐ 4

Office Use

13.2 Which joints are affected: (Tick **all** that apply)

q40q13_2_knees Knees ☐ 1

q40q13_2_Hips Hips ☐ 1

q40q13_2_Feet Feet ☐ 1

q40q13_2_Ankle Ankle ☐ 1

q40q13_2_Hands_fingers Hands and/or fingers ☐ 1

Wrists ☐ 1 q40q13_2_Wrists

Back ☐ 1 q40q13_2_Back

Neck ☐ 1 q40q13_2_Neck

Shoulders ☐ 1 q40q13_2_Shoulders

Other, please specify ☐ 1 _____ q40q13_2_other

q40q13_2_other_box

Office Use

Joint pain, swelling or stiffness

14.0 During **the past year,** have you had pain, aching, stiffness or swelling on most days **for at least one month**? Yes ☐ No ☐ q40q14.0

14.1 **If yes**, which joints are affected: (Tick **all** that apply)

q40q14_1_knees	Knees	☐ 1	Wrists	☐ 1	q40q14_1_Wrists
q40q14_1_Hips	Hips	☐ 1	Back	☐ 1	q40q14_1_Back
q40q14_1_Feet	Feet	☐ 1	Neck	☐ 1	q40q14_1_Neck
q40q14_1_Ankle	Ankle	☐ 1	Shoulders	☐ 1	q40q14_1_Shoulders
q40q14_1_Hands_fingers	Hands and/or fingers	☐ 1	Other, please specify	☐ 1	q40q14_1_other q40q14_1_other_box

Office Use

Lower back pain

15.0 Have you **ever** had pain in your lower back on **most days** for at **least one month**? Yes ☐ No ☐ q40q15_0

15.1 **If yes**, have you had this in the **last year**? ☐ ☐ q40q15_1

Falls

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

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

q40q16_0

Fractures and falls

17.0 Have you had spells of dizziness, loss of balance or a sensation of spinning **in the last year**? Yes ☐ No ☐ q40q17_0

Please give year

17.1 Have you **ever** fractured your hip? q40q17_1 ☐ ☐ q40q17_1_year

17.2 Have you **ever** fractured your wrist? q40q17_2 ☐ ☐ q40q17_2_year

17.3 Have you had a fall in the **last year**? q40q17_3 ☐ ☐

17.4 **If yes**, how many times q40q17_4_times

17.5 Did you receive medical attention for any of these falls? Yes ☐ No ☐ q40q17_5

17.6 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	q40q17_6a
b	damage to muscle or ligament	☐ 1	q40q17_6b
c	broken or fractured **hip** bone	☐ 1	q40q17_6c
d	broken or fractured **wrist** bone	☐ 1	q40q17_6d
e	other broken or fractured bone	☐ 1	q40q17_6e

Your overall health

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

18.0 **General health**

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

q40q18_0

18.1 **Pain/discomfort**

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

q40q18_1

18.2 **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

q40q18_2

18.3 **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

q40q18_3

18.4 **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

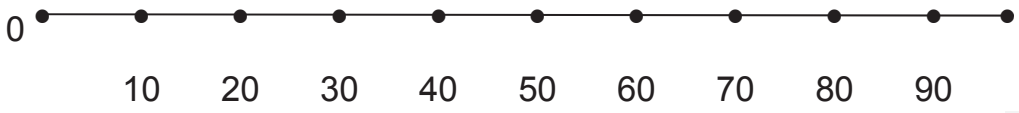
q40q18_4

18.5 **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



Office Use

q40q18_5

Eyesight

		Yes	No	
19.0	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**)?	☐	☐	q40q19_0
19.1	**If no**, can you see well enough to recognise a friend at a distance of three feet/ one yard?	☐	☐	q40q19_1

Hearing

		Yes	No	
20.0	Have you **ever** had a hearing test?	☐	☐	q40q20_0
20.1	**If yes**, were you offered a hearing aid?	☐	☐	q40q20_1

		Yes	No	Occasionally	
20.2	Do you use a **hearing aid?**	☐	☐	☐ 3	q40q20_2

		Yes	No	
20.3	Is your hearing good enough to follow a TV programme at a volume others find acceptable (using a hearing aid if needed)?	☐	☐	q40q20_3
20.4	**If no**, can you follow a TV programme with the volume turned up?	☐	☐	q40q20_4

Weight

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

q40q21_0stones ___ ___ Stones q40q21_0pounds ___ ___ Pounds **or** q40q21_0kilograms ___ ___ ___ Kilograms

21.1 **If you have no scales** and have made an estimate please tick here ☐ 1 q40q21_1

21.2 Has your weight changed in the **last four years**?

Not changed	☐ 1	
Increased	☐ 2	q40q21_2
Decreased	☐ 3	
Both increased and decreased	☐ 4	
Don't know	☐ 5	

If your weight has changed in the last four years:

		Yes	No	
21.3	Was this change intentional?	☐	☐	q40q21_3

(Tick **all** that apply)

21.4	a	Was it the result of	Personal choice ☐ 1	q40q21_4a
	b		Medical advice ☐ 1	q40q21_4b
	c		Illness or ill health ☐ 1	q40q21_4c

Cigarette Smoking

		Yes	No	
22.1	Have you ever smoked cigarettes?	☐	☐	q40q22_1
22.2	Do you smoke cigarettes at present?	☐	☐	q40q22_2

If yes, how many cigarettes do your smoke per day q40q22_2_cig_per_day _____ per day

Alcohol Intake

23.0 Would you describe your present alcohol intake as

Daily/most days	☐ 1	
Weekends only	☐ 2	q40q23_0
Occasionally once or twice a month	☐ 3	
Special occasions only	☐ 4	
None	☐ 5	

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

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

More than 6 drinks	☐ 1	
5-6 drinks	☐ 2	q40q23_1
3-4 drinks	☐ 3	
1-2 drinks	☐ 4	

23.2 How many alcoholic drinks do you have during an average week? ___ ___ q40q23_2

23.3 What type of drink do you usually take? (Tick **all** that apply)

a	Beers, Lagers	☐ 1	q40q23_3a
b	Wines, Sherry	☐ 1	q40q23_3b
c	Spirits	☐ 1	q40q23_3c
d	Combination of Beers, Wines or Spirits	☐ 1	q40q23_3d
e	Low alcohol drinks	☐ 1	q40q23_3e

Water intake

24.0 How many glasses of **water** do you drink **a day**? q40q24_0 ___ ___ glasses per day

Snacks

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

a Savoury snacks (e.g. crisps/ salted nuts)? q40q24_0a ___ ___ times per day

b Sweet snacks(e.g. biscuits/cakes/chocolate/sweets)? q40q24_0b ___ ___ times per day

Meals

		Yes	No	
25.1	Do you receive help preparing your meals?			q40q25_1 ☐ ☐
a	**If yes,** is this from Social/Local Authority services or private provider?	☐ 1		q40q25_1a
b	Friends/family?	☐ 1		q40q25_1b
c	Other, please give details _____ q40q25_1c	☐ 1		q40q25_1c_box

