

Questionnaire Number

Study Number :

Town:

BRITISH WOMEN'S HEART & HEALTH STUDY

BASELINE SURVEY

- This questionnaire asks about your health, your life-style and your social background.

This will give vital information for our research.

- Most questions can be answered simply by ticking the correct box
- All the information collected will be treated as strictly confidential.
- **Please complete the form today, or as soon as possible, and return in the reply paid envelope.** If you have any difficulties with the questions, please phone us on 0117 928 7327 and leave your phone number so that we can call you back and answer your queries.

Thank you for your help.

**British Womens' Heart & Health Study
Department of Social Medicine
Canyng Hall
Whiteladies Road
Bristol BS8 2PR**

Please give the following information to help us contact you in the future.

1.0 Your telephone number _____

1.2 Your date of birth

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day		Month		Year	

1.3 Today's date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Day		Month		Year	

1.4 Your maiden name, if you are married, divorced or widowed:

Name and address of family member or friend we could contact only if necessary:

1.5 Surname _____

1.6 First name _____

1.7 Address _____

1.8 Post code: _____

1.9 Telephone Number: _____

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

2.0 Health at present
 How would you describe your health at present ?

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

3.0 Conditions affecting the heart or circulation
 Have you ever been told by a doctor that you have or have had any of the following conditions ?

	Yes	No		If Yes, please give year when first diagnosed, if possible
3.1 Heart attack (coronary thrombosis or myocardial infarction)	<input type="checkbox"/>	<input type="checkbox"/>	3.7	19_____
3.2 Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	3.8	19_____
3.3 Angina	<input type="checkbox"/>	<input type="checkbox"/>	3.9	19_____
3.4 Other heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	3.10	19_____
3.5 High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	3.11	19_____
3.6 Stroke	<input type="checkbox"/>	<input type="checkbox"/>	3.12	19_____

4.0 Cancers

4.1 Have you ever been told by a doctor that you have or have had a cancer?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If yes, please state what kind of cancer(s):

	office use	
4.2 _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4.5 19_____
4.3 _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4.6 19_____
4.4 _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4.7 19_____

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

5.0 Other medical conditions

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

	Yes	No	Please give year when first diagnosed, if possible	
5.1 Asthma	<input type="checkbox"/>	<input type="checkbox"/>	5.11	19_____
5.2 Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	5.12	19_____
5.3 Depression	<input type="checkbox"/>	<input type="checkbox"/>	5.13	19_____
5.4 Gastric, peptic or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	5.14	19_____
5.5 Gout	<input type="checkbox"/>	<input type="checkbox"/>	5.15	19_____
5.6 Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	5.16	19_____
5.7 Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	5.17	19_____
5.8 Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	5.18	19_____
5.9 Cataract	<input type="checkbox"/>	<input type="checkbox"/>	5.19	19_____
5.10 Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	5.20	19_____

6.0 Falls and Fractures

6.1	Have you had a fall in the last 12 months ?	Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	
6.2	<i>If Yes</i> , how many times ? _____			
6.3	Did you have medical attention for any of these falls ?	Yes	No	
		<input type="checkbox"/>	<input type="checkbox"/>	
Fractures:				
6.4	Have your ever fractured or broken your hip?	Yes	No	Please give year
		<input type="checkbox"/>	<input type="checkbox"/>	6.6 19_____
6.5	or, your wrist?	<input type="checkbox"/>	<input type="checkbox"/>	6.7 19_____

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

7.0 Arthritis

7.1 Have you ever been told by a doctor that you have or have had arthritis? Yes No

If Yes, please state what kind of arthritis:

	Yes	No	Don't know		Please give year first diagnosed
7.2 rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7.5	19_____
7.3 osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7.6	19_____
7.4 other type of arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7.7	19_____

Which joints are or were affected?

	Yes	No
7.8 hips	<input type="checkbox"/>	<input type="checkbox"/>
7.9 knees/ankles	<input type="checkbox"/>	<input type="checkbox"/>
7.10 shoulders	<input type="checkbox"/>	<input type="checkbox"/>
7.11 hands/fingers	<input type="checkbox"/>	<input type="checkbox"/>
7.12 back/spine	<input type="checkbox"/>	<input type="checkbox"/>

8.0 Operations

8.1 Have you ever had an operation(s)? Yes No

If Yes, please give details including the year:

	office use		Please give year of operation(s)
8.2 _____	<input type="text"/> <input type="text"/> <input type="text"/>	8.5	19_____
8.3 _____	<input type="text"/> <input type="text"/> <input type="text"/>	8.6	19_____
8.4 _____	<input type="text"/> <input type="text"/> <input type="text"/>	8.7	19_____

