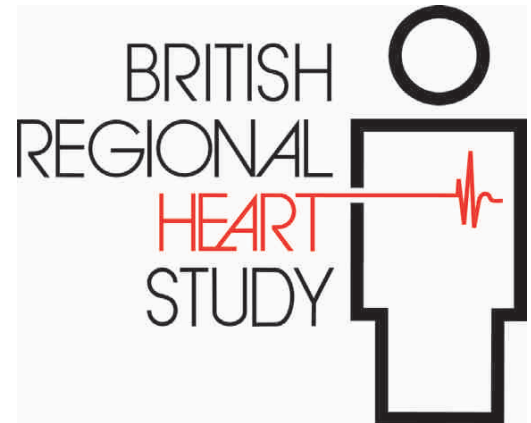


Study Number:

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serial

q2020coder

☐

BRITISH REGIONAL HEART STUDY 2023

FINAL QUESTIONNAIRE OF THE STUDY

Thank you very much for taking the time to complete this questionnaire, which will bring us up to date with your present health and circumstances. 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 need any help answering the questions, or would like a large-print copy, please phone us on **020 8016 8021** and give us your telephone number. We will then call you back to answer your query.

This is the last questionnaire which will send you because funding for the British Regional Heart Study is coming to an end.

Thank you for your help with this questionnaire and with providing information on many earlier occasions.

Best wishes to all study members and thank you for your help.

Professor S Goya Wannamethee & Ms Lucy Lennon
on behalf of the British Regional Heart Study research team

**Department of Primary Care & Population Health, UCL Medical School, Royal Free
Campus, Rowland Hill Street, London NW3 2PF**

1. Dates

- 1.0 Please enter today's date q23q1_0d q23q1_0m **20** q23q1_0y
day month year
- 1.1 Please give your Date of Birth q23q1_1d q23q1_1m **19** q23q1_1y
day month year

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

2. Conditions affecting the heart or circulation

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

- | | | Yes | No | |
|------|------------------------------------------------------------------------|---------------------------------------|---------------------------------------|----------|
| 2.0 | Acute coronary syndrome | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_0 |
| 2.1 | Angina | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_1 |
| 2.2 | Aortic Aneurysm | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_2 |
| 2.3 | Atrial Fibrillation | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_3 |
| 2.4 | Deep Vein Thrombosis
(clot in the deep leg vein) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_4 |
| 2.5 | Heart attack
(coronary thrombosis or myocardial infarction) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_5 |
| 2.6 | Heart failure | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_6 |
| 2.7 | High blood pressure | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_7 |
| 2.8 | High cholesterol | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_8 |
| 2.9 | Narrowing or hardening of the leg arteries
(including claudication) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_9 |
| 2.10 | Pulmonary Embolism
(clot on the lung) | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_10 |
| 2.11 | Other problems of the heart and circulation | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | q23q2_11 |

- 2.12 **If yes**, please give details q23q2_12BOX ☐ Office Use

3. Stroke

		Yes	No	Year of last occurrence
3.0	Have you ever been told by a doctor that you have had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q3_0</u>
3.1	Did the symptoms last for more than 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q3_1</u>
3.2	Have you made a complete recovery from your stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q3_2</u>
3.3	Following your stroke, do you still need any help in carrying out everyday activities?	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q3_3</u>

4. Investigations and special treatment for conditions affecting your heart and circulation

	Have you ever had one of the following?	Yes	No	Year of last occurrence
4.0	A referral for an echocardiogram ("echo")	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q4_0</u>
4.1	An exercise ECG ("stress" or "treadmill") test	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q4_1</u>
4.2	CT Scan of coronary arteries	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q4_2</u>
4.3	Angiogram or X-ray of coronary arteries (using a dye)	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q4_3</u>
4.4	Angioplasty (balloon treatment of coronary artery, PCI, stents)	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q4_4</u>
4.5	Coronary artery bypass graft operation ("heart bypass" or "CABG")	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q4_5</u>
4.6	Other tests, investigations or operations on your heart, arteries or veins?	<input type="checkbox"/>	<input type="checkbox"/>	<u>q23q4_6</u>
4.7	If yes , please give details:			

Office Use
q23q4_7BOX ☐

Cardiac rehabilitation

- 4.8 Have you **ever** taken part in an exercise programme (cardiac rehabilitation) after experiencing a heart problem, cardiac surgery or procedure or a stroke? Yes ☐ No ☐
q23q4_8 1 2
- 4.9 If yes, which year was this? q23q4_9

5. Diabetes

- 5.0 Have you **ever** been told by a doctor that you have or have had diabetes? Yes ☐ No ☐ Year of diagnosis
q23q5_0 1 2 q23q5_0y
- If yes**, do you have any complications of diabetes affecting your:
- (Tick **all** that apply)
- 5.1 feet ☐ q23q5_1 1
- 5.2 kidneys ☐ q23q5_2 1
- 5.3 eyes ☐ q23q5_3 1
- 5.4 nerves ☐ q23q5_4 1
- 5.5 none ☐ q23q5_5 1

6. Cancer

- 6.0 Have you **ever** been told by a doctor that you have or have had cancer? Yes ☐ No ☐ Year of **first** diagnosis
q23q6_0 1 2 q23q6_0y
- 6.1 **If yes**, please give the Cancer Site (parts of the body affected)
- Office Use
ICD 9 code
- | | | | |
|-------------------------------|----------------------|----------------------|----------------------|
| <u>q23q6_1Cancer_site1Box</u> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <u>q23q6_1Cancer_site2Box</u> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <u>q23q6_1Cancer_site3Box</u> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

7. Other medical conditions

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

		Yes	No	
7.0	Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_0
		1	2	
7.1	Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_1
		1	2	
7.2	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_2
		1	2	
7.3	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_3
		1	2	
7.4	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_4
		1	2	
7.5	Chronic Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_5
		1	2	
7.6	Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_6
		1	2	
7.7	Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_7
		1	2	
7.8	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_8
		1	2	
7.9	Depression	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_9
		1	2	
7.10	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_10
		1	2	
7.11	Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_11
		1	2	
7.12	Gastric, peptic or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_12
		1	2	
7.13	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_13
		1	2	
7.14	Gout	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_14
		1	2	
7.15	Liver disease, cirrhosis or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_15
		1	2	
7.16	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_16
		1	2	
7.17	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_17
		1	2	
7.18	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_18
		1	2	
7.19	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_19
		1	2	
7.20	Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_20
		1	2	
7.21	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_21
		1	2	
7.22	COVID-19	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_22
		1	2	
7.23	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_23
		1	2	
7.24	Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	q23q7_24
		1	2	
	Other conditions, please give details:	Office Use ICD 9 code		
7.25		q23q7_25BOX <input type="text"/>		
7.26		q23q7_26BOX <input type="text"/>		

8. Chest Pain

- 8.0 Do you **ever** have any pain or discomfort in your chest? Yes No ☐₁ ☐₂ q23q8_0
- 8.1 When you walk at an ordinary pace on the level, does this produce the chest pain? Yes No Unable to walk on level ☐₁ ☐₂ ☐₃ q23q8_1
- 8.2 When you walk uphill or hurry, does this produce the chest pain? Yes No Unable to walk uphill ☐₁ ☐₂ ☐₃ q23q8_2

9. Breathlessness

- 9.0 Do you **ever** get short of breath walking with other people of your own age on level ground? Yes No Unable to walk ☐₁ ☐₂ ☐₃ q23q9_0
- 9.1 On walking uphill or upstairs, do you get more breathless than people of your own age? ☐₁ ☐₂ ☐₃ q23q9_1
- 9.2 Do you **ever** have to stop walking because of breathlessness? ☐₁ ☐₂ ☐₃ q23q9_2
- 9.3 In the **past year** have you at any time been awoken at night by an attack of shortness of breath? ☐₁ ☐₂ q23q9_3

10. Cough and Wheeze

- 10.0 Do you usually bring up phlegm (or spit) from your chest first thing in the morning in the winter? Yes No ☐₁ ☐₂ q23q10_0
- 10.1 Do you bring up phlegm like this on most days for as much as three months in the winter each year? ☐₁ ☐₂ q23q10_1
- 10.2 In the **past four years** have you had a period of increased cough and phlegm lasting for 3 weeks or more?
- Yes, once ☐₁ q23q10_2
- Yes, twice or more ☐₂
- Never ☐₃
- 10.3 Does your chest ever sound wheezy or whistling? Yes No ☐₁ ☐₂ q23q10_3
- 10.4 **If yes**, does this happen on most days or nights? ☐₁ ☐₂ q23q10_4

Chest infections and antibiotics

10.5 How many times in the **past year** have you had a **chest infection** requiring **antibiotic** treatment from your doctor?