Office Use

Physical activity

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

No ☐ 1
Walk ☐ 2
Cycle ☐ 3
Both ☐ 4

q40q26

26.1 How many hours do you normally spend **walking** e.g. on errands or for leisure in an average week? q40q26_1 hours

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

Slow ☐ 1
Steady average ☐ 2
Fast ☐ 3

q40q26_2

26.3 How long do you spend **cycling** in an average week? q40q26_3 hours

26.4 On a normal day, how many times do you **climb a flight of stairs** (assuming that 1 flight of stairs has 10 steps)? q40q26_4 times /day

q40q26_4Donotclimbstairs

a Do not climb stairs ☐ 0

26.5 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

q40q26_5

26.6 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

q40q26_6

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

_____

Office Use

q40q26_6_box

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

(please give overall total)

26.8 In winter q40q26_8 times a month

26.9 In summer q40q26_9 times a month

General Fitness

Can you do any of the following activities:

			Yes	No
27.0	q40q27_0	run a short distance?	☐	☐
27.1	q40q27_1	do heavy work around the house (e.g. lifting & moving heavy furniture)	☐	☐
27.2	q40q27_2	do gardening (e.g. raking leaves, weeding & pushing the lawn mower)	☐	☐
27.3	q40q27_3	participate in moderate activities like golf, bowling, dancing or doubles tennis?	☐	☐
27.4	q40q27_4	participate in strenuous sports like swimming or singles tennis?	☐	☐
27.5	q40q27_5	have sexual relations?	☐	☐

Muscle strength and endurance

28.0 Do you engage in exercises to increase muscle strength and endurance such as lifting weights, doing push-ups, using exercise machines? Yes ☐ No ☐ q40q28_0

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

q40q28_1hours ___ ___ hours q40q28_1mins ___ ___ minutes

Grip Strength

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

Very good ☐ 1 q40q29_0
Good ☐ 2
Fair ☐ 3
Poor ☐ 4

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**).

30.0

		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	q40q30_0a M	R
b	Doing exercises – e.g. push ups, sit ups, chair aerobics, an exercise routine.	7	6	5	4	3	2	1	q40q30_0b M	R
c	Balance and co-ordination - e.g. dancing, standing on one leg, or Tai Chi style exercises.	7	6	5	4	3	2	1	q40q30_0c M	R

Long standing illness, disability or infirmity

		Yes	No	
31.0	Do you have any **long-standing** illness, disability or infirmity?	☐	☐	q40q31_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?	☐	☐	q40q31_0a
b	do you receive a disability allowance?	☐	☐	q40q31_0b

Disability

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

		Yes	No	
a	Going up or down stairs	☐	☐	q40q32_0a
b	Bending down	☐	☐	q40q32_0b
c	Straightening up	☐	☐	q40q32_0c
d	Keeping your balance	☐	☐	q40q32_0d
e	Going out of the house	☐	☐	q40q32_0e
f	Walking 400 yards	☐	☐	q40q32_0f

32.1 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	q40q32_1a
b	Household chores	☐	☐		q40q32_1b
c	Social life	☐	☐		q40q32_1c
d	Interests and hobbies	☐	☐		q40q32_1d
e	Holidays and outings	☐	☐		q40q32_1e

32.2 Do you have any difficulties getting about outdoors?

No difficulty	☐ 1	q40q32_2
Slight	☐ 2	
Moderate	☐ 3	
Severe	☐ 4	
Unable to do	☐ 5	

Mobility Aids

33.0 Do you use any mobility aids? Yes ☐ No ☐ q40q33_0

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

(Tick **all** that apply)

a Walking stick ☐1 q40q33_1a

b Walking frame ☐1 q40q33_1b

c Wheelchair/ mobility scooter ☐1 q40q33_1c

d Other ☐1 q40q33_1d

Office Use q40q33_1d_box

Activities of daily living

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

34.0 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
q40q34_0

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

Yes ☐1
Yes, only if I hold on and take a rest ☐2
Not at all ☐3
q40q34_1

34.2 When standing, can you bend down and pick up a shoe **from the floor**? Yes ☐ No ☐ q40q34_2

34.3 When sitting, can you rise from a chair of knee height, **without using your hands**? ☐ ☐ q40q34_3

34.4 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
Worse ☐3
Much Worse ☐4
q40q34_4

Difficulties with Activities of daily living

35.0 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 q40q35_0a	Reaching or extending your arms above shoulder level	☐	☐	☐
b q40q35_0b	Pulling or pushing large objects like a living room chair	☐	☐	☐
c q40q35_0c	Walking across a room	☐	☐	☐
d q40q35_0d	Getting in and out of bed on your own	☐	☐	☐
e q40q35_0e	Getting in and out of a chair on your own	☐	☐	☐
f q40q35_0f	Dressing and undressing yourself on your own	☐	☐	☐
g q40q35_0g	Bathing or showering	☐	☐	☐
h q40q35_0h	Feeding yourself, including cutting food	☐	☐	☐
i q40q35_0i	Getting to and using the toilet on your own	☐	☐	☐
j q40q35_0j	Lifting and carrying something as heavy as 10 lbs, (e.g. a bag of groceries)	☐	☐	☐
k q40q35_0k	Shopping for personal items such as toilet items or medicine by yourself	☐	☐	☐
l q40q35_0l	Doing light housework (e.g. washing up)	☐	☐	☐
m q40q35_0m	Preparing your own meals by yourself	☐	☐	☐
n q40q35_0n	Using the telephone by yourself	☐	☐	☐
o q40q35_0o	Taking medications by yourself	☐	☐	☐
p q40q35_0p	Managing money (e.g. paying bills etc)	☐	☐	☐
q q40q35_0q	Using public transport on your own	☐	☐	☐
r q40q35_0r	Driving a car on your own	☐	☐	☐
s q40q35_0s	Gripping with hands (e.g. opening a jam jar)	☐	☐	☐

Appetite

Which of the following statements best describes your appetite:

36.0 My appetite is

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

q40q36_0

36.1 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

q40q36_1

36.2 Food generally tastes

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

q40q36_2

36.3 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

q40q36_3

36.4 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

q40q36_4

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

_____

q40q36_5

Office Use

Appetite and eating

37.0 Do you have an **illness or a physical condition** that interferes with your appetite or ability to eat? Yes ☐ No ☐ q40q37_0

If Yes, please indicate the conditions that interfere with your appetite or ability to eat.

