Study Number: | | | | | | | | | | |
Serial q2020coder

BRITISH REGIONAL HEART STUDY

2020 - 2021

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. We have added questions to ask about the experience of Heart Study members during the COVID-19 outbreak. 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 8016 8021** and give us your telephone number. We will then call you back to answer your query.

Best wishes to all study members, and thank you for your help.

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

Department of Primary Care & Population Health, UCL Medical School, Royal Free Campus, Rowland Hill Street, London NW3 2PF

Dates

1.0 Please enter today's date q2020q1_0D (day) q2020q1_0M (month) **20** q2020q1_0Y (year)

1.1 Please give your Date of Birth q2020q1_1D (day) q2020q1_1M (month) **19** q2020q1_1Y (year)

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

COVID-19

C1.0 Do you think that **you have or have had** the Coronavirus (COVID-19)? q2020C1_0

- Yes, confirmed by a positive test ☐ 1
- Yes, based on strong personal suspicion or medical advice ☐ 2
- Unsure ☐ 3
- No ☐ 4

C1.1 Do you think **anyone else in your household** has had or currently has COVID-19? q2020C1_1

- Yes, confirmed by a positive test ☐ 1
- Yes, based on strong personal suspicion or medical advice ☐ 2
- Unsure ☐ 3
- No ☐ 4

C1.2 If **you** had COVID-19, which month was this in ?_____ q2020C1_2

C1.3 Would you describe your symptoms as q2020C1_3

- Mild ☐ 1
- Moderate ☐ 2
- Severe ☐ 3

C1.4 How long did it take to recover q2020C1_4

- 1-4 weeks ☐ 1
- 1-2 months ☐ 2
- Still recovering ☐ 3

C1.5 Have you been admitted to hospital because of COVID-19 symptoms? Yes ☐ No ☐ q2020C1_5

Have you experienced any of the following symptoms related to COVID-19 since February 2020?

Please select all that apply

C2.0 Fever ☐ 1 q2020C2_0

C2.1 Persistent Cough ☐ 1 q2020C2_1

C2.3 Loss of smell ☐ 1 q2020C2_3

C2.4 Loss of taste ☐ 1 q2020C2_4

If **yes**, did you have any of the following accompanying symptoms

C2.5 q2020C2_5 Sore throat ☐ 1

C2.6 q2020C2_6 Chest tightness ☐ 1

C2.7 q2020C2_7 Shortness of breath ☐ 1

C2.8 q2020C2_8 Runny nose ☐ 1

C2.9 q2020C2_9 Nasal congestion ☐ 1

C2.10 q2020C2_10 Sneezing ☐ 1

C2.11 q2020C2_11 Muscle or body aches ☐ 1

C2.12 q2020C2_12 Fatigue ☐ 1

C2.13 q2020C2_13 Unusual loose motions or diarrhoea ☐ 1

C2.14 q2020C2_14 Vomiting ☐ 1

C2.15 q2020C2_15 Skin rash ☐ 1

C2.16 q2020C2_16 Headaches ☐ 1

C2.17 q2020C2_17 Other ☐ 1

C2.18 q2020C2_18 No - none of these ☐ 1

		Yes	No
C3.0 q2020C3_0	Have you received a letter or text message from the NHS or Chief Medical Officer saying that you have been identified as someone at risk of severe illness if you catch COVID-19?	☐	☐

Difficulties related COVID-19 lockdown

How difficult did you find the lockdown and other measures for COVID-19 in terms of:

		Not Difficult 1	Some Difficulty 2	Difficult 3	Very Difficult 4	Not applicable 5
C4.0 q2020C4_0	Doing your food shopping?	☐	☐	☐	☐	☐
C4.1 q2020C4_1	Getting your medication?	☐	☐	☐	☐	☐
C4.2 q2020C4_2	Accessing GP and NHS services	☐	☐	☐	☐	☐
C4.3 q2020C4_3	Accessing dental health care services	☐	☐	☐	☐	☐
C4.4 q2020C4_4	Accessing social care or other support services	☐	☐	☐	☐	☐
C4.5 q2020C4_5	Managing your health	☐	☐	☐	☐	☐
C4.6 q2020C4_6	Managing the health of others in your household	☐	☐	☐	☐	☐
C4.7 q2020C4_7	Maintaining your physical activity	☐	☐	☐	☐	☐
C4.8 q2020C4_8	Doing your usual social activities	☐	☐	☐	☐	☐
C4.9 q2020C4_9	Managing household finances	☐	☐	☐	☐	☐
C4.10 q2020C4_10	Obtaining up to date information about COVID-19	☐	☐	☐	☐	☐
C4.11 q2020C4_11	Using online activities/services	☐	☐	☐	☐	☐
C4.12 q2020C4_12	Communicating via video calls- e.g. Zoom	☐	☐	☐	☐	☐
C4.13 q2020C4_13	Following social media e.g. Facebook, Twitter	☐	☐	☐	☐	☐
C4.14 q2020C4_14	Not being able to freely go out	☐	☐	☐	☐	☐
C4.15 q2020C4_15	Not being able to see your friends	☐	☐	☐	☐	☐
C4.16 q2020C4_16	Not being able to see your family	☐	☐	☐	☐	☐

During the period of lockdown due to COVID-19, what were the main reasons for leaving your home?

		Daily 1	3-4 days 2	Weekly 3	Did not do 4
C5.0 q2020C5_0	Shopping for food	☐	☐	☐	☐
C5.1 q2020C5_1	Go to the Pharmacy	☐	☐	☐	☐
C5.2 q2020C5_2	Go to hospital	☐	☐	☐	☐
C5.3 q2020C5_3	Bank/post office	☐	☐	☐	☐
C5.4 q2020C5_4	Walk/exercise	☐	☐	☐	☐
C5.5 q2020C5_5	Walk my dog	☐	☐	☐	☐
C5.6 q2020C5_6	Provide assistance for someone self-isolating	☐	☐	☐	☐
C5.7 q2020C5_7	Other	☐	☐	☐	☐

Office Use

C5.8 If 'Other', please specify: _____ q2020C5_8

As a result of the COVID-19 pandemic, did you experience difficulties with any of the following:

			No Difficulty 1	Difficult 2	Cancelled / delayed 4	Not applicable 5
C6.0	q2020C6_0	Medical appointments	☐	☐	☐	☐
C6.1	q2020C6_1	Hospital appointments	☐	☐	☐	☐
C6.2	q2020C6_2	Planned surgeries	☐	☐	☐	☐
C6.3	q2020C6_3	Dental treatment	☐	☐	☐	☐
C6.4	q2020C6_4	Physiotherapy	☐	☐	☐	☐
C6.5	q2020C6_5	Other planned treatment (e.g. chemotherapy)	☐	☐	☐	☐

			Yes	No	
C7.0		Have you avoided contacting health services for an appointment about health problems that worry you?	☐	☐	q2020C7_0
C7.1		Have you contacted health services using NHS 111	☐	☐	q2020C7_1

As a result of the COVID-19 pandemic have you felt

			Never 1	Sometimes 2	Most times 3	All the time 4	Don't know 5
C8.0	q2020C8_0	Worried	☐	☐	☐	☐	☐
C8.1	q2020C8_1	Anxious	☐	☐	☐	☐	☐
C8.2	q2020C8_2	Fearful	☐	☐	☐	☐	☐
C8.3	q2020C8_3	Isolated	☐	☐	☐	☐	☐
C8.4	q2020C8_4	Lonely	☐	☐	☐	☐	☐
C8.5	q2020C8_5	Sad	☐	☐	☐	☐	☐
C8.6	q2020C8_6	Unable to cope with things	☐	☐	☐	☐	☐

Compared to **before** COVID-19 measures were introduced, (i.e., January 2020), how have the following been affected

			Less than before 1	about the same 2	more than before 3	Does not apply 4
C9.0	q2020C9_0	How healthy is your diet now	☐	☐	☐	☐
C9.1	q2020C9_1	Are you snacking	☐	☐	☐	☐
C9.2	q2020C9_2	Are you eating	☐	☐	☐	☐
C9.3	q2020C9_3	Are you smoking	☐	☐	☐	☐
C9.4	q2020C9_4	Are you drinking alcohol	☐	☐	☐	☐
C9.5	q2020C9_5	Are you sleeping (at night)	☐	☐	☐	☐
C9.6	q2020C9_6	Are you napping during the day	☐	☐	☐	☐
C9.7	q2020C9_7	Is your weight	☐	☐	☐	☐

C10.0 How much has COVID-19 changed your daily routine? q2020C10_0

- A lot ☐ 1
- some ☐ 2
- A little ☐ 3
- No change ☐ 4

			Yes	No
C11.0	Has the COVID-19 outbreak affected how often you left your home or garden **in the past week**?		☐	☐ q2020C11_0
C11.1	On how many days in a typical week do you leave your own home or garden now?		_____ days/week	q2020C11_1
C11.2	Is this……	about the same as before	☐ 1	q2020C11_2
		a little less than before	☐ 2	
		a lot less than before	☐ 3	
	I do not leave my home as I am shielding myself to protect my health		☐ 4	

Do you have access to any of the following outdoor spaces?

