

Supporting Information S3 Text

Health Risk Appraisal for Older Persons (HRA-O) questionnaire (U.K. English version)

for: A Collaborative Care Model of Health Risk Assessment and Counselling in Older Persons: A Randomised Clinical Trial

Older Persons Health Profile Questionnaire



Please check whether your personal details are correct. If there are mistakes please correct them on the following lines. It would be helpful for us to have your daytime home phone number.

Please fill out your Older Persons Health Profile Questionnaire to receive your confidential and personal Older Persons Health Profile Report. Your report will give you information on how you are doing in areas of your health – such as nutrition, safety, medication use, and preventive care.

Remember...

- *Read each question carefully, and follow all directions.*
- *Tick boxes as shown here:*

- *Print all written responses clearly, as shown here:*

M	A	R	Y
---	---	---	---

- *Please do not write comments in the margins -- these cannot be responded to.*
- *Complete all sections and items.*
- *Do not leave any answers blank, even if your answer is "No".*
- *Be careful to fill out each page.*

Medical History

Here is a list of medical conditions that usually last for some time.

Has a doctor <u>ever</u> told you that you have...	No	Yes
1. ... High blood pressure?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
2. ... Coronary heart disease or heart attack?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
3. ... Heart failure?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
4. ... Irregular heart beat?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
5. ... Stroke?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
6. ... Chronic bronchitis or emphysema?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
7. ... Asthma?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
8. ... Arthritis or rheumatism?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
9. ... Osteoporosis?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
10. ... Diabetes?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
11. ... Depression?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
12. ... Emotional or mental illness other than depression?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
13. ... Glaucoma?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
14. ... Irreversible / untreatable retinal disease?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
15. ... Cataracts?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

Your Health Measurements

1. What is your height (in feet/inches or meters/centimeters, without shoes)?

feet inches or m cm

2. What is your weight (in stones/pounds or kilograms, wearing light clothing without shoes)?

stones pounds or kg

3. Have you lost 5 kg (a stone) or more over the past six months without trying to do so?

₁ No
₂ Yes

4. Have you gained 5 kg (a stone) or more over the past six months without trying to do so?

₁ No
₂ Yes

5. What is your blood pressure?

(Systolic) (Diastolic)

₁ Don't know/not sure

6. What is your total cholesterol level?

₁ Don't know/not sure

Medications/Prescriptions

Indicate whether or not you are now taking:		No	Yes
1.	Medicine for heart conditions	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
2.	Medicine for high blood pressure	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
3.	Medicine for high cholesterol	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
4.	Medicine for diabetes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
5.	Medicine to help you fall asleep (3 or more times per week)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
6.	Medicine for anxiety (nerves or nervousness)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
7.	Medicine for depression	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
8.	Medicine to replace female hormones (Women only)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
9.	Medicine for arthritis or pain in the joints (3 or more times per week)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
10.	Aspirin regularly to prevent heart attack or stroke	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

The following questions ask, by name, about specific medications you may take.

During the last 4 weeks , have you taken any of these medications at least once?		No	Yes
11.	Valium, Diazepam, Nitrazepam or Mogadon?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
12.	Chlordiazepoxide or Librium?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
13.	Amitriptyline?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

14. How many different medications are you currently taking? *Include those to which you answered "Yes" above*

(Write in "0" if you are taking no medications.)

Number of prescription medications

Number of over-the-counter medications (for example hay fever remedies or pain killers)

Number of herbal remedies (for example St. John's Wort)

15. Do you think that you are having any symptoms due to your medications?

₁ No

₂ Yes

16. Which of the following keep you from taking your medication as prescribed?

Please tick all that apply.

- a. ₁ I have not been prescribed any medications
- b. ₁ I take my medications as prescribed
- c. ₁ I forget or don't think about it
- d. ₁ It's not that important
- e. ₁ I don't have time/don't get around to it
- f. ₁ Cost
- g. ₁ Side effects
- h. ₁ Other

Signs & Symptoms

These questions are about symptoms you had during the last month.

	Indicate how frequently <u>during the last month</u> you have been bothered by the following symptoms for any reason:	Never	Seldom or Some-times	Often or Always
1.	Fever	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
2.	Unexplained tiredness/weakness	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
3.	Inability to think well	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
4.	Nightmares	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
5.	Depression/feeling low	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
6.	Anxiety/agitation	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
7.	Blurred eyesight (<i>despite wearing glasses or contact lenses</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
8.	Nasal stuffiness	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
9.	Abnormal taste	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
10.	Dry mouth	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
11.	Sleepiness other than at bedtime	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
12.	Shortness of breath at night	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
13.	Shortness of breath with little exercise	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
14.	Leg swelling	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
15.	Heart pounding or irregular heart beat	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
16.	Dizziness when standing up	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
17.	Fainting spells	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
18.	Chest pain	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
19.	Cough	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
20.	Constipation	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5
21.	Loose stools (diarrhoea)	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 5

Indicate how frequently <u>during the last month</u> you have been bothered by the following symptoms for any reason:		Never	Seldom or Sometimes	Often or Always
22.	Sickness in stomach (nausea)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
23.	Abdominal pain	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
24.	Heartburn	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
25.	Inability to pass urine	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
26.	Urinating at night more than twice	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
27.	Excessive urination	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
28.	Skin rash	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
29.	Skin itching	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
30.	Breast tenderness (for men and women)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
31.	Leg ache when exercising	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
32.	Unexplained muscle aches	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
33.	Sexual problems	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
34.	Headache	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅
35.	Cold or painful hands or feet	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₅

Bladder control

Loss of bladder control becomes more common with age; however, in many cases, bladder control can be improved.

