



45 and Up Study Follow-up Questionnaire for Men



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.

Bubbles are provided where only one choice is permitted

Boxes indicate that multiple responses are permitted

Fully shade the appropriate box(es)/bubble(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
---	---	---	---	---	---

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?

		/			/	2	0	2
day			month			year		

2. How tall are you without shoes?

			OR			
cm				feet	inches	

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

3. About how much do you weigh?

			OR			
kg				stone	lbs	

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

5. Are you a regular smoker now?

Yes No

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

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 days

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

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
--	--	--------------------------------------

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

		days each week
--	--	----------------

12. At present do you consider yourself:

- a non-drinker a social drinker
 an ex-drinker a heavy drinker
 an occasional drinker a binge drinker
 a light 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 widowed
 married divorced
 de facto/living with a partner separated

15. What BEST describes your current housing?

(choose **one** only)

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

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

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

(put "1" if you live alone)

people

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) times in the last week

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

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)**

- | | |
|---|---|
| <input type="checkbox"/> ill health | <input type="checkbox"/> not interested |
| <input type="checkbox"/> no appropriate activities in my area | <input type="checkbox"/> activities which exist are too expensive |
| <input type="checkbox"/> no transport to reach activities | <input type="checkbox"/> no access to appropriate childcare |
| <input type="checkbox"/> too busy | <input type="checkbox"/> caring for a family member |
| | <input type="checkbox"/> 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"/>	bowel cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	early onset lung cancer < 60 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	late onset lung cancer ≥ 60 years	<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"/>
breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	do not know	<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"/> Avapro, Karvea, irbesartan |
| <input type="checkbox"/> multivitamins alone | <input type="checkbox"/> warfarin, Coumadin |
| <input type="checkbox"/> fish oil, omega 3 | <input type="checkbox"/> Noten, Tenormin, atenolol |
| <input type="checkbox"/> Vitamin D | <input type="checkbox"/> aspirin for the heart |
| <input type="checkbox"/> Caltrate, calcium carbonate | <input type="checkbox"/> aspirin for other reasons |
| <input type="checkbox"/> Fosamax, alendronate | <input type="checkbox"/> paracetamol with codeine |
| <input type="checkbox"/> glucosamine | <input type="checkbox"/> paracetamol |
| <input type="checkbox"/> Lipitor, atorvastatin | <input type="checkbox"/> Ventolin, salbutamol |
| <input type="checkbox"/> Pravachol, pravastatin | <input type="checkbox"/> Diabex, Diaformin, metformin |
| <input type="checkbox"/> Cavstat, Crestor, rosuvastatin | <input type="checkbox"/> Cipramil, citalopram |
| <input type="checkbox"/> Zocor, Lipex | <input type="checkbox"/> Zoloft, sertraline |
| <input type="checkbox"/> Lasix, furosemide, frusemide | <input type="checkbox"/> venlafaxine |
| <input type="checkbox"/> Norvasc, amlodipine | <input type="checkbox"/> Nexium, esomeprazole |
| <input type="checkbox"/> Cardizem, Vasocardol, diltiazem anti-hypertensive | <input type="checkbox"/> Somac, pantoprazole |
| <input type="checkbox"/> Tritace, ramipril | <input type="checkbox"/> Losec, Acimax, omeprazole |
| <input type="checkbox"/> Coversyl, Coversyl Plus, perindopril | <input type="checkbox"/> Oroxine, thyroxine |
| <input type="checkbox"/> Micardis, telmisartan | <input type="checkbox"/> Zyloprim, Progot 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? /
month year

29. Have you ever been a plasma donor?

Yes ▼ No Unsure

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

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
prostate cancer	<input type="checkbox"/>	<input type="text"/> age
other cancer	<input checked="" type="checkbox"/>	<input type="text"/> age

(describe type of cancer)

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	<input type="checkbox"/>	<input type="text"/> age

(describe type of heart disease)

high blood pressure	<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
enlarged prostate	<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	age
cancer	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
heart attack or angina	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
other heart disease	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
high blood pressure	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
high blood cholesterol	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
blood clotting problems	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
asthma	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
osteoarthritis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
thyroid problems	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
osteoporosis or low bone density	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
depression	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
anxiety	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
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 ever had a blood test ordered by your doctor to check for prostate disease? (PSA test)

Yes ▼ No ► if No, go to question 43

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





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?

