DEMOGRAPHY

D1. Date of Birth: __/__/__

D2. Gender: □ Male □ Female

D3. Marital status: □ Single □ Married □ Widowed □ Divorced □ Separated □ De Facto

D4. Which of the following describes your current situation?  
   □ Retired  □ In paid employment or self-employed  □ Unable to work due to sickness or disability  
   □ Unemployed □ Doing unpaid or voluntary work □ Looking after home and/or family  
   □ None of the above

D5. What has been your usual occupation or job (the one you have worked at the longest)?

D6. For how many years have you worked at this job? ___ years

D7. What is your current occupation (different from above)?

D8. What is the average annual total income before tax received by your household?
   (Please include all wages, salaries, government benefits, pensions, allowances and other income the person usually receives.)
   □ Less than $20,000  □ $20,001 to $40,000  □ $40,001 to $60,000  □ $60,001 to $80,000  □ $80,001 and over
   □ None of the above  □ Prefer not to say

D9. What is the highest level of education you have completed?
   □ Primary school □ Secondary school □ Other educational institute (e.g. TAFE, college)
   □ University □ Did not go to school

D9a. How old were you when you completed your continuous full-time education? ___ years old

D10. What type of accommodation do you live in?
   □ A house □ A unit/apartment/mews house  
   □ Mobile or temporary structure (e.g. caravan, park home) □ None of the above

D11. The dwelling is:
   □ Owned outright □ Owned with a mortgage □ Being purchased under a mortgage scheme  
   □ Being rented □ Being occupied rent free □ Being occupied under a lease or tenancy scheme  
   □ None of the above

D12. For how many years have you lived at this address? ___ years  □ less than a year

D13. Please describe which group(s) best defines the ancestry/ethnicity (based on a mixture of culture, religion, skin colour and language) of you and your biological parents. You may choose more than one group for each person.

A. Caucasian - Australia/New Zealand
   - European, Europe (includes Russia, Central and West Asia) & North Mediterranean, America, Canada, South Africa & Zimbabwe.
B. Indigenous Australian - Aboriginal, Torres Strait Islander.
C. Pacific Islander - New Zealand Moari or Pacific Islander, Hawaii, New Guinean.
D. South East Asian - Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar/Burma, Philippines, Singapore, Thailand, Vietnam.
E. South Asian - Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka.
F. North East Asia - China, Hong Kong, Japan, Korea, Macau, Taiwan.
G. North Asia - Mongolia, Siberia.
H. Middle Eastern, North Africa, Somalia Peninsula - Algeria, Bahrain, Iraq, Jordan, Kuwait, Lebanon, Libya, Oman, Palestinian Territories, Turkey, Turkmenistan, Qatar, Saudi Arabia, Somalia, Syria, Yemen, United Arab Emirates, Yemen.
J. Central/South American - Central/South America.
K. Other: __________________________
   - (please specify below)
L. Don't know
   - (please specify below)

D13a. Your Biological Father: __________________________
   - (please specify below)

D13b. Your Biological Mother: __________________________
   - (please specify below)

D13c. You: __________________________
   - (please specify below)

D14. If other, please specify for each:

   D14a. Your biological father: __________________________
   - (please specify below)

   D14b. Your biological mother: __________________________
   - (please specify below)

   D14c. You: __________________________
   - (please specify below)

D15. In which country were you born?

Page 1 of 40
Participant Questionnaire V4
Busselton Healthy Ageing Study

Page 2 of 40
Participant Questionnaire V4
Busselton Healthy Ageing Study
### SMOKING HISTORY

- **SM1.** Have you ever smoked cigarettes?
  - No
  - Yes (YES means more than 1 cigarette per day for a year, or 30 packs in a lifetime)

- **SM2.** Do you currently smoke manufactured or hand-rolled cigarettes?
  - No
  - Yes

- **SM3.** How many cigarettes per day do you smoke?
  - Cigarettes per day

- **SM4.** At what age did you start smoking?
  - Years old

- **SM5.** How old were you when you last stopped smoking?
  - Years old

- **SM6.** How many people in your household currently smoke (excluding yourself)?
  - People

- **SM7.** Are you exposed to tobacco smoke at work?
  - Yes
  - No
  - I don't work

### GENERAL HEALTH

**GH1.** In the last 2 years, have you experienced any of the following? (select all that apply)
- Serious illness, injury or assault to yourself
- Serious illness, injury or assault to a close relative
- Death of a close relative
- Death of a spouse or partner
- Marital separation/divorce
- Financial difficulties
- None of the above

**GH2.** Do you have any long-standing illness, disability or infirmity?
- No
- Yes

These next questions ask for your views about your health. This information will help to keep track of how you feel and how well you are able to do your usual activities. For each of the following questions, please fill in the circle that best describes your answer.

**GH3.** In general, would you say your health is:
- Excellent
- Very good
- Good
- Fair
- Poor

**GH4.** The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- **GH4a.** Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf.
  - No, not limited at all
  - Yes, limited a little
  - Yes, limited a lot
  - Not limited at all

- **GH4b.** Climbing several flights of stairs.
  - No, not limited at all
  - Yes, limited a little
  - Yes, limited a lot
  - Not limited at all

**GH5.** During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

<table>
<thead>
<tr>
<th>Activity</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accustomed less than you would like</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were limited in the kind of work or other regular activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GH6.** During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

<table>
<thead>
<tr>
<th>Activity</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accustomed less than you would like</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did work or other activities less carefully than usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GH7.** 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
- Moderately
- A lot
- Extremely

**GH8.** These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

<table>
<thead>
<tr>
<th>Activity</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you felt calm and peaceful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you have a lot of energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt downhearted and depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GH9.** During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives etc.)?

<table>
<thead>
<tr>
<th>Activity</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### DIET AND NUTRITION

**DN1.** Approximately how many times each week do you eat the following, including all meals and snacks: Write '0' if never eaten or eaten less than once a week.

- [ ] free, lamb or pork
- [ ] cheese
- [ ] chicken, turkey or duck
- [ ] processed meat (includes bacon, sausages, salami, bologna, burgers, etc.)
- [ ] fish or seafood

**DN2.** Approximately how many of the following do you usually eat per week: Write '0' if never eaten or eaten less than once a week.

