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

BRITISH REGIONAL HEART STUDY

2003 QUESTIONNAIRE

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

Most questions can be answered by ticking the correct box ☑

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

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

THANK YOU FOR YOUR HELP

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Rowland Hill Street, London NW3 2PF

1.0 Date of birth q03q1_dob (day) q03q1_mob (month) 19 q03q1_yob (year)

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

Conditions affecting the heart or circulation

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

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

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

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

Investigations and special treatment for conditions affecting the heart and circulation

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

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

If **Yes**, please give details:

_____ q03q4_7_d

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Diabetes

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

If **Yes**,

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

		Yes	No	
5.2	Do you have any complications of diabetes affecting…….. your feet?	☐	☐	q03q5_2_f
	your nerves?	☐	☐	q03q5_2_n
	your kidneys?	☐	☐	q03q5_2_k
	your eyes?	☐	☐	q03q5_2_e
5.3	Have your eyes been checked for signs of diabetes? (Please give year of last check)	☐	☐	_____ (Year) q03q5_3 q03q5_3_y

Cancer

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

If **Yes**, please give:

(a) Year first diagnosed q03q6_0a

(b) Cancer Site q03q6_0_s q03q6_0_s2

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Arthritis

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

If **Yes**,

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

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7.2 Year first diagnosed q03q7_2

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

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

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Other Medical Conditions

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

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

		Yes	No	Year			Yes	No	Year
(a)	Asthma q03q8_0a	☐	☐	q03q8_0a_y	(b)	Bronchitis q03q8_0b	☐	☐	q03q8_0b_y
(c)	Cataract q03q8_0c	☐	☐	q03q8_0c_y	(d)	Depression q03q8_0d	☐	☐	q03q8_0d_y
(e)	Emphysema q03q8_0e	☐	☐	q03q8_0e_y	(f)	Gall bladder disease q03q8_0f	☐	☐	q03q8_0f_y
(g)	Gastric, peptic or duodenal ulcer q03q8_0g	☐	☐	q03q8_0g_y	(h)	Glaucoma q03q8_0h	☐	☐	q03q8_0h_y
(i)	Gout q03q8_0i	☐	☐	q03q8_0i_y	(j)	Osteoporosis q03q8_0j	☐	☐	q03q8_0j_y
(k)	Parkinson's disease q03q8_0k	☐	☐	q03q8_0ak_y	(l)	Pneumonia q03q8_0l	☐	☐	q03q8_0l_y
(m)	Prostate trouble q03q8_0m	☐	☐	q03q8_0m_y					

(n) Other conditions, please give details:

_____ q03q8_0n_y _____ (year) q03q8_0n

_____ q03q8_0n2_y _____ (year) q03q8_0n2

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Joint pain, swelling or stiffness

9.0 During **the past year** have you had pain, aching, stiffness or swelling on most days for at least one month, in your…

	Yes	No	
(a) Hands or wrists	☐	☐	q03q9_0a
(b) Knees	☐	☐	q03q9_0b
(c) Hips	☐	☐	q03q9_0c
(d) Feet	☐	☐	q03q9_0d
(e) Other joint	☐	☐	(please specify)_____ q03q9_0e q03q9_0e_x

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Lower back pain

	Yes	No	
10.0 Have you **ever** had pain in your lower back on most days for at least one month?	☐	☐	q03q10_0
10.1 If **Yes**, have you had this in the last year?	☐	☐	q03q10_1

Fractures and falls

		Yes	No	Please give year
11.0	Have you **ever** fractured your hip? q03q11_0	☐	☐	q03q11_0_y
11.1	Have you **ever** fractured your wrist? q03q11_1	☐	☐	q03q11_1_y
11.2	Have you had a fall in the last 12 months? q03q11_2	☐	☐	
	If **Yes**,			
	(a) how many times? ☐☐ times q03q11_2a			
	(b) Did you receive medical attention for any of these falls?	☐	☐	q03q11_2b

