

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.

Be sure to complete the questionnaire as shown:

Please shade fully the appropriate box(es)

Place a cross over any incorrect selection you wish to cancel

Place numbers or CAPITAL letters in the appropriate boxes

Yes No

Yes No

0	1	2	3	4	5	6	7	8	9	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

General questions about you

- What is your date of birth?

day	month	year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
- What is today's date?

day	month	year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
- How tall are you without shoes?

cm	OR	feet	inches
<input type="text"/>		<input type="text"/>	<input type="text"/>
<input type="text"/>		<input type="text"/>	<input type="text"/>

(please give to the nearest cm or inch - no decimals or fractions)
- About how much do you weigh?

kg	OR	stone	lbs
<input type="text"/>		<input type="text"/>	<input type="text"/>
<input type="text"/>		<input type="text"/>	<input type="text"/>
- 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? years old

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?)

<input type="text"/>	cigarettes per day	<input type="text"/>	pipes and cigars per day
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- 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	hours per week
<input type="text"/>	<input type="text"/>
at home	in other places (e.g. work, going out, cars)
- About how many alcoholic drinks do you have each week? one drink = a glass of wine, midday of beer or nip of spirits (put "0" if you do not drink, or have less than one drink each week)

<input type="text"/>	number of alcoholic drinks each week
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- On how many days each week do you usually drink alcohol? days each week

- What BEST describes your current situation? (shade one box)

<input type="checkbox"/> single	<input type="checkbox"/> married	<input type="checkbox"/> de facto / living with a partner
<input type="checkbox"/> widowed	<input type="checkbox"/> divorced	<input type="checkbox"/> separated
- What BEST describes your current housing? (shade one box)

<input type="checkbox"/> house	<input type="checkbox"/> flat, unit, apartment	<input type="checkbox"/> house on farm
<input type="checkbox"/> hostel for the aged	<input type="checkbox"/> mobile home	<input type="checkbox"/> other
<input type="checkbox"/> nursing home	<input type="checkbox"/> retirement village, self care unit	
- Including yourself, how many people in total live in your household? people (put "1" if you live alone)
- How many TIMES did you do each of these activities LAST WEEK? (put "0" if you did NOT do this activity)

Walking continuously, for at least 10 minutes (for recreation or exercise or to get to or from places)	times in the last week
<input type="text"/>	<input type="text"/>
Vigorous physical activity (that made you breathe harder or puff and pant, like jogging, cycling, aerobics, competitive tennis, but not household chores or gardening)	<input type="text"/>
Moderate physical activity (like gentle swimming, social tennis, vigorous gardening, or work around the house)	<input type="text"/>
- 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)

Walking continuously, for at least 10 minutes (for recreation or exercise or to get to or from places)	hours	minutes
<input type="text"/>	<input type="text"/>	<input type="text"/>
Vigorous physical activity (that made you breathe harder or puff and pant, like jogging, cycling, aerobics, competitive tennis, but not household chores or gardening)	<input type="text"/>	<input type="text"/>
Moderate physical activity (like gentle swimming, social tennis, vigorous gardening, or work around the house)	<input type="text"/>	<input type="text"/>



Questions about your family

14. Have your mother, father, brother(s) or sister(s) ever had:
blood relatives only: shade the appropriate box(es)

m=mother f=father s/b=sister/brother

	m	f	s/b		m	f	s/b
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:

multivitamins + minerals multivitamins alone

fish oil, omega 3 glucosamine paracetamol with codeine

paracetamol aspirin for the heart aspirin for other reasons

Lipitor Avapro, Karvea warfarin, Coumadin

Pravachol Coversyl, Coversyl Plus Lasix, frusemide

Zocor, Lipex Cardizem, Vasocordol Micardis

Nexium Norvasc Fosamax

Somac Tritace Caltrate

Losec, Acimax omeprazole Noten, Tenormin atenolol Oroxine, thyroxine

Ventolin salbutamol Zyloprim, Pro gout 300 allopurinol Diabex, Diaformin metformin

Zoloff sertraline Cipramil, citalopram Effexor 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

month year

If YES, when did you last donate blood?

/

19. Have you ever been a plasma donor?

Yes No Unsure

month year

If YES, when did you last donate plasma?

/

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? (shade all that apply)

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, shade the box and give your age when the condition was first found)

Yes

age when condition was first found

skin cancer (not melanoma) age

melanoma age

prostate cancer age

other cancer (please describe type of cancer) age

heart failure (cardiac failure, weak heart, enlarged heart) age

atrial fibrillation age

other heart disease (please describe type of heart disease) age

high blood pressure age

stroke age

diabetes age

blood clot (thrombosis) age

enlarged prostate age

asthma age

hayfever age

osteoarthritis age

depression age

anxiety age

Parkinson's disease age

none of these



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

(If YES, shade 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?

month / year

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?

month / year

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 31

If YES, what best describes your situation? (shade 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

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

Yes No if NO, go to question 32

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

32. 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

33. Over the last month, how often have you:

	not at all	some times	often	almost always
found it difficult to postpone urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
had to push or strain to start urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
had a weak urinary stream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stopped and started again several times when you urinated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
had to urinate again less than 2 hours after you finished urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
had the feeling that you had not emptied your bladder completely after urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many times per night do you usually get up to urinate?

never less than once per night times each night

34. How often are you able to get and keep an erection that is firm enough for satisfactory sexual activity?

never sometimes usually always
 I would rather not answer this question

Do you ever use medication (e.g. Viagra) to have an erection that is firm enough for satisfactory sexual activity?

