

serial

# BRITISH REGIONAL HEART STUDY QUESTIONNAIRE

1992

Royal Free Hospital School of Medicine  
Department of Public Health and Primary Care  
Rowland Hill Street  
London NW3 2PF

*Health*

card 1

Please answer the following questions by filling in the appropriate box with a tick or an answer in the space provided.

q92card1

1.0 Please write your date of birth here

<i>office use</i>	
0	1

q92q1_0db_day	q92q1_0db_m	q92q1_0db_y
day	month	year

9-10

11-16

2.0 How would you describe your health at present?

Excellent	<input type="checkbox"/>	1
Good	<input type="checkbox"/>	2
Fair	<input type="checkbox"/>	3
Poor	<input type="checkbox"/>	4

q92q2\_0healt

17

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

	Yes	No	
Heart attack, coronary thrombosis or myocardial infarction	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0ha 18
Angina	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0an 19
Other heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0oht 20
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0hbp 21
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0str 22
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0di 23
Aortic aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0aa 24
Gastric, peptic or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0gpu 25
Gout	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0gout 26
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0gb 27
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0thy 28
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0ar 29
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0br 30
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0as 31
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	q92q3_0ca 32

If you have ever had cancer please state what kind of cancer

*office use*

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q92q3\_0box

33-34

4.0 Have you ever had any of the following ?

card 1

- |  | Yes                      | No                       |                                   |
|--|--------------------------|--------------------------|-----------------------------------|
| A referral to a heart specialist             | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0_ref_specialist 35         |
| An ECG Exercise test - bicycle               | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0ECG_bicycle 36             |
| - treadmill                                  | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0ECG_treadmill 37           |
| X-ray or angiogram of your coronary arteries | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0Xray_angiogram 38          |
| Angioplasty of coronary arteries             | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0_angioplasty 39            |
| Coronary artery by-pass graft                | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0_CABG 40                   |
| Surgery to aorta for aneurysm                | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0_surg_aorta_aneu 41        |
| Other heart surgery - Valves                 | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0_other_heart_surg_valve 42 |
| - Pacemaker                                  | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0_other_heart_surg_pace 43  |
| Any other major surgery?                     | <input type="checkbox"/> | <input type="checkbox"/> | q92q4_0_other_major_surg 44       |

If you have had any other major surgery please give details

office use

q92q4\_0\_box

45-46

5.0

Are you on any regular treatment from a doctor for any condition?

Yes No

q92q5\_0

47

If you answered YES

5.1 Please tick all those you are on and give the name of tablets if possible

- |                          | Yes                      | No                       | Name of tablet |    |
|--------------------------|--------------------------|--------------------------|----------------|----|
| q92q5_1_tablets_BP       | <input type="checkbox"/> | <input type="checkbox"/> | _____          | 48 |
| q92q5_1_diuretics        | <input type="checkbox"/> | <input type="checkbox"/> | _____          | 49 |
| q92q5_1_tranquillisers   | <input type="checkbox"/> | <input type="checkbox"/> |                | 50 |
| q92q5_1_anti_depressants | <input type="checkbox"/> | <input type="checkbox"/> |                | 51 |
| q92q5_1_sleeping         | <input type="checkbox"/> | <input type="checkbox"/> |                | 52 |
| q92q5_1_insulin          | <input type="checkbox"/> | <input type="checkbox"/> |                | 53 |
| q92q5_1_diet_diabetes    | <input type="checkbox"/> | <input type="checkbox"/> |                | 54 |
| q92q5_1_other_reg_treat  | <input type="checkbox"/> | <input type="checkbox"/> |                | 55 |

Please specify other treatments

5.2 Do you take aspirin on a regular of daily basis?

Yes No

q92q5\_2

56

If you answered YES,  
How many tablets of aspirin do you usually take each week

q92q5\_2\_ifyes\_tablets

57-58

5.3	What year was your diabetes first diagnosed?	19	<input type="text" value="q92q5_3"/>	59-60
5.4	What year did you begin regular treatment with diet or drugs for diabetes?	19	<input type="text" value="q92q5_4"/>	61-62
5.5	Do you currently attend a diabetic clinic?			
	No not at all	<input type="checkbox"/>	1 <input type="text" value="q92q5_5"/>	
	Yes, at the hospital	<input type="checkbox"/>	2	63
	Yes, at the GP surgery	<input type="checkbox"/>	3	

