UNIVERSITY OF BRISTOL
FACULTY OF MEDICINE

DEPARTMENT OF SOCIAL MEDICINE

0a) Study Number: ☐☐☐☐☐☐☐☐

CONFIDENTIAL

0b) Centre: ☐

FOLLOW UP STUDY OF HEALTH AND DIET

CLINIC QUESTIONNAIRE

Thank you for agreeing to complete the questionnaire. Please take as much time as you need. When you have finished please return the questionnaire to the nurse or doctor before leaving the clinic.

Most questions can be answered simply by ticking the correct box ☑

Although this questionnaire is entirely voluntary, your response to each question is very important to us and we would appreciate it if you attempted every question to the best of your knowledge. It is important that you fill this in, even if your health is excellent. We need to find out about the health of everyone.

All your answers will be completely CONFIDENTIAL and will not be released to anyone else. Neither your name nor any other identifying details will be included in any reports that result from this research.

We are very grateful for your co-operation.
Thank you

SECTION A: ABOUT YOURSELF

The questions below are about your personal characteristics and where you live

Please provide your contact details below.

1a) First name (s) ……

1b) Surname ……

1c) Title ……

1d) Name by which your GP knows you (if different from above)……..……..

……

1e) Date of birth? ____ ____ / ____ ____ / ____ ____ ____ ____

D D M M Y Y Y Y

2a) What is your current address?

…….....……

.....

.....

.....

2b) Postcode ☐☐☐☐☐☐☐

2ci) Telephone number (Home): …….

2cii) Telephone number (Work): ……..

2ciii) Email: …….

2d) GP's Name: :.....….....….....

2e) Practice Name: ……:.....….....….....

2f) Address: **.....**……..

2g) Town: **.....**

2h) County: **.....**…..…

2i) Postcode ☐☐☐☐☐☐☐

2j) Telephone Number: ……..

2k) NHS Number (if known): ……..

SECTION B: YOUR GENERAL HEALTH

3a) Have you ever been told by a doctor that you have, or have had, any of the following? *(Please tick **one** box on each line)*

	Yes	No
i) Angina	☐ 1	☐ 2
ii) High cholesterol level	☐ 1	☐ 2
iii) Diabetes	☐ 1	☐ 2
iv) Stroke	☐ 1	☐ 2
v) Heart attack (coronary thrombosis, myocardial infarction)	☐ 1	☐ 2
vi) Nervous trouble or depression	☐ 1	☐ 2
vii) Asthma	☐ 1	☐ 2
viii) Hay Fever	☐ 1	☐ 2
ix) Emphysema	☐ 1	☐ 2
x) Chronic Bronchitis	☐ 1	☐ 2
xi) Breast Cancer	☐ 1	☐ 2
xii) Bowel/Colon Cancer	☐ 1	☐ 2
xiii) Prostate Cancer	☐ 1	☐ 2
xiv) Other Cancer- *please specify*	☐ 1	☐ 2

xiv-a) …….

xv) Other Illness – *please specify*	☐ 1	☐ 2

xv-a) ……

(Please answer all the above questions)

Office use

3b) Over the last 12 months would you say your health has been? *(Please tick **one** box only)*

Very good ☐ 1 Good ☐ 2 Fair ☐ 3 Bad ☐ 4 Very Bad ☐ 5

4a) Have you ever had any pain or discomfort in your chest?

Yes ☐ 1 No ☐ 2

If **No** go to **Q6a**

If **Yes,**

4b) Do you get this pain and discomfort when you walk uphill or hurry?

Yes ☐ 1 No ☐ 2

4c) Do you get the pain and discomfort when you walk at an ordinary pace on the level?

Yes ☐ 1 No ☐ 2

4d) When you get pain or discomfort in your chest what do you do?
*(Please tick **one** box only)*

Stop ☐ 1

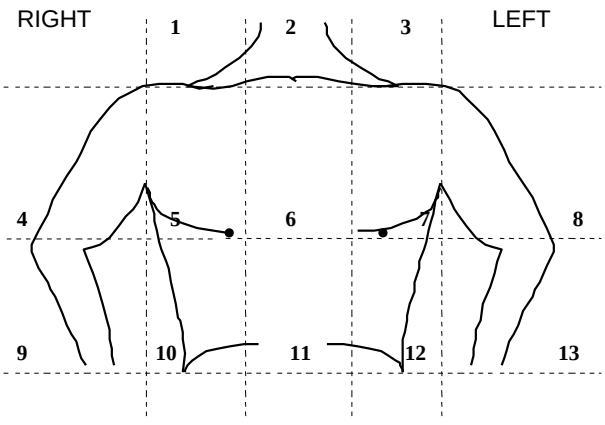
Slow down ☐ 2

Continue at the same pace ☐ 3

4e) Does it go away when you stand still? Yes ☐ 1 No ☐ 2

4f) How soon? 10 minutes or less ☐ 1 More than 10 minutes ☐ 2

4g) Where do you get this pain or discomfort?
(Mark the place(s) with an X on the diagram below)



FRONT VIEW

5a) Have you ever had a severe pain across the front of your chest lasting for half an hour or more?

