

45 and Up Study Follow-up Questionnaire for Women

The 45 and Up Study, managed by the Sax Institute, relies on the willingness of its participants to share information about their experiences and health which allows researchers to answer key health questions facing Australia over the coming years. We are contacting you again because we need to find out how your health and lifestyle have changed in the recent past.

To participate in the Follow-up of the 45 and Up Study, please fill in the questionnaire and return it in the envelope provided. A participant information leaflet is also provided. Participation is completely voluntary, and you are free to withdraw from the Study at any time.

For any questions or comments please contact the 45 and Up Study team on 1300 45 11 45 or by email to 45andUp@saxinstitute.org.au

COMPLETION GUIDELINES

To help us read your answers, please write as clearly as possible using a **BLACK** or **DARK BLUE** pen.

Circles are provided where only one choice is permitted
Boxes indicate that multiple responses are permitted

Fully shade the appropriate box(es) / circle(s) Yes No

Place a cross over any incorrect selection you wish to cancel Yes No

Place numbers or CAPITAL letters in appropriate boxes

A	B	C	1	2	3
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For written responses, please cross out your incorrect response and write your new response just above or below the one you have crossed out.

I	N	C	O	R	R	E	C	T

CORRECT

GENERAL QUESTIONS ABOUT YOU

1. What is today's date? day month year

		/			/	2	0	1
--	--	---	--	--	---	---	---	---

2. How tall are you without shoes? cm feet inches

			OR			
--	--	--	----	--	--	--

(give to the nearest cm or inch - no decimals or fractions)

3. About how much do you weigh? kg stone lbs

			OR				
--	--	--	----	--	--	--	--

4. Have you ever been a regular smoker?
 Yes ▼ No ► if No, go to question 8

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

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5. Are you a regular smoker now?
 Yes No

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

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6. 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

7. During the past 12 months, have you stopped smoking for 24 hours or more because you were trying to quit?
 Yes ▼ No

If YES, what is the longest you have stayed quit for in the last 12 months?

		days
		weeks

8. Have you ever tried an electronic cigarette or e-cigarette, even just one time?
 Yes ▼ No

If YES, in the last month, on how many days did you use an e-cigarette? number of days

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9. 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

10. 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 have less than one drink each week)

		number of alcoholic drinks each week
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11. On how many days each week do you usually drink alcohol? days each week

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12. At present do you consider yourself:

<input type="radio"/> a non-drinker	<input type="radio"/> an occasional drinker	<input type="radio"/> a social drinker
<input type="radio"/> an ex-drinker	<input type="radio"/> a light drinker	<input type="radio"/> a heavy drinker
<input type="radio"/> a light drinker	<input type="radio"/> a binge drinker	

If non-drinker or ex-drinker ► go to question 14

13. In a typical month, what is the largest number of drinks you have in one day? drinks

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14. What BEST describes your current situation?

(choose **one** only)

- single
- married
- de facto / living with a partner
- widowed
- divorced
- separated

15. What BEST describes your current housing?

(choose **one** only)

- house
- flat, unit, apartment
- house on farm
- retirement village, self care unit
- nursing home
- hostel for the aged
- mobile home
- other

16. Do you (or any member of this household) own this home, rent it, or do you live here rent free?

- own
- currently paying off mortgage/involved in a rent-buy scheme
- rent (or pay board)
- live here rent free

If you rent this home, do you:

- rent privately
- rent through Housing NSW
- rent through a housing organisation

17. Including yourself, how many people in total live in your household?

people (put "1" if you live alone)

18. 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

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)

19. 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

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)

:

20. Is there anything that stops you from participating in physical activity?

(shade **all** that apply)

- ill health
- no appropriate activities in my area
- no transport to reach activities
- too busy
- not interested
- activities which exist are too expensive
- no access to appropriate childcare
- caring for a family member
- other (please specify)