Please list any other operations here:

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

9.0 **Hearing and vision**

Do you have trouble with

9.1 your hearing	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
9.2 your eyesight (not simply needing specs)	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, please give details:

9.3 Hearing _____	office use <input type="checkbox"/> <input type="checkbox"/>
9.4 Vision _____	<input type="checkbox"/> <input type="checkbox"/>

10.0 **Diabetes**

	Yes	No	Don't know	
10.1 Has anyone in your close family (your parents, brothers, sisters) ever had diabetes ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	Don't know	Year first diagnosed
10.2 Have you ever been told by a doctor that you have or have had diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10.3 19_____

If Yes:

10.4 Are you on a regular diet for your diabetes ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.5 Are you on regular tablets for your diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.6 Are you on regular treatment with insulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.7 Do you attend a hospital or GP diabetic clinic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

11.0 **Breathlessness**

	Yes	No	Unable
11.1 Do you get short of breath walking with other people of your own age on level ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.2 On walking uphill or stairs do you get more breathless than people of your own age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.3 Do you ever have to stop walking because of breathlessness ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

12.0 **Leg pain**

		Yes	No	Unable
12.1	Do you ever get pain or discomfort in your leg, thighs or buttocks when you walk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If, No or Unable to walk go on to question 13 "Ankle swelling" on next page.

12.2	Do you know the cause of the pain?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

12.3 *If Yes*, what is the cause? _____

office use

12.4	Does this pain ever begin when you are standing still or sitting?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

12.5	Do you get the pain if you walk up hill or hurry?	Yes	No	Unable
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12.6	Do you get the pain walking at an ordinary pace on the level?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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12.7 What happens to the pain if you stand still?

Usually continues more than 10 minutes ₁ Usually disappears in <10 minutes ₂

12.8 Where do you get the pain? **Shade regions affected**

Front

RIGHT SIDE LEFT SIDE

Back

LEFT SIDE RIGHT SIDE

office use

Please answer the following questions by filling in the appropriate box with a tick or

writing the answer in the space provided.

13.0 <u>Ankle swelling</u>	Yes	No	Don't know
13.1 Do your ankles swell up regularly ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.2 <i>If Yes</i> , is this because of varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14.0 <u>Cough and Wheeze</u>	Yes	No	Don't know
14.1 Do you usually bring up phlegm (spit) from your chest first thing in the morning in the winter ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.2 <i>If Yes</i> , do you bring up phlegm like this on most days for as much as 3 months in the winter each year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.3 In the past 4 years have you ever had a period of increased cough and phlegm lasting for 3 weeks or more?	Yes, <input type="checkbox"/>	Yes, once more <input type="checkbox"/>	Never <input type="checkbox"/>
14.4 Does your chest ever sound wheezy or whistling?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
14.5 <i>If Yes</i> , does this happen on most days or nights?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>

15.0 <u>Treatment with aspirin</u>	Yes	No
15.1 Do you take aspirin regularly?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If Yes</i> ,		
15.2 Is this on doctor's advice?	<input type="checkbox"/>	<input type="checkbox"/>
15.3 When did you start taking aspirin regularly ?	19 _____	
15.4 On how many days each week do you take aspirin? daily <input type="checkbox"/> ₁ alternate days <input type="checkbox"/> ₂ other <input type="checkbox"/> ₃		
15.5 What dose of aspirin do you take each day that you take it? 75mg/1/2junior <input type="checkbox"/> ₁ 125mg/junior <input type="checkbox"/> ₂ 300mg/adult <input type="checkbox"/> ₃ other <input type="checkbox"/> ₄		
15.6 For what condition are you taking aspirin ? Please state _____ office use <input type="checkbox"/> <input type="checkbox"/>		

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

16.0 Hormone replacement therapy (HRT)

- | | Yes | No | Don't know |
|--|--------------------------|--------------------------|---|
| 16.1 Have you ever taken HRT? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If Yes,</i> | | | |
| 16.2 Are you still taking it? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16.3 How long have you (or did you) taken it ? _____ years | | | |
| <i>If stopped now,</i> | | | |
| 16.4 How long ago did you stop taking it? _____ years | | | |
| 16.5 Which preparation do/did you use? _____ | | | office use
<input type="checkbox"/> <input type="checkbox"/> |