36a. In the last year, have you had leakage of urine and got wet?

₁ No → Skip to page 8 (Pain)

₂ Yes ↓

36b. **If Yes:** Have you had leakage of urine on at least 6 separate days?

₁ No

₂ Yes

Pain

1. Over the **last 4 weeks**, have you had any pain?

- ₁ No → Skip to page 10 (Oral Health)
₂ Yes

The next 2 questions ask about your experience of pain, based on a scale from zero to ten, with "0" meaning "no pain" and "10" meaning "the worst pain you can imagine".

2. How severe is your pain **today**?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₉	<input type="checkbox"/> ₁₀
no pain										worst pain

3. In the **last 7 days**, how severe has your pain been **on average**?

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆	<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₉	<input type="checkbox"/> ₁₀
no pain										worst pain

The next questions ask about pain that can occur with different activities. Choose the answer that comes closest to being accurate for you.

	No	Yes
4. Do you have pain <u>every day</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
5. Do you have pain <u>several times a week</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
6. Do you have pain that <u>never completely goes away</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
7. Do you take medicine for pain <u>3 or more times</u> per week?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
8. Over the <u>last 7 days</u> , has pain caused you to feel sad and depressed?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

Do you currently have pain with the following activities? Or have you stopped doing any of them because of <u>pain</u>?		No	Yes
9.	Bathing or dressing	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
10.	Lifting or carrying groceries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
11.	Walking 200 yards or less	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
12.	Walking more than 200 yards	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
13.	Climbing only a few steps	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
14.	Climbing more than one flight of stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
15.	Moderate activities <i>such as moving a heavy table, pushing a vacuum cleaner, bowling, or playing golf</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
16.	Vigorous activities <i>such as running, lifting heavy objects, or participating in strenuous sports</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

Does <u>pain</u> prevent you from...		No	Yes
17.	... travelling or using public transport?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
18.	... attending religious activities?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
19.	... enjoying any other social or recreational activities (other than religious services)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

Because of <u>pain</u>, ...		No	Yes
20.	... have you cut down the amount of time you spend on work or other activities?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
21.	... have you been accomplishing less than you would like to?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
22.	... have you limited the kind of work or other activities you do?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
23.	... does the work or activities you do require extra effort?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
24.	... do you have trouble sleeping?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
25.	... do you feel fatigued or tired?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
26.	... do you have to rely on family members or friends for help?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

Oral Health

1. Do you wear a removable set of dentures (either full or partial)?

- ₁ No
₂ Yes

In the <u>past 3 months</u> , how often ...		Never	Seldom	Some- times	Often	Always
2.	... did you limit the kinds or amounts of food you ate because of problems with your teeth or dentures?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3.	... did you have trouble biting or chewing any kinds of food, <i>such as firm meat or apples?</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4.	... were you able to swallow comfortably ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5.	... have your teeth or dentures prevented you from speaking the way you wanted?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6.	... were you able to eat anything without feeling discomfort?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7.	... did you limit contacts with people because of the condition of your teeth or dentures?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8.	... were you pleased or happy with the look of your teeth and gums or dentures?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9.	... did you use medication to relieve pain or discomfort from around your mouth?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10.	... were you worried or concerned about the problems with your teeth, gums or dentures?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11.	... did you feel nervous or self-conscious because of problems with your teeth, gums or dentures?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12.	... did you feel uncomfortable eating in front of people because of problems with your teeth or dentures?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13.	... were your teeth or gums sensitive to hot, cold or sweets?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Vision

The following questions address problems which involve your eyesight or feelings that you have about your eyesight condition. After each question, please choose the response that best describes your situation.

1. At the present time, would you say your eyesight using both eyes (*with your glasses or contact lenses, if you wear them*) is:

- ₁ Excellent → Skip to page 14 (Hearing)
₂ Good
₃ Fair
₄ Poor
₅ Very Poor
₆ Completely Blind

2. How much of the time do you worry about your eyesight?

- ₁ None of the time
₂ A little of the time
₃ Some of the time
₄ Most of the time
₅ All of the time

3. Have you noticed any recent worsening of your eyesight?

- ₁ No
₂ Yes

The next questions are about how much difficulty, if any, you have doing certain activities (*wearing your glasses or contact lenses if you use them for that activity*).

