

Health Survey



Stress and Health Study

Phase 11: 2012-13

Department of Epidemiology and Public Health
University College London

Thank you for your continuing participation in our study of stress and health. We would be very grateful if you could complete this further questionnaire which will bring us up to date with any changes to your life circumstances, any new illnesses you may have had, and your use of health services.

As always, the answers to these questions will be kept strictly confidential. The study results will never be in a form which can reveal your identity. All the information you provide will be used for research purposes only.

Why repeat the same questions every time?

Some people ask us why the same questions keep appearing in questionnaires. There are several reasons for this.

- **Some questions are about events** – for example, your date of retirement or changes to your marital status – that might happen to people at any time in the study.
- **Other questions are designed to track changes** in your health or personal circumstances over time.
- **Some questions are about a specific period** – for example, the last 4 weeks or the last 14 days. These questions may look familiar but they are specific to that period before filling in the questionnaire.

Repeating these questions means that the questionnaire looks very long. We apologise for this, but do hope that you understand why it's so important.

Some questions don't apply to everybody. This questionnaire indicates where you need to skip questions, and guides you to the next applicable question.

Most of the questions can be answered by putting a tick in the box next to the answer that applies to you, like this:

Yes

No

or sometimes you have to write a number in the box,

for example

We may contact you to clarify your responses to some questions.

If you have any questions, please call us on freephone 0800 068 1562.

Section 1: About your health

1 Please enter today's date:

Day	Month	Year		
		2	0	1

FDOC

FMOC

FYOC

2 In general would you say your health is:

Please tick one

Excellent

Very good

Good

Fair

Poor

FGENHLTH

3 Compared to one year ago, how would you rate your health in general now?

Please tick one

Much better now than one year ago

Somewhat better now than one year ago

About the same as one year ago

Somewhat worse than one year ago

Much worse than one year ago

FHLTHNOW

4 The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

Please tick one box for each question

Yes, limited a lot	Yes, limited a little	No, not limited at all
--------------------------	-----------------------------	------------------------------

(a) Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports

1	2	3
---	---	---

FACTIV01

(b) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf

1	2	3
---	---	---

FACTIV02

(c) Lifting or carrying groceries

1	2	3
---	---	---

FACTIV03

(d) Climbing several flights of stairs

1	2	3
---	---	---

FACTIV04

(e) Climbing one flight of stairs

1	2	3
---	---	---

FACTIV05

(f) Bending, kneeling or stooping

1	2	3
---	---	---

FACTIV06

(g) Walking more than one mile

1	2	3
---	---	---

FACTIV07

(h) Walking half a mile

1	2	3
---	---	---

FACTIV08

(i) Walking one hundred yards

1	2	3
---	---	---

FACTIV09

(j) Bathing and dressing yourself

1	2	3
---	---	---

FACTIV10

5 During the **past four weeks** have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

Please tick one answer for each question

Yes No

- | | | | |
|---|----------------------------|----------------------------|----------------|
| (a) Cut down the amount of time you spent on work or other activities | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | FNKHL01 |
| (b) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | FNKHL02 |
| (c) Were limited in the kind of work or other activities you could do | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | FNKHL03 |
| (d) Had difficulty performing your work or other activities (for example, it took extra effort) | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | FNKHL04 |

6 During the **past four weeks** have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

Please tick one answer for each question

Yes No

- | | | | |
|---|----------------------------|----------------------------|----------------|
| (a) Cut down the amount of time you spent on work or other activities | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | FNKEM01 |
| (b) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | FNKEM02 |
| (c) Didn't do work or other activities as carefully as usual | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | FNKEM03 |

7 During the **past four weeks** to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups?

Please tick one

- | | | |
|-------------|----------------------------|---------------|
| Not at all | <input type="checkbox"/> 1 | FHLSOC |
| Slightly | <input type="checkbox"/> 2 | |
| Moderately | <input type="checkbox"/> 3 | |
| Quite a bit | <input type="checkbox"/> 4 | |
| Extremely | <input type="checkbox"/> 5 | |

8 How much **bodily** pain have you had during the **past four weeks**?

Please tick one

- None 1
- Very mild 2
- Mild 3
- Moderate 4
- Severe 5
- Very severe 6

FBODPAIN

9 During the **past four weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

Please tick one

- Not at all 1
- A little bit 2
- Moderately 3
- Quite a bit 4
- Extremely 5

FPAININT

10 How much of the time during the **past four weeks**:

Please tick one box for each question

	All of the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	None of the time	
(a) Did you feel full of life?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FTIME01
(b) Have you been a very nervous person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FTIME02
(c) Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FTIME03
(d) Have you felt calm and peaceful?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FTIME04
(e) Did you have a lot of energy?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FTIME05
(f) Have you felt downhearted and low?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FTIME06
(g) Did you feel worn out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FTIME07
(h) Have you been a happy person?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FTIME08
(i) Did you feel tired?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FTIME09

11 During the **past four weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc)?

Please tick one answer

All of the time	Most of the time	Some of the time	A little bit of the time	None of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5

FHLEMSOC

12 Please choose the answer that best describes how **true or false** each of the following statements is for you:

Please tick one box for each question

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false	
(a) I seem to get sick a little easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FSICKSEAS
(b) I'm as healthy as anyone I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FHLTHAN
(c) I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FHLTHWRS
(d) My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FHLTHEXC

Medical consultation

13 How many times have you consulted your GP in the last 12 months?

Enter number

FGPVISYR

14 **(a)** Do you have any longstanding illnesses, diseases or medical conditions for which you have sought treatment in the last 12 months? (Longstanding means anything that has troubled you over a period of time or that is likely to affect you over a period of time).

Yes

No

Go to **15 (a)**

FLONGI

(b) If yes, please list below

(i)

FLONGIL1

(vi)

FLONGIL6

(ii)

FLONGIL2

(vii)

FLONGIL7

(iii)

FLONGIL3

(viii)

FLONGIL8

(iv)

FLONGIL4

(ix)

FLONGIL9

(v)

FLONGIL5

(x)

FLONGIL10

15

(a) This question concerns any medicines that you may have taken during the last fourteen days. Have you been taking any medicines, tablets, tonics or pills within the last fourteen days? You may want to check your medicine bottles, pill box or prescription sheet for the exact name.

FPRESDOC

Yes 1

No 2

→ Go to **16 (a)**

(b) If yes, please list any medicines below

Was this prescribed by a doctor?

And the reasons for taking them

(i)

FPRDRG1

Yes No

1 2

FPRESDC1

(ii)

FPRDRG2

Yes No

1 2

FPRESDC2

(iii)

FPRDRG3

Yes No

1 2

FPRESDC3

(iv)

FPRDRG4

Yes No

1 2

FPRESDC4

(v)

FPRDRG5

Yes No

1 2

FPRESDC5

(vi)

FPRDRG6

Yes No

1 2

FPRESDC6

(vii)

FPRDRG7

Yes No

1 2

FPRESDC7

(viii)

FPRDRG8

Yes No

1 2

FPRESDC8

FPRDRG9

FPRESDC9

FPRDR10

FPRESDC10

FPRDR11

FPRESDC11

FPRDR12

FPRESDC12

FPRDR13

FPRESDC13

FPRDR14

FPRESDC14

FPRDR15

FPRESDC15

Chest pain and other aspects of heart disease

16 (a) Since January 2008 have you had any pain or discomfort in your chest?