Chest pain

		Yes	No	Unable to walk on level	
12.0	Do you **ever** have any pain or discomfort in your chest?	☐	☐		q03q12_0
	If **Yes**,				
(a)	When you walk at an ordinary pace on the level, does this produce the pain?	☐	☐	☐	q03q12_0a
		Yes	No	Unable to walk uphill	
(b)	When you walk uphill or hurry, does this produce the pain?	☐	☐	☐	q03q12_0b

Breathlessness

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

Weight

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

q03q14_0st _____ Stones q03q14_0lb _____ Pounds / or q03q14_0kg _____ Kilograms

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

			Yes	No	
14.1	Have you tried to lose weight in the last four years?	q03q14_1	☐	☐	
	If **Yes**, did you:				
	Change your diet?	q03q14_1c	☐	☐	
	Take more exercise?	q03q14_1t	☐	☐	
	Other (please give details) _____	q03q14_o			OFFICE USE ☐

			Yes	No	
14.2	Have you been advised by a doctor or other health professional to lose weight in the last four years?		☐	☐	q03q14_2

14.3	Has your weight changed in the last four years?	Not changed	☐1	q03q14_3
		Increased	☐2	
		Decreased	☐3	
		Both increased and decreased)	☐4	
		Don't know	☐5	

			Yes	No	
14.4	**If your weight has changed** -was this change intentional?		☐	☐	q03q14_4
	-was it the result of:-	Personal choice	☐1		q03q14_4p
		Medical advice	☐1		q03q14_4m
		Illness or ill health	☐1		q03q14_4i

14.5	Do you consider your present weight to be:-	about right	☐1	q03q14_5
		too high	☐2	
		too low	☐3	

Disability

	Yes	No	
15.0 Do you have any long-standing illness, disability or infirmity?	☐	☐	q03q15_0

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

If **Yes,**

	Yes	No	
(a) Does this illness or disability limit your activities in any way?	☐	☐	q03q15_0a
(b) Do you receive a disability allowance?	☐	☐	q03q15_0b

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

		Yes	No	
(a)	Going up or down stairs	☐	☐	q03q15_1a
(b)	Bending down	☐	☐	q03q15_1b
(c)	Straightening up	☐	☐	q03q15_1c
(d)	Keeping your balance	☐	☐	q03q15_1d
(e)	Going out of the house?	☐	☐	q03q15_1e
(f)	Walking 400 yards	☐	☐	q03q15_1f

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

		Yes	No	
(a)	Job at work (paid employment)	☐	☐	q03q15_2a
(b)	Household chores	☐	☐	q03q15_2b
(c)	Social life	☐	☐	q03q15_2c
(d)	Sex life	☐	☐	q03q15_2d
(e)	Interests and hobbies	☐	☐	q03q15_2e
(f)	Holidays and outings	☐	☐	q03q15_2f

Eyesight

	Yes	No	
16.0 Using glasses or corrective lenses if needed, can you see well enough to recognise a friend at a distance of 12 feet/ four yards (across a road)?	☐	☐	q03q16_0
If **No**, can you see well enough to recognise a friend at a distance of one yard?	☐	☐	q03q16_0_no

Hearing

	Yes	No	
17.0 Do you use a hearing aid?	☐	☐	q03q17_0
17.1 Using a hearing aid if needed, is your hearing good enough to follow a TV programme at a volume others find acceptable?	☐	☐	q03q17_1
If **No**, can you follow a TV programme with the volume turned up?	☐	☐	q03q17_1_no

Your Health Overall

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

18.0	General Health:-	Excellent	☐1	
		Good	☐2	q03q18_0
		Fair	☐3	
		Poor	☐4	
18.1	Pain/Discomfort:-	I have no pain or discomfort	☐1	
		I have moderate pain or discomfort	☐2	q03q18_1
		I have extreme pain or discomfort	☐3	
18.2	Mobility:-	I have no problems in walking about	☐1	
		I have some problems in walking about	☐2	q03q18_2
		I am confined to a chair/wheelchair	☐3	
18.3	Anxiety/Depression:-	I am not anxious or depressed	☐1	
		I am moderately anxious and/or depressed	☐2	q03q18_3
		I am extremely anxious and/or depressed	☐3	

