

You and your health

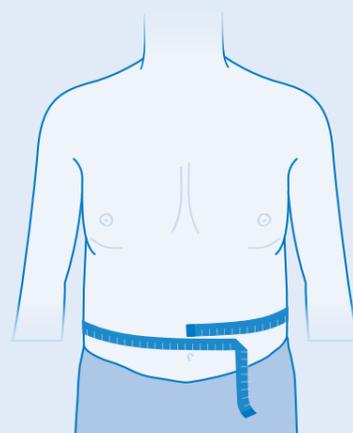
Your sex Male Female

Your date of birth
D D M M Y Y Y Y

Your height feet inches **OR** cm

Your weight stone lbs **OR** kgs

Your waist measurement inches **OR** cm



Please use the tape measure enclosed and measure at the narrowest point between your hips and your ribs, usually just above the belly button.

Thinking about your own life and personal circumstances, how satisfied are you with your life as a whole? *Please indicate by ticking one box below:*

Completely Dissatisfied											Completely Satisfied
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>											

The following questions ask about your own health.

By placing a tick in one box in each group below, please indicate which statements best describe your own health TODAY

Mobility	Please tick one:
I have no problems in walking about	<input type="checkbox"/>
I have slight problems in walking about	<input type="checkbox"/>
I have moderate problems in walking about	<input type="checkbox"/>
I have severe problems in walking about	<input type="checkbox"/>
I am unable to walk about	<input type="checkbox"/>
Self-care	Please tick one:
I have no problems washing or dressing myself	<input type="checkbox"/>
I have slight problems washing or dressing myself	<input type="checkbox"/>
I have moderate problems washing or dressing myself	<input type="checkbox"/>
I have severe problems washing or dressing myself	<input type="checkbox"/>
I am unable to wash or dress myself	<input type="checkbox"/>

(Table continues overleaf)

You and others

About you

Do you have a carer? Yes No

If yes, who cares for you? Spouse Friends/relatives Paid carers

Where do you live? At home In a care home

How many hours of care have you received over the past week hours

Which of the following best describes your main activity?

In employment/self-employment	<input type="checkbox"/>	Unemployed	<input type="checkbox"/>
Retired	<input type="checkbox"/>	Long-term sick	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>	Carer for someone over 18 years	<input type="checkbox"/>
Student	<input type="checkbox"/>	Other: <i>(please state)</i>	<input type="checkbox"/>
Seeking work	<input type="checkbox"/>		

Which of the options below represents your household's total monthly or weekly income after tax, national insurance etc? *Please include income from all sources (e.g. earnings, pension, benefits, investment income).*

Monthly				Weekly					
Less than £500	<input type="checkbox"/>	£2,000 to £2,499	<input type="checkbox"/>	Less than £125	<input type="checkbox"/>	£500 to £624	<input type="checkbox"/>		
£500 to £999	<input type="checkbox"/>	£2,500 to £2,999	<input type="checkbox"/>	£125 to £249	<input type="checkbox"/>	£625 to £749	<input type="checkbox"/>		
£1,000 to £1,499	<input type="checkbox"/>	£3,000 to £3,999	<input type="checkbox"/>	£250 to £374	<input type="checkbox"/>	£750 to £999	<input type="checkbox"/>		
£1,500 to £1,999	<input type="checkbox"/>	£4,000 or more	<input type="checkbox"/>	£375 to £499	<input type="checkbox"/>	£1,000 or more	<input type="checkbox"/>		
Prefer not to answer				<input type="checkbox"/>	Prefer not to answer				<input type="checkbox"/>

About others

Including yourself, how many people live in your household?

Do you have a spouse or partner living with you? Yes No

How many children (under 18) do you have living with you?

Have you given first aid to anyone in the last year? Yes No

If yes, did you know the person? Yes No

Does anyone in your family have diabetes? Yes No Don't know

If you are a carer for someone else, then how many hours have you spent caring for them over the past week? hours

Your healthcare and medication

In the last 3 MONTHS, how many times have you visited the following:

Hospital	Times	Other carers	Times
Accident & Emergency (A&E)	<input type="text"/>	Counsellor	<input type="text"/>
Hospital - day case	<input type="text"/>	Care worker	<input type="text"/>
Hospital - outpatients	<input type="text"/>	Social worker	<input type="text"/>
Hospital - in-patients (<i>how many nights</i>)	<input type="text"/>	Health visitor	<input type="text"/>
		Community health champion	<input type="text"/>
		Health trainer	<input type="text"/>
Other healthcareers	Times	Alternative therapist	Times
GP	<input type="text"/>	Acupuncturist	<input type="text"/>
Nurse	<input type="text"/>	Chiropractor	<input type="text"/>
Physiotherapist	<input type="text"/>	Herbalist	<input type="text"/>
Dietitian	<input type="text"/>	Homeopath	<input type="text"/>
Midwife	<input type="text"/>	Osteopath	<input type="text"/>
Mental health worker	<input type="text"/>		
Psychotherapist	<input type="text"/>	Other (please describe)	Times
Dentist	<input type="text"/>		<input type="text"/>
Chiropodist/Podiatrist	<input type="text"/>		
Optician	<input type="text"/>		

