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
Canynge 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

Day  Month  Year

1.3 Today’s date

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 🅱️
- Good ☑️
- Fair ☀️
- Poor ☀️

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?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Heart attack (coronary thrombosis or myocardial infarction)</td>
<td>☐️</td>
<td>☑️</td>
<td>19___</td>
</tr>
<tr>
<td>3.2 Heart failure</td>
<td>☐️</td>
<td>☑️</td>
<td>3.8</td>
</tr>
<tr>
<td>3.3 Angina</td>
<td>☐️</td>
<td>☑️</td>
<td>3.9</td>
</tr>
<tr>
<td>3.4 Other heart trouble</td>
<td>☐️</td>
<td>☑️</td>
<td>19___</td>
</tr>
<tr>
<td>3.5 High blood pressure</td>
<td>☐️</td>
<td>☑️</td>
<td>3.11</td>
</tr>
<tr>
<td>3.6 Stroke</td>
<td>☐️</td>
<td>☑️</td>
<td>3.12</td>
</tr>
</tbody>
</table>

4.0 **Cancers**

4.1 Have you ever been told by a doctor that you have or have had a cancer?  
- Yes ☐️  
- No ☑️  

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

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐️</td>
<td>☑️</td>
</tr>
<tr>
<td>☐️</td>
<td>☑️</td>
</tr>
<tr>
<td>☐️</td>
<td>☑️</td>
</tr>
</tbody>
</table>

Please give year when first diagnosed.
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?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Please give year when first diagnosed, if possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Asthma</td>
<td>☐</td>
<td>☐</td>
<td>5.11 19________________________________________</td>
</tr>
<tr>
<td>5.2 Bronchitis</td>
<td>☐</td>
<td>☐</td>
<td>5.12 19________________________________________</td>
</tr>
<tr>
<td>5.3 Depression</td>
<td>☐</td>
<td>☐</td>
<td>5.13 19________________________________________</td>
</tr>
<tr>
<td>5.4 Gastric, peptic or duodenal ulcer</td>
<td>☐</td>
<td>☐</td>
<td>5.14 19________________________________________</td>
</tr>
<tr>
<td>5.5 Gout</td>
<td>☐</td>
<td>☐</td>
<td>5.15 19________________________________________</td>
</tr>
<tr>
<td>5.6 Gall bladder disease</td>
<td>☐</td>
<td>☐</td>
<td>5.16 19________________________________________</td>
</tr>
<tr>
<td>5.7 Osteoporosis</td>
<td>☐</td>
<td>☐</td>
<td>5.17 19________________________________________</td>
</tr>
<tr>
<td>5.8 Thyroid disease</td>
<td>☐</td>
<td>☐</td>
<td>5.18 19________________________________________</td>
</tr>
<tr>
<td>5.9 Cataract</td>
<td>☐</td>
<td>☐</td>
<td>5.19 19________________________________________</td>
</tr>
<tr>
<td>5.10 Glaucoma</td>
<td>☐</td>
<td>☐</td>
<td>5.20 19________________________________________</td>
</tr>
</tbody>
</table>

### 6.0 Falls and Fractures

- 6.1 Have you had a fall in the last 12 months? Yes No
- 6.2 If Yes, how many times? __________
- 6.3 Did you have medical attention for any of these falls? Yes No

Fractures: Yes No Please give year
6.4 Have your ever fractured or broken your hip? □ □ 19_______

6.5 or, your wrist? □ □ 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? □ □

If Yes, please state what kind of arthritis:

Yes No Don’t know Please give year first diagnosed

7.2 rheumatoid arthritis □ □ □ 7.5 19___________

7.3 osteoarthritis □ □ □ 7.6 19___________

7.4 other type of arthritis □ □ 7.8 19___________

Which joints are or were affected?

Yes No

7.8 hips □ □

7.9 knees/ankles □ □

7.10 shoulders □ □

7.11 hands/fingers □ □

7.12 back/spine □ □

8.0 Operations

8.1 Have you ever had an operation(s)? □ □

If Yes, please give details including the year:

office use Please give year of operation(s)

8.2 _______________________________ □ □ 8.5 19___________

8.3 _______________________________ □ □ 8.6 19___________
Please list any other operations here:

<p>| | | | |</p>
<table>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1 your hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.2 your eyesight</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(not simply needing specs)*

If Yes, please give details:

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
</table>

### 10.0 Diabetes

10.1 Has anyone in your close family (your parents, brothers, sisters) ever had diabetes?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

10.2 Have you ever been told by a doctor that you have or have had diabetes?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>Year first diagnosed</th>
</tr>
</thead>
</table>

If Yes:

10.4 Are you on a regular diet for your diabetes?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</table>

10.5 Are you on regular tablets for your diabetes?

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<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

10.6 Are you on regular treatment with insulin?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
</table>

10.7 Do you attend a hospital or GP diabetic clinic?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
11.0 **Breathlessness**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>Do you get short of breath walking with other people of your own age on level ground?</td>
<td>Yes</td>
</tr>
<tr>
<td>11.2</td>
<td>On walking uphill or stairs do you get more breathless than people of your own age?</td>
<td>Yes</td>
</tr>
<tr>
<td>11.3</td>
<td>Do you ever have to stop walking because of breathlessness?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>Do you ever get pain or discomfort in your leg, thighs or buttocks when you walk?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12.2</td>
<td>Do you know the cause of the pain?</td>
<td>Yes</td>
</tr>
<tr>
<td>12.3</td>
<td><em>If Yes,</em> what is the cause? ____________________________</td>
<td></td>
</tr>
<tr>
<td>12.4</td>
<td>Does this pain ever begin when you are standing still or sitting?</td>
<td>Yes</td>
</tr>
<tr>
<td>12.5</td>
<td>Do you get the pain if you walk up hill or hurry?</td>
<td>Yes</td>
</tr>
<tr>
<td>12.6</td>
<td>Do you get the pain walking at an ordinary pace on the level?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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**
### Ankle Swelling

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.0 Ankle swelling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.1 Do your ankles swell up regularly?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.2 If Yes, is this because of varicose veins?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Cough and Wheeze

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.0 Cough and Wheeze</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.1 Do you usually bring up phlegm (spit) from your chest first thing in the morning in the winter?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.2 If Yes, do you bring up phlegm like this on most days for as much as 3 months in the winter each year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.3 In the past 4 years have you ever had a period of increased cough and phlegm lasting for 3 weeks or more?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.4 Does your chest ever sound wheezy or whistling?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.5 If Yes, does this happen on most days or nights?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Treatment with aspirin

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.0 Treatment with aspirin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.1 Do you take aspirin regularly?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If Yes,  
15.2 Is this on doctor’s advice?  
15.3 When did you start taking aspirin regularly? 19 _____________  
15.4 On how many days each week do you take aspirin?  
- daily 1  
- alternate days 2  
- other 3  
15.5 What dose of aspirin do you take each day that you take it?  
- 75mg/1/2junior 1  
- 125mg/junior 2  
- 300mg/adult 3  
- other 4  
15.6 For what condition are you taking aspirin?  
Please state ____________________________  

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)**  

16.1 Have you ever taken HRT?  

If Yes,  
16.2 Are you still taking it?  
16.3 How long have you (or did you) taken it? ________________ years  

If stopped now,  
16.4 How long ago did you stop taking it? ________________ years  

16.5 Which preparation do/did you use? ____________________________  

17.0 **Vitamin or mineral tablets**  

17.1 Do you take any vitamin or mineral tablets or supplements?  

If Yes, please give details: ____________________________  

17.2
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?

1
2
3

yes, regularly   yes, on and off   no

18.6 Has your weight changed in the last four years?

1
2
3
4
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)  □  □

19.0 **Smoking**

19.1 Have you ever smoked cigarettes regularly (at least 1/day)?  □  □

*If Yes:*

19.2 Do you smoke cigarettes at present?  □  □

*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?
How old were you when you started smoking regularly? ______years

Have you changed your cigarette smoking habits over the last 4 years?

Yes, increased  Yes, cut down  Yes, given up  No

Do you currently smoke tobacco in any other form (e.g. pipe, cigar)?

Yes  No

If No.

Have you ever regularly done so?

Yes  No

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

Were you previously a regular cigarette smoker?  Yes  No

If Yes.

How many cigarettes did you usually smoke each day?_____________cigarettes

At what age did you give up? ______________ years old

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

Personal choice  Financial reasons  Health precaution

Doctor's advice  Illness or ill-health  Other reasons

Does/did your husband/partner smoke cigarettes?

