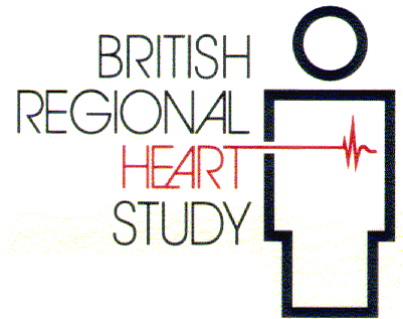




UCL



British Regional Heart Study **Activity Survey: Questionnaire**

This questionnaire asks about your health, activity and things which may affect the amount of activity you do.

Please complete this questionnaire as soon as is convenient and return it along with the red monitor and blue activity log at the end of the week. A pre-paid envelope is provided.

It is important that we receive this package as soon as possible after you have had the monitor for seven days.

All the information that you provide will be treated as strictly confidential and will only be seen by the Research Team.

If you have any questions about this survey, please phone us on 020 7830 2335.

Thank you very much for your help.

British Regional Heart Study
Department of Primary Care & Population Health
UCL Medical School
Royal Free Campus
Rowland Hill Street.
London NW3 2PF
Telephone: 020 7830 2335

<http://www.ucl.ac.uk/pcph/research-groups-themes/brhs-pub>

DATES

1.0 Please enter today's date:// 20.....
 Day / Month / Year

1.1 Please enter your date of birth// 19.....
 Day / Month / Year

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

YOUR CURRENT HEALTH

2.0 In the **past year**, have you been told by a doctor that you have or have had any of the following conditions?

		Yes	No
a	Heart attack (coronary thrombosis or myocardial infarction)	<input type="checkbox"/>	<input type="checkbox"/>
b	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
c	Angina	<input type="checkbox"/>	<input type="checkbox"/>
d	Other heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
e	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
f	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
g	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
h	Arthritis affecting knees, hips or feet	<input type="checkbox"/>	<input type="checkbox"/>
i	Narrowing or hardening of the leg arteries(including claudication)	<input type="checkbox"/>	<input type="checkbox"/>
j	Chest trouble (eg bronchitis or emphysema)	<input type="checkbox"/>	<input type="checkbox"/>
k	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
l	Depression	<input type="checkbox"/>	<input type="checkbox"/>
m	Cancer	<input type="checkbox"/>	<input type="checkbox"/>

SMOKING & DRINKING

	Yes	No
3.0 Do you currently smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>
3.1 Do you currently smoke cigars or a pipe?	<input type="checkbox"/>	<input type="checkbox"/>
3.2 In the past week, how many units of alcohol have you drunk? (1 unit is half a pint of beer, a glass of wine or sherry, or a measure of spirits)	_____	units/week

WEIGHT

4.0 What is your present weight(indoor clothes, without shoes)?
 _____ Stones _____ Pounds or _____ Kilograms

4.1 If you have no scales and have made an estimate please tick here _1

	Yes	No
4.2 If you have lost weight in the past year, was it intentional?	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate which statements best describe your health in the **past week**

(tick **one** answer for each question)

5.0 **General Health**

Excellent ₁

Good ₂

Fair ₃

Poor ₄

5.1 **Pain / discomfort**

I have no pain or discomfort ₁

I have moderate pain or discomfort ₂

I have extreme pain or discomfort ₃

5.2 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

5.3 **Self Care**

I have no problems with washing and dressing ₁

I have some problems with washing and dressing myself ₂

I am unable to wash or dress myself ₃

5.4 **Mobility**

I have no problems walking about ₁

I have some problems walking about ₂

I am confined to a chair /wheelchair ₃

5.5 **Anxiety/Depression:-**

I am not anxious or depressed ₁

I am moderately anxious and /or depressed ₂

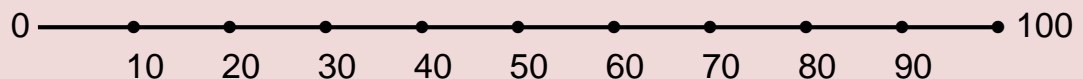
I am extremely anxious and /or depressed ₃

5.6 **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

LONGSTANDING ILLNESS OR DISABILITY**Yes No**6.0 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

6.1 If **YES**, does this illness or disability limit your activities in any way? 7.0 Please indicate if you have difficulty doing any of the following activities: (tick **one** box)

