British Regional Heart Study
Activity Survey: Questionnaire

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

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

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

All the information that you provide will be treated as strictly confidential and will only be seen by the Research Team. If you have any questions about this survey please phone us on020 7830 2335.

Thank you very much for your help.

British Regional Heart Study
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http://www.ucl.ac.uk/pcph/research/brhs

DATES

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

1.1 Please enter your date of birth ……../ ……./ 19…….
Day / Month / Year
(This information is necessary for us to ensure that you are the correct recipient).

YOUR CURRENT HEALTH

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

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

Smoking & Drinking

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

Weight

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

____ ____ Stones _____ _____ Pounds or _____ _____ _____ Kilograms

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

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

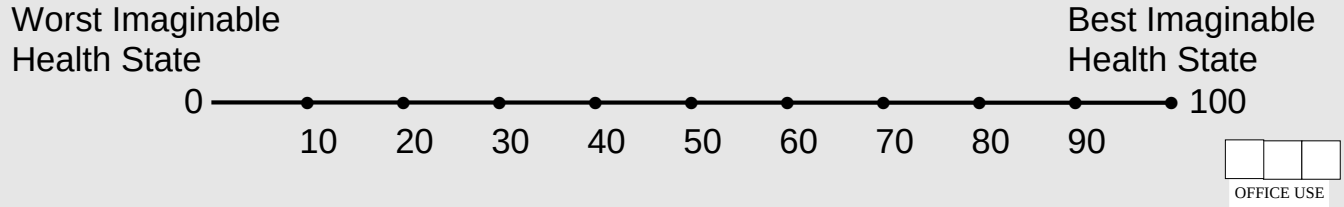
(tick **one** answer for each question)

5.1	**General Health**	Excellent	☐1
		Good	☐2
		Fair	☐3
		Poor	☐4
5.2	**Pain / discomfort**	I have no pain or discomfort	☐1
		I have moderate pain or discomfort	☐2
		I have extreme pain or discomfort	☐3
5.3	**Usual Activities** (e.g. work, study, housework, family or leisure activities):		
		I have no problems with performing my usual activities	☐1
		I have some problems with performing my usual activities	☐2
		I am unable to perform my usual activities	☐3
5.4	**Self Care**	I have no problems with washing and dressing	☐1
		I have some problems with washing and dressing myself	☐2
		I am unable to wash or dress myself	☐3
5.5	**Mobility**	I have no problems walking about	☐1
		I have some problems walking about	☐2
		I am confined to a chair /wheelchair	☐3
5.6	**Anxiety/Depression:-**	I am not anxious or depressed	☐1
		I am moderately anxious and /or depressed	☐2
		I am extremely anxious and /or depressed	☐3

5.7 **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

LONGSTANDING ILLNESS OR DISABILITY		**Yes**	**No**
6.0	Do you have any long-standing illness, disability or infirmity?	☐	☐
	"long-standing" means anything which has troubled you over a period of time or is likely to do so		
6.1	If **YES**, does this illness or disability limit your activities in any way?	☐	☐
6.2	do you receive a disability allowance?	☐	☐

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

		No difficulty	**Yes, a little difficulty**	**Yes, a lot of difficulty**
a	Going up or down stairs	☐1	☐2	☐3
b	Bending down	☐1	☐2	☐3
c	Straightening up	☐1	☐2	☐3
d	Keeping your balance	☐1	☐2	☐3
e	Going out of the house	☐1	☐2	☐3
f	Walking 400 yards	☐1	☐2	☐3