None ☐ ₁ q23q10_5
Once ☐ ₂
More than once ☐ ₃

10.6 Do you receive the annual influenza (flu) vaccination?

Always ☐ ₁ q23q10_6
Most years ☐ ₂
Rarely or never ☐ ₃

11. Operations

11.0 Have you had any major operations in the **last 5 years**? Yes No
☐ ₁ ☐ ₂ q23q11_0

11.1 **If yes**, please give details:

Office Use
q23q11_1BOX

Bladder control/ Faecal Incontinence

Many people complain that they leak urine or faecal matter unintentionally.

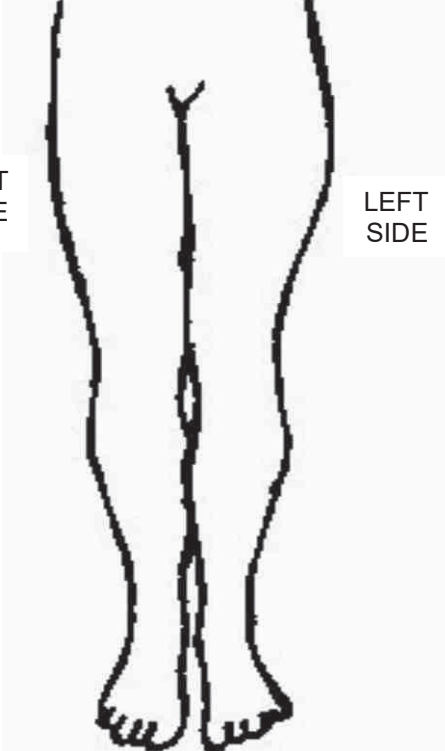
In the **past 12 months**-

	Yes	No
11.2 have you leaked even a small amount of urine?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ q23q11_2
11.3 If yes, when you had this problem, did it last for more than a month?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ q23q11_3
11.4 have you leaked even a small amount of faecal matter?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ q23q11_4
11.5 If yes, when you had this problem, did it last for more than a month?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ q23q11_5

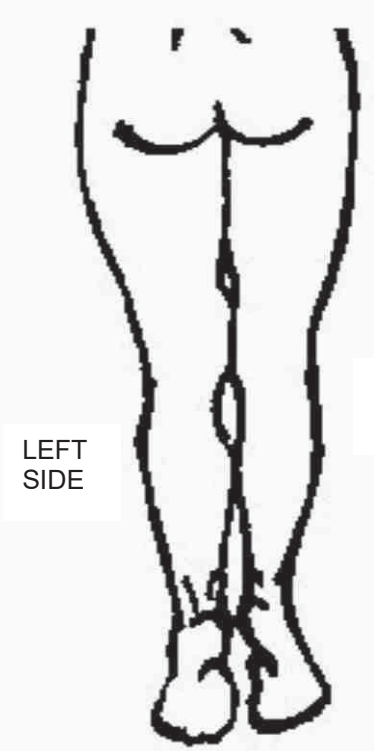
12. Leg Pain

- 12.0 Do you get pain or discomfort in your leg or legs when you walk? Yes ☐₁ No ☐₂ Unable to walk ☐₃ [q23q12_0](#)
- 12.1 Does this pain ever begin when you are standing still or sitting? ☐₁ ☐₂ [q23q12_1](#)
- 12.2 Do you get the pain if you walk uphill or hurry? ☐₁ ☐₂ ☐₃ [q23q12_2](#)
- 12.3 Do you get the pain walking at an ordinary pace on the level? ☐₁ ☐₂ ☐₃ [q23q12_3](#)
- 12.4 What happens to the pain if you stand still? [q23q12_4](#)
- Usually continues more than 10 minutes ☐₁
- Usually disappears in 10 minutes or less ☐₂
- 12.5 Please mark on the diagram below where you get the pain.

FRONT



BACK



Office Use

[q23q12_5L_Box](#)

L ☐

R ☐

[q23q12_5R_Box](#)

13. Arthritis

13.0 Have you **ever** been told by a doctor that you have or have had arthritis? Yes ☐ q23q13_0_1 No ☐ q23q13_0_2 Year of diagnosis q23q13_0_y

13.1 **If yes**, please give the type of arthritis if known:

Osteoarthritis ☐ q23q13_1_1

Rheumatoid arthritis ☐ q23q13_1_2

Other (please give details) ☐ q23q13_1_3 q23q13_1BOX

Don't know ☐ q23q13_1_4

Office Use ☐

Which joints are affected: (Tick **all** that apply)

13.2 Knees ☐ q23q13_2_1

13.3 Hips ☐ q23q13_3_1

13.4 Feet ☐ q23q13_4_1

13.5 Ankle ☐ q23q13_5_1

13.6 Hands and /or fingers ☐ q23q13_6_1

13.7 Wrists ☐ q23q13_7_1

13.8 Back ☐ q23q13_8_1

13.9 Neck ☐ q23q13_9_1

13.10 Shoulders ☐ q23q13_10_1 Office Use

13.11 Other (please specify) ☐ q23q13_11_1 q23q13_11BOX

14. Joint pain, swelling or stiffness

14.0 During **the past year**, have you had pain, aching, stiffness or swelling on most days **for at least one month**? Yes ☐_1 No ☐_2 q23q14_0

If yes, which joints are affected: (Tick **all** that apply)

14.1 Knees ☐_1 q23q14_1

14.2 Hips ☐_1 q23q14_2

14.3 Feet ☐_1 q23q14_3

14.4 Ankle ☐_1 q23q14_4

14.5 Hands and /or fingers ☐_1 q23q14_5

14.6 Wrists ☐_1 q23q14_6

14.7 Back ☐_1 q23q14_7

14.8 Neck ☐_1 q23q14_8

14.9 Shoulders ☐_1 q23q14_9

14.10 Other (please specify) ☐_1 q23q14_10 q23q14_10BOX ☐ Office Use

15. Lower back pain

15.0 Have you **ever** had pain in your lower back on **most days** for at **least one month**? Yes ☐_1 No ☐_2 q23q15_0

15.1 **If yes**, have you had this in the **last year**? ☐_1 ☐_2 q23q15_1

16. Falls

16.0 At the **present time**, are you afraid that you may fall over?

Very fearful ☐_1 q23q16_0

Somewhat fearful ☐_2

Not fearful ☐_3

17. Fractures and falls

		Yes	No	
17.0	Have you had a fall in the last year ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q17_0
17.1	If yes, how many times	_____	_____	q23q17_1
17.2	Did you receive medical attention for any of these falls?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q17_2

Did you suffer any of the following as a **result of a fall** in the **past year**?

(Tick **all** that apply)

17.3	cuts and bruises	<input type="checkbox"/> ₁	q23q17_3
17.4	damage to muscle or ligament	<input type="checkbox"/> ₁	q23q17_4
17.5	broken or fractured hip bone	<input type="checkbox"/> ₁	q23q17_5
17.6	broken or fractured wrist bone	<input type="checkbox"/> ₁	q23q17_6
17.7	other broken or fractured bone	<input type="checkbox"/> ₁	q23q17_7

		Yes	No	Please give year
17.8	Have you ever fractured your hip?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q17_8 q23q17_8y
17.9	Have you ever fractured your wrist?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q17_9 q23q17_9y

Dizziness

		Yes	No	
17.10	Have you had spells of dizziness, loss of balance or a sensation of spinning in the last year ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q17_10

18. Your overall health

Please indicate which statements best describe your health **TODAY**.

18.0 General health

- Excellent ☐ ₁ [q23q18_0](#)
- Good ☐ ₂
- Fair ☐ ₃
- Poor ☐ ₄

18.1 Pain/discomfort

- I have no pain or discomfort ☐ ₁ [q23q18_1](#)
- I have moderate pain or discomfort ☐ ₂
- I have extreme pain or discomfort ☐ ₃

18.2 Usual activities e.g. work, study, housework, family or leisure activities:

- I have no problems with performing my usual activities ☐ ₁ [q23q18_2](#)
- I have some problems with performing my usual activities ☐ ₂
- I am unable to perform my usual activities ☐ ₃

18.3 Mobility

- I have no problems in walking about ☐ ₁ [q23q18_3](#)
- I have some problems in walking about ☐ ₂
- I am confined to a chair/wheelchair ☐ ₃

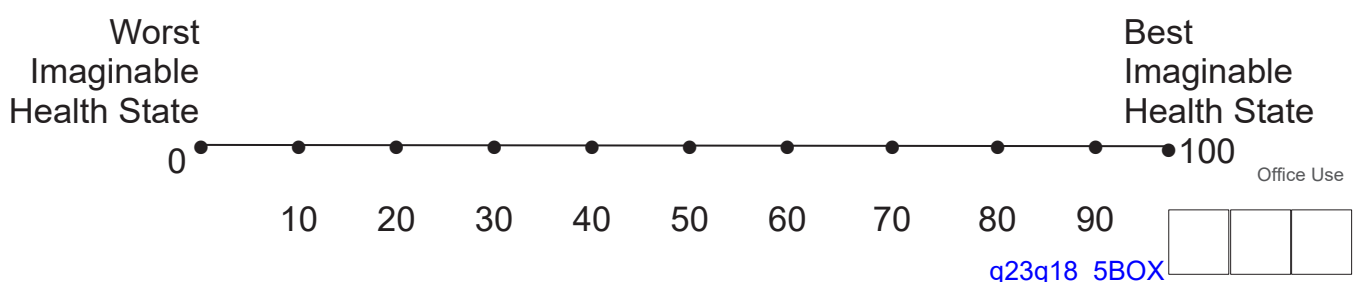
18.4 Anxiety/depression

- I am not anxious or depressed ☐ ₁ [q23q18_4](#)
- I am moderately anxious and/or depressed ☐ ₂
- I am extremely anxious and/or depressed ☐ ₃

18.5 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**.



