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

BRITISH REGIONAL HEART STUDY

2003 QUESTIONNAIRE

Thank you very much for taking the time to complete this questionnaire, which will bring us up to date with your present state of health. All the information will be treated as **strictly confidential** and will only be seen by the Research Team.

Most questions can be answered by ticking the correct box ☑

Please check that you have answered as many questions as you can and return it to us in the envelope provided – you do not need to use a stamp.

If you have any trouble answering the questions, or would like a large-print copy, please phone us on 020 7830 2335 and give us your telephone number. We will then call you back to answer your query.

THANK YOU FOR YOUR HELP

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Rowland Hill Street, London NW3 2PF

1.0 Date of birth q03q1_dob day q03q1_mob month 19 q03q1_yob 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?

If you tick **Yes**, please give the year of **last occurrence**

		Yes	No	Year of last occurrence
(a)	Heart attack (coronary thrombosis or myocardial infarction)	☐	☐	q03q2_0a q03q2_0a_y
(b)	Heart failure	☐	☐	q03q2_0b q03q2_0b_y
(c)	Angina	☐	☐	q03q2_0c q03q2_0c_y
(d)	Other heart trouble	☐	☐	q03q2_0d q03q2_0d_y
(e)	High blood pressure	☐	☐	q03q2_0e q03q2_0e_y
(f)	High blood cholesterol	☐	☐	q03q2_0f q03q2_0f_y
(g)	Aortic Aneurysm	☐	☐	q03q2_0g q03q2_0g_y
(h)	Narrowing or hardening of the leg arteries (including claudication)	☐	☐	q03q2_0h q03q2_0h_y
(i)	Deep Vein Thrombosis (clot in the deep leg vein)	☐	☐	q03q2_0i q03q2_0i_y
(j)	Pulmonary Embolism (clot on the lung)	☐	☐	q03q2_0j q03q2_0j_y

Stroke	Yes	No	Year of last occurrence
3.0 Have you **ever** been told by a doctor that you have had a stroke?	☐	☐	q03q3_0 q03q3_0_y
If **Yes,**			
3.1 Did the symptoms last for more than 24 hours?	☐	☐	q03q3_1
3.2 Have you made a complete recovery from your stroke?	☐	☐	q03q3_2
3.3 Following your stroke, do you still need any help in carrying out everyday activities?	☐	☐	q03q3_3

Investigations and special treatment for conditions affecting the heart and circulation

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

		Yes	No	Year of last occurrence
4.1	A referral to a heart specialist	☐	☐	q03q4_1 q03q4_1_y ________
4.2	A referral to a chest pain clinic	☐	☐	q03q4_2 q03q4_2_y ________
4.3	An exercise ECG (“stress” or “treadmill”) test	☐	☐	q03q4_3 q03q4_3_y ________
4.4	Angiogram or X-ray of coronary arteries (using a dye)	☐	☐	q03q4_4 q03q4_4_y ________
4.5	Angioplasty (balloon treatment of coronary artery for angina)	☐	☐	q03q4_5 q03q4_5_y ________
4.6	Coronary artery bypass graft operation (“heart bypass” or “CABG”)	☐	☐	q03q4_6 q03q4_6_y ________
4.7	Other tests, investigations or operations on the heart, arteries or veins?	☐	☐	q03q4_7 q03q4_7_y ________

If **Yes**, please give details:

____ q03q4_7_d

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Diabetes

		Yes	No	
5.0	Have you **ever** been told by a doctor that you have or have had diabetes?	☐	☐	q03q5_0

If **Yes**,

5.1 In what year was it first diagnosed? ________ (Year) q03q5_1

		Yes	No	
5.2	Do you have any complications of diabetes affecting……….. your feet?	☐	☐	q03q5_2_f
	your nerves?	☐	☐	q03q5_2_n
	your kidneys?	☐	☐	q03q5_2_k
	your eyes?	☐	☐	q03q5_2_e
5.3	Have your eyes been checked for signs of diabetes? (Please give year of last check)	☐	☐	________ (Year)

q03q5_3 q03q5_3_y

Cancer

6.0 Have you **ever** been told by a doctor that you have or have had cancer? q03q6_0 Yes ☐ No ☐

If **Yes**, please give:

(a) Year first diagnosed q03q6_0a ________ (b) Cancer Site q03q6_0_s q03q6_0_s2 ________ OFFICE USE ☐☐☐☐

Arthritis

7.0 Have you **ever** been told by a doctor that you have or have had arthritis? q03q7_0 Yes ☐ No ☐

If **Yes**,

7.1 Type of arthritis (if known), (eg. osteoarthritis, rheumatoid arthritis, other): q03q7_1 OFFICE USE ☐

____

7.2 Year first diagnosed ________ q03q7_2

7.3 Joint(s) affected:
please tick the relevant box(es)

Knees	☐	q03q7_3_k
Hips	☐	q03q7_3_h
Feet	☐	q03q7_3_f
Hands and/or wrists	☐	q03q7_3_ha
Other (please specify)	________	q03q7_3_o