C11.3	Your own garden, patio or yard	☐ 1 q2020C11_3
C11.4	A communal garden	☐ 1 q2020C11_4
C11.5	A roof terrace or balcony	☐ 1 q2020C11_5
C11.6	None of the above	☐ 1 q2020C11_6

Just **before** COVID-19 measures were introduced (i.e. January 2020), how regularly did you have contact with your family and friends?

		Every day 1	3-4 days a week 2	1-2 days a week 3	Less than once a week 4	Rarely / Never 5
	Contact with family					
C12.0	q2020C12_0 Meet face-to-face	☐	☐	☐	☐	☐
C12.1	q2020C12_1 Call (speak on the telephone)	☐	☐	☐	☐	☐
C12.2	q2020C12_2 Video call (e.g. Skype, FaceTime)	☐	☐	☐	☐	☐
C12.3	q2020C12_3 Text message (e.g. SMS, WhatsApp, Facebook Messenger or email)	☐	☐	☐	☐	☐
	Contact with friends					
C12.4	q2020C12_4 Meet face-to-face	☐	☐	☐	☐	☐
C12.5	q2020C12_5 Call (speak on the telephone)	☐	☐	☐	☐	☐
C12.6	q2020C12_6 Video call (e.g. Skype, FaceTime)	☐	☐	☐	☐	☐
C12.7	q2020C12_7 Text message (e.g. SMS, WhatsApp, Facebook Messenger or email)	☐	☐	☐	☐	☐

Since the COVID-19 measures have been in place, how regularly do you have contact with your family and friends?

		Every day 1	3-4 days a week 2	1-2 days a week 3	Less than once a week 4	Rarely / Never 5
	Contact with family					
C13.0	q2020C13_0 Meet face-to-face	☐	☐	☐	☐	☐
C13.1	q2020C13_1 Call (speak on the telephone)	☐	☐	☐	☐	☐
C13.2	q2020C13_2 Video call (e.g. Skype, FaceTime)	☐	☐	☐	☐	☐
C13.3	q2020C13_3 Text message (e.g. SMS, WhatsApp, Facebook Messenger or email)	☐	☐	☐	☐	☐

Since the COVID-19 measures have been in place, how regularly do you have contact with your family and friends?

		Every day 1	3-4 days a week 2	1-2 days a week 3	Less than once a week 4	Rarely / Never 5
	Contact with friends					
C13.4 q2020C13_4	Meet face-to-face	☐	☐	☐	☐	☐
C13.5 q2020C13_5	Call (speak on the telephone)	☐	☐	☐	☐	☐
C13.5 q2020C13_6	Video call (e.g. Skype, FaceTime)	☐	☐	☐	☐	☐
C13.7 q2020C13_7	Text message (e.g. SMS, WhatsApp, Facebook Messenger or email)	☐	☐	☐	☐	☐

C14.0 Have any of the following living arrangements occurred since the Coronavirus outbreak?

q2020C14_0famin	At least one of my family members or friend has **moved into** my home	☐ 1
q2020C14_0famout	At least one of my family members or friend has **moved out** of my home	☐ 1
q2020C14_0imoved	**I have moved into** a family member's or friend's home	☐ 1
q2020C14_0none	None of these	☐ 1

Physical Activity

Vigorous physical activity is activity that makes you breathe much harder than normal, e.g., running, fast cycling, heavy gardening (digging, chopping or moving wood), swimming.

How long did you spend doing **vigorous physical activity** …

C15.0	in the **last week**	_____hours _____minutes
C15.1	in a **typical week before COVID-19** measures were introduced (i.e., January 2020)	_____hours _____minutes

Moderate physical activity is activity that makes you breathe somewhat harder than normal, e.g., brisk walking (for leisure or errands), moderate gardening (mowing, weeding, sweeping leaves), heavier chores (vacuuming, washing floors).

How long did you spend doing **moderate physical activity** …

C15.2	in the **last week**	q2020C15_0h hours q2020C15_0m minutes
C15.3	in a **typical week before COVID-19** measures were introduced (i.e., January 2020)	_____hours _____minutes

Light physical activity is activity that does not make you breathe harder than normal, e.g., leisurely walking (for leisure or errands), light gardening (watering, looking after pot plants), light household chores (washing up, dusting).

How long did you spend doing **light physical activity** …

C15.4	in the **last week**	_____hours _____minutes
C15.5	in a **typical week before COVID-19** measures were introduced (i.e., January 2020)	_____hours _____minutes

End of Section on COVID-19

2. Conditions affecting the heart or circulation

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

		Yes	No	
2.0	Acute coronary syndrome	☐	☐	q2020q2_0
2.1	Angina	☐	☐	q2020q2_1
2.2	Aortic Aneurysm	☐	☐	q2020q2_2
2.3	Atrial Fibrillation	☐	☐	q2020q2_3
2.4	Deep Vein Thrombosis (clot in the deep leg vein)	☐	☐	q2020q2_4
2.5	Heart attack (coronary thrombosis or myocardial infarction)	☐	☐	q2020q2_5
2.6	Heart failure	☐	☐	q2020q2_6
2.7	High blood pressure	☐	☐	q2020q2_7
2.8	High cholesterol	☐	☐	q2020q2_8
2.9	Narrowing or hardening of the leg arteries (including claudication)	☐	☐	q2020q2_9
2.10	Pulmonary Embolism (clot on the lung)	☐	☐	q2020q2_10
2.11	Other problems of the heart and circulation	☐	☐	q2020q2_11

Office Use

2.12 **If yes**, please give details _____ q2020q2_12othbox

3. Stroke

		Yes	No	Year of last occurrence
3.0	Have you **ever** been told by a doctor that you have had a stroke?	☐	☐	_____
	If yes,		q2020q3_0	
3.1	Did the symptoms last for more than 24 hours?	☐	☐	q2020q3_0yc
3.2	Have you made a complete recovery from your stroke?	☐	☐	
3.3	Following your stroke, do you still need any help in carrying out everyday activities?	☐	☐	

4. Investigations and special treatment for conditions affecting your heart and circulation

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

			Yes	No	Year of last occurrence
4.0	q2020q4_0	A referral for an echocardiogram ("echo")	☐	☐	_____ q2020q4_0y
4.1	q2020q4_1	An exercise ECG ("stress" or "treadmill") test	☐	☐	_____ q2020q4_1y
4.2	q2020q4_2	CT Scan of coronary arteries	☐	☐	_____ q2020q4_2y
4.3	q2020q4_3	Angiogram or X-ray of coronary arteries (using a dye)	☐	☐	_____ q2020q4_3y
4.4	q2020q4_4	Angioplasty (balloon treatment of coronary artery, PCI, stents	☐	☐	_____ q2020q4_4y
4.5	q2020q4_5	Coronary artery bypass graft operation ("heart bypass" or "CABG")	☐	☐	_____ q2020q4_5y
4.6	q2020q4_6	Other tests, investigations or operations on your heart, arteries or veins?	☐	☐	_____ q2020q4_6y

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

Office Use

_____ q2020q4_7othbox

Cardiac rehabilitation

4.8 Have you ever taken part in an exercise programme (cardiac rehabilitation) after experiencing a heart problem, cardiac surgery or procedure or a stroke?