Yes ☐ 1 No ☐ 2

If **No**, go to **Q6a**

If **Yes,**

5b) Did you talk to a doctor about it? Yes ☐ 1 No ☐ 2

If **No**, go to **Q6a**

If **Yes,**

5c) What did they say it was? .....

.....

5d) How many of these attacks have you had? ☐

Number

6a) Have you ever had heart trouble suspected or confirmed?

Yes ☐ 1 No ☐ 2

If **No**, go to **Q7a**

If **Yes**,

6b) When was the first time? *(Give year)*

____ ____ ____ ____

Y Y Y Y

6c) Have you ever had either of the following operations to improve the circulation to your heart? *(If yes, please tick box)*

i) Open heart surgery (*Coronary Artery Bypass Surgery*): Yes ☐ 1 No ☐ 2

ii) Balloon angioplasty (*PTCA*): Yes ☐ 1 No ☐ 2

7a) Has your blood pressure ever been checked? Yes ☐ 1 No ☐ 2

7b) Has a doctor ever told you that your blood pressure was above normal?

Yes ☐ 1 No ☐ 2

If **No**, go to **Q8a**

If **Yes,**

7c) When was the first time? *(Give year)*

____ ____ ____ ____

Y Y Y Y

7d) Have you ever had drug treatment for high blood pressure? Yes ☐ 1 No ☐ 2

7e) Are you taking drug treatment for high blood pressure now? Yes ☐ 1 No ☐ 2

8a) Have you ever been told by your doctor that you have (or have had) diabetes?

Yes ☐ 1 No ☐ 2

If **No**, go to **Q9a**

If **Yes,**

8b) In what year was your diabetes first diagnosed? ____ ____ ____ ____
Y Y Y Y

8c) In what year did you begin regular treatment? ____ ____ ____ ____
(With diet, tablets or injections for your diabetes?) **Y Y Y Y**

8d) Are you on a regular diet for your diabetes? Yes ☐ 1 No ☐ 2

8e) Are you on regular tablets for your diabetes? Yes ☐ 1 No ☐ 2

8f) If **Yes**, please give name of medication……..……..……..…

……

8g) Are you on regular treatment with insulin for your diabetes? Yes ☐ 1 No ☐ 2

9a) Are you currently taking any medicines prescribed by your doctor?

Yes ☐ 1 No ☐ 2

If **No,** go to **Q10a**

If **Yes,**

9b) Please list all the medicines you are currently taking *(Please copy from the label on the medicine bottle)* and why this was prescribed:

	1) Medication Name	**2) Reason for taking it *(if known)***
i)		
ii)		
iii)		
iv)		
v)		
vi)		

9c) Are you currently taking aspirin on a regular basis?

Yes ☐ 1 No ☐ 2

9d) **If Yes**, please explain your reason for doing so:

……...……

……..…….

10a) Do you smoke cigarettes now? Yes ☐ 1 No ☐ 2

If **No,** go to **11a**

If **Yes**,

10b) ***(Only if you currently smoke cigarettes)***
How many cigarettes (manufactured or hand rolled) do you smoke each day?
*(Please tick **one** box only)*

Under 10 a day ☐ 1

10 or more a day but less than 20 ☐ 2

20 or more a day but less than 30 ☐ 3

30 a day or more ☐ 4

10c) ***(Only if you currently smoke cigarettes)***
How old were you when you started smoking cigarettes regularly?

Age ☐
Years

Now go to Q12a

11a) *(Only if you **do not** currently smoke cigarettes)*
Have you **ever** smoked cigarettes regularly?

Yes, I used to smoke regularly ☐ 1

No, I have never smoked regularly ☐ 2

If ***No*** go to **Q12a**

If **Yes,**

11b) *(Only if you have **stopped** smoking cigarettes)*
How old were you when you started smoking cigarettes regularly?