Yes  No
### Alcohol Intake

20.1 Would you describe your present alcohol intake as
- Daily/most days [ ] 1
- Weekends only [ ] 2
- Once or twice a month [ ] 3
- Special occasions [ ] 4
- Never [ ] 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 [ ] 1
- 3-6 drinks a day [ ] 2
- 2 drinks a day or less [ ] 3
- None [ ] 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)

20.4 What type of drink do you usually take?
- Beers, Lagers [ ] 1
- Sherry, wine [ ] 2
- Spirits [ ] 3
- Variety of beer, wines or spirits [ ] 4
- Low alcohol drinks [ ] 5

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>If Yes, glasses per week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20.5 Do you drink white wine?
- Yes [ ]
- No [ ]
[ ] glasses/week

20.6 Do you drink red wine?
- Yes [ ]
- No [ ]
[ ] glasses/week

20.7 Have you changed your alcohol intake in the last four years?
- No [ ] 1
- Yes, increased [ ] 2
If you have **CUT DOWN** or **GIVEN UP**

20.8 Was this due to: Tick one main reason only.

- [ ] 1 Personal choice  
- [ ] 2 Financial reasons  
- [ ] 3 Health precaution  
- [ ] 4 Doctor’s advice  
- [ ] 5 Illness or ill-health  
- [ ] 6 On medication  
- [ ] 7 Other reasons

**For those not drinking at present**

20.9 Did you drink in the past?  

- [ ] Yes  
- [ ] No

If Yes,

20.10 would you describe your previous alcohol intake as

- [ ] Daily/most days  
- [ ] Weekends only  
- [ ] Once or twice a month  
  or special occasions

20.11 How many alcoholic drinks did you take during an average week?  

20.12 How many years ago did you stop?  

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

**21.0 Your diet**

21.1 Do you eat any special diet?  

- [ ] Yes  
- [ ] No

21.2 If Yes, please specify

- [ ] 1 low fat  
- [ ] 2 high fibre  
- [ ] 3 vegetarian  
- [ ] 4 diabetic  
- [ ] 5 sliming/low calorie  
- [ ] 6 other

21.3 What kind of bread do you eat?  

- [ ] 1 White  
- [ ] 2 Brown  
- [ ] 3 Wholemeal  
- [ ] 4 Various

21.4 Spreading fat: What kind do you use at home?  

- [ ] 1 Butter  
- [ ] 2 Margarine  
- [ ] 3 Margarine  
- [ ] 4 Low calorie  
- [ ] 5 Various  
- [ ] 6 None
How often do you eat the following foods? (Please tick the appropriate box for each food item)

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

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

- [ ] Car
- [ ] Public Transport
- [ ] Cycle
- [ ] Walk
- [ ] Not applicable

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

- [ ] No
- [ ] Walk
- [ ] Cycle
- [ ] Both

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

- [ ] Slow
- [ ] Steady average
- [ ] Fairly brisk
- [ ] Fast (at least 4 miles/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?

- [ ] No
- [ ] Occasionally
- [ ] Frequent
- [ ] (less than monthly)
- [ ] (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
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
22.24 Compared with your activity level of three years ago, are you doing:

- [ ] More
- [ ] Same
- [ ] Less

22.25 If less, please give the reason: ____________________________________________

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

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

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?
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Please give the year this first started</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.5</td>
<td>Going up or down stairs</td>
<td>☐</td>
<td>☐</td>
<td>24.11</td>
</tr>
<tr>
<td>24.6</td>
<td>Bending down</td>
<td>☐</td>
<td>☐</td>
<td>24.12</td>
</tr>
<tr>
<td>24.7</td>
<td>Straightening up</td>
<td>☐</td>
<td>☐</td>
<td>24.13</td>
</tr>
<tr>
<td>24.8</td>
<td>Keeping your balance</td>
<td>☐</td>
<td>☐</td>
<td>24.14</td>
</tr>
<tr>
<td>24.9</td>
<td>Going out of the house</td>
<td>☐</td>
<td>☐</td>
<td>24.15</td>
</tr>
<tr>
<td>24.10</td>
<td>Walking 400 yards</td>
<td>☐</td>
<td>☐</td>
<td>24.16</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.17</td>
<td>Walking stick</td>
<td>☐</td>
</tr>
<tr>
<td>24.18</td>
<td>Walking frame</td>
<td>☐</td>
</tr>
<tr>
<td>24.19</td>
<td>Wheelchair</td>
<td>☐</td>
</tr>
<tr>
<td>24.20</td>
<td>Toilet raised seat</td>
<td>☐</td>
</tr>
<tr>
<td>24.21</td>
<td>Bath board/shower</td>
<td>☐</td>
</tr>
<tr>
<td>24.22</td>
<td>Extra rails in bathroom</td>
<td>☐</td>
</tr>
<tr>
<td>24.23</td>
<td>Stair lift</td>
<td>☐</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.24 Job (paid employment)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>24.25 Household chores</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>24.26 Social life</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>24.27 Sex life</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>24.28 Interests and hobbies</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>24.29 Holidays and outings</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>24.30 Family relationships</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

25.0 **Your present circumstances**

25.1 Are you:

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>1</td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>