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

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
VIGOROUS activities (e.g. running, strenuous sports)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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"/>
bending, kneeling or stooping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
bathing or dressing yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

45. In general, how would you rate your:

	excellent	very good	good	fair	poor
overall health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
quality of life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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"/>
memory?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
teeth and gums?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
hearing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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)

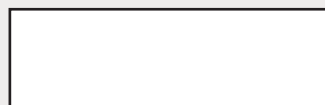
- private health insurance – with extras
- private health insurance – without extras
- Department of Veterans' Affairs White or Gold Card
- health care concession card
- none of these

QUESTIONS ABOUT TIME AND WORK

51. What is your usual yearly HOUSEHOLD income before tax, from all sources?

(include wages, benefits, pensions, superannuation etc.)

- 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





52. What is your current work status?

(shade **all** that apply)

- | | |
|---|--|
| <input type="checkbox"/> in full time paid work | <input type="checkbox"/> self-employed |
| <input type="checkbox"/> in part time paid work | <input type="checkbox"/> doing unpaid work |
| <input type="checkbox"/> completely retired/pensioner | <input type="checkbox"/> studying |
| <input type="checkbox"/> partially retired | <input type="checkbox"/> looking after home/family |
| <input type="checkbox"/> disabled/sick | <input type="checkbox"/> unemployed |
| <input type="checkbox"/> other | |

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)**

- | | |
|---|---|
| <input type="checkbox"/> reached usual retirement age | <input type="checkbox"/> lifestyle reasons |
| <input type="checkbox"/> to care for family member/friend | <input type="checkbox"/> ill health |
| <input type="checkbox"/> made redundant | <input type="checkbox"/> could not find a job |
| <input type="checkbox"/> to do voluntary work | <input type="checkbox"/> 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	<input type="text"/>	<input type="text"/>	<input type="text"/>	paid work
	<input type="text"/>	<input type="text"/>	<input type="text"/>	voluntary/unpaid work

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

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	<input type="text"/>	<input type="text"/>	sleeping (including at night and naps)
	<input type="text"/>	<input type="text"/>	standing

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

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

60. 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?	<input type="text"/>	<input type="text"/>	times in the last week
talk to someone (friends, relatives or others) on the telephone?	<input type="text"/>	<input type="text"/>	times in the last week
go to meetings of social clubs, religious groups or other groups you belong to?	<input type="text"/>	<input type="text"/>	times in the last week

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

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: (shade **all** that apply)

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

70. In the last twelve months, were there any times that you ran out of food and couldn't afford to buy more?

Yes No

QUESTIONS ABOUT ASPIRIN USE

71. Do you take aspirin regularly?

Yes No Don't know ▶ if No or Don't know, go to question 72

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 YOUR CHILDHOOD

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

	For what period?	
	whole period	years
both natural parents	<input type="checkbox"/>	OR <input type="text"/> <input type="text"/>
single parent family	<input type="checkbox"/>	OR <input type="text"/> <input type="text"/>
natural parent and step parent	<input type="checkbox"/>	OR <input type="text"/> <input type="text"/>
grandparents or other relatives as main carers	<input type="checkbox"/>	OR <input type="text"/> <input type="text"/>
adoptive parents	<input type="checkbox"/>	OR <input type="text"/> <input type="text"/>
foster family	<input type="checkbox"/>	OR <input type="text"/> <input type="text"/>
welfare home or an institution (excluding boarding school)	<input type="checkbox"/>	OR <input type="text"/> <input type="text"/>
other living arrangements (specify)	<input type="checkbox"/>	OR <input type="text"/> <input type="text"/>
	<input type="text"/>	
	<input type="text"/>	

QUESTIONS ABOUT COPD

73. 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
chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/>	<input type="text"/> <input type="text"/> age





QUESTIONS ABOUT MEDICAL EXPENSES

74. In the past 12 months, about how much have you spent out-of-pocket on YOUR healthcare? Please EXCLUDE costs covered by Medicare or private health insurance.