6.0 Family History

6.1	Is your father alive	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	<input type="text" value="q92q6_1"/>	64	
6.2	How old is he now? or How old was he when he died?	<input type="text"/>		<input type="text" value="q92q6_2"/>			65-66	
6.3	Did / does he ever suffer from:	If dead, did he die from						
		Yes	No	Yes	No			
<input type="text" value="q92q6_3_HT_suffer"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_3_HT_died"/>	67-68	
<input type="text" value="q92q6_3_HBP_suffer"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_3_HBP_died"/>	69-70	
<input type="text" value="q92q6_3_Stroke_suffer"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_3_Stroke_died"/>	71-72	
<input type="text" value="q92q6_3_Diab_suffer"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_3_Diab_died"/>	73-74	
<input type="text" value="q92q6_3_Cancer_suffer"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_3_Cancer_died"/>	75-76	
<i>office use</i>								
		<input type="text" value="0"/>		<input type="text" value="2"/>				
6.4	Is your mother alive	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	<input type="text" value="q92q6_4"/>	11	
6.5	How old is she now? or How old was she when she died?	<input type="text"/>		<input type="text" value="q92q6_5"/>			12-13	
6.6	Did / does she ever suffer from:	If dead, did she die from						
		Yes	No	Yes	No			
<input type="text" value="q92q6_6_HT_suffer"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_6_HT_died"/>	14-15	
<input type="text" value="q92q6_6_HBP_suffer"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_6_HBP_died"/>	16-17	
<input type="text" value="q92q6_6_Stroke_suffer"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_6_Stroke_died"/>	18-19	
<input type="text" value="q92q6_6_Diab_suffer"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_6_Diab_died"/>	20-21	
<input type="text" value="q92q6_6_Cancer_suffer"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="q92q6_6_Cancer_died"/>	22-23	

Family history continued

card 2

6.7 How many older brothers or sisters do you have? (include any who have died) q92q6\_7 24-25

6.8 How many younger brothers or sisters do you have? (include any who have died) q92q6\_8 26-27

6.9 Are you one of twins or triplets Yes No q92q6\_9 28

6.10 Have any of your brothers and sisters ever suffered from

	Yes	No	How many of them have this problem	
q92q6_10_HT_suffer Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	q92q6_10_HT_num 29-30
q92q6_10_HBP_suffer High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	q92q6_10_HBP_num 31-32
q92q6_10_Stroke_suffer Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	q92q6_10_Stroke_num 33-34
q92q6_10_Diab_suffer Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	q92q6_10_Diab_num 35-36
q92q6_10_Cancer_suffer Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	q92q6_10_Cancer_num 37-38

6.11 Did any of your brothers or sisters die at birth or in their first year of life? Yes No q92q6\_11 39

7.0 Chest pain

7.1 Do you ever have any pain or discomfort in your chest? Yes No q92q7\_1 40

7.2 Where do you get this pain or discomfort?  
Please mark X on the appropriate places

**YOUR  
RIGHT  
SIDE**

**YOUR  
LEFT  
SIDE**

office use

q92q7\_2\_box1  
q92q7\_2\_box2  
q92q7\_2\_box3

41  
42  
43

*Chest pain continued*

7.3	When you walk at an ordinary pace on the level, does this produce the pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	card 2 44
7.4	When you walk uphill or hurry, does this produce the pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	45
7.5	When you get any pain or discomfort in your chest on walking, what do you do?		
	Stop	<input type="checkbox"/> 1	q92q7_5 46
	Slow down	<input type="checkbox"/> 2	
	Continue at the same pace	<input type="checkbox"/> 3	
7.6	Does the pain or discomfort in your chest go away if you stand still?	<input type="checkbox"/> Yes <input type="checkbox"/> No	47
7.7	How long does it take to go away?		
	10 minutes or less	<input type="checkbox"/> 1	48
	more than 10 minutes	<input type="checkbox"/> 2	q92q7_7

*8.0 Severe chest pain*

8.1	Have you ever had a severe pain across the front of your chest lasting for half an hour or more ? If you answered No please go to section 9.0	<input type="checkbox"/> Yes <input type="checkbox"/> No	49
		q92q8_1	
	If you answered Yes,		
8.2	Did you see a doctor because of this pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	50
		q92q8_2	
8.3	What year(s) did this happen? 19 <input type="text"/> and 19 <input type="text"/>		51-54
		q92q8_3_year1      q92q8_3_year2	