4. How much difficulty do you have reading ordinary print in newspapers? Would you say you have:

- ₁ No difficulty at all
₂ A little difficulty
₃ Moderate difficulty
₄ Extreme difficulty
₅ Stopped doing this because of your eyesight
₆ Stopped doing this for other reasons or not interested in doing this

5. How much difficulty do you have doing work or hobbies that require close vision, such as *cooking, sewing, fixing things around the house, or using hand tools*? Would you say, you have:

- ₁ No difficulty at all
₂ A little difficulty
₃ Moderate difficulty
₄ Extreme difficulty
₅ Stopped doing this because of your eyesight
₆ Stopped doing this for other reasons or not interested in doing this

6. Because of your eyesight, how much difficulty do you have going down steps, stairs, or kerbs in dim light or at night?
- ₁ No difficulty at all
 - ₂ A little difficulty
 - ₃ Moderate difficulty
 - ₄ Extreme difficulty
 - ₅ Stopped doing this because of your eyesight
 - ₆ Stopped doing this for other reasons
7. Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?
- ₁ No difficulty at all
 - ₂ A little difficulty
 - ₃ Moderate difficulty
 - ₄ Extreme difficulty
 - ₅ Stopped doing this because of your eyesight
 - ₆ Stopped doing this for other reasons
8. Because of your eyesight, how much difficulty do you have finding something on a crowded shelf up close to you?
- ₁ No difficulty at all
 - ₂ A little difficulty
 - ₃ Moderate difficulty
 - ₄ Extreme difficulty
 - ₅ Stopped doing this because of your eyesight
 - ₆ Stopped doing this for other reasons
9. Are you limited in how long you can work or do other activities because of your eyesight?
- ₁ None of the time
 - ₂ A little of the time
 - ₃ Some of the time
 - ₄ Most of the time
 - ₅ All of the time

The next questions are about car driving.

10a. Are you currently driving, at least once in a while?

- ₁ Yes → Skip to question 11 on this page
₂ No

10b. **If No:** Have you never driven a car, or have you given up driving?

- ₁ Never drove → Skip to page 14 (Hearing)
₂ Gave up ↓

10c. Why did you give up driving? Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?

- ₁ Mainly eyesight
₂ Mainly other reasons
₃ Both eyesight and other reasons } → Skip to page 14 (Hearing)

The following question is for current drivers.

11. How much difficulty do you have driving during the daytime in familiar places

Would you say you have:

- ₁ No difficulty at all
₂ A little difficulty
₃ Moderate difficulty
₄ Extreme difficulty

Hearing

1. How would you rate your hearing *(with your hearing aid on, if applicable)*?

- ₁ Excellent → Skip to page 15 (Psychosocial & Well Being)
 - ₂ Good
 - ₃ Fair
 - ₄ Poor
 - ₅ Very poor
 - ₆ Deaf
-

Does your hearing (with your hearing aid, if you wear one) cause you ...	No	Some-times	Yes
2. ... to feel embarrassed when you meet new people?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3. ... to feel frustrated when talking to members of your family?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
4. ... to have difficulty when visiting friends, relatives, or neighbours?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
5. ... to attend religious services less often than you would like?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
6. ... to have arguments with family members?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
7. ... to have difficulty when listening to radio or television?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
8. ... to have difficulty when in a restaurant with relatives or friends?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
9. ... to have difficulty hearing when someone speaks in a whisper?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
10. ... to feel handicapped by a hearing problem?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
11. ... to limit/hamper your personal or social life?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

12a. Do you wear a hearing aid?

- ₁ No → Skip to page 15 (Psychosocial & Well Being)
- ₂ Yes ↓

12b. **If Yes:** On average, how often do you change the batteries in your hearing aid?

- ₁ Every 1-2 weeks or more
- ₂ Every 3-4 weeks
- ₃ Once a month or less

Social Network

People sometimes look to others for friendship, assistance, or other types of support.

The following three questions are about your family members, including your spouse, in-laws, and any other relatives.

1. How many relatives or family members do you see or hear from at least once a month?
(Note: Include spouse, in-laws, and any other relatives.)

<input type="checkbox"/> ₁	Nine or more	<input type="checkbox"/> ₄	Two
<input type="checkbox"/> ₂	Five to eight	<input type="checkbox"/> ₅	One
<input type="checkbox"/> ₃	Three or four	<input type="checkbox"/> ₆	None

2. How many relatives or family members do you feel close to that you can call on for help?
(Note: Include spouse, in-laws, and any other relatives.)

<input type="checkbox"/> ₁	Nine or more	<input type="checkbox"/> ₄	Two
<input type="checkbox"/> ₂	Five to eight	<input type="checkbox"/> ₅	One
<input type="checkbox"/> ₃	Three or four	<input type="checkbox"/> ₆	None

3. With how many relatives or family members can you comfortably discuss private matters?
(Note: Include spouse, in-laws, and any other relatives.)

