### QUESTIONS ABOUT YOU AND YOUR HEALTH

Please use a BLACK PEN if possible.

We know it may be difficult to answer some questions, but an approximate answer is better than none.

<table>
<thead>
<tr>
<th>Question</th>
<th>Rarely/Never</th>
<th>Monthly</th>
<th>Weekly/Fortnightly</th>
<th>Most Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. How often are you troubled by:</td>
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<tr>
<td>difficulty swallowing?</td>
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<tr>
<td>reflux/heartburn?</td>
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<tr>
<td>difficulty breathing?</td>
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<tr>
<td>coughing?</td>
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<tr>
<td>wheezing?</td>
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<tr>
<td>constipation?</td>
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<tr>
<td>diarrhoea?</td>
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<tr>
<td>10. About how many hours sleep do you usually get (in every 24 hours)?</td>
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<tr>
<td>11. How often do you:</td>
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<tr>
<td>have trouble falling asleep?</td>
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<tr>
<td>have disturbed sleep?</td>
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<tr>
<td>take medication to sleep?</td>
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<tr>
<td>fall asleep or doze off during the day, without meaning to?</td>
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<td>12. About how often do you feel:</td>
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<tr>
<td>happy?</td>
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<tr>
<td>relaxed?</td>
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<tr>
<td>in control?</td>
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<tr>
<td>stressed?</td>
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<tr>
<td>tired during the day?</td>
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<tr>
<td>lonely?</td>
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<tr>
<td>in pain?</td>
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</tbody>
</table>

| Additional Questions                                                     |              |         |                    |           |
| 4. Do you find any of the following tasks difficult?                     |              |         |                    |           |
| walking?                                                                 |              |         |                    |           |
| climbing stairs?                                                         |              |         |                    |           |
| dressing?                                                                |              |         |                    |           |
| washing?                                                                |              |         |                    |           |
| shopping?                                                                |              |         |                    |           |
| preparing meals?                                                         |              |         |                    |           |
| 5. Do you now use any of the following:                                  |              |         |                    |           |
| walking stick                                                            |              |         |                    |           |
| zimmer frame                                                             |              |         |                    |           |
| wheelchair                                                               |              |         |                    |           |
| 6. Are you now?                                                          |              |         |                    |           |
| housebound                                                               |              |         |                    |           |
| bedbound                                                                 |              |         |                    |           |
| neither                                                                  |              |         |                    |           |
| 7. How would you describe your usual walking pace?                       |              |         |                    |           |
| brisk                                                                    |              |         |                    |           |
| average                                                                  |              |         |                    |           |
| slow                                                                     |              |         |                    |           |
| cannot walk                                                              |              |         |                    |           |
| 8. About how many falls have you had in the last year? (0 if none)        |              |         |                    |           |

Any questions? Ring Freephone 0800 262 872
13. Are you currently:  
- married / living with a partner  
- divorced  
- separated  
- widowed  
- single  
- other

14. How many people live in your household?  
- If you live with others, how are they related to you?  
  (you can cross more than one box)  
- husband/partner  
- parents (yours/your partner's)  
- children/stepchildren  
- grandchildren  
- other relatives  
- other unrelated

15. In the last 5 years, have you experienced:  
- death of a spouse or partner?  
- death of any other close relative or friend?  
- divorce or permanent separation?

16. How often do you look after your grandchildren:  
- most days  
- about weekly  
- less often/never  
- no grandchildren

17. Do you have someone to talk to about your problems:  
- never  
- sometimes  
- most of the time  
- always

18. About how often do you talk to:  
- relatives?  
- friends?  
- neighbours?  
- others?

19. Do you regularly care for family members or others because of their health, disability or other problems?  
- No  
- Yes  

If Yes:  
- how much caring do you do?  
- how many people do you care for?  
- is the person you provide most care for your:  
- husband/partner  
- parent  
- child  
- other  
- what health, disability or other problem do they have:  
- dementia  
- cancer  
- other  
- how long have you been caring for them?  
- total years