QUESTIONS ABOUT YOUR FAMILY HISTORY

21. Have your mother, father, brother(s) or sister(s) ever had: (blood relatives only: shade **all that apply)**

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"/>	early onset lung cancer < 60 years	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	late onset lung cancer ≥ 60 years	<input type="checkbox"/>	<input type="checkbox"/>
stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	melanoma	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>
dementia/Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
severe depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hip fracture	<input type="checkbox"/>	<input type="checkbox"/>
severe arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	do not know	<input type="checkbox"/>	<input type="checkbox"/>
breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
bowel cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

22. How many biological (half or full) siblings do you have? (include deceased siblings)

number of brothers number of sisters no siblings do not know

QUESTIONS ABOUT YOUR HEALTH

23. 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

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

Yes No if No, go to question 25

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



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

Yes ▼ No ► if No, go to question 26

If YES, did you take:

- | | |
|--|--|
| <input type="checkbox"/> multivitamins + minerals | <input type="checkbox"/> Micardis, telmisartan |
| <input type="checkbox"/> multivitamins alone | <input type="checkbox"/> Avapro, Karvea, irbesartan |
| <input type="checkbox"/> fish oil, omega 3 | <input type="checkbox"/> warfarin, Coumadin |
| <input type="checkbox"/> Vitamin D | <input type="checkbox"/> Noten, Tenormin, atenolol |
| <input type="checkbox"/> Caltrate, calcium carbonate | <input type="checkbox"/> aspirin for the heart |
| <input type="checkbox"/> Fosamax, alendronate | <input type="checkbox"/> aspirin for other reasons |
| <input type="checkbox"/> glucosamine | <input type="checkbox"/> paracetamol with codeine |
| <input type="checkbox"/> Lipitor, atorvastatin | <input type="checkbox"/> paracetamol |
| <input type="checkbox"/> Pravachol, pravastatin | <input type="checkbox"/> Ventolin, salbutamol |
| <input type="checkbox"/> Cavstat, Crestor, rosuvastatin | <input type="checkbox"/> Diabex, Diaformin, metformin |
| <input type="checkbox"/> Zocor, Lipex | <input type="checkbox"/> Cipramil, citalopram |
| <input type="checkbox"/> Lasix, furosemide, frusemide | <input type="checkbox"/> Zoloft, sertraline |
| <input type="checkbox"/> Norvasc, amlodipine | <input type="checkbox"/> venlafaxine |
| <input type="checkbox"/> Cardizem, Vasocardol, diltiazem anti-hypertensive | <input type="checkbox"/> Nexium, esomeprazole |
| <input type="checkbox"/> Tritace, ramipril | <input type="checkbox"/> Somac, pantoprazole |
| <input type="checkbox"/> Coversyl, Coversyl Plus, perindopril | <input type="checkbox"/> Losec, Acimax, omeprazole |
| | <input type="checkbox"/> Oroxine, thyroxine |
| | <input type="checkbox"/> Zylprim, Progout 300, allopurinol |

(please list any other regular medications or supplements)

26. 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

27. Do you feel you have a hearing loss?

- Yes No

28. Have you ever been a blood donor?

- Yes ▼ No Unsure

If YES, when did you last donate blood? /

29. Have you ever been a plasma donor?

- Yes ▼ No Unsure

If YES, when did you last donate plasma? /

30. Have you ever had a blood transfusion in Australia?

- Yes ▼ No Unsure

If YES, please indicate a reason(s)

- cancer treatment trauma/emergency
 surgery other

31. 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)	<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 (describe type of cancer)	<input type="checkbox"/>	<input type="text"/>	age
lymphoedema	<input type="checkbox"/>	<input type="text"/>	age
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 (describe type of heart disease)	<input type="checkbox"/>	<input type="text"/>	age
high blood pressure - when not pregnant	<input type="checkbox"/>	<input type="text"/>	age
stroke	<input type="checkbox"/>	<input type="text"/>	age
diabetes - type 1	<input type="checkbox"/>	<input type="text"/>	age
diabetes - type 2 or unsure	<input type="checkbox"/>	<input type="text"/>	age
diabetes - gestational	<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"/>		



32. 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"/>			

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

Yes ▼ No

If YES, please list any other illnesses.