Sleep:-

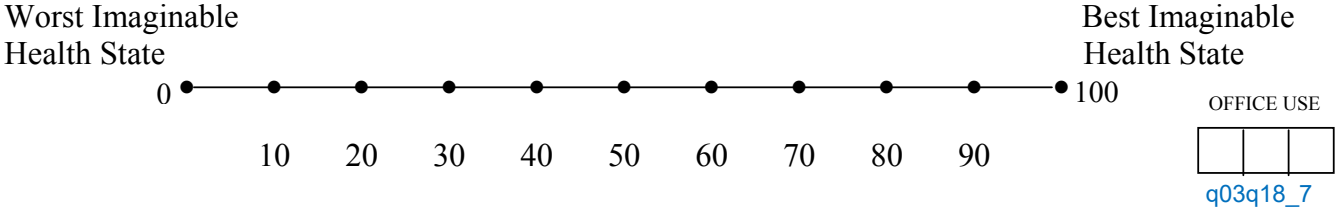
18.4 On average, how many hours' sleep do you have each night? q03q18_4h : q03q18_4m ☐☐ hours

18.5 On average, how much sleep (if any) do you have during the daytime? q03q18_5h : q03q18_5m ☐☐ hours

18.6	Do you snore while asleep?	Yes, regularly	☐1	
		Yes, occasionally	☐2	q03q18_6
		No, never	☐3	
		Don't know	☐4	

18.7 **Health Scale**

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



OFFICE USE ☐☐☐ q03q18_7

Physical activity

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

No	☐1	
Walk	☐2	q03q19_0
Cycle	☐3	
Both	☐4	

(a) How many hours do you normally spend walking (e.g. on errands or for leisure) in an average week? ☐☐ hours q03q19_0a

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

Slow	☐1	q03q19_1
Steady average	☐2	
Fast	☐3	

19.2 How long do you spend cycling in an average week? ☐☐ hours q03q19_2

19.3 Compared with a man who spends four hours on most weekends on activities such as: walking, gardening, household chores, DIY projects, how physically active would you consider yourself?

Much more active	☐1	q03q19_3
More active	☐2	
Similar	☐3	
Less active	☐4	
Much less active	☐5	

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

No	☐1	q03q19_4
Occasionally (less than once a month)	☐2	
Frequently (once a month or more)	☐3	

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

q03q19_4a

_____

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

In winter ☐☐ times q03q19_4b_w

In summer ☐☐ times q03q19_4b_s

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

Yes	☐	q03q19_5
No	☐	

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

q03q19_5_h

Cigarette smoking

		Yes	No	
20.0	Do you smoke cigarettes at present?	☐	☐	q03q20_0

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

20.1 How many cigarettes do you smoke a day at present? ☐☐ q03q20_1

20.2 If hand-rolled, how much tobacco do you use a week? ☐☐ oz / ☐☐☐ grams
q03q20_2oz q03q20_2gr

		Yes	No	
20.3	Do you want to give up smoking?	☐	☐	q03q20_3
20.4	Have you tried to stop smoking?	☐	☐	q03q20_4

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

	Yes	No	
(a) Advice from a health professional (e.g. doctor or nurse)	☐	☐	q03q20_5a
(b) Referral to a stop-smoking clinic	☐	☐	q03q20_5b
(c) Nicotine replacement treatment (including sprays, patches etc)	☐	☐	q03q20_5c
(d) Zyban tablets	☐	☐	q03q20_5d
(e) Other treatment (please specify) _____			q03q20_5e