19. Weight

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

q23q19_0st q23q19_0pounds **or** q23q19_0kg Kilograms

_____ Stones _____ Pounds _____ Kilograms

19.1 **If you have no scales** and have made an estimate, please tick here ☐ [q23q19_1](#)

19.2 Has your weight changed in the **last four years**?

Not changed	<input type="checkbox"/>	1
Increased	<input type="checkbox"/>	2
Decreased	<input type="checkbox"/>	3
Both increased and decreased	<input type="checkbox"/>	4
Don't know	<input type="checkbox"/>	5

q23q19_2

19.3 If your weight has changed in the last four years: Yes No
Was this change intentional? ☐_1 ☐_2

Was it the result of: (Tick **all** that apply)

19.4 Personal choice ☐_q23q19_4

19.5 Medical advice ☐ q23q19_5

19.6 Illness or ill health ☐ q23q19_6

20. Hearing

20.0 Have you **ever** had a hearing test?

Yes No

☐ ☐

1 2

q23q20_0

20.1 If **yes**, were you offered a hearing aid? ☐ ☐ q23q20_1

20.2 Do you use a **hearing aid**? Yes ☐ No ☐ Occasionally ☐ q23q20_2

20.3 Is your hearing good enough to follow a TV programme at a volume others find acceptable (using a hearing aid if needed)?

Yes ☐_1 No ☐_2 [q23q20_3](#)

20.4 **If no**, can you follow a TV programme with the volume turned up? ☐₁ ☐₂ q23q20_4

21. Eyesight

21.0 Using glasses or corrective lenses if needed, can you see well enough to recognise a friend at a distance of 13 feet/ four yards (**across a road**)?

21.1 If **no**, can you see well enough to recognise a friend at a distance of three feet/ one yard? ☐ ₁ ☐ ₂ q23q21_1

Height

- 21.2 What is your present height? q23q21_2feet Feet q23q21_2inches Inches or q23q21_2cm cm
- 21.3 Not sure of my height, I am unable to stand ☐ q23q21_3

Your normal posture

- 21.4 Which of the figures below best matches your posture when you are standing or moving around?

Please tick one of the boxes below

☐

1

☐

2

☐

3

☐

4

q23q21_4

Unable to stand

☐

5

Not sure

☐

6

22. Cigarette Smoking

- 22.0 Have you **ever** smoked cigarettes? q23q22_0 Yes ☐ 1 No ☐ 2
- 22.1 Do you smoke cigarettes at present? q23q22_1 Yes ☐ 1 No ☐ 2

23. Alcohol Intake

- 23.0 Would you describe your present alcohol intake as
- Daily/most days ☐ 1 q23q23_0
- Weekends only ☐ 2
- Occasionally once or twice a month ☐ 3
- Special occasions only ☐ 4
- None ☐ 5

One drink is **HALF A PINT** of beer/cider, or **SINGLE** whisky, gin, 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 [q23q23_1](#)
5-6 drinks ☐ ₂
3-4 drinks ☐ ₃
1-2 drinks ☐ ₄

23.2 How many alcoholic drinks do you have during an average week? [q23q23_2](#)

What type of drink do you usually take? (Tick **all** that apply)

- 23.3 Beers, Lagers ☐ ₁ [q23q23_3](#)
23.4 Wines, Sherry ☐ ₁ [q23q23_4](#)
23.5 Spirits ☐ ₁ [q23q23_5](#)
23.6 Combination of Beers, Wines or Spirits ☐ ₁ [q23q23_6](#)
23.7 Low alcohol drinks ☐ ₁ [q23q23_7](#)

24. Water intake

24.0 How many glasses of **water** do you drink **a day**? [q23q24_0](#) glasses per day

25. Physical activity

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

- No ☐ ₁ [q23q25_0](#)
Walk ☐ ₂
Cycle ☐ ₃
Both ☐ ₄

25.1 How many hours do you normally spend **walking** e.g. on errands or for leisure in an average **week**? [q23q25_1](#) hours

25.2 Which of the following best describes your **usual walking pace**?

- Slow ☐ ₁ [q23q25_2](#)
Steady average ☐ ₂
Fast ☐ ₃

25.3 How long do you spend **cycling** in an average week? q23q25_3 hours

25.4 On a normal day, how many times do you **climb a flight of stairs** (assuming that 1 flight of stairs has 10 steps)? q23q25_4 times /day

25.5 Do not climb stairs ☐ q23q25_5

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

- Much more active ☐ q23q25_6₁
- More active ☐₂
- Similar ☐₃
- Less active ☐₄
- Much less active ☐₅

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

- No ☐₁ q23q25_7
- Occasionally less than once a month ☐₂
- Frequently once a month or more ☐₃

25.8 If you ticked **frequently** please state type of activities:

q23q25_8BOX

Office Use

--	--

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

(please give overall total)

25.9 In winter q23q25_9 times a month

25.10 In summer q23q25_10 times a month

26. General Fitness

Can you do any of the following activities:

		Yes	No
26.0	run a short distance?	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q26_0
26.1	do heavy work around the house (e.g. lifting & moving heavy furniture)	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q26_1
26.2	do gardening (e.g. raking leaves, weeding & pushing the lawn mower)	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q26_2
26.3	participate in moderate activities like golf, bowling, dancing or doubles tennis?	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q26_3
26.4	participate in strenuous sports like swimming or singles tennis?	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q26_4
26.5	have sexual relations?	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q26_5

27. Muscle strength and endurance

		Yes	No
27.0	Do you engage in exercises to increase muscle strength and endurance such as lifting weights, doing push-ups, using exercise machines?	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q27_0
27.1	If yes , on average, how much time each week do you engage in these exercises?		
	q23q27_1h hours 23q27_1m minutes		

28. Grip Strength

28.0	How would you rate your hand grip strength compared to other people your age?	Very good	<input type="checkbox"/> _1 q23q28_0
		Good	<input type="checkbox"/> _2
		Fair	<input type="checkbox"/> _3
		Poor	<input type="checkbox"/> _4

29. Strengthening and Balance Exercises

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

(Please circle the number of times you do the activity).

		Number of days each week							Monthly	Rarely / Never
		7	6	5	4	3	2	1	0	8
29.0	Carrying or moving heavy loads e.g. carrying shopping or grandchildren, pushing a wheelchair or lawnmower.	7	6	5	4	3	2	1	M	R
29.1	Doing exercises e.g. push ups, sit ups, chair aerobics, an exercise routine.	7	6	5	4	3	2	1	M	R
29.2	Balance and co-ordination e.g. dancing, standing on one leg, or Tai Chi style exercises.	7	6	5	4	3	2	1	M	R

30. Long standing illness, disability or infirmity

30.0 Do you have any **long-standing** illness, disability or infirmity? ☐ Yes ☐ No [q23q30_0](#)

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

If yes,

30.1 does this illness or disability limit your activities in any way? ☐ Yes ☐ No [q23q30_1](#)

30.2 do you receive a disability allowance? ☐ Yes ☐ No [q23q30_2](#)

31. Disability

Do you currently have difficulty carrying out any of the following activities on your own?