25.2 Are you at present living alone | [ ] |

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>living with a husband or partner</td>
<td>2</td>
</tr>
<tr>
<td>living with other family member(s)</td>
<td>3</td>
</tr>
<tr>
<td>living with other people</td>
<td>4</td>
</tr>
</tbody>
</table>

25.3 Do you have a car available for use in your household? | Yes | No |

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>[ ]</td>
</tr>
<tr>
<td>No</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

25.4 Your accommodation: are you:

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>an owner occupier</td>
<td>1</td>
</tr>
<tr>
<td>renting from a local authority</td>
<td>2</td>
</tr>
<tr>
<td>renting privately</td>
<td>3</td>
</tr>
<tr>
<td>other (please specify)</td>
<td>4</td>
</tr>
</tbody>
</table>

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 1
- retired 2
- employed, full time 3
- employed, part time 4

25.7 If you are retired, is this due to normal retiring age

- early retirement, voluntary 1
- early retirement, compulsory 2
- illness/disability 3
- other reasons 4
- not applicable 5

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 1
- Non-Manual 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.

- Heart attack Yes No
- Stroke
- Cancer
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
2 employed, part time
3 unemployed, seeking work
4 unemployed, not seeking work
5 not applicable (eg. widowed)

25.14 If he is retired, is this due to normal retiring age
1 early retirement, voluntary
2 early retirement, compulsory
3 illness/disability
4 other reasons
5 not applicable

25.15 If he is retired, in which year did retired?
19 ___________

25.16 If he is unemployed, is this due to
1 redundancy
2 illness/disability
3 other reasons

25.17 What job has your husband or partner done for the longest period of time? Please answer even if he is now deceased, or you are now divorced or separated.
_______________________________________________________

25.18 __________________________

25.19 Would you describe this work as Manual
1 1
2 Non-Manual
2

22
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

<table>
<thead>
<tr>
<th></th>
<th>Every day 1</th>
<th>Every week 2</th>
<th>Every few months 3</th>
<th>Every year 4</th>
<th>Rarely or never 5</th>
<th>Does not apply 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.21 Your children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.22 Brothers/sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.23 Friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.24 Neighbours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Please tick the appropriate box in each row

<table>
<thead>
<tr>
<th></th>
<th>Too little 1</th>
<th>About right 2</th>
<th>Too much 3</th>
<th>Does not apply 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.25 Your children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.26 Brothers/sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.27 Friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please answer the following questions by filling in the appropriate box with a tick $\checkmark$ or writing the answer in the space provided.

### 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.

#### 26.0

**How much did you weigh when you were born?**

Write 00/00 if you don’t know. $\underline{\text{_________lbs}}$ $\underline{\text{_________ozs}}$

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.2 A bathroom</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>26.3 Hot water</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>26.4 Your own bedroom</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>26.5 Use of a car</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### Your periods

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

$\underline{\text{______________________}}$

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

$\underline{\text{______________________}}$

**Did your periods stop naturally**

<p>| | | | |</p>
<table>
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<tbody>
<tr>
<td></td>
<td>[ ]</td>
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</tbody>
</table>

**because of an operation**

<p>| | | | |</p>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**Office use**

(please give details) $\underline{\text{______________________}}$ 26.9 $\checkmark$

**Have you ever taken the oral contraceptive pill?**

Yes $\checkmark$ No

**If Yes, which type of pill did you take?**

Combined pill 1

Progestogen only (mini-pill) 2
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 your 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?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.3 High Blood Pressure</td>
<td>□   □</td>
</tr>
<tr>
<td>27.4 Sugar in the urine</td>
<td>□   □</td>
</tr>
<tr>
<td>27.5 Diabetes</td>
<td>□   □</td>
</tr>
<tr>
<td>27.6 Swelling of the hands or feet</td>
<td>□   □</td>
</tr>
<tr>
<td>27.7 Pre-eclampsia</td>
<td>□   □</td>
</tr>
</tbody>
</table>

28.0 **Family history**

**Your father**

28.1 Is your father still alive □   □

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 □ 1  Other cancer □ 6
- High blood pressure □ 2  Accident or injury □ 7
- Stroke □ 3  Other cause □ 8
- □   □
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

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 1 Other cancer 6
High blood pressure 2 Accident or injury 7
Stroke 3 Other cause 8
Respiratory disease 4 Don’t know 9
Cancer of breast 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

26
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>28.14</td>
<td>Heart attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.15</td>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Brothers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.16</td>
<td>Heart attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.17</td>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.
CHECK CAREFULLY THAT YOU HAVE ANSWERED EACH PAGE AND THEN RETURN IT IN THE REPLY PAID ENVELOPE PROVIDED.