37.1

(Tick **all** that apply)		(Tick **all** that apply)	
Problems with your teeth q40q37_1_problems_with_teeth	☐ 1	Stomach/ abdominal pain q40q37_1_stomach_abdominal	☐ 1
Swallowing problems q40q37_1_swallowing	☐ 1	Gas/ bloating q40q37_1_Gas_bloating	☐ 1
Pain on chewing q40q37_1_pain_on_chewing	☐ 1	Indigestion/ heartburn q40q37_1_indegestion_heartburn	☐ 1
Poor taste q40q37_1_poor_taste	☐ 1	Constipation/Diarrhoea q40q37_1_constipation_diarrhoea	☐ 1
Poor smell q40q37_1_poor_smell	☐ 1	Other _____ q40q37_1_other	☐ 1

Office Use q40q37_1_other_box

37.2 Are there days when you **don't feel like eating at all**? Yes ☐ No ☐ q40q37_2

If yes,

37.3 About how often would you say you don't feel like eating at all?

About once a month	☐ 1
About once a week	☐ 2
More than once a week	☐ 3
Every day	☐ 4

q40q37_3

37.4 What do you think are the reasons you do not feel like eating? (Tick **all** that apply)

a	Not hungry	☐ 1 q40q37_4a
b	In general, food is not appealing to me	☐ 1 q40q37_4b
c	Taste of the food	☐ 1 q40q37_4c
d	Smell of the food	☐ 1 q40q37_4d
e	Look of the food	☐ 1 q40q37_4e
f	No specific reason	☐ 1 q40q37_4f
g	Other (please specify) _____ q40q37_4g	☐ 1 q40q37_4g_box

Office Use

Shopping for food

38.0 Do you have any difficulty shopping for food because of a health or physical problem? Yes ☐ No ☐ q40q38_0

38.1 Can you easily access a supermarket or grocery for your food shopping? ☐ ☐ q40q38_1

38.2 Would you say you get the groceries that you need?

All of the time	☐ 1
Most of the time	☐ 2
Some of the time	☐ 3
Never/rarely	☐ 4

q40q38_2

Your food intake and weight loss

39.0 During the **past month**, would you say you have you had enough food to satisfy your hunger

- All of the time ☐ 1
- Most of the time ☐ 2
- Some of the time ☐ 3
- Never/rarely ☐ 4

q40q39_0

39.1 Do you feel you are undernourished?

- Yes ☐ 1
- No ☐ 2
- I don't know ☐ 3

q40q39_1

39.2 Has your food intake declined over the **past 3 months**?

- no decrease in food intake ☐ 1
- moderate decrease in food intake ☐ 2
- severe decrease in food intake ☐ 3

q40q39_2

39.3 How much weight (if any) have you lost in the **past 3 months**?

- no weight loss or weight loss less than 2 pounds (1Kg) ☐ 1
- weight loss between 2 and 7 pounds (1 and 3Kg) ☐ 2
- weight loss greater than 7 pounds (3 Kg) ☐ 3
- do not know the amount of weight lost ☐ 4

q40q39_3

Current mobility

40.0 How would you describe your current mobility?

- Able to leave my home ☐ 1
- Able to get out of bed or a chair, but unable to go out of my home ☐ 2
- Unable to get out of a bed, a chair, or a wheelchair without the assistance of another person ☐ 3

q40q40_0

Stress and illness in last 3 months

41.0 Have you been stressed or severely ill in the past 3 months? Yes ☐ No ☐

q40q41_0

41.1 Are you currently experiencing **dementia** and/or **prolonged severe sadness**?

- No ☐ 1
- yes, mild dementia, but no prolonged severe sadness ☐ 2
- yes, severe dementia and/**or** prolonged severe sadness ☐ 3

q40q41_0

Your Dental Health (mouth, teeth and or dentures)

General Dental Health

50.0 Would you say that your dental health is:

Excellent ☐ 1
Good ☐ 2 q40q50_0
Fair ☐ 3
Poor ☐ 4

Your teeth

51.1 Do you have **any** of your own teeth? Yes ☐ No ☐ q40q51_1

51.2 How many of your own (natural) teeth do you have? ___ ___ q40q51_2

51.3 How many of your own (natural) teeth have **you lost** in the **last five years**? ___ ___ q40q51_3

Back teeth(molars)

52.1 Do you have **any** of your own back teeth(molars) in your **lower teeth**? Yes No

a on the **left** side ☐ ☐ q40q52_1a

b on the **right** side ☐ ☐ q40q52_1b

52.2 Do you have **any** of your own back teeth(molars) in your **upper teeth**?

a on the **left** side ☐ ☐ q40q52_2a

b on the **right** side ☐ ☐ q40q52_2b

Chewing difficulties

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

No ☐ 1
Yes, some difficulty ☐ 2 q40q53_1
Yes, great difficulty ☐ 3

53.2 Do you avoid eating some foods because of problems with your teeth, mouth or dentures? Yes ☐ No ☐ q40q53_2

53.3 Does it take you longer to finish a meal than other people of your own age? ☐ ☐ q40q53_3

Tooth brushing

54.1 How frequently do you brush your teeth?

More than once a day ☐ 1 q40q54_1
Once a day ☐ 2
Less than once a day ☐ 3

54.2 Do you have difficulty brushing your teeth? Yes ☐ No ☐ q40q54_2

Visiting the dentist

		Yes	No	
55.0	Have you seen your dentist in the last year?	☐	☐	q40q55_0

55.1 In general do you go to the dentist / hygienist for:

Regular check-up	☐ 1	q40q55_1
Occasional check up	☐ 2	
Only when having trouble	☐ 3	
Rarely or never go to the dentist	☐ 4	

55.2 If you rarely or never visit the dentist, what are the reasons? (Tick **all** that apply)

q40q55_2_difficult_dent_surgery	Difficult to get to the dental surgery	☐ 1
q40q55_2_expensive	Expensive	☐ 1
q40q55_2_dont_need_dentist	Don't need to see a dentist	☐ 1
q40q55_2_other	Other_____	☐ 1

Office Use

q40q55_2_other_box

Other dental problems

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

(Tick **all** that apply)

56.1	Pain related to teeth or mouth	☐ 1	q40q56_1
56.2	Loose tooth	☐ 1	q40q56_2
56.3	Sensitivity to hot/ cold food or drink	☐ 1	q40q56_3
56.4	Mouth ulcers	☐ 1	q40q56_4
56.5	Bleeding gums	☐ 1	q40q56_5
56.6	Other gum problems	☐ 1	q40q56_6
56.7	Soreness or cracking around the corners of the mouth	☐ 1	q40q56_7

Dental problems affecting your daily life

57.0 Have any problems with mouth, teeth or dentures caused any of the following difficulty or problem effecting your daily life?