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

No	☐1	q03q21_0
Yes, increased	☐2	
Yes, cut down	☐3	
Yes, given up	☐4	

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

	Yes	No	
(a) Advice from a health professional (e.g. doctor or nurse)	☐	☐	q03q21_1a
(b) Referral to a stop-smoking clinic	☐	☐	q03q21_1b
(c) Nicotine replacement treatment (including sprays, patches etc)	☐	☐	q03q21_1c
(d) Zyban tablets	☐	☐	q03q21_1d
(e) Illness or ill-health	☐	☐	q03q21_1e
(f) Cost of cigarettes	☐	☐	q03q21_1f
(g) Other factors (please specify) _____			q03q21_1g

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Pipe and cigar smoking

			Yes	No
22.0	Do you currently smoke a pipe?	q03q22_0	☐	☐
22.1	Do you currently smoke cigars?	q03q22_1	☐	☐

Alcohol intake

23.0 Would you describe your present alcohol intake as

Daily/most days	☐1
Weekends only	☐2 q03q23_0
Occasionally (once or twice a month)	☐3
Special occasions only	☐4
None	☐5

One drink is **HALF** a pint of beer/lager/cider, a **SINGLE** whisky, gin, etc. or **ONE GLASS** of wine or sherry

23.1 How much do you usually drink on the days when you drink alcohol?

More than 6 drinks	☐1
5-6 drinks	☐2
3-4 drinks	☐3 q03q23_1
1-2 drinks	☐4

23.2 How many alcoholic drinks do you have during an average week? ☐☐ q03q23_2

23.3 What type of drink do you usually take?

Beers, Lagers	☐1
Wines, Sherry	☐2 q03q23_3
Spirits	☐3
Combination of Beers, Wines or Spirits	☐4
Low alcohol drinks	☐5

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

	PER WEEK					
Type of drink	Never/ hardly ever	Less than 1	1-6	7-13	14-20	21+
Beer or lager (pints)	☐q03q23_4be	☐	☐	☐	☐	☐
Red wine (single glass)	☐q03q23_4rw	☐	☐	☐	☐	☐
White wine (single glass)	☐ q03q23_4ww	☐	☐	☐	☐	☐
Spirits (1 drink/shot)	☐q03q23_4sp	☐	☐	☐	☐	☐

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

before meals	☐1 q03q23_5b
with meals	☐1 q03q23_5w
after meals	☐1 q03q23_5a
separate from meals	☐1 q03q23_5s

Alcohol Intake continued

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

No	☐1	q03q23_6
Yes, increased	☐2	
Yes, cut down	☐3	
Yes, given up	☐4	

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

Personal choice	☐1	Being on medication	☐1	q03q23_7_1
Doctor's advice	☐1	Financial reasons	☐1	q03q23_7_2
Illness or ill health	☐1	Other	☐1	q03q23_7_3
Health precaution	☐1			q03q23_7_4
				q03q23_7_5
				q03q23_7_6
				q03q23_7_7

Preventive Health Care

24.0 In what **year** did you last consult a GP about a health problem? q03q24_0

24.1 Have you ever had any of the following

			Yes	No	If **Yes**, year of most recent
(a)	Blood pressure check	q03q24_1a	☐	☐	q03q24_1a_y
(b)	Blood cholesterol check	q03q24_1b	☐	☐	q03q24_1b_y
(c)	Flu vaccination	q03q24_1c	☐	☐	q03q24_1c_y
(d)	Dental check	q03q24_1d	☐	☐	q03q24_1d_y
(e)	Foot care from a chiropodist	q03q24_1e	☐	☐	q03q24_1e_y

24.2 Approximately, how many times in the **last twelve months** have you consulted your GP about a health problem? ☐☐ times q03q24_2

Questions about medicines

			Yes	No	
25.0	Do you take any regular medication?		☐	☐	q03q25_0
	If **Yes**, do you take any of the following medicines regularly?				Year started
(a)	Aspirin tablets	q03q25_0a	☐	☐	q03q25_0a_y
(b)	Treatment for any form of heart disease	q03q25_0b	☐	☐	q03q25_0b_y
(c)	Treatment to lower blood pressure	q03q25_0c	☐	☐	q03q25_0c_y
(d)	Treatment to lower blood cholesterol	q03q25_0d	☐	☐	q03q25_0d_y