		Yes	No
31.0	Going up or down stairs	<input type="checkbox"/>	<input type="checkbox"/>
31.1	Bending down	<input type="checkbox"/>	<input type="checkbox"/>
31.2	Straightening up	<input type="checkbox"/>	<input type="checkbox"/>
31.3	Keeping your balance	<input type="checkbox"/>	<input type="checkbox"/>
31.4	Going out of the house	<input type="checkbox"/>	<input type="checkbox"/>
31.5	Walking 400 yards	<input type="checkbox"/>	<input type="checkbox"/>

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

		Yes	No	Does not apply
31.6	Job at work paid employment	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q31_6
31.7	Household chores	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q31_7
31.8	Social life	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q31_8
31.9	Interests and hobbies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q31_9
31.10	Holidays and outings	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q31_10

31.11 Do you have any difficulties getting about outdoors?

No difficulty	<input type="checkbox"/> ₁	q23q31_11
Slight	<input type="checkbox"/> ₂	
Moderate	<input type="checkbox"/> ₃	
Severe	<input type="checkbox"/> ₄	
Unable to do	<input type="checkbox"/> ₅	

32. Mobility

32.0 How would you describe your current mobility?

Able to leave my home	<input type="checkbox"/> ₁	q23q32_0
Able to get out of bed or a chair, but unable to go out of my home	<input type="checkbox"/> ₂	
Unable to get out of a bed, a chair, or a wheelchair without the assistance of another person	<input type="checkbox"/> ₃	

Mobility Aids

	Yes	No	
32.1 Do you use any mobility aids?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	q23q32_1
If yes, which aids or appliances do you use to help with day to day activities?			
(Tick all that apply)			
32.2 Walking stick	<input type="checkbox"/> ₁		q23q32_2
32.3 Walking frame	<input type="checkbox"/> ₁		q23q32_3
32.4 Wheelchair/ mobility scooter	<input type="checkbox"/> ₁		q23q32_4
32.5 Other	<input type="checkbox"/> ₁		q23q32_5
			q23q32_5BOX

Office Use

33. Activities of daily living

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

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

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

[q23q33_0](#)

33.1 Can you walk up and down a flight of 13 stairs without resting?

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

[q23q33_1](#)

33.2 When standing, can you bend down and pick up a shoe **from the floor?**

- Yes No
- ☐ ₁ ☐ ₂

[q23q33_2](#)

33.3 When sitting, can you rise from a chair of knee height, **without using your hands?**

- ☐ ₁ ☐ ₂

[q23q33_3](#)

33.4 Would you say there has been any change in your ability to do **practical things** in the **past two years?**

- No change ☐ ₁
- Better ☐ ₂
- Worse ☐ ₃
- Much Worse ☐ ₄

[q23q33_4](#)

34. Difficulties with Activities of daily living

Please indicate **if you have difficulty** doing any of the following activities:

	No Difficulty	Some difficulty	Unable to do or need help
34.0 Reaching or extending your arms above shoulder level	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_0
34.1 Pulling or pushing large objects like a living room chair	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_1
34.2 Walking across a room	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_2
34.3 Getting in and out of bed on your own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_3
34.4 Getting in and out of a chair on your own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_4
34.5 Dressing and undressing yourself on your own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_5
34.6 Bathing or showering	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_6
34.7 Feeding yourself, including cutting food	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_7
34.8 Getting to and using the toilet on your own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_8
34.9 Lifting and carrying something as heavy as 10 lbs,(e.g. a bag of groceries)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_9
34.10 Shopping for personal items such as toilet items or medicine by yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_10
34.11 Doing light housework (e.g. washing up)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_11
34.12 Preparing your own meals by yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_12
34.13 Using the telephone by yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_13
34.14 Taking medications by yourself	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_14
34.15 Managing money (e.g. paying bills etc)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_15
34.16 Using public transport on your own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_16
34.17 Driving a car on your own	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_17
34.18 Gripping with hands (e.g. opening a jam jar)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q34_18

35. Appetite

Which of the following statements best describes your appetite:

35.0 My appetite is

- very poor ☐ ₁ [q23q35_0](#)
- poor ☐ ₂
- average ☐ ₃
- good ☐ ₄
- very good ☐ ₅

35.1 When I eat, I feel full after eating

- only a few mouthfuls ☐ ₁ [q23q35_1](#)
- about a third of a meal ☐ ₂
- over half a meal ☐ ₃
- most of the meal ☐ ₄
- hardly ever ☐ ₅

35.2 Food generally tastes

- very bad ☐ ₁ [q23q35_2](#)
- bad ☐ ₂
- average ☐ ₃
- good ☐ ₄
- very good ☐ ₅

35.3 Normally I eat

- less than one meal a day ☐ ₁ [q23q35_3](#)
- one meal a day ☐ ₂
- two meals a day ☐ ₃
- three meals a day ☐ ₄
- more than three meals a day ☐ ₅

35.4 Have you noticed any **change** in your appetite over the **past three months**?

- no change in my appetite ☐ ₁ [q23q35_4](#)
- moderate loss of appetite ☐ ₂
- severe loss of appetite ☐ ₃
- improvement of appetite ☐ ₄

35.5 **If you have had a loss of appetite**, what was the reason for this?

q23q35_5_BOX

Office

35.6 How often do you skip a meal?

Never ☐ ₁

Once a week ☐ ₂

2-3 times a week ☐ ₃

More than 3 times a week ☐ ₄

q23q35_6

35.7 If you skip a meal, what is the most common reason for doing so?

q23q35_7BOX

Office

35.8 Do you need outside help preparing your meals?

Yes No

☐ ₁ ☐ ₂

q23q35_8

If yes, who provides help?

(Tick all that apply)

35.9 Family, friends or neighbours ☐ ₁ q23q35_9

35.10 Social services (home help, meals on wheels) /care staff ☐ ₁ q23q35_10

35.11 Privately paid help ☐ ₁ q23q35_11

35.12 I need help but no help is received ☐ ₁ q23q35_12

36. Appetite and eating

36.0 Do you have an **illness or a physical condition** that interferes with your appetite or ability to eat?

Yes No

☐ ₁ ☐ ₂

q23q36_0

If Yes, please indicate the conditions that interfere with your appetite or ability to eat

(Tick **all** that apply)

36.1 Problems with your teeth ☐ ₁ q23q36_1

36.2 Swallowing problems ☐ ₁ q23q36_2

36.3 Pain on chewing ☐ ₁ q23q36_3

36.4 Poor taste ☐ ₁ q23q36_4

36.5 Poor smell ☐ ₁ q23q36_5

36.6 Stomach/ abdominal pain ☐ ₁ q23q36_6

36.7 Gas/ bloating ☐ ₁ q23q36_7

36.8 Indigestion/ heartburn ☐ ₁ q23q36_8

36.9 Constipation/Diarrhoea ☐ ₁ q23q36_9

36.10 Other (please specify) ☐ ₁ q23q36_10

q23q36_10BOX

Office Use

36.11 Are there days when you **don't feel like eating at all?** Yes ☐_1 No ☐_2 q23q36_11

If yes,
36.12 About how often would you say you don't feel like eating at all?

About once a month ☐_1 q23q36_12
About once a week ☐_2
More than once a week ☐_3
Every day ☐_4

What do you think are the reasons you do not feel like eating?

(Tick **all** that apply)

36.13 Not hungry ☐_1 q23q36_13
36.14 In general, food is not appealing to me ☐_1 q23q36_14
36.15 Taste of the food ☐_1 q23q36_15
36.16 Smell of the food ☐_1 q23q36_16
36.17 Look of the food ☐_1 q23q36_17
36.18 No specific reason ☐_1 q23q36_18 Office Use
36.19 Other (please specify) _____ ☐_1 q23q36_19 q23q36_19BOX

37. Your food intake and weight loss

37.0 During the **past month**, would you say you have you had enough food to satisfy your hunger

All of the time ☐_1 q23q37_0
Most of the time ☐_2
Some of the time ☐_3
Never/rarely ☐_4

37.1 Do you feel you are undernourished?

Yes ☐_1 q23q37_1
No ☐_2
I don't know ☐_3

37.2 Has your food intake declined over the **past 3 months**?

- no decrease in food intake ☐ ₁ [q23q37_2](#)
- moderate decrease in food intake ☐ ₂
- severe decrease in food intake ☐ ₃

37.3 How much weight (if any) have you lost in the **past 3 months**?

- no weight loss or weight loss less than 2 pounds (1Kg) ☐ ₁ [q23q37_3](#)
- weight loss between 2 and 7 pounds (1 and 3Kg) ☐ ₂
- weight loss greater than 7 pounds (3 Kg) ☐ ₃
- do not know the amount of weight lost ☐ ₄

Shopping for food

37.4 Do you have any difficulty shopping for food because of a health or physical problem? Yes No
☐ ₁ ☐ ₂ [q23q37_4](#)

37.5 Can you easily access a supermarket or grocery for your food shopping? ☐ ₁ ☐ ₂ [q23q37_5](#)

37.6 Would you say you get the groceries that you need?

All of the time ☐ ₁ [q23q37_6](#)

Most of the time ☐ ₂

Some of the time ☐ ₃

Never/rarely ☐ ₄

38. Stress and illness in last 3 months

38.0 Have you been stressed or severely ill in the past 3 months? Yes No
☐ ₁ ☐ ₂ [q23q38_0](#)

38.1 Are you currently experiencing **dementia** and/or **prolonged severe sadness**? No
☐ ₁

yes, mild dementia, but no prolonged severe sadness ☐ ₂ [q23q38_1](#)

yes, severe dementia and/or prolonged severe sadness ☐ ₃

39. General Dental Health

39.0 Would you say that your **dental health** is:

Excellent ☐ ₁ [q23q39_0](#)
Good ☐ ₂
Fair ☐ ₃
Poor ☐ ₄

Yes No

39.1 Do you have **any** of your **own (natural) teeth**?

☐ ₁ ☐ ₂ [q23q39_1](#)

39.2 How many of your own (natural) teeth do you have?

 [q23q39_2](#)

39.3 How many of your own (natural) teeth have **you lost** in the **last five years**?

 [q23q39_3](#)

40. Back teeth (molars)

Do you have **any** of your own back teeth(molars) in your **lower teeth**?