	No Difficulty	Some Difficulty	Unable to do or need help
	1	2	3
a Reaching or extending your arms above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Pulling or pushing large objects like a living room chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Walking across a room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Getting in and out of bed on your own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e Getting in and out of a chair on your own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Dressing and undressing yourself on your own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g Bathing or showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h Feeding yourself, including cutting food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i Getting to and using the toilet on your own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j Lifting and carrying something as heavy as 10 lbs (eg a bag of groceries)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k Shopping for personal items such as toilet items or medicine by yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l Doing light housework such as washing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m Preparing your own meals by yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n Using the telephone by yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o Taking medications by yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p Managing money (e.g. paying bills etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q Using public transport on your own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r Driving a car on your own.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s Gripping with hands (eg opening a jam jar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.0	How would you rate your hand grip strength compared to other people your age?								
	<table style="width: 100%; text-align: center;"> <tr> <td>Very good ¹</td> <td>Good ²</td> <td>Fair ³</td> <td>Poor ⁴</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Very good ¹	Good ²	Fair ³	Poor ⁴	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Very good ¹	Good ²	Fair ³	Poor ⁴						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

MOBILITY

9.0 Do you currently have difficulty carrying out any of the following activities on your own as a result of a **long term** health problem? (tick **one** box for each statement)

	No difficulty 1	Yes, a little difficulty 2	Yes, a lot of difficulty 3
a	Going up or down stairs	<input type="checkbox"/>	<input type="checkbox"/>
b	Bending down	<input type="checkbox"/>	<input type="checkbox"/>
c	Straightening up	<input type="checkbox"/>	<input type="checkbox"/>
d	Keeping your balance	<input type="checkbox"/>	<input type="checkbox"/>
e	Going out of the house	<input type="checkbox"/>	<input type="checkbox"/>
f	Walking 400 yards	<input type="checkbox"/>	<input type="checkbox"/>

9.1 Thinking about the last seven days, on which days (if any) did you go out of your house? (tick **all** that apply, it doesn't matter if you were wearing the monitor or not)

Monday	<input type="checkbox"/> ₁	Friday	<input type="checkbox"/> ₁
Tuesday	<input type="checkbox"/> ₁	Saturday	<input type="checkbox"/> ₁
Wednesday	<input type="checkbox"/> ₁	Sunday	<input type="checkbox"/> ₁
Thursday	<input type="checkbox"/> ₁		

I did not go out of the house in the last seven days ₁

9.2 Do you have any difficulties getting about outdoors? (tick **one** box only)

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

9.3 Do you use any mobility aids? Yes No

9.4 If **YES**, which aids or appliances do you use to help with day to day activities?:

Walking stick <input type="checkbox"/> ₁	Toilet raised seat <input type="checkbox"/> ₁
Walking frame <input type="checkbox"/> ₁	Bath board/shower <input type="checkbox"/> ₁
Push wheelchair <input type="checkbox"/> ₁	Extra rails in bathroom <input type="checkbox"/> ₁
Electric wheelchair or mobility scooter <input type="checkbox"/> ₁	Stair lift <input type="checkbox"/> ₁

HOSPITALISATION

10.0 How many times in the past 12 months have you been admitted to a hospital (ie stayed in overnight)? _____

FALLS & DIZZINESS

11.0 Have you had a fall in the past 12 months? Yes No

11.1 If **YES**, How many falls have you had in past 12 months? _____ falls
 Yes No

11.2 Did you receive medical attention for any of these falls? Yes No

11.3 Did you suffer any of the following:

- a Cuts and bruises ₁
- b Damage to muscle or ligament ₁
- c Broken or fractured **hip** bone ₁
- d Broken or fractured **wrist** bone ₁
- e **Other** Broken or fractured bone(s) ₁

11.4 At the present time, are you afraid that you may fall over? (tick **one** box)

Very fearful

₁

Somewhat fearful

₂

Not fearful

₃

Yes No

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

GENERAL FITNESS

Can you do any of the following activities?

Yes No

12.0 Run a short distance Yes No

12.1 Do heavy work around the house
(eg lift & moving heavy furniture) Yes No

12.2 Do gardening
(eg raking leaves, weeding & pushing the lawn mower) Yes No

12.3 Participate in moderate activities
(eg golf, bowling, dancing or doubles tennis) Yes No

12.4 Participate in strenuous sports
(eg swimming or singles tennis) Yes No

12.6 Have sexual relations Yes No

PHYSICAL ACTIVITY

- 13.0 Do you make regular journeys every day or most days either walking or cycling?
(tick **one** box)
- No ₁
Walking ₂
Cycling ₃
Both ₄

- 13.1 How many hours do you normally spend walking (eg. on errands or for leisure) in an average week?

_____ Hours/week in winter _____ Hours/week in summer

- 13.2 Which of the following best describes your usual walking pace? Slow ₁
Steady average ₂
Fast ₃

- 13.3 How long do you spend cycling in an average week?