Yes ☐ No ☐ q2020q4_8

4.9 If yes, which year was this? q2020q4_9 _____

5. Diabetes

5.0 Have you **ever** been told by a doctor that you <u>have or have had</u> diabetes?

Yes ☐ No ☐ q2020q5_0

Year of diagnosis _____ q2020q5_0y

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

(Tick **all** that apply)

5.1	feet	☐ 1	q2020q5_1
5.2	kidneys	☐ 1	q2020q5_2
5.3	eyes	☐ 1	q2020q5_3
5.4	nerves	☐ 1	q2020q5_4
5.5	none	☐ 1	q2020q5_5

6. Cancer

6.0 Have you **ever** been told by a doctor that you <u>have or have had</u> cancer?

Yes ☐ No ☐ q2020q6_0

Year of **first** diagnosis _____ q2020q6_0year

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

Office Use

_____ q2020q6_1Cancersite1

_____ q2020q6_1Cancersite2

q2020q6_1Cancersite3

7. Other medical conditions

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

		Yes	No	
7.0	Alzheimer's disease	☐	☐	q2020q7_0
7.1	Anaemia	☐	☐	q2020q7_1
7.2	Asthma	☐	☐	q2020q7_2
7.3	Bronchitis	☐	☐	q2020q7_3
7.4	Cataract	☐	☐	q2020q7_4
7.5	Chronic Kidney disease	☐	☐	q2020q7_5
7.6	Chronic obstructive pulmonary disease (COPD)	☐	☐	q2020q7_6
7.7	Crohn's disease	☐	☐	q2020q7_7
7.8	Dementia	☐	☐	q2020q7_8
7.9	Depression	☐	☐	q2020q7_9
7.10	Emphysema	☐	☐	q2020q7_10
7.11	Gall bladder disease	☐	☐	q2020q7_11
7.13	Gastric, peptic or duodenal ulcer	☐	☐	q2020q7_13gastric
7.13	Glaucoma	☐	☐	q2020q7_13glauc
7.14	Gout	☐	☐	q2020q7_14
7.15	Liver disease, cirrhosis or hepatitis	☐	☐	q2020q7_15
7.16	Macular degeneration	☐	☐	q2020q7_16
7.17	Osteoporosis	☐	☐	q2020q7_17
7.18	Parkinson's disease	☐	☐	q2020q7_18
7.19	Pneumonia	☐	☐	q2020q7_19
7.20	Prostate trouble	☐	☐	q2020q7_20
7.21	Shingles	☐	☐	q2020q7_21
7.22	Thyroid disease	☐	☐	q2020q7_22
7.23	Ulcerative colitis	☐	☐	q2020q7_23

Office Use

7.24 Other conditions, please give details _____ q2020q7_24

7.25 _____ q2020q7_25

8. Chest Pain

		Yes	No		
8.0	Do you **ever** have any pain or discomfort in your chest?	☐	☐		q2020q8_0
		Yes	No	Unable to walk on level	
8.1	When you walk at an ordinary pace on the level, does this produce the chest pain?	☐1	☐2	☐3	q2020q8_1
		Yes	No	Unable to walk uphill	
8.2	When you walk uphill or hurry, does this produce the chest pain?	☐1	☐2	☐3	q2020q8_2

9. 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?	☐ 1	☐ 2	☐ 3	q2020q9_0
9.1	On walking uphill or upstairs, do you get more breathless than people of your own age?	☐ 1	☐ 2	☐ 3	q2020q9_1
9.2	Do you **ever** have to stop walking because of breathlessness?	☐ 1	☐ 2	☐ 3	q2020q9_2
9.3	In the **past year** have you at any time been awoken at night by an attack of shortness of breath?	☐	☐		q2020q9_3

10. 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?	☐	☐	q2020q10_0
10.1	Do you bring up phlegm like this on most days for as much as three months in the winter each year?	☐	☐	q2020q10_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

q2020q10_2

		Yes	No	
10.3	Does your chest ever sound wheezy or whistling?	☐	☐	q2020q10_3
10.4	**If yes**, does this happen on most days or nights?	☐	☐	q2020q10_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

q2020q10_5

11. Operations

		Yes	No	
11.0	Have you had any major operations in the **last 5 years**?	☐	☐	q2020q11_0

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

_____

Office Use
q2020q11_1

Bladder control/ Faecal Incontinence

Many people complain that they leak urine or faecal matter unintentionally.

	In the **past 13 months-**	Yes	No	
11.2	have you leaked even a small amount of urine?	☐	☐	q2020q11_2
11.3	If yes, when you had this problem, did it last for more than month?	☐	☐	q2020q11_3
11.4	have you leaked even a small amount of faecal matter?	☐	☐	q2020q11_4
11.5	If yes, when you had this problem, did it last for more than month?	☐	☐	q2020q11_5

12. Leg Pain

		Yes	No	Unable to walk	
12.0	Do you get pain or discomfort in your leg or legs when you walk?	☐ 1	☐ 2	☐ 3	q2020q12_0
12.1	Does this pain ever begin when you are standing still or sitting?	☐ 1	☐ 2		q2020q12_1
12.2	Do you get the pain if you walk uphill or hurry?	☐ 1	☐ 2	☐ 3	q2020q12_2
12.3	Do you get the pain walking at an ordinary pace on the level?	☐ 1	☐ 2	☐ 3	q2020q12_3

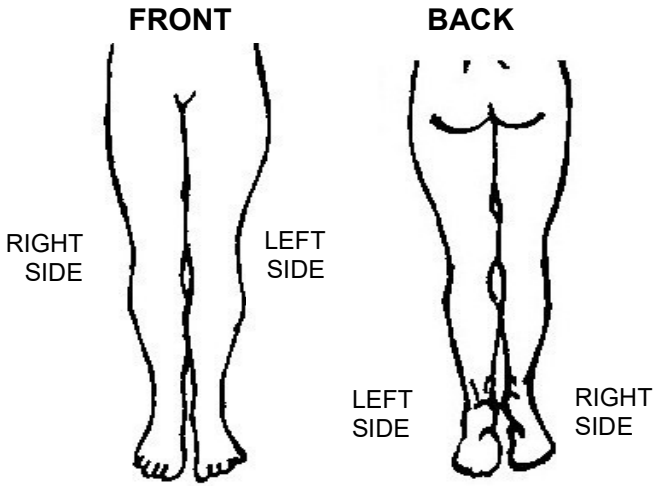
12.4 What happens to the pain if you stand still?

Usually continues more than 10 minutes ☐ 1

Usually disappears in 10 minutes or less ☐ 2

q2020q12_4

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



Office Use

q2020q12_5L L ☐

q2020q12_5R R ☐

13. 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?	☐	☐	q2020q13_0y

q2020q13_0

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

Osteoarthritis ☐ 1

Rheumatoid arthritis ☐ 2

Other (please give details) ☐ 3

Don't know ☐ 4

q2020q13_1

Office Use

q2020q13_1othbox

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

13.2	q2020q13_2	Knees ☐ 1	13.7	Wrists ☐ 1	q2020q13_7	
13.3	q2020q13_3	Hips ☐ 1	13.8	Back ☐ 1	q2020q13_8	
13.4	q2020q13_4	Feet ☐ 1	13.9	Neck ☐ 1	q2020q13_9	
13.5	q2020q13_5	Ankle ☐ 1	13.10	Shoulders ☐ 1	q2020q13_10	
13.6	q2020q13_6	Hands and/or fingers ☐ 1	13.11	Other, please specify ☐ 1	q2020q13_11	q2020q13_11othbox

Office Use

14. 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 ☐ q2020q14_0

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

14.1	q2020q14_1	Knees ☐1	14.6	Wrists ☐1	q2020q14_6	
14.2	q2020q14_2	Hips ☐1	14.7	Back ☐1	q2020q14_7	
14.3	q2020q14_3	Feet ☐1	14.8	Neck ☐1	q2020q14_8	Office Use
14.4	q2020q14_4	Ankle ☐1	14.9	Shoulders ☐1	q2020q14_9	
14.5	q2020q14_5	Hands and/or fingers ☐1	14.10	Other, please specify ☐1	q2020q14_10 _____ q2020q14_10othbox	