	N/A	\$0	\$1-\$250	\$251-\$1000	\$1001-\$10,000	more than \$10,000
medications (prescription or over the counter)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
doctors, specialists (e.g. GP, oncologist)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
medical tests (e.g. x-rays, pathology)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
hospitalisation/outpatient (e.g. surgery)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
dental care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
allied health care (e.g. physiotherapy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
other complementary/alternative treatments (e.g. naturopathy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
medical equipment (e.g. crutches)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
practical/travel (e.g. parking, accommodation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
home/other modifications (e.g. ramps)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
any other healthcare costs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

75. In the past 12 months, about how much did you spend out-of-pocket on YOUR healthcare for all of the above combined?

- \$0 \$10,001-\$25,000
 \$1-\$250 more than \$25,000
 \$251-\$1000 unsure
 \$1001-\$10,000

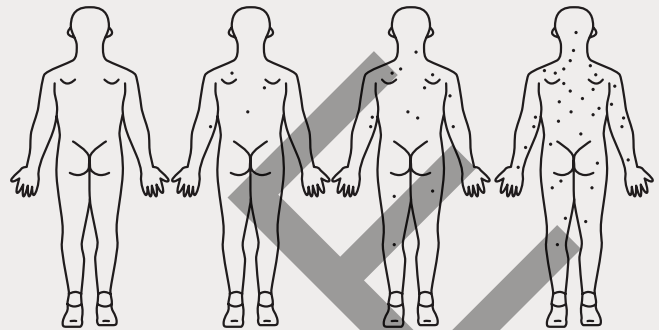
76. In the past 12 months, did you delay or go without a medical test, treatment, or follow-up that was recommended by a doctor, because of a shortage of money?

- Yes No Unsure

QUESTIONS ABOUT YOUR SKIN HEALTH

77. Most people have some moles. Moles are brown spots that do not come and go with sunlight. Some are flat and look almost like a freckle while others are raised or bumpy if you run your fingers over them. Spotty freckles on the upper back or shoulders are not moles.

Which one of these diagrams best illustrates your moles?



- none few some many

78. In the past 12 months, have you had a health professional (e.g. a doctor, specialist or nurse) check at least some of your skin for any suspicious spots that might be skin cancer?

- Yes No

If YES:

a) Was it

- all or nearly all of your body
 part of your body
 checking a specific mole or spot

b) How many times in the past 12 months did you have your skin checked by a health professional?

times

QUESTIONS ABOUT GENETIC TESTING

79. Have you ever had genetic testing?

- Yes No Don't know/don't want to say

▶ if No or Don't know, go to question 81

80. What did the genetic testing aim to determine?

(shade all that apply)

- disease risk, diagnosis or treatment
 my ancestry
 other (e.g. targeting diet or fitness)
 don't know/don't want to say





QUESTIONS ABOUT COVID-19

The following questions are about the novel coronavirus (COVID-19) and how it has affected you. The COVID-19 outbreak was first identified in Australia in January 2020 and unless otherwise specified the following questions relate to the time since January 2020.

81. Are you or have you been infected with COVID-19?

- Yes, had positive test result
- I think so, but not confirmed
- No
- Don't know

82. If you have been tested for COVID-19, when were you last tested?

		/	2	0	2	
month			year			

- I have not been tested for COVID-19

83. Since January 2020 have you:

	Yes	No	Don't know
had someone in your household known to have COVID-19?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
had close personal contact with someone outside your house known to have COVID-19?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
travelled overseas or on a cruise ship?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
worked in an aged care facility or hospital?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
had other exposure to COVID-19?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

(if other exposure, please specify)

84. During the COVID-19 outbreak, how often did you wear a face mask when you were in close personal contact with others outside of your household?

- never
- rarely
- sometimes
- often
- all the time

85. Did you reduce your personal contact with other people because of the COVID-19 outbreak?

- Yes ▼ No

If YES, what were the reasons you reduced contact? (shade all that apply)

- concerns about your own health
- concern for others' health
- government recommendations
- government restrictions

86. During the COVID-19 outbreak:

	not at all	a little	moderately	very	extremely
how uncertain did you feel about the future?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
how concerned were you that you would get sick with COVID-19?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
how concerned were you that your family or friends would get sick with COVID-19?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
how confused were you about information you read or heard about COVID-19?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
how worried were you about your financial situation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

87. As a result of COVID-19, has your financial situation changed?

- Yes ▼ No Don't know

If YES, my financial situation is:

- a lot worse
- slightly worse
- same
- slightly better
- a lot better





88. How confident are you:

	not at all	a little	moderately	very	extremely
in your knowledge about COVID-19 prevention?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
in your knowledge about social distancing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
that you have all the necessary information to make decisions about COVID-19 prevention?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
filling out medical forms by yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

89. The next question relates to how you are CURRENTLY feeling:

	Yes	More or less	No
I experience a general sense of emptiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
there are plenty of people I can rely on when I have problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
there are many people I can trust completely	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
there are enough people I feel close to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I miss having people around	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I often feel rejected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

90. As a result of the COVID-19 outbreak, I feel:

	a lot worse	a little worse	the same	a little better	a lot better
my overall health has been	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
my emotional and psychological health has been	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

91. As a result of COVID-19, have you missed or delayed any of the following health care services?

	Yes	No
a visit to a GP	<input type="radio"/>	<input type="radio"/>
a visit to a specialist doctor	<input type="radio"/>	<input type="radio"/>
hospital care	<input type="radio"/>	<input type="radio"/>
a blood test	<input type="radio"/>	<input type="radio"/>
psychological or emotional health care	<input type="radio"/>	<input type="radio"/>
an aged care service	<input type="radio"/>	<input type="radio"/>
a vaccination	<input type="radio"/>	<input type="radio"/>
cancer screening	<input type="radio"/>	<input type="radio"/>
a dental visit	<input type="radio"/>	<input type="radio"/>
getting a regular prescription medication	<input type="radio"/>	<input type="radio"/>
getting non-prescription medication	<input type="radio"/>	<input type="radio"/>
other health care you needed	<input type="radio"/>	<input type="radio"/>

(please specify)

92. If you selected YES in ANY of the above, did your health get worse because of missing the health care service?

Yes
 No
 Don't know
 Not applicable

93. Since January 2020, have you used telehealth services (an appointment with a health care provider by video or phone instead of an in-person visit)?

Yes No ► if No, go to question 98





94. If you used telehealth services, were they done by:

- telephone
- video
- both

95. How did the telehealth services compare to a traditional in-person medical visit?

- better than a traditional visit
- just as good as a traditional visit
- worse than a traditional visit
- not sure

96. How likely would you be to recommend telehealth services to someone else?

- definitely will not
- probably will not
- probably will
- definitely will

97. How useful do you think it will be to have appointments via telehealth after the COVID-19 emergency is over?

- not at all
- slightly
- moderately
- very
- extremely

98. Compared with 12 months ago, how much time did you spend in the LAST WEEK doing the following activities?

Compared with 12 months ago, I spent:

	less time	similar time	more time
walking continuously for at least 10 minutes <i>(for recreation or exercise or to get to or from places)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
vigorous physical activity <i>(that made you puff and pant, like jogging, but not household chores or gardening)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
moderate physical activity <i>(that made you breathe somewhat harder, like gentle swimming or vigorous gardening)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
overall physical activity <i>(counting everything mentioned above)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
sleeping <i>(including at night and naps)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

99. How often do you get COVID-19 information from the following?

Use the scale below to shade the bubbles, where 1 indicates never, and 7 indicates very often.

	never						very often
	1	2	3	4	5	6	7
public TV or radio <i>(e.g. ABC or SBS)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
commercial TV or radio	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
social media (e.g. Facebook, Twitter etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
newspapers (online and print)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
government websites or sources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
your doctor or your other healthcare providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
family and friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





100. How MUCH do you trust the following sources of information in their reporting about COVID-19?

Use the scale below to shade the bubbles, where 1 indicates no trust, and 7 indicates a great deal of trust.

	very little trust			a great deal of trust			
	1	2	3	4	5	6	7
public TV or radio (e.g. ABC or SBS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
commercial TV or radio	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
social media (e.g. Facebook, Twitter etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
newspapers (online and print)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
government websites or sources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
your doctor or your other healthcare providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
family and friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

101. There are many ways 45 and Up participants can support COVID-19 research. Would you consider participating in any of the following approved research?

	Yes	No	Maybe
short online surveys	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
providing a blood sample to a registered pathology clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
providing a saliva sample through a home delivered testing kit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 90441
SILVERWATER NSW 1811