- [ ] White or plain of brown/wholemeal bread each week (also include multigrain, rye bread, etc.)
- [ ] Bowls of breakfast cereal per week

If you eat breakfast cereal, in it usually:
- [ ] bran cereal (atton, branflakes, etc.)
- [ ] muesli
- [ ] instant cereal (wheat, toasted wheat, etc.)
- [ ] other (cornflakes, rice bubbles, etc.)
- [ ] oat cereal (porridge, etc.)

**DN3.** What type of milk do you usually drink?

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

**DN4.** Approximately how many serves of vegetables do you usually eat each day? One serve equals half a cup of cooked vegetables or one cup of salad. Please include potatoes and write '0' if less than one a day.

- [ ] number of serves of COOKED vegetables each day
- [ ] number of serves of RAW vegetables each day (e.g., salad)
- [ ] I don't eat vegetables

**DN5.** Approximately how many serves of fruit or glasses of fruit juice do you usually have each day? One serve is 1 medium piece or 2 small pieces or 1 cup of sliced or canned fruit pieces.

- [ ] number of serves of fruit each day
- [ ] number of glasses of fruit juice each day
- [ ] I don't eat fruit

**DN6.** Please fill in the circle if you NEVER eat:

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

---

### DIET AND NUTRITION (continued)

The following questions are about how often you drink alcohol.

**DN7.** Over the last 12 months, how often did you drink beer, wine and/or spirits?

<table>
<thead>
<tr>
<th>How often</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 times</td>
<td>1-2 times</td>
<td>3-4 times</td>
<td>5-6 times</td>
<td>7 times</td>
<td>8 times</td>
<td>9 times</td>
<td>10 times</td>
<td>11 times</td>
<td>12 times</td>
</tr>
</tbody>
</table>

**DN7a.** Beer (low alcohol)

**DN7b.** Beer (full strength)

**DN7c.** Red wine

**DN7d.** White wine (include sparkling wines)

**DN7e.** Fortified wines, port, sherry, etc.

**DN7f.** Spirits, liqueurs, etc.

---

### IF YOU HAVE NOT CONSUMED ANY ALCOHOL IN THE LAST 12 MONTHS

**Please go to question 9D on page 5.**

When answering the next two questions, please convert the amounts you drank into glasses using the examples given below:

For spirits, liqueurs and mixed drinks containing spirits, please count each nip (35ml) as one glass.

- 1 can or bottle of beer = 2 glasses
- 1 bottle of wine (750ml) = 5 glasses
- 1 large bottle of beer (750ml) = 4 glasses
- 1 bottle of port or sherry (750ml) = 12 glasses

**DN8.** Over the last 12 months, on days when you were drinking, how many glasses of beer, wine and/or spirits altogether did you usually drink?

<table>
<thead>
<tr>
<th>Number of glasses per day</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 or more</th>
</tr>
</thead>
</table>

**DN9.** Over the last 12 months, what was the maximum number of glasses of beer, wine and/or spirits that you drank in 24 hours?

<table>
<thead>
<tr>
<th>Maximum number of glasses per 24 hours</th>
<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
<th>7-8</th>
<th>9-10</th>
<th>11-12</th>
<th>13-14</th>
<th>15-16</th>
<th>17-18</th>
<th>19 or more</th>
</tr>
</thead>
</table>
**MEDICATION**

*Please provide as much information as you can about your medications. Thank you.*

**MED1.** Do you currently take medication(s) prescribed by a doctor?
- **Yes**
- **No** ← please go to MED2

**MED2.** Please list your doctor prescribed medications. If possible, please copy the name of each medicine exactly as it appears on the package or container (include tablets, pills, eye drops, creams, patches, suppositories, injections).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
</table>

**MED3.** Please list your current medication which is purchased from a pharmacy, without a prescription. If possible, please copy the name of each medicine exactly as it appears on the package or container (include vitamin & supplements, tablets, pills, cream, patches, suppositories, aspirin etc).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
</table>

**MEDICAL HISTORY**

We would be grateful if you could indicate if your doctor has ever told you that you had any of the following conditions. If you answer "Yes", please write how old you were when you were first diagnosed (in the box to the right). Thank you for working through this list.

**CANCER**

<table>
<thead>
<tr>
<th>MH1a.</th>
<th>Cancer</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CARDIOVASCULAR DISEASE**

| MH2. Angina | No | Yes | yrs |
| MH3. Claudication | No | Yes | yrs |
| MH4. High blood pressure | No | Yes | yrs |
| MH5. High cholesterol | No | Yes | yrs |
| MH6. Implant of cardiac pacemaker | No | Yes | yrs |
| MH7. Myocardial infarction / Heart attack | No | Yes | yrs |
| MH8. Transient ischaemic attack (TIA) | No | Yes | yrs |
| MH9. Stroke | No | Yes | yrs |
| MH10. Carotid surgery (endarterectomy or stent) | No | Yes | yrs |
| MH11. Coronary angioplasty or stent | No | Yes | yrs |
| MH12. Coronary bypass | No | Yes | yrs |

**DIABETES**

| MH13. Diabetes | No | Yes | yrs |
| MH13a. | | | |
| Type 1 diabetes (also known as insulin dependent diabetes) | No | Yes | yrs |
| Type 2 diabetes (also known as non-insulin dependent diabetes) | No | Yes | yrs |