<input type="checkbox"/> ₁	Nine or more	<input type="checkbox"/> ₄	Two
<input type="checkbox"/> ₂	Five to eight	<input type="checkbox"/> ₅	One
<input type="checkbox"/> ₃	Three or four	<input type="checkbox"/> ₆	None

The following three questions are about contacts with friends or neighbours.

4. How many friends/neighbours do you see or hear from at least once a month?

<input type="checkbox"/> ₁	Nine or more	<input type="checkbox"/> ₄	Two
<input type="checkbox"/> ₂	Five to eight	<input type="checkbox"/> ₅	One
<input type="checkbox"/> ₃	Three or four	<input type="checkbox"/> ₆	None

5. How many friends/neighbours do you feel close to that you can call on for help?

<input type="checkbox"/> ₁	Nine or more	<input type="checkbox"/> ₄	Two
<input type="checkbox"/> ₂	Five to eight	<input type="checkbox"/> ₅	One
<input type="checkbox"/> ₃	Three or four	<input type="checkbox"/> ₆	None

6. With how many friends/neighbours can you comfortably discuss private matters?

<input type="checkbox"/> ₁	Nine or more	<input type="checkbox"/> ₄	Two
<input type="checkbox"/> ₂	Five to eight	<input type="checkbox"/> ₅	One
<input type="checkbox"/> ₃	Three or four	<input type="checkbox"/> ₆	None

7. How often do you have someone who shows you love and affection if you need it?

- | | |
|--|---|
| <input type="checkbox"/> ₁ Always | <input type="checkbox"/> ₄ Sometimes |
| <input type="checkbox"/> ₂ Very Often | <input type="checkbox"/> ₅ Seldom |
| <input type="checkbox"/> ₃ Often | <input type="checkbox"/> ₆ Never |

8. How often do you have someone to share your most private worries and fears with if you need it?

- | | |
|--|---|
| <input type="checkbox"/> ₁ Always | <input type="checkbox"/> ₄ Sometimes |
| <input type="checkbox"/> ₂ Very Often | <input type="checkbox"/> ₅ Seldom |
| <input type="checkbox"/> ₃ Often | <input type="checkbox"/> ₆ Never |

9. How often do you have someone to love and make you feel wanted?

- | | |
|--|---|
| <input type="checkbox"/> ₁ Always | <input type="checkbox"/> ₄ Sometimes |
| <input type="checkbox"/> ₂ Very Often | <input type="checkbox"/> ₅ Seldom |
| <input type="checkbox"/> ₃ Often | <input type="checkbox"/> ₆ Never |

10. How many times per month do you participate in social groups or organisations? *For example, hobby or recreational groups; community organisations including political or charity groups; and church or religious organisations.*

- | | |
|---|--|
| <input type="checkbox"/> ₁ Nine or more | <input type="checkbox"/> ₄ Two |
| <input type="checkbox"/> ₂ Five to eight | <input type="checkbox"/> ₅ One |
| <input type="checkbox"/> ₃ Three or four | <input type="checkbox"/> ₆ Zero |

Your General Health

1. All in all, would you say that your health is generally ...

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

Functioning

	Please indicate if you are <u>able</u> to do each of the following activities. If you do not do them, answer as if you tried to do them yourself.	Yes	Yes, with difficulty	Yes, with a device	Yes, with help from someone	No
1.	Feed yourself?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2.	Move from your bed to a chair or to standing up?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3.	Get yourself to the toilet?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4.	Dress yourself?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5.	Bathe yourself?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6.	Use the telephone?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7.	Get beyond walking distance of your home; for example, by driving or using public transport?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8.	Shop for groceries?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9.	Prepare meals?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10.	Do housework?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
11.	Do D.I.Y. work?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12.	Do laundry?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13.	Take medicines?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14.	Manage money?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15.	Walk a quarter of a mile?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
16.	Walk 1 mile at least 3 times a week?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
17.	Participate in active sports enough to work up a sweat or become winded at least 3 times a week?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

For each activity listed above, you were asked if you were **able** to do them. For each activity that follows, you are being asked whether you have regularly or permanently **changed the way** (questions 18-20) you do them or **decreased how often** (questions 21-23) you do them for health or physical reasons.

For health or physical reasons: In the past 12 months, have you changed the way you ...		No	Yes	Have not done in the past year
18.	... Walk ½ mile? <i>For example, you walk more slowly or carefully; you use a different stance or gait; you use a walkingstick, frame, or other aid; you take more frequent rest stops.</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
19.	... Climb 10 steps? <i>For example, you use the handrail more often; you reduce the number of steps taken at a time; you walk more slowly or carefully; you make more frequent rest stops.</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
20.	... Get into or out of a car or bus? <i>For example, you use the door or seat to help steady you; you rely more on your arms to help you; you enter or exit more slowly; you require help from others.</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

For health or physical reasons: In the past 12 months, have you decreased how often you ...		No	Yes	Have not done in the past year
21.	... Walk ½ mile? <i>For example, you cut down from walking every day to walking 3-4 times per week because you tire more easily.</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
22.	... Climb 10 steps? <i>For example, you take the elevator more often whenever possible because of pain in your joints.</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
23.	... Get into or out of a car or bus? <i>For example, you decrease the number of car trips you take because it is difficult to get yourself out of the seat.</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Tobacco Use

This section is for ALL respondents.