20. Are you now being treated for depression or anxiety?  
- No  
- Yes  

If Yes, are you being treated with:  
(you can cross more than one box)  
- medication  
- talking therapy (eg counselling, CBT)

21. In a typical WEEK, how much VIGOROUS activity do you do?  
  (eg running, fast swimming, fast cycling)  
  (0 if less than one hour in a week)  
- summer  
- winter

22. In a typical WEEK, how much MODERATE activity do you do?  
  (eg brisk walking, heavy housework, heavy gardening, gym, swimming or cycling)  
- summer  
- winter

23. In a typical DAY, how much LIGHT activity do you do?  
  (walking, general housework, cooking, shopping, gardening)  
- summer  
- winter

24. In a typical DAY, how much time do you spend outdoors?  
  (0 if less than one hour in a day)  
- summer  
- winter

25. How many hours in each day do you usually spend:  
- reading?  
- watching television?  
- using a computer?  
  (including tablet, laptop, smartphone)  
- on your feet?  
  (eg standing, cooking, housework, walking)

26. How often do you take part in any of these activities:  
- voluntary or charity work?  
- adult education classes?  
- art or music groups?  
- social clubs?  
- church or religious groups?  
- neighbourhood groups?  
- exercise classes, sports clubs?

27. Do you regularly do any of these hobbies or pastimes:  
- crosswords  
- sudoku  
- jigsaws  
- other puzzles  
- drawing/painting  
- knitting  
- sewing  
- reading

28. For how many years in total have you used a gas hob for cooking?  
- total years  
- (0 if less than one)

29. In winter have you regularly used:  
- a gas fire?  
- an open coal or wood fire?

If so, for about how many years in total?  
- total years  
- (0 if less than one)

30. When you were a child:  
- was gas used for cooking at home?  
- did you have a gas fire at home?  
- did you have an open coal or wood fire at home?
### Personal Care

19. Have you ever regularly used:

<table>
<thead>
<tr>
<th>Item</th>
<th>No</th>
<th>Yes</th>
<th>If Yes, for about how long?</th>
</tr>
</thead>
<tbody>
<tr>
<td>mouthwash?</td>
<td></td>
<td></td>
<td>total years (0 if less than one)</td>
</tr>
<tr>
<td>underarm deodorant</td>
<td></td>
<td></td>
<td>total years (0 if less than one)</td>
</tr>
<tr>
<td>talcum powder for feminine hygiene?</td>
<td></td>
<td></td>
<td>total years (0 if less than one)</td>
</tr>
<tr>
<td>diaphragm (cap) for contraception?</td>
<td></td>
<td></td>
<td>total years (0 if less than one)</td>
</tr>
<tr>
<td>a sunbed?</td>
<td></td>
<td></td>
<td>total years (0 if less than one)</td>
</tr>
</tbody>
</table>

### Scans & Medications

40. Have you ever used HRT (hormone replacement therapy)?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes, in the past</th>
<th>Yes, currently</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- for how many years in total?</td>
<td></td>
<td>total years of use (0 if less than one)</td>
<td></td>
</tr>
<tr>
<td>- are you still using HRT?</td>
<td></td>
<td>years ago (0 if less than one)</td>
<td></td>
</tr>
<tr>
<td>still using HRT</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

41. Has a doctor ever said that you had osteoporosis?

<table>
<thead>
<tr>
<th></th>
<th>No (go to 42)</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes,</td>
<td></td>
<td>years old</td>
</tr>
<tr>
<td>- age first diagnosed</td>
<td></td>
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<tr>
<td>- have you ever used any of these osteoporosis drugs? (you can cross more than one box)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alendronate / Fosamax / Fosavance</td>
<td>Daily</td>
<td>Weekly</td>
</tr>
<tr>
<td>Risedronate / Actonel / Actonel Combi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- if so, for how long?</td>
<td></td>
<td>total years of use of any type (0 if less than one)</td>
</tr>
<tr>
<td>- are you still using any of them?</td>
<td></td>
<td>years ago (0 if less than one)</td>
</tr>
<tr>
<td>Yes, still using an osteoporosis drug</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

