

1. Your current weight?

POUNDS		
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
	7	7
	8	8
	9	9

2. Do you currently smoke cigarettes?

No

Yes → How many/day? 1-4 5-14 15-24

25-34 35-44 45+

3. Have you had your uterus removed?

No Yes → Date of surgery: Before June 1, 2012 After June 1, 2012

4. Have you ever had either of your ovaries surgically removed?

No Yes → a) How many ovaries do you have remaining? None One

5. Since June 2012, have you used prescription female hormones? (Not including over-the-counter/herbal/soy preparations.)

Yes → a) How many months did you use hormones since June 2012?

No 1-4 months 5-9 10-14 15-19 20-25 26-30 31-35 36+ months

b) Are you currently using them (within the last month)? Yes No If No, skip to question 6.

c) Mark the type(s) of hormones you are CURRENTLY using:

Prempro Oral estrogen (e.g., Premarin, Estrace, etc.) Patch Estrogen Vaginal Estrogen

Estrogen gels, creams, or sprays on skin Other Estrogen (specify in box below)

Oral Progesterone (e.g., Provera/MPA) Micronized progesterone (e.g., Prometrium)

Vaginal progesterone Other progesterone (specify in box below)

Other hormones CURRENTLY used (e.g., Tri-est), Specify:

[Text input box]

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

6. Do you have difficulty with your balance?

No Occasionally Often

7. Do you usually use a cane, walker or wheelchair/scooter? (Mark all that apply.)

No Cane Walker Wheelchair/scooter Unable to walk

8. Number of times you have fallen to the ground in the past year:

None 1 2 3 4 5 6 7 8 9 or more

9. Do you live in any of the following special residential settings?

Nursing home Senior/retirement housing or community exclusively for people age 55+

Assisted living facility None of the above

10. Do you currently take multi-vitamins?

No Yes → a) How many do you take per week? 2 or less 3-5 6-9 10 or more

11. Aside from multi-vitamins, do you currently take Vitamin D (separately or in calcium supplement)?

No Yes, seasonal only Yes, most months → If Yes, } Dose per day: Less than 600 IU 600 to 900 IU 1000 to 1500 IU 2000 IU or more Don't know

12. Is this your correct date of birth?

Yes No → If No, please write correct date. [MONTH / DAY / YEAR]

1	1	1	1	1	1	1
2	2	2	2	2	2	2
4	4	4	4	4	4	4
8	8	8	8	8	8	8
P	P	P	P	P	P	P

381 PERF

13. Since June 2012, have you had any of these clinician-diagnosed illnesses?

MARK HERE FOR "YES,"
LEAVE BLANK FOR "NO"

YEAR OF DIAGNOSIS

BEFORE JUNE 1 2012 JUNE '12 TO MAY 2014 AFTER JUNE 1 2014

<input checked="" type="checkbox"/> Fibrocystic/other benign breast disease Confirmed by breast biopsy? <input type="radio"/> No <input checked="" type="radio"/> Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 a
Breast cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2
Cancer of the ovary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	3
Colon or rectal polyp (benign)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	4
Cancer of the colon or rectum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	5
Leukemia or Lymphoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	6
Melanoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	7
Basal cell skin cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	8
Squamous cell skin cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	9
Other cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	10
Specify site of other cancer → <small>(e.g., uterus, pancreas, lung, etc.)</small>				
Diabetes mellitus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	11
Elevated cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	12
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	13
Myocardial infarction (heart attack) Hospitalized for MI? <input type="radio"/> No <input checked="" type="radio"/> Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	14 a
Angina pectoris Confirmed by angiogram? <input type="radio"/> No <input checked="" type="radio"/> Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	15 a
Coronary bypass, angioplasty, or stent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	16
Congestive heart failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	17
Stroke (CVA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	18
TIA (Transient ischemic attack)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	19
Peripheral artery disease or claudication of legs (not varicose veins)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20
Carotid surgery (Endarterectomy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	21
Pulmonary embolus or Deep vein thrombosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	22
Atrial fibrillation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	23