15. Lower back pain

		Yes	No	
15.0	Have you **ever** had pain in your lower back on **most days** for at **least one month**?	☐	☐	q2020q15_0
15.1	**If yes**, have you had this in the **last year**?	☐	☐	q2020q15_1

16. Falls

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

Very fearful ☐1 q2020q16_0
Somewhat fearful ☐2
Not fearful ☐3

17. Fractures and falls

		Yes	No	
17.0	Have you had a fall in the **last year**?	☐	☐	q2020q17_0
17.1	**If yes**, how many times ____ ____			q2020q17_1
17.2	Did you receive medical attention for any of these falls?	☐	☐	q2020q17_2

Did you suffer any of the following as a **result of a fall** in the **past year**? (Tick **all** that apply)

17.3	cuts and bruises ☐1	q2020q17_3
17.4	damage to muscle or ligament ☐1	q2020q17_4
17.5	broken or fractured **hip** bone ☐1	q2020q17_5
17.6	broken or fractured **wrist** bone ☐1	q2020q17_6
17.7	other broken or fractured bone ☐1	q2020q17_7

			Yes	No	Please give year
17.8	Have you **ever** fractured your hip?	q2020q17_8	☐	☐	q2020q17_8y
17.9	Have you **ever** fractured your wrist?	q2020q17_9	☐	☐	q2020q17_9y

Dizziness

		Yes	No	
17.10	Have you had spells of dizziness, loss of balance or a sensation of spinning **in the last year**?	☐	☐	q2020q17_10

18. Your overall health

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

18.0 **General health**

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

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

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

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

q2020q18_0

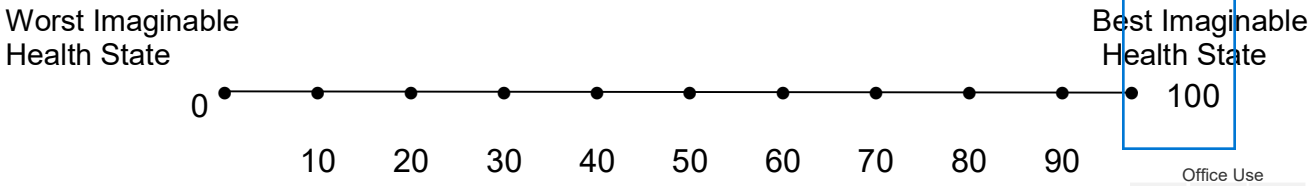
18.4 **Anxiety/depression**

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

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**.



Office Use

19. Weight

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

q2020q19_0st ___ ___ Stones q2020q19_0lb ___ ___ Pounds **or** q2020q19_0kg ___ ___ ___ Kilograms

19.1 **If you have no scales** and have made an estimate please tick here ☐ 1 q2020q19_1

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

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

q2020q19_2

If your weight has changed in the last four years:

		Yes	No	
19.3	Was this change intentional?	☐	☐	q2020q19_3

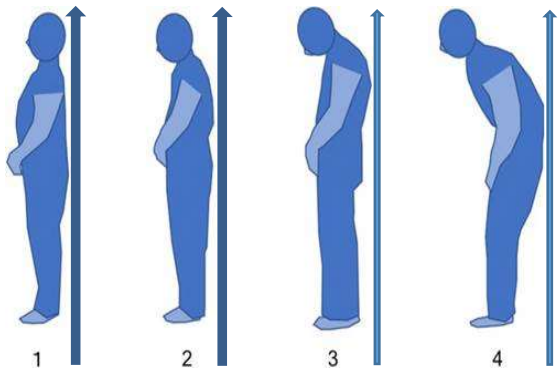
(Tick **all** that apply)

19.4	Was it the result of Personal choice	☐ 1	q2020q19_4
19.5	Medical advice	☐ 1	q2020q19_5
19.6	Illness or ill health	☐ 1	q2020q19_6

Height

19.7 What is your present height? q2020q19_7feet _____ Feet q2020q19_7inch _____ _____ Inches **or** q2020q19_7cm _____ _____ _____ cm

19.8 Which diagram reflects your posture-



Please circle

q2020q19_8

20. Hearing

		Yes	No	
20.0	Have you **ever** had a hearing test?	☐	☐	q2020q20_0
20.1	**If yes**, were you offered a hearing aid?	☐	☐	q2020q20_1

		Yes	No	Occasionally	
20.2	Do you use a **hearing aid?**	☐ 1	☐ 2	☐ 3	q2020q20_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)?	☐	☐	q2020q20_3
20.4	**If no**, can you follow a TV programme with the volume turned up?	☐	☐	q2020q20_4

21. Eyesight

		Yes	No	
21.0	Using glasses or corrective lenses if needed, can you see well enough to recognise a friend at a distance of 13 feet/ four yards (**across a road**)?	☐	☐	q2020q21_0
21.1	**If no**, can you see well enough to recognise a friend at a distance of three feet/ one yard?	☐	☐	q2020q21_1

22. Cigarette Smoking

		Yes	No	
22.0	Have you ever smoked cigarettes?	☐	☐	q2020q22_0
22.1	Do you smoke cigarettes at present?	☐	☐	q2020q22_1

23. Alcohol Intake

23.0 Would you describe your present alcohol intake as

Daily/most days	☐ 1	q2020q23_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/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	q2020q23_1
5-6 drinks	☐ 2	
3-4 drinks	☐ 3	
1-2 drinks	☐ 4	

23.2 How many alcoholic drinks do you have during an average week? ___ ___ q2020q23_2

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

23.3	Beers, Lagers	☐ 1	q2020q23_3
23.4	Wines, Sherry	☐ 1	q2020q23_4
23.5	Spirits	☐ 1	q2020q23_5
23.6	Combination of Beers, Wines or Spirits	☐ 1	q2020q23_6
23.7	Low alcohol drinks	☐ 1	q2020q23_7

24. Water intake

24.0 How many glasses of **water** do you drink **a day**? q2020q24_0 ____ ____ glasses per day

25. Meals

		Yes	No	
25.0	Do you receive help preparing your meals?	☐	☐	q2020q25_0
25.1	**If yes,** is this from Social/Local Authority services or private provider?	☐ 1		q2020q25_1
25.2	Friends/family?	☐ 1		q2020q25_2
25.3	Other, please give details _____	☐ 1		q2020q25_3

Office Use q2020q25_3othbox

26. Physical activity

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

No ☐1 q2020q26_0
Walk ☐2
Cycle ☐3
Both ☐4

26.1 How many hours do you normally spend **walking** e.g. on errands or for leisure in an average week? q2020q26_1 ___ ___ hours

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

Slow ☐1 q2020q26_2
Steady average ☐2
Fast ☐3

26.3 How long do you spend **cycling** in an average week? q2020q26_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)? q2020q26_4 ___ ___ times /day

26.5 Do not climb stairs ☐1 q2020q26_5

26.6 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 q2020q26_6
More active ☐2
Similar ☐3
Less active ☐4
Much less active ☐5

26.7 Do you take active sporting physical exercise such as running, swimming, dancing, golf, tennis, squash, jogging, bowls, cycling, hiking, etc.?