**ENDOCRINE DISEASE**

<p>| MH15. Osteoporosis | No | Yes | yrs |
| MH16. Kidney disease | No | Yes | yrs |
| MH17. Thyroid disease | No | Yes | yrs |</p>
<table>
<thead>
<tr>
<th>Neurological Conditions</th>
<th>If yes, age when first diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer's disease</td>
<td>No</td>
</tr>
<tr>
<td>Vascular dementia (Multi-infarct dementia)</td>
<td>No</td>
</tr>
<tr>
<td>Parkinson's disease</td>
<td>No</td>
</tr>
<tr>
<td>Attention Deficit (Hyperactivity) Disorder (AD/HD)</td>
<td>No</td>
</tr>
<tr>
<td>Anxiety disorder (including Post Traumatic Stress Disorder)</td>
<td>No</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>No</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>No</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergies and Respiratory Disease</th>
<th>If yes, age when first diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma or bronchial asthma</td>
<td>No</td>
</tr>
<tr>
<td>Eczema</td>
<td>No</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>No</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD)</td>
<td>No</td>
</tr>
<tr>
<td>Hay fever or allergic rhinitis</td>
<td>No</td>
</tr>
<tr>
<td>Pleurisy</td>
<td>No</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>No</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sleep Problems</th>
<th>If yes, age when first diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcolepsy</td>
<td>No</td>
</tr>
<tr>
<td>Obstructive sleep apnoea</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal Disorders</th>
<th>If yes, age when first diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon polyp</td>
<td>No</td>
</tr>
<tr>
<td>Coeliac disease</td>
<td>No</td>
</tr>
<tr>
<td>Gastro-oesophageal reflux disease</td>
<td>No</td>
</tr>
<tr>
<td>Hiatus Hernia</td>
<td>No</td>
</tr>
<tr>
<td>Crohn's disease</td>
<td>No</td>
</tr>
<tr>
<td>Ulcerative colitis (or proctitis)</td>
<td>No</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
<td>No</td>
</tr>
<tr>
<td>Diverticular disease</td>
<td>No</td>
</tr>
<tr>
<td>Gallstones</td>
<td>No</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Medical Conditions</th>
<th>If yes, age when first diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic ear infection</td>
<td>No</td>
</tr>
<tr>
<td>Meniere's Disease</td>
<td>No</td>
</tr>
<tr>
<td>Trauma to the head or neck</td>
<td>No</td>
</tr>
<tr>
<td>Anemia</td>
<td>No</td>
</tr>
<tr>
<td>Arthritis</td>
<td>No</td>
</tr>
<tr>
<td>Migraine</td>
<td>No</td>
</tr>
<tr>
<td>Headache</td>
<td>No</td>
</tr>
<tr>
<td>Cirrhosis of the liver</td>
<td>No</td>
</tr>
<tr>
<td>Fatty liver</td>
<td>No</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>No</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>No</td>
</tr>
</tbody>
</table>
MEDICAL HISTORY (continued)

OTHER MEDICAL CONDITION (continued)

MH50. Other major medical condition(s)

If Yes, please specify below

Condition 1

Yes

Condition 2

Yes

Condition 3

Yes

Condition 4

Yes

HEAD INJURY

It helps if we know about any history of head injury, even old injuries that occurred as a child.

H1a. Have you ever sustained any head injury involving loss of consciousness?

☐ No --> please go to EARS AND HEARING EH1 on page 12

☐ Yes

H1b. If yes, when did the head injury occur?

dd mm yyyy

H1c. If you were hospitalized at the time, how long were you in hospital for?

[ ] days [ ] months [ ] years ☐ Don't know

EARS AND HEARING

EH1. Have you worked in a place where it was so noisy that you had to raise your voice to be heard by others?

☐ No --> please go to EH1c

☐ Yes

EH1a. If yes, did you wear hearing protection?

☐ Never ☐ Occasionally ☐ Frequently ☐ Always

EH1b. Do you have a hearing impairment?

☐ No --> please go to EH2

☐ Yes

EH1c. If you have a hearing impairment, does it affect your daily life and activities?

☐ Not at all ☐ Occasionally ☐ Frequently ☐ Constantly

EH1d. Do you use a hearing aid or other hearing device?

☐ No

☐ Hearing aid in one ear

☐ Hearing aid in both ears

☐ Cochlear implant

☐ Bone anchored hearing aid (BAHA)

EH2. Do you experience tinnitus [sound in your ears and head] for longer than 5 minutes, which does not have an obvious cause?

☐ No --> please go to EH3 on page 13

☐ Yes

EH2a. What is the frequency of your tinnitus?

☐ Intermittent ☐ Constant

EH2b. What is the nature of your tinnitus?

☐ Ringing or buzzing ☐ Roaring ☐ Pulsing ☐ Other

EH2c. How does tinnitus affect your daily life and activities?

☐ Not at all ☐ Occasionally ☐ Frequently ☐ Constantly
### EARS AND HEARING (continued)

#### EH3 - HYPERACUSIS (INTOLERANCE TO SOUND)

**EH3a. Do you consider yourself sensitive or intolerant to everyday sounds?**
- No ❌
- Yes ⧫

**EH3b. Is it possible for you to concentrate on a task if it is not completely quiet around you?**
- No ❌
- Yes ⧫

**EH3c. Are you sensitive to any of these sounds? (select all that apply)**
- Noise ⧫
- Paper ⧫
- Talk ⧫
- Music ⧫
- Clatter ⧫
- Mechanical and mechanical sounds ⧫
- Other ⧫

**EH3d. How do you feel when you are exposed to these sounds? (select all that apply)**
- Tense ⧫
- Afraid ⧫
- Distressed ⧫
- Angry ⧫
- Vague ⧫
- Nervous ⧫
- Frustrated ⧫

**EH3e. If you are intolerant to some sound, how often does it affect your daily life and activities?**
- Not at all ⧫
- Occasionally ⧫
- Frequently ⧫
- Constantly ⧫

#### EH4 - IMBALANCE (continued)

**EH4a. Do you experience any imbalance or dizziness?**
- No ❌
- Yes ⧫

**EH4b. What is the nature of your imbalance or dizziness? (Select all that apply)**
- Spinning or sensation of movement ⧫
- Light-headedness ⧫
- Unsteadiness on feet ⧫

**EH4c. How often do you experience this imbalance or dizziness?**
- Daily ⧫
- Weekly ⧫
- Monthly ⧫
- Less frequent than monthly ⧫

**EH4d. How long do the specific episodes of imbalance or dizziness last?**
- Less than 2 minutes ⧫
- 2 to 20 minutes ⧫
- Over 20 minutes to hours ⧫
- Hours to days ⧫

**EH4e. How long do the after-effects of feeling unwell or off-colour last?**
- No after-effects ⧫
- Minutes ⧫
- Hours ⧫
- Days ⧫

#### EYES AND VISION

**EV1. Do you wear glasses or contact lenses to correct your vision for seeing in the distance?**
- No ❌
- Yes ⧫

**EV2. Have you any other problems with your eyes or eyesight?**
- No ❌
- Yes ⧫

**EV3. Has a doctor ever told you that you have any of the following problems with your eyes? (Select all that apply)**
- Diabetes related eye disease ⧫
- Injury or trauma resulting in loss of vision ⧫
- Macular degeneration ⧫
- Glaucoma ⧫
- Cataract ⧫
- Other serious eye condition ⧫
- None of the above ⧫
- Don't know ⧫
RESPIRATORY

These questions ask about your breathing and the factors that affect how well you breathe.