8.0 Please indicate if you have difficulty doing any of the following activities: (tick **one** box)

		No Difficulty	**Some Difficulty**	**Unable to do or need help**
a	Getting in and out of a chair on your own	☐1	☐2	☐3
b	Dressing and undressing yourself on your own	☐1	☐2	☐3
c	Bathing or showering	☐1	☐2	☐3
d	Feeding yourself, including cutting food	☐1	☐2	☐3
e	Shopping for personal items such as toilet items or medicine by yourself	☐1	☐2	☐3
f	Doing light housework such as washing up	☐1	☐2	☐3
g	Preparing your own meals by yourself	☐1	☐2	☐3
h	Using the telephone by yourself	☐1	☐2	☐3
i	Taking medications by yourself	☐1	☐2	☐3
j	Managing money (e.g. paying bills etc)	☐1	☐2	☐3
k	Using public transport on your own	☐1	☐2	☐3
l	Driving a car on your own.	☐1	☐2	☐3

YOUR MOBILITY

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

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

GOING OUT OF THE HOUSE

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

Monday ☐1 Tuesday ☐1 Wednesday ☐1 Thursday ☐1

Friday ☐1 Saturday ☐1 Sunday ☐1

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

MOBILITY AIDS

		Yes	No
9.2	Do you use any mobility aids?	☐	☐

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

Walking stick	☐1	Toilet raised seat	☐1
Walking frame	☐1	Bath board/shower	☐1
Push wheelchair	☐1	Extra rails in bathroom	☐1
Electric wheelchair or mobility scooter	☐1	Stair lift	☐1

FALLS

		Yes	No
10.0	Have you had a fall in the past 12 months?	☐	☐
10.1	If **YES,** How many falls have you had in past 12 months?	_____falls	

		Yes	No
10.2	Did you receive medical attention for any of these falls?	☐	☐
10.3	Did you suffer any of the following:		
a	Cuts and bruises	☐1	
b	Damage to muscle or ligament	☐1	
c	Broken or fractured **hip** bone	☐1	
d	Broken or fractured **wrist** bone	☐1	
e	**Other** Broken or fractured bone(s)	☐1	

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

Very fearful	Somewhat fearful	Not fearful
☐1	☐2	☐3

PHYSICAL ACTIVITY

11.0 Do you make regular journeys every day or most days either walking or cycling? (tick **one** box)

a	No	☐1
b	Walking	☐2
c	Cycling	☐3
d	Both	☐4

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

_____Hours/week in winter _____Hours/week in summer

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

Slow	☐1
Steady average	☐2
Fast	☐3

11.3 How long do you spend cycling in an average week?

_____Hours/week in Winter _____Hours/week in Summer

11.4 On a normal day, how many times do you climb a flight of stairs _____
(assuming that 1 flight of stairs has 10 steps)?

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

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

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

No ☐1

Occasionally (less than once a month) ☐2

Frequently (once a month or more) ☐3

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

_____

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

_____times /month in Winter _____times /month in Summer

		Yes	No
11.9	Do you engage in exercises to increase muscle strength and endurance such as lifting weights, doing push-ups, using exercise machines?	☐	☐

11.10 If **YES,** on average, how many hours per week do you engage in these exercises?

_____ hours/week

		Yes	No
12.0	Do you own a dog at the moment?	☐	☐
12.1	Do you regularly walk a dog at the moment?	☐	☐

13.0 On a normal day, how many hours do you spend sitting (eg to eat, read, watch TV) or lying down, excluding your night time sleep?

_____ hours/day None ☐

14.0 On a normal day, how much time do you spend watching television (including videos and DVDs)?

_____ hours _____ minutes/day None ☐

BREATHLESSNESS		Yes	No	Unable to walk
15.0	Do you ever get short of breath walking with other people of your own age on level ground?	☐	☐	☐
15.1	On walking uphill or upstairs, do you get more breathless than people of your own age?	☐	☐	☐
15.2	Do you ever have to stop walking because of breathlessness?	☐	☐	☐

YOUR FEELINGS ABOUT EXERCISE (eg. going for a walk, doing particular sports, gardening or DIY)

16.0 How much do you agree with the following statements about the exercise you do?
(tick **one** box for each statement)