Yes 1

No 2

Go to **18** **FCHPAIN**

(b) If yes:

Do you get this pain or discomfort when you walk uphill or hurry?

Yes 1

FCHPUPH

No 2

(c) Do you get it when you walk at an ordinary pace on the level?

Yes 1

FCHPLEV

No 2

(d) When you get any pain or discomfort in your chest, what do you do?

Please tick one

Stop 1

FCHPACT

Slow down 2

Continue at the same pace 3

(e) Does it go away when you stand still?

Yes 1

FCHPSTOP

No 2 → Go to **(g)**

(f) If yes, how soon?

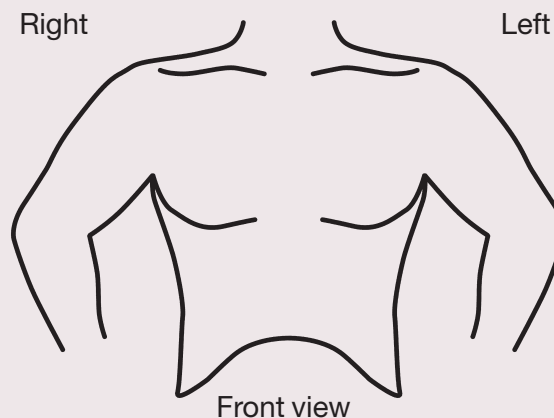
Please tick one

In 10 minutes or less 1

FCHPTIME

More than 10 minutes 2

(g) Where do you get this pain or discomfort? Mark the place(s) with an **X** on the diagram.



FCHPSIT1 ...- ... FCHPSIT9

17 (a) Since January 2008 have you had a severe pain across the front of your chest lasting half an hour or more?

Yes 1

No 2 → Go to **18**

FCHPEXT



(b) If yes:
Did you talk to a doctor about it?

Yes 1

FCHPDOC

No 2 → Go to **18**

(c) If yes:
What did he/she say it was?

FCHPDIAG

Tests and treatments

18 These questions concern any **test(s)** or **treatment(s)** you may have had for chest pain or heart disease.

Since January 2008 have you had any of the following? (Please answer Yes or No to each question)

If yes: Please give year, hospital and town for each occasion.

(a) An exercise/stress ECG heart tracing whilst walking or running on a treadmill (not as part of the Stress & Health Study)

FEXECCG

	Year since 2008	Hospital name, Town				
Yes <input type="checkbox"/>	<table border="1"><tr><td>2</td><td>0</td><td></td><td></td></tr></table>	2	0			<div style="border: 1px solid black; height: 60px;"></div>
2	0					
No <input type="checkbox"/>	FEXECCGY1					

	Year since 2008	Hospital name, Town				
	<table border="1"><tr><td>2</td><td>0</td><td></td><td></td></tr></table>	2	0			<div style="border: 1px solid black; height: 60px;"></div>
2	0					
	FEXECCGY2					

(b) Angiogram or X-ray of your coronary arteries (a dye test of the arteries)

FAGRAM

	Year since 2008	Hospital name, Town				
Yes <input type="checkbox"/>	<table border="1"><tr><td>2</td><td>0</td><td></td><td></td></tr></table>	2	0			<div style="border: 1px solid black; height: 60px;"></div>
2	0					
No <input type="checkbox"/>	FAGRAMY1					

	Year since 2008	Hospital name, Town				
	<table border="1"><tr><td>2</td><td>0</td><td></td><td></td></tr></table>	2	0			<div style="border: 1px solid black; height: 60px;"></div>
2	0					
	FAGRAMY2					

(c) Angioplasty of coronary arteries (balloon treatment for angina) or insertion of a stent

FAPLAS

	Year since 2008	Hospital name, Town				
Yes <input type="checkbox"/>	<table border="1"><tr><td>2</td><td>0</td><td></td><td></td></tr></table>	2	0			<div style="border: 1px solid black; height: 60px;"></div>
2	0					
No <input type="checkbox"/>	FAPLASY1					

	Year since 2008	Hospital name, Town				
	<table border="1"><tr><td>2</td><td>0</td><td></td><td></td></tr></table>	2	0			<div style="border: 1px solid black; height: 60px;"></div>
2	0					
	FAPLAS2					

(d) Coronary artery bypass graft (CABG) operation

FCABG

Year since 2008

Yes 1

2	0		
---	---	--	--

No 2

FCABGY1

Hospital name, Town

--

Year since 2008

2	0		
---	---	--	--

FCABGY2

Hospital name, Town

--

(e) An admission to hospital with chest pain, angina or heart attack

FADMCH

Year since 2008

Yes 1

2	0		
---	---	--	--

No 2

FADMCHY1

Hospital name, Town

--

Year since 2008

2	0		
---	---	--	--

FADMCHY2

Hospital name, Town

--

(f) Other heart tests or operations, or admissions to hospital for other heart trouble (not as part of the Stress and Health Study).

FOHTOA

Year since 2008

Yes 1

2	0		
---	---	--	--

No 2

FOHTOAY1

Hospital name, Town

--

If yes to (f), please specify (for example, 24 hour ECG, pacemaker, thallium scan, echocardiogram, or resting ECG **not** done as part of the Stress & Health study)

FOHTOAT1 ...-... FOHTOAT9

19

(a) Since January 2008 has a doctor told you that you have had angina?

FANG

Yes 1 Month Year since 2008
 No 2 2 0 FANGM FANGY

(b) Since January 2008 has a doctor told you that you have had a heart attack (myocardial infarct/coronary thrombosis)?

FMI

Yes 1 Month Year since 2008
 No 2 2 0 FMIM FMIY

(c) Since January 2008 have you had any other heart trouble suspected or confirmed? (For example, valve disease, congenital heart disease or irregular heartbeat.)

FOHT

Yes 1 Month Year since 2008
 No 2 2 0 FOHTM FOHTY

If yes, please specify

FOHTDX1 FOHTDX4

20

(a) Have you been admitted to hospital (including as a day case) in the last 12 months? (this excludes outpatient appointments)

Yes 1 No 2 → Go to FHSADMYR

(b) If yes, please specify the number of times:

Enter number FHSADMNO

and the reason for hospitalisation(s) and the dates:

Cause 1	FHS1RSN	Month	Year
		<input type="text"/> <input type="text"/>	2 0 1 <input type="text"/>
		FHS1MNTH	FHS1YR
Cause 2	FHS2RSN	Month	Year
		<input type="text"/> <input type="text"/>	2 0 1 <input type="text"/>
		FHS2MNTH	FHS2YR
Cause 3	FHS3RSN	Month	Year
		<input type="text"/> <input type="text"/>	2 0 1 <input type="text"/>
		FHS3MNTH	FHS3YR
Cause 4	FHS4RSN	Month	Year
		<input type="text"/> <input type="text"/>	2 0 1 <input type="text"/>
		FHS4MNTH	FHS4YR

21 (a) Since January 2008 have you been told by a doctor that you have had a stroke or transient ischaemic attack (mini stroke/TIA)?

