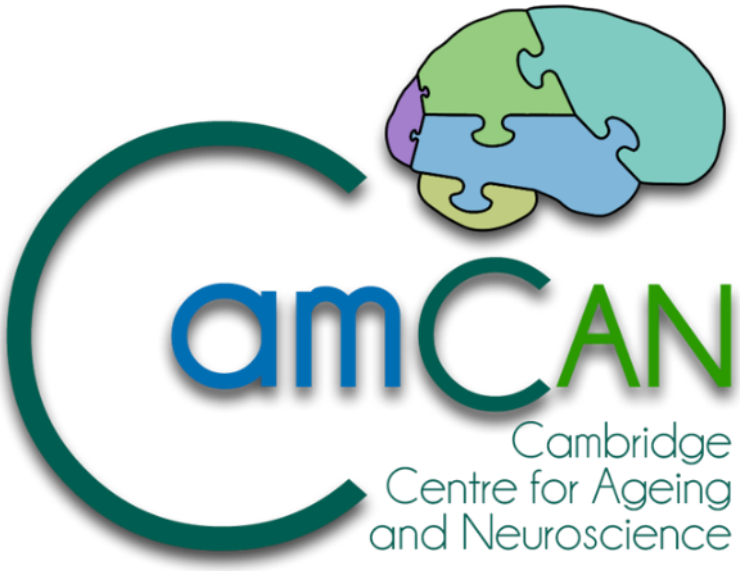
The Science of Ageing: Questionnaire



Thank you for agreeing to take part in more Cam-CAN research. This questionnaire is designed to gather further information that will contribute to the science of ageing. With your continued help, we can better understand the influences that affect our psychological and physical health as we grow older, and learn about how we can age more healthily.

The questions asked here are purely to help us understand you and your circumstances a little better, it is not a test. Because people's circumstances and experiences change over time, we sometimes ask the same questions on different occasions to strengthen our research, so you may recognise some of the questions asked here. Some of the questions may not be relevant to you, so by answering no or don't know you will skip some questions. Simply respond as honestly as possible. Please remember that your answers will be treated as strictly confidential, and will be used only for scientific research. Your name does not appear in association with this questionnaire.

The completion of the questionnaire will take approximately 25 minutes. If you are not able to complete the questionnaire at once, you can complete it in multiple sittings. If there are any questions you prefer not to answer, simply continue to the next one.

Thank you for your participation.

Please complete the following before beginning the questionnaire:

Today's date: _____/_____/_____ (dd/mm/yyyy)
Height: ___ ft ___ inches OR _____ cms
Weight: ___ st ___ lbs OR _____ Kgs

Section A: Current Circumstances

Your Current Circumstances

The first few questions are about your current demographic.

1. Which of the following describes your current situation? You can select more than one:
   - ☐ In paid employment, full time (at least 30 hours per week)
   - ☐ In paid employment, part- time (less than 30 hours per week)
   - ☐ Employed in organisation with 10 or less employees
   - ☐ Employed in organisation with more than 10 employees
   - ☐ Self-employed
   - ☐ Employer with less than 10 employees
   - ☐ Employer with more than 10 employees
   - ☐ Retired, age of retirement: ____ (years)
   - ☐ Looking after home and/or family
   - ☐ Unable to work because of sickness or disability
   - ☐ Unemployed, short term (< 12 months)
   - ☐ Unemployed, long term (> 12 months)
   - ☐ Never worked
   - ☐ Doing unpaid or voluntary work
   - ☐ Student
   - ☐ Other (please state): _____

2. Which of the following best fits your current job, or (if no longer working) your last held job?
   - ☐ Unskilled job that usually doesn't need any schooling
   - ☐ Job that usually needs secondary school qualifications or specific training, but not college/vocational training
   - ☐ Job that usually needs a college/vocational training, but not a university degree
   - ☐ Job that usually needs a university degree
   - ☐ I have never had a job

3. What is the specific job title, level of function and responsibility for other personnel (if any) of your current or last held profession? If applicable, please describe the nature and size of the organization you work for:

   For example: Lead nurse, in charge of 35 nurses in a group of hospital wards in a hospital (1000 employees); Retail assistant in a clothes shop (7 employees); Self-employed builder, responsible for 5 staff working for me; no responsibility for other staff.