17.0 Vitamin or mineral tablets

- | | Yes | No |
|---|---|--------------------------|
| 17.1 Do you take any vitamin or mineral tablets or supplements? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If Yes, please give details:</i> _____ | | |
| 17.2 | <input type="checkbox"/> <input type="checkbox"/> | |

18.0 Weight

- 18.1 What is your present weight ? _____Stones _____ Pounds
- 18.2 What is your current dress size? _____
- 18.3 What was your weight as a young woman aged 21? _____Stones _____ Pounds
- 18.4 What was your dress size as a young woman aged 21? _____
- 18.5 Have you dieted during your adult life?
- | | | |
|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| yes, regularly | yes, on and off | no |
- 18.6 Has your weight changed in the last four years?
- | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| not changed | increased | decreased | up/down | don't know |

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Weight (continued)

18.7 If your weight has increased or decreased in the last 4 years,

how much weight have you gained or lost? _____ stones _____ lbs

18.8 If you have lost weight, was this intentional? (eg. dieting) Yes No

19.0 Smoking

19.1 Have you ever smoked cigarettes regularly (at least 1/day)? Yes No

If Yes:

19.2 Do you smoke cigarettes at present? Yes No

If Yes:

19.3 How many cigarettes do you smoke a day? _____ cigarettes

19.4 If hand-rolled, how much tobacco do you use a week ?
_____ ounces 19.5 _____ grams

19.6 How old were you when you started smoking regularly? _____ years

19.7 Have you changed your cigarette smoking habits over the last 4 years ?
 1 2 3 4
Yes, increased Yes, cut down Yes, given up No

19.8 Do you currently smoke tobacco in any other form (e.g. pipe, cigar)? Yes No

If No,

19.9 Have you ever regularly done so? Yes No

**If No,
go to
19.8**

**If No,
go to
19.6**

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Smoking (continued)

For ex-smokers

19.10 Were you previously a regular cigarette smoker? Yes No

If Yes,

19.11 How many cigarettes did you usually smoke each day ? _____ cigarettes

19.12 At what age did you give up? _____ years old

19.13 Why did you give up? Tick one main reason only.

- | | | |
|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Personal choice | Financial reasons | Health precaution |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| Doctor's advice | Illness or ill-health | Other reasons |

19.14 Does/did your husband/partner smoke cigarettes?

- | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| Yes | No | Ex-smoker | Not applicable |

20.0 Alcohol Intake

20.1 Would you describe your present alcohol intake as

Daily/most days	<input type="checkbox"/> 1
Weekends only	<input type="checkbox"/> 2
Once or twice a month	<input type="checkbox"/> 3
Special occasions	<input type="checkbox"/> 4
Never	<input type="checkbox"/> 5

20.2 One drink is **HALF** a pint of beer, a **SINGLE** whisky, gin etc., or **ONE GLASS** of wine or sherry. How much do you usually drink each day ?

- | | |
|--------------------------|----------------------------|
| More than 6 drinks a day | <input type="checkbox"/> 1 |
| 3-6 drinks a day | <input type="checkbox"/> 2 |
| 2 drinks a day or less | <input type="checkbox"/> 3 |
| None | <input type="checkbox"/> 4 |

20.3 How many alcoholic drinks do you take during an average week? _____ drinks

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Alcohol (continued)

21.1	Do you eat any special diet?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>
21.2	<i>If Yes</i> , please specify		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	low fat	high fibre	vegetarian
	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
	diabetic	slimming/low calorie	other
21.3	What kind of bread do you eat?		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	White	Brown	Wholemeal
	<input type="checkbox"/> 4		
	Various		
21.4	Spreading fat: What kind do you use at home?		
	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	Butter	Margarine	Margarine
		(Hard)	(Soft)
	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
	Low calorie	Various	None
	spread		
	(e.g. Delight)		

How often do you eat the following foods? (Please tick the appropriate box for each food item)

	1	2	3	4	5	6
	More than once a day	Once a day	Most days	One or two days a week	Less than once a week	Never
21.5 Fresh fruit summer						
21.6 Fresh fruit winter						
21.7 Salads in summer						
21.8 Salads in winter						
21.9 Green vegetables						
21.10 Fish (all kinds)						
21.11 Poultry (eg. chicken, turkey)						
21.12 Red meat (eg. beef, pork, ham, bacon)						
21.13 Processed meat (eg. burgers, sausages, pies, pasties, pate)						
21.14 Cereals						
21.15 Nuts						
21.16 Cheese						