Yes No

40.0 on the **left** side ☐ ₁ ☐ ₂ [q23q40_0](#)

40.1 on the **right** side ☐ ₁ ☐ ₂ [q23q40_1](#)

Do you have **any** of your own back teeth(molars) in your **upper teeth**?

Yes No

40.2 on the **left** side ☐ ₁ ☐ ₂ [q23q40_2](#)

40.3 on the **right** side ☐ ₁ ☐ ₂ [q23q40_3](#)

41. Chewing difficulties

41.0 Do you have **difficulty chewing any foods** because of problems with your teeth, mouth or dentures?

No ☐ ₁ [q23q41_0](#)

Yes, some difficulty ☐ ₂

Yes, great difficulty ☐ ₃

Yes No

41.1 Do you **avoid eating some foods** because of problems with your teeth, mouth or dentures? ☐ ₁ ☐ ₂ [q23q41_1](#)

41.2 Does it take you **longer to finish a meal** than other people of your own age?

☐ ₁ ☐ ₂ [q23q41_2](#)

42. Tooth brushing

42.0 What type of toothbrush do you use?

Manual toothbrush (non-electric) ☐ ₁ [q23q42_0](#)

Electric toothbrush ☐ ₂

Both ☐ ₃

Do not brush ☐ ₄

42.1 How frequently do you **brush your teeth**?

More than once a day ☐ ₁ [q23q42_1](#)

Once a day ☐ ₂

Less than once a day ☐ ₃

Do not brush (e.g. no teeth) ☐ ₄

Yes No

42.2 Do you have difficulty brushing your teeth?

☐ ₁ ☐ ₂ [q23q42_2](#)

Mouthwash

42.3 Do you currently use a chlorhexidine mouthwash such as Corsodyl, Covonia, Dermal, Savlon or Germolene?

Yes No

☐ ₁ ☐ ₂ [q23q42_3](#)

42.4 If yes, what is the name of the mouthwash you use?

Office Use

[q23q42_4BOX](#)

42.5 How many times a day do you use it?

once daily ☐ ₁ [q23q42_5](#)

twice daily ☐ ₂

42.6 How long have you been using it for?

Up to one week ☐ ₁ [q23q42_6](#)

1-2 weeks ☐ ₂

More than 2 weeks ☐ ₃

42.7 In the last 5 years, have you ever used a chlorhexidine mouthwash such as Corsodyl, Covonia, Dermal, Savlon or Germolene?

Yes No

☐ ₁ ☐ ₂ [q23q42_7](#)

43. Visiting the dentist

43.0 Have you seen your dentist in the last year? Yes No
☐ ₁ ☐ ₂ [q23q43_0](#)

43.1 In general, do you go to the dentist / hygienist for: [q23q43_1](#)

Regular check-up ☐ ₁

Occasional check up ☐ ₂

Only when having trouble ☐ ₃

Rarely or never go to the dentist ☐ ₄

If you rarely or never visit the dentist, what are the reasons? (Tick **all** that apply)

43.2 Difficult to get to the dental surgery ☐ ₁ [q23q43_2](#)

43.3 Expensive ☐ ₁ [q23q43_3](#)

43.4 Don't need to see a dentist ☐ ₁ [q23q43_4](#)

43.5 Other _____ ☐ ₁ [q23q43_5](#) Office Use ☐
[q23q43_5BOX](#)

44. Other dental problems

In the **past 6 months**, have you had any of following **dental problems**?

(Tick **all** that apply)

44.0 Pain related to teeth or mouth ☐ ₁ [q23q44_0](#)

44.1 Loose tooth ☐ ₁ [q23q44_1](#)

44.2 Sensitivity to hot/ cold food or drink ☐ ₁ [q23q44_2](#)

44.3 Mouth ulcers ☐ ₁ [q23q44_3](#)

44.4 Bleeding gums ☐ ₁ [q23q44_4](#)

44.5 Other gum problems ☐ ₁ [q23q44_5](#)

44.6 Soreness or cracking around the corners of the mouth ☐ ₁ [q23q44_6](#)

45. Dental problems affecting your daily life

Have any problems with mouth, teeth or dentures caused any of the following difficulty or problem effecting your daily life?

(Tick **all** that apply)

- | | | | |
|------|--------------------------------------------------------------------------|--------------------------|----------|
| 45.0 | Difficulty speaking clearly | <input type="checkbox"/> | q23q45_0 |
| 45.1 | Difficulty going out, for example to shop or visit someone | <input type="checkbox"/> | q23q45_1 |
| 45.2 | Difficulty relaxing (including sleeping) | <input type="checkbox"/> | q23q45_2 |
| 45.3 | Problems smiling, laughing and showing teeth without embarrassment | <input type="checkbox"/> | q23q45_3 |
| 45.4 | Emotional problems e.g. becoming more easily upset than usual | <input type="checkbox"/> | q23q45_4 |
| 45.5 | Problems enjoying the company of others e.g. family, friends, neighbours | <input type="checkbox"/> | q23q45_5 |
| 45.6 | None of these | <input type="checkbox"/> | q23q45_6 |

46. Dentures

- | | | | |
|------|---------------------------------------------------------------------------------|------------------------------|--------------------------|
| | | Yes | No |
| 46.0 | Do you wear full or partial dentures (plate or false teeth that are removable)? | <input type="checkbox"/> | <input type="checkbox"/> |
| | If you wear dentures , do you have any problems such as: | (Tick all that apply) | |
| 46.1 | Loose dentures | <input type="checkbox"/> | q23q46_1 |
| 46.2 | Difficulty eating with dentures | <input type="checkbox"/> | q23q46_2 |
| 46.3 | Other, please specify _____ | <input type="checkbox"/> | q23q46_3BOX |

Using your dentures (if you have them)

- | | | | |
|------|------------------------------------------------------------------|--------------------------|--------------------------|
| | | Yes | No |
| 46.4 | Do you take out your dentures (false teeth) while eating? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46.5 | Do you take out your dentures (false teeth) before going to bed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46.6 | Do you clean your dentures every day? | <input type="checkbox"/> | <input type="checkbox"/> |

Upper Teeth

- | | | | |
|-------|----------------------------------------------------------------------------------------|--------------------------|--------------------------|
| | | Yes | No |
| 46.7 | Do you wear a denture (plate or false teeth) for upper teeth ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46.8 | If yes I wear a full set of dentures | <input type="checkbox"/> | |
| | I wear a partial set of dentures
(to replace some but not all missing teeth) | <input type="checkbox"/> | |
| 46.9 | How long have you had this denture? _____ Years _____ Months | | |
| | | q23q46_9y | q23q46_9m |
| 46.10 | Do you use this denture every day? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | q23q46_10 | |

Lower Teeth

46.11	Do you wear a denture (plate or false teeth) for lower teeth ?	q23q46_11	Yes <input type="checkbox"/> _1	No <input type="checkbox"/> _2
46.12	If yes I wear a full set of dentures	q23q46_12	<input type="checkbox"/> _1	
	I wear a partial set of dentures (to replace some but not all missing teeth)		<input type="checkbox"/> _2	
46.13	How long have you had this denture? _____ Years _____ Months	q23q46_13y	q23q46_13m	
46.14	Do you use this denture every day?	q23q46_14	Yes <input type="checkbox"/> _1	No <input type="checkbox"/> _2

47. Dry Mouth

The following statements will help assess the extent to which you have dryness of mouth.
In the last 4 weeks, have you experienced any of the following?