   _____

   _____

The next three questions are about your total household income.

This refers to the combined income that is distributed across those in your household (e.g. partners, children, other relatives). This does not include household members with whom you are financially independent (i.e., those who you do not share finances with).

4. Including yourself, how many people share your total household income (please include any dependent children)? If you are financially independent, please write 1: _____

5. What is your total household income **after tax** (per annum)? If you are financially independent, please tick your own income **after tax**. Please include any child support or benefits that you may receive:
   - ☐ £0 - £9,999
   - ☐ £10,000 - £19,999
   - ☐ £20,000 - £29,999
   - ☐ £30,000 - £39,999
   - ☐ £40,000 - £49,999
   - ☐ £50,000 - £59,999
   - ☐ £60,000 - £69,999
   - ☐ £70,000 - £79,999
   - ☐ >£80,000
   - ☐ Prefer not to answer

6. How would you rate your **current** economic standing compared to others?
   - ☐ Poor/difficult
   - ☐ Below average
   - ☐ Average
   - ☐ Above average
   - ☐ Well-off

Section B: Changes since we last saw you

Please tick **one response** for each of the following questions since we initially saw you, approximately 10 years ago:

1. Have you, or a person you live with, lost their job (not through retirement)?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

2. Have you, or a person you live with, had any major financial difficulties? (e.g. unable to pay household bills)
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

3. Have you separated from a partner?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

4. Have here been any deaths, serious illnesses/injuries in your immediate family?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

5. Have you had any life-changing injuries?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

6. Have you had a serious fall, or found your balance getting worse?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

7. Have you had any other serious illnesses (e.g. cancer)? If yes, please specify below:
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

Please write below any serious illnesses you have had since we last heard from you. Please include the year of your diagnosis:

_____

_____

8. Have you had any other significant event you would like to inform us of? If yes, please specify below:
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

_____

_____

Section C: Questions about your health

Questions about your health

Please read the following statements and **select one response** (unless specified otherwise), adding details where requested.
For certain questions, if you answer yes, you will be asked to enter your age at first diagnosis.

1. Would you say for someone of your age, your own health in general is:
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. Over the last twelve months would you say your health has on the whole been:
   - ☐ Good
   - ☐ Fairly good
   - ☐ Not good
   - ☐ Don't know

3. Do you have any long-standing illness, disability or infirmity?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

4. Do you receive any of the following? <u>You can select more than one answer.</u>
   - ☐ Attendance allowance
   - ☐ Disability living allowance
   - ☐ Blue badge
   - ☐ Personal Independence Payment (PIP)
   - ☐ None of the above

5. Compared with one year ago, has your weight changed?
   - ☐ No, weight about the same
   - ☐ Yes, gained weight
   - ☐ Yes, lost weight
   - ☐ Don't know

6. Do you have any difficulty with your hearing?
   - ☐ Yes
   - ☐ No ➤ Skip to question 7
   - ☐ Don't know

   6a. If yes, do you use a hearing aid most of the time?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

   6b. Do these hearing problems interfere with your day to day living?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

7. Do you find it difficult to follow a conversation if there is background noise (such as TV, radio, children playing)?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

8. Do you wear glasses or contact lenses to correct your vision?
   - ☐ Yes
   - ☐ No ➤ Skip to question 9

   8a. If yes, what age did you first start to wear either glasses or contact lenses?

   _____

8b. Are you short sighted, i.e. do you need glasses to help you see objects in the distance (myopia)?

- ☐ Yes
- ☐ No ➤ Skip to question 8d
- ☐ Don't know

8c. If yes, what is your prescription for your short sighted glasses? This is usually a negative number, e.g. -2.50, for each of your left and right eyes).

Left eye _____ Right eye _____

8d. Are you farsighted, i.e. you may be able to see distant objects clearly, but closer objects are usually out of focus (hyperopia)?