Age ☐
Years

11c) *(Only if you have **stopped** smoking cigarettes)*
What is the largest number of cigarettes that you used to smoke regularly?
*(Please tick **one** box only)*

Less than 10 a day ☐ 1

10 or more a day but less than 20 ☐ 2

20 or more a day but less than 30 ☐ 3

30 a day or more ☐ 4

11d) *(Only if you have **stopped** smoking cigarettes)*
When did you **(finally)** stop smoking cigarettes?
(give month and year - eg 09/1997)

____ ____ / ____ ____ ____ ____
M M Y Y Y Y

12a) Do you smoke cigars? Yes ☐ 1 No ☐ 2

If **No,** go to **Q12c**

If Y**es**,

12b) If yes, how many cigars per week? ☐

cigars

12c) Do you smoke a pipe? Yes ☐ 1 No ☐ 2

If **No,** go to **Q13a**

If **Yes**,

12d) How many ounces of tobacco do you smoke per week? ☐

Ounces

13a) In the past 12 months have you taken an alcoholic drink? *(Please tick **one** box only)*

Daily	☐ 1
Almost daily	☐ 2
Once or twice a week	☐ 3
Once or twice a month	☐ 4
Special occasions only	☐ 5
No	☐ 6

13b) In the last 5 years have you changed your drinking habits?

Yes ☐ 1 No ☐ 2

If **No,** go to **Q14a**

If **Yes**,

13c) Compared with your current habits, did you drink.....? *(Please tick **one** box only)*

A lot more	☐ 1
A bit more	☐ 2
A bit less	☐ 3
A lot less	☐ 4

13d) If you have given up or reduced drinking, what was the main reason? *(Please tick **one** box only)*

Illness/doctor's orders	☐ 1
Health precautions	☐ 2
Finance	☐ 3
Other (Please specify)	☐ 4

13e) Other: .....

.....

If you have not had a drink in the last year, please go to Section C page 13

14a) Have you had an alcoholic drink in the last seven days?

Yes ☐ 1 No ☐ 2

If **No,** go to **Q15a**

If Yes,

14b) In the last seven days how many drinks have you had of each of the following? *[Please remember that a drink poured at home could be equivalent to 2 or 3 pub measures]*

i) Spirit (whisky, gin, rum, brandy, vodka, etc) or liqueurs	☐ *measures*
ii) Wine (including sherry, port, vermouth)	☐ *glasses*
iii) Beer (including lager or cider)	☐ *pints*

15a) When you drink spirits or wine how many drinks do you **usually** have during one occasion? [If you have both wine and spirits, add them together - e.g. 1 measure of whisky and 2 glasses of wine = 3] *(Please tick* **one** *box only)*

1 - 2 ☐ 1

3 - 4 ☐ 2

5 or more ☐ 3

I don't drink wine or spirits ☐ 4

15b) When you drink beer how many *pints* do you **usually** have during one occasion? *(Please tick* **one** *box only)*

1 - 2 ☐ 1

3 - 4 ☐ 2

5 or more ☐ 3

I don't drink beer ☐ 4

15c) What is the **maximum** quantity of spirits you would drink at one sitting nowadays?
[If none write 0]

spirits:
☐
Number of pub measures

15d) What is the **maximum** quantity of wine you would drink at one sitting nowadays?
[If none write 0]

wine:
☐
Number of pub measures

15e) What is the **maximum** quantity of beer you would drink during one occasion?
[If none write 0]

beer:
☐
Number of pints

SECTION C: DIET AND NUTRITION

The following section asks about what you eat. This is a very important part of the study. Completing this may take you some time but will provide very valuable information about the effects of diet on health.

Please do not be put off once you've started. It may be quite lengthy but is straight forward and quick to work your way through.

Listed below are food items divided into sections according to food type. Please put a tick in the box to indicate how often on average you have eaten the food during the last 12 months.

Example: If you usually have a helping of chips twice a week you should put a tick in the column headed 2-4 a week.

Foods	**Average Use In The Last 12 Months**								
Potatoes, Rice and Pasta	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
Chips				✓					

Example: If you usually have 4 or 5 slices of white bread per day you should put a tick in the column headed 4-5 per day.

Foods	**Average Use In the Last 12 Months**								
Bread and Savoury Biscuits (one slice or biscuit)	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
White bread and rolls								✓	

If you make a mistake and put a tick in the wrong box just cross through the tick as shown below, and put another tick in the correct box.

Example: If you usually have apples twice a week but ticked the 2-3 times daily by mistake, just cross this through and tick the 2-4 a week box instead.