(Tick **all** that apply)

a	Difficulty speaking clearly	☐ 1	q40q57_0a
b	Difficulty going out, for example to shop or visit someone	☐ 1	q40q57_0b
c	Difficulty relaxing (including sleeping)	☐ 1	q40q57_0c
d	Problems smiling, laughing and showing teeth without embarrassment	☐ 1	q40q57_0d
e	Emotional problems e.g. becoming more easily upset than usual	☐ 1	q40q57_0e
f	Problems enjoying the company of others e.g. family, friends, neighbours	☐ 1	q40q57_0f
g	None of these	☐ 1	q40q57_0g

Dentures

58.0 Do you wear full or partial dentures(plate or false teeth that are removable)? Yes ☐ No ☐ q40q58_0

If you wear dentures, do you have any problems such as: (Tick **all** that apply)

a q40q58_0a Loose dentures ☐1

b q40q58_0b Difficulty eating with dentures ☐1

c q40q58_0c Other, please specify_____ ☐1

Office Use q40q58_0c_box

Using your dentures (if you have them)

		Yes	No	
58.1	Do you take out your dentures (false teeth) while eating?	☐	☐	q40q58_1
58.2	Do you take out your dentures (false teeth) before going to bed?	☐	☐	q40q58_2
58.3	Do you clean your dentures every day?	☐	☐	q40q58_3

Upper Teeth

59.0 Do you wear a denture (plate or false teeth) for **upper teeth**? Yes ☐ No ☐ q40q59_0

a **If yes**

I wear a **full set** of dentures ☐1

I wear a **partial set** of dentures (to replace some but not all missing teeth) ☐2 q40q59_0a

b How long have you had this denture? q40q59_0b_years ___ Years q40q59_0b_months ___ Months

c Do you use this denture every day? Yes ☐ No ☐ q40q59_0c

Lower Teeth

60.0 Do you wear a denture (plate or false teeth) for **lower teeth**? Yes ☐ No ☐ q40q60_0

If yes

a

I wear a **full set** of dentures ☐1

I wear a **partial set** of dentures (to replace some but not all missing teeth) ☐2 q40q60_0a

b How long have you had this denture? q40q60_0b_years ___ Years q40q60_0b_months ___ Months

c Do you use this denture every day? Yes ☐ No ☐ q40q60_0c

Dry Mouth

The following statements will help assess the extent to which you have dryness of mouth.
In the last 4 weeks, have you experienced any of the following?

(Please **tick one box** for each statement)

61.0		Never	Hardly ever	Occasionally	Fairly often	Very often
		1	2	3	4	5
a q40q61_0a	My mouth feels dry	☐	☐	☐	☐	☐
b q40q61_0b	My mouth feels dry when eating a meal	☐	☐	☐	☐	☐
c q40q61_0c	I have difficulty in eating dry foods	☐	☐	☐	☐	☐
d q40q61_0d	I have difficulties swallowing certain foods	☐	☐	☐	☐	☐
e q40q61_0e	I sip liquids to aid in swallowing food	☐	☐	☐	☐	☐
f q40q61_0f	I suck sweets to relieve dry mouth	☐	☐	☐	☐	☐
g q40q61_0g	I get up at night to drink	☐	☐	☐	☐	☐
h q40q61_0h	My lips feel dry	☐	☐	☐	☐	☐
i q40q61_0i	My eyes feel dry	☐	☐	☐	☐	☐
j q40q61_0j	The skin of my face feels dry	☐	☐	☐	☐	☐
k q40q61_0k	The inside of my nose feels dry	☐	☐	☐	☐	☐

Taste and smell

During the past **12 months**

		Yes	No
62.1	Have you had a problem with your ability to **smell**, such as not being able to smell things?	☐	☐
		q40q62_1	
62.2	Have you had a problem with your ability to **taste** food or drink?	☐	☐
		q40q62_2	

Sleeping Patterns

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

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

q40q63_0

63.1 On average how many **hours of sleep** do you have at:

a q40q63_1aNighttime_hours Night time? ___ ___ hours q40q63_1aNighttime_mins __ __minutes

b q40q63_1bDaytime_hours Day time? ___ ___ hours q40q63_1bDaytime_mins __ __minutes

63.2 How often do you feel **excessively sleepy** during the day?

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

q40q63_2

During **the last month**,

63.3 Did you have **difficulties falling asleep** at night?

rarely ☐ 1
sometimes ☐ 2
often ☐ 3

q40q63_2

63.4 Do you often wake up during the early hours and are unable to get back to sleep?

Yes ☐ No ☐ q40q63_4

63.5 Do you have **trouble maintaining sleep** at night?

rarely ☐ 1
sometimes ☐ 2
often ☐ 3

q40q63_5

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

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

q40q63_6

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

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

q40q63_7

Diagnosis of sleep apnoea

63.8 Have you ever been told by a **doctor** that you suffer with sleep apnoea

Yes ☐ No ☐ q40q63_8

Memory

In the past year,

64.0 How often did you have trouble remembering things?

never ☐ 1
rarely ☐ 2 q40q64_0
sometimes ☐ 3
often ☐ 4

		Yes	No	
64.1	Did you have more trouble than usual remembering recent events?	☐	☐	q40q64_1
64.2	Did you have more trouble than usual remembering a short list of items such as a shopping list?	☐	☐	q40q64_2
64.3	Did you have trouble remembering things from one second to the next?	☐	☐	q40q64_3
64.4	Did you have any difficulty in understanding or following spoken instruction?	☐	☐	q40q64_4
64.5	Did you have more trouble than usual following a group conversation or a plot on TV due to your memory?	☐	☐	q40q64_5
64.6	Did you have trouble finding your way around familiar streets?	☐	☐	q40q64_6
64.7	Did you have trouble getting things organised/ organising your day?	☐	☐	q40q64_7
64.8	Did you have trouble concentrating on things e.g. reading a book?	☐	☐	q40q64_8

Forgetfulness

		Yes	No	
65.0	**In past 12 months,** have you been forgetful to the extent that it has affected your daily life?	☐	☐	q40q65_0

Recent major life events

66.0 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	q40q66_0a
b	death of a close relative/friend	☐ 1	q40q66_0b
c	illness/accident to a family member	☐ 1	q40q66_0c
d	financial difficulties	☐ 1	q40q66_0d
e	personal illness, accident or injury	☐ 1	q40q66_0e
f	moving house	☐ 1	q40q66_0f
g	divorce	☐ 1	q40q66_0g
h	addition to family circle e.g. grandchild	☐ 1	q40q66_0h
I	death of a pet	☐ 1	q40q66_0i
j	Other, please give details	☐ 1	q40q66_0j
k	none	☐ 1	q40q66_0k

Office Use q40q66_0j_box

Time spent on various activities

67.0 Do you spend any time on these activities?
For some activities we ask you to tell us how many **hours** a **week** you spend doing them.

			Yes	No	Hours per week
a	q40q67_0a	Looking after wife/partner	☐	☐	q40q67_0a_hours
b	q40q67_0b	Looking after other adult family member or friend	☐	☐	q40q67_0b_hours
c	q40q67_0c	Looking after grandchildren	☐	☐	q40q67_0c_hours
d	q40q67_0d	Spending time with family, friends and neighbours	☐	☐	
e	q40q67_0e	Talking to friends/relatives on the telephone/video calls	☐	☐	
f	q40q67_0f	In paid work	☐	☐	
g	q40q67_0g	In voluntary work	☐	☐	
h	q40q67_0h	In a pub or club	☐	☐	
i	q40q67_0i	Attending religious services	☐	☐	
j	q40q67_0j	Playing cards, games, or bingo	☐	☐	
k	q40q67_0k	Visiting the cinema/restaurants/sporting events	☐	☐	

67.0 **Do you spend any time on these activities?**
If yes, how many hours a week do you spend doing these?