Yes 1 **FSTROKE**

No 2

Don't know 3 → Go to **22**

(b) If yes, was it:

Please tick one

Stroke 1 **FSTRDIAG**

Transient Ischaemic Attack (mini stroke/TIA) 2

Other (please specify) 3

(c) If yes, please give the month, year, GP practice/hospital name and town

Month	Year since 2008	GP practice/Hospital name, Town
<input type="text"/>	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/>	<div style="border: 1px solid black; height: 50px;"></div>
FSTRKM1	FSTRKY1	

Month	Year since 2008	GP practice/Hospital name, Town
<input type="text"/>	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/>	<div style="border: 1px solid black; height: 50px;"></div>
FSTRKM2	FSTRKY2	

General health questions

Please read this carefully. We should like to know if you have had any medical complaints, and how your health has been in general **over the past few weeks**. Please answer **ALL** questions on the following pages simply by indicating the answer which you think most nearly applies to you. Remember that we want to know about your **present** and **recent** complaints, not those you had in the past. It is important that you try to answer **ALL** the questions.

Have you recently...

Please tick one box for each question

	Better than usual	Same as usual	Rather less than usual	Much less than usual	
22 Been able to concentrate on whatever you're doing?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ01
23 Lost much sleep over worry?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ02
24 Been having restless, disturbed nights?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ03
25 Been managing to keep yourself busy and occupied?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ04
26 Been getting out of the house as much as usual?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ05
27 Been managing as well as most people would in your shoes?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ06
28 Felt on the whole you were doing things well?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ07
29 Been satisfied with the way you've carried out your task(s)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ08

30	Been able to feel warmth and affection for those near to you?	Better than usual <input type="checkbox"/> 1	About the same as usual <input type="checkbox"/> 2	Less well than usual <input type="checkbox"/> 3	Much less well <input type="checkbox"/> 4	FGHQ09
31	Been finding it easy to get on with other people?	Better than usual <input type="checkbox"/> 1	About the same as usual <input type="checkbox"/> 2	Less well than usual <input type="checkbox"/> 3	Much less well <input type="checkbox"/> 4	FGHQ10
32	Spent much time chatting with people?	More time than usual <input type="checkbox"/> 1	About the same as usual <input type="checkbox"/> 2	Less time than usual <input type="checkbox"/> 3	Much less than usual <input type="checkbox"/> 4	FGHQ11
33	Felt that you are playing a useful part in things?	More so than usual <input type="checkbox"/> 1	Same as usual <input type="checkbox"/> 2	Less useful than usual <input type="checkbox"/> 3	Much less useful <input type="checkbox"/> 4	FGHQ12
34	Felt capable of making decisions about things?	More so than usual <input type="checkbox"/> 1	Same as usual <input type="checkbox"/> 2	Less so than usual <input type="checkbox"/> 3	Much less capable <input type="checkbox"/> 4	FGHQ13
35	Felt constantly under strain?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ14
36	Felt you couldn't overcome your difficulties?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ15
37	Been finding life a struggle all the time?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ16
38	Been able to enjoy your normal day-to-day activities?	More so than usual <input type="checkbox"/> 1	Same as usual <input type="checkbox"/> 2	Less so than usual <input type="checkbox"/> 3	Much less than usual <input type="checkbox"/> 4	FGHQ17
39	Been taking things hard?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ18

40	Been getting scared or panicky for no good reason?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ19
41	Been able to face up to your problems?	More so than usual <input type="checkbox"/> 1	Same as usual <input type="checkbox"/> 2	Less able than usual <input type="checkbox"/> 3	Much less able <input type="checkbox"/> 4	FGHQ20
42	Found everything getting on top of you?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ21
43	Been feeling unhappy and depressed?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ22
44	Been losing confidence in yourself?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ23
45	Been thinking of yourself as a worthless person?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ24
46	Felt that life is entirely hopeless?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ25
47	Been feeling hopeful about your own future?	More so than usual <input type="checkbox"/> 1	About the same as usual <input type="checkbox"/> 2	Less so than usual <input type="checkbox"/> 3	Much less hopeful <input type="checkbox"/> 4	FGHQ26
48	Been feeling reasonably happy, all things considered?	More so than usual <input type="checkbox"/> 1	About the same as usual <input type="checkbox"/> 2	Less so than usual <input type="checkbox"/> 3	Much less than usual <input type="checkbox"/> 4	FGHQ27
49	Been feeling nervous and strung-up all the time?	Not at all <input type="checkbox"/> 1	No more than usual <input type="checkbox"/> 2	Rather more than usual <input type="checkbox"/> 3	Much more than usual <input type="checkbox"/> 4	FGHQ28

		Not at all	No more than usual	Rather more than usual	Much more than usual	
50	Felt that life isn't worth living?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ29

		Not at all	No more than usual	Rather more than usual	Much more than usual	
51	Found at times you couldn't do anything because your nerves were too bad?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	FGHQ30

52 Here are a few everyday activities. Please tell us if you have any difficulties with these because of a physical, mental, emotional or memory problem. Exclude any difficulties you expect to last less than **three months**.

	Yes	No	
(a) Dressing, including putting on shoes and socks	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL1
(b) Walking across a room	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL2
(c) Bathing or showering	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL3
(d) Eating, such as cutting up your food	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL4
(e) Getting in or out of bed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL5
(f) Using the toilet, including getting up or down	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL6
(g) Using a map to figure out how to get around in a strange place	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL7
(h) Preparing a hot meal	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL8
(i) Shopping for groceries	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL9
(j) Making telephone calls	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL10
(k) Taking medication	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL11
(l) Doing work around the house or garden	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL12
(m) Managing money, such as paying bills and keeping track of expenses	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL13
(n) Controlling bowel and bladder completely by yourself	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL14
(o) Doing personal laundry completely	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL15
(p) Travelling independently on public transport or drive own car	<input type="checkbox"/> 1	<input type="checkbox"/> 2	FADL16

Please indicate how well each of the following describes you.

Please tick one box on each line

	A lot	Some	A little	Not at all	
(a) Outgoing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI01
(b) Helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI02
(c) Moody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI03
(d) Organised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI04
(e) Self-confident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI05
(f) Friendly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI06
(g) Warm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI07
(h) Worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI08
(i) Responsible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI09
(j) Forceful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI10
(k) Lively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI11
(l) Caring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI12
(m) Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI13
(n) Creative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI14
(o) Assertive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI15
(p) Hardworking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI16
(q) Imaginative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI17
(r) Softhearted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI18
(s) Calm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI19
(t) Outspoken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI20
(u) Intelligent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI21
(v) Curious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI22
(w) Active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI23
(x) Careless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI24
(y) Broad-minded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI25
(z) Sympathetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI26
(za) Talkative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI27
(zb) Sophisticated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI28
(zc) Adventurous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI29
(zd) Dominant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FMIDI30

54 Over the last **12 months** would you say your health has been?

Please tick one

Very good 1

Good 2

Average 3

Poor 4

Very poor 5

FHLTHYR

55 How many hours of sleep do you have on an average week-night?

Please tick one

5 hours or less 1

6 hours 2

7 hours 3

8 hours 4

9 hours or more 5

FSLEEP

56 How often in the **past month** did you:

Please tick one box for each question

	Not at all	1-3 days	4-7 days	8-14 days	15-20 days	21-31 days	
(a) Have trouble falling asleep?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FSLPFALL
(b) Wake up several times per night?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FSLWAKS
(c) Have trouble staying asleep (including waking far too early)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FSLPSTAY
(d) Wake up after your usual amount of sleep feeling tired and worn out?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FSLPWAK
(e) Have disturbed or restless sleep?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FSLPDIST

57**(a) Do you doze or take a nap anytime during the day or before you go to bed?**Yes 1**FSLPNAP**No 2 → Go to **58****(b) If yes, does this happen:**

Please tick one

About once a week or less 1Two or three times per week 2Once every day 3Two or more times per day 4**FSLPNAPF****(c) On average, how long is each nap?**

Please tick one

15 mins or less 130 mins 21 hour 31.5 hours 42 hours or more 5**FSLPNAPL****58****Many people leak urine some of the time. We are trying to find out how many people leak urine, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average over the past four weeks.****(a) How often do you leak urine?**

Please tick one

Never 1 → Go to **59**About once a week or less often 2Two or three times a week 3About once a day 4Several times a day 5All the time 6**FURINF****(b) We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)?**

Please tick one

None 1Small amount 2A moderate amount 3A large amount 4**FURINAM**

(c) Overall, how much does leaking urine interfere with your everyday life?