Foods	**Average Use In The Last 12 Months**								
Fruit	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
Apples				✓		✗	✓		

*16) Please tick **one** box on each line.*

Foods	**Average Use In The Last 12 Months**								
a) Meat and Fish	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
i) Beef including mince									
ii) Beefburgers									
iii) Pork									
iv) Lamb									
v) Chicken or other poultry									
vi) Ham, Bacon									
vii) Corned beef, spam, luncheon meat									
viii) Sausages									
ix) Savoury pies e.g meat pie, pork pie, sausage roll									
x) Liver, liver paté, liver sausage, kidney, offal.									
xi) Fried fish in batter									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

*16) Cont/… Please tick **one** box on each line.*

a) Meat and Fish *Cont/*	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
xii) Fish fingers, fish cakes									
xiii) Other white fish, fresh or frozen e.g. cod, haddock, plaice, sole									
xiv) Oily fish, fresh or canned e.g. mackerel, kippers, tuna, salmon, sardines, herring									
xv) Shellfish, e.g. prawns, mussels, crab									
b) Bread and savoury biscuits									
i) White Bread and rolls									
ii) Brown bread and rolls									
iii) Wholemeal bread and rolls									
iv) Cream crackers, cheese biscuits									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

*16) Cont/… Please tick **one** box on each line.*

Foods	**Average Use In The Last 12 Months**								
b) Bread and savoury biscuits *Cont/*	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
v) Crispbread e.g. Ryvita									
c) Cereals									
i) Porridge, Readybrek									
ii) Other cereal, cornflakes, muesli etc.									
d) Potatoes, Rice & Pasta									
i) Potatoes – boiled, mashed, jacket									
ii) Chips									
iii) Roast potatoes									
iv) White rice (not pudding rice)									
v) Brown rice									
vi) Pasta e.g. spaghetti, macaroni									
vii) Pizza									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

*16) Cont/… Please tick **one** box on each line.*

Foods	**Average Use In The Last 12 Months**								
e) Dairy Products & Fats	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
i) Single or sour cream									
ii) Double or clotted cream									
iii) Yoghurt									
iv) Cheese e.g. cheddar									
v) Cottage cheese, low fat soft cheese									
vi) Eggs - boiled, fried, scrambled etc.									
vii) Quiche									
viii) Low calorie, low fat salad cream									
ix) Salad cream, mayonnaise									
x) French dressing									
xi) Other salad dressing									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

*16) Cont/… Please tick **one** box on each line.*

Foods	Average Use In The Last 12 Months								
f) The following on bread or vegetables	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
i) Butter									
ii) Block margarine e.g. Stork, Krona									
iii) Polyunsaturated margarine e.g. Flora, sunflower, Vitalite.									
iv) Other soft margarine, Blue Band, Clover, own brand.									
v) Low fat spread e.g. Outline, Gold									
g) Sweets and Snacks									
i) Chocolate biscuits e.g. chocolate digestive									
ii) Plain sweet biscuits e.g. Nice, ginger, digestive									
iii) Cake e.g. fruit cake, sponge									
iv) Buns, pastries e.g. scones, flapjacks, doughnuts									
v) Fruit pies, tarts, crumbles									
vi) Sponge puddings									
vii) Milk puddings eg. Rice, custard									
viii) Ice cream, choc ices									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

*16) Cont/… Please tick **one** box on each line.*

Foods	**Average Use In The Last 12 Months**								
g) Sweets and Snacks *Cont/*	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
ix) Chocolates, single or squares									
x) Chocolate bars e.g. mars, crunchie (whole bar)									
xi) Sweets, toffees, mints									
xii) Sugar added to tea, coffee, cereal									
xiii) Crisps or other packet snacks									
xiv) Peanuts or other nuts									
h) Soups, sauces and spreads									
i) Meat soup									
ii) Vegetable soup									
iii) Sauces e.g. white sauce, cheese sauce									
iv) Gravy									
v) Tomato ketchup									
vi) Brown sauce e.g. HP Sauce									
vii) Pickles, chutney									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

*16) Cont/……. Please tick **one** box on each line.*

	Average Use In The Last 12 Months								
h) Soups, sauces and spreads ***Cont/***	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
viii) Marmite, Bovril									
ix) Jam, marmalade, honey									
x) Peanut butter									
i) Drinks									
i) Tea									
ii) Coffee, instant or ground									
iii) Coffee, decaffeinated									
iv) Coffee whitener e.g. Coffee-mate									
v) Cocoa, hot chocolate									
vi) Horlicks, ovaltine									
vii) Low calorie or diet fizzy soft drink									
viii) Fizzy soft drink eg. Coca cola									
ix) Pure fruit juice e.g. orange, apple									
x) Fruit squash or cordial									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