*9.0 Leg Pain*

9.1	Do you ever get pain in your calf when walking at an ordinary pace on the level?	<input type="checkbox"/> Yes <input type="checkbox"/> No	card 2 55
9.2	Do you get pain in your calf muscle when you walk uphill or hurry?	<input type="checkbox"/> Yes <input type="checkbox"/> No	56
	If YES,		
9.3	Does the pain go away if you stop or stand still?	<input type="checkbox"/> Yes <input type="checkbox"/> No	57
		q92q9_3	
9.4	How long does it take to go away?		
	10 minutes or less	<input type="checkbox"/> 1	58
	more than 10 minutes	<input type="checkbox"/> 2	q92q9_4

10.0 *Breathlessness*

		Yes	No	card 2
10.1	Do you get short of breath walking with other people of your own age on level ground?	<input type="checkbox"/>	<input type="checkbox"/>	59 q92q10_1
10.2	On walking uphill or stairs do you get more breathlessness than people of your own age?	<input type="checkbox"/>	<input type="checkbox"/>	60 q92q10_2
10.3	Do you ever have stop walking because of breathlessness?	<input type="checkbox"/>	<input type="checkbox"/>	61 q92q10_3

11.0 *Cough and Wheeze*

		Yes	No	
11.1	Do you usually bring up phlegm (spit) from your chest first thing in the morning in the winter? If you answered No then go to question 11.4	<input type="checkbox"/>	<input type="checkbox"/>	62 q92q11_1
11.2	Do you bring up phlegm like this on most days for as much as 3 months in the winter each year?	<input type="checkbox"/>	<input type="checkbox"/>	63 q92q11_2
11.3	In the past 5 years have you ever had a period of increased cough and phlegm lasting 3 weeks or more?			
	Yes, once	<input type="checkbox"/>	1	
	Yes, twice or more	<input type="checkbox"/>	2	64 q92q11_3
	Never	<input type="checkbox"/>	3	
11.4	Does your chest sound wheezy or whistling on most days or nights?	<input type="checkbox"/>	<input type="checkbox"/>	65 q92q11_4
11.5	Does the weather affect your breathing and if so what season of the year is it most affected?			
	Not affected	<input type="checkbox"/>	1	
	Winter	<input type="checkbox"/>	2	66 q92q11_5
	Summer	<input type="checkbox"/>	3	
	Both	<input type="checkbox"/>	4	

12.0 *Weight*

12.1	Has your weight changed in the last five years?			
	No change	<input type="checkbox"/>	1	
	Increased	<input type="checkbox"/>	2	
	Decreased	<input type="checkbox"/>	3	67 q92q12_0
	Don't Know	<input type="checkbox"/>	4	
12.2	What is your present weight? (Indoor clothes, no shoes) <i>If you have no scale, please fill in an estimate.</i>			
		q92q12_2wt_st	q92q12_2wt_lb	or
		stones	pounds	q92q12_2wt_kg
				kilos
				68-73

13.0 *Personal Circumstances*

card 3

		<i>office use</i>				
		<table border="1" style="display: inline-table;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">3</td> </tr> </table>		0	3	9-10
0	3					
13.1	Are you	Married <span style="float: right;">q92q13_1</span> <input type="checkbox"/> 1 Single <input type="checkbox"/> 2 Widowed <input type="checkbox"/> 3 Divorced or separated <input type="checkbox"/> 4 Other <input type="checkbox"/> 5	11			
13.2	Please describe your accommodation. Are you	an owner occupier <input type="checkbox"/> 1 renting privately <input type="checkbox"/> 2 renting from the council <input type="checkbox"/> 3 other (please specify below) <input type="checkbox"/> 4  <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 150px; height: 20px; margin-right: 10px;"></div> <div style="text-align: right;"> <table border="1" style="display: inline-table;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>                 q92q13_2_box             </div> </div>			12	
		<i>office use</i>				
		<table border="1" style="display: inline-table;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>				13-14
13.2	How many cars are there available for use in your household?	None <span style="float: right;">q92q13_3</span> <input type="checkbox"/> 1 One <input type="checkbox"/> 2 Two or more <input type="checkbox"/> 3	15			