Please tick a number between 0 (not at all) and 10 (great deal).

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not at all										A great deal

FURININT

(d) When does urine leak?

Please tick all that apply

Never – urine does not leak	<input type="checkbox"/>	FURINWH1
Leaks before you can get to the toilet	<input type="checkbox"/>	FURINWH2
Leaks when you cough or sneeze	<input type="checkbox"/>	FURINWH3
Leaks when you are asleep	<input type="checkbox"/>	FURINWH4
Leaks when you are physically active/exercising	<input type="checkbox"/>	FURINWH5
Leaks when you have finished urinating and are dressed	<input type="checkbox"/>	FURINWH6
Leaks for no obvious reason	<input type="checkbox"/>	FURINWH7
Leaks all the time	<input type="checkbox"/>	FURINWH8

59

(a) Is your eyesight (with your glasses if you wear them):

Please tick one

Excellent	<input type="checkbox"/>
Very good	<input type="checkbox"/>
Good	<input type="checkbox"/>
Fair	<input type="checkbox"/>
Poor	<input type="checkbox"/>

FSIGHT

(b) Is your hearing (with your hearing aids if you use them):

Please tick one

Excellent	<input type="checkbox"/>
Very good	<input type="checkbox"/>
Good	<input type="checkbox"/>
Fair	<input type="checkbox"/>
Poor	<input type="checkbox"/>

FHEAR

To be answered by men only – women please go to Question 61

60 Over the past **six months**:
How do you rate your **confidence** that you could get and keep an erection?

Please tick one

Very low 1

Low 2

Moderate 3

High 4

Very high 5

FCONFER

To be answered by everyone

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

Please tick one answer per row

		Yes	No		If yes, what was the year?	
(a) Osteoarthritis ('wear and tear')	FOST_ART	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	FOST_AYR
(b) Rheumatoid arthritis	FRHE_ART	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	FRHE_AYR
(c) Gout	FGOUT	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	FGOUT_YR
(d) Osteoporosis	FOST_POR	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	FOST_PYR
(e) Diabetes	FDIABET	<input type="checkbox"/> 1	<input type="checkbox"/> 2	Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	FDIABYR

62 (a) Since January 2006 have you broken/fractured a bone?

FFRBEVER

Yes 1

No 2 → Go to **63**

(b) Details of bones broken/ fractured

	Name of bone(s) broken/fractured	Year since 2006				
(i) First injury	FFRB1LO1 FFRB1LO2 FFRB1LO3	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">2</td> <td style="width: 20px; text-align: center;">0</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table> FFRB1YR	2	0		
2	0					

	Name of bone(s) broken/fractured	Year since 2006				
(ii) Second injury	FFRB2LO1 FFRB2LO2 FFRB2LO3	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">2</td> <td style="width: 20px; text-align: center;">0</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table> FFRB1YR	2	0		
2	0					

	Name of bone(s) broken/fractured	Year since 2006				
(iii) Third injury	FFRB3LO1 FFRB3LO2 FFRB3LO3	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">2</td> <td style="width: 20px; text-align: center;">0</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table> FFRB1YR	2	0		
2	0					

(c) Please specify what caused the bone(s) to break/fracture?

Please tick one answer per column

	First injury	Second injury	Third injury
(i) Fall from greater than standing height. (For example, from a chair or stairs)	FFRB1RSN <input type="checkbox"/>	<input type="checkbox"/> 1	FFRB3RSN <input type="checkbox"/>
(ii) Fall from standing height. (For example, walking)	<input type="checkbox"/> 2	FFRB2RSN <input type="checkbox"/> 2	<input type="checkbox"/> 2
(iii) Fall from less than standing height. (For example, getting out of a chair)	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
(iv) Road traffic accident	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
(v) High energy trauma. (For example, sports injury)	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
(vi) Other (<i>please specify</i>)	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6

Section 2: About your lifestyle

Exercise

We would like to know about your activities in your free time and at work that involve physical activity.

63 Thinking about the days of the PAST WEEK.

(a) On average, for how long did you walk outside your home/workplace?

(If you did not walk, please enter zero ('00') in the boxes in each row.)

For example 1 hour 30 minutes, **not** 90 minutes

Hours Minutes

FWLKOUTA

On each weekday

--	--

FWLKOUTB

On each weekend day

--	--

(b) On average, for how long did you cycle?

(If you did not cycle, please enter zero ('00') in the boxes in each row.)

Hours Minutes

FPEDCYCA

On each weekday

--	--

FPEDCYCB

On each weekend day

--	--

64 Other physical activities in the PAST FOUR WEEKS

Please indicate the number of **occasions** and **total time** spent on each of the activities listed. Write in other types of activity not listed, as applicable.

(a) SPORTS AND GAMES

Football
(including coaching,
etc)

Occasions in the past 4 weeks (*please tick one*)

None 1-2 3-4 5-10 11-15 16-20 21+

0 1 2 3 4 5 6

FSOCCERF

Total hours in the past 4 weeks (*please tick one*)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+

0 1 2 3 4 5 6

FSOCCERH

Golf

Occasions in the past 4 weeks (*please tick one*)

None 1-2 3-4 5-10 11-15 16-20 21+

0 1 2 3 4 5 6

FGOLFF

Total hours in the past 4 weeks (*please tick one*)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+

0 1 2 3 4 5 6

FGOLFH

Swimming

Occasions in the past 4 weeks (*please tick one*)

None 1-2 3-4 5-10 11-15 16-20 21+

0 1 2 3 4 5 6

FSWIMF

Total hours in the past 4 weeks (*please tick one*)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+

0 1 2 3 4 5 6

FSWIMH

**Other sports and
games activities for
example, aerobics,
ballroom dancing,
keep fit, jogging,
tennis.**

Other, activity 1 (*please specify*)

FSPORT11 FSPORT12 FSPORT13

Occasions in the past 4 weeks (*please tick one*)

None 1-2 3-4 5-10 11-15 16-20 21+

0 1 2 3 4 5 6

FSPORT1F

Total hours in the past 4 weeks (*please tick one*)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+

0 1 2 3 4 5 6

FSPORT1H

Other sports and games activities for example, aerobics, ballroom dancing, keep fit, jogging, tennis.