*16) Cont/……. Please tick **one** box on each line.*

	Average Use In The Last 12 Months								
j) Fruit	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
For very seasonal fruits such as strawberries, please estimate your average use when the fruit is in season.									
i) Apples									
ii) Pears									
iii) Oranges, grapefruit, satsumas									
iv) Bananas									
v) Grapes									
vi) Melon									
vii) Peaches, plums, apricots									
viii) Strawberries, raspberries, kiwi fruit									
ix) Tinned fruit, stewed fruit									
x) Dried fruit e.g. raisins, prunes (not in cakes).									
k) Vegetables – Fresh, frozen or tinned									
i) Carrots									
ii) Spinach									
iii) Broccoli, spring greens, kale									
iv) Cabbage, brussels sprouts									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

*16) Cont/… Please tick **one** box on each line.*

	Average Use In The Last 12 Months								
j) Vegetables *Cont/*	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
v) Peas									
vi) Green beans, broad beans									
vii) Marrow, courgettes									
viii) Cauliflower									
ix) Parsnips, turnips, swedes									
x) Leeks									
xi) Onions									
xii) Garlic									
xiii) Mushrooms									
xiv) Sweet peppers									
xv) Green salad, lettuce, cucumber **In Summer**									
xvi) Green salad, lettuce, cucumber **In Winter**									
xvii) Watercress									
xviii) Tomatoes **In Summer**									
xvix) Tomatoes **In Winter**									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

*16) Cont/… Please tick **one** box on each line.*

	Average Use In The Last 12 Months								
j) Vegetables Cont/	Never or less than once/ month	1-3 per month	Once a week	2-4 a week	5-6 a week	Once a day	2-3 per day	4-5 per day	6 + times per day
xx) Sweetcorn									
xxi) Beetroot									
xxii) Avocado									
xiii) Baked beans									
xxiv) Dried lentils, red beans, kidney beans, dried peas									
	1	2	3	4	5	6	7	8	9

PLEASE CHECK YOU HAVE A TICK (✓) ON EACH LINE.

17a) What do you do with the visible fat on meat? *(Tick **one** box only)*

☐ 1 Eat most of the fat

☐ 2 Eat some of the fat

☐ 3 Eat as little as possible

☐ 4 Do not eat meat

17b) What kind of fat do you most often use for frying, roasting, grilling etc.?
(T*ick **one** box only)*

☐ 1 Butter

☐ 2 Lard/ dripping

☐ 3 Vegetable oil

☐ 4 Solid vegetable fat

☐ 5 Margarine

☐ 6 None

If you use vegetable oil or margarine please give the type below eg corn, sunflower:

17c) .....

17d) What type of milk do you most often use? *(Tick **one** box only)*

☐ 1 Full cream/ silver top

☐ 2 Skimmed/ blue top

☐ 3 Dried milk

☐ 4 Semi-skimmed/ red-white top

☐ 5 Channel island/ gold top

☐ 6 None

17e) Other, please specify: .....

17f) How much milk do you drink each day, including milk with tea, coffee, cereals etc.?
*(Tick **one** box only)*

☐ 1 More than one pint

☐ 2 One Pint

☐ 3 ¾ of a Pint

☐ 4 ½ of a Pint

☐ 5 ¼ of a Pint

☐ 6 None

17g) How many servings of vegetables or vegetable containing dishes (excluding potatoes) do you usually eat each week?

☐

17h) How many servings of fruit or fruit containing dishes do you usually eat each week?

☐

17i) Do you add salt to your food at table? *(Tick **one** box only)*

Yes, most of the time	☐1	Yes, occasionally	☐3
Yes, some of the time	☐2	No, never	☐4

17j) Do you currently follow any of these diets? (*Tick more than one box if necessary*)

☐1	☐2	☐3	☐4	☐5	☐6
Low Fat	Slimming	Low Salt	Gluten free	Diabetic	High Fibre

17k) Please give details:

.....

17l) Have you taken any vitamins, minerals, fish oils, fibre or other food supplements during the past year? *(Tick **one** box only)*

☐1	☐2	☐3
Yes	No	Don't Know

17m) If **Yes**, please complete the table below. If you have taken more than five types of supplements, please put the most frequently consumed brands first.

.

(a) Vitamin supplements **Name and brand** Please list full name **brand** and strength	**(b) Dose** Please state number of pills, capsules or teaspoons consumed	**(c) Average Frequency** Tick **one** box per line to show how often on average you consumed supplements								
		Less than once a month 1	1 - 3 per month 2	Once a week 3	2 - 4 a week 4	5 - 6 a week 5	Once a day 6	2 - 3 per day 7	4 - 5 per day 8	6 + times per day 9
i) …… ……										
ii) …… ……										
iii) …… ……										
iv) …… ……										
v) …… ……										

17n) Have you changed your diet over the last 12 months?

