



The 45 and Up Study relies on the willingness of its participants to share information about their experiences and health, to provide knowledge that will help people live healthy and fulfilling lives for as long as possible. We are contacting you again because we need to find out more about your health and lifestyle and how these have changed in the recent past. Participation is completely voluntary, and you are free to withdraw from the Study at any time.

To participate in the Follow-up of the 45 and Up Study, please read the participant information leaflet, then fill in the questionnaire and consent form and return them in the envelope provided. Information from you, and from other people taking part in the 45 and Up Study, will allow researchers to answer key health questions facing Australia over the coming years.

Questions or comments? Call the Infoline 1300 45 11 45 or go to www.saxinstitute.org.au/our-work/45-up-study

Your answers and experiences are important to us.

To help us read your answers, please write as clearly as possible using a **BLACK** or **BLUE** pen, and be sure to complete the questionnaire as shown:

Please put a cross in the appropriate box(es) Yes No
OR put numbers in the appropriate box, e.g. 21st June 1945

2 1 / 0 6 / 1 9 4 5 age 6 8

General questions about you

1. What is your date of birth? / / 1 9

2. What is today's date? / / 2 0

3. How tall are you without shoes? cm OR feet inches
(please give to the nearest cm or inch)

4. About how much do you weigh? kg OR stone lbs

5. Have you ever been a regular smoker?
 Yes No *if NO, go to question 6*

If YES, how old were you when you started smoking regularly? years old

Are you a regular smoker now? Yes No

If NO, how old were you when you stopped smoking regularly?

About how much do you/did you smoke on average each day?
(If you are an ex-smoker, how much did you smoke on average when you smoked?)
 cigarettes per day pipes and cigars per day

6. About how many hours a week are you exposed to someone else's tobacco smoke? *(put "0" if you are not exposed or are exposed for less than one hour per week)*
hours per week at home hours per week in other places
(e.g. work, going out, cars)

7. About how many alcoholic drinks do you have each week?
One drink = a glass of wine, middy of beer or nip of spirits
(put "0" if you do not drink, or have less than one drink each week)
 number of alcoholic drinks each week

8. On how many days each week do you usually drink alcohol? days each week

9. What best describes your current situation? *(cross one box)*
 single married de facto / living with a partner
 widowed divorced separated

10. What best describes your current housing? *(cross one box)*
 house flat, unit, apartment house on farm
 hostel for the aged mobile home other
 nursing home retirement village, self care unit

11. Including yourself, how many people in total live in your household?
 people *(put "1" if you live alone)*

12. How many TIMES did you do each of these activities LAST WEEK?
(put "0" if you did NOT do this activity) times in the last week

Walking continuously, for at least 10 minutes
(for recreation or exercise or to get to or from places)

Vigorous physical activity
(that made you breathe harder or puff and pant, like jogging, cycling, aerobics, competitive tennis, but not household chores or gardening)

Moderate physical activity
(like gentle swimming, social tennis, vigorous gardening, or work around the house)

13. If you add up all the time you spent doing each activity LAST WEEK, how much time did you spend ALTOGETHER doing each type of activity?
(put "0" if you did NOT do this activity) hours minutes

Walking continuously, for at least 10 minutes
(for recreation or exercise or to get to or from places) :

Vigorous physical activity
(that made you breathe harder or puff and pant, like jogging, cycling, aerobics, competitive tennis, but not household chores or gardening) :

Moderate physical activity
(like gentle swimming, social tennis, vigorous gardening, or work around the house) :

Questions about your family

14. Have your mother, father, brother(s) or sister(s) ever had:

blood relatives only: put a cross in the appropriate box(es)

	mother	father	brother/sister		mother	father	brother/sister
heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dementia/Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
severe depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
severe arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hip fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
do not know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Questions about your health

15. Have you taken any medications, vitamins or supplements for most of the last 4 weeks?

Yes No *if NO, go to question 16*

If YES,

did you take:

<input type="checkbox"/> fish oil, omega 3	<input type="checkbox"/> glucosamine	<input type="checkbox"/> paracetamol with codeine
<input type="checkbox"/> paracetamol	<input type="checkbox"/> aspirin for the heart	<input type="checkbox"/> aspirin for other reasons
<input type="checkbox"/> Lipitor	<input type="checkbox"/> Avapro, Karvea	<input type="checkbox"/> warfarin, Coumadin
<input type="checkbox"/> Pravachol	<input type="checkbox"/> Coversyl, Coversyl Plus	<input type="checkbox"/> Lasix, frusemide
<input type="checkbox"/> Zocor, Lipex	<input type="checkbox"/> Cardizem, Vasocordol	<input type="checkbox"/> Micardis
<input type="checkbox"/> Nexium	<input type="checkbox"/> Norvasc	<input type="checkbox"/> Fosamax
<input type="checkbox"/> Somac	<input type="checkbox"/> Tritace	<input type="checkbox"/> Caltrate
<input type="checkbox"/> Losec, Acimax omeprazole	<input type="checkbox"/> Noten, Tenormin atenolol	<input type="checkbox"/> Oroxine, thyroxine
<input type="checkbox"/> Ventolin salbutamol	<input type="checkbox"/> Zyloprim, Prologout 300 allopurinol	<input type="checkbox"/> Diabex, Diaformin metformin
<input type="checkbox"/> Zoloft sertraline	<input type="checkbox"/> Cipramil, citaloprim	<input type="checkbox"/> Efexor venlafaxine

please list any other regular medications or supplements here

16. How many of your own teeth do you have left?

None – all of my teeth are missing 1-9 teeth left
 10-19 teeth left 20 or more teeth left

17. Do you feel you have a hearing loss? Yes No

18. Have you ever been a blood donor?

Yes No Unsure

If YES, when did you last donate blood? / month / year

19. Have you ever been a plasma donor?

Yes No Unsure

If YES, when did you last donate plasma?

/ month / year

20. During the past 12 months, how many times have you fallen to the floor or ground? (put "0" if you haven't fallen in this time)

times

21. Have you had a broken/fractured bone in the last 5 years?

Yes No *if NO, go to question 22*

If YES, which bones were broken?

wrist arm hip finger/toe
 rib ankle other _____

How old were you when it happened?

(give age at most recent fracture if more than one) years old

22. Has a doctor EVER told you that you have:

(if YES, cross the box and give your age when the condition was first found)

	Yes	Age when condition was first found
skin cancer (not melanoma)	<input type="checkbox"/>	<input type="text"/> age
melanoma	<input type="checkbox"/>	<input type="text"/> age
breast cancer	<input type="checkbox"/>	<input type="text"/> age
other cancer	<input type="checkbox"/>	<input type="text"/> age
type of cancer (please describe)		
heart failure (cardiac failure, weak heart, enlarged heart)	<input type="checkbox"/>	<input type="text"/> age
atrial fibrillation	<input type="checkbox"/>	<input type="text"/> age
other heart disease	<input type="checkbox"/>	<input type="text"/> age
type of heart disease (please describe)		
high blood pressure – when not pregnant	<input type="checkbox"/>	<input type="text"/> age
stroke	<input type="checkbox"/>	<input type="text"/> age
diabetes	<input type="checkbox"/>	<input type="text"/> age
blood clot (thrombosis)	<input type="checkbox"/>	<input type="text"/> age
asthma	<input type="checkbox"/>	<input type="text"/> age
hayfever	<input type="checkbox"/>	<input type="text"/> age
osteoarthritis	<input type="checkbox"/>	<input type="text"/> age
depression	<input type="checkbox"/>	<input type="text"/> age
anxiety	<input type="checkbox"/>	<input type="text"/> age
Parkinson's disease	<input type="checkbox"/>	<input type="text"/> age
none of these	<input type="checkbox"/>	

23. In the last month have you been treated for:

(if YES, cross the box and give your age when the treatment started)

	Yes	Age started treatment
cancer	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
heart attack or angina	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
other heart disease	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
high blood pressure	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
high blood cholesterol	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
blood clotting problems	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
asthma	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
osteoarthritis	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
thyroid problems	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
osteoporosis or low bone density	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
depression	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
anxiety	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age
none of these	<input type="checkbox"/>	

24. Are you NOW suffering from any other important illness?

Yes No

please describe this illness and its treatment

25. Have you ever had the flu vaccine?

Yes No Unsure

If YES, when did you last have the flu vaccine? /

26. Have you ever had the adult whooping cough vaccine?

Yes No Unsure

If YES, when did you last have the adult whooping cough vaccine? /

27. How much bodily pain have you had during the past 4 weeks?

none moderate
 very mild severe
 mild very severe

28. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

not at all moderately
 a little bit extremely
 quite a bit

29. In the past 4 weeks, have you had pain in your lower back?

Yes No if NO, go to question 30

If YES, was this pain bad enough to limit your usual activities or change your daily routine for more than one day?