R1 - WHEEZE

R1a. Has your chest ever made a wheezing or whistling sound?  ○ No  ○ Yes

R1b. If yes, in the last 12 months?  ○ No  ○ Yes

R2 - BREATHLESSNESS

R2a. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?  ○ No  ○ Yes

R2b. Do you get short of breath walking with other people your own age on level ground?  ○ No  ○ Yes

R2c. Do you have to slow for breath when walking at your own pace on level ground?  ○ No  ○ Yes

R2d. Do you ever get short of breath at rest?  ○ No  ○ Yes

R3 - COUGH

R3a. Do you usually cough first thing in the morning?  ○ No  ○ Yes

R3b. Do you usually cough during the day or at night?  ○ No  ○ Yes

R3c. Do you cough like this on most days for as much as three months each year?  ○ No  ○ Yes

→ If you answered NO to BOTH questions R3a and R3b, please go on to question R4

R4 - PHLEGM

R4a. Do you usually bring up phlegm from your chest first thing in the morning?  ○ No  ○ Yes

R4b. Do you usually bring up phlegm from your chest during the day or at night?  ○ No  ○ Yes

(If you answered Yes to R4a or R4b, please answer R4c.)

→ If you answered NO to BOTH questions R4a and R4b, please go on to question R6 on page 16

R4c. Do you bring up phlegm like this on most days for as much as three months each year?  ○ No  ○ Yes

R6 - CHEST TIGHTNESS

R6a. Have you ever felt tight in the chest?  ○ No  ○ Yes

R6b. If yes - in the last 12 months?  ○ No  ○ Yes

R6 - CARPET

R6a. Which rooms in your house are carpeted or have large rugs (more than 50% of the floor space)? (Select all that apply)

○ Your bedroom
○ Lounge
○ Living/Family
○ No carpet

R7 - PETS

R7a. Do you have a dog at home? (and where does it spend most of its time?)

○ Inside
○ Outside
○ No dog

R7b. Do you have a cat at home? (and where does it spend most of its time?)

○ Inside
○ Outside
○ No cat

R7c. Do you have a pet other than a cat or dog at home? (and where does it spend most of its time?)

○ Inside
○ Outside
○ No other pet

R7d. Please specify the type of other pets you have, if any:

Pet 1

Pet 2

Pet 3

Pet 4

Pet 5
FOOD AND ALLERGIES

Another factor which can affect well-being is allergies. Please answer as fully as you can.

A1 - FOOD ALLERGIES

A1a. Have you ever been sick as a result of having eaten a particular food?
- No — please go to A2 on page 16
- Yes — A1b. If yes, do you think you have a food allergy?
  - No
  - Yes

A1c. Has anyone ever told you that you have a food allergy?
- No — please go to A1e
- Yes — A1d. If yes, who told you this? Please select all that apply
  - GP
  - Dietician/other medical specialist
  - Naturopath/other complimentary medicine practitioner
  - Other (such as a friend or relative)

A1e. In what way did the food make you feel ill when you ate it? (Select all that apply)
- An itchy rash
- Difficulty breathing
- Flare up of eczema
- Cough
- Swelling of part of the body
- Difficulty swallowing
- Sore stomach
- Vomiting
- Hoarse voice
- Felt like passing out
- Other (please specify below)

A1f. How long after swallowing the food did you feel unwell?
- Less than 2 hours
- More than 2 hours
  If more than 2 hours, how many hours was it? ___ hours

A1g. Which foods caused you to feel unwell (as described above)? (Please shade all that apply)
- Eggs
- Stone fruits
- Peanuts
- Soy
- Other (Please specify below)

FOOD AND ALLERGIES (continued)

A2 - ANAPHYLAXIS

A2a. Have you ever had a severe allergic reaction (also known as anaphylaxis) with light-headedness, a generalised rash, swelling of some part of the body, difficulty breathing, or loss of consciousness?
- No — please go to SLEEP SL1
- Yes

A2b. If yes, what did you react to? (Select all that apply)
- Insect sting
- Latex
- Medication (such as antibiotic)
- Food
- Other (Please specify below)

A2c. Was this diagnosed by any of the following?
- GP
- Dietician/other medical specialist
- Naturopath/other complementary medicine practitioner
- Other (such as a friend or relative)

SLEEP

Below is a series of questions which ask about your sleep, a powerful determinant of well-being. Even if some of the questions seem similar, please answer each question independently and carefully.

SL1. How many hours of actual sleep do you usually get on a typical day, including naps? ___ hours

SL2. Has your weight changed in the last 5 years?
- Increased
- Decreased
- No change

SL3. Do you snore?
- No — please go to SL7 on page 19
- Yes
- Don't know

SL4. Has your snoring usually been:
- About as loud as breathing
- As loud as talking
- Louder than talking
- Very loud
- Don't know
SLEEP (continued)

SL5. Does your snoring bother other people?
   ○ No   ○ Yes

SL6. How often do you snore?
   Never or almost never
   1-2 times per month
   1-2 times per week
   3-4 times per week
   Almost every day
   Don't know

SL7. How often have breathing pauses been noticed in your sleep?
   ○ ○ ○ ○ ○ ○ ○

SL8. Are you tired after sleeping?
   ○ ○ ○ ○ ○ ○ ○

SL9. Are you tired during wake time?
   ○ ○ ○ ○ ○ ○ ○

SL10. Have you ever fallen asleep while driving?
   ○ No
   ○ Yes

SL11. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Please select only one answer for each question.
   Sitting and resting
   Never doze
   Slight chance of dozing
   Moderate chance of dozing
   High chance of dozing

SL11a. Sitting and resting
   ○ ○ ○ ○

SL11b. Watching TV
   ○ ○ ○ ○

SL11c. Sitting quietly in a public place (e.g. a theatre or meeting)
   ○ ○ ○ ○

SL11d. As a passenger in a car for an hour without a break
   ○ ○ ○ ○

SL11e. Lying down to rest in the afternoon when circumstances permit
   ○ ○ ○ ○

SL11f. Sitting and talking to someone
   ○ ○ ○ ○

SL11g. Sitting quietly after a lunch without alcohol
   ○ ○ ○ ○

SL11h. In a car, while stopped for a few minutes in the traffic
   ○ ○ ○ ○

Page 16 of 40
Participant Questionnaire 4
Backbone Healthy Aging Study

BACK PAIN

Back pain is one of the biggest contributors to loss of function, and days off work, so we want to understand this better.