			Yes	No	Hours per week
l	q40q67_0l	On housework	☐	☐	q40q67_0l_hours
m	q40q67_0m	On light gardening (pruning and weeding)	☐	☐	q40q67_0m_hours
n	q40q67_0n	On heavy gardening (digging & mowing)	☐	☐	q40q67_0n_ hours
o	q40q67_0o	Watching television/videos/DVD's	☐	☐	q40q67_0o_hours
p	q40q67_0p	Reading	☐	☐	q40q67_0p_hours
q	q40q67_0q	Attending class or course of study	☐	☐	q40q67_0q_hours
r	q40q67_0r	Using a computer	☐	☐	q40q67_0r_hours
s	q40q67_0s	Driving or sitting in a car	☐	☐	q40q67_0s_hours

Other activities

68.0

		Yes	No	
a	Have you been on any day or overnight trips in the last year?	☐	☐	q40q68_0a
b	Have you been on holiday in the last year?	☐	☐	q40q68_0b
c	Are you planning to go on holiday next year?	☐	☐	q40q68_0c
d	Do you use the internet and/or email?	☐	☐	q40q68_0d
e	Do you use social media?	☐	☐	q40q68_0e
f	Do you use a “touch screen” mobile phone?	☐	☐	q40q68_0f
g	Have you written a personal letter or email in the last week?	☐	☐	q40q68_0g
h	Do you take a weekly or monthly magazine or journal?	☐	☐	q40q68_0h
i	Did you vote in the last general or local elections?	☐	☐	q40q68_0i

Social contact

69.0

			Hardly ever /never 1	Sometimes 2	Often 3
a	q40q69_0a	How often do you feel you lack companionship?	☐	☐	☐
b	q40q69_0b	How often do you feel isolated from others?	☐	☐	☐
c	q40q69_0c	How often do you feel left out?	☐	☐	☐
d	q40q69_0d	How often do you feel in tune with the people around you?	☐	☐	☐

Tiredness / Exhaustion

		Rarely/never (less than 1 day) 1	Sometimes (1-2 days) 2	Often (more than 3 days) 3
70.1 q40q70_1	During the **past week**, how often did you feel that everything you did **was an effort?**	☐	☐	☐
70.2 q40q70_2	During the **past week**, how often did you feel that you **could not get “going”**?	☐	☐	☐

Your feelings

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

		Yes	No	
a	were you basically satisfied with your life?	☐	☐	q40q71_0a
b	did you feel that your life is empty?	☐	☐	q40q71_0b
c	were you afraid that something bad is going to happen to you?	☐	☐	q40q71_0c
d	did you feel happy most of the time?	☐	☐	q40q71_0d
e	did you drop many of your activities and interests?	☐	☐	q40q71_0e
f	did you prefer to stay at home, rather than going out to do new things?	☐	☐	q40q71_0f
g	did you feel full of energy?	☐	☐	q40q71_0g
h	did you often feel helpless?	☐	☐	q40q71_0h

72.0 Please indicate **how much you agree** with each of the following statements:

	(Please tick **one** box for each statement)	strongly agree 1	agree 2	neither agree nor disagree 3	disagree 4	strongly disagree 5
a	q40q72_0a I enjoy my life overall	☐	☐	☐	☐	☐
b	q40q72_0b I look forward to things	☐	☐	☐	☐	☐
c	q40q72_0c I am healthy enough to get out and about	☐	☐	☐	☐	☐
d	q40q72_0d My family, friends or neighbours would help me if needed	☐	☐	☐	☐	☐
e	q40q72_0e I have social or leisure activities/hobbies that I enjoy doing	☐	☐	☐	☐	☐
f	q40q72_0f I try to stay involved with things	☐	☐	☐	☐	☐
g	q40q72_0g I am healthy enough to have my independence	☐	☐	☐	☐	☐
h	q40q72_0h I can please myself in what I do	☐	☐	☐	☐	☐
i	q40q72_0i I feel safe where I live	☐	☐	☐	☐	☐
j	q40q72_0j I get pleasure from my home	☐	☐	☐	☐	☐
k	q40q72_0k I take life as it comes and make the best of things	☐	☐	☐	☐	☐
l	q40q72_0l I feel lucky compared to most people	☐	☐	☐	☐	☐
m	q40q72_0m I have enough money to pay for household bills	☐	☐	☐	☐	☐
n	q40q72_0n I feel lonely	☐	☐	☐	☐	☐

Present circumstances

73.1 Are you at present:- q40q73_1

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

73.2 If you are widowed, divorced/separated, please give **the year** when this occurred: q40q73_2 _____

73.3 Are you at present:- q40q73_3

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

Pets

Office Use

74.0 Do you have any pets?

none ☐ 1 q40q74_0_none dog ☐ 1 q40q74_0_dog cat ☐ 1 q40q74_0_cat other ☐ 1 _____ q40q74_0_other q40q74_0_box

Your accommodation

75.0 Are you:-

living in your own home	☐ 1	q40q75_0
living in a residential or nursing home	☐ 2	
living in sheltered accommodation	☐ 3	
other	☐ 4	

Managing financially

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

manage very well	☐ 1	q40q76_0
manage quite well	☐ 2	
get by alright	☐ 3	
don't manage very well	☐ 4	

Transport

	Yes	No	
77.0 Do you have a car available for your own use?	☐	☐	q40q77_0
77.1 Do you currently drive yourself?	☐	☐	q40q77_1

Heating

	Yes	No	
78.0 During the cold winter weather, can you normally keep **comfortably warm** in your **living room**?	☐	☐	q40q78_0

If no, is this because:

a	it costs too much to keep your heating on?	☐	q40q78_0a
b	it is not possible to heat the room to a comfortable standard?	☐	q40q78_0b

78.1 Do you experience any difficulties meeting your heating/fuel costs?

No difficulty	☐ 1	q40q78_1
Minor difficulty	☐ 2	
Moderate difficulty	☐ 3	
Serious difficulty	☐ 4	

Vitamins and minerals

79.0 Do you take any of the following individual vitamin/ minerals regularly (ie on most days)?
Please **do not include multivitamin** supplements you are taking.

a	**Vitamin:**	**A**	**B**	**C**	**D**	**E**
	(tick the ones you take regularly)	☐ 1	☐ 1	☐ 1	☐ 1	☐ 1
		q40q79_0a_Vit_A	q40q79_0a_Vit_B	q40q79_0a_Vit_C	q40q79_0a_Vit_D	40q79_0a_Vit_E

b	**Minerals/fish oils:**	**Calcium**	**Magnesium**	**Cod liver Oil**	**Fish oil**
	(tick the ones you take regularly)	☐ 1	☐ 1	☐ 1	☐ 1
		q40q79_0b_Cal	q40q79_0b_Mag	q40q79_0b_Cod	q40q79_0b_Fish