_____ Hours/week in Winter _____ Hours/week in Summer

- 13.4 On a normal day, how many times do you climb a flight of stairs _____
(assuming that 1 flight of stairs has 10 steps)? ₁ None

- 13.5 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

- 13.6 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

- 13.7 If you ticked **frequently**, please list the types of activities:

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

_____ times /month in Winter _____ times /month in Summer

		Yes	No
13.9	Do you engage in exercises to increase muscle strength and endurance such as lifting weights, doing push-ups, using exercise machines?	<input type="checkbox"/>	<input type="checkbox"/>
13.10	If YES , on average, how much time do you engage in these exercises? _____ hours _____ minutes each week		
		Yes	No
13.11	Do you regularly walk a dog at the moment?	<input type="checkbox"/>	<input type="checkbox"/>
13.12	On a normal day, how many hours do you spend sitting (eg to eat, read, watch TV) or lying down, excluding your night time sleep? _____ hours/day	<input type="checkbox"/>	₁ None
13.13	On a normal day, how much time do you spend watching television (including videos and DVDs)? _____ hours _____ minutes/day	<input type="checkbox"/>	₁ None

STRENGTHENING EXERCISES

We are interested to know about activities that you do, either through exercise or part of your everyday living, that use your muscles.

- 13.14 Thinking back to the past week, on **how many days** did you do activities that you find at least moderately hard work for your muscles? eg -carrying or moving heavy loads (eg carrying shopping or grandchildren, pushing a wheelchair or manual lawn mower), activities that involve stepping and jumping (eg dancing but not walking) or doing exercises (push ups, sit ups, chair aerobics, an exercise routine).

_____ days/ week ₁ Less than one day/ week ₂ Never

BALANCE EXERCISES

Some activities/exercises are good for improving balance and co-ordination.

- 13.15 Thinking back to the past week, on **how many days** did you do activities which help to improve your balance and co-ordination? eg standing on one leg, dance or Tai Chi style exercises

_____ days/ week ₁ Less than one day /week ₂ Never

YOUR FEELINGS

16.0 Please tell us about how you have been feeling in the past week:		Yes	No
a	Are you basically satisfied with your life?	<input type="checkbox"/>	<input type="checkbox"/>
b	Do you feel that your life is empty?	<input type="checkbox"/>	<input type="checkbox"/>
c	Are you afraid that something bad is going to happen to you?	<input type="checkbox"/>	<input type="checkbox"/>
d	Do you feel happy most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
e	Have you dropped many of your activities and interests?	<input type="checkbox"/>	<input type="checkbox"/>
f	Do you prefer to stay at home, rather than going out to do new things?	<input type="checkbox"/>	<input type="checkbox"/>
g	I felt that everything I did was an effort	<input type="checkbox"/>	<input type="checkbox"/>
h	I could not get going	<input type="checkbox"/>	<input type="checkbox"/>

17.0 Please indicate how much you agree with the following statements: (tick <u>one</u> box for each statement)		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
		1	2	3	4	5
a	I enjoy my life overall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	I look forward to things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	I am healthy enough to get out and about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	My family, friends or neighbours would help me if needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	I have social or leisure activities/hobbies that I enjoy doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	I try to stay involved with things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	I am healthy enough to have my independence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	I can please myself what I do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	I feel safe where I live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	I get pleasure from my home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k	I take life as it comes and make the best of things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l	I feel lucky compared to most people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m	I have enough money to pay for household bills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n	I feel lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SHOPPING

	Yes	No	Someone else shops for me
20.0 Do you do most of your shopping (food, household necessities etc) at shops within easy walking distance (less than 15 minutes) of your home?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

20.1 How do you mostly go shopping? (tick **one** box only)

Walking	<input type="checkbox"/> ₁	By bus	<input type="checkbox"/> ₂	Other public transport	<input type="checkbox"/> ₃
Dial a ride	<input type="checkbox"/> ₄	By taxi	<input type="checkbox"/> ₅	Drive myself	<input type="checkbox"/> ₆
A friend/relative drives me	<input type="checkbox"/> ₇	Internet delivery	<input type="checkbox"/> ₈		
I don't go shopping	<input type="checkbox"/> ₉				

TRANSPORT

	Yes	No
21.0 Do you drive a car?	<input type="checkbox"/>	<input type="checkbox"/>

21.1 Which of the following means of transport do you use regularly? (tick **all** that apply)

Car	<input type="checkbox"/> ₁	Public transport	<input type="checkbox"/> ₁
Cycle	<input type="checkbox"/> ₁	Walk	<input type="checkbox"/> ₁
Taxi/ Dial a ride	<input type="checkbox"/> ₁	Not applicable	<input type="checkbox"/> ₁

Thank you very much for completing the questionnaire.
Please return it to us, along with the blue activity log and red monitor,
in the pre-paid envelope provided.