SPI - BACK PAIN BELIEFS

SPI. We are trying to find out what people think about back trouble. Please indicate your general views towards back trouble, even if you have never had any. Please answer ALL statements.

Completely disagree
Completely agree

SPIa. There is no real treatment for back trouble
   ○ ○ ○ ○ ○ ○

SPIb. Back trouble will eventually stop you from working
   ○ ○ ○ ○ ○ ○

SPIc. Back trouble means periods of pain for the rest of one's life
   ○ ○ ○ ○ ○ ○

SPId. Doctors cannot do anything for back trouble
   ○ ○ ○ ○ ○ ○

SPIe. A bad back should be excised
   ○ ○ ○ ○ ○ ○

SPIf. Back trouble makes everything in life worse
   ○ ○ ○ ○ ○ ○

SPIg. Surgery is the most effective way to treat back trouble
   ○ ○ ○ ○ ○ ○

SPIh. Back trouble may mean you end up in a wheelchair
   ○ ○ ○ ○ ○ ○

SPIi. Alternative treatments are the answer to back trouble
   ○ ○ ○ ○ ○ ○

SPIj. Back trouble means long periods of time off work
   ○ ○ ○ ○ ○ ○

SPIk. Medication is the only way of relieving back trouble
   ○ ○ ○ ○ ○ ○

SPIl. Once you have had back trouble there is always a weakness
   ○ ○ ○ ○ ○ ○

SPIm. Back trouble must be rested
   ○ ○ ○ ○ ○ ○

SPIn. Later in life back trouble gets progressively worse
   ○ ○ ○ ○ ○ ○

SPIo. Have your arms or legs been painful in the last month?
   ○ No
   ○ Yes

Page 20 of 40
Participant Questionnaire 4
Backbone Healthy Aging Study
SP2 - NECK/SHOULDER PAIN

SP2a. Have you ever had neck/shoulder pain? (Anywhere in the shaded area in the picture)
   ○ No → please go to SP3a on page 22
   ○ Yes

SP2b. Has your neck/shoulder been painful at any time in the last month?
   ○ No → please go to SP3a on page 22
   ○ Yes

SP2c. How would you rate the neck/shoulder pain that you have had during the past week? Select one.

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<th>10</th>
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</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Pain as bad as it could be</td>
<td></td>
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</table>

SP2d. Has your present neck/shoulder pain lasted for more than 3 months continuously? (It hurt more or less every day)
   ○ No
   ○ Yes

SP2e. Has your present neck/shoulder pain lasted for more than 3 months off and on? (It hurt at least once a week but not every day)
   ○ No
   ○ Yes

SP2f. Was your neck/shoulder pain initially caused by a specific injury or incident?
   ○ No
   ○ Yes

SP2g. Do you usually seek health professional advice or treatment for your neck/shoulder pain?
   ○ No
   ○ Yes

SP2h. Does your neck/shoulder pain usually interfere with your normal activities?
   ○ No
   ○ Yes

SP3 - MID BACK PAIN

SP3a. Have you ever had mid back pain? (Anywhere in the shaded area in the picture)
   ○ No → please go to SP4a on page 23
   ○ Yes

SP3b. Has your mid back been painful at any time in the last month?
   ○ No → please go to SP4a on page 23
   ○ Yes

SP3c. How would you rate the mid back pain that you have had during the past week? Select one.

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</tr>
</thead>
<tbody>
<tr>
<td>No Pain</td>
<td>Pain as bad as it could be</td>
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</tbody>
</table>

SP3d. Has your present mid back pain lasted for more than 3 months continuously? (It hurt more or less every day)
   ○ No
   ○ Yes

SP3e. Has your present mid back pain lasted for more than 3 months off and on? (It hurt at least once a week but not every day)
   ○ No
   ○ Yes

SP3f. Was your mid back pain initially caused by a specific injury or incident?
   ○ No
   ○ Yes

SP3g. Do you usually seek health professional advice or treatment for your mid back pain?
   ○ No
   ○ Yes

SP3h. Does your mid back pain usually interfere with your normal activities?
   ○ No
   ○ Yes
SP4a. Have you ever had low back pain? [Anywhere in the shaded area in the picture]
- No ---- please go to FAMILY HISTORY FH1 on page 28
- Yes

SP4b. Has your low back been painful at any time in the last month?
- No ---- please go to FAMILY HISTORY FH1 on page 28
- Yes

SP4c. How would you rate the low back pain that you have had during the past week? Select one.
- Pain as bad as it could be
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

SP4d. Has your present low back pain lasted for more than 3 months continuously? (It hurt more or less every day)
- No
- Yes

SP4e. Has your present low back pain lasted for more than 3 months off and on? (It hurt at least once a week but not every day)
- No
- Yes

SP4f. Was your low back pain initially caused by a specific injury or incident?
- No
- Yes

SP4g. Do you usually seek health professional advice or treatment for your low back pain?
- No
- Yes

SP4h. Do you usually take medication to relieve your low back pain?
- No
- Yes

SP4i. Do you usually miss work due to your low back pain?
- No
- Yes

SP4j. Does your low back pain usually interfere with your normal activities?
- No
- Yes

SP4k. Does your low back pain usually interfere with recreational physical activities? (eg. sports, walking, cycling, etc.)
- No
- Yes

SP4l. At what age did you first get low back pain?

SP5 - Low Back Pain & Everyday Life

The following questions have been designed to give information as to how your back pain has affected your ability to manage every day life. Please answer every section. Mark one box only in each section that most closely describes you today.