14.0 *Smoking*

14.1	Do you regularly smoke cigarettes at present?	q92q14_1 <input type="checkbox"/> Yes <input type="checkbox"/> No	16
		If YES,	
14.2	How many cigarettes do you smoke a day?	<table border="1" style="display: inline-table; width: 50px; height: 20px;"></table> q92q14_2	17-18
14.3	Have you changed your smoking habits over the last 5 years?	q92q14_3 No <input type="checkbox"/> 1 Yes increased <input type="checkbox"/> 2 Yes decreased <input type="checkbox"/> 3 Yes given up <input type="checkbox"/> 4	19
14.4	Do you currently smoke a pipe or cigars?	q92q14_4 <input type="checkbox"/> Yes <input type="checkbox"/> No	20
		If No,	
14.5	Have you ever regularly smoked a pipe or cigars?	q92q14_5 <input type="checkbox"/> Yes <input type="checkbox"/> No	21

*For those not smoking at present*

14.6	Were you previously a regular cigarette smoker?	q92q14_6	Yes <input type="checkbox"/>	No <input type="checkbox"/>	22
	If YES,				
14.7	At what age did you give up?	q92q14_7	<input type="text"/>		23-24
14.8	Why did you give up?				
	Personal choice	q92q14_8	<input type="checkbox"/>	1	
	Doctor's advice		<input type="checkbox"/>	2	25
	Definite illness		<input type="checkbox"/>	3	

15.0 *Drinking Alcohol*

15.1	Would you describe your present alcohol intake as	q92q15_1			
	Daily / most days		<input type="checkbox"/>	1	
	Weekends only		<input type="checkbox"/>	2	26
	Once or twice a month		<input type="checkbox"/>	3	
	None		<input type="checkbox"/>	4	
15.2	<i>One drink is HALF a pint of beer, a SINGLE whisky, gin etc or a glass of wine or sherry.</i>				
	How much do you usually drink?	q92q15_2			
	More than 6 drinks a day		<input type="checkbox"/>	1	
	3-6 drinks a day		<input type="checkbox"/>	2	27
	2 drinks a day or less		<input type="checkbox"/>	3	
	None		<input type="checkbox"/>	4	
15.3	Have you <b>ever</b> been a regular drinker of more than 6 drinks daily?	q92q15_3	Yes <input type="checkbox"/>	No <input type="checkbox"/>	28
15.4	What type of drink do you usually take?	q92q15_4			
	Beers, lagers		<input type="checkbox"/>	1	
	Wines, sherry		<input type="checkbox"/>	2	
	Spirits		<input type="checkbox"/>	3	29
	Variety of beers, wines or spirits		<input type="checkbox"/>	4	
	Low alcohol drinks		<input type="checkbox"/>	5	

*Drinking continued*

15.5	Have you reduced your alcohol intake in the last five years?	<b>q92q15_5</b>	Yes	No	card 3
	If NO, go to question 16.0		<input type="checkbox"/>	<input type="checkbox"/>	30
	If YES				
15.6	Was this due to	<b>q92q15_6</b>			
	Personal choice		<input type="checkbox"/>	1	
	Doctor's advice		<input type="checkbox"/>	2	31
	Definite illness		<input type="checkbox"/>	3	

*16.0 For drinkers and ex drinkers*

16.1	Have you ever felt that you should cut down on your drinking?		Yes	No	32	<b>q92q16_1</b>
			<input type="checkbox"/>	<input type="checkbox"/>		
16.2	Have other people annoyed you by criticising your drinking habits?		<input type="checkbox"/>	<input type="checkbox"/>	33	<b>q92q16_2</b>
16.3	Have you ever felt guilty about drinking?		<input type="checkbox"/>	<input type="checkbox"/>	34	<b>q92q16_3</b>
16.4	Have you ever taken a drink in the morning to steady your nerves or get rid of a hangover?		<input type="checkbox"/>	<input type="checkbox"/>	35	<b>q92q16_4</b>