No ☐1 q2020q26_7
Occasionally less than once a month ☐2
Frequently once a month or more ☐3

26.8 **If** you ticked **frequently** please state type of activities: Office Use

_____ q2020q26_8

How many **times a month** on average do you take part in these activities?
(please give overall total)

26.9 In winter q2020q26_9 ___ ___ times a month

26.10 In summer q2020q26_10 ___ ___ times a month

27. General Fitness

Can you do any of the following activities:

		Yes	No
27.0 q2020q27_0	run a short distance?	☐	☐
27.1 q2020q27_1	do heavy work around the house (e.g. lifting & moving heavy furniture)	☐	☐
27.2 q2020q27_2	do gardening (e.g. raking leaves, weeding & pushing the lawn mower)	☐	☐
27.3 q2020q27_3	participate in moderate activities like golf, bowling, dancing or doubles tennis?	☐	☐
27.4 q2020q27_4	participate in strenuous sports like swimming or singles tennis?	☐	☐
27.5 q2020q27_5	have sexual relations?	☐	☐

28. Muscle strength and endurance

		Yes	No
28.0	Do you engage in exercises to increase muscle strength and endurance such as lifting weights, doing push-ups, using exercise machines? q2020q28_0	☐	☐

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

q2020q28_1h ___ ___ hours q2020q28_1m ___ ___ minutes

29. Grip Strength

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

q2020q29_0

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

30. 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
30.0 q2020q30_0	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
30.1 q2020q30_1	Doing exercises – e.g. push ups, sit ups, chair aerobics, an exercise routine.	7	6	5	4	3	2	1	M	R
30.2 q2020q30_2	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

31. Long standing illness, disability or infirmity

		Yes	No	
31.0	Do you have any **long-standing** illness, disability or infirmity?	☐	☐	q2020q31_0

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

		Yes	No	
31.1	**If yes**, does this illness or disability limit your activities in any way?	☐	☐	q2020q31_1
31.2	do you receive a disability allowance?	☐	☐	q2020q31_2

32. Disability

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

		Yes	No	
32.0	Going up or down stairs	☐	☐	q2020q32_0
32.1	Bending down	☐	☐	q2020q32_1
32.2	Straightening up	☐	☐	q2020q32_2
32.3	Keeping your balance	☐	☐	q2020q32_3
32.4	Going out of the house	☐	☐	q2020q32_4
32.5	Walking 400 yards	☐	☐	q2020q32_5

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

		Yes	No	Does not apply	
32.6	Job at work paid employment	☐	☐	☐3	q2020q32_6
32.7	Household chores	☐	☐		q2020q32_7
32.8	Social life	☐	☐		q2020q32_8
32.9	Interests and hobbies	☐	☐		q2020q32_9
32.10	Holidays and outings	☐	☐		q2020q32_10

32.11 Do you have any difficulties getting about outdoors?

No difficulty	☐1	q2020q32_11
Slight	☐2	
Moderate	☐3	
Severe	☐4	
Unable to do	☐5	

33. Mobility

33.0 How would you describe your current mobility?

Able to leave my home	☐1	q2020q33_0
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	

Mobility Aids

33.1 Do you use any mobility aids? Yes ☐ No ☐ q2020q33_1

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

(Tick **all** that apply)

33.2 Walking stick ☐ q2020q33_2

33.3 Walking frame ☐ q2020q33_3

33.4 Wheelchair/ mobility scooter ☐ q2020q33_4

33.5 Other ☐ q2020q33_5 _____ q2020q33_5othbox

Office Use

34. 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

q2020q34_0

34.1 Can you walk up and down a flight of 13 stairs without resting?

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

q2020q34_1

34.2 When standing, can you bend down and pick up a shoe **from the floor**? Yes ☐ No ☐ q2020q34_2

34.3 When sitting, can you rise from a chair of knee height, **without using your hands**? ☐ ☐ q2020q34_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

q2020q34_4

35. Difficulties with Activities of daily living

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
35.0	q2020q35_0	Reaching or extending your arms above shoulder level	☐	☐	☐
35.1	q2020q35_1	Pulling or pushing large objects like a living room chair	☐	☐	☐
35.2	q2020q35_2	Walking across a room	☐	☐	☐
35.3	q2020q35_3	Getting in and out of bed on your own	☐	☐	☐
35.4	q2020q35_4	Getting in and out of a chair on your own	☐	☐	☐
35.5	q2020q35_5	Dressing and undressing yourself on your own	☐	☐	☐
35.6	q2020q35_6	Bathing or showering	☐	☐	☐
35.7	q2020q35_7	Feeding yourself, including cutting food	☐	☐	☐
35.8	q2020q35_8	Getting to and using the toilet on your own	☐	☐	☐
35.9	q2020q35_9	Lifting and carrying something as heavy as 10 lbs, (e.g. a bag of groceries)	☐	☐	☐
35.10	q2020q35_10	Shopping for personal items such as toilet items or medicine by yourself	☐	☐	☐
35.11	q2020q35_11	Doing light housework (e.g. washing up)	☐	☐	☐
35.12	q2020q35_12	Preparing your own meals by yourself	☐	☐	☐
35.13	q2020q35_13	Using the telephone by yourself	☐	☐	☐
35.14	q2020q35_14	Taking medications by yourself	☐	☐	☐
35.15	q2020q35_15	Managing money (e.g. paying bills etc)	☐	☐	☐
35.16	q2020q35_16	Using public transport on your own	☐	☐	☐
35.17	q2020q35_17	Driving a car on your own	☐	☐	☐
35.18	q2020q35_18	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

q2020q36_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

q2020q36_1

36.2 Food generally tastes

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

q2020q36_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

q2020q36_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

q2020q36_4

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

q2020q36_5

Office Use

_____

37. 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 ☐ q2020q37_0

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

(Tick **all** that apply)

37.1 q2020q37_1 Problems with your teeth ☐1

37.2 q2020q37_2 Swallowing problems ☐1

37.3 q2020q37_3 Pain on chewing ☐1

37.4 q2020q37_4 Poor taste ☐1

37.5 q2020q37_5 Poor smell ☐1

37.6 q2020q37_6 Stomach/ abdominal pain ☐1

37.7 q2020q37_7 Gas/ bloating ☐1

37.8 q2020q37_8 Indigestion/ heartburn ☐1

37.9 q2020q37_9 Constipation/Diarrhoea ☐1

37.10 q2020q37_10 Other_____ ☐1 q2020q37_10othbox

Office Use

3

		Yes	No	
37.11	Are there days when you **don't feel like eating at all**?	☐	☐	q2020q37_11

If yes,

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

About once a month	☐ 1	q2020q37_12
About once a week	☐ 2	
More than once a week	☐ 3	
Every day	☐ 4	

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

37.13	Not hungry	☐ 1	q2020q37_13
37.14	In general, food is not appealing to me	☐ 1	q2020q37_14
37.15	Taste of the food	☐ 1	q2020q37_15
37.16	Smell of the food	☐ 1	q2020q37_16
37.17	Look of the food	☐ 1	q2020q37_17
37.18	No specific reason	☐ 1	q2020q37_18
37.19	Other (please specify) _____ q2020q37_19	☐ 1	q2020q37_19othbox

Office Use

38. Your food intake and weight loss

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

All of the time	☐ 1	q2020q38_0
Most of the time	☐ 2	
Some of the time	☐ 3	
Never/rarely	☐ 4	

38.1 Do you feel you are undernourished?

Yes	☐ 1	q2020q38_1
No	☐ 2	
I don't know	☐ 3	

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

no decrease in food intake	☐ 1	q2020q38_2
moderate decrease in food intake	☐ 2	
severe decrease in food intake	☐ 3	

38.3 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	q2020q38_3
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	

Shopping for food

		Yes	No	
38.4	Do you have any difficulty shopping for food because of a health or physical problem?	☐	☐	q2020q38_4
38.5	Can you easily access a supermarket or grocery for your food shopping?	☐	☐	q2020q38_5

38.6 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

q2020q38_6

39. Stress and illness in last 3 months

		Yes	No	
39.0	Have you been stressed or severely ill in the past 3 months?	☐	☐	q2020q39_0

39.1 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

q2020q39_1

Your Dental Health (mouth, teeth and or dentures)

40. General Dental Health

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

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

q2020q40_0

		Yes	No
40.1	Do you have **any** of your **own (natural) teeth**?	☐	☐
40.2	How many of your own (natural) teeth do you have?	___ ___	
40.3	How many of your own (natural) teeth have **you lost** in the **last five years**?	___ ___	

41. Back teeth(molars)

		Yes	No
	Do you have **any** of your own back teeth(molars) in your **lower teeth**?		
41.0	on the **left** side	☐	☐
41.1	on the **right** side	☐	☐
	Do you have **any** of your own back teeth(molars) in your **upper teeth**?		
41.2	on the **left** side	☐	☐
41.3	on the **right** side	☐	☐

q2020q40_1

42. Chewing difficulties

42.0 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

		Yes	No
42.1	Do you **avoid eating some foods** because of problems with your teeth, mouth or dentures?	☐	☐
42.2	Does it take you **longer to finish a meal** than other people of your own age?	☐	☐