If you have never had low back pain please go to Family History FH1 on page 28

SP5a. Pain Intensity
- I have no pain at all
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

SP5b. Personal Care (washing, dressing, etc.)
- I can look after myself normally without causing extra pain
- I can look after myself normally but it is very painful
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help everyday in most aspects of self care
- I do not get dressed, wash with difficulty and stay in bed
SP5e. Lifting
○ I can lift heavy weights without extra pain
○ I can lift heavy weights but it gives extra pain
○ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g. belted)
○ Pain prevents me from lifting heavy weights but I can manage light to medium weight if they are conveniently positioned
○ I can lift only very light weights
○ I cannot lift or carry anything at all

SP5d. Walking
○ Pain does not prevent me from walking any distance
○ Pain prevents me from walking more than 2 kilometres
○ Pain prevents me from walking more than 1 kilometre
○ Pain prevents me from walking more than 500 metres
○ I can only walk using a stick or crutches
○ I am in bed most of the time and have to crawl to the toilet

SP5c. Sitting
○ I can sit in any chair as long as I like
○ I can only sit in my favourite chair as long as I like
○ Pain prevents me from sitting for more than 1 hour
○ Pain prevents me from sitting for more than 30 minutes
○ Pain prevents me from sitting for more than 10 minutes
○ Pain prevents me from sitting at all

SP5b. Standing
○ I can stand as long as I want without extra pain
○ I can stand as long as I want but it gives me extra pain
○ Pain prevents me from standing for more than 1 hour
○ Pain prevents me from standing for more than 30 minutes
○ Pain prevents me from standing for more than 10 minutes
○ Pain prevents me from standing at all

SP5a. Sleeping
○ My sleep is never disturbed by pain
○ My sleep is occasionally disturbed by pain
○ Because of pain I have less than 6 hours sleep
○ Because of pain I have less than 4 hours sleep
○ Because of pain I have less than 2 hours sleep
○ Pain prevents me from sleeping at all

SP5h. Sex life (if applicable)
○ My sex life is normal and causes no extra pain
○ My sex life is normal but causes some extra pain
○ My sex life is nearly normal but is very painful
○ My sex life is severely restricted by pain
○ My sex life is nearly absent because of pain
○ Pain prevents any sex life at all

SP5i. Social life
○ My social life is normal and gives me no extra pain
○ My social life is normal but increases the degree of pain
○ Pain has no significant effect on my social life apart from limiting my more social interests, e.g. sport
○ Pain has restricted my social life and I do not go out as often
○ Pain has restricted my social life to my home
○ I have no social life because of pain

SP5j. Travelling
○ I can travel anywhere without pain
○ I can travel anywhere but it gives me extra pain
○ Pain is bad but I manage journeys over two hours
○ Pain restricts me to journeys of less than one hour
○ Pain restricts me to short necessary journeys under 30 minutes
○ Pain prevents me from travelling except to receive treatment
BACK PAIN (continued)

SP5. Listed below are some of the things that people have told us about their pain.

For each statement below, please indicate any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving, affect or would affect your back pain.

<table>
<thead>
<tr>
<th>Statement</th>
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</thead>
<tbody>
<tr>
<td>My pain was caused by physical activity</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Physical activity makes my pain worse</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Activity might harm my back</td>
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<tr>
<td>I should not do physical activities which (might) make my pain worse</td>
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<tr>
<td>I cannot do physical activities which (might) make my pain worse</td>
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The following statements are about how your normal work affects or would affect your back pain.

<table>
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<tr>
<th>Statement</th>
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<tbody>
<tr>
<td>My pain was caused by my work or by an accident at work</td>
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<tr>
<td>My work aggravated my pain</td>
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<tr>
<td>I have a claim for compensation for my pain</td>
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<td>My work is too tiring for me</td>
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<tr>
<td>My work makes or would make my pain worse</td>
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<tr>
<td>My work might harm my back</td>
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<tr>
<td>I should not do my normal work with my present pain</td>
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<tr>
<td>I cannot do my normal work with my present pain</td>
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<td>I cannot do my normal work until my pain is treated</td>
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<td>I do not think that I will be back to my normal work within 3 months</td>
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<tr>
<td>I do not think that I will ever be able to go back to that work</td>
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BACK PAIN (continued)

SP6. Individuals who experience pain have developed a number of ways to cope, or deal with their pain. These include saying things to themselves when they experience pain, or engaging in different activities. Below is a list of things that people have reported doing when they feel pain. For each activity, please indicate how much you engage in that activity when you feel pain.

When I feel pain...

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never do that</th>
<th>Always do that</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Activity</td>
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</tbody>
</table>

Have you retained a lawyer for your pain problem?

- No
- Yes

SP6c. In your estimation, what are the chances that you will be able to work in six months?

| Chances | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very large chance
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<tr>
<td>Chances</td>
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</table>

FAMILY HISTORY

This next set of questions ask about your family history of medical problems. It helps us understand what contribution, if any, family history makes to our well-being.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHH: Is your biological mother still alive?</td>
<td></td>
</tr>
<tr>
<td>I don’t know if my biological mother is still alive</td>
<td></td>
</tr>
<tr>
<td>Yes =&gt; please go to FHHa. How old is your mother?</td>
<td></td>
</tr>
<tr>
<td>No =&gt; please go to FHHb. How old was your mother when she died?</td>
<td></td>
</tr>
<tr>
<td>FHHa. How old is your mother?</td>
<td>years</td>
</tr>
<tr>
<td>FHHb. How old was your mother when she died?</td>
<td>years</td>
</tr>
<tr>
<td>FHHc. If no longer alive, cause of death if known</td>
<td></td>
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</tbody>
</table>
### FAMILY HISTORY (continued)

- **FH2**: Is your biological father still alive?
  - I don't know if my biological father is still alive
  - Yes → go to FH2a
  - No → go to FH2b

- **FH2a**: How old is your father? ___ years

- **FH2b**: How old was your father when he died? ___ years

- **FH2c**: If no longer alive, cause of death if known

- **FH3**: Do you have any full (biological) brothers or sisters (same mother and same father as you)?
  - No → go to question FH3 on page 30
  - Yes → go to FH3a

- **FH3a**: How many brothers and sisters do you have? ___ brothers, ___ sisters

- **FH4a**: How many brothers are still living?
  - ___ brothers living

- **FH4b**: How many sisters are still living?
  - ___ sisters living

- **FH5**: If any of your full (biological) brother(s) have died, please list ages when deceased:
  - Brother 1 - Age when died: ___ years
  - Brother 2 - Age when died: ___ years
  - Brother 3 - Age when died: ___ years
  - Brother 4 - Age when died: ___ years