34. Have you ever had the flu vaccine?

Yes ▼ No Unsure

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

35. 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

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

none very mild mild
 moderate severe very severe

37. 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 a little bit quite a bit
 moderately extremely

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

Yes ▼ No

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

Yes No

39. 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 YES, what best describes your situation? (choose **one** only)

- 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

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

Yes ▼ No ► if No, go to question 41

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

If YES, do you usually live with the person you care for? Yes No

41. 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

42. Have you been through menopause?

no
 not sure (because of hysterectomy, taking HRT, etc.)
 my periods have become irregular
 yes ▼

If YES, how old were you when you went through menopause? years old

42A. Have you been for a breast screening mammogram?

Yes ▼ No ► if No, go to question 43

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

How many times have you been for breast screening altogether? times



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

Yes ▼ No ► if No, go to question 44

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?

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

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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

44. 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)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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MODERATE activities (e.g. pushing a vacuum cleaner, playing golf)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

lifting or carrying shopping

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

climbing several flights of stairs

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

climbing one flight of stairs

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

walking one kilometre

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

walking half a kilometre

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------	-----------------------

walking 100 metres

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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bending, kneeling or stooping

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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bathing or dressing yourself

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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45. In general, how would you rate your:

	excellent	very good	good	fair	poor
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overall health?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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quality of life?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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eyesight (with glasses or contact lenses, if you wear them)?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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memory?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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teeth and gums?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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hearing?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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46. Thinking about your own life and personal circumstances, how satisfied are you with your life as a whole?

0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

On this scale zero means you feel no satisfaction at all. 10 means you feel completely satisfied.

47. How satisfied are you with:

	0	1	2	3	4	5	6	7	8	9	10
your standard of living?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
your health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
what you are achieving in life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
your personal relationships?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
how safe you feel?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
feeling part of your community?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
your future security?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

48. In the last 12 months have you had a medical problem but avoided seeing a doctor because of the cost of medicine that may be prescribed?

Yes No Don't know

49. In the last 12 months have you not collected, stopped using or cut down the dose of medicine prescribed by your doctor because of the cost?

Yes No Don't know

50. Which of the following do you have (excluding Medicare)? (shade all that apply)

- 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

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

- | | |
|---|---|
| <input type="radio"/> less than \$5,000 | <input type="radio"/> \$70,000 - \$79,999 |
| <input type="radio"/> \$5,000 - \$9,999 | <input type="radio"/> \$80,000 - \$89,999 |
| <input type="radio"/> \$10,000 - \$19,999 | <input type="radio"/> \$90,000 - \$119,999 |
| <input type="radio"/> \$20,000 - \$29,999 | <input type="radio"/> \$120,000 - \$149,999 |
| <input type="radio"/> \$30,000 - \$39,999 | <input type="radio"/> \$150,000 or more |
| <input type="radio"/> \$40,000 - \$49,999 | <input type="radio"/> I would rather not answer this question |
| <input type="radio"/> \$50,000 - \$59,999 | |
| <input type="radio"/> \$60,000 - \$69,999 | |



52. What is your current work status?

(shade all that apply)

- 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

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

years old

54. Why did you retire? (shade all that apply)

- 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

55. 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

voluntary/unpaid work

56. What is your MAIN (or most common) means of transport? (choose one only)

- car or taxi
- motorcycle/scooter
- other
- public transport
- mobility scooter
- bicycle
- walk

QUESTIONS ABOUT ACTIVITIES AND SUPPORT

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

	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"/>

58. 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)

standing

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

hours per day

weekday

weekend

60. How many TIMES in the last WEEK did you:
(put "0" if you did not spend any time doing it)

times in the last week

spend time with friends or family who do not live with you?