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

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(a) Please give the name of this medicine: q03q25_1a _____

(b) Please give the amount you take each day: q03q25_1b _____ ☐☐☐
(details of the amount in each tablet should be on the bottle)

Details of ALL medicines

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

	Name of medicine	Reason for taking (if you know)	Date started	Is this prescribed? Yes	No	OFFICE USE
1	q03q26_0_bnf12_1 q03q26_0_bnf34_1 q03q26_0_bnf5_1 q03q26_0_bnf6_1	q03q26_0_icd1 q03q26_0_icd_x4d1	q03q26_0_med_year1	☐	☐	q03q26_0_medpr1
2	q03q26_0_bnf12_2 q03q26_0_bnf34_2 q03q26_0_bnf5_2 q03q26_0_bnf6_2	q03q26_0_icd2 q03q26_0_icd_x4d2	q03q26_0_med_year2	☐	☐	q03q26_0_medpr2
3	q03q26_0_bnf12_3 q03q26_0_bnf34_3 q03q26_0_bnf5_3 q03q26_0_bnf6_3	q03q26_0_icd3 q03q26_0_icd_x4d3	q03q26_0_med_year3	☐	☐	q03q26_0_medpr3
4	q03q26_0_bnf12_4 q03q26_0_bnf34_4 q03q26_0_bnf5_4 q03q26_0_bnf6_4	q03q26_0_icd4 q03q26_0_icd_x4d4	q03q26_0_med_year4	☐	☐	q03q26_0_medpr4
5	q03q26_0_bnf12_5 q03q26_0_bnf34_5 q03q26_0_bnf5_5 q03q26_0_bnf6_5	q03q26_0_icd5 q03q26_0_icd_x4d5	q03q26_0_med_year5	☐	☐	q03q26_0_medpr5
6	q03q26_0_bnf12_6 q03q26_0_bnf34_6 q03q26_0_bnf5_6 q03q26_0_bnf6_6	q03q26_0_icd6 q03q26_0_icd_x4d6	q03q26_0_med_year6	☐	☐	q03q26_0_medpr6
7	q03q26_0_bnf12_7 q03q26_0_bnf34_7 q03q26_0_bnf5_7 q03q26_0_bnf6_7	q03q26_0_icd7 q03q26_0_icd_x4d7	q03q26_0_med_year7	☐	☐	q03q26_0_medpr7
8	q03q26_0_bnf12_8 q03q26_0_bnf34_8 q03q26_0_bnf5_8 q03q26_0_bnf6_8	q03q26_0_icd8 q03q26_0_icd_x4d8	q03q26_0_med_year8	☐	☐	q03q26_0_medpr8
9	q03q26_0_bnf12_9 q03q26_0_bnf34_9 q03q26_0_bnf5_9 q03q26_0_bnf6_9	q03q26_0_icd9 q03q26_0_icd_x4d9	q03q26_0_med_year9	☐	☐	q03q26_0_medpr9
10	q03q26_0_bnf12_10 q03q26_0_bnf34_10 q03q26_0_bnf5_10 q03q26_0_bnf6_10	q03q26_0_icd10 q03q26_0_icd_x4d10	q03q26_0_med_year10	☐	☐	q03q26_0_medpr10

Present circumstances

27.0 Are you at present:-

single	☐1	q03q27_0
married	☐2	
widowed	☐3	
divorced or separated	☐4	
other	☐5	

(a) If you are widowed or divorced/separated, please give the year when this occurred:- q03q27_0a _____

27.1 Are you at present:-

living alone	☐1	q03q27_1
living with a partner or spouse	☐2	
living with other family member(s)	☐3	
living with other people	☐4	

27.2 Your accommodation

Are you:-

an owner occupier	☐1	q03q27_2
renting from the local authority	☐2	
renting privately	☐3	
living in a residential home	☐4	
living in a nursing home	☐5	
other (please give details)	☐6	