43. Tooth brushing

43.0 What type of toothbrush do you use?

- Manual toothbrush (non-electric) ☐ 1
- Electric toothbrush ☐ 2
- Both ☐ 3
- Do not brush ☐ 4

q2020q43_0

43.1 How frequently do you **brush your teeth**?

- More than once a day ☐ 1
- Once a day ☐ 2
- Less than once a day ☐ 3
- Do not brush (e.g. no teeth) ☐ 4

q2020q43_1

43.2 Do you have difficulty brushing your teeth? Yes ☐ No ☐ q2020q43_2

44. Visiting the dentist

44.0 Have you seen your dentist in the last year? Yes ☐ No ☐ q2020q44_0

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

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

q2020q44_1

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

44.2 q2020q44_2 Difficult to get to the dental surgery ☐ 1

44.3 q2020q44_3 Expensive ☐ 1

44.4 q2020q44_4 Don't need to see a dentist ☐ 1

44.5 q2020q44_5 Other_____ ☐ 1

Office Use q2020q44_5othbox

45. Other dental problems

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

(Tick **all** that apply)

45.0 Pain related to teeth or mouth ☐ 1 q2020q45_0

45.1 Loose tooth ☐ 1 q2020q45_1

45.2 Sensitivity to hot/ cold food or drink ☐ 1 q2020q45_2

45.3 Mouth ulcers ☐ 1 q2020q45_3

45.4 Bleeding gums ☐ 1 q2020q45_4

45.5 Other gum problems ☐ 1 q2020q45_5

45.6 Soreness or cracking around the corners of the mouth ☐ 1 q2020q45_6

46. Dental problems affecting your daily life

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

(Tick **all** that apply)

46.0	Difficulty speaking clearly	☐ 1	q2020q46_0
46.1	Difficulty going out, for example to shop or visit someone	☐ 1	q2020q46_1
46.2	Difficulty relaxing (including sleeping)	☐ 1	q2020q46_2
46.3	Problems smiling, laughing and showing teeth without embarrassment	☐ 1	q2020q46_3
46.4	Emotional problems e.g. becoming more easily upset than usual	☐ 1	q2020q46_4
46.5	Problems enjoying the company of others e.g. family, friends, neighbours	☐ 1	q2020q46_5
46.6	None of these	☐ 1	q2020q46_6

47. Dentures

		Yes	No	
47.0	Do you wear full or partial dentures (plate or false teeth that are removable)?	☐	☐	q2020q47_0

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

47.1	q2020q47_1	Loose dentures	☐ 1	
47.2	q2020q47_2	Difficulty eating with dentures	☐ 1	
47.3	q2020q47_3	Other, please specify_____	☐ 1	Office Use q2020q47_3othbox

Using your dentures (if you have them)

		Yes	No	
47.4	Do you take out your dentures (false teeth) while eating?	☐	☐	q2020q47_4
47.5	Do you take out your dentures (false teeth) before going to bed?	☐	☐	q2020q47_5
47.6	Do you clean your dentures every day?	☐	☐	q2020q47_6

Upper Teeth

47.7	Do you wear a denture (plate or false teeth) for **upper teeth**?	☐	☐	q2020q47_7
47.8	**If yes** I wear a **full set** of dentures	☐ 1		q2020q47_8
	I wear a **partial set** of dentures (to replace some but not all missing teeth)	☐ 2		
47.9	How long have you had this denture? ____ Years ____ Months			q2020q47_9y q2020q47_9m
47.10	Do you use this denture every day?	☐	☐	q2020q47_10

Lower Teeth

47.11	Do you wear a denture (plate or false teeth) for **lower teeth**?	☐	☐	q2020q47_11
47.12	**If yes** I wear a **full set** of dentures	☐ 1		q2020q47_12
	I wear a **partial set** of dentures (to replace some but not all missing teeth)	☐ 2		
47.13	How long have you had this denture? ____ Years ____ Months			q2020q47_13y q2020q47_13m
47.14	Do you use this denture every day?	☐	☐	q2020q47_14

48. 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)

		Never 1	Hardly ever 2	Occasionally 3	Fairly often 4	Very often 5
48.0 q2020q48_0	My mouth feels dry	☐	☐	☐	☐	☐
48.1 q2020q48_1	My mouth feels dry when eating a meal	☐	☐	☐	☐	☐
48.2 q2020q48_2	I have difficulty in eating dry foods	☐	☐	☐	☐	☐
48.3 q2020q48_3	I have difficulties swallowing certain foods	☐	☐	☐	☐	☐
48.4 q2020q48_4	I sip liquids to aid in swallowing food	☐	☐	☐	☐	☐
48.5 q2020q48_5	I suck sweets to relieve dry mouth	☐	☐	☐	☐	☐
48.6 q2020q48_6	I get up at night to drink	☐	☐	☐	☐	☐
48.7 q2020q48_7	My lips feel dry	☐	☐	☐	☐	☐
48.8 q2020q48_8	My eyes feel dry	☐	☐	☐	☐	☐
48.9 q2020q48_9	The skin of my face feels dry	☐	☐	☐	☐	☐
48.10 q2020q48_10	The inside of my nose feels dry	☐	☐	☐	☐	☐

49. Taste and smell

During the past **12 months**

		Yes	No
49.0 q2020q49_0	Have you had a problem with your ability to **smell**, such as not being able to smell things?	☐	☐
49.1 q2020q49_1	Have you had a problem with your ability to **taste** food or drink?	☐	☐

50.Sleeping Patterns

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

q2020q50_0

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

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

50.1 Night time? q2020q50_1nh ___ ___ hours q2020q50_1nm ___ ___ minutes

50.2 Day time? q2020q50_2dh ___ ___ hours q2020q50_2dm ___ ___ minutes

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

Never/rarely ☐1
sometimes ☐2
Frequently ☐3
Always ☐4
q2020q50_3

During **the last month**,

50.4 Did you have **difficulties falling asleep** at night?
rarely ☐1
sometimes ☐2
often ☐3
q2020q50_4

50.5 Do you often wake up during the early hours and are unable to get back to sleep?
Yes ☐ No ☐
q2020q50_5

50.6 Do you have **trouble maintaining sleep** at night?
rarely ☐1
sometimes ☐2
often ☐3
q2020q50_6

50.7 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
q2020q50_7

50.8 Do you **snore loudly** while asleep?
no ☐1
sometimes ☐2
Often ☐3
don't know ☐4
q2020q50_8

Diagnosis of sleep apnoea

50.9 Have you ever been told by a **doctor** that you suffer with sleep apnoea
Yes ☐ No ☐
q2020q50_9

51. Memory

In the past year,

51.0 How often did you have trouble remembering things?
never ☐1
rarely ☐2
sometimes ☐3
often ☐4
q2020q51_0

Yes No

51.1 Did you have more trouble than usual remembering recent events? ☐ ☐ q2020q51_1

51.2 Did you have more trouble than usual remembering a short list of items such as a shopping list? ☐ ☐ q2020q51_2

51.3 Did you have trouble remembering things from one second to the next? ☐ ☐ q2020q51_3

51.4 Did you have any difficulty in understanding or following spoken instruction? ☐ ☐ q2020q51_4

51.5 Did you have more trouble than usual following a group conversation or a plot on TV due to your memory? ☐ ☐ q2020q51_5

51.6 Did you have trouble finding your way around familiar streets? ☐ ☐ q2020q51_6

51.7 Did you have trouble getting things organised/ organising your day? ☐ ☐ q2020q51_7

51.8 Did you have trouble concentrating on things e.g. reading a book? ☐ ☐ q2020q51_8

52. Forgetfulness

		Yes	No	
52.0	**In past 13 months,** have you been forgetful to the extent that it has affected your daily life?	☐	☐	q2020q52_0