☐ 1 Yes ☐ 2 No ☐ 3 Don't Know

17o) If **Yes**, please indicate if the change was for any of the reasons listed below.
(Tick more than one box if necessary)

	YES	**NO**
i) High blood pressure	☐ 1	☐ 2
ii) Bowel Problem (e.g. irritable bowel or diverticulitis)	☐ 1	☐ 2
iii) Concern over family history of illness	☐ 1	☐ 2
iv) Overweight/Obesity	☐ 1	☐ 2
v) Allergies (e.g. skin rash)	☐ 1	☐ 2
vi) Stomach problems (e.g. ulcer or gastritis)	☐ 1	☐ 2
vii) Concern over eating a healthy diet	☐ 1	☐ 2
viii) High Blood Cholesterol/Lipids	☐ 1	☐ 2
ix) Diabetes	☐ 1	☐ 2
x) Other:	☐ 1	☐ 2

xi) *Please specify* …….....……..….....

.....

17p) Describe below how your diet has changed:

.....

.....

……

SECTION D: EXERCISE

18a) How often do you take part in sports or activities that are....?
(Please tick **<u>one</u>** *box for each question i - iii)*

	3 times a week or more 1	Once or twice a week 2	About once to three times a month 3	Never/Hardly ever 4
i) Mildly energetic (e.g. walking, woodwork, weeding, hoeing, playing darts, general housework)				
ii) Moderately energetic (e.g. scrubbing, polishing car, dancing, golf, cycling, decorating, lawn mowing, leisurely swimming).				
iii) Vigorous (e.g. running, hard swimming, tennis, squash, digging, cycle racing)				

18b) Please give the average number of hours per week you spend in such sports or activities.

i) Mildly energetic ☐ hours .....

ii) Moderately energetic ☐ hours .....

ii) Vigorous ☐ hours .....

SECTION E: FAMILY HISTORY

19a) Do you know, or know of, your **natural mother**? Yes ☐ 1 No ☐ 2

If **No,** go to **Q20a**

If Yes,

19b) During her life, did your **natural mother** suffer from any of the following conditions? *(Please tick **one** box on each line)*

	(a)			**(b)**
	Yes	**No**	**Don't Know**	**Age at onset (*first 3 conditions only*)**
i) Diabetes	☐ 1	☐ 2	☐ 3	☐☐ *years of age*
ii) Stroke	☐ 1	☐ 2	☐ 3	☐☐ *years of age*
iii) Heart attack (coronary thrombosis, myocardial infarction)	☐ 1	☐ 2	☐ 3	☐☐ *years of age*
iv) Angina	☐ 1	☐ 2	☐ 3	
v) High cholesterol level	☐ 1	☐ 2	☐ 3	
vi) Nervous trouble or depression	☐ 1	☐ 2	☐ 3	
vii) Asthma	☐ 1	☐ 2	☐ 3	
viii) Emphysema	☐ 1	☐ 2	☐ 3	
ix) Chronic Bronchitis	☐ 1	☐ 2	☐ 3	
x) Breast Cancer	☐ 1	☐ 2	☐ 3	
xi) Lung Cancer	☐ 1	☐ 2	☐ 3	
xii) Bowel/Colon Cancer	☐ 1	☐ 2	☐ 3	
xiii) Other Cancer - *specify below*	☐ 1	☐ 2	☐ 3	

a) ……

(Please make sure you have answered all the above questions)

20a) Do you know, or know of, your **natural father**? Yes ☐ 1 No ☐ 2

If **No,** go to **Qu 21a**

If Yes,

20b) During his life, did your **natural father** suffer from any of the following conditions?
*(Please tick **one** box on each line)*

	(a)			**(b)**
	Yes	**No**	**Don't Know**	**Age at onset (*first 3 conditions only*)**
i) Diabetes	☐ 1	☐ 2	☐ 3	☐☐ *years of age*
ii) Stroke	☐ 1	☐ 2	☐ 3	☐☐ *years of age*
iii) Heart attack (coronary thrombosis, myocardial infarction)	☐ 1	☐ 2	☐ 3	☐☐ *years of age*
iv) Angina	☐ 1	☐ 2	☐ 3	
v) High cholesterol level	☐ 1	☐ 2	☐ 3	
vi) Nervous trouble or depression	☐ 1	☐ 2	☐ 3	
vii) Asthma	☐ 1	☐ 2	☐ 3	
viii) Emphysema	☐ 1	☐ 2	☐ 3	
ix) Chronic Bronchitis	☐ 1	☐ 2	☐ 3	
x) Lung Cancer	☐ 1	☐ 2	☐ 3	
xi) Bowel/Colon Cancer	☐ 1	☐ 2	☐ 3	
xii) Prostate Cancer	☐ 1	☐ 2	☐ 3	
xiii) Other Cancer - *specify below*	☐ 1	☐ 2	☐ 3	

a) ……

(Please make sure you have answered all the above questions)