Do you buy any medications not prescribed by your doctor (e.g. vitamins and mineral supplements, dietary supplements, diet pills, herbal or homeopathic remedies)? Yes No

If yes, please describe:

Name and strength of any medications not prescribed by your doctor	What is this for?
<i>(Example) Cod liver oil 550mg capsule</i>	<i>Nutritional supplement</i>

Your health

Usual Activities (<i>e.g. work, study, housework, family or leisure activities</i>)	Please tick one:
I have no problems doing my usual activities	<input type="checkbox"/>
I have slight problems doing my usual activities	<input type="checkbox"/>
I have moderate problems doing my usual activities	<input type="checkbox"/>
I have severe problems doing my usual activities	<input type="checkbox"/>
I am unable to do my usual activities	<input type="checkbox"/>
Pain / Discomfort	Please tick one:
I have no pain or discomfort	<input type="checkbox"/>
I have slight pain or discomfort	<input type="checkbox"/>
I have moderate pain or discomfort	<input type="checkbox"/>
I have severe pain or discomfort	<input type="checkbox"/>
I have extreme pain or discomfort	<input type="checkbox"/>
Anxiety / Depression	Please tick one:
I am not anxious or depressed	<input type="checkbox"/>
I am slightly anxious or depressed	<input type="checkbox"/>
I am moderately anxious or depressed	<input type="checkbox"/>
I am severely anxious or depressed	<input type="checkbox"/>
I am extremely anxious or depressed	<input type="checkbox"/>

Long standing conditions

Do you have any long-standing illness, health problem, condition or disability? Yes No

If yes, please tick all that apply:

Tiredness / Fatigue	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
Pain	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>
Anxiety / Nerves	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	Other (<i>please state</i>):	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>		
Breathing problems e.g. chronic bronchitis, asthma or emphysema	<input type="checkbox"/>		

Overall, how bothersome has your long standing condition been in the last 2 weeks?

Name the one or two that bother you the most here and then tick your response:

Illness	Not at all	Slightly	Moderately	Very much	Extremely
	<input type="checkbox"/>				
	<input type="checkbox"/>				

Your food and drink

Please tell us about your diet by ticking one option for each of the food types below:

	Never/ Occasionally	1-3 times a week	4-6 times a week	Daily	More than once a day
Bacon or ham	<input type="checkbox"/>				
Chicken (coated, fried)	<input type="checkbox"/>				
Oily fish (sardines, salmon, mackerel, herring)	<input type="checkbox"/>				
White bread	<input type="checkbox"/>				
Wholemeal bread	<input type="checkbox"/>				
Chips	<input type="checkbox"/>				
Salad or raw vegetables	<input type="checkbox"/>				
Crisps and savoury snacks	<input type="checkbox"/>				
Biscuits, cakes and pastries	<input type="checkbox"/>				
Sugary drinks (fizzy pop, squash)	<input type="checkbox"/>				
Beer, lager or cider	<input type="checkbox"/>				

How many pieces of fruit, of any sort, do you eat on a typical day? pieces

How many portions of vegetables, excluding potatoes, do you eat on a typical day? portions

Please tell us about your alcohol intake by ticking one option for each of the options below:

How often do you have a drink containing alcohol?	Never <input type="checkbox"/>	Monthly or less <input type="checkbox"/>	2-4 times per month <input type="checkbox"/>	3-4 times per week <input type="checkbox"/>	4+ times per week <input type="checkbox"/>
How many units of alcohol do you drink on a typical day when you are drinking?*	1-2 units <input type="checkbox"/>	3-4 units <input type="checkbox"/>	5-6 units <input type="checkbox"/>	7-9 units <input type="checkbox"/>	10+ units <input type="checkbox"/>
How often have you had 6 or more units (if female) or 8 or more units (if male) on a single occasion in the last year?	Never <input type="checkbox"/>	Less than monthly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Weekly <input type="checkbox"/>	Daily or almost daily <input type="checkbox"/>

* **A unit of alcohol is equal to:** ½ a pint of ordinary beer, lager or cider; 1 single measure of spirits; 1 small glass of wine; or 1 measure of fortified wine.

Smoking

Which of these best describes you?

- I smoke daily
 I smoke occasionally but not every day
 I used to smoke daily but now not at all
 I used to smoke occasionally but now not at all
 I have never smoked

Your work and exercise

During the last WEEK, how many hours did you spend on each of the following activities?
(Please answer, whether you are in employment or not)

	None	Some but less than 1 hour	At least 1 hour but less than 3 hours	3 hours or more
a Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Cycling, including cycling to work and during leisure time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Walking, including walking to work, shopping, for pleasure etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the last 3 MONTHS, on how many days has your ill health prevented you from carrying out your:

Household tasks: days

Leisure activities: days

Paid work: days

Please tell us the type and amount of physical activity involved in your work (Please tick one box only)

a	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc)	<input type="checkbox"/>
b	I spend most of my time at work sitting (such as in an office)	<input type="checkbox"/>
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc)	<input type="checkbox"/>
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery worker, etc)	<input type="checkbox"/>
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc)	<input type="checkbox"/>