(Please tick one box for each statement)						
		Never	Hardly ever	Occasionally	Fairly often	Very often
47.0	My mouth feels dry	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_0 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.1	My mouth feels dry when eating a meal	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_1 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.2	I have difficulty in eating dry foods	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_2 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.3	I have difficulties swallowing certain foods	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_3 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.4	I sip liquids to aid in swallowing food	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_4 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.5	I suck sweets to relieve dry mouth	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_5 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.6	I get up at night to drink	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_6 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.7	My lips feel dry	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_7 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.8	My eyes feel dry	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_8 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.9	The skin of my face feels dry	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_9 <input type="checkbox"/> _4	<input type="checkbox"/> _5
47.10	The inside of my nose feels dry	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	q23q47_10 <input type="checkbox"/> _4	<input type="checkbox"/> _5

48. Taste and smell

During the past **12 months**

48.0 Have you had a problem with your ability to **smell**, such as not being able to smell things?

Yes No

☐☐

q23q48_0

48.1 Have you had a problem with your ability to **taste** food or drink?

☐☐

q23q48_1

49. Sleeping Patterns

49.0 On most nights, how would you rate the **quality of your sleep**?

Excellent ☐

1

q23q49_0

Good ☐

2

Fair ☐

3

Poor ☐

4

On average how many **hours of sleep** do you have at:

49.1

Night time? hours minutes

q23q49_1h

q23q49_1m

49.2

Day time? hours minutes

q23q49_2h

q23q49_2m

49.3 How often do you feel **excessively sleepy** during the day?

Never/rarely ☐

1

q23q49_3

sometimes ☐

2

Frequently ☐

3

Always ☐

4

During **the last month**,

49.4 Did you have **difficulties falling asleep** at night?

rarely ☐

1

q23q49_4

sometimes ☐

2

often ☐

3

49.5 Do you often wake up during the early hours and are unable to get back to sleep?

Yes No

☐☐

q23q49_5

49.6 Do you have **trouble maintaining sleep** at night?

rarely ☐ ₁

sometimes ☐ ₂ [q23q49_6](#)

often ☐ ₃

49.7 How often do you wake up feeling tired and worn out after the usual amount of sleep?

rarely ☐ ₁ [q23q49_7](#)

sometimes ☐ ₂

(at least 3 times/week) often ☐ ₃

49.8 Do you **snore loudly** while asleep?

no ☐ ₁ [q23q49_8](#)

sometimes ☐ ₂

often ☐ ₃

don't know ☐ ₄

Diagnosis of sleep apnoea

49.9 Have you ever been told by a **doctor** that you suffer with sleep apnoea

Yes No

☐ ₁ ☐ ₂

[q23q49_9](#)

50. Memory

50.0 **In the past year**, How often did you have trouble remembering things? [q23q50_0](#)

never ☐ ₁

rarely ☐ ₂

sometimes ☐ ₃

often ☐ ₄

In the past year,		Yes	No
50.1	Did you have more trouble than usual remembering recent events?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
50.2	Did you have more trouble than usual remembering a short list of items such as a shopping list?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
50.3	Did you have trouble remembering things from one second to the next?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
50.4	Did you have any difficulty in understanding or following spoken instruction?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
50.5	Did you have more trouble than usual following a group conversation or a plot on TV due to your memory?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
50.6	Did you have trouble finding your way around familiar streets?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
50.7	Did you have trouble getting things organised/ organising your day?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
50.8	Did you have trouble concentrating on things e.g. reading a book?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

51. Forgetfulness		Yes	No
51.0	In past 12 months, have you been forgetful to the extent that it has affected your daily life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

52. Recent major life events	
Have you experienced any of the following major life events in the last two years ?	
(Tick all that apply)	
52.0	death of a spouse <input type="checkbox"/> ₁
52.1	death of a close relative/friend <input type="checkbox"/> ₁
52.2	illness/accident to a family member <input type="checkbox"/> ₁
52.3	financial difficulties <input type="checkbox"/> ₁
52.4	personal illness, accident or injury <input type="checkbox"/> ₁
52.5	moving house <input type="checkbox"/> ₁

52. Recent major life events- continued

Have you experienced any of the following **major** life events in the **last two years**?

(Tick **all** that apply)

- | | | | | |
|-------|-------------------------------------------|--------------------------|------------------------|--------------------------------------|
| 52.6 | divorce | <input type="checkbox"/> | ₁ q23q52_6 | |
| 52.7 | addition to family circle e.g. grandchild | <input type="checkbox"/> | ₁ q23q52_7 | |
| 52.8 | death of a pet | <input type="checkbox"/> | ₁ q23q52_8 | Office Use |
| 52.9 | Other, please give details | <input type="checkbox"/> | ₁ q23q52_9 | q23q52_9BOX <input type="checkbox"/> |
| 52.10 | none | <input type="checkbox"/> | ₁ q23q52_10 | |

53. Time spent on various activities

Do you spend any time on these activities? For some activities we ask you to tell us how many **hours a week** you spend doing them.

- | | | Yes | No | If Yes hours per week |
|-------|-----------------------------------------------------------|--------------------------|--------------------------|----------------------------------------------|
| 53.0 | Looking after wife/partner | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_0 q23q53_0h |
| 53.1 | Looking after other adult family member or friend | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_1 q23q53_1h |
| 53.2 | Looking after grandchildren | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_2 q23q53_2h |
| 53.3 | Spending time with family, friends and neighbours | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_3 |
| 53.4 | Talking to friends/relatives on the telephone/video calls | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_4 |
| 53.5 | In paid work | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_5 |
| 53.6 | In voluntary work | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_6 |
| 53.7 | In a pub or club | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_7 |
| 53.8 | Attending religious services | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_8 |
| 53.9 | Playing cards, games, or bingo | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_9 |
| 53.10 | Visiting the cinema/restaurants/sporting events | <input type="checkbox"/> | <input type="checkbox"/> | ₁ ₂ q23q53_10 |

Do you spend any time on these activities?

If yes, how many hours a week do you spend doing these?

		Yes	No	Hours per week
53.11	On housework	<input type="checkbox"/>	<input type="checkbox"/>	q23q53_11 q23q53_11h
53.12	On light gardening (pruning and weeding)	<input type="checkbox"/>	<input type="checkbox"/>	q23q53_12 q23q53_12h
53.13	On heavy gardening (digging & mowing)	<input type="checkbox"/>	<input type="checkbox"/>	q23q53_13 q23q53_13h
53.14	Watching television/videos/DVD's	<input type="checkbox"/>	<input type="checkbox"/>	q23q53_14 q23q53_14h
53.15	Reading	<input type="checkbox"/>	<input type="checkbox"/>	q23q53_15 q23q53_15h
53.16	Attending class or course of study	<input type="checkbox"/>	<input type="checkbox"/>	q23q53_16 q23q53_16h
53.17	Using a computer	<input type="checkbox"/>	<input type="checkbox"/>	q23q53_17 q23q53_17h
53.18	Driving or sitting in a car	<input type="checkbox"/>	<input type="checkbox"/>	q23q53_18 q23q53_18h

54. Other activities

		Yes	No	
54.1	Have you been on any day or overnight trips in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	q23q54_1
54.2	Have you been on holiday in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	q23q54_2
54.3	Are you planning to go on holiday next year?	<input type="checkbox"/>	<input type="checkbox"/>	q23q54_3
54.4	Do you use the internet and/or email?	<input type="checkbox"/>	<input type="checkbox"/>	q23q54_4
54.5	Do you use social media?	<input type="checkbox"/>	<input type="checkbox"/>	q23q54_5
54.6	Do you use a "touch screen" mobile phone?	<input type="checkbox"/>	<input type="checkbox"/>	q23q54_6
54.7	Have you written a personal letter or email in the last week?	<input type="checkbox"/>	<input type="checkbox"/>	q23q54_7
54.8	Do you take a weekly or monthly magazine or journal?	<input type="checkbox"/>	<input type="checkbox"/>	q23q54_8
54.9	Did you vote in the last general or local elections?	<input type="checkbox"/>	<input type="checkbox"/>	q23q54_9

55. Social contact / Companionship

		Hardly ever / never	Sometimes	Often
55.0	How often do you feel you lack companionship?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ q23q55_0	<input type="checkbox"/> ₃
55.1	How often do you feel isolated from others?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ q23q55_1	<input type="checkbox"/> ₃
55.2	How often do you feel left out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ q23q55_2	<input type="checkbox"/> ₃
55.3	How often do you feel in tune with the people around you?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ q23q55_3	<input type="checkbox"/> ₃

How regularly do you have contact with your family?

		Every day	3-4 days a week	1-2 days a week	Less than once a week	Rarely / Never
Contact with family						
55.4	Meet face-to-face	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q55_4	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
55.5	Call (speak on the telephone)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q55_5	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
55.6	Video call (e.g. Skype, FaceTime)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q55_6	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
55.7	Text message (e.g. SMS, WhatsApp, Facebook Messenger or email)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q55_7	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

How regularly do you have contact with your friends?