OFFICE USE ☐

Other Medical Conditions

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

If **Yes**, please give the year when **first** diagnosed, if possible

	Condition	Variable	Yes	No	Year		Condition	Variable	Yes	No	Year
(a)	Asthma	q03q8_0a	☐	☐	q03q8_0a_y	(b)	Bronchitis	q03q8_0b	☐	☐	q03q8_0b_y
(c)	Cataract	q03q8_0c	☐	☐	q03q8_0c_y	(d)	Depression	q03q8_0d	☐	☐	q03q8_0d_y
(e)	Emphysema	q03q8_0e	☐	☐	q03q8_0e_y	(f)	Gall bladder disease	q03q8_0f	☐	☐	q03q8_0f_y
(g)	Gastric, peptic or duodenal ulcer	q03q8_0g	☐	☐	q03q8_0g_y	(h)	Glaucoma	q03q8_0h	☐	☐	q03q8_0h_y
(i)	Gout	q03q8_0i	☐	☐	q03q8_0i_y	(j)	Osteoporosis	q03q8_0j	☐	☐	q03q8_0j_y
(k)	Parkinson's disease	q03q8_0k	☐	☐	q03q8_0k_y	(l)	Pneumonia	q03q8_0l	☐	☐	q03q8_0l_y
(m)	Prostate trouble	q03q8_0m	☐	☐	q03q8_0m_y						

(n) Other conditions, please give details: OFFICE USE

________________________ q03q8_0n_y ________ (year) q03q8_0n ☐☐☐☐

________________________ q03q8_0n2_y ________ (year) q03q8_0n2 ☐☐☐☐

Breathlessness

		Yes	No	
13.0	Do you **ever** get short of breath walking with other people of your own age on level ground?	☐	☐	q03q13_0
13.1	On walking up hill or stairs do you get more breathless than people of your own age?	☐	☐	q03q13_1
13.2	Do you **ever** have to stop walking because of breathlessness?	☐	☐	q03q13_2
13.3	In the **past twelve months** have you at any time been awoken at night by an attack of shortness of breath?	☐	☐	q03q13_3

Weight

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

q03q14_0st _________Stones q03q14_0lb ________ Pounds / or q03q14_0kg ________ Kilograms

(If you have no scales and have made an estimate please tick here ☐) q03q14_0e

		Yes	No
14.1	Have you tried to lose weight in the last four years?	☐	☐
	If **Yes**, did you:		
	Change your diet?	☐	☐
	Take more exercise?	☐	☐

Other (please give details) ___________________________

OFFICE USE ☐

		Yes	No
14.2	Have you been advised by a doctor or other health professional to lose weight in the last four years?	☐	☐

14.3 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

		Yes	No
14.4	**If your weight has changed**		
	-was this change intentional?	☐	☐

-was it the result of:-

- Personal choice ☐1
- Medical advice ☐1
- Illness or ill health ☐1

14.5 Do you consider your present weight to be:-

- about right ☐1
- too high ☐2
- too low ☐3

Disability

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

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

If **Yes,**

	Yes	No
(a) Does this illness or disability limit your activities in any way?	☐	☐
(b) Do you receive a disability allowance?	☐	☐

15.1 Do you currently have difficulty carrying out any of the following activities on your own as a result of a **long term** health problem?

		Yes	No
(a)	Going up or down stairs	☐	☐
(b)	Bending down	☐	☐
(c)	Straightening up	☐	☐
(d)	Keeping your balance	☐	☐
(e)	Going out of the house?	☐	☐
(f)	Walking 400 yards	☐	☐

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

		Yes	No
(a)	Job at work (paid employment)	☐	☐
(b)	Household chores	☐	☐
(c)	Social life	☐	☐
(d)	Sex life	☐	☐
(e)	Interests and hobbies	☐	☐
(f)	Holidays and outings	☐	☐

Eyesight

	Yes	No
16.0 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)?	☐	☐
If **No**, can you see well enough to recognise a friend at a distance of one yard?	☐	☐

Hearing

	Yes	No
17.0 Do you use a hearing aid?	☐	☐
17.1 Using a hearing aid if needed, is your hearing good enough to follow a TV programme at a volume others find acceptable?	☐	☐
If **No**, can you follow a TV programme with the volume turned up?	☐	☐

Your Health Overall

Please indicate which statements best describe your health **TODAY.** (Please tick **only one box**)

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	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
18.3	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

Sleep:-

18.4 On average, how many hours' sleep do you have each night? ☐☐ hours

18.5 On average, how much sleep (if any) do you have during the daytime? ☐☐ hours

18.6	Do you snore while asleep?	Yes, regularly	☐1
		Yes, occasionally	☐2
		No, never	☐3
		Don't know	☐4

18.7 **Health Scale**

We have drawn a health scale (rather like a thermometer) on which perfect health is 100 and very poor health is 0. Please put a cross (**X**) on the scale to reflect how good or bad your health is today.

