TROMSØ HEALTH SURVEY
for the over 70s

The main aim of the Tromsø survey is to improve our knowledge of heart and circulatory conditions in order to aid prevention. The survey is also intended to improve our knowledge of cancer and other general conditions, such as allergies, muscle pains and nervous conditions. The ultimate aim is to gain an overview of the general health of the elderly population. We would therefore like you to answer the questions below.

This form is part of the Health Survey, which has been approved by the Norwegian Data Inspectorate and the Regional Board of Research Ethics. The answers will only be used for research purposes and will be treated in strict confidence. The information you give us may later be stored along with information from other public health registers in accordance with the rules laid down by the Data Inspectorate and the Regional Board of Research Ethics.

If you are unsure about what to answer, tick the box that you feel fits best.

The completed form should be sent to us in the enclosed pre-paid envelope.

Thank you in advance for helping us.

Yours sincerely,

Faculty of Medicine  National Health
University of Tromsø  Screening Service

Date for filling in this form: Day/Month/Year

CHILDHOOD/YOUTH
What Norwegian municipality did you live in at the age of 1 year?
If you did not live in Norway, give country instead of municipality.

How was your family's financial situation while you were growing up?
Very good
Good
Difficult
Very difficult

How old were your parents when they died?
Mother  _____ years
Father  _____ years

HOME
Who do you live with?
Tick one box for each item and give the number of persons.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other persons over 18 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons under 18 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What type of home do you live in?
Villa/detached house
Farm
Apartment/flat in block/terrace
Terraced/semi-detached house
Other

How long have you lived in your present home?  ____ years

Is your home adapted to your needs?  YES  NO

If "No", do you have problems with:
Space
Variable temperature/too cold/too warm
Stairs
Toilet
Bath/shower
Maintenance
Other (please specify)

Would you like to move into a retirement home?  YES  NO

PREVIOUS WORK AND FINANCIAL SITUATION
Which statement best describes the type of work you did for the last 5-10 years before you retired?

I was mainly seated while working  (e.g., desk/assembly work)
My work required a lot of walking  (e.g., shop assistant, housewife, teaching)
My work required a lot of walking and lifting  (e.g., postman, nurse, construction work)
I did heavy physical work  (e.g., forestry, heavy agricultural work, heavy construction work)

Did you do any of the following jobs (full- or part-time)?
Tick one box only for each item.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver</td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td></td>
</tr>
<tr>
<td>Fisherman</td>
<td></td>
</tr>
</tbody>
</table>

How old were you when you retired?  _____ years

What kind of pension do you have?
Basic state pension
Additional pension
How is your current financial situation?

Very good □
Good □
Difficult □
Very difficult □

HEALTH AND ILLNESS
Has your state of health changed in the last year?

Yes, it has got worse □
No, unchanged □
Yes, it has got better □

How do you feel your health is now compared to others of your age?

Much worse □
A little worse □
About the same □
A little better □
Much better □

YOUR OWN ILLNESSES
Have you ever had:
Tick one box only for each item. Give your age at the time. If you have had the condition several times, how old were you last time?

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip fracture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist/forearm fracture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whiplash</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury requiring hospital admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach ulcer</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Duodenal ulcer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach/duodenal ulcer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Throat/neck surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever had, or do you still have:

Tick one box only for each item.

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psoriasis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fibromyalgia/fibrositis/chronic pain syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological problems for which you have sought help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent urinary incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cataract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthrosis (osteoarthritis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney stone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy and hypersensitivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atopic eczema (e.g., childhood eczema)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand eczema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hay fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food allergy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other hypersensitivity (not allergy)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How many times have you had a cold, influenza (flu), diarrhea/vomiting, or similar in the last six months?

______ times

Have you had any of these in the last two weeks?

YES □ NO □

ILLNESS IN THE FAMILY
Tick off relatives who have, or have ever had, any of the following conditions:

"None" for conditions which none of your relatives have had.

Mother Father Brother Sister Child None

Stroke or brain haemorrhage □ □ □ □ □ □
Myocardial infarction before age 60 □ □ □ □ □ □
Cancer □ □ □ □ □ □
Hypertension □ □ □ □ □ □
Asthma □ □ □ □ □ □
Osteoporosis □ □ □ □ □ □
Arthrosis (osteoarthritis) □ □ □ □ □ □
Psychological problems □ □ □ □ □ □
Dementia □ □ □ □ □ □
Diabetes □ □ □ □ □ □

- age when they got diabetes

SYMPTOMS
Do you cough daily for periods of the year? YES NO

If "Yes":
Is your cough productive?

Have you had this kind of cough for as long as 3 months in each of the last two years?

Have you had periods of wheezing in your chest?

Have you had this kind of cough for as long as 3 months in each of the last two years?

Have you noticed sudden changes in your pulse or heart rhythm in the last year?

Have you lost weight in the last year?

If "Yes":
How many kilograms?

How often do you suffer from sleeplessness?