- ☐ Yes
- ☐ No ➤ Skip to question 9
- ☐ Don't know

8e. If yes, what is your prescription for your farsighted glasses? This is usually a positive number, e.g. +3.25, for each of your left and right eyes)

Left eye _____ Right eye _____

9. Do you have any other problems with your eyes or eyesight?

- ☐ Yes
- ☐ No ➤ Skip to question 11
- ☐ Don't know

9a. If yes, do any of these eye problems interfere with day to day living?

- ☐ Yes
- ☐ No
- ☐ Don't know

10. Has a doctor told you that you have any of the following problems with your eyes?
<u>You can select more than one answer</u>.

- ☐ Diabetes related eye disease
- ☐ Glaucoma
- ☐ Injury OR trauma resulting in loss of vision
- ☐ Cataract
- ☐ Macular degeneration
- ☐ Other serious eye condition
- ☐ None of the above

11. Have you ever been diagnosed with dementia?

- ☐ Yes
- ☐ No
- ☐ Don't know

11a. Have you ever been diagnosed with any other neurological disorders (e.g. Parkinson's)?

- ☐ Yes
- ☐ No
- ☐ Don't know

11b. Was your father ever diagnosed with dementia (e.g. Alzheimer's disease)?

- ☐ Yes
- ☐ No
- ☐ Don't know

11c. Was your mother ever diagnosed with dementia (e.g. Alzheimer's disease)?

- ☐ Yes
- ☐ No
- ☐ Don't know

11d. Have any of your brothers or sisters ever been diagnosed with dementia (e.g. Alzheimer's disease)?

- ☐ Yes
- ☐ No
- ☐ Don't know

Conditions diagnosed by your doctor

Has the doctor ever told you that you have any of the following?

- If you tick **yes,** please enter:
  - ➢ **Age** at first diagnosis in the box on the right hand side of the question.

For example, your table might look something like this:

	Has the doctor ever told you that you have any of the following?			If yes, please state your age at first diagnosis
	Yes	No	Don't know	Age (in years)
High blood cholesterol (hyperlipidaemia)	☑	☐	☐	55
Angina	☐	☑	☐	
Heart Attack (myocardial infraction)	☐	☑	☐	
Varicose veins	☐	☑	☐	
Migraine	☐	☐	☑	
Pulmonary embolism	☑	☐	☐	57
Deep vein thrombosis	☐	☑	☐	

➤ Turn to the next page to fill in the table

12. Has the doctor ever told you that you have any of the following? Please tick yes, no or don't know for every condition listed.

	Has the doctor ever told you that you have any of the following?			If yes, please state your age at first diagnosis
	Yes	No	Don't know	Age (in years)
High blood cholesterol (hyperlipidaemia)	☐	☐	☐	
Angina	☐	☐	☐	
Heart Attack (myocardial infraction)	☐	☐	☐	
Varicose veins	☐	☐	☐	
Migraine	☐	☐	☐	
Pulmonary embolism	☐	☐	☐	
Deep vein thrombosis	☐	☐	☐	
Diabetes **(not during pregnancy)**	☐	☐	☐	
Meningitis or encephalitis	☐	☐	☐	
Polyps in the large intestine	☐	☐	☐	
Pancreatitis	☐	☐	☐	
Appendicitis	☐	☐	☐	
Hayfever/eczema	☐	☐	☐	
Asthma	☐	☐	☐	
Asthma in **childhood only**	☐	☐	☐	
Bronchitis/emphysema	☐	☐	☐	
Osteoporosis	☐	☐	☐	
Insomnia requiring treatment	☐	☐	☐	
Depression requiring treatment	☐	☐	☐	
Did you ever receive ECT treatment	☐	☐	☐	
Intermittent claudication	☐	☐	☐	
Parkinson's disease	☐	☐	☐	
Multiple Sclerosis	☐	☐	☐	
Chronic Bronchitis	☐	☐	☐	

More conditions diagnosed by the doctor.