Yes No

30. Do you regularly need help with daily tasks because of long-term illness or disability?

(e.g. personal care, getting around, preparing meals)

Yes No if NO, go to question 32

31. If YES, what best describes your situation?

(cross one box)

I need help with tasks and am getting all the help I need
 I need help with tasks and am not getting the help I need

32. Do you regularly care for a sick or disabled family member or friend?

Yes No if NO, go to question 33

If YES, about how much time each week do you usually spend caring for this person?

full time OR hours each week

If YES, do you usually live with the person you care for?

Yes No

33. About how many times a week are you usually troubled by leaking urine?

never once a week or less
 2-3 times 4-6 times every day

34. Have you been through menopause?

No
 Not sure (because of hysterectomy, taking HRT, etc)
 My periods have become irregular
 Yes – How old were you when you went through menopause? years old

35. Have you been for a breast screening mammogram?

Yes No if NO, go to question 36

If YES, what year did you have your last mammogram? (e.g. 2005)

How many times have you been for breast screening altogether?

times

36. Have you ever been screened for colorectal (bowel) cancer?

Yes ▼ No ► if NO, go to question 37

If YES, please indicate which of these test(s) you had:

- faecal occult blood test (test for blood in the stool/faeces)
- sigmoidoscopy (test using a tube to examine the lower bowel: usually done in a doctor's office without pain relief)
- colonoscopy (test using a long tube to examine the whole large bowel; you would usually have an enema or drink large amounts of special liquid to prepare the bowel for this)

What year did you have the most recent one of these tests? (e.g. 2009)

How many bowel screening examinations have you had in the last 5 years?

Were you tested because you received an invitation to be screened for bowel cancer as part of the National Bowel Cancer Screening Program?

Yes No Don't know

Has your doctor ever told you that your bowel screening test results were abnormal or required further investigation?

Yes No Don't know

37. Does your health now LIMIT YOU in any of the following activities?

	YES limited a lot	YES limited a little	NO limited at all
VIGOROUS activities (e.g. running, strenuous sports)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MODERATE activities (e.g. pushing a vacuum cleaner, playing golf)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lifting or carrying shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
walking one kilometre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
walking half a kilometre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
walking 100 metres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bending, kneeling or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

38. In general, how would you rate your:

	excellent	very good	good	fair	poor
overall health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
quality of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
eyesight (with glasses or contact lenses, if you wear them)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
memory?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

39. Which of the following do you have? (excluding Medicare)

- private health insurance – with extras
- private health insurance – without extras
- Department of Veterans' Affairs white or gold card
- health care concession card
- none of these

Questions about time and work

40. What is your usual yearly HOUSEHOLD income before tax, from all sources? (include wages, benefits, pensions, superannuation etc)

- Less than \$5,000
- \$5,000 - \$9,999
- \$10,000 - \$19,999
- \$20,000 - \$29,999
- \$30,000 - \$39,999
- \$40,000 - \$49,999
- \$50,000 - \$59,999
- \$60,000 - \$69,999
- \$70,000 - \$79,999
- \$80,000 - \$89,999
- \$90,000 - \$119,999
- \$120,000 - \$149,999
- \$150,000 or more
- I would rather not answer this question

41. What is your current work status?

(you can cross more than one box)

- in full time paid work
- in part time paid work
- completely retired/pensioner
- partially retired
- disabled/sick
- other
- self-employed
- doing unpaid work
- studying
- looking after home/family
- unemployed

42. If you are partially or completely retired, how old were you when you retired?

years old

Why did you retire? (you can cross more than one box)

- reached usual retirement age
- to care for family member/friend
- made redundant
- to do voluntary work
- lifestyle reasons
- ill health
- could not find a job
- other