Yes No I would rather not answer this question

35. Have you ever had a blood test ordered by your doctor to check for prostate disease? (PSA test)

Yes No if NO, go to question 36

If YES, what year did you have your last PSA test? (e.g. 2009)

How many times have you had a PSA test 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 not limited at all
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- VIGOROUS activities (e.g. running, strenuous sports)
- MODERATE activities (e.g. pushing a vacuum cleaner, playing golf)
- lifting or carrying shopping
- climbing several flights of stairs
- climbing one flight of stairs
- walking one kilometre
- walking half a kilometre
- walking 100 metres
- bending, kneeling or stooping
- bathing or dressing yourself

38. In general, how would you rate your:

excellent	very good	good	fair	poor
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- overall health?
- quality of life?
- eyesight (with glasses or contact lenses, if you wear them)?
- memory?
- teeth and gums?
- hearing?

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

41. What is your current work status?

- (you can shade more than one box)
- in full time paid work self-employed
 - in part time paid work doing unpaid work
 - completely retired/pensioner studying
 - partially retired looking after home/family
 - disabled/sick unemployed
 - other

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

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

- reached usual retirement age lifestyle reasons
- to care for family member/friend ill health
- made redundant could not find a job
- to do voluntary work 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	hours per week
<input type="text"/> <input type="text"/> <input type="text"/> paid work	<input type="text"/> <input type="text"/> <input type="text"/> 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	hours per day
<input type="text"/> <input type="text"/> sleeping (including at night and naps)	<input type="text"/> <input type="text"/> standing

27072



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

talk to someone (friends, relatives or others) on the telephone?

go to meetings of social clubs, religious groups or other groups you belong to?

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? (shade one box only)

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> car or taxi | <input type="checkbox"/> public transport | <input type="checkbox"/> bicycle |
| <input type="checkbox"/> motorcycle/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? (shade 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)

	number of times eaten each week
beef, lamb or pork	<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 shade the box if you NEVER eat: (shade all that apply)

- | | | | |
|-----------------------------------|--|-----------------------------------|---|
| <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:

slices/pieces of brown/wholemeal bread each WEEK (also include multigrain/rye bread etc)

bowls of breakfast cereal each WEEK

If you eat breakfast cereal is it usually: (shade one box only)

- | |
|---|
| <input type="checkbox"/> bran cereal (All-Bran, Bran Flakes etc.) |
| <input type="checkbox"/> biscuit cereal (Weet-Bix, Shredded Wheat etc.) |
| <input type="checkbox"/> oat cereal (porridge etc.) |
| <input type="checkbox"/> muesli |
| <input type="checkbox"/> other (Corn Flakes, 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)

- I don't eat vegetables

number of serves of cooked vegetables each day

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)

- I don't eat fruit

number of serves of fruit each day

number of glasses of fruit juice each day



Questions about your health care

59. Is there a place you **USUALLY** go when you need healthcare?

- Yes No if NO, go to question 61 Not sure

If YES, is it: (select the main place only)

- GP / family doctor clinic medical specialist clinic
 hospital emergency department other
 hospital outpatient clinic

60. At the place where you **USUALLY** go for healthcare, how often:

	always/ often	some times	rarely/ never	not applicable
can you get a same or next day appointment when you are sick?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
do the medical staff you see know about your medical history?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
does someone help co-ordinate the care you receive from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

61. In the past 2 years, was there ever a time when doctors or other health care professionals failed to share important information about your medical history or treatment with each other?

- Yes No Unsure Not applicable

62. In the past 2 years, have you ever been given the wrong medicine or wrong dose at a pharmacy or while hospitalised?

- Yes No Unsure Not applicable

63. In the past 2 years, do you believe a medical mistake was made in your treatment or care?

- Yes No Unsure Not applicable

64. If you become seriously ill, how confident are you that you will:

	very	some- what	not very	not sure
get high quality care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
receive the most effective medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
be able to afford the care you need?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

65. Have you done any of the following: (shade all that apply)

- discussed your wishes for your future health care with someone close to you?
 legally nominated a person to make health decisions for you if you lose capacity to do this for yourself (e.g. by nominating an enduring power of attorney)?
 written down your wishes for your future health care in a document such as an advanced care directive?
 made a will?

66. Have you ever served in the Australian Defence Force (this includes permanent and reservists)?

- Yes No

67. Are you a client of the Department of Veterans' Affairs or have you received a benefit or support from the Department of Veterans' Affairs?

- Yes No if NO, go to question 68

If YES, what types of benefits or support have you received? (shade all that apply)

- DVA Gold Card
 DVA White Card
 other

Questions about difficult life events

The following questions relate to difficult life events and may be hard to answer. You do not have to respond if you do not want to.

68. When you were growing up in the first 18 years of your life did you see a parent or household member in your home being:

	never	once	a few times	many times
yelled at, screamed at, sworn at, insulted or humiliated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
slapped, kicked, punched, hit, beaten up or cut with an object?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

69. When you were growing up in the first 18 years of your life did a parent, guardian or other household member:

	never	once	a few times	many times
spank, slap, punch, hit, beat or cut you with an object?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

70. Within the last year have you been hit, slapped or physically hurt in other ways?

- Yes – by a partner Yes – by an ex-partner
 Yes – by someone else No

If YES, are you frightened of that person?

- Yes No

If you would like support or would like to talk to someone regarding these questions on difficult life events, please call 1800 737 732. **1800RESPECT.**

**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.

First Name:	Middle Name:
Surname:	Date Today: day month year
Your Signature:	/ / 201

Is your contact information up to date? Please let us know of any changes (please use CAPITAL letters)

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

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