In this next section you will be asked about <u>any other</u> medical conditions that have been diagnosed by the doctor.

Please read the following statements and tick one response (unless specified otherwise), adding details where requested. If **yes**, please enter **age at first diagnosis**.

13. High blood pressure (hypertension) (hypertension during pregnancy does not count here)?
    - ☐ Yes
    - ☐ No ➤ Skip to question 14
    - ☐ Don't know

    13a. Please state your age (in years) at first diagnosis.

    _____

    13b. Are you still awaiting more specialist investigation?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

    13c. Did/do you receive medication for your high blood pressure (hypertension)?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

    13d. Is your high blood pressure still uncontrolled?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

14. Cardiac arrhythmia/palpitations/ irregular heartbeat?
    - ☐ Yes
    - ☐ No ➤ Skip to question 15
    - ☐ Don't know

    14a. If yes, please state your age (in years) at first diagnosis.

    _____

    14b. If yes, give details

    _____

    _____

15. Stroke
    - ☐ Yes
    - ☐ No ➤ Skip to question 16
    - ☐ Don't know

15a. If yes, please state your age (in years) at first diagnosis.

_____

15b. If yes, give details

_____

_____

16. Other vascular disease (not covered in other questions)

- ☐ Yes
- ☐ No ➤ Skip to question 17
- ☐ Don't know

16a. If yes, please state your age (in years) at first diagnosis.

_____

16b. If yes, specify

_____

_____

_____

17. Thyroid disease

- ☐ Yes
- ☐ No ➤ Skip to question 18
- ☐ Don't know

17a. If yes, please state your age (in years) at first diagnosis.

_____

17b. If yes, specify thyroid disease type **(Hypo, Hyper, don't know)**

_____

18. Peptic Ulcer

- ☐ Yes
- ☐ No ➤ Skip to question 19
- ☐ Don't know

18a. If yes, please state your age (in years) at first diagnosis.

_____

18b. If yes, specify Peptic Ulcer details

_____

19. Gallstones
    - ☐ Yes
    - ☐ No ➤ Skip to question 20
    - ☐ Don't know

    19a. If yes, please state your age (in years) at first diagnosis.

    _____

20. Have you had your gall bladder removed?
    - ☐ Yes
    - ☐ No ➤ Skip to question 21
    - ☐ Don't know

    20a. If yes, please state your age (in years) at first diagnosis.

    _____

21. Liver disease
    - ☐ Yes
    - ☐ No ➤ Skip to question 22
    - ☐ Don't know

    21a. If yes, please state your age (in years) at first diagnosis. _____

    21b. If yes, specify liver disease details

    _____

22. Allergies
    - ☐ Yes
    - ☐ No ➤ Skip to question 23
    - ☐ Don't know

    22a. If yes, please state your age (in years) at first diagnosis. _____
    22b. If yes, specify details

    _____

23. Arthritis
    - ☐ Yes
    - ☐ No ➤ Skip to question 24
    - ☐ Don't know

    23a. If yes, please state your age (in years) at first diagnosis. _____
    23b. If yes, specify details

    _____

24. Are you currently suffering from arthritis? If yes, does it limit your day-to day activities?
    - ☐ Not currently suffering from arthritis
    - ☐ Currently suffering but not limiting
    - ☐ Currently suffering and limiting

25. Tuberculosis
    - ☐ Yes
    - ☐ No ➤ Skip to question 26
    - ☐ Don't know

    25a. If yes, please state your age (in years) at first diagnosis. _____
    25b. If yes, specify details

    _____

26. Any other psychiatric illness (not covered in previous questions)
    - ☐ Yes
    - ☐ No ➤ Skip to question 27
    - ☐ Don't know

    26a. If yes, please state your age (in years) at first diagnosis. _____
    26b. If yes, specify details

    _____

27. Shingles
    - ☐ No ➤ Skip to question 28
    - ☐ Yes, in the body
    - ☐ Yes, in the head
    - ☐ Don't know

    27a. If yes, please state your age (in years) at first diagnosis. _____

28. Benign growths (non-cancer)
    - ☐ Yes
    - ☐ No ➤ Skip to question 29
    - ☐ Don't know

    28a. If yes, please state your age (in years) at first diagnosis. _____
    28b. If yes, specify details