Never, or just a few times a year □
1-2 times a month □
Approximately once a week □
More than once a week □

If you suffer from periods of sleeplessness, what times of the year does it affect you most?

No particular time of year □
Especially during the 'dark winter months' □
Especially during the midnight sun period □
Especially in spring and autumn □

Do you usually take a nap during the day? YES NO

Do you feel that you normally get enough sleep? YES NO
Do you suffer from:
- Dizziness
- Poor memory
- Lack of energy
- Constipation

Does the thought of getting a serious illness ever worry you?
- Not at all
- Only a little
- Some
- Very much

BODILY FUNCTIONS
Can you manage the following everyday activities on your own without help from others?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>With some help</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking indoors on one level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking up/down stairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking outdoors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking approx. 500 metres</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Going to the toilet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing yourself</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking a bath/shower</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing and undressing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting in and out of bed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating meals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing light housework (e.g., washing up)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing heavier housework (e.g., cleaning floors)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Going shopping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking the bus</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Can you hear normal speech (if necessary with a hearing aid)?

- Yes
- With difficulty
- No

Can you read (if necessary with glasses)?

- Yes
- No

Are you dependent on any of the following aids?

<table>
<thead>
<tr>
<th>Aid</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking stick</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crutches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking frame/Zimmer frame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety alarm device</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

USE OF HEALTH SERVICES
How many visits have you made during the past year due to your own health or illness:

Tick 0 if you have not had such contact

Number of times the past year

To a general practitioner (GP)/emergency GP
Psychologist or psychiatrist
Other medical specialist (not at a hospital)
Hospital out-patient clinic
Hospital admission
Physiotherapist
Chiropractor
Acupuncturist

MEDICATION AND DIETARY SUPPLEMENTS
Have you for any length of time in the past year used any of the following medicines every day or almost daily? Indicate how many months you used them for.

Write 0 for items you have not used.

Medication:
- Painkillers
- Sleeping pills
- Tranquillizers
- Antidepressants
- Allergy drugs
- Asthma drugs
- Heart medicine (not blood pressure)
- Insulin
- Diabetes tablets
- Thyroxin tablets
- (for metabolic disorder)
- Cortisone tablets
- Remedies for constipation

Dietary supplements:
- Iron tablets
- Vitamin D supplement
- Other vitamin supplements
- Calcium tablets or bonemeal
- Cod liver oil or fish oil capsules

FAMILY AND FRIENDS
Do you have close relatives who can give you help and support when you need it?

- Yes
- No

If "Yes", who can give you help?
- Spouse/partner
- Children
- Others

How many good friends do you have whom you can talk confidentially with and who give you help when you need it?

_______good friends

Do not count people you live with, but do include other relatives!

Do you feel you have enough good friends?

- Yes
- No
Do you feel that you belong to a community or group of people who can depend on each other and who feel committed to each other (e.g., a political party, religious group, relatives, neighbours, work place, or organisation)?

- Strong sense of belonging
- Some sense of belonging
- Not sure
- Little or no sense of belonging

How often do you normally take part in organised gatherings, e.g., sewing circles, sports clubs, political meetings, religious or other associations?

- Never, or just a few times a year
- 1-2 times a month
- Approximately once a week
- More than once a week

Diet

How many meals a day do you normally eat (dinner and smaller meals)?

______ Number

How many times a week do you eat a hot dinner?

______ Number

What kind of bread (bought or home-made) do you usually eat? Tick one or two boxes!

- Coarse brown bread
- Ordinary brown bread
- Light textured brown bread
- White bread

The bread I eat is most similar to

_____ Number

How much (in number of glasses, cups, potatoes or slices) do you usually eat or drink daily of the following foodstuffs? Tick a box for each foodstuff.

Less

<table>
<thead>
<tr>
<th>Foodstuffs</th>
<th>Less</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk of all types (glasses)</td>
<td></td>
</tr>
<tr>
<td>Orange juice (glasses)</td>
<td></td>
</tr>
<tr>
<td>Potatoes</td>
<td></td>
</tr>
<tr>
<td>Slices of bread in total</td>
<td></td>
</tr>
<tr>
<td>Slices of bread with fish</td>
<td></td>
</tr>
<tr>
<td>- cheese (e.g., Norwegia)</td>
<td></td>
</tr>
<tr>
<td>- smoked cod caviar</td>
<td></td>
</tr>
</tbody>
</table>

How many times per week do you normally eat the following foodstuffs? Tick a box for all foodstuffs listed.

Less

<table>
<thead>
<tr>
<th>Foodstuffs</th>
<th>Never</th>
<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
<th>6-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yoghurt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boiled or fried egg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breakfast cereal/ oat meal, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For dinner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- meat</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- fat fish (e.g., salmon/redfish)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- lean fish (e.g., cod)</td>
<td></td>
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</tr>
</tbody>
</table>

Thank you for helping us! Remember to post the form today! Tromsø Health Survey