Medicines

80.0 Do you take any regular medication? Yes ☐ No ☐ q40q80_0

Details of ALL medicines

81.0 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	*Office use ONLY*
1	q40q81_0bnf12_1 q40q81_0bnf34_1 q40q81_0bnf5_1 q40q81_0bnf6_1	q40q81_0icd1	☐ ☐ q40q81_0medpr1	
2	q40q81_0bnf12_2 q40q81_0bnf34_2 q40q81_0bnf5_2 q40q81_0bnf6_2	q40q81_0icd2	☐ ☐ q40q81_0medpr2	
3	q40q81_0bnf12_3 q40q81_0bnf34_3 q40q81_0bnf5_3 q40q81_0bnf6_3	q40q81_0icd3	☐ ☐ q40q81_0medpr3	
4	q40q81_0bnf12_4 q40q81_0bnf34_4 q40q81_0bnf5_4 q40q81_0bnf6_4	q40q81_0icd4	☐ ☐ q40q81_0medpr4	
5	q40q81_0bnf12_5 q40q81_0bnf34_5 q40q81_0bnf5_5 q40q81_0bnf6_5	q40q81_0icd5	☐ ☐ q40q81_0medpr5	
6	q40q81_0bnf12_6 q40q81_0bnf34_6 q40q81_0bnf5_6 q40q81_0bnf6_6	q40q81_0icd6	☐ ☐ q40q81_0medpr6	
7	q40q81_0bnf12_7 q40q81_0bnf34_7 q40q81_0bnf5_7 q40q81_0bnf6_7	q40q81_0icd7	☐ ☐ q40q81_0medpr7	
8	q40q81_0bnf12_8 q40q81_0bnf34_8 q40q81_0bnf5_8 q40q81_0bnf6_8	q40q81_0icd8	☐ ☐ q40q81_0medpr8	
9	q40q81_0bnf12_9 q40q81_0bnf34_9 q40q81_0bnf5_9 q40q81_0bnf6_9	q40q81_0icd9	☐ ☐ q40q81_0medpr9	
10	q40q81_0bnf12_10 q40q81_0bnf34_10 q40q81_0bnf5_10 q40q81_0bnf6_10	q40q81_0icd10	☐ ☐ q40q81_0medpr10	
11	q40q81_0bnf12_11 q40q81_0bnf34_11 q40q81_0bnf5_11 q40q81_0bnf6_11	q40q81_0icd11	☐ ☐ q40q81_0medpr11	
12	q40q81_0bnf12_12 q40q81_0bnf34_12 q40q81_0bnf5_12 q40q81_0bnf6_12	q40q81_0icd12	☐ ☐ q40q81_0medpr12	
13	q40q81_0bnf12_13 q40q81_0bnf34_13 q40q81_0bnf5_13 q40q81_0bnf6_13	q40q81_0icd13	☐ ☐ q40q81_0medpr13	

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

PART II : 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.

If you usually eat a food **every day**, ring **7** days a week.
If you usually eat a food on **three days a week**, ring **3**, and so on.

For foods which you eat **less than once a week:-**
Ring **M** if you eat it **at least** once a month.
Ring **R** if you eat it **less than** once a month, or if you **never** eat it at all.

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

EXAMPLE

	Number of days each week	Monthly	Rarely / Never
Food eaten every day 7 days a week	(7) 6 5 4 3 2 1	M	R
Food eaten on three days a week	7 6 5 4 3 (2) 1	M	R
Food eaten less often than once a week but at least once a month	7 6 5 4 3 2 1	(M)	R
Food eaten never or less than once a month	7 6 5 4 3 2 1	M	(R)

Special Diet

		Yes	No	
D1.0	Are you on any special diet e.g. vegetarian, low fat, diabetic?	☐	☐	q40D1_0
D1.1	If **yes**, please give details: _____	Office Use ☐		q40D1_1_box

Meat		Number of days each week	Monthly	Rarely / Never
D2.0	Beef including minced beef, beef burgers	7 6 5 4 3 2 1	M	R
D2.1	q40D2_0 q40D2_1 Lamb	7 6 5 4 3 2 1	M	R
D2.2	q40D2_2 Pork, bacon, ham, salami	7 6 5 4 3 2 1	M	R
D2.3	q40D2_3 Chicken, turkey, other poultry	7 6 5 4 3 2 1	M	R
D2.4	q40D2_4 Tinned meat all types, corned beef, etc	7 6 5 4 3 2 1	M	R
D2.5	q40D2_5 Pork Sausages	7 6 5 4 3 2 1	M	R
D2.6	q40D2_6 Beef Sausages	7 6 5 4 3 2 1	M	R
D2.7	q40D2_7 Meat Pie, Pasties	7 6 5 4 3 2 1	M	R
D2.8	q40D2_8 Liver, kidney, heart	7 6 5 4 3 2 1	M	R

Fish		Number of days each week	Monthly	Rarely / Never
D3.0	q40D3_0 White fish cod, haddock, hake, plaice, fish fingers, etc	7 6 5 4 3 2 1	M	R
D3.1	q40D3_1 Kippers, herrings, pilchards, tuna, sardines, salmon, mackerel including tinned	7 6 5 4 3 2 1	M	R
D3.2	q40D3_2 Shellfish	7 6 5 4 3 2 1	M	R

Please remember to circle ® if you never eat a food

Please remember to circle ® if you never eat a food

	Vegetables fresh, tinned, dried, frozen	Number of days each week	Monthly	Rarely / Never
D4.0 q40D4_0	**Potatoes:** boiled, baked, mashed	7 6 5 4 3 2 1	M	R
D4.1 q40D4_1	chips or fried from shop	7 6 5 4 3 2 1	M	R
D4.2 q40D4_2	chips or fried cooked at home	7 6 5 4 3 2 1	M	R
D4.3 q40D4_3	roast potatoes	7 6 5 4 3 2 1	M	R
D4.4 q40D4_4	Green vegetables, salads	7 6 5 4 3 2 1	M	R
D4.5 q40D4_5	Carrots	7 6 5 4 3 2 1	M	R
D4.6 q40D4_6	Parsnips, swedes, turnips, beetroot, and other root vegetables	7 6 5 4 3 2 1	M	R
D4.7 q40D4_7	Baked or butter beans, lentils, peas, chickpeas, sweetcorn	7 6 5 4 3 2 1	M	R
D4.8 q40D4_8	Onions cooked, raw, pickled	7 6 5 4 3 2 1	M	R
D4.9 q40D4_9	Garlic	7 6 5 4 3 2 1	M	R
D4.10 q40D4_10	Spaghetti and other pasta	7 6 5 4 3 2 1	M	R
D4.11 q40D4_11	Rice all types except pudding rice	7 6 5 4 3 2 1	M	R
D4.12 q40D4_12	Tomatoes fresh, tinned, pureed	7 6 5 4 3 2 1	M	R
	How often do you eat **fresh vegetables** in:			
D4.13 q40D4_13	summer	7 6 5 4 3 2 1	M	R
D4.14 q40D4_14	winter	7 6 5 4 3 2 1	M	R

Fresh Fruit		Number of days each week	Monthly	Rarely / Never
	How often do you eat fresh fruit in :			
D5.0 q40D5_0	summer	7 6 5 4 3 2 1	M	R
D5.1 q40D5_1	winter	7 6 5 4 3 2 1	M	R