Other, activity 2 (please specify)

FSPORT21 FSPORT22 FSPORT23

Occasions in the past 4 weeks (please tick one)

None 1-2 3-4 5-10 11-15 16-20 21+

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

FSPORT2F

Total hours in the past 4 weeks (please tick one)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

FSPORT2H

(b) GARDENING

Weeding, hoeing, pruning (not mowing)

Occasions in the past 4 weeks (please tick one)

None 1-2 3-4 5-10 11-15 16-20 21+

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

FWEEDF

Total hours in the past 4 weeks (please tick one)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

FWEEDH

Manual lawn mowing

Occasions in the past 4 weeks (please tick one)

None 1-2 3-4 5-10 11-15 16-20 21+

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

FMOWF

Total hours in the past 4 weeks (please tick one)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

FMOWH

Other gardening for example, digging, planting, clearing ground, etc

(please specify)

FGARDN11 FGARDN12 FGARDN13

Occasions in the past 4 weeks (please tick one)

None 1-2 3-4 5-10 11-15 16-20 21+

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

FGARDN1F

Total hours in the past 4 weeks (please tick one)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6

FGARDN1H

(c) HOUSEWORK

Carrying heavy shopping

Occasions in the past 4 weeks (*please tick one*)

None 1-2 3-4 5-10 11-15 16-20 21+

0 1 2 3 4 5 6

FCARRYHF

Total hours in the past 4 weeks (*please tick one*)

None 1/2 1-1½ 2-3 4-5 6-10 11+

0 1 2 3 4 5 6

FCARRYHH

Cooking

Occasions in the past 4 weeks (*please tick one*)

None 1-2 3-4 5-10 11-15 16-20 21+

0 1 2 3 4 5 6

FCOOKF

Total hours in the past 4 weeks (*please tick one*)

None 1/2 1-1½ 2-3 4-5 6-10 11+

0 1 2 3 4 5 6

FCOOKH

Hanging out washing

Occasions in the past 4 weeks (*please tick one*)

None 1-2 3-4 5-10 11-15 16-20 21+

0 1 2 3 4 5 6

FHANGWF

Total hours in the past 4 weeks (*please tick one*)

None 1/2 1-1½ 2-3 4-5 6-10 11+

0 1 2 3 4 5 6

FHANGWH

Other housework for example, dusting, ironing, hoovering

Other housework, activity 1 (*please specify*)

FHOUSW11 FHOUSW12 FHOUSW13

Occasions in the past 4 weeks (*please tick one*)

None 1-2 3-4 5-10 11-15 16-20 21+

0 1 2 3 4 5 6

FHOUSW1F

Total hours in the past 4 weeks (*please tick one*)

None 1/2 1-1½ 2-3 4-5 6-10 11+

0 1 2 3 4 5 6

FHOUSW1H

Other housework for example, dusting, ironing, hoovering

Other housework, activity 2 (please specify)

FHOUSW21 FHOUSW22 FHOUSW23

Occasions in the past 4 weeks (please tick one)

None 1-2 3-4 5-10 11-15 16-20 21+
 0 1 2 3 4 5 6

FHOUSW2F

Total hours in the past 4 weeks (please tick one)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+
 0 1 2 3 4 5 6

FHOUSW2H

(d) DO-IT-YOURSELF

Manual car washing

Occasions in the past 4 weeks (please tick one)

None 1-2 3-4 5-10 11-15 16-20 21+
 0 1 2 3 4 5 6

FCARWASF

Total hours in the past 4 weeks (please tick one)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+
 0 1 2 3 4 5 6

FCARWASH

Painting/decorating

Occasions in the past 4 weeks (please tick one)

None 1-2 3-4 5-10 11-15 16-20 21+
 0 1 2 3 4 5 6

FPAIDECF

Total hours in the past 4 weeks (please tick one)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+
 0 1 2 3 4 5 6

FPAIDECH

Other DIY for example, household repairs, woodwork, bricklaying

(please specify)

FDIY11 FDIY12 FDIY13

Occasions in the past 4 weeks (please tick one)

None 1-2 3-4 5-10 11-15 16-20 21+
 0 1 2 3 4 5 6

FDIY1F

Total hours in the past 4 weeks (please tick one)

None 1/2 1-1 1/2 2-3 4-5 6-10 11+
 0 1 2 3 4 5 6

FDIY1H

(e) ADDITIONAL/OTHER Additional/other activity 1 (please specify)

FPHYSA11 FPHYSA12 FPHYSA13

Occasions in the past 4 weeks (please tick one)

None	1-2	3-4	5-10	11-15	16-20	21+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FPHYSA1F

Total hours in the past 4 weeks (please tick one)

None	½	1-1½	2-3	4-5	6-10	11+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FPHYSA1H

Additional/other activity 2 (please specify)

FPHYSA21 FPHYSA22 FPHYSA23

Occasions in the past 4 weeks (please tick one)

None	1-2	3-4	5-10	11-15	16-20	21+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FPHYSA2F

Total hours in the past 4 weeks (please tick one)

None	½	1-1½	2-3	4-5	6-10	11+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FPHYSA2H

65 How many times a week do you engage in vigorous physical activity enough to make you out of breath, and for how long in total? (please specify the activity)

FVIG_OB1 ... FVIG_OB5

Occasions per week (please tick one)

None	1	2	3	4	5	6+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FVIG_OBF

Total hours per week (please tick one)

None	½	1	1½	2	2½	3+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FVIG_OBH

66**Time spent sitting down in the PAST FOUR WEEKS.****(a) In the last four weeks, how much time did you spend sitting down watching TV (including DVDs and videos)?**For example 1 hour 30 minutes, **not** 90 minutes

Hours Minutes

FSITTVA

On each weekday

--	--

FSITTVB

On each weekend day

--	--

(b) In the last four weeks, how much time did you spend sitting down doing any other activity? For example reading, studying, drawing, using a computer, playing video games, driving or sitting in a car, travelling by public transport.

Hours Minutes

FSITOTHA

On each weekday

--	--

FSITOTHB

On each weekend day

--	--

Smoking habits**67****(a) Do you smoke cigarettes now (that is, not cigars or a pipe)?**Yes No → Go to **68**Social/Occasional smoker **FSMOKE****If Yes or Social/Occasional smoker...****(b) How many cigarettes do you smoke per day?**

Enter number

FCIGNUM**68****Do you currently smoke cigars or a pipe?**Yes No **FCGRPIPE**

Drinking habits

69 (a) In the past **12 months** have you taken an alcoholic drink?

Yes 1 → Go to **70**

FDRNKYR

No 2

(b) If **No**, have you always been a non-drinker?

Yes 1

FNONDRNK

No 2 → Go to **72**

(c) If always a non-drinker, which of the following would best describe your main reason(s) for never drinking?

Please tick all that apply

No interest in drinking 1

FNONDRS1

Religion/moral/social objection 2

FNONDRS2

Brought up not to drink 3

FNONDRS3

Drinking is not healthy 4

FNONDRS4

Family members/friends had alcohol problems 5

FNONDRS5

Drinking is a waste of money 6

FNONDRS6

Other (*please specify*) 7

FNONDRS7

Please go to question 79 if you have never drunk alcohol.

70 (a) Have you had an alcoholic drink in the last **seven days**?

Yes 1

FALCWK

No 2 → Go to **71 (a)**

If Yes...

In the last seven days, how many of each of the following drinks have you had?

Please remember that a drink poured at home could be equivalent to 2 or 3 pub measures.

If none, please indicate 0.