		Every day	3-4 days a week	1-2 days a week	Less than once a week	Rarely / Never
Contact with friends						
55.8	Meet face-to-face	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q55_8	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
55.9	Call (speak on the telephone)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q55_9	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
55.10	Video call (e.g. Skype, FaceTime)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q55_10	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
55.11	Text message (e.g. SMS, WhatsApp, Facebook Messenger or email)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q55_11	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

56. Tiredness / Exhaustion

Rarely/never
(less than
1 day)

Sometimes
(1-2 days)

Often
(more than
3 days)

56.0 During the **past week**, how often did you feel that everything you did **was an effort**? ☐₁ ☐₂ ☐₃ [q23q56_0](#)

56.1 During the **past week**, how often did you feel that you **could not get “going”**? ☐₁ ☐₂ ☐₃ [q23q56_1](#)

57. Your feelings

In the **past week**, please tell us about how you have been feeling

Yes No

57.0 were you basically satisfied with your life? ☐₁ ☐₂ [q23q57_0](#)

57.1 did you feel that your life is empty? ☐₁ ☐₂ [q23q57_1](#)

57.2 were you afraid that something bad is going to happen to you? ☐₁ ☐₂ [q23q57_2](#)

57.3 did you feel happy most of the time? ☐₁ ☐₂ [q23q57_3](#)

57.4 did you drop many of your activities and interests? ☐₁ ☐₂ [q23q57_4](#)

57.5 did you prefer to stay at home, rather than going out to do new things? ☐₁ ☐₂ [q23q57_5](#)

57.6 did you feel full of energy? ☐₁ ☐₂ [q23q57_6](#)

57.7 did you often feel helpless? ☐₁ ☐₂ [q23q57_7](#)

58 Please indicate **how much you agree** with each of the following statements:

(Please tick **one** box for each statement)

		strongly agree	agree	neither agree nor disagree	disagree	strongly disagree
58.0	I enjoy my life overall	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_0	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.1	I look forward to things	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_1	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.2	I am healthy enough to get out and about	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_2	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.3	My family, friends or neighbours would help me if needed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_3	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.4	I have social or leisure activities/hobbies that I enjoy doing	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_4	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.5	I try to stay involved with things	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_5	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.6	I am healthy enough to have my independence	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_6	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.7	I can please myself in what I do	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_7	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.8	I feel safe where I live	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_8	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.9	I get pleasure from my home	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_9	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.10	I take life as it comes and make the best of things	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_10	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.11	I feel lucky compared to most people	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_11	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.12	I have enough money to pay for household bills	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_12	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
58.13	I feel lonely	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃ q23q58_13	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

59. Present circumstances

59.0 Are you at present:-

- | | | | |
|-----------------------|--------------------------|---|----------|
| single | <input type="checkbox"/> | 1 | q23q59_0 |
| married | <input type="checkbox"/> | 2 | |
| widowed | <input type="checkbox"/> | 3 | |
| divorced or separated | <input type="checkbox"/> | 4 | |
| other | <input type="checkbox"/> | 5 | |

59.1 If you are widowed, divorced/separated, please give **the year** when this occurred:

_____ q23q59_1

59.2 Are you at present:-

- | | | | |
|----------------------------------|--------------------------|---|----------|
| living alone | <input type="checkbox"/> | 1 | q23q59_2 |
| living with a partner or spouse | <input type="checkbox"/> | 2 | |
| living with other family members | <input type="checkbox"/> | 3 | |
| living with other people | <input type="checkbox"/> | 4 | |

60. Your accommodation

60.0 Which of the following best describes your current living situation.

Are you:-

- | | | | |
|-----------------------------------------|--------------------------|---|----------|
| living in your own home | <input type="checkbox"/> | 1 | q23q60_0 |
| living in a residential or nursing home | <input type="checkbox"/> | 2 | |
| living in sheltered accommodation | <input type="checkbox"/> | 3 | |
| other | <input type="checkbox"/> | 4 | |

61. Managing financially

61.0 Which of the following phrases best describes how you are managing financially these days?

- | | | | |
|------------------------|--------------------------|---|----------|
| manage very well | <input type="checkbox"/> | 1 | q23q61_0 |
| manage quite well | <input type="checkbox"/> | 2 | |
| get by alright | <input type="checkbox"/> | 3 | |
| don't manage very well | <input type="checkbox"/> | 4 | |

61.1 During the recent cost of living crisis, have you struggled to pay

(Tick **all** that apply)

- | | | | | |
|----|-------------------------------------------------|--------------------------|--------------|-----------|
| a) | Utility bills (gas, electricity, water) | <input type="checkbox"/> | ₁ | q23q61_1a |
| b) | Petrol bill/ transport costs (car, train, taxi) | <input type="checkbox"/> | ₁ | q23q61_1b |
| c) | Credit card bills | <input type="checkbox"/> | ₁ | q23q61_1c |
| d) | Council Tax | <input type="checkbox"/> | ₁ | q23q61_1d |
| e) | Food bills | <input type="checkbox"/> | ₁ | q23q61_1e |
| f) | Telephone / Broadband bills | <input type="checkbox"/> | ₁ | q23q61_1f |

62. Heating

62.0	During the cold winter weather, can you normally keep comfortably warm in your living room ?	Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	_{1 2} q23q62_0

If no, is this because:

- | | | | | |
|------|----------------------------------------------------------------|--------------------------|--------------------------|-------------------------|
| 62.1 | it costs too much to keep your heating on? | <input type="checkbox"/> | <input type="checkbox"/> | _{1 2} q23q62_1 |
| 62.2 | it is not possible to heat the room to a comfortable standard? | <input type="checkbox"/> | <input type="checkbox"/> | _{1 2} q23q62_2 |

62.3 Do you experience any difficulties meeting your heating/fuel costs?

- | | | | |
|---------------------|--------------------------|--------------|----------|
| No difficulty | <input type="checkbox"/> | ₁ | q23q62_3 |
| Minor difficulty | <input type="checkbox"/> | ₂ | |
| Moderate difficulty | <input type="checkbox"/> | ₃ | |
| Serious difficulty | <input type="checkbox"/> | ₄ | |

62.4	If you have experienced difficulty, has this worsened during the 2022 / 2023 fuel crisis?	Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	_{1 2} q23q62_4

63. Transport


63.0	Do you have a car available for your own use?	Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	_{1 2} q23q63_0
63.1	Do you currently drive yourself?	<input type="checkbox"/>	<input type="checkbox"/>	_{1 2} q23q63_1

64. Pets

64.0 Do you have any pets?

(Tick **all** that apply)

64.1 None _1 q23q64_1no

64.2 Dog  q23q64 2dog

64.3 cat q23q64 3cat

64.4 other ☐ 1 q23q64_4oth

Office

q23q64_4BOX

65. Difficulties impacting your daily life

Do you experience any difficulty with the following:

Not Difficult	Some Difficulty	Difficult	Very Difficult	Not applicable

65.1 Managing your health ☐_1 ☐_2 ☒_3 q23q65_1 ☐_4 ☐_5

65.2 Managing the health of others in your household

65.3 Maintaining your physical activity

66. Accessing healthcare and treatment

Do you experience difficulties accessing the following health care services:

No Difficulty	Difficult	Cancelled/ delayed	Not applicable
------------------	-----------	-----------------------	-------------------

66.0 Getting your medication ☐₁ ☒₂q23q66_0 ☐₃ ☐

66.1 Accessing GP and NHS services ☐_1 ☐_2q23q66_1 ☐_3 ☐

66.2 Accessing dental health _1 _2 q23q66_2 _3

66.3 Accessing social care or other support services _1 _2 q23q66_3 _3

66.4 Medical appointments ☐₁ ☐₂ q23q66_4 ☐₃ ☐

66.5 Hospital appointments ☐₁ ☐₂ q23q66_5 ☐₃ ☐

		No Difficulty	Difficult	Cancelled/ delayed	Not applicable
66.6	Planned surgeries	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q66_6	<input type="checkbox"/> _3	<input type="checkbox"/> _4
66.7	Dental treatment	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q66_7	<input type="checkbox"/> _3	<input type="checkbox"/> _4
66.8	Physiotherapy	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q66_8	<input type="checkbox"/> _3	<input type="checkbox"/> _4
66.9	Other planned treatment (e.g. chemotherapy)	<input type="checkbox"/> _1	<input type="checkbox"/> _2 q23q66_9	<input type="checkbox"/> _3	<input type="checkbox"/> _4

67. Vitamins and minerals

Do you take any of the following individual vitamin/ minerals regularly (i.e. on most days)?

Please **do not include multivitamin** supplements you are taking.

Vitamins:

(tick the ones you take regularly)

- | | | | |
|------|-----------|-----------------------------|------------------------------|
| 67.1 | Vitamin A | <input type="checkbox"/> _1 | q23q67_1VitA |
| 67.2 | Vitamin B | <input type="checkbox"/> _1 | q23q67_2VitB |
| 67.3 | Vitamin C | <input type="checkbox"/> _1 | q23q67_3VitC |
| 67.4 | Vitamin D | <input type="checkbox"/> _1 | q23q67_4VitD |
| 67.5 | Vitamin E | <input type="checkbox"/> _1 | q23q67_5VitE |

Minerals/fish oils:

(tick the ones you take regularly)

- | | | | |
|------|---------------|-----------------------------|-----------------------------------|
| 67.6 | Calcium | <input type="checkbox"/> _1 | q23q67_6Calc |
| 67.7 | Magnesium | <input type="checkbox"/> _1 | q23q67_7Magn |
| 67.8 | Cod liver oil | <input type="checkbox"/> _1 | q23q67_8Codeliver |
| 67.9 | Fish oil | <input type="checkbox"/> _1 | q23q67_9Fishoil |