21) Children

a) Do you have any children of your own? Yes ☐ 1 No ☐ 2

If **No,** go to **Q22**

If Yes,

b) **Women only:** Did you smoke during the pregnancy of your children? *Please give information for the first three of your children only.*

(a) Child number	**(b) Did you smoke during the pregnancy of your children?**	**(c) Date of birth of the child**
i) Child one	Yes ☐ 1 No ☐ 2	__ __ /__ __ / __ __ __ __
ii) Child two	Yes ☐ 1 No ☐ 2	__ __ /__ __ / __ __ __ __
iii) Child three	Yes ☐ 1 No ☐ 2	__ __ /__ __ / __ __ __ __

(c) **Men only**: Did your partner smoke during the pregnancy of your first three children? *Please give information for the first three of your children only.*

(a) Child number	**(b) Did your partner smoke during the pregnancy of your children?**	**(c) Date of birth of the child**
i) Child one	Yes ☐ 1 No ☐ 2	__ __ /__ __ / __ __ __ __
ii) Child two	Yes ☐ 1 No ☐ 2	__ __ /__ __ / __ __ __ __
iii) Child three	Yes ☐ 1 No ☐ 2	__ __ /__ __ / __ __ __ __

SECTION F: ABOUT YOUR FEELINGS

22. We would like to know how you have felt in general over the past few weeks. Please answer all the questions by **circling** *the most appropriate answer* for each question. Please circle one answer per question only.

HAVE YOU RECENTLY:		1	2	3	4
(a)	**Been able to concentrate on whatever you are doing**	Better than usual	Same as usual	Less than usual	Much less than usual
(b)	**Lost much sleep over worry**	Not at all	No more than usual	Rather more than usual	Much more than usual
(c)	**Felt that you were playing a useful part in things**	More so than usual	Same as usual	Less than usual	Much less useful
(d)	**Felt capable of making decisions about things**	More so than usual	Same as usual	Less so than usual	Much less capable
(e)	**Felt constantly under strain**	Not at all	No more than usual	Rather more than usual	Much more than usual
(f)	**Felt that you couldn't overcome your difficulties**	Not at all	No more than usual	Rather more than usual	Much more than usual
(g)	**Been able to enjoy your normal day-to-day activities**	More so than usual	Same as usual	Less so than usual	Much less than usual
(h)	**Been able to face up to your problems**	More so than usual	Same as usual	Less able than usual	Much less able
(i)	**Been feeling unhappy and depressed**	Not at all	No more than usual	Rather more than usual	Much more than usual
(j)	**Been losing confidence in yourself**	Not at all	No more than usual	Rather more than usual	Much more than usual
(k)	**Been thinking of yourself as a worthless person**	Not at all	No more than usual	Rather more than usual	Much more than usual
(l)	**Been feeling reasonably happy, all things considered**	More so than usual	About the same as usual	Less so than usual	Much less than usual
(m)	**Felt that life is entirely hopeless**	Not at all	No more than usual	Rather more than usual	Much more than usual
(n)	**Felt that life isn't worth living**	Not at all	No more than usual	Rather more than usual	Much more than usual
(o)	**Found yourself wishing you were dead and away from it all**	Not at all	No more than usual	Rather more than usual	Much more than usual
(p)	**Found the idea of taking your own life kept coming into your head**	Definitely not	I don't think so	Has crossed my mind	Definitely has
(q)	**Thought of the possibility that you might do away with yourself**	Definitely not	I don't think so	Has crossed my mind	Definitely has

SECTION G: HEALTHY AGEING

23). **Your health overall**

Thinking about your health TODAY which of the following is the most applicable.
*(Please tick **one** box only)*

a) I have no pain or discomfort ☐ 1
I have moderate pain or discomfort ☐ 2
I have extreme pain or discomfort ☐ 3

b) 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

c) I have no problems in walking about ☐ 1
I have some problems in walking about ☐ 2
I am confined to a chair/wheelchair ☐ 3

d) I am not anxious or depressed ☐ 1
I am moderately anxious and/or depressed ☐ 2
I am extremely anxious and/or depressed ☐ 3

e) Compared to five years ago, is your memory:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Improved	Same	Almost as good	Worse	Much worse

24) **Disability**

		Yes	No
a)	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)**	☐ 1	☐ 2

If **Yes**

		Yes	No
b)	Does this illness or disability limit your activities in any way?	☐ 1	☐ 2

c) What is the **main** medical problem causing this disability? If you have several medical problems, please give the most severe one.