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a	Makes me feel better physically	☐1	☐2	☐3	☐4	☐5
b	Makes my mood better in general	☐1	☐2	☐3	☐4	☐5
c	Helps me feel less tired	☐1	☐2	☐3	☐4	☐5
d	Makes my muscles stronger	☐1	☐2	☐3	☐4	☐5
e	Is an activity I enjoy doing	☐1	☐2	☐3	☐4	☐5
f	Gives me a sense of personal accomplishment	☐1	☐2	☐3	☐4	☐5
g	Makes me more alert mentally	☐1	☐2	☐3	☐4	☐5
h	Improves my endurance in performing daily activities	☐1	☐2	☐3	☐4	☐5
i	Helps to strengthen my bones	☐1	☐2	☐3	☐4	☐5
j	Helps to improve my balance and prevent me falling over	☐1	☐2	☐3	☐4	☐5

HOW YOU FEEL ABOUT EXERCISE

17.0 Please indicate how confident you are that you could exercise (or walk) if you had to, for 20 minutes three times a week in each of the following cases:

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

		Not confident									Very confident
		1	2	3	4	5	6	7	8	9	10
a	If the weather was bothering you	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
b	If you were bored by the activity	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
c	If you felt pain when exercising	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
d	If you had to exercise alone	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
e	If you did not enjoy it	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
f	If you were too busy with other activities	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
g	If you felt tired	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
h	If you felt stressed	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10
i	If you felt depressed	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

YOUR FEELINGS

18.0	Please tell us about how you have been feeling in the past week:	Yes	No
a	Are you basically satisfied with your life?	☐	☐
b	Do you feel that your life is empty?	☐	☐
c	Are you afraid that something bad is going to happen to you?	☐	☐
d	Do you feel happy most of the time?	☐	☐
e	Have you dropped many of your activities and interests?	☐	☐
f	Do you prefer to stay at home, rather than going out to do new things?	☐	☐

FAMILY AND FRIENDS

19.0 **FAMILY**: Considering the people to whom you are related either by birth or marriage:

		None	1	2	3 or 4	5 to 8	9 or more
a	How many relatives do you see or hear from at least once a month?	☐1	☐2	☐3	☐4	☐5	☐6
b	How many relatives do you feel emotionally close to, such that you could call on them for help?	☐1	☐2	☐3	☐4	☐5	☐6
c	How many relatives do you feel at ease with that you can talk about private matters?	☐1	☐2	☐3	☐4	☐5	☐6

20.0 **FRIENDS**: Considering all of your friends including those who live in your neighbourhood:

		None	1	2	3 or 4	5 to 8	9 or more
a	How many friends do you see or hear from at least once a month?	☐1	☐2	☐3	☐4	☐5	☐6
b	How many friends do you feel emotionally close to, such that you could call on them for help?	☐1	☐2	☐3	☐4	☐5	☐6
c	How many friends do you feel at ease with that you can talk about private matters?	☐1	☐2	☐3	☐4	☐5	☐6

PRESENT CIRCUMSTANCES

21.0 Are you at present:

Single	☐1
Married	☐2
Widowed	☐3
Divorced or separated	☐4
Other	☐5

22.0 At present are you living:

At home, with family	☐1
At home, alone	☐2
In a residential home	☐3
In a nursing home	☐4

		Yes	No	Someone else shops for me
23.0	Do you do most of your shopping (food, household necessities etc) at shops within easy walking distance (less than 15 minutes) of your home?	☐	☐	☐

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

Walking ☐1 By bus ☐2 Other public transport ☐3 Dial a ride ☐4

By taxi ☐5 Drive myself ☐6 A friend/relative drives me ☐7 Internet delivery ☐8

I don't go shopping ☐9

TRANSPORT		Yes	No
25.0	Do you own a car?	☐	☐
25.1	Do you drive a car?	☐	☐

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

Car ☐1 Public transport ☐1 Cycle ☐1 Walk ☐1 Dial a ride ☐1

Not applicable ☐1

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