YEAR OF DIAGNOSIS

BEFORE JUNE 1 2012 JUNE '12 TO MAY 2014 AFTER JUNE 1 2014

<input checked="" type="checkbox"/> ICD-Implantable Cardiac Defibrillator	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	24
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	25
Hip fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	26
Vertebral (spine) fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	27
Hyperparathyroidism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	28
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	29
Macular degeneration of retina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	30
Cataract—1st (Dx)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	31
Cataract extraction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	32
Parkinson's Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	33
Lou Gehrig's Disease/ Amyotrophic Lat Sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	34
Alzheimer's or other type of dementia (e.g., vascular, FTD, Lewy Body)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	35
Kidney stones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	36
Ulcerative colitis or Crohn's or microscopic colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	37
Gastric/duodenal ulcer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	38
Barrett's esophagus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	39
Celiac disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	40
Rheumatoid Arthritis or Systemic Lupus (SLE)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	41
Gout	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	42
Depression, clinician diagnosed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	43
Fatty liver disease and/or cirrhosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	44
Chronic hepatitis (B or C)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	45
Other major illness or surgery since June 2012	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	46
Please specify: _____ Date: _____ <small>(e.g., hip replacement, GERD, etc.)</small>				

3/8" PERF

1 1 1 1 1 1 1

17. What is your usual walking pace outdoors?

- Unable to walk
- Brisk pace (3–3.9 mph)
- Easy, casual (less than 2 mph)
- Very brisk/ striding (4 mph or faster)
- Normal, average (2–2.9 mph)

18. How many total flights of stairs (not individual steps) do you climb daily?

- None
- 2 flights or less
- 3–4
- 5–9
- 10–14
- 15 or more flights

19. In the past two years, have you been diagnosed with an episode of:

a) Diverticulitis of the colon that required antibiotics and/or hospitalization?

- No
- Yes → Surgery for diverticulitis?
- No
- Yes

b) Diverticular bleeding that required blood transfusion and/or hospitalization?

- No
- Yes → Surgery for diverticular bleeding?
- No
- Yes

c) Diverticulosis of the colon without diverticulitis or diverticular bleeding?

- No
- Yes

20. In the past two years, have you had gastrointestinal bleeding that required hospitalization or a transfusion?

- Yes → Site(s):
- No
- Esophagus
- Stomach
- Duodenum
- Colon/Rectum
- Other
- Site(s) unknown

21. On average, during the past year, on how many days did you consume an alcoholic beverage of any type?

- No days
- Less than one/month
- 1 day/mo
- 2–4 days/mo
- 1–2 days/wk
- 3–4 days/wk
- 5–6 days/wk
- 7 days/wk

22. In a typical month, what is the largest number of drinks of beer, wine, and/or liquor you have in one day?

- None
- 1 drink/day
- 2
- 3
- 4
- 5–6
- 7–9
- 10–14
- 15 or more drinks/day

23. For each alcoholic beverage, fill in the circle indicating how often on average you have used the amount specified during the past year.

BEVERAGES	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Beer, regular (1 glass, bottle, can)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Light Beer e.g., Bud Light (1 glass, bottle, can)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red wine (5 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White wine (5 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liquor, e.g., vodka, gin, etc. (1 drink or shot)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

24. For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.

FOODS	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Blueberries, fresh, frozen or canned (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strawberries, fresh, frozen or canned (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Olive oil, for cooking or added to food or salads (1 Tbs.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peanuts (small packet or 1 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walnuts (1 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other nuts (small packet or 1 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peanut butter (1 Tbs.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Refined grain foods (e.g., white bread, rice, cereals, pasta, etc.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Whole grain foods (e.g., whole grain bread, cereals, brown rice)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

25. How many times each week (including weekdays and weekends) do you eat breakfast?

- Never or almost never
- 1–2 times per week
- 3–4 times per week
- 5 or more times per week

3/8" PERF

26. Regular Medication (Mark if used regularly in past 2 years)

26

Analgesics

- Acetaminophen (e.g., Tylenol)
 Days per week: 1 2-3 4-5 6+ days
 Total tablets per week: 1-2 3-5 6-14 15+ tablets

- "Baby" or low dose aspirin (100 mg or less/tablet)
 Days per week: 1 2-3 4-5 6+ days
 Total tablets per week: 1-2 3-5 6-14 15+ tablets

- Aspirin or aspirin-containing products (325mg or more/tablet)
 Days per week: 1 2-3 4-5 6+ days
 Total tablets per week: 1-2 3-5 6-14 15+ tablets

- Ibuprofen (e.g., Advil, Motrin, Nuprin)
 Days per week: 1 2-3 4-5 6+ days
 Total tablets per week: 1-2 3-5 6-14 15+ tablets

- Celebrex (COX-2 inhibitors)
 Days per week: 1 2-3 4-5 6+ days

- Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)