43. About how many HOURS each WEEK do you usually spend doing the following? (put "0" if you do not spend any time doing it)

hours per week paid work hours per week voluntary/unpaid work

44. During the LAST 7 DAYS, how much time did you spend SITTING on a usual WEEK day and a usual WEEKEND day:

(write your answers in the spaces provided)

	WEEK day		WEEKEND day	
	hours	minutes	hours	minutes
for TRANSPORT (e.g. in car, bus, train etc)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
at WORK (e.g. sitting at desk or using a computer)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
watching TV	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
using a computer at home (e.g. email, games, information, chatting)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
other leisure activities (e.g. socialising, movies etc but NOT including TV or computer use)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

45. About how many HOURS in each 24 hour DAY do you usually spend doing the following?

(put "0" if you do not spend any time doing it)

hours per day sleeping (including at night and naps) hours per day standing

46. About how many hours a DAY would you usually spend outdoors on a weekday and on the weekend?

hours per day	hours per day
<input type="text"/> <input type="text"/> weekday	<input type="text"/> <input type="text"/> weekend

47. When you are outdoors between 11am and 3pm for more than 5 minutes on sunny days in summer, how often do you wear sunscreen?

never rarely sometimes usually always

48. How many TIMES in the last WEEK did you:

(put "0" if you did not spend any time doing it)

spend time with friends or family who do not live with you?	times in the last week
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
talk to someone (friends, relatives or others) on the telephone?	<input type="text"/> <input type="text"/>
go to meetings of social clubs, religious groups or other groups you belong to?	<input type="text"/> <input type="text"/>

49. How many people outside your home, but within one hour of travel, do you feel you can depend on or feel very close to?

people

50. What is your main (or most common) means of transport?

(cross one box only)

<input type="checkbox"/> car or taxi	<input type="checkbox"/> public transport	<input type="checkbox"/> bicycle
<input type="checkbox"/> motor cycle/scooter	<input type="checkbox"/> mobility scooter	<input type="checkbox"/> walk
<input type="checkbox"/> other		

51. During the past 4 weeks, about how often did you feel:

	none of the time	a little of the time	some of the time	most of the time	all of the time
tired out for no good reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
so nervous that nothing could calm you down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
so restless that you could not sit still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
that everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
so sad that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

52. During the past 4 weeks, about how often did you have any of the following problems?

	none of the time	a little of the time	some of the time	most of the time	all of the time
being irritable, grumpy or in a bad mood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
being unable to stop or control worrying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
trouble falling or staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Questions about your diet

53. Which type of milk do you mostly have? (cross one box only)

<input type="checkbox"/> whole milk	<input type="checkbox"/> reduced fat milk	<input type="checkbox"/> skim milk
<input type="checkbox"/> soy milk	<input type="checkbox"/> other milk	<input type="checkbox"/> I don't drink milk

54. About how many times each WEEK do you eat:

(count all meals and snacks; put "0" if never eaten or if eaten less than once a week)

beef, lamb or pork	number of times eaten each week
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
chicken, turkey or duck	<input type="text"/> <input type="text"/>
processed meat (include bacon, sausages, salami, devon, burgers etc)	<input type="text"/> <input type="text"/>
fish or seafood	<input type="text"/> <input type="text"/>
cheese	<input type="text"/> <input type="text"/>

55. Please put a cross in the box if you NEVER eat:

<input type="checkbox"/> red meat	<input type="checkbox"/> chicken/poultry	<input type="checkbox"/> pork/ham	<input type="checkbox"/> dairy products
<input type="checkbox"/> any meat	<input type="checkbox"/> eggs	<input type="checkbox"/> sugar	<input type="checkbox"/> wheat products
<input type="checkbox"/> fish	<input type="checkbox"/> seafood	<input type="checkbox"/> cream	<input type="checkbox"/> cheese

56. About how many of the following do you usually eat:

<input type="text"/> <input type="text"/>	slices/pieces of brown/wholemeal bread each WEEK (also include multigrain/rye bread etc)
<input type="text"/> <input type="text"/>	bowls of breakfast cereal each WEEK

If you eat breakfast cereal is it usually: (cross main one)