D5.2 Number of apples eaten a week _____ _____ q40D5_2

D5.3 Number of pears eaten a week _____ _____ q40D5_3

D5.4 Number of oranges or grapefruit eaten a week _____ _____ q40D5_4

D5.5 Number of bananas eaten a week _____ _____ q40D5_5

D5.6 Number of other fruits eaten a week (please give name and quantity)

NAME OF FRUIT	QUANTITY

Office Use

q40D5_6_box1

q40D5_6_box2

q40D5_6_box3

q40D5_6_box4

q40D5_6_box5

Please remember to circle ® if you never eat a food

Please remember to circle ® if you never eat a food

Cheese		Number of days each week	Monthly	Rarely / Never
D6.0 q40D6_0	Full- fat cheese e.g. Cheddar, Leicester, Stilton, Brie, soft cheeses	7 6 5 4 3 2 1	M	R
D6.1 q40D6_1	Low-fat cheese e.g. Edam, Cottage cheese, reduced fat cheeses	7 6 5 4 3 2 1	M	R

Bread		Number of days each week	Monthly	Rarely / Never
D7.0 q40D7_0	White bread	7 6 5 4 3 2 1	M	R
D7.1 q40D7_1	Brown bread	7 6 5 4 3 2 1	M	R
D7.3 q40D7_3	Wholemeal	7 6 5 4 3 2 1	M	R
D7.4 q40D7_4 q40D7_5	Bread rolls	7 6 5 4 3 2 1	M	R
D7.5	Crispbread Ryvita, cream crackers, etc	7 6 5 4 3 2 1	M	R
D7.6	please give name of crispbread etc: _____			

Further details about your bread:

		How many slices/ Rolls per day?	Are the slices thick, medium or thin?		
D7.7	White Bread	q40D7_7_Rolls_per_day	THICK ☐ 1	MEDIUM ☐ 2	THIN ☐ 3 q40D7_7_thickness
D7.8	Brown Bread	q40D7_8_Rolls_per_day	THICK ☐ 1	MEDIUM ☐ 2	THIN ☐ 3 q40D7_8_thickness
D7.9	Wholemeal Bread	q40D7_9_Rolls_per_day	THICK ☐ 1	MEDIUM ☐ 2	THIN ☐ 3 q40D7_9_thickness
D7.10	Bread Rolls	q40D7_10_Rolls_per_day	LARGE ☐ 1	MEDIUM ☐ 2	SMALL ☐ 3 q40D7_10_thickness

Breakfast Cereals		Number of days each week	Monthly	Rarely / Never
D8.0 q40D8_0	Grapenuts, Porridge, Ready Brek, Special K, Sugar Puffs, Rice Crispies	7 6 5 4 3 2 1	M	R
D8.1 q40D8_1	Cornflakes, Muesli, Shredded Wheat, Sultana Bran, Weetabix	7 6 5 4 3 2 1	M	R
D8.2 q40D8_2	Bran Flakes, Puffed wheat	7 6 5 4 3 2 1	M	R
D8.3 q40D8_3	All Bran, Wheat Bran	7 6 5 4 3 2 1	M	R
D8.4 q40D8_4	Another Cereal	7 6 5 4 3 2 1	M	R
	please give name: ----------			

Biscuits, puddings and sweets		Number of days each week	Monthly	Rarely / Never
D9.0 q40D9_0	Digestive biscuits, plain biscuits	7 6 5 4 3 2 1	M	R
D9.1 q40D9_1	Sweet biscuits, sponge cakes, scones, buns	7 6 5 4 3 2 1	M	R
D9.2 q40D9_2	Ice cream, sweet yoghurts, trifle	7 6 5 4 3 2 1	M	R
D9.3 q40D9_3	Fruit cake, fruit bread, plum pudding	7 6 5 4 3 2 1	M	R
D9.4 q40D9_4	Fruit tart, jam tart, fruit crumble	7 6 5 4 3 2 1	M	R
D9.5 q40D9_5	Milk puddings rice, tapioca	7 6 5 4 3 2 1	M	R
D9.6 q40D9_6	Tinned fruit, jellies	7 6 5 4 3 2 1	M	R
D9.7 q40D9_7	Sweet sauces, chocolate, custard	7 6 5 4 3 2 1	M	R
D9.8 q40D9_8	Chocolate, chocolate bars, sweets all types	7 6 5 4 3 2 1	M	R

Please remember to circle ® if you never eat a food

Please remember to circle ® if you never eat a food

Eggs	Number of days each week	Monthly	Rarely / Never
D10.0 q40D10_0 Eggs boiled, poached, fried, scrambled	7 6 5 4 3 2 1	M	R
D10.1 q40D10_1 Eggs in baked dishes e.g. flans, quiches, soufflés, egg custard, etc	7 6 5 4 3 2 1	M	R

Other foods	Number of days each week	Monthly	Rarely / Never
D11.0 q40D11_0 Soups all kinds, home-made, tinned, packet	7 6 5 4 3 2 1	M	R
D11.1 q40D11_1 Nuts, nut butter e.g. salted or unsalted peanuts	7 6 5 4 3 2 1	M	R
D11.2 q40D11_2 Savoury snacks e.g. potato crisps, corn chips, crackers	7 6 5 4 3 2 1	M	R
D11.3 q40D11_3 Chutney, brown sauce, tomato sauce	7 6 5 4 3 2 1	M	R
D11.4 q40D11_4 Sweet spreads e.g. jam, honey, marmalade chocolate spread	7 6 5 4 3 2 1	M	R

Drinks and Juices non-alcoholic	Number of days each week	Monthly	Rarely / Never
D12.0 q40D12_0 Natural fruit juices including tomato juice	7 6 5 4 3 2 1	M	R
D12.1 q40D12_1 Fizzy drinks and Non-diet squashes	7 6 5 4 3 2 1	M	R
D12.2 q40D12_2 **Low calorie** (diet) squashes and fizzy drinks	7 6 5 4 3 2 1	M	R

Milk

D13.0 What type of milk do you usually drink?

Cow's Milk ☐1 q40D13_0
Soya Milk ☐2
Other, please give details ..... q40D13_0_box

Office Use ☐

D13.1 Roughly how much milk do you drink a day in tea, coffee, milky drinks or cereals?

none at all ☐1
half pint or less ☐2 q40D13_1
between half and one pint ☐3
more than one pint ☐4

D13.2 What kind of milk do you usually use?

full fat milk, fresh or dried ☐1
semi-skimmed milk, fresh or dried ☐2 q40D13_2
fully skimmed milk, fresh or dried ☐3
other kinds of milk, e.g. condensed, evaporated ☐4

Salt

D14.0 How much salt is added to your food in cooking?

a lot ☐1
a little ☐2 q40D14_0
none ☐3

D14.1 How much salt is added to your food on your plate?

a lot ☐1
a little ☐2 q40D14_1
none ☐3

Fats

D15.0 What do you usually spread on bread?