    _____

29. Cancer
    - ☐ Yes
    - ☐ No ➤ Skip to question 32
    - ☐ Don't know

29a. If yes, please state your age (in years) at first diagnosis. _____

29b. If yes, specify details

_____

30. Are you currently receiving treatment or have you had any treatment for your cancer **in the last 6 months**?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

31. Are you currently in remission
    - ☐ Yes
    - ☐ No ➤ Skip to question 32
    - ☐ Don't know

    31a. If yes, how long have you been in remission?
    - ☐ Less than five years
    - ☐ More than five years

32. Have you ever had fits or epilepsy?
    - ☐ More than 1 fit
    - ☐ Only 1 known fit
    - ☐ No
    - ☐ Don't know

33. Have you ever experienced sudden problems with your speech, memory or vision which got better after a day, e.g. unclear speech, altered vision?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

34. Have you experienced a sudden weakness in an arm or leg which got better after a day? e.g clumsiness due to decreased power, tired/heavy limbs, losing grip on objects?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

35. Have you ever had a general anaesthetic?
    - ☐ Yes
    - ☐ No ➤ Skip to question 36
    - ☐ Don't know

    35a. If yes, how many times

    _____

36. Have you ever fallen?
    - ☐ Yes
    - ☐ No ➤ Skip to question 37
    - ☐ Don't know

36a. If yes, have you fallen in the last year? (By falling, we mean unintentionally coming to the floor, or ground or lower level such as landing on a chair or stair.)

_____

36b. If you have ever fallen, how many months ago was the last time you fell?

- ☐ Month's ago (please specify how many months ago) _____
- ☐ Don't know

36c. In which months did the fall(s) happen? Please specify approximate month and year for the most recent 6 falls:

- ☐ Fall 1 _____
- ☐ Fall 2 _____
- ☐ Fall 3 _____
- ☐ Fall 4 _____
- ☐ Fall 5 _____
- ☐ Fall 6 _____

36d. Number of times you have fallen in the last year (please specify how many falls). _____

36e. For the most recent fall as far as you are aware did you:

- ☐ Trip, slip or stumble
- ☐ Fall for no obvious reason
- ☐ Don't know

37. Have you ever had a serious head injury and been unconscious after it? (Have you ever been knocked out?)

- ☐ Yes
- ☐ No ➤ Skip to question 38
- ☐ Don't know

37a. Did you lose consciousness for more than 2 hours?

- ☐ Yes
- ☐ No
- ☐ Don't know

38. Have you ever fractured any bones?

- ☐ Yes
- ☐ No ➤ Skip to question 39
- ☐ Don't know

38a. Fracture of the hip

- ☐ Yes
- ☐ No
- ☐ Don't know

38b. Fracture of the wrist after age 20

- ☐ Yes
- ☐ No
- ☐ Don't know

38c. Fracture of the vertebra(e)

- ☐ Yes
- ☐ No
- ☐ Don't know

38d. Fracture of the skull

- ☐ Yes
- ☐ No
- ☐ Don't know

39. Do you have any of the following? **You can select more than one answer.**

- ☐ Mouth ulcers
- ☐ Loose teeth
- ☐ Painful gums
- ☐ Bleeding gums
- ☐ Toothache
- ☐ Dentures
- ☐ None
- ☐ Don't know

40. Have you had any other medical problem or operation that we have not covered?
Only doctor diagnosed conditions.

- ☐ Yes
- ☐ No ➤ Skip to question 41
- ☐ Don't know

40a. Please give details of each other medical problem or operation (not covered by the previous questions) in the table below. For each condition, please include your age when it was first diagnosed.