(b) Spirits (Whisky, gin, rum, brandy, vodka etc) or liqueurs?

Measures

FSPRTWK

(c) Wine (including sherry, port, vermouth)?

Glasses

FWINEWK

(d) Beer (including lager and cider)?

Pints

FBEERWK

71 Thinking about the past 12 months:

Please tick one box for each question

	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
(a) How often do you have a drink containing alcohol?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKF

	1-2 drinks	3-4 drinks	5-6 drinks	7-9 drinks	10+ drinks	
(b) How many drinks do you have on a typical day when you are drinking?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKNO

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
(c) How often do you have six or more drinks in one occasion?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNK6

72 (a) Have you given up or reduced your alcohol consumption in the past 10 years?

Yes 1 **FALCRED**
 No 2 → Go to **73**

(b) If yes, what were the main reasons:

Please tick all that apply

Illness/medication	<input type="checkbox"/> 1	FALCRED1
Health precaution/To prevent illness	<input type="checkbox"/> 2	FALCRED2
I've had alcohol problems in the past	<input type="checkbox"/> 3	FALCRED3
Pressure/concern from family/friends	<input type="checkbox"/> 4	FALCRED4
To save money	<input type="checkbox"/> 5	FALCRED5
Fewer social occasions involving alcohol consumption	<input type="checkbox"/> 6	FALCRED6
Other (please specify)	<input type="checkbox"/> 7	FALCRED7

73**(a) Have you increased your alcohol consumption in the past 10 years?**Yes **FALCINC**No Go to **74****(b) If yes, what were the main reasons:**

Please tick all that apply

More social occasions involving alcohol **FALCINC1**Less responsibilities **FALCINC2**Bereavement/loneliness **FALCINC3**To get to sleep **FALCINC4**To relieve pain **FALCINC5**To reduce stress/anxiety/depression **FALCINC6**Other (*please specify*) **FALCINC7**

Yes No

74**(a) Have you ever felt that you ought to cut down on your drinking?****FDRNKCUT****(b) Have people annoyed you by criticising your drinking?****FDRNKANN****(c) Have you ever felt bad or guilty about your drinking?****FDRNKGLT****(d) Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?****FDRNKHNG****75****How old were you the first time you had a proper alcoholic drink (a whole drink, not just a sip)?**

Answer in years

FDRNKFST

76

The next sets of questions are about your alcohol consumption across different decades in your life. We realise that these may be difficult for you to answer, but we ask that you try to give the closest approximation as possible. Please complete up to the decade you are currently in and leave the rest blank

How often did you have a drink containing alcohol?

Please tick one box for each question / decade of life

Never Monthly 2-4 times 2-3 times 4+ times
or less or less per month per week per week

When you were...

(a) 16-19 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKF1
(b) 20-29 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKF2
(c) 30-39 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKF3
(d) 40-49 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKF4
(e) 50-59 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKF5
(f) 60-69 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKF6
(g) 70-79 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKF7
(h) 80+ years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNKF8

77

How many drinks did you have on a typical day when you were drinking?

Please tick one box for each question / decade of life

0 drinks/
didn't drink 1-2 3-4 5-6 7-9 10+
drinks drinks drinks drinks drinks drinks

When you were...

(a) 16-19 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FDRNKNO1
(b) 20-29 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FDRNKNO2
(c) 30-39 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FDRNKNO3
(d) 40-49 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FDRNKNO4
(e) 50-59 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FDRNKNO5
(f) 60-69 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FDRNKNO6
(g) 70-79 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FDRNKNO7
(h) 80+ years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	FDRNKNO8

78**How often did you have six or more drinks on one occasion?**

Please tick one box for each question / decade of life

Never Less than monthly Monthly Weekly Daily or almost daily

When you were...

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
(a) 16-19 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNK6_1
(b) 20-29 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNK6_2
(c) 30-39 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNK6_3
(d) 40-49 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNK6_4
(e) 50-59 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNK6_5
(f) 60-69 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNK6_6
(g) 70-79 years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNK6_7
(h) 80+ years	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	FDRNK6_8

Food habits**79****(a) What type of bread do you eat most frequently?**

Please tick one

- White 1
- Wholemeal 2
- Granary or Wheatmeal 3
- Other brown 4
- Both Brown and White 5
- Do not eat bread 6

FBREAD**(b) What type of milk do you most often use?**

Please tick one

- Whole milk 1
- Semi-skimmed 2
- Skimmed/fat free 3
- Channel Islands whole milk 4
- Dried milk 5
- Soya 6
- Other (please specify) 7
- None 8

FMLKUSE

80 How often do you eat fresh fruit or vegetables?

Please tick one

- Seldom or never 1
- Less than once a month 2
- 1-3 times a month 3
- 1-2 times a week 4
- 3-4 times a week 5
- 5-6 times a week 6
- Once a day 7
- 2-3 times daily 8
- 4 or more times daily 9

FFRUITVG

81 Are you trying to lose weight at present?

- Yes 1
- No 2

FDIET

82 Over the past year have you noticed any unexplained weight loss?

- Yes 1
- No 2

FWEILOSS

83 In general, how well are you able to bite or chew food that you eat nowadays? Would you say you have:

Please tick one

- No difficulty 1
- A little difficulty 2
- A fair amount of difficulty 3
- A great amount of difficulty 4

FDENCHEW

84 How many natural teeth do you have? Please count them and write the number in the box. Please include only natural teeth, not false teeth (dentures).

Number of natural teeth

FDTEETHN

Food Frequency Questionnaire

For each food, please tick the box to indicate how often, on average, you have eaten the specified amount during the past 12 months. Please answer all questions and do not leave any lines blank.

If someone helps you with the shopping and cooking you may wish to ask for their help in completing this questionnaire.

(a) Meat, fish, eggs

(Including meat, fish, poultry and eggs eaten in sandwiches)

Average use in the last 12 months

	Amount	Never or less than once/mth	1-3 per mth	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
REDMEAT	Red meat e.g. beef, beef burgers, pork, lamb <i>Medium serving/ one beef burger</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
CHICK	Chicken or other poultry <i>Medium serving</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
BACSAUS	Bacon or sausages <i>Two rashers (bacon)/ Two medium sausages</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
HAMOTH	Ham, corned beef, spam, luncheon meats <i>One medium thick slice</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
LIVER	Liver, liver pate, liver sausages <i>Medium serving</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
FISH	Fish <i>One medium fillet or serving</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
BATFISH	Fried fish in batter <i>One medium fillet</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
FISHFIN	Fish fingers or fish cakes <i>Two pieces</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
EGGS	Eggs as boiled, fried, scrambled, etc <i>One</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9

(b) Cereals

Average use in the last 12 months

	Amount	Never or less than once/mth	1-3 per mth	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
CERRFG	Refined grain ready to eat cereals <i>One bowl</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
CERWHG	Whole grain ready to eat cereals <i>One bowl</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9

(c) Bread

(Including bread eaten in sandwiches)

Average use in the last 12 months

	Amount	Never or less than once/mth	1-3 per mth	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
WHIBRD	White bread and rolls <i>One slice or roll</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
BWHBRD	Brown/wholemeal bread and rolls <i>One slice or roll</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9