1. Which best describes your cigarette smoking habits?
- ₁ I am presently a cigarette smoker
- ₂ I used to smoke cigarettes
- ₃ I never smoked cigarettes
2. Do you presently use tobacco in other forms (cigar or pipe)?
- ₁ No
- ₂ Yes

If you are a former cigarette smoker, **skip to page 21 (question 8).**

If you never smoked cigarettes, **skip to page 21 (Alcohol Use).**

This section is for CURRENT cigarette smokers only.

3. How many cigarettes do you usually smoke in a day?
- ₁ 1 per day or less
- ₂ More than 1 per day cigarettes per day
4. How old were you when you first started smoking cigarettes (fairly regularly)?
- Years old
5. Have you seriously thought about quitting smoking in the next 6 months?
- ₁ No → **skip to question 7 on this page**
- ₂ Yes
6. Are you planning to quit smoking in the next 30 days?
- ₁ No
- ₂ Yes
7. Which of the following keep you from quitting smoking?
Please tick all that apply and then skip to page 21 (Alcohol Use)
- a. ₁ I don't want to quit
- b. ₁ I don't think I can do it
- c. ₁ Stress
- d. ₁ Weight gain
- e. ₁ Other

For FORMER cigarette smokers only:

8. How old were you when you first started smoking cigarettes (fairly regularly)?

Years old

9. About how old were you when you last smoked cigarettes (fairly regularly)?

Years old

Alcohol Use

Please count one drink of alcohol as equal to one of the following:



One half-pint
or can of beer

or



One normal wine
glass or sherry
glass

or



One pub
measure
of spirits

or



One cocktail
containing a single
measure of spirits

1. How often do you have a drink containing alcohol?

1 Never



Skip to page 23 (Physical Activity)

2 Monthly or less

3 Two to four times a month

4 Two to three times a week

5 Four or more times a week

Please answer the following questions 2 to 10 even if you have a drink rarely

2. How many drinks containing alcohol do you have on a typical occasion when you drink?

1 1 or 2

2 3 or 4

3 5 or 6

4 7 to 9

5 10 or more

3. How often do you have **four** or more drinks on one occasion?

1 Never

2 Less than monthly

3 Monthly

4 Weekly

5 Daily or almost daily

4. During the last year, how often have you found that you were not able to stop drinking once you had started?

₁ Never

₂ Less than monthly

₃ Monthly

₄ Weekly

₅ Daily or almost daily

5. During the last year, how often have you failed to do what was normally expected from you because of drinking?

₁ Never

₂ Less than monthly

₃ Monthly

₄ Weekly

₅ Daily or almost daily

6. During the last year, how often have you needed a first drink in the morning to get yourself going after a heavy drinking session?

₁ Never

₂ Less than monthly

₃ Monthly

₄ Weekly

₅ Daily or almost daily

7. During the last year, how often have you had a feeling of guilt or remorse after drinking?

₁ Never

₂ Less than monthly

₃ Monthly

₄ Weekly

₅ Daily or almost daily

8. During the last year, how often have you been unable to remember what happened the night before because you had been drinking?

₁ Never

₂ Less than monthly

₃ Monthly

₄ Weekly

₅ Daily or almost daily

9. Have you been injured as a result of your drinking?

₁ No

₂ Yes, but not in the last year

₃ Yes, during the last year

10. Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested that you should cut down?

₁ No

₂ Yes, but not in the last year

₃ Yes, during the last year

Physical Activity

The following questions ask about your physical activities over the past 7 days. If the past 7 days were not typical for you, please answer for a typical week. Answer all items as accurately as possible. Please remember to complete both parts of each question, if requested.

1a. Over the past 7 days, how often did you participate in **sitting activities** such as reading, watching TV or doing handicrafts?

- ₁ Never → Skip to question 2a on this page
₂ 1-2 days per week
₃ 3-4 days per week
₄ 5-7 days per week

1b. On average, how many hours per day did you engage in these sitting activities?

- ₁ Less than 1 hour per day
₂ 1 but less than 2 hours per day
₃ 2 - 4 hours per day
₄ More than 4 hours per day

2a. Over the past 7 days, how often did you take a **walk** outside your home or garden for any reason? For example, for fun or exercise, walking to work, walking the dog, etc.?

- ₁ Never → Skip to question 3a on this page
₂ 1-2 days per week
₃ 3-4 days per week
₄ 5-7 days per week

2b. On average, how many hours per day did you spend walking?