68. Medicines			Yes No	
68.0	Do you take any regular medication?	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂ q23q68_0		
Details of ALL medicines Please write down details of all medicines– including tablets, injections, inhalers, eye-drops etc – which you take regularly, including any medications which you buy for yourself.				
	Name of medicine	Reason for taking (if known)	Is this prescribed?	
			Yes No	Office use ONLY
68.1	q23q68_1BNF12_1 q23q68_1BNF34_1 q23q68_1BNF5_1 q23q68_1BNF6_1	q23q68_1icd1	q23q68_1medpr1 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.2	q23q68_1BNF12_2 q23q68_1BNF34_2 q23q68_1BNF5_2 q23q68_1BNF6_2	q23q68_1icd2	q23q68_1medpr2 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.3	q23q68_1BNF12_3 q23q68_1BNF34_3 q23q68_1BNF5_3 q23q68_1BNF6_3	q23q68_1icd3	q23q68_1medpr3 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.4	q23q68_1BNF12_4 q23q68_1BNF34_4 q23q68_1BNF5_4 q23q68_1BNF6_4	q23q68_1icd4	q23q68_1medpr4 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.5	q23q68_1BNF12_5 q23q68_1BNF34_5 q23q68_1BNF5_5 q23q68_1BNF6_5	q23q68_1icd5	q23q68_1medpr5 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.6	q23q68_1BNF12_6 q23q68_1BNF34_6 q23q68_1BNF5_6 q23q68_1BNF6_6	q23q68_1icd6	q23q68_1medpr6 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.7	q23q68_1BNF12_7 q23q68_1BNF34_7 q23q68_1BNF5_7 q23q68_1BNF6_7	q23q68_1icd7	q23q68_1medpr7 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.8	q23q68_1BNF12_8 q23q68_1BNF34_8 q23q68_1BNF5_8 q23q68_1BNF6_8	q23q68_1icd8	q23q68_1medpr8 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.9	q23q68_1BNF12_9 q23q68_1BNF34_9 q23q68_1BNF5_9 q23q68_1BNF6_9	q23q68_1icd9	q23q68_1medpr9 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.10	q23q68_1BNF12_10 q23q68_1BNF34_10 q23q68_1BNF5_10 q23q68_1BNF6_10	q23q68_1icd10	q23q68_1medpr10 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.11	q23q68_1BNF12_11 q23q68_1BNF34_11 q23q68_1BNF5_11 q23q68_1BNF6_11	q23q68_1icd11	q23q68_1medpr11 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.12	q23q68_1BNF12_12 q23q68_1BNF34_12 q23q68_1BNF5_12 q23q68_1BNF6_12	q23q68_1icd12	q23q68_1medpr12 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
68.13	q23q68_1BNF12_13 q23q68_1BNF34_13 q23q68_1BNF5_13 q23q68_1BNF6_13	q23q68_1icd13	q23q68_1medpr13 <input type="checkbox"/> ₁ <input type="checkbox"/> ₂	<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"/>
Please use the back of the questionnaire if more space is needed to record this information				

YOUR DIET

How to fill in the diet questionnaire

The following questions are mostly about how often you **USUALLY** eat different sorts of food each week.

Please ring **one** answer for each of the foods listed. Remember to circle **R** if you never eat a food.

Please ring the correct number or letter for every food item

(one circle only per line)

			Number of days each week		Monthly (0)	Rarely / Never (8)
D1	Meat					
D1.0	Red meat (including beef, minced beef, beef burgers, lamb, pork, bacon, ham, salami) q23D1_0		7 6 5 4 3 2 1		M	R
D1.1	Chicken, turkey, other poultry q23D1_1		7 6 5 4 3 2 1		M	R
D1.2	Tinned meat (all types, corned beef, etc) q23D1_2		7 6 5 4 3 2 1		M	R
D1.3	Pork sausages, beef sausages, pies, pasties q23D1_3		7 6 5 4 3 2 1		M	R
D1.4	Liver, kidney, heart q23D1_4		7 6 5 4 3 2 1		M	R
D2	Fish					
D2.0	White fish (cod, haddock, hake, plaice, fish fingers, etc) q23D2_0		7 6 5 4 3 2 1		M	R
D2.1	Kippers, herrings, pilchards, tuna, sardines, salmon, mackerel (including tinned) q23D2_1		7 6 5 4 3 2 1		M	R
D2.2	Shellfish q23D2_2		7 6 5 4 3 2 1		M	R
D3	Fruit and vegetables					
D3.0	Fresh fruit in the summer q23D3_0		7 6 5 4 3 2 1		M	R
D3.1	Fresh fruit in the winter q23D3_1		7 6 5 4 3 2 1		M	R
D3.2	Fresh vegetables in the summer q23D3_2		7 6 5 4 3 2 1		M	R
D3.3	Fresh vegetables in the winter q23D3_3		7 6 5 4 3 2 1		M	R
D3.4	Legumes (e.g. baked or butter beans, lentils, peas, chickpeas) q23D3_4		7 6 5 4 3 2 1		M	R
D4	Bread					
D4.0	White bread / bread rolls q23D4_0		7 6 5 4 3 2 1		M	R
D4.1	Brown or wholemeal bread / bread rolls q23D4_1		7 6 5 4 3 2 1		M	R

Please ring the correct number or letter for every food item (one circle only per line)

Please ring the correct number or letter for every food item (one circle only per line)

			Number of days each week							Monthly (0)	Rarely / Never (8)	
D5	Dairy											
D5.0	Full-fat cheese (e.g. Cheddar, Leicester, Stilton, Brie, soft cheese)	q23D5_0	7	6	5	4	3	2	1	M	R	
D5.1	Low-fat cheese (e.g. Edam, Cottage cheese, reduced fat cheese)	q23D5_1	7	6	5	4	3	2	1	M	R	
D6	Cereals											
D6.0	Spaghetti and other pasta	q23D6_0	7	6	5	4	3	2	1	M	R	
D6.1	Rice (all types excluding rice pudding)	q23D6_1	7	6	5	4	3	2	1	M	R	
D6.2	Crispbread (Ryvita, cream crackers, etc)	q23D6_2	7	6	5	4	3	2	1	M	R	
D6.3	Breakfast cereal (all types including porridge)	q23D6_3	7	6	5	4	3	2	1	M	R	
D7.0	Olive oil (for cooking, salads etc)	q23D7_0	7	6	5	4	3	2	1	M	R	
D8	Snacks											
D8.0	Savoury snacks (e.g. crisps/ salted nuts)	q23D8_0	7	6	5	4	3	2	1	M	R	
D8.1	Sweet snacks (e.g. biscuits/cakes/ chocolate/sweets)	q23D8_1	7	6	5	4	3	2	1	M	R	
D9	Milk											
D9.0	Roughly how much milk do you drink a day in tea, coffee, milky drinks or cereals? (Tick only one box)											
	none at all	<input type="checkbox"/>	1									q23D9_0
	half pint or less	<input type="checkbox"/>	2									
	between half and one pint	<input type="checkbox"/>	3									
	more than one pint	<input type="checkbox"/>	4									
D9.1	What kind of milk do you usually use? (Tick only one box)											
	full fat milk, fresh or dried	<input type="checkbox"/>	1									q23D9_1
	semi-skimmed milk, fresh or dried	<input type="checkbox"/>	2									
	fully skimmed milk, fresh or dried	<input type="checkbox"/>	3									
	other kinds of milk, e.g. condensed, evaporated	<input type="checkbox"/>	4									

D10 Daily Snacks		
How many times a day do you snack on		
D10.0	Savoury snacks (e.g. crisps/ salted nuts)?	<u>q23D10_0</u> times per day
D10.1	Sweet snacks (e.g. biscuits/cakes/ chocolate/sweets)?	<u>q23D10_1</u> times per day
D11 Alcoholic drinks		
How much did you drink in the last seven days?		Number of drinks
D11.0	Number of half pints of beers or lagers	<u>q23D11_0</u>
D11.1	Number of glasses of wine or sherry	<u>q23D11_1</u>
D11.2	Number of singles glasses of spirits	<u>q23D11_2</u>

S1. Your views on what research is needed.	
We would value your view on research topics in relation to improving the health and well-being of older people.	
In your opinion, what plays the most important role in your health or a healthy long life?	
1.
2.
3.
4.
5.

s2. Your experience of being part of the British Regional Heart Study

You have been part of the BRHS now for approximately 45 years. Your contributions have been of enormous value to understanding heart disease and how to improve the health of older people so they can live a longer and healthier life.

As this is our last questionnaire to you, we would like to invite you to say something about your experience of being part of this study.

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s3. General comments:

Office use

q23S3GeneralcommentsBOX

s4. Have you needed/received help in completing this form?

Yes No

q23S4Received_help

Office use:
Date stamp

q23DATESTAMP_DAY
q23DATESTAMP_MONTH
q23DATESTAMP_YEAR

Thank you very much for completing the questionnaire.
Please return it to us in the envelope provided.
No stamp is needed.

Professor S G Wannamethee
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Web: <https://www.ucl.ac.uk/epidemiology-health-care/research/primary-care-and-population-health/research/brhs>