<input type="checkbox"/> bran cereal (allbran, branflakes etc.)
<input type="checkbox"/> biscuit cereal (weetbix, shredded wheat etc.)
<input type="checkbox"/> oat cereal (porridge etc.)
<input type="checkbox"/> muesli
<input type="checkbox"/> other (cornflakes, rice bubbles etc)

57. About how many serves of vegetables do you usually eat each DAY?

A serve is half a cup of cooked vegetables or one cup of salad (put "0" if less than one a day, and include potatoes)

<input type="checkbox"/> I don't eat vegetables
<input type="text"/> <input type="text"/> number of serves of cooked vegetables each day
<input type="text"/> <input type="text"/> number of serves of raw vegetables each day (e.g. salad)

58. About how many serves of fruit or glasses of fruit juice do you usually have each DAY?

A serve is 1 medium piece or 2 small pieces or 1 cup of diced or canned fruit pieces (put "0" if you eat less than one serve a day)

<input type="checkbox"/> I don't eat fruit
<input type="text"/> <input type="text"/> number of serves of fruit each day
<input type="text"/> <input type="text"/> number of glasses of fruit juice each day

**Thank you very much for filling in the questionnaire
WE CAN ONLY USE THIS INFORMATION IF YOU SIGN THE CONSENT FORM OVERLEAF**

Follow-up consent form - please read and sign to participate



**THE 45
AND UP
STUDY**

The 45 and Up Study relies on the willingness of people to share information about their lives and experiences and to have their health followed over time. By signing this form you are agreeing to take part in the 45 and Up Study Follow-up and for that information to be used for health research. Participation is completely voluntary, and you are free to ask questions or to withdraw from the Study at any time by calling the **Study Infoline on 1300 45 11 45**. **More information on the Study can be found at www.saxinstitute.org.au/our-work/45-up-study**

I agree to take part in the 45 and Up Study Follow-up by:

- permitting the long-term storage and use of the information from my questionnaire for health-related research;
- the 45 and Up Study team combining the information I have given in this questionnaire with other health information that is part of the 45 and Up Study, including other questionnaire information and Medicare, medication, hospital, cancer, death and other health-related records, as outlined in the leaflet "Follow-up Questionnaire Information for Participants";

I give my consent on the understanding that:

- **my information will only be used for the purposes outlined in the participant information leaflet** entitled "Follow-up Questionnaire Information for Participants", of which I have a copy;

- **my information will be kept strictly confidential** and will be used for health research only;
- **reports and publications from the Study will be based on de-identified information** and will not identify any individual taking part;
- **my participation in this Study is entirely voluntary** and my consent will continue to be valid following death or disablement unless withdrawn by my next of kin or other person responsible. I am free to withdraw from the 45 and Up Study and/or the 45 and Up Study Follow-up at any time by calling the Study Infoline on 1300 45 11 45;
- **my decision whether or not to take part** in the 45 and Up Study Follow-up or in any additional research will not disadvantage me or affect my future health care in any way.

I have been provided with information about the 45 and Up Study Follow-up, including how it will gather, store, use and disclose information about me, in the participant information leaflet. I have been given an opportunity to ask questions and have been fully informed about the Study.

Title _____ First Name _____ Last Name _____
Your Signature _____ Date Today / /

Is your contact information up to date? Please let us know of any changes

Surname: _____
Given name(s): _____
Postal address: _____
Town or Suburb: _____
State or Territory: _____ Postcode: _____
Home phone: _____ Mobile: _____
Email address: _____

(please complete using block letters)

Sometimes we find that people have moved when we try to contact them again. It would be very helpful if you could give us the contact details of someone close to you (such as a relative or friend) who would be happy for us to contact them if we are unable to reach you. We would only get in touch with that person if we were unable to contact you directly and we would need to tell them our reason for contacting you. Please leave this section blank if you do not wish to provide these extra contact details.

Full name of contact person _____
Phone number of contact person _____

If you have any questions, please ring the **45 and Up Study Infoline on 1300 45 11 45**. You can also write directly to:
Professor Emily Banks, Scientific Director
The 45 and Up Study
GPO Box 5289, Sydney NSW 2001

Please return your questionnaire in the reply paid envelope or post (no stamp required) to:
Confidential
The 45 and Up Study
Reply Paid 1005
BROADWAY NSW 2007

Thank you very much for taking part