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Your diet (continued)

21.17 What kind of cooking fat do you usually use at home?

1 Lard, butter, animal fat 2 Vegetable oil 3 Olive oil 4 Various fats 5 Other fats

21.18 What type of milk do you usually use?

1 Full cream 2 Semi-skimmed 3 Skimmed 4 Dried 5 Tinned 6 None 7 Other

22.0 **Physical Activity**

22.1 Which of the following forms of transport do you use most often? Please tick only one box

1 Car 2 Public Transport 3 Cycle 4 Walk 5 Not applicable

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

1 No 2 Walk 3 Cycle 4 Both

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

1 Slow 2 Steady average 3 Fairly brisk 4 Fast (at least 4miles/hr)

22.4 If you cycle regularly, how long do you spend cycling in an average week? _____
hours/week

22.5 Do you take physical activity such as running, swimming, dancing, golf, tennis, squash, jogging, bowls?

1 No 2 Occasionally (less than monthly) 3 Frequently (once a month or more)

If you take part in these physical activities frequently, (once a month or more):
How many **times** a month on average do you take part in these activities?

22.6 Summer _____ times/month

22.7 Winter _____ times/month

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Physical activities (continued)

In a **typical week** during the past year, how many hours did you spend each week in the following activities? Write 0 if no activity.

Walking to work, shopping and leisure 22.8 Summer _____ hours/week

22.9 Winter _____ hours/week

Cycling, including to work and leisure 22.10 Summer _____ hours/week

22.11 Winter _____ hours/week

Gardening, light eg. pruning, watering 22.12 Summer _____ hours/week

22.13 Winter _____ hours/week

Gardening, heavy eg. digging, mowing 22.14 Summer _____ hours/week

22.15 Winter _____ hours/week

Physical exercise eg. fitness, aerobics, 22.16 Summer _____ hours/week

swimming, jogging, tennis 22.17 Winter _____ hours/week

DIY eg. on house, car 22.18 _____ hours/week

Housework activities, light eg. cooking 22.19 _____ hours/week
washing up, dusting

Housework, heavy, eg. Hoovering, floors 22.20 _____ hours/week
window cleaning

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Physical activity (continued)

22.21 In a **typical week** in the last year, did you do any of these activities vigorously enough to cause breathlessness, sweating or a faster heart beat? Yes No

22.22 *If Yes*, for how many minutes each week did you perform vigorous activity? _____ minutes/week

22.23 In a typical week in the last year, how many flights of stairs do you climb a day? _____ flights/day

22.24 Compared with your activity level of three years ago, are you doing

1 2 3
More Same Less

22.25 *If less*, please give the reason _____

office use

22.26 Compared with other woman of your age, are you:

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

23.0 **Your health overall**

Thinking about your health TODAY which of the following is the most applicable.

23.1 I have no pain or discomfort 1
I have moderate pain or discomfort 2
I have extreme pain or discomfort 3

23.2 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

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Your health overall (continued)

23.3 I have no problems with washing and dressing 1
 I have some problems with washing and dressing 2
 I am unable to wash and dress myself 3

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

23.5 I am not anxious or depressed 1
 I am moderately anxious and/or depressed 2
 I am extremely anxious and/or depressed 3

23.6 Compared to five years ago, is your memory

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

24.0 **Disability**

24.1 Do you have any long-standing illness, disability or infirmity? Yes No
 (**long-standing' means anything which has troubled you over a period of time or is likely to do so**)
If Yes

24.2 Does this illness or disability limit your activities in any way? Yes No

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

_____ office use

24.4 Do you receive a disability or other allowance for this? Yes No

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Disability (continued)

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?

		Yes	No	Please give the year this first started	
24.5	Going up or down stairs	<input type="checkbox"/>	<input type="checkbox"/>	24.11	19_____
24.6	Bending down	<input type="checkbox"/>	<input type="checkbox"/>	24.12	19_____
24.7	Straightening up	<input type="checkbox"/>	<input type="checkbox"/>	24.13	19_____
24.8	Keeping your balance	<input type="checkbox"/>	<input type="checkbox"/>	24.14	19_____
24.9	Going out of the house	<input type="checkbox"/>	<input type="checkbox"/>	24.15	19_____
24.10	Walking 400 yards	<input type="checkbox"/>	<input type="checkbox"/>	24.16	19_____