- **FH6**: If any of your full (biological) sister(s) have died, please list ages when deceased:
  - Sister 1 - Age when died: ___ years
  - Sister 2 - Age when died: ___ years
  - Sister 3 - Age when died: ___ years
  - Sister 4 - Age when died: ___ years

---

### FAMILY HISTORY (continued)

Below is a table which asks about a history of a range of specific health conditions in your immediate biological family (mother, father, siblings and brothers). Please take the time to indicate, for each family member and for each condition, if that person had that condition or not. If you do not know, please check 'Don't know'. Any other information you can give us would also be helpful (e.g., about conditions we have not listed, but which you feel are important).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Biological father</th>
<th>Biological mother</th>
<th>Any of your siblings</th>
<th>Any of your biological brothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>FH7a. Asthma</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
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<tr>
<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
</tr>
<tr>
<td>FH7a. Diabetes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
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<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
</tr>
<tr>
<td>FH7c. If Yes to FH7b, was this only during pregnancy?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
</tr>
<tr>
<td>FH7d. Hay Fever - seasonal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
</tr>
<tr>
<td>FH7e. Hay Fever - all year round</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
</tr>
<tr>
<td>FH7f. Hearing loss</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
</tr>
<tr>
<td>FH7g. High blood pressure</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
</tr>
<tr>
<td>FH7h. Myocardial Infarction (Heart Attack)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
</tr>
<tr>
<td>FH7i. Stroke</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
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<td>No</td>
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<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
</tr>
<tr>
<td>FH7j. Glaucoma</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
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</tbody>
</table>
### FAMILY HISTORY (continued)

- **FHM**: Have any of your following family members ever had any of the following conditions?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Biological mother</th>
<th>Biological father</th>
<th>Any of your biological sisters</th>
<th>Any of your biological brothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macular degeneration</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cancer</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
<td>Don't know</td>
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</tbody>
</table>

- **FHM**: If yes, type of cancer

<table>
<thead>
<tr>
<th>Type of cancer</th>
<th>Biological mother</th>
<th>Biological father</th>
<th>Biological sister 1</th>
<th>Biological sister 2</th>
<th>Biological brother 1</th>
<th>Biological brother 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### MOOD AND WELL-BEING

Now we would like to ask some questions about your general mood and well-being. We realise that some of these questions may seem very personal, but all information you provide us is helpful. As before, even if some questions seem remarkably similar, we need to ask you each and every one. So, please answer them carefully and independently.

- **MD1.** Please read each statement and select a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD1a. I found it hard to wind down</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1b. I was aware of dryness of my mouth</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MD1c. I couldnt seem to experience any positive feeling at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MD1d. I experienced breathing difficulty (eg. sometimes too breathless)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MD1e. I found it difficult to work up the initiative to do things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1f. I tended to over-react to situations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1g. I experienced trembling (eg. in hands)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1h. I felt that I was using a lot of mental energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1i. I was worried about situations in which I might panic and make a fool of myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1j. I felt that I had nothing to look forward to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1k. I found myself getting agitated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1l. I found it difficult to relax</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1m. I felt down-hearted and blue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1n. I was bewildered of anything that kept me from getting on with what I was doing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1o. I felt I was close to panic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1p. I was unable to become enthusiastic about anything</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1q. I felt I wasn't worth much as a person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1r. I felt that I was rather touchy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1s. I was aware of the actions of my heart in the absence of physical exertion (eg. sense of heart being, heat, feeling a lead)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1t. I felt scared without any good reason</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD1u. I felt that life was meaningless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MOOD AND WELL-BEING (continued)

MD2. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and fill in your response.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the day</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD2a. Little interest or pleasure in doing things</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>MD2b. Feeling down, depressed, or hopeless</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>MD2c. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>MD2d. Feeling tired or having little energy</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>MD2e. Poor appetite or overeating</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>MD2f. Feeling sad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>MD2g. Trouble concentrating on things such as reading, or making plans or talking to people</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>MD2h. Moving or speaking so slowly that other people could have noticed; or being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>MD2i. Thinking that you would be better off dead or that you want to hurt yourself or others</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

MD3. If you have noted any problem in questions MD1-MD2, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

DEPRESSION

We are particularly interested in learning whether you have ever experienced depression.

DP1. Have you ever been told by a doctor that you have depression?

- ○ No — please go to PHYSICAL ACTIVITY PA1 on page 54

- ○ Yes

DP2. Please state your age when you were first told that you had depression.

[ ] years

DP3. Have you ever been given advice or treatment for your depression?

- ○ No — please go to PHYSICAL ACTIVITY PA1 on page 54

- ○ Yes

DP4. What kind of advice or treatment were given for your depression? (Please answer each question)

- Tablets ○ Yes ○ No
- Exercise ○ Yes ○ No
- Psychological treatment or counseling ○ Yes ○ No
- Electroconvulsive therapy (ECT) ○ Yes ○ No
- Other (please specify below) ○ Yes ○ No

PHYSICAL ACTIVITY

Earlier, we asked you a few brief questions about your general physical activity. Here, we would like to go into this in more detail. We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent doing physically active in the last 7 days. Please answer each question, even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise, or sport.

Think about all the vigorous physical activities that you did in the last 7 days. Vigorous physical activities refer to activities that make your heart beat and make you breathe much harder than normal. Think about all the moderate physical activities that you did for at least 10 minutes at a time.

PA1. During the last 7 days, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?

- ○ No vigorous activities — please go to PA3

- ○ [ ] days per week

PA2. How much time did you usually spend doing vigorous physical activities on one of those days?

[ ] hours per day [ ] minutes per day

- ○ Don't know/Not sure

PA3. During the last 7 days, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or walking a bit? Do not include walking.

- ○ No moderate activities — please go to PA5 on page 35

- ○ [ ] days per week
**PHYSICAL ACTIVITY (continued)**

PA4. How much time did you usually spend doing moderate physical activities on one of those days?
- [ ] hours per day
- [ ] minutes per day

O Don’t know/Not sure

Think about the time you spent walking in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

PA5. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?
- [ ] days per week

PA6. How much time did you usually spend walking on one of those days?
- [ ] hours per day
- [ ] minutes per day

O Don’t know/Not sure

**INFORMATION TECHNOLOGY**

This section asks about your use of information technology (mobile phone, computer, internet, etc).