*17.0 For people who do not drink at present*

17.1	Why do you not drink at present?	<b>q92q17_1</b>			
	Personal choice		<input type="checkbox"/>	1	
	Doctor's advice		<input type="checkbox"/>	2	36
	Definite illness		<input type="checkbox"/>	3	
17.2	Did you drink in the past?	<b>q92q17_2</b>	Yes	No	37
			<input type="checkbox"/>	<input type="checkbox"/>	
	If YES				
17.3	For how long have you given up?	<b>q92q17_3</b>			
	Less than 5 years		<input type="checkbox"/>	1	
	5-10 years		<input type="checkbox"/>	2	38
	11-20 years		<input type="checkbox"/>	3	
	more than 20 years		<input type="checkbox"/>	4	

18.0 *Physical activity*

18.1 Do you usually walk or cycle in the course of your journey to or from work each day?

- No q92q18\_1  1  
Walk  2  
Cycle  3  
Not applicable  4

39

If YES,

18.2 How many minutes do these journeys take in total each day? q92q18\_2  minutes

40-42

18.3 Apart from any journeys to or from work, do you usually walk or cycle on weekdays?

- No q92q18\_3  1  
Walk  2  
Cycle  3

43

If YES,

18.4 How many minutes do these journeys take in total each day? q92q18\_4  minutes

44-46

18.5 Would you say that in your occupation you are or were physically

- q92q18\_5  
Very active  1  
Fairly active  2  
Average  3  
Fairly inactive  4  
Very inactive  5

47

18.6 *On average a man of your age spends 4 hours on most weekends on some of the following activities: walking, gardening, household chores, DIY projects.*

Compared to such a man, how physically active do you consider yourself? q92q18\_6

- Very active  1  
Fairly active  2  
Average  3  
Fairly inactive  4  
Very inactive  5

48

Physical activity continued

card 3

18.7 How many hours a week do you spend gardening

In the spring/summer In the autumn/ winter?

Hours of light gardening work per week

q92q18\_7\_light\_garden\_summer

q92q18\_7\_heavy\_garden\_winter

49-52

Hours of moderate gardening work per week

q92q18\_7\_mod\_garden\_summer

q92q18\_7\_mod\_garden\_winter

53-56

Hours of heavy digging gardening work per week

q92q18\_7\_heavy\_garden\_summer

q92q18\_7\_light\_garden\_winter

57-60

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

q92q18\_8

No  1

Occasionally (less than once a month)  2

Frequently (once a month or more)  3

61

If you ticked **No** or **Occasionally** then please go to question 19.0

If you ticked **Frequently** (once a month or more),

18.9 Please state type of activities :

q92q18\_9

office use

62-63

18.10 How many years have you been involved in this activities ?

q92q18\_10

64-65

18.11 How many **times** a month (on average) do you take part in this activities in

Winter

q92q18\_11winter

66-67

Summer

q92q18\_11summer

68-69

19.0 *Disability*

card 3

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

		Yes	No	
q92q19_1stairs	Going up or down stairs	<input type="checkbox"/>	<input type="checkbox"/>	70
q92q19_1bend	Bending down	<input type="checkbox"/>	<input type="checkbox"/>	71
q92q19_1straighten	Straightening up	<input type="checkbox"/>	<input type="checkbox"/>	72
q92q19_1balance	Keeping your balance	<input type="checkbox"/>	<input type="checkbox"/>	73
q92q19_1go_out	Going out of the house	<input type="checkbox"/>	<input type="checkbox"/>	74
q92q19_1walk400	Walking 400 yards	<input type="checkbox"/>	<input type="checkbox"/>	75

*office use*

0	4
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card 4

9-10

If you ticked No in all cases then please go to question 20.0

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

		Yes	No	
q92q19_2job	Job at work (paid employment)	<input type="checkbox"/>	<input type="checkbox"/>	11
q92q19_2house_chores	Household chores	<input type="checkbox"/>	<input type="checkbox"/>	12
q92q19_2social_life	Social life	<input type="checkbox"/>	<input type="checkbox"/>	13
q92q19_2sex_life	Sex life	<input type="checkbox"/>	<input type="checkbox"/>	14
q92q19_2inter_hobbies	Interests and hobbies	<input type="checkbox"/>	<input type="checkbox"/>	15
q92q19_2holidays	Holidays and outings	<input type="checkbox"/>	<input type="checkbox"/>	16
q92q19_2fam_relat	Family relationships	<input type="checkbox"/>	<input type="checkbox"/>	17

19.3 If you have ticked YES in questions 19.1 or 19.2 please give details of the condition that you have which causes you these difficulties?