_____

27.3 During the winter, is your accommodation usually:

Very warm	☐1	q03q27_3
Warm	☐2	
Medium	☐3	
Cold	☐4	
Very cold	☐5	

	Yes	No	
27.4 Do you have a car available for your own use?	☐	☐	q03q27_4
27.5 Are you currently in full-time paid employment?	☐	☐	q03q27_5
27.6 Do you have private medical insurance?	☐	☐	q03q27_6
27.7 Have you ever had private medical treatment?	☐	☐	q03q27_7

Activities of daily living

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

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

200 metres or more ☐1 q03q28_0
More than a few steps but less than 200 metres ☐2
Only a few steps ☐3

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

Yes ☐1
Only if I hold on and take a rest ☐2 q03q28_1
Not at all ☐3

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

Yes ☐ q03q28_2
No ☐

29.0 Please indicate if you have difficulty doing any of the following activities:	No difficulty	Some difficulty	Unable to do or need help
Reaching or extending your arms above shoulder level	☐	☐ q03q29_0_1	☐
Pulling or pushing large objects like a living room chair	☐	☐ q03q29_0_2	☐
Walking across a room	☐	☐ q03q29_0_3	☐
Getting in and out of bed on your own?	☐	☐ q03q29_0_4	☐
Getting in and out of a chair on your own?	☐	☐ q03q29_0_5	☐
Dressing and undressing yourself on your own?	☐	☐ q03q29_0_6	☐
Bathing or showering?	☐	☐ q03q29_0_7	☐
Feeding yourself, including cutting food?	☐	☐ q03q29_0_8	☐
Getting to and using the toilet on your own?	☐	☐ q03q29_0_9	☐
Lifting and carrying something as heavy as 10 lbs, for example a bag of groceries	☐	☐ q03q29_0_10	☐
Shopping for personal items such as toilet items or medicine by yourself	☐	☐ q03q29_0_11	☐
Doing light housework such as washing up	☐	☐ q03q29_0_12	☐
Preparing your own meals by yourself	☐	☐ q03q29_0_13	☐
Using the telephone by yourself	☐	☐ q03q29_0_14	☐
Taking medications by yourself	☐	☐ q03q29_0_15	☐
Managing money (e.g. paying bills etc)	☐	☐ q03q29_0_16	☐
Using public transport on your own	☐	☐ q03q29_0_17	☐
Driving a car on your own	☐	☐ q03q29_0_18	☐

Time spent on various activities

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

				Tick box if you never do
q03q30_0_1 q03q30_0_2	Looking after wife/partner?	☐☐	hours per week	☐
q03q30_0_3 q03q30_0_4	Looking after other adult family member or friend?	☐☐		☐
q03q30_0_5 q03q30_0_6	Looking after grandchildren?	☐☐		☐
q03q30_0_7 q03q30_0_8	In paid work?	☐☐	hours per week	☐
q03q30_0_9 q03q30_0_10	In voluntary work?	☐☐		☐
q03q30_0_11 q03q30_0_12	On housework?	☐☐	hours per week	☐
q03q30_0_13 q03q30_0_14	On gardening?	☐☐		☐
q03q30_0_15 q03q30_0_16	In a pub or club?	☐☐	hours per week	☐
q03q30_0_17 q03q30_0_18	Attending religious services?	☐☐		☐
q03q30_0_19 q03q30_0_20	Playing cards, games, or bingo?	☐☐	hours per week	☐
q03q30_0_21 q03q30_0_22	Visiting the cinema/restaurants/sporting events?	☐☐		☐
q03q30_0_23 q03q30_0_24	Watching television/videos?	☐☐	hours per week	☐
q03q30_0_25 q03q30_0_26	Reading?	☐☐		☐
q03q30_0_27 q03q30_0_28	Attending class or course of study?	☐☐		☐

31.0 Do you go on day or overnight trips… Never ☐1 Sometimes ☐2 Often ☐3 q03q31_0

		Yes	No	
31.1	Have you been on holiday in the last year?	☐	☐	q03q31_1

Thank you very much for completing the questionnaire.

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

No stamp is needed.