Worst Imaginable Health State — Best Imaginable Health State

0 — 10 — 20 — 30 — 40 — 50 — 60 — 70 — 80 — 90 — 100

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Physical activity

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

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

(a) How many hours do you normally spend walking (e.g. on errands or for leisure) in an average week? [|] hours

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

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

19.2 How long do you spend cycling in an average week? [|] hours

19.3 Compared with a man who spends four hours on most weekends 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

19.4 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

(a) If you ticked **frequently** please state type of activities:

OFFICE USE [|]

____

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

In winter [|] times

In summer [|] times

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

- Yes ☐
- No ☐

If Yes, on average how many hours per week do you engage in these exercises? [|] hours per week

Cigarette smoking

		Yes	No
20.0	Do you smoke cigarettes at present?	☐	☐

If **Yes**, please answer the following questions:

20.1 How many cigarettes do you smoke a day at present? ☐☐

20.2 If hand-rolled, how much tobacco do you use a week? ☐☐ oz / ☐☐☐ grams

		Yes	No
20.3	Do you want to give up smoking?	☐	☐
20.4	Have you tried to stop smoking?	☐	☐

20.5 Have you been offered any of the following to help you stop smoking?

	Yes	No
(a) Advice from a health professional (e.g. doctor or nurse)	☐	☐
(b) Referral to a stop-smoking clinic	☐	☐
(c) Nicotine replacement treatment (including sprays, patches etc)	☐	☐
(d) Zyban tablets	☐	☐

(e) Other treatment (please specify) ________________________

OFFICE USE ☐

21.0 Have you changed your cigarette smoking habits during the past four years?

No	☐ 1
Yes, increased	☐ 2
Yes, cut down	☐ 3
Yes, given up	☐ 4

21.1 **If you have given up smoking** in the last four years, were any of these factors important?

	Yes	No
(a) Advice from a health professional (e.g. doctor or nurse)	☐	☐
(b) Referral to a stop-smoking clinic	☐	☐
(c) Nicotine replacement treatment (including sprays, patches etc)	☐	☐
(d) Zyban tablets	☐	☐
(e) Illness or ill-health	☐	☐
(f) Cost of cigarettes	☐	☐

(g) Other factors (please specify) ________________________

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Pipe and cigar smoking

		Yes	No
22.0	Do you currently smoke a pipe?	☐	☐
22.1	Do you currently smoke cigars?	☐	☐

Alcohol intake

23.0 Would you describe your present alcohol intake as

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

One drink is **HALF** a pint of beer/lager/cider, a **SINGLE** whisky, gin, etc. 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
- 3-4 drinks ☐3
- 1-2 drinks ☐4

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

23.3 What type of drink do you usually take?

- Beers, Lagers ☐1
- Wines, Sherry ☐2
- Spirits ☐3
- Combination of Beers, Wines or Spirits ☐4
- Low alcohol drinks ☐5

23.4 What is your usual consumption of these alcoholic beverages? Please tick boxes

	PER WEEK					
Type of drink	Never/ hardly ever	Less than 1	1-6	7-13	14-20	21+
Beer or lager (pints)	☐	☐	☐	☐	☐	☐
Red wine (single glass)	☐	☐	☐	☐	☐	☐
White wine (single glass)	☐	☐	☐	☐	☐	☐
Spirits (1 drink/shot)	☐	☐	☐	☐	☐	☐

23.5 Is the alcohol which you drink usually taken (tick whichever applies):-

- before meals ☐1
- with meals ☐1
- after meals ☐1
- separate from meals ☐1

Alcohol Intake continued

23.6 Have you changed your alcohol intake in the last four years?

No	☐1
Yes, increased	☐2
Yes, cut down	☐3
Yes, given up	☐4

23.7 If you have **CUT DOWN** or **GIVEN UP**, was this due to (tick whichever applies):-

Personal choice	☐1	Being on medication	☐1
Doctor's advice	☐1	Financial reasons	☐1
Illness or ill health	☐1	Other	☐1
Health precaution	☐1		

Preventive Health Care

24.0 In what **year** did you last consult a GP about a health problem? ___________

24.1 Have you ever had any of the following

	Yes	No	If **Yes**, year of most recent
(a) Blood pressure check	☐	☐	________
(b) Blood cholesterol check	☐	☐	________
(c) Flu vaccination	☐	☐	________
(d) Dental check	☐	☐	________
(e) Foot care from a chiropodist	☐	☐	________