53. Recent major life events

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

			(Tick **all** that apply)		Was this COVID-19 related? Yes	No	
53.0	q2020q53_0	death of a spouse	☐	1	☐	☐	q2020q53_0cv19
53.1	q2020q53_1	death of a close relative/friend	☐	1	☐	☐	q2020q53_1cv19
53.2	q2020q53_2	illness/accident to a family member	☐	1	☐	☐	q2020q53_2cv19
53.3	q2020q53_3	financial difficulties	☐	1	☐	☐	q2020q53_3cv19
53.4	q2020q53_4	personal illness, accident or injury	☐	1			
53.5	q2020q53_5	moving house	☐	1			
53.6	q2020q53_6	divorce	☐	1			
53.7	q2020q53_7	addition to family circle e.g. grandchild	☐	1			
53.8	q2020q53_8	death of a pet	☐	1			
53.9	q2020q53_9	Other, please give details	☐	1			
53.10	q2020q53_10	none	☐	1			

Office Use

q2020q53_9othbox

54. Time spent on various activities

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 1	No 2	No - due to COVID-19 3	If **Yes** hours per week
54.0	q2020q54_0	Looking after wife/partner	☐	☐	☐	q2020q54_0h ___ ___
54.1	q2020q54_1	Looking after other adult family member or friend	☐	☐	☐	q2020q54_1h ___ ___
54.2	q2020q54_2	Looking after grandchildren	☐	☐	☐	q2020q54_2h ___ ___
54.3	q2020q54_3	Spending time with family, friends and neighbours	☐	☐	☐	
54.4	q2020q54_4	Talking to friends/relatives on the telephone/video calls	☐	☐	☐	
54.5	q2020q54_5	In paid work	☐	☐	☐	
54.6	q2020q54_6	In voluntary work	☐	☐	☐	
54.7	q2020q54_7	In a pub or club	☐	☐	☐	
54.8	q2020q54_8	Attending religious services	☐	☐	☐	
54.9	q2020q54_9	Playing cards, games, or bingo	☐	☐	☐	
54.10	q2020q54_10	Visiting the cinema/restaurants/sporting events	☐	☐	☐	

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
54.11	q2020q54_11	On housework	☐	☐	___ ___ q2020q54_11h
54.12	q2020q54_12	On light gardening (pruning and weeding)	☐	☐	___ ___ q2020q54_12h
54.13	q2020q54_13	On heavy gardening (digging & mowing)	☐	☐	___ ___ q2020q54_13h
54.14	q2020q54_14	Watching television/videos/DVD's	☐	☐	___ ___ q2020q54_14h
54.15	q2020q54_15	Reading	☐	☐	___ ___ q2020q54_15h
54.16	q2020q54_16	Attending class or course of study	☐	☐	___ ___ q2020q54_16h
54.17	q2020q54_17	Using a computer	☐	☐	___ ___ q2020q54_17h
54.18	q2020q54_18	Driving or sitting in a car	☐	☐	___ ___ q2020q54_18h

55. Other activities

			Yes	No	No - due to COVID-19	
			1	2	3	
55.1		Have you been on any day or overnight trips in the last year?	☐	☐	☐	q2020q55_1
55.2		Have you been on holiday in the last year?	☐	☐	☐	q2020q55_2
55.3		Are you planning to go on holiday next year?	☐	☐	☐	q2020q55_3
55.4		Do you use the internet and/or email?	☐	☐		q2020q55_4
55.5		Do you use social media?	☐	☐		q2020q55_5
55.6		Do you use a "touch screen" mobile phone?	☐	☐		q2020q55_6
55.7		Have you written a personal letter or email in the last week?	☐	☐		q2020q55_7
55.8		Do you take a weekly or monthly magazine or journal?	☐	☐		q2020q55_8
55.9		Did you vote in the last general or local elections?	☐	☐		q2020q55_9

56. Social contact

			Hardly ever / never	Sometimes	Often
			1	2	3
56.0	q2020q56_0	How often do you feel you lack companionship?	☐	☐	☐
56.1	q2020q56_1	How often do you feel isolated from others?	☐	☐	☐
56.2	q2020q56_2	How often do you feel left out?	☐	☐	☐
56.3	q2020q56_3	How often do you feel in tune with the people around you?	☐	☐	☐

57.Tiredness / Exhaustion

			Rarely/never (less than 1 day)	Sometimes (1-2 days)	Often (more than 3 days)
			1	2	3
57.0	q2020q57_0	During the **past week**, how often did you feel that everything you did **was an effort?**	☐	☐	☐
57..1	q2020q57_1	During the **past week**, how often did you feel that you **could not get "going"**?	☐	☐	☐

58. Your feelings

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

		Yes	No	
58.0	were you basically satisfied with your life?	☐	☐	q2020q58_0
58.1	did you feel that your life is empty?	☐	☐	q2020q58_1
58.2	were you afraid that something bad is going to happen to you?	☐	☐	q2020q58_2
58.3	did you feel happy most of the time?	☐	☐	q2020q58_3
58.4	did you drop many of your activities and interests?	☐	☐	q2020q58_4
58.5	did you prefer to stay at home, rather than going out to do new things?	☐	☐	q2020q58_5
58.6	did you feel full of energy?	☐	☐	q2020q58_6
58.7	did you often feel helpless?	☐	☐	q2020q58_7

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

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

			strongly agree	agree	neither agree nor disagree	disagree	strongly disagree
			1	2	3	4	5
59.0	q2020q59_0	I enjoy my life overall	☐	☐	☐	☐	☐
59.1	q2020q59_1	I look forward to things	☐	☐	☐	☐	☐
59.2	q2020q59_2	I am healthy enough to get out and about	☐	☐	☐	☐	☐
59.3	q2020q59_3	My family, friends or neighbours would help me if needed	☐	☐	☐	☐	☐
59.4	q2020q59_4	I have social or leisure activities/hobbies that I enjoy doing	☐	☐	☐	☐	☐
59.5	q2020q59_5	I try to stay involved with things	☐	☐	☐	☐	☐
59.6	q2020q59_6	I am healthy enough to have my independence	☐	☐	☐	☐	☐
59.7	q2020q59_7	I can please myself in what I do	☐	☐	☐	☐	☐
59.8	q2020q59_8	I feel safe where I live	☐	☐	☐	☐	☐
59.9	q2020q59_9	I get pleasure from my home	☐	☐	☐	☐	☐
59.10	q2020q59_10	I take life as it comes and make the best of things	☐	☐	☐	☐	☐
59.11	q2020q59_11	I feel lucky compared to most people	☐	☐	☐	☐	☐
59.12	q2020q59_12	I have enough money to pay for household bills	☐	☐	☐	☐	☐
59.13	q2020q59_13	I feel lonely	☐	☐	☐	☐	☐

60. Present circumstances

60.0 Are you at present:-

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

q2020q60_0

60.1 If you are widowed, divorced/separated, please give **the year** when this occurred: _____ q2020q60_1

60.2 Are you at present:-

- living alone ☐1
- living with a partner or spouse ☐2 q2020q60_2
- living with other family members ☐3
- living with other people ☐4

Pets

Office Use

61.0 Do you have any pets? q2020q61_0no none ☐1 q2020q61_0dog dog ☐1 q2020q61_0cat cat ☐1 q2020q61_0oth other ☐1_____ q2020q61_0othbox

Your accommodation

62.0 Are you:-

- living in your own home ☐1 q2020q62_0
- living in a residential or nursing home ☐2
- living in sheltered accommodation ☐3
- other ☐4

Managing financially

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

- manage very well ☐1
- manage quite well ☐2 q2020q62_1
- get by alright ☐3
- don't manage very well ☐4

Transport

		Yes	No	
63.0	Do you have a car available for your own use?	☐	☐	q2020q63_0
63.1	Do you currently drive yourself?	☐	☐	q2020q63_1

Heating

		Yes	No	
64.0	During the cold winter weather, can you normally keep **comfortably warm** in your **living room**?	☐	☐	q2020q64_0

If no, is this because:

64.1	it costs too much to keep your heating on?	☐	☐	q2020q64_1
64.2	it is not possible to heat the room to a comfortable standard?	☐	☐	q2020q64_2

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

- No difficulty ☐1 q2020q64_3
- Minor difficulty ☐2
- Moderate difficulty ☐3
- Serious difficulty ☐4

65. Vitamins and minerals

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	B	C	D	E
65.1	**Vitamin:** (tick the ones you take regularly)	☐1 q2020q65_1va	☐1 q2020q65_1vb	☐1 q2020q65_1vc	☐1 q2020q65_1vd	☐1 q2020q65_1ve