- ₁ Less than 1 hour per day
₂ 1 but less than 2 hours per day
₃ 2 - 4 hours per day
₄ More than 4 hours per day

3a. Over the past 7 days, how often did you engage in **light sport or recreational activities** such as bowls, fishing, yoga, tai chi or other similar activities?

- ₁ Never → Skip to page 24 (question 4a)
₂ 1-2 days per week
₃ 3-4 days per week
₄ 5-7 days per week

3b. On average, how many hours per day did you engage in these light sport or recreational activities?

- ₁ Less than 1 hour per day
₂ 1 but less than 2 hours per day
₃ 2 - 4 hours per day
₄ More than 4 hours per day

4a. Over the past 7 days, how often did you engage in **moderate sport or recreational activities** such as ice skating, badminton, brisk walking, 10pin bowling, keep fit class or other similar activities?

- ₁ Never → Skip to question 5a on this page
₂ 1-2 days per week
₃ 3-4 days per week
₄ 5-7 days per week

4b. On average, how many hours per day did you engage in these moderate sport or recreational activities?

- ₁ Less than 1 hour per day
₂ 1 but less than 2 hours per day
₃ 2 - 4 hours per day
₄ More than 4 hours per day

5a. Over the past 7 days, how often did you engage in **strenuous sport or recreational activities** such as jogging, swimming, cycling, tennis, aerobic class, skiing (downhill or cross-country) or other similar activities (including those using exercise machines)?

- ₁ Never → Skip to question 6a on this page
₂ 1-2 days per week
₃ 3-4 days per week
₄ 5-7 days per week

5b. On average, how many hours per day did you engage in these strenuous sport or recreational activities?

- ₁ Less than 1 hour per day
₂ 1 but less than 2 hours per day
₃ 2 - 4 hours per day
₄ More than 4 hours per day

6a. *Another type of physical activity is muscle strengthening or conditioning.*

Over the past 7 days, how often did you do any **exercises** specifically to increase muscle strength and endurance, such as lifting weights, doing pushups, using exercise machines for different muscle groups, etc.?

- ₁ Never → Skip to page 25 (question 7)
₂ 1-2 days per week
₃ 3-4 days per week
₄ 5-7 days per week

6b. On average, how many hours per day did you engage in exercises to increase muscle strength and endurance?

- ₁ Less than 1 hour per day
₂ 1 but less than 2 hours per day
₃ 2 - 4 hours per day
₄ More than 4 hours per day

7.	During the <u>past 7 days</u> , have you done any	No	Yes
a.	Light housework, <i>such as dusting or washing dishes?</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b.	Heavy housework or chores, <i>such as vacuuming, scrubbing floors or washing windows, or carrying wood?</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
c.	Home repairs <i>like painting, wallpapering, electrical work, etc.?</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
d.	Heavy gardening?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
e.	Light gardening?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
f.	Caring for another person, <i>such as a child, dependent spouse, or another adult?</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

8a. **During the past 7 days, did you work for pay or as a volunteer?**

- ₁ No → Skip to question 9 on this page
₂ Yes ↓

8b. **If Yes:** How many hours per week did you work for pay and/or as a volunteer?

Hours per week

8c. **If Yes:** Which of the following categories best describes **the amount of physical activity required** on your job and/or volunteer work?

- ₁ Mainly sitting with slight arm movements (*for example: office worker, watchmaker, seated assembly line worker, bus driver, etc.*).
₂ Sitting or standing with some walking (*for example: cashier, general office worker, light tool and machinery worker*).
₃ Walking, with some handling of heavy weight (*for example: postman, waiter/waitress, construction worker, heavy tool and machinery worker*).
₄ Walking and heavy manual work often requiring handling of heavy materials (*for example: construction or building worker*).

9. Do you participate in some form of light, moderate or strenuous physical activity on most days, such as those described in the questions above?

Include both work and non-work related activity.

- ₁ Yes, I have been for more than 6 months
₂ Yes, I have been but for less than 6 months
₃ No, but I plan to in the next month
₄ No, but I plan to in the next 6 months
₅ No, and I do not intend to in the next 6 months

10. Which of the following keep you from participating more in physical activity?

Please tick ALL that apply.

- a. ₁ I already exercise frequently and regularly
- b. ₁ I don't have anyone to exercise with
- c. ₁ There is nowhere to exercise
- d. ₁ I don't have time/don't get around it
- e. ₁ Cost
- f. ₁ Weather
- g. ₁ I have an illness limiting my physical activity
- h. ₁ I have a physical limitation
- i. ₁ I have pain with physical activity
- j. ₁ Other reasons

Nutrition

Think about your eating habits over the past month. About how often do you eat food in each of the following categories?

In your answer, exclude non-fat versions of these foods

Tick ONE answer for each food category.