24.2 Approximately, how many times in the **last twelve months** have you consulted your GP about a health problem? ☐☐ times

Questions about medicines

	Yes	No	
25.0 Do you take any regular medication?	☐	☐	
If **Yes**, do you take any of the following medicines regularly?			Year started
(a) Aspirin tablets	☐	☐	________
(b) Treatment for any form of heart disease	☐	☐	________
(c) Treatment to lower blood pressure	☐	☐	________
(d) Treatment to lower blood cholesterol	☐	☐	________

25.1 If you are on treatment to lower your blood cholesterol:-

OFFICE USE

(a) Please give the name of this medicine: ______________________________ ☐☐

(b) Please give the amount you take each day: ______________________________ ☐☐☐
(details of the amount in each tablet should be on the bottle)

Details of ALL medicines

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

	Name of medicine	Reason for taking (if you know)	Date started	Is this prescribed? Yes	No	OFFICE USE
1				☐	☐	
2				☐	☐	
3				☐	☐	
4				☐	☐	
5				☐	☐	
6				☐	☐	
7				☐	☐	
8				☐	☐	
9				☐	☐	
10				☐	☐	

Present circumstances

27.0 Are you at present:-

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

(a) If you are widowed or divorced/separated, please give the year when this occurred:- ________

27.1 Are you at present:-

living alone	☐ 1
living with a partner or spouse	☐ 2
living with other family member(s)	☐ 3
living with other people	☐ 4

27.2 Your accommodation
Are you:-

an owner occupier	☐ 1
renting from the local authority	☐ 2
renting privately	☐ 3
living in a residential home	☐ 4
living in a nursing home	☐ 5
other (please give details)	☐ 6

____

27.3 During the winter, is your accommodation usually:

Very warm	☐ 1
Warm	☐ 2
Medium	☐ 3
Cold	☐ 4
Very cold	☐ 5

		Yes	No
27.4	Do you have a car available for your own use?	☐	☐
27.5	Are you currently in full-time paid employment?	☐	☐
27.6	Do you have private medical insurance?	☐	☐
27.7	Have you ever had private medical treatment?	☐	☐

Activities of daily living

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

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

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

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

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

28.2 Can you, when standing, bend down and pick up a shoe from the floor?

Yes ☐
No ☐

29.0 Please indicate if you have difficulty doing any of the following activities:	No difficulty	Some difficulty	Unable to do or need help
Reaching or extending your arms above shoulder level	☐	☐	☐
Pulling or pushing large objects like a living room chair	☐	☐	☐
Walking across a room	☐	☐	☐
Getting in and out of bed on your own?	☐	☐	☐
Getting in and out of a chair on your own?	☐	☐	☐
Dressing and undressing yourself on your own?	☐	☐	☐
Bathing or showering?	☐	☐	☐
Feeding yourself, including cutting food?	☐	☐	☐
Getting to and using the toilet on your own?	☐	☐	☐
Lifting and carrying something as heavy as 10 lbs, for example a bag of groceries	☐	☐	☐
Shopping for personal items such as toilet items or medicine by yourself	☐	☐	☐
Doing light housework such as washing up	☐	☐	☐
Preparing your own meals by yourself	☐	☐	☐
Using the telephone by yourself	☐	☐	☐
Taking medications by yourself	☐	☐	☐
Managing money (e.g. paying bills etc)	☐	☐	☐
Using public transport on your own	☐	☐	☐
Driving a car on your own	☐	☐	☐

Time spent on various activities

30.0 Approximately how many **hours each week** (if any) do you spend:

			Tick box if you never do
Looking after wife/partner?	☐☐	hours per week	☐
Looking after other adult family member or friend?	☐☐		☐
Looking after grandchildren?	☐☐		☐
In paid work?	☐☐	hours per week	☐
In voluntary work?	☐☐		☐
On housework?	☐☐	hours per week	☐
On gardening?	☐☐		☐
In a pub or club?	☐☐	hours per week	☐
Attending religious services?	☐☐		☐
Playing cards, games, or bingo?	☐☐	hours per week	☐
Visiting the cinema/restaurants/sporting events?	☐☐		☐
Watching television/videos?	☐☐	hours per week	☐
Reading?	☐☐		☐
Attending class or course of study?	☐☐		☐

31.0 Do you go on day or overnight trips…

Never ☐1
Sometimes ☐2
Often ☐3

31.1 Have you been on holiday in the last year? Yes ☐ No ☐

Thank you very much for completing the questionnaire.

Please return it to us, along with the blue consent form, in the envelope provided.

No stamp is needed.