IT1a. For approximately how many years have you been using a mobile phone at least once per week to make or receive calls?
- [ ] Never used a mobile phone — please go to IT2a
- [ ] 1 year or less
- [ ] 2-4 years
- [ ] 5-8 years
- [ ] More than 8 years

IT1b. Over the last 3 months, on average how much time per week did you spend making or receiving calls on a mobile phone?
- [ ] hours per day
- [ ] minutes per day

IT2a. Have you ever used a computer?
- [ ] No — please go to COMMUNITY AND VALUES CV1 on page 38
- [ ] Yes

IT1b. During the last 7 days, how much time did you spend sitting on a day?
- [ ] hours per day
- [ ] minutes per day

O Don’t know/Not sure

IT1c. In the last month, in how often did you watch TV or videos on DVDs?
- [ ] Not at all — please go to IT3a
- [ ] Once a month
- [ ] Once a week
- [ ] Two or three times a week
- [ ] Daily

IT1c. In the last month, for how long did you usually watch TV or videos or DVDs each day?
- [ ] Less than 30 minutes
- [ ] 30-60 minutes
- [ ] 1-2 hours
- [ ] 2-5 hours
- [ ] More than 5 hours

IT1d. About what age were you when you started using a computer?
- [ ] years

The next few questions ask you about computer use at work only.

IT2a. In the last month, how often did you use a computer at work?
- [ ] Not at all — please go to IT4a on page 37
- [ ] Do not work — please go to IT3a on page 37
- [ ] Once a month
- [ ] Once a week
- [ ] Two or three times a week
- [ ] Daily

IT2b. In the last month, for how long did you usually use a computer at work each time?
- [ ] Less than 30 minutes
- [ ] 30-60 minutes
- [ ] 1-2 hours
- [ ] 2-5 hours
- [ ] More than 5 hours

In the last month, how often did you do the following activities on a computer at work?

Please select one answer for each statement.

**IT4a. Play games**
- [ ] Daily
- [ ] 2-3 times a week
- [ ] Once a week
- [ ] Once a month
- [ ] Rarely or Never

**IT4b. Use create multimedia (e.g., pictures and music)**
- [ ] Daily
- [ ] 2-3 times a week
- [ ] Once a week
- [ ] Once a month
- [ ] Rarely or Never

**IT4c. Use documents/spreadsheets**
- [ ] Daily
- [ ] 2-3 times a week
- [ ] Once a week
- [ ] Once a month
- [ ] Rarely or Never

**IT4d. Search the internet**
- [ ] Daily
- [ ] 2-3 times a week
- [ ] Once a week
- [ ] Once a month
- [ ] Rarely or Never

**IT4e. Send/receive emails**
- [ ] Daily
- [ ] 2-3 times a week
- [ ] Once a week
- [ ] Once a month
- [ ] Rarely or Never

**IT4f. Chat room**
- [ ] Daily
- [ ] 2-3 times a week
- [ ] Once a week
- [ ] Once a month
- [ ] Rarely or Never

**IT4g. Other activities e.g., learning new programs, work databases**
- [ ] Daily
- [ ] 2-3 times a week
- [ ] Once a week
- [ ] Once a month
- [ ] Rarely or Never

**IT4h. Thinking about the last seven days, in total how many hours have you spent using a computer at work?**
- [ ] hours
INFORMATION TECHNOLOGY (continued)

IT5a. Do you have access to a computer at home?
- No — please go to IT8a on page 38
- Yes

IT5b. Do you have internet access at home?
- No
- Yes

IT5c. How many desktop computers do you have at home? [ ]

IT5d. How many laptop computers do you have at home? [ ]

IT5e. In the last month, how often did you use a computer at home?
- Not at all — please go to IT6a on page 39
- Once a month
- Once a week
- Two or three times a week
- Daily

IT5f. In the last month, how long did you usually use a computer at home each time?
- Less than 1 hour
- 1-2 hours
- 2-5 hours
- More than 5 hours

In the last month, how often did you do the following activities on a computer at home?
Please select one answer for each statement.

IT5g. Play games [ ]
IT5h. Use/create multimedia (e.g., pictures and music) [ ]
IT5i. Use documents/spreadsheets [ ]
IT5j. Surf the internet [ ]
IT5k. Send/receive e-mails [ ]
IT5l. Chat room [ ]
IT5m. Other activities (e.g., learning programs, databases) [ ]
IT5n. Thinking about the text given above, in total how many hours have you spent using a computer at home or at a friend's home? [ ] hours

COMMUNITY VALUES

It seems that who you know and where you live can influence your health and wellbeing. We are interested to know how you feel about where you live and the people around you.

CV1a. Do you feel safe walking down your street after dark? [ ]
CV1b. Do you agree that most people can be trusted? [ ]
CV1c. If someone's car breaks down outside your house, do you invite them into your house to use the phone? [ ]
CV1d. Can you get help from friends when you need it? [ ]
CV1e. Does your area have a reputation for being a safe place? [ ]
CV1f. If you were caring for a child and needed to go out for a while, would you ask a neighbour for help? [ ]
CV1g. Have you visited a neighbour in the past week? [ ]
CV1h. Does your local community feel like home? [ ]
CV1i. When you go shopping in your local area, are you likely to run into friends and acquaintances? [ ]
COMMUNITY VALUES (continued)

What kind of values do you uphold as an Australian family? We are interested to know what life values are important to you. For every item, please select the answer that best suits your family.

CV2a. Having money for nice things
CV2b. Being popular with lots of people
CV2c. Having a high status job
CV2d. Playing an active role in the community
CV2e. Helping others who are less well off
CV2f. Looking after our planet
CV2g. Saving or investing for the future
CV2h. Having a financial plan for the future
CV2i. Having a fit and healthy lifestyle
CV2j. Having close personal relationships

You have reached the end of the questionnaire!

Thank you very much for your time and effort!

We appreciate that there were many questions and realise that it will have taken you quite some time to complete the survey. We are grateful to you for your patience in helping us with this important study.

If you have any queries about any of the questions - for example, you were not sure how to answer a question - please ask the BHAS survey staff for clarification when you visit for your appointment.