	How often do you eat . . . ?	Never or less than once per MONTHS	1-3 times per MONTHS	1-2 times per WEEK	3-4 times per WEEK	5 times or more per WEEK
1.	Hamburgers, cheeseburgers, minced beef	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
2.	Beef or pork, such as steak, roasts, chops	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
3.	Fried chicken with skin, fried fish	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
4.	Hot dogs, frankfurters, or other sausages	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
5.	Cold cuts, lunch meats (salami, etc.)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
6.	Salad cream (not diet) or mayonnaise	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
7.	Margarine, butter or gravy	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
8.	Eggs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
9.	Bacon, ham	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
10.	Cheese spread or cheese (not low-fat)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

How often do you eat . . . ?		Never or less than once per MONTHS	1-3 times per MONTHS	1-2 times per WEEK	3-4 times per WEEK	5 times or more per WEEK
11.	Whole milk, semi-skimmed milk or cream	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
12.	French fries, fried potatoes, or chips	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
13.	Crisps, popcorn, cracker biscuits	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
14.	Ice cream (not low-fat)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
15.	Doughnuts, pastries, pies, cake, cookies, biscuits	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

How often do you eat . . . ?		Never or less than once per WEEK	About 1time per WEEK	2-3 time per WEEK	4-6 time per WEEK	Every day
16.	Orange juice or other 100% fruit juices	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
17.	Fruit (do not count juice)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
18.	Green salad	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
19.	Potatoes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
20.	Beans, baked beans, kidney beans	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
21.	Other vegetables	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
22.	High-fibre or bran cereal	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
23.	Dark bread, such as whole wheat or rye	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
24.	Whole-grain rice or whole-grain pasta	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

25. Do you consistently take steps to limit eating high-fat foods?

- ₁ Yes, I have been for more than 6 months
- ₂ Yes, I have been but for less than 6 months
- ₃ No, but I plan to in the next month
- ₄ No, but I plan to in the next 6 months
- ₅ No, and I do not intend to in the next 6 months

26. Which of the following keep you from eating less fat?

Please tick ALL that apply.

- a. ₁ I already minimise fat intake
- b. ₁ I don't think it's important to eat less fat
- c. ₁ I like the taste of high-fat foods
- d. ₁ My friends/family members don't want to cut down on high-fat foods
- e. ₁ It is too much trouble to shop for or prepare low-fat foods
- f. ₁ High-fat foods are easily available
- g. ₁ Low-fat items are more expensive
- h. ₁ Other

27. Do you consistently take steps to include fruits, vegetables and fibre into your diet?

- ₁ Yes, I have been for more than 6 months
- ₂ Yes, I have been but for less than 6 months
- ₃ No, but I plan to in the next month
- ₄ No, but I plan to in the next 6 months
- ₅ No, and I do not intend to in the next 6 months

28. Which of the following keep you from increasing your fruit, vegetable and fibre intake?

Please tick ALL that apply

- a. ₁ I already eat plenty of fruits, vegetables and fibre
- b. ₁ I don't think it's important to add them to my diet
- c. ₁ I don't like the taste of fruits and vegetables
- d. ₁ My friends/family members don't want me to include more of them
- e. ₁ It's too much trouble to shop for or prepare fruits, vegetables and fibre
- f. ₁ Good produce is not easily available
- g. ₁ Good produce is expensive
- h. ₁ Other

Injury Prevention

Motor vehicle safety

1. How often do you forget to use safety belts when you drive or ride in a car?
 - ₁ Never forget
 - ₂ Seldom forget
 - ₃ Sometimes forget
 - ₄ Nearly always forget
 - ₅ Always forget

2. How often did you worry when you were a driver (or a passenger) in a car that you (or the driver) had too much alcohol to drink?
 - ₁ Never
 - ₂ Less than once a year
 - ₃ Less than once a month, but at least once a year
 - ₄ Less than once a week, but at least once a month
 - ₅ One or two times a week
 - ₆ Three or more times a week
 - ₇ Daily

Balance

3. Do you limit your activities because you are afraid you will fall?
 - ₁ No
 - ₂ Yes

4. Have you ever fallen and not been able to get up?
 - ₁ No
 - ₂ Yes

- 5a. During the past 12 months have you fallen to the ground or floor?
 - ₁ No → Skip to page 30 (Preventive Care)
 - ₂ Yes ↓

- 5b. How many times did you fall
 - ₁ One time
 - ₂ More than one time

- 5c. Was the fall (were the falls) indoors or out of doors?
 - ₁ Indoors
 - ₂ Outdoors
 - ₃ Indoors and outdoors

Preventive Care

Have you had a ...	No	Yes
1. Blood pressure measurement <u>within the past year</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
2. Eyesight checkup <u>within the past year</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
3. Hearing checkup <u>within the past year</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
4. Dental checkup <u>within the past year</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
5. Cholesterol measurement <u>within the past 5 years</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
6. Fasting blood glucose measurement <u>within the past 3 years</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
7. Colon cancer screen <u>within the past year</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
8. Immunisation against influenza ("flu jab") <u>within the past year</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
9. Immunisation against pneumonia ("Pneumovax") <u>within the past 10 years</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
<i>For Women Only:</i>		
10. Mammogram <u>within the past 2 years</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
11. Cervical smear <u>within the past 3 years</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

12. For those preventive services listed above that you have not had, which of the following keep you from having them?

Please tick ALL that apply

- a. ₁ I have already had these preventive services
- b. ₁ I have no need to; I have no health problems
- c. ₁ I've never thought about it
- d. ₁ Financial reasons/cost, insurance
- e. ₁ I don't think it's important
- f. ₁ My general practitioner never recommended it
- g. ₁ I don't have the time/don't get around to it
- h. ₁ Other

Occupation & Retirement

1. What type of work did you do most of your life?

Please tick only ONE response.