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

		Yes	No
24.17	Walking stick	<input type="checkbox"/>	<input type="checkbox"/>
24.18	Walking frame	<input type="checkbox"/>	<input type="checkbox"/>
24.19	Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
24.20	Toilet raised seat	<input type="checkbox"/>	<input type="checkbox"/>
24.21	Bath board/shower	<input type="checkbox"/>	<input type="checkbox"/>
24.22	Extra rails in bathroom	<input type="checkbox"/>	<input type="checkbox"/>
24.23	Stair lift	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Health problems

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

	Yes	No
24.24 Job (paid employment)	<input type="checkbox"/>	<input type="checkbox"/>
24.25 Household chores	<input type="checkbox"/>	<input type="checkbox"/>
24.26 Social life	<input type="checkbox"/>	<input type="checkbox"/>
24.27 Sex life	<input type="checkbox"/>	<input type="checkbox"/>
24.28 Interests and hobbies	<input type="checkbox"/>	<input type="checkbox"/>
24.29 Holidays and outings	<input type="checkbox"/>	<input type="checkbox"/>
24.30 Family relationships	<input type="checkbox"/>	<input type="checkbox"/>

25.0 Your present circumstances

25.1 Are you:

1 2 3 4 5
Single Married Widowed Divorced/separated Other

25.2 Are you at present

living alone	<input type="checkbox"/> 1
living with a husband or partner	<input type="checkbox"/> 2
living with other family member(s)	<input type="checkbox"/> 3
living with other people	<input type="checkbox"/> 4

25.3 Do you have a car available for use in your household ?

	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

25.4 Your accommodation: are you

an owner occupier	<input type="checkbox"/> 1
renting from a local authority	<input type="checkbox"/> 2
renting privately	<input type="checkbox"/> 3
other (please specify)	<input type="checkbox"/> 4

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Education and employment

25.5 How old were you when you finished full time education. _____ years old

25.6 At present are you

a housewife	<input type="checkbox"/>	1
retired	<input type="checkbox"/>	2
employed, full time	<input type="checkbox"/>	3
employed, part time	<input type="checkbox"/>	4

25.7 If you are retired, is this due to

normal retiring age	<input type="checkbox"/>	1
early retirement, voluntary	<input type="checkbox"/>	2
early retirement, compulsory	<input type="checkbox"/>	3
illness/disability	<input type="checkbox"/>	4
other reasons	<input type="checkbox"/>	5
not applicable	<input type="checkbox"/>	6

25.8 If you are retired, please give the year in which you retired 19 _____

25.9 What job have you done for the longest period of time ?

_____ 25.10

25.11 Would you describe this work as

Manual	<input type="checkbox"/>	1
Non-Manual	<input type="checkbox"/>	2

Concerning your husband or partner:

25.12 Has your husband or partner ever suffered with any of the following? Please answer even if you are now widowed or divorced/separated.

	Yes	No
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Concerning your husband or partner (continued):

25.13 At present is your husband/partner retired 1

	employed, full time	<input type="checkbox"/>	2
	employed, part time	<input type="checkbox"/>	3
	unemployed, seeking work	<input type="checkbox"/>	4
	unemployed, not seeking work	<input type="checkbox"/>	5
	not applicable (eg. widowed)	<input type="checkbox"/>	6
25.14	<u>If he is are retired</u> , is this due to		
	normal retiring age	<input type="checkbox"/>	1
	early retirement, voluntary	<input type="checkbox"/>	2
	early retirement, compulsory	<input type="checkbox"/>	3
	illness/disability	<input type="checkbox"/>	4
	other reasons	<input type="checkbox"/>	5
	not applicable	<input type="checkbox"/>	6
25.15	<u>If he is retired</u> , in which year did retired ?	19 _____	
25.16	If he is unemployed , is this due to		
	redundancy	<input type="checkbox"/>	1
	illness/disability	<input type="checkbox"/>	2
	other reasons	<input type="checkbox"/>	3
25.17	What job has your husband or partner done for the <u>longest period of time</u> ? Please answer even if he is now deceased, or you are now divorced or separated.		
	_____	<input type="checkbox"/>	25.18 <input type="checkbox"/> <input type="checkbox"/>
25.19	Would you describe this work as		
	Manual	<input type="checkbox"/>	1
	Non-Manual	<input type="checkbox"/>	2