(d) Pasta, rice and potatoes**Average use in the last 12 months**

	Amount	Never or less than once/mth	1-3 per mth	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
WHIPASR	White pasta or white rice <i>One cup (pasta) Half a cup (rice)</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
BWHPASR	Wholemeal pasta or brown rice <i>One cup (pasta) Half a cup (rice)</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
RDMPASR	Ready meal with rice or pasta e.g. lasagne <i>One serving</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
BOILPOT	Boiled, mashed or jacket potatoes <i>One medium serving</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
ROFRPOT	Roast potatoes, chips or french fries <i>One medium serving</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
QUIPIZZ	Quiche/pie/pizza <i>One slice</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9

(e) Dairy products and fats**Average use in the last 12 months**

	Amount	Never or less than once/mth	1-3 per mth	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
BUTTER	Butter <i>Teaspoon</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
MARSPRD	Margarine or spreads <i>Teaspoon</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
OLIVOIL	Olive oil <i>Teaspoon</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
OTHOIL	Other oils e.g. sunflower <i>Teaspoon</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
CHEESE	Cheese <i>1oz or 30g piece (matchbox size)</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
FULLFAT	Full fat milk, double or clotted cream <i>One pint</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9
SEMISKM	Semi-skimmed, skimmed, sterilized, dried milk or single cream or yoghurt <i>One pint (milk), Teaspoon (dried milk), Tablespoon (cream), Carton (yoghurt)</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9

(f) Soups, sauces and spreads**Average use in the last 12 months**

	<i>Amount</i>	Never or less than once/mth	1-3 per mth	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
SOUP	Soups (vegetable or meat) <i>Medium soup bowl</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VINAIGR	Salad dressing e.g. French vinaigrette, <i>Tablespoon</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONDIM	Condiments e.g. sauces, tomato ketchup, pickles, marmite <i>Tablespoon</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MAYO	Salad cream, mayonnaise <i>Teaspoon</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(g) Drinks

'Average glass' means 200ml/7oz

'Wine glass means 125ml/4.5oz

Average use in the last 12 months

	<i>Amount</i>	Never or less than once/mth	1-3 per mth	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
WINE	Wine <i>Wine glass</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BEER	Beer, lager or cider <i>Half pint</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LIQUALL	Liqueurs, port, sherry and spirits <i>Liqueurs, port & sherry (50ml). Spirits (25ml)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TEACOFF	Tea or coffee <i>One cup</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHOCDRK	Cocoa, hot chocolate, chicory, ovaltine <i>One cup</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FIZZSQU	Fizzy soft drink or fruit squash <i>Average glass</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LOWCAL	Low calorie or diet fizzy soft drinks <i>Average glass</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FJUICE	Real fruit juice (100%) e.g. orange, apple juice <i>Average glass</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(h) Sweets and snacks**Average use in the last 12 months**

	<i>Amount</i>	Never or less than once/mth	1-3 per mth	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
CRISPS	Crisps or other packet snacks e.g. wotsits, cheese biscuits <i>1 small packet (25g)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONFECT	Pastries, fruit pies, cakes, tarts, sweet biscuits <i>Medium slice/serving</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICECREA	Ice cream <i>One scoop</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHOCWE	Chocolate bars, sweets, toffees <i>One bar or one sweet/ toffee</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
JAM	Jam, marmalade, honey <i>Teaspoon</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUGAR	Sugar added to tea, coffee, cereal <i>Teaspoon</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(i) Fruit and vegetables

Average use in the last 12 months

	Amount	Never or less than once/mth	1-3 per mth	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
FRUITS	Fruits <i>One medium/ one medium serving</i>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>	<input type="text" value="7"/>	<input type="text" value="8"/>	<input type="text" value="9"/>
VEGETS	Vegetables <i>One medium/ one medium serving</i>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>	<input type="text" value="7"/>	<input type="text" value="8"/>	<input type="text" value="9"/>
PEAS/LEGU	Peas and dried legume e.g. beans, peas, baked beans, dried lentils <i>One medium/ one medium serving</i>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>	<input type="text" value="7"/>	<input type="text" value="8"/>	<input type="text" value="9"/>
SOYA	Soya product e.g. tofu, soya meat, vegeburger <i>Medium serving</i>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>	<input type="text" value="7"/>	<input type="text" value="8"/>	<input type="text" value="9"/>
NUTS	Peanuts or other nuts <i>10 whole</i>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>	<input type="text" value="7"/>	<input type="text" value="8"/>	<input type="text" value="9"/>

Section 3: About your life in general

86 (a) Are you married/cohabiting/in a civil partnership?

Yes → Go to **87**

No **FMARCOH**

(b) If not married/cohabiting/in a civil partnership, are you

Please tick one

Single, never married → Go to **87**

Widowed **FNOTMAR**

Divorced

Separated

(c) If widowed/divorced/separated or you have lost a partner – what year did this last happen?

Year

FWDSYEAR

Friends and relatives

87 The following questions concern people in your life who you feel close to and from whom you can obtain support (either emotional or practical) including close relatives and good friends.

Please tick one box for each question

Hardly ever to never Some of the time Often

(a) How often do you feel you lack companionship? **FCOMPAN**

(b) How often do you feel isolated from others? **FISOLATE**

(c) How often do you feel left out? **FLEFTOUT**

(d) How often do you feel in tune with the people around you? **FINTUNE**

88

(a) Are there any relatives outside your household with whom you have regular contact (either by visit, telephone, e-mail or letters)? (Not necessarily the same person each time)

Please tick one

Almost daily 1

About once a week 2

About once a month 3

Once every few months 4

Never/Almost never 5

No relatives outside household 6 → Go to **89**

FCONREL

(b) How often do you regularly visit or are visited by these relatives?

Please tick one

Almost daily 1

About once a week 2

About once a month 3

Once every few months 4

Never/Almost never 5

FVSTREL

(c) How many relatives do you see once a month or more?

Please tick one

None 1

1-2 2

3-5 3

6-10 4

More than 10 5

FVSTRLM

89

(a) Are there friends or acquaintances with whom you have regular contact (either by visit, telephone, e-mail or letters)? (Not necessarily the same person each time)

Please tick one

- Almost daily 1
- About once a week 2
- About once a month 3
- Once every few months 4
- Never/Almost never 5

FCONFRND

(b) How often do you regularly visit or are visited by these friends or acquaintances

Please tick one

- Almost daily 1
- About once a week 2
- About once a month 3
- Once every few months 4
- Never/Almost never 5

FVSTFRND

(c) How many friends or acquaintances do you see once a month or more?

Please tick one

- None 1
- 1-2 2
- 3-5 3
- 6-10 4
- More than 10 5

FVSTFRM

Feelings and life events

90

The sentences that follow concern your feelings and behaviour over the **past week**. Please read the statements carefully and tick one box for each statement that best describes how often you felt this way during the **past week**.

Please tick one box on each line

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	
(a) I was bothered by things that usually don't bother me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN01
(b) I did not feel like eating, my appetite was poor	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN02
(c) I felt that I could not shake off the blues even with help from my family and friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN03
(d) I felt that I was just as good as other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN04
(e) I had trouble keeping my mind on what I was doing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN05
(f) I felt depressed	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN06
(g) I felt that everything I did was an effort	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN07
(h) I felt hopeful about the future	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN08
(i) I thought my life had been a failure	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN09
(j) I felt fearful	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN10
(k) My sleep was restless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN11
(l) I was happy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN12
(m) I talked less than usual	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN13
(n) I felt lonely	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN14
(o) People were unfriendly	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN15
(p) I enjoyed life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN16
(q) I had crying spells	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN17
(r) I felt sad	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN18
(s) I felt that people disliked me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN19
(t) I could not get going	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	FDPN20

The following is a list of things that can happen to people. Try to remember if any of these things happened to you and when they happened.