42. Have you regularly taken aspirin for a year or longer?

<table>
<thead>
<tr>
<th></th>
<th>No (go to 43)</th>
<th>Yes</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes,</td>
<td></td>
<td>years old</td>
<td></td>
</tr>
<tr>
<td>- about when did you start?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- about how many years have you taken aspirin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- are you still taking aspirin?</td>
<td></td>
<td>years ago (0 if less than one)</td>
<td></td>
</tr>
<tr>
<td>Yes, still taking aspirin</td>
<td></td>
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</tr>
</tbody>
</table>

43. Have you taken any of the following medications for most of the last 4 weeks? (you can cross more than one box)

- ibuprofen
- paracetamol
- statins for cholesterol (e.g., simvastatin (Zocor), atorvastatin (Lipitor), rosuvastatin (Crestor))
- warfarin
- clopidogrel
- drugs for heartburn/acid reflux (e.g., omeprazole (Losec), lansoprazole (Zoten), ranitidine (Zantac))
- thyroxine
- prednisolone
- blood pressure drugs (e.g., bendrofluamide, bisoprolol (Cardior), lisinopril (Zestri), amlopidine (Istin))
- sertraline
- mirtazapine
- other
44. How much TEA do you usually drink? (include all types) [ ] cups a day (0 if not every day)

- is the type of tea usually:
  □ standard tea (eg Tetley, PG Tips, Breakfast, Earl Grey)
  □ fruit/herbal □ green □ rooibos/redbush

- do you have your tea:
  □ very hot □ hot □ warm □ cool

- do you usually add:
  □ milk □ sugar □ artificial sweetener

45. How much COFFEE do you usually drink? (include all types) [ ] cups a day (0 if not every day)

- do you have your coffee:
  □ very hot □ hot □ warm □ cool

- do you usually add:
  □ milk □ sugar □ artificial sweetener

- is your coffee usually:
  □ caffeinated □ decaffeinated

46. Have you ever had an alcoholic drink?
□ No, I am a lifelong non-drinker (go to 48) □ Yes

47. In the past year, did you have an alcoholic drink?
□ No □ Yes
If No, age when you last drank alcohol [ ] years old
If Yes, about how many “units” in a typical week?
a unit = glass of wine, half pint of beer or cider, or 25ml tot of spirits (0 if less than one)
[ ] units of alcohol a week, in total
- when you drink alcohol is it usually with meals?
□ No □ Yes □ It varies

48. Have you ever smoked tobacco?
□ No □ Yes
If Yes,
- at what age did you begin smoking regularly? (daily, or on most days) [ ] years old
- at what age did you last smoke regularly? (daily, or on most days) [ ] years old
- about how many cigarettes a day did you smoke in the past year?
[ ] typical number of cigarettes a day (0 if less than one, or an ex-smoker)

49. Have you ever tried vaping / e-cigarettes?
□ No / a few times □ Yes, regularly in past □ Yes, regularly but now stopped □ Yes, regularly now
If Yes,
- were you also smoking tobacco when you started vaping?
□ No □ Yes
- did vaping have an effect on your tobacco use?
□ No □ Yes, helped me reduce □ Yes, helped me stop altogether

50. About how much do you weigh now?
[ ] stone [ ] lbs OR [ ] kgs

51. Compared to about 5 years ago, have you lost weight?
□ No □ Yes
If Yes, how did you lose it:
you can cross more than one box)
[ ] dieting □ exercise □ illness □ other

52. Have YOU or any of your BLOOD RELATIVES ever had, to your knowledge:

heart attack
other heart disease
stroke
high blood pressure
diabetes
severe arthritis
hip fracture
osteoarthritis
emphysema or chronic bronchitis
asthma
glaucoma
Parkinson’s disease
Alzheimer’s disease
other dementia
severe depression
breast cancer
bowel cancer
lung cancer
prostate cancer

53. Optional: print your email address below if you might consider answering similar questions online in the future

54. Optional: write your phone number (with area code)

55. If your name/address has CHANGED or is incorrect please give the correct details below

Thank you for your help. Professor Valerie Beral. Please post the completed form back to me using the envelope provided. Postage is pre-paid.