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

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

61. 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

62. 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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
so restless that you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
that everything was an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

63. 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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
being unable to stop or control worrying?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
trouble falling or staying asleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
poor appetite?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



QUESTIONS ABOUT YOUR DIET

64. 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

chicken, turkey or duck

processed meat (include bacon, sausages, salami, devon, burgers etc.)

fish or seafood

cheese

65. Which type of milk do you mostly have?

(choose **one** only)

- whole milk reduced fat milk skim milk
 soy milk other milk I don't drink milk

66. Please shade the box if you NEVER eat:

(choose **all** that apply)

- red meat eggs cream
 any meat seafood dairy products
 fish pork/ham wheat products
 chicken/poultry sugar cheese

67. 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:

(choose **one** only)

- bran cereal (*All-Bran, Bran Flakes etc.*)
 biscuit cereal (*Weet-Bix, Shredded Wheat etc.*)
 oat cereal (*porridge etc.*)
 muesli
 other (*Corn Flakes, Rice Bubbles etc.*)

68. 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)

69. 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 ASPIRIN USE

70. Do you take aspirin regularly?

- Yes ▼ No Don't know ▶ If No or Don't know, go to question 71

If YES, when did you start?

years ago

How many years have you taken aspirin, in total? (put "0" if less than one)

total years

Do you take aspirin:

- every day every second day less often

Is each aspirin tablet:

- low dose standard dose (300mg) not sure

QUESTIONS ABOUT TECHNOLOGY USE

71. Do you use a computer or mobile device (e.g. phone with a touch screen, tablet or smart watch) regularly?

- Yes ▼ No ▶ if No, go to question 75

If YES, which of the following devices do you use regularly?

	Yes	No	Unsure
Apple desktop or laptop computer (e.g. iMac, MacBook)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Windows desktop or laptop computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Apple tablet (iPad)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
other tablet (e.g. Samsung, Microsoft Surface, Lenovo)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Apple phone with a touch screen (iPhone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Android phone with a touch screen (e.g. Samsung, Huawei, Google)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
other phone with a touch screen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Apple Watch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
other smart watch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
fitness tracker (e.g. Fitbit, Garmin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



72. If you use applications (apps) on a mobile phone or tablet, how many have you ever downloaded yourself? (choose one only)

- I don't use apps/don't know what apps are
 ► go to question 75
- None 1-5 6 or more

73. How often do you use apps on your mobile phone or tablet to track the following:

	never	less than once a month	at least once a month	at least once a week	every day
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activity or fitness (e.g. number of steps, exercise)

-

vital signs (e.g. heart rate, blood pressure, breathing)

-

nutrition or weight

-

mood or well-being

-

sleep

-

medications (e.g. reminders, alerts)

-

74. Which health or fitness apps do you use? (shade all that apply)

- Apple Health MapMyWalk
 MyFitnessPal Fitbit
 other (please list app name/s)

75. As the use of technology increases, many research studies on health are carried out using applications (apps) developed for mobile phones or tablets. How do you feel about studies by accredited researchers that involve using health research apps:

	good idea	not a good idea	unsure / no opinion
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with questions on health, nutrition, mood etc

-

that are able to use information from health/fitness apps or a fitness tracker

-

QUESTIONS ABOUT YOUR CHILDHOOD

76. What family circumstances did you live in before you were 18 years of age? (choose all that apply)

For what period?
 whole period years

both natural parents

- OR

single parent family

- OR

natural parent and step parent

- OR

grandparents or other relatives as main carers

- OR

adoptive parents

- OR

foster family

- OR

welfare home or an institution (excluding boarding school)

- OR

other living arrangements (specify)

- OR

Thank you for completing the questionnaire

If you have any questions, please ring the **45 and Up Study Infoline on 1300 45 11 45** or email 45andUp@saxinstitute.org.au

You can also write directly to
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