If yes, please give the **years** when the events occurred, e.g. 1995

(a) Personal serious illness, injury or operation

Yes

No

FEVENT1

FEVEN1Y1 FEVEN1Y2 FEVEN1Y3

(b) Death of a close relative or friend

Yes

No

FEVENT2

FEVEN2Y1 FEVEN2Y2 FEVEN2Y3

(c) Serious illness, injury or operation of a close relative or friend

Yes

No

FEVENT3

FEVEN3Y1 FEVEN3Y2 FEVEN3Y3

(d) Major financial difficulty

Yes

No

FEVENT4

FEVEN4Y1 FEVEN4Y2 FEVEN4Y3

(e) Divorce, separation or break up of a personal intimate relationship

Yes

No

FEVENT5

FEVEN5Y1 FEVEN5Y2 FEVEN5Y3

(f) Other marital or family problem

Yes

No

FEVENT6

FEVEN6Y1 FEVEN6Y2 FEVEN6Y3

(g) Robbery, mugging or similar criminal event

Yes

No

FEVENT7

FEVEN7Y1 FEVEN7Y2 FEVEN7Y3

Activities

92

In your spare time are you involved in any of the following activities?
How often have you taken part in these activities
in the last **12 months**?

Please tick one box on each line

Weekly Monthly Less often Never

Are you involved in any of the following?

		Weekly	Monthly	Less often	Never
(a) Religious activities/observance	FSPARLGF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(b) Positions of office (for example, school governor, councillor)	FSPAPOSF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(c) Voluntary work	FSPAVOLF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(d) Courses and education/evening classes	FSPAEDNF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(e) Cultural visits to stately homes, galleries, theatres, cinema or live music events	FSPACULF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(f) Social indoor games, cards, bingo, chess, etc.	FSPAGAMF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(g) Visiting friends and relatives	FSPAVSTF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(h) Going to pubs and social clubs	FSPAPUBF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(i) Individual occupations (for example, reading, listening to music)	FSPASOLF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(j) Household tasks (for example, DIY, maintenance, decorating)	FSPAHTF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(k) Practical activities, making things with your hands (for example, pottery, drawing)	FSPAHANF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(l) Gardening	FSPAGDNF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
(m) Using a home computer for leisure	FSPACOMF	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Heating the home

93

Do you ever have the home colder than you would like during the winter
(December to March)?

Please tick one

Yes, always 1

Yes, often 2

Yes, sometimes 3

No 4

→ Go to **95**

FCOLD

94

What are the reasons for having your home colder than you would like?

Please tick all that apply

Trying to keep cost of heating down 1

FCOLDRS1

Any heat just disappears 2

FCOLDRS2

I like to have windows open 3

FCOLDRS3

It is healthy to keep your body cooler 4

FCOLDRS4

Other household members like it cooler 5

FCOLDRS5

We only have a heater in one room 6

FCOLDRS6

I can't afford to heat it more 7

FCOLDRS7

Other (please specify) 8

FCOLDRS8

95

(a) Do you spend more than 10% of your disposable household income on your fuel bills (for gas, electricity, etc.) to heat your home up to an adequate standard of warmth?

Yes 1 → Go to **96**

FCOLD10

No 2

Don't know 3 → Go to **96**

(b) If no, what is the reason:

Please tick one

Fuel bills are less than 10% of my disposable household income 1

I cannot afford to heat my home adequately 2

FCOLD10R

Other (please specify) 3

Don't know 4

Section 4: About your past and present work

96 (a) Are you still working as a civil servant?

FCSSTILL

Yes 1

No 2 → Go to **97 (a)**

(b) Which of the following is closest to your current grade in the Civil Service?

Please tick one

Administrative Assistant (AA) 1

Administrative Officer (AO) 2

Executive Officer (EO) 3

Higher Executive Officer (HEO) 4

Senior Executive Officer (SEO) 5

Grade 7 6

Grade 6 7

Grade 5 8

Grade 4 9

Grade 3 10

Grade 2 11

Grade 1 12

FCSCCLGD

→ Go to **103**

97 (a) When did you leave the civil service? Was it:

On or before 31st December 2007 1 → Go to **100**

On or after 1st January 2008 2 **FLR2007**

(b) Please give the date when you left the Civil Service:

Month Year

FLRMONTH **FLRYEAR**

98

Which of the following is closest to your last grade in the Civil Service?

Please tick one

- Administrative Assistant (AA) 1
- Administrative Officer (AO) 2
- Executive Officer (EO) 3
- Higher Executive Officer (HEO) 4
- Senior Executive Officer (SEO) 5
- Grade 7 6
- Grade 6 7
- Grade 5 8
- Grade 4 9
- Grade 3 10
- Grade 2 11
- Grade 1 12

FLRCLGD

99

By which route did you leave the Civil Service?

Please tick one

- Retirement at 60 1
- Voluntary Early Retirement 2
- Retirement on health grounds 3
- Voluntary Compulsory Redundancy 4
- Redundancy 5
- Transfer to company through privatisation 6
- Left to take a post outside the Civil Service 7
- Left to become self-employed 8
- Other (please specify) 9

FLRROUT

FLRROUTO

100

Are you in paid employment NOW (including self-employment or employment after retirement)?

FLREMPPL

- Yes 1 → Go to **102 (a)**
- No 2

101

If you are not currently in paid employment, would you classify yourself as:

FLRNE

Unemployed seeking work

Retired

Long term sick/disabled

Looking after family or home

Other (please specify)

Please tick one

Go to 104

102

(a) What is the exact title of your main paid job, including those of you who are self-employed? (If you have more than one job, the main job is either the one in which the most hours are worked, or if you do equal hours it is the one that is the highest paid.) Please give the full title by which the job is known and give the rank or grade if you have one.

FJOBSOC

(b) What kind of work do you do in it? (list the main things you do in the job)

(c) Are you an employee or self-employed?

FLREMPEE

Please tick one

Employee

Go to (f)

Self-employed

Go to (d)

(d) If you are self-employed, do you employ other people?

FLREMPPL

Please tick one

Yes

No

Go to 103

(e) How many people do you employ?

FLREPPLN

Please tick one

1-24

25 or more

Go to 103

(f) If you are an employee, are you:

FLRECHAR

Please tick one

A manager

A foreman or supervisor

None of the above

Go to (g)

Go to 103

(g) How many people do you manage or supervise?

FLRECHNO

Please tick one

1-24

25 or more

103 If you are currently in employment. Thinking about your main job, how many hours do you work in a normal week, including work brought home?

Hours

FEMAINHR

104 This questionnaire was completed...

Please tick one

Independently 1

With assistance (for example, if you have trouble writing or have lost your eye sight) 2

By someone else on my behalf 3

FCOMPLET

Please use the space below to add any further comments

FCMNT (FCMT_Q1, FCMT_Q2, FCMT_Q3, FCMT_Q4,
FCMT_Q5, FCMT_Q6, FCMT_Q7, FCMT_Q8)

Thank you for completing this questionnaire