*office use*

q92q19\_3

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18-19

20.0 *Falls*

card 4

20.1	Have you had a fall in the last year? If NO please go to question 21.0 If YES,	q92q20_1	Yes <input type="checkbox"/>	No <input type="checkbox"/>	20
20.2	How many times?	q92q20_2	<input type="text"/>		21-22
20.3	Did you have medical attention for any of these falls?	q92q20_3	Yes <input type="checkbox"/>	No <input type="checkbox"/>	23

21.0 *Present Employment*

21.1	At present are you	q92q21_1	Employed full time <input type="checkbox"/>	1	24
			Employed part time <input type="checkbox"/>	2	
			Unemployed, seeking work <input type="checkbox"/>	3	
			Unemployed, not seeking work <input type="checkbox"/>	4	
			Retired <input type="checkbox"/>	5	
21.2	If unemployed, is this due to	q92q21_2	Redundancy <input type="checkbox"/>	1	25
			Illness/ disability <input type="checkbox"/>	2	
			Other reasons <input type="checkbox"/>	3	
	If you ticked Other reasons please give details below				26-27
	<input type="text"/>		office use <input type="text"/>	<input type="text"/>	
		q92q21_2_box			
21.3	If retired, is this due to	q92q21_3	Normal retiring age <input type="checkbox"/>	1	28
			Early retirement opportunity <input type="checkbox"/>	2	
			Illness/ disability <input type="checkbox"/>	3	
			Redundancy <input type="checkbox"/>	4	
			Other reasons <input type="checkbox"/>	5	

*Employment continued*

card 4

21.4 What job have you done for the longest period of time?

*office use*

**21.4**

21.6 Would you describe this work as

q92q21\_4\_man\_nonman

Manual

 1

Non-manual

 2

29

21.5 What job did you father do for the longest period of his working life?

*office use*

21.6 Would you describe this work as

q92q21\_6\_man\_nonman

Manual

 1

Non-manual

 2

30

22.0 *When you were a child (up to 10 years old)*

22.1 Did you have a bathroom in your house?

q92q22\_1

Yes No

 

31

22.2 Did you have a hot water tap in the house?

q92q22\_2

Yes No

 

32

22.3 Did you share a bedroom with brothers or sisters?

q92q22\_3

Yes No

 

33

22.4 Did your family own a car?

q92q22\_4

Yes No

 

34

*Please turn over*

23.0 *At present*

23.1	Do you have access to a telephone in your house?	q92q23_1	Yes <input type="checkbox"/>	No <input type="checkbox"/>	35
23.2	Have you made a personal phone call in the last week?	q92q23_2	Yes <input type="checkbox"/>	No <input type="checkbox"/>	36
23.3	Have you written a personal letter in the last week?	q92q23_3	Yes <input type="checkbox"/>	No <input type="checkbox"/>	37
23.4	Do you take a weekly or monthly magazine or journal?	q92q23_4	Yes <input type="checkbox"/>	No <input type="checkbox"/>	38
23.5	Do you attend religious services or meetings?	q92q23_5	Yes <input type="checkbox"/>	No <input type="checkbox"/>	39
23.6	Did you vote in the last general or local elections?	q92q23_6	Yes <input type="checkbox"/>	No <input type="checkbox"/>	40
23.7	Have you been on holiday in the last year?	q92q23_7	Yes <input type="checkbox"/>	No <input type="checkbox"/>	41
23.8	Are you planning to go on holiday next year?	q92q23_8	Yes <input type="checkbox"/>	No <input type="checkbox"/>	42
23.9	Do you use the public library?	q92q23_9	Yes <input type="checkbox"/>	No <input type="checkbox"/>	43
23.10	Are you a member of any club, society or group?	q92q23_10	Yes <input type="checkbox"/>	No <input type="checkbox"/>	44
23.11	If YES, In the past month have you attended a meeting of a club, society or group?	q92q23_11	Yes <input type="checkbox"/>	No <input type="checkbox"/>	45

Thank you for you help

All your answers will be treated in complete confidence and will not be identifiable. Please you would check that you have answered all the questions you can, and then return the form in the envelope provided, **NO STAMP IS NEEDED.**