		1.	2.	3.	4.
65.2	**Minerals/fish oils:** (tick the ones you take regularly)	**Calcium** ☐1 q2020q65_2ca	**Magnesium** ☐1 q2020q65_2mg	**Cod liver Oil** ☐1 q2020q65_2coil	**Fish oil** ☐1 q2020q65_2foil

66. Medicines

66.0 Do you take any regular medication? Yes ☐ No ☐ q2020q66_0

Details of ALL medicines

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*
66.1	q2020q66_0bnf12_1 q2020q66_0bnf34_1 q2020q66_0bnf5_1 q2020q66_0bnf6_1	q2020q66_0icd1	☐ ☐	
66.2	q2020q66_0bnf12_2 q2020q66_0bnf34_2 q2020q66_0bnf5_2 q2020q66_0bnf6_2	q2020q66_0icd2	☐ ☐	
66.3	q2020q66_0bnf12_3 q2020q66_0bnf34_3 q2020q66_0bnf5_3 q2020q66_0bnf6_3	q2020q66_0icd3	☐ ☐	
66.4	q2020q66_0bnf12_4 q2020q66_0bnf34_4 q2020q66_0bnf5_4 q2020q66_0bnf6_4	q2020q66_0icd4	☐ ☐	
66.5	q2020q66_0bnf12_5 q2020q66_0bnf34_5 q2020q66_0bnf5_5 q2020q66_0bnf6_5	q2020q66_0icd5	☐ ☐	
66.6	q2020q66_0bnf12_6 q2020q66_0bnf34_6 q2020q66_0bnf5_6 q2020q66_0bnf6_6	q2020q66_0icd6	☐ ☐	
66.7	q2020q66_0bnf12_7 q2020q66_0bnf34_7 q2020q66_0bnf5_7 q2020q66_0bnf6_7	q2020q66_0icd7	☐ ☐ q2020q66_0medpr1	
66.8	q2020q66_0bnf12_8 q2020q66_0bnf34_8 q2020q66_0bnf5_8 q2020q66_0bnf6_8	q2020q66_0icd8	☐ ☐	
66.9	q2020q66_0bnf12_9 q2020q66_0bnf34_9 q2020q66_0bnf5_9 q2020q66_0bnf6_9	q2020q66_0icd9	☐ ☐	
66.10	q2020q66_0bnf12_10 q2020q66_0bnf34_10 q2020q66_0bnf5_10 q2020q66_0bnf6_10	q2020q66_0icd10	☐ ☐	
66.11	q2020q66_0bnf12_11 q2020q66_0bnf34_11 q2020q66_0bnf5_11 q2020q66_0bnf6_11	q2020q66_0icd11	☐ ☐	
66.12	q2020q66_0bnf12_12 q2020q66_0bnf34_12 q2020q66_0bnf5_12 q2020q66_0bnf6_12	q2020q66_0icd12	☐ ☐	
66.13	q2020q66_0bnf12_13 q2020q66_0bnf34_13 q2020q66_0bnf5_13 q2020q66_0bnf6_13	q2020q66_0icd13	☐ ☐	

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.

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

			Number of days each week							Monthly	Rarely/
										0	Never 8
D1	**Meat**										
D1.0	Red meat (including beef, minced beef, beef burgers, lamb, pork, bacon, ham, salami)	q2020D1_0	7	6	5	4	3	2	1	M	R
D1.1	Chicken, turkey, other poultry	q2020D1_1	7	6	5	4	3	2	1	M	R
D1.2	Tinned meat (all types, corned beef, etc)	q2020D1_2	7	6	5	4	3	2	1	M	R
D1.3	Pork sausages, beef sausages, pies, pasties	q2020D1_3	7	6	5	4	3	2	1	M	R
D1.4	Liver, kidney, heart	q2020D1_4	7	6	5	4	3	2	1	M	R
D2	**Fish**										
D2.0	White fish (cod, haddock, hake, plaice, fish fingers, etc)	q2020D2_0	7	6	5	4	3	2	1	M	R
D2.1	Kippers, herrings, pilchards, tuna, sardines, salmon, mackerel (including tinned)	q2020D2_1	7	6	5	4	3	2	1	M	R
D2.2	Shellfish	q2020D2_2	7	6	5	4	3	2	1	M	R
D3	**Fruit and vegetables**										
D3.0	Fresh fruit in the **summer**	q2020D3_0	7	6	5	4	3	2	1	M	R
D3.1	Fresh fruit in the **winter**	q2020D3_1	7	6	5	4	3	2	1	M	R
D3.2	Fresh vegetables in the **summer**	q2020D3_2	7	6	5	4	3	2	1	M	R
D3.3	Fresh vegetables in the **winter**	q2020D3_3	7	6	5	4	3	2	1	M	R
D3.4	Legumes (e.g. baked or butter beans, lentils, peas, chickpeas)	q2020D3_4	7	6	5	4	3	2	1	M	R
D4	**Bread**										
D4.0	White bread / bread rolls	q2020D4_0	7	6	5	4	3	2	1	M	R
D4.1	Brown or wholemeal bread / bread rolls	q2020D4_1	7	6	5	4	3	2	1	M	R
D5	**Dairy**										
D5.0	Full-fat cheese (e.g. Cheddar, Leicester, Stilton, Brie, soft cheese)	q2020D5_0	7	6	5	4	3	2	1	M	R
D5.1	Low-fat cheese (e.g. Edam, Cottage cheese, reduced fat cheese)	q2020D5_1	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**										
D6.0	Spaghetti and other pasta	q2020D6_0	7	6	5	4	3	2	1	M	R
D6.1	Rice (all types excluding rice pudding)	q2020D6_1	7	6	5	4	3	2	1	M	R
D6.2	Crispbread (Ryvita, cream crackers, etc)	q2020D6_2	7	6	5	4	3	2	1	M	R
D6.3	Breakfast cereal (all types including porridge)	q2020D6_3	7	6	5	4	3	2	1	M	R
D7.0	**Olive oil** (for cooking, salads etc)	q2020D7_0	7	6	5	4	3	2	1	M	R
D8	**Snacks**										
D8.0	Savoury snacks (e.g. crisps/ salted nuts)	q2020D8_0	7	6	5	4	3	2	1	M	R
D8.1	Sweet snacks (e.g. biscuits/cakes/ chocolate/sweets)	q2020D8_1	7	6	5	4	3	2	1	M	R

D9 **Milk**

D9.0 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
- between half and one pint ☐ 3
- more than one pint ☐ 4

q2020D9_0

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
- fully skimmed milk, fresh or dried ☐ 3
- other kinds of milk, e.g. condensed, evaporated ☐ 4

q2020D9_1

D10 **Daily Snacks**

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

D10.0 Savoury snacks (e.g. crisps/ salted nuts)? q2020D10_0 ____ times per day

D10.1 Sweet snacks (e.g. biscuits/cakes/ chocolate/sweets)? q2020D10_1 ____ times per day

D11 **Alcoholic drinks**

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

D11.0 Number of half pints of beers or lagers q2020D11_0 ____

D11.1 Number of glasses of wine or sherry q2020D11_1 ____

D11.2 Number of singles glasses of spirits q2020D11_2 ____

We are considering conducting some future surveys over the phone or online (via the web). These will not replace the current paper postal format.

Would you be happy to consider

		Yes 1	No 2	Unable to 3	
S1	Completing an online questionnaire via the web:	☐	☐	☐	q2020S1Qr_online
S2	Answering a short questionnaire over the telephone?	☐	☐	☐	q2020S2Qr_byphone

General comments:

S3 In this section you may like to share any comments including how COVID-19 has affected you.

Office Use

q2020General_comments_bd

Office use:

q2020Date_stamp_day
q2020Date_stamp_month
q2020Date_stamp_year

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
Department of Primary Care & Population Health, UCL Medical School,
Royal Free Campus, Rowland Hill Street, London NW3 2PF

Tel : 020 8016 8021 Email: l.lennon@ucl.ac.uk

Web: https://www.ucl.ac.uk/british-regional-heart-study