Give brand name

butter	☐1	q40D15_0_butter
full-fat soft margarine	☐1	q40D15_0_full_fat_soft_marg / q40D15_0_full_fat_soft_margbox
low-fat soft margarine	☐1	q40D15_0_low_fat_soft_marg / q40D15_0_low_fat_soft_margbox
hard margarine	☐1	q40D15_0_hard_marg

Office Use ☐ ☐

D15.1 How do you normally spread the fat?

thinly ☐1
average ☐2
thickly ☐3

q40D15_1

How often do you eat home-fried food including chips, cooked with :-

		Number of days each week	Monthly	Rarely / Never
D15.2	q40D15_2 Lard, dripping, solid vegetable oil	7 6 5 4 3 2 1	M	R
	Give brand name and type _____			

Office Use q40D15_2_box ☐

D15.3	q40D15_3 Liquid vegetable oil	7 6 5 4 3 2 1	M	R
	Give brand name and type _____			

Office Use q40D15_3_Brand_box ☐

Your household

D16.0 How many people normally eat in your household?

Number of adults including yourself ___ (q40D16_0_Num_adults)

Number of children 1 to 4 years old ___ (q40D16_0_Num_children_1_4)

Number of children 5 to 16 years old ___ (q40D16_0_Num_children_5_16)

Number of babies under 1 year old ___ (q40D16_0_Num_babies_under1)

How much of the following foods does **your household** use **on average each week** including cooking and baking?

If you live on your own, please give the amounts which you yourself eat a week.

D16.1	Butter	q40D16_1_Butter_lbs ___ ___ lbs	q40D16_1_Butter_ozs ___ ___ozs	q40D16_1_Butter_grams or ___ ___ ___ grams
D16.2	Margarine	q40D16_2_Margarine_lbs ___ ___ lbs	q40D16_2_Margarine_ozs ___ ___ozs	q40D16_2_Margarine_grams or ___ ___ ___ grams
D16.3	Lard and solid vegetable oil	q40D16_3_Lard_lbs ___ ___ lbs	q40D16_3_Lard_ozs ___ ___ozs	q40D16_3_Lard_grams or ___ ___ ___ grams
D16.4	Liquid vegetable oil eg Sunflower, Corn, Groundnut oil		q40D16_4_Liquid_Veg_Oil_ozs ___ ___ozs	q40D16_4_Liquid_Veg_Oil_ml or ___ ___ ___ ml
D16.5	Olive Oil		q40D16_5_Olive_Oil_ozs ___ ___ozs	q40D16_5_Olive_Oil_ml or ___ ___ ___ ml
D16.6	Cream		q40D16_6_Cream_ozs ___ ___ozs	q40D16_6_Cream_ml or ___ ___ ___ ml
D16.7	Full- fat cheese e.g. Cheddar, Leicester, Stilton, Brie, & soft cheeses	q40D16_7_Full_fat_cheese_lbs ___ ___ lbs	q40D16_7_Full_fat_cheese_ozs ___ ___ozs	q40D16_7_Full_fat_cheese_grams or ___ ___ ___ grams
D16.8	Low-fat cheese e.g. reduced fat cheddar, reduced fat soft cheeses, Edam	q40D16_8_Low_fat_cheese_lbs ___ ___ lbs	q40D16_8_Low_fat_cheese_ozs ___ ___ozs	q40D16_8_Low_fat_cheese_grams or ___ ___ ___ grams
D16.9	Sugar	q40D16_9_Sugar_lbs ___ ___ lbs	q40D16_9_Sugar_ozs ___ ___ozs	q40D16_9_Sugar_grams or ___ ___ ___ grams

Hot drinks

Coffee

D17.0 How many cups of **coffee** do you have a day? Q40D17_0 _____ Cups per day

D17.1 Is this: Ground coffee ☐1 Instant coffee ☐2 Q40D17_1

D17.2 Is it decaffeinated? Yes ☐ No ☐ Q40D17_2

D17.3 How many teaspoons of **sugar** do you take in each cup? Q40D17_3 _____ Teaspoons of sugar
Do not count artificial sweeteners

Tea

D17.4 How many cups of **tea** do you have **a day**? Q40D17_4 _____ Cups per day

D17.5 How many teaspoons of **sugar** do you take in **each cup**? Q40D17_5 _____ Teaspoons of sugar
Do not count artificial sweeteners

Other Hot Drinks

D17.7 How many cups of other hot drinks Q40D17_7
(e.g. hot chocolate, malted milk, Horlicks) do you have a day? _____ Cups per day

Alcoholic Drinks

D18.0 Have you ever consumed alcoholic drinks? Yes ☐ No ☐ Seldom Q40D18_0

D18.1 Do you take alcoholic drinks at present? ☐1 ☐2 ☐3 Q40D18_1

Think back carefully over the last seven days. Please write the number of alcoholic drinks you have consumed on each day during the past week. It may help if you try to remember where you were and who you were with on each day. For each day, write in how much you have drunk:

(i) the **number** of **half pints** of non-alcoholic beer, lager, etc
(ii) the **number** of **half pints** of low-alcohol beer, lager, etc
(iii) the **number** of **half pints** of beer, lager, shandy, cider, stout, etc
(iv) the **number** of **single glasses** of whisky, vodka, gin, rum, etc
(v) the **number** of **single glasses** of wine, sherry, martini, port, etc

	(i) Half-pints of **non-alcoholic** beer	(ii) Half-pints of **low-alcohol** beer	(iii) Half-pints of **beer, lager, shandy**	(iv) Single glasses **of Spirits**	(v) Single glasses **of wine**
Monday	q40D18_Monday_i	q40D18_Monday_ii	q40D18_Monday_iii	q40D18_Monday_iv	q40D18_Monday_v
Tuesday	q40D18_Tuesday_i	q40D18_Tuesday_ii	q40D18_Tuesday_iii	q40D18_Tuesday_iv	q40D18_Tuesday_v
Wednesday	q40D18_Wednesday_i	q40D18_Wednesday_ii	q40D18_Wednesday_iii	q40D18_Wednesday_iv	q40D18_Wednesday_v
Thursday	q40D18_Thursday_i	q40D18_Thursday_ii	q40D18_Thursday_iii	q40D18_Thursday_iv	q40D18_Thursday_v
Friday	q40D18_Friday_i	q40D18_Friday_ii	q40D18_Friday_iii	q40D18_Friday_iv	q40D18_Friday_v
Saturday	q40D18_Saturday_i	q40D18_Saturday_ii	q40D18_Saturday_iii	q40D18_Saturday_iv	q40D18_Saturday_v
Sunday	q40D18_Sunday_i	q40D18_Sunday_ii	q40D18_Sunday_iii	q40D18_Sunday_iv	q40D18_Sunday_v

D18.2 Would you say last week was fairly typical of what you usually have to drink in one week? Yes ☐1 No ☐2 Q40D18_2

D18.3 If last week was not typical, would you normally drink more or less in a week? More ☐1 Less ☐2 Q40D18_3

The BRHS team are also interested in getting a more in depth understanding about your physical activity.

Would you be happy for a member of our research team to contact you in the future to discuss this further?

Yes ☐ No ☐

q40contanctyouinthefuture

General comments:

Office Use

q40General_comments

Office use:

Thank you very much for completing the questionnaire.

Please return it to us in the envelope provided, along with the **appointment reply slip.**

No stamp is needed.

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