Other Regularly Used Medications

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="radio"/> Thiazide diuretic <input type="radio"/> Lasix <input type="radio"/> Potassium <input type="radio"/> Calcium blocker (e.g., Calan, Procardia, Cardizem, Norvasc) <input type="radio"/> Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard) <input type="radio"/> ACE Inhibitors (e.g., Capoten, Vasotec, Zestril) <input type="radio"/> Angiotensin receptor blocker (e.g., Diovan, Losartan, Avapro) <input type="radio"/> Other anti-hypertensive (e.g., clonidine, doxazosin) <input type="radio"/> Coumadin <input type="radio"/> Pradaxa/Xarelto/Eliquis <input type="radio"/> Plavix <input type="radio"/> Digoxin <input type="radio"/> Antiarrhythmic "Statin" cholesterol-lowering drug: <ul style="list-style-type: none"> <input type="radio"/> Mevacor (lovastatin) <input type="radio"/> Lipitor (atorvastatin) <input type="radio"/> Pravachol (pravastatin) <input type="radio"/> Crestor <input type="radio"/> Zocor (simvastatin) <input type="radio"/> Other <input type="radio"/> Other cholesterol-lowering drug <input type="radio"/> Steroids taken orally (e.g., Prednisone, Decadron, Medrol) <input type="radio"/> Insulin <input type="radio"/> Metformin (glucophage) <input type="radio"/> Actos <input type="radio"/> Other oral hypoglycemic medication <input type="radio"/> Opioid pain medications (e.g., codeine, Percocet, Vicodin, tramadol) | <ul style="list-style-type: none"> <input type="radio"/> Evista (raloxifen) <input type="radio"/> Nolvadex (tamoxifen) <input type="radio"/> SSRIs (Celexa, Lexapro, Prozac, Paxil, Zoloft, Luvox, fluoxetine, citalopram) <input type="radio"/> Tricyclics (e.g., amitriptyline, nortriptyline, imipramine) <input type="radio"/> SNRIs /Other antidepressants (Wellbutrin, Effexor, Remeron, Cymbalta, veniafaxine, bupropion) <input type="radio"/> Minor tranquilizers (e.g., Valium, alprazolam, lorazepam) <input type="radio"/> Prilosec, Nexium, Prevacid, Protonix, Aciphex <input type="radio"/> H2 blocker (e.g., Pepcid, Zantac, Axid, Tagamet) <input type="radio"/> Aricept, Exelon, Razadyne <input type="radio"/> Namenda <input type="radio"/> Fosamax, Actonel, or other bisphosphonate <input type="radio"/> Thyroid hormone (e.g., Synthroid, Levothroid, extract) <input type="radio"/> Ambien, Sonata, Lunesta or zolpidem <input type="radio"/> Other prescription sleep medications (e.g., Trazodone, Rozerem) <input type="radio"/> Other regular medications (no need to specify) |
|---|--|

27. Have you EVER used Metformin (aka Glucophage)?

Yes → a) When did you FIRST take it?
 No
 Before 1996
 1997-2000
 2001-2004
 2005-2008
 2009-2012
 After 2012
 ↓ b) In all, how many years have you used Metformin?
 Less than 1 year
 1-2
 3-5
 6-8
 9-12
 13-15
 16+ years

28. Choose the best answer for how you felt the past month:

Are you basically satisfied with your life?	<input type="radio"/> Yes	<input type="radio"/> No
Have you dropped <u>many</u> of your activities and interests?	<input type="radio"/> Yes	<input type="radio"/> No
Do you feel that your life is empty?	<input type="radio"/> Yes	<input type="radio"/> No
Do you often get bored?	<input type="radio"/> Yes	<input type="radio"/> No
Are you in good spirits <u>most</u> of the time?	<input type="radio"/> Yes	<input type="radio"/> No
Are you afraid that something bad is going to happen to you?	<input type="radio"/> Yes	<input type="radio"/> No
Do you feel happy <u>most</u> of the time?	<input type="radio"/> Yes	<input type="radio"/> No
Do you <u>often</u> feel helpless?	<input type="radio"/> Yes	<input type="radio"/> No
Do you prefer to stay at home, rather than going out and doing new things?	<input type="radio"/> Yes	<input type="radio"/> No
Do you feel you have <u>more</u> problems with memory than most?	<input type="radio"/> Yes	<input type="radio"/> No
Do you think it is wonderful to be alive now?	<input type="radio"/> Yes	<input type="radio"/> No
Do you feel pretty worthless the way you are now?	<input type="radio"/> Yes	<input type="radio"/> No
Do you feel full of energy?	<input type="radio"/> Yes	<input type="radio"/> No
Do you feel that your situation is hopeless?	<input type="radio"/> Yes	<input type="radio"/> No
Do you think that <u>most</u> people are better off than you are?	<input type="radio"/> Yes	<input type="radio"/> No

29. Over the last 4 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following questions relate to your usual sleep habits during the **past month**. Your answers should indicate the most accurate reply for the majority of days and nights in the past month.