- ₁ Managerial and Professional
- ₂ Technical, Sales, and Administrative Support Occupations
- ₃ Service Occupations
- ₄ Farming, Forestry, and Fishing Occupations
- ₅ Precision Production, Craft, and Repair Occupations
- ₆ Machine Operators, Factory or Labouring
- ₇ Military Occupations
- ₈ Housewife
- ₉ Volunteer Work
- ₁₀ Other

2. Are you currently retired?

- ₁ No → Skip to question 4 on this page
- ₂ Yes ↓

3. Did you retire mainly because you thought your work would cause a health problem?

- ₁ No
- ₂ Yes

4. Are you currently working for pay?

- ₁ No
- ₂ Yes, part time
- ₃ Yes, full time

5. Are you currently doing unpaid work?

- ₁ No
- ₂ Yes, part time
- ₃ Yes, full time

About You

1. Where were you born?

₁ Britain: Which place and which county?

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

place

--	--

county

₂ In some other country: Which country?

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2. What is your racial/ethnic background?

₁ White UK

₂ White Irish (non UK)

₃ Black Caribbean

₄ Black African

₅ Black other

₆ Indian

₇ Pakistani

₈ Bangladeshi

₉ Chinese

₁₀ Other (please specify) _____

3. What are your current living arrangements?

₁ I live alone

₂ I live with my spouse

₃ I live with someone else

4. Please describe your living location? I live in a ...

₁ Private flat/home

₂ Residential Care or Residential Home

₃ Nursing Home

5. At what age did you complete your education in school or college?

₁ Before the age of 15 years

₂ At the age of 15 or 16 years

₃ Between the age of 17 and 20 years

₄ After the age of 21 years

6. Do you receive only the state pension?

₁ Yes

₂ No

Questionnaire Evaluation Form

This brief survey asks questions about your recent experience completing the Older Persons Health Profile Questionnaire. Your honest responses will help us improve it for future use with others.

1. In general, how difficult was it for you to understand the questions and instructions in the Questionnaire?

- ₁ Very difficult
₂ Somewhat difficult
₃ Somewhat easy
₄ Very easy

If you answered **Very difficult** or **Somewhat difficult**, what sections, questions, or instructions did you find difficult to understand?

2. In general, how difficult was it for you to complete the Questionnaire?

- ₁ Very difficult
₂ Somewhat difficult
₃ Somewhat easy
₄ Very easy

If you answered **Very difficult** or **Somewhat difficult**, what sections or questions did you find difficult to complete?

3. Please mark the response that best corresponds to the assistance you received in completing this questionnaire.

- ₁ Someone else completed the Questionnaire for me.
₂ I completed it with assistance from someone else.
₃ I completed it without assistance, but would have liked assistance.
₄ I completed it without assistance, and not feel I needed assistance .

4. How would you describe the length of the Questionnaire?

- ₁ Too long
₂ About right
₃ Too short

5. About how much time did it take you to complete the Questionnaire?

minutes

6. Did you dislike any specific sections or questions on the Questionnaire?

- ₁ No
₂ Yes

If you answered **Yes**, what sections or questions did you dislike?

7. Are there any topic areas that were not covered in the Questionnaire that you think should have been covered in the Questionnaire?

- ₁ No
₂ Yes

If you answered **Yes**, what topic areas should have been covered?

Please take a moment to look back and make sure you have not missed any pages or questions.

Date Completed:

Day

Month

Year

--	--

--	--

--	--	--	--



Would you kindly return this questionnaire within 20 days using the enclosed stamped addressed envelope.

Thank you for completing this survey!

Version 2.5: This questionnaire was developed by the Geriatric Research Unit Bern (Spital Bern Ziegler, Morillonstrasse 75, CH-3001 Bern/Switzerland) in collaboration with the Department of Health Care of the Elderly, King's College London, the Department of Primary Care and Population Sciences, University College London, and other organisations based on a license to use granted by the Regents of the University of California, Los Angeles. This questionnaire is protected by copyright and may not (as a whole or in part) be reproduced or used for other purposes without prior written permission of the copyright owners.
Version 2.5: © 2000, Regents of the University of California, Los Angeles.
Section "Physical activity": © 1991 New England Research Institutes, 9 Galen Street, Watertown, MA 02472 USA.