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Pensions

25.20 What type of financial income do you (and your husband/partner) have or will you have on retirement ?

state pension only 1

occupational pension, fixed amount 2

occupational pension, index linked 3

private pension 4

occupational and private pensions 5

don't know 6

Contact with relatives and friends

How often do you see or speak to :-

Please tick the appropriate box in each row

		Every day 1	Every week 2	Every few months 3	Every year 4	Rarely or never 5	Does not apply 6
25.21	Your children						
25.22	Brothers/sisters						
25.23	Friends						
25.24	Neighbours						

Is the amount of contact you have with each of these:-

Please tick the appropriate box in each row

		Too little 1	About right 2	Too much 3	Does not apply 4
25.25	Your children				
25.26	Brothers/sisters				
25.27	Friends				
25.28	Neighbours				

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

26.0 **Your earlier life and health**

Recent research suggests that your weight at birth may be important in later life. We need to ask you some questions about your early life.

26.1 How much did you weigh when you were born?

Write 00/00 if you don't know. _____ lbs _____ ozs

As a child, did the home you lived in longest have:

	Yes	No	Don't know
26.2 A bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.3 Hot water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.4 Your own bedroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.5 Use of a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your periods

26.6 At what age did your periods **start** ? _____

26.7 At what age did your periods **stop** ? _____

26.8 Did your periods stop naturally 1
because of an operation 2 office use
(please give details) _____ 26.9

26.10 Have you ever taken the oral contraceptive pill ? Yes No

26.11 If Yes, which type of pill did you take?
Combined pill 1
Progestogen only (mini-pill) 2
Don't know 3

26.12 If Yes, for how long did you take it ? _____ years

26.13 In what year did you last take the pill ? 19_____

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

27.0 **Your pregnancies**

27.1 How many pregnancies did you have? Give number _____

27.2 How many live births did you have? Give number _____

For you first born child, please give the following details: If no live births, please go to 27.7

27.3 Boy Girl 27.4 Born on time Early Late

27.5 Birthweight _____ lbs _____ ozs

Did you have any of the following complications during any of your pregnancies?

	Yes	No
27.3 High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
27.4 Sugar in the urine	<input type="checkbox"/>	<input type="checkbox"/>
27.5 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
27.6 Swelling of the hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
27.7 Pre-eclampsia	<input type="checkbox"/>	<input type="checkbox"/>

28.0 Family history

Your father

	Yes	No
28.1 Is your father still alive	<input type="checkbox"/>	<input type="checkbox"/>

If No, 28.2 How old was he when he died? _____ years

28.3 What were you told was the cause of his death. Please tick only one cause.

Heart attack	<input type="checkbox"/> 1	Other cancer	<input type="checkbox"/> 6
High blood pressure	<input type="checkbox"/> 2	Accident or injury	<input type="checkbox"/> 7
Stroke	<input type="checkbox"/> 3	Other cause	<input type="checkbox"/> 8
Respiratory disease	<input type="checkbox"/> 4	Don't know	<input type="checkbox"/> 9
Cancer of lung	<input type="checkbox"/> 5		

28.4 What job did your father do for the longest period of time? office use

_____ 28.5

28.6 Would you describe this job as: Manual 1 Non-manual 2

Please answer the following questions by filling in the appropriate box with a tick or writing the answer in the space provided.

Your mother	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

28.7 Is your mother still alive

If No, 28.8 How old was she when he died? _____ years

28.9 What were you told was the cause of her death. Please tick only one cause.

- | | | | | | |
|---------------------|--------------------------|---|--------------------|--------------------------|---|
| Heart attack | <input type="checkbox"/> | 1 | Other cancer | <input type="checkbox"/> | 6 |
| High blood pressure | <input type="checkbox"/> | 2 | Accident or injury | <input type="checkbox"/> | 7 |
| Stroke | <input type="checkbox"/> | 3 | Other cause | <input type="checkbox"/> | 8 |
| Respiratory disease | <input type="checkbox"/> | 4 | Don't know | <input type="checkbox"/> | 9 |
| Cancer of breast | <input type="checkbox"/> | 5 | | | |

Family history of heart attacks and stroke

Are any of your relations affected by heart attacks and strokes either now or before they died?

Mother

Yes No Don't know

28.10 Heart attack

28.11 Stroke

Father

28.12 Heart attack

28.13 Stroke

Sisters

Yes No Don't know No sisters or brothers

28.14 Heart attack

28.15 Stroke

Brothers

28.16 Heart attack

28.17 Stroke

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

CHECK CAREFULLY THAT YOU HAVE ANSWERED EACH PAGE AND THEN RETURN IT IN THE REPLY PAID ENVELOPE PROVIDED.