30. In a typical week, on how many days do you nap for at least 20 minutes?
(You need not be in bed to nap.)

- None 1 or 2 days 3-4 days 5-6 days Almost every day

30

31. During the past month, how many hours of **actual sleep** did you get most nights?

- Less than 4 hours 4 hrs 5 hrs 6 hrs 7 hrs 8 hrs 9 hrs 10 hrs 11+ hrs

31

32. During the past month, how long has it usually taken you to fall asleep each night?

- 1-4 min 5-19 min 20-59 min One hour 1-1.5 hrs 1.5 or more hrs

32

33. During the past month, how often have you had **trouble sleeping** because you...

	Not during the past month	Less than once a week	1 or 2 times a week	3+ times a week
cannot get to sleep within 30 minutes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
wake up in the middle of the night or early morning?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
have to get up to use the bathroom?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
cannot breathe comfortably?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
cough or snore loudly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
feel too cold?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
feel too hot?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
had a bad dream?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
have pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other reason you have trouble sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

33

34. During the past month, how would you rate your **sleep quality** overall?

- Very good Fairly good Fairly bad Very bad

34

35. During the past month, how often have you taken medicine to help you sleep?
(Prescribed or "over the counter")

- Not during the past month Less than once a week 1 or 2 times a week 3+ times a week

35

36. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

- Not during the past month Less than once a week 1 or 2 times a week 3+ times a week

36

37. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

- No problem at all Only a very slight problem Somewhat of a problem A very big problem

37

38. Please rate your ability to do the following activities. (Mark one answer for each row.)

Are you able to . . .	Without Help	With Some Help	Unable
a. Get to places out of walking distance	<input type="radio"/> Drive car, or travel alone on bus, train, or taxi	<input type="radio"/> Need someone to help you or go with you	<input type="radio"/> Unable to travel except by ambulance, etc.
b. Go shopping for groceries or clothes (assuming you had transportation)	<input type="radio"/> Can shop by yourself, assuming you had transportation	<input type="radio"/> Need someone to help you on all shopping trips	<input type="radio"/> Completely unable to do any shopping
c. Prepare your own meals	<input type="radio"/> Plan and cook full meals yourself	<input type="radio"/> Can prepare some things. Unable to cook full meals	<input type="radio"/> Completely unable to prepare any meals
d. Do your own housework	<input type="radio"/> Can clean floors, bathroom, etc.	<input type="radio"/> Need help with heavy housework & cleaning	<input type="radio"/> Completely unable to do any housework
e. Handle your own money	<input type="radio"/> Write checks, pay bills, etc., by yourself	<input type="radio"/> Can manage day-to-day buying. Need help with checkbook & paying bills	<input type="radio"/> Completely unable to handle money
f. Handle your medications	<input type="radio"/> Able to keep track of and take meds yourself	<input type="radio"/> Need someone to help manage medications	<input type="radio"/> Completely unable to manage medications

38

39. Please answer Yes or No for each of the following questions about your memory:

- Have you recently experienced any change in your ability to remember things? Yes No
- Do you have more trouble than usual remembering recent events? Yes No
- Do you have more trouble than usual remembering a short list of items, such as a shopping list? Yes No
- Do you have trouble remembering things from one second to the next? Yes No
- Do you have any difficulty in understanding or following spoken instructions? Yes No
- Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory? Yes No
- Do you have trouble finding your way around familiar streets? Yes No

40. In the last month, how often have you...

	Never	Almost never	Sometimes	Fairly often	Very often
a. felt that you were unable to control the important things in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. felt confident about your ability to handle your personal problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. felt that things were going your way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. felt difficulties were piling up so high that you could not overcome them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

41. Would you be interested in completing your future NHS questionnaires online?

- No Yes → If Yes, make sure you have provided your email address, if you have one, on the bottom of the cover letter.

42. Did you need any help from someone else to complete this questionnaire?

- No Yes, I received help from someone else but I provided most of the input
 Yes, someone else completed it on my behalf with minimal input from me

If Yes: **I needed help with:** Vision Writing Memory Other
Who helped? Spouse/partner Child Other

Please elaborate in the space below and include your name, address, telephone number or email address, and your relationship to the participant. Please explain briefly why your help was needed (e.g., macular degeneration, Parkinson's, dementia, etc.).

43. Please indicate the name of someone at a *DIFFERENT PERMANENT ADDRESS* to whom we might write in the event we are unable to contact you:

Name: _____

Address: _____

Phone or Email: _____

3/8" PERF