……

		Yes	No
d)	Do you receive a disability or other allowance for this?	☐ 1	☐ 2

25) Do you currently have difficulty carrying out any of the following activities on your own as a result of a long term health or medical problems, or due to old age? (*(Please tick **one** box on each line)*

		(i) Yes	**(i)** No	**(ii)** Please give the year this first started
a)	Going up or down stairs	☐ 1	☐ 2	_ _ _ _ (year)
b)	Bending down	☐ 1	☐ 2	_ _ _ _ (year)
c)	Straightening up	☐ 1	☐ 2	_ _ _ _ (year)
d)	Keeping your balance	☐ 1	☐ 2	_ _ _ _ (year)
e)	Going out of the house	☐ 1	☐ 2	_ _ _ _ (year)
f)	Walking 400 yards	☐ 1	☐ 2	_ _ _ _ (year)

26) Do you currently use any aids or appliances to help with day to day activities?

		Yes	No
a)	Walking stick	☐ 1	☐ 2
b)	Walking frame	☐ 1	☐ 2
c)	Wheelchair	☐ 1	☐ 2
d)	Raised toilet seat	☐ 1	☐ 2
e)	Bath board/shower	☐ 1	☐ 2
f)	Extra rails in bathroom	☐ 1	☐ 2
g)	Stair lift	☐ 1	☐ 2

27) **Health problems**

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

		Yes	No
a)	Job (paid employment)	☐ 1	☐ 2
b)	Household chores	☐ 1	☐ 2
c)	Social life	☐ 1	☐ 2
d)	Sex life	☐ 1	☐ 2
e)	Interests and hobbies	☐ 1	☐ 2
f)	Holidays and outings	☐ 1	☐ 2
g)	Family relationships	☐ 1	☐ 2

---

28) **Memory**

Below are listed some examples of things that happen to people in everyday life. Some of them may happen frequently and some may happen very rarely. We should like to know how often on average you think each one has happened to you over the past month.

We realise that people vary from day to day depending on their mood and the exact circumstances they are in. However, we would like you to try and give us an OVERALL impression of how often these things happen to you.

Please put a tick in the box to indicate how often these things happened to you over the past month. If you are really stuck on any item, just make the best guess you can.

Example: If you forgot where you had put something in the house twice in the last month, you should put a tick in the column headed more than once a month but less than once a week.

	Rarely/never	**More than once a month but less than once a week**	**About once a week**	**More than once a week but less than daily**	**Daily**
Forgetting where you have put something in the house		✓			

*Please **tick** (✓) one box on each line*

	Rarely/never	**More than once a month but less than once a week**	**About once a week**	**More than once a week but less than daily**	**Daily**
	1	**2**	**3**	**4**	**5**
i) Forgetting where you have put something in the house.					
ii) Finding a television or radio story difficult to follow.					
iii) Finding that a word is 'on the tip of your tongue'. You know what it is but cannot quite find it.					
iv) Forgetting important details about yourself, e.g. your birthdate or where you live.					
v) Getting the details of what someone has told you mixed up and confused.					
vi) Finding that the faces of famous people seen on television, or in photographs, look unfamiliar.					
vii) Forgetting to tell somebody something important. Perhaps forgetting to pass on a message or remind someone of something.					
viii) Getting lost or turning in the wrong direction on a journey, on a walk, or in a building where you have OFTEN been before					
ix) Doing some routine thing twice by mistake, e.g. putting two lots of tea in the teapot, or going to brush/comb your hair when you have just done so.					
x) Having difficulty picking up a new skill, eg finding it hard to learn a new game or to work some new gadget after you have practised it once or twice.					

29) What is your current shoe size
(Please give UK size or European size, eg UK size 9 or Eur size 44)

UK size ☐☐ OR European size ☐☐

---

30) Today's date ____ ____ / ____ ____ / ____ ____ ____ ____
D D M M Y Y Y Y

Thank you for your help with this questionnaire

CHECK CAREFULLY THAT YOU HAVE ANSWERED EACH PAGE AND THEN RETURN IT TO THE RESEARCHER