- ☐ Other Medical Problem or Operation 1 _____
- ☐ Other Medical Problem or Operation 2 _____
- ☐ Other Medical Problem or Operation 3 _____
- ☐ Other Medical Problem or Operation 4 _____
- ☐ Other Medical Problem or Operation 5 _____
- ☐ Other Medical Problem or Operation 6 _____

Now we would like to ask some questions about smoking tobacco:

41. Do you smoke tobacco **now?**
    - ☐ Yes, on most or all days
    - ☐ Yes, only occasionally
    - ☐ No ➤ Skip to question 42

Current smoker

41a. How old were you when you started smoking on most days? _____

41b. About how many cigarettes do you smoke on average each day? Include hand-rolled cigarettes if smoked first started smoking on most days? (Include hand-rolled cigarettes if smoked) _____

41c. Compared to 10 years ago do you smoke?

- ☐ More nowadays
- ☐ About the same
  ➤ Skip to question 43
- ☐ Less nowadays ➤ Skip to question 42c
- ☐ Don't know

42. Did you previously smoke tobacco? **I.e. Ex-Smoker**
    - ☐ Yes
    - ☐ No ➤ Skip to question 43

Ex-smoker

42a. How old were you when you first started smoking on most days?

- ☐ Age: _____
- ☐ Don't know

42b. In the past, how often have you smoked tobacco?

- ☐ Smoked on most or all days
- ☐ Smoked occasionally
- ☐ Just tried once or twice

42c. Why did you reduce your smoking? You can select more than one

- ☐ Illness or ill health
- ☐ Health precaution
- ☐ Doctor's advice
- ☐ Financial reasons
- ☐ Vape instead
- ☐ None of these reasons
- ☐ Don't know

43. How often do you have a drink containing alcohol?
    - ☐ Never ➤ Skip to question 44
    - ☐ Monthly or less
    - ☐ 2-4 times a month
    - ☐ 2-3 times a week
    - ☐ 4 or more times a week

43a. How many units of alcohol do you have on a typical day when drinking? One unit of alcohol is approximately 1 medium glass of wine; half a pint of beer/cider; or one 25ml measure of spirit.
- ☐ 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ more than 9

44. What was your sex assigned at birth:
    - ☐ Male
    - ☐ Female
    - ☐ Don't know
    - ☐ Prefer not to say

Men only section ➤If not applicable, skip to question 46

45. Has the doctor has ever told you that you have an enlarged prostate?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

Women only section ➤If not applicable, skip to question 47

46. How old were you when your periods started?
    - ☐ Age: _____
    - ☐ Don't know

46a. Have you had your menopause (periods stopped)
- ☐ Yes
- ☐ No ➤ Skip to question 46d
- ☐ Not sure – had a hysterectomy
- ☐ Not sure – other reason Don't know

46b. How old were you when your periods stopped?
- ☐ Age: _____
- ☐ Don't know

46c. Have you ever been on hormone replacement therapy (HRT) due to menopause?
- ☐ Yes
- ☐ No

46d. How many days is it since your last menstrual period?

- ☐ Enter number of days: _____
- ☐ Don't know

46e. How long, in days, is (or was) your usual menstrual cycle? **The number of days between each menstrual period.**

- ☐ Enter number of days: _____
- ☐ Irregular cycles
- ☐ Don't know

46f. Do you have an IUD or coil?

- ☐ Yes
- ☐ No ➤ Skip to question 47
- ☐ Don't know

46g. What type?

- ☐ Mirena
- ☐ Nova
- ☐ Other sort
- ☐ Don't know

Medications

The next few questions are related to any medicines, tablets or injections you are currently taking.

47. Are you currently taking any medicines, tablets or injections of any kind either that you buy yourself or that are prescribed by your doctors?

- ☐ Yes
- ☐ No
- ☐ Don't know

47a. Number of prescribed drugs _____

47b. In the box below please provide detail for **each prescribed drug**, including names, frequency and doses.

_____

_____

_____

47c. Number of **vitamins and over the counter drugs**. _____

47d. In the box below please provide detail for each vitamins and over the counter drug, including names, frequency and doses.

_____

_____

_____

Section D: Feelings in the past week

Tick the box beside the reply that is closest to how you have been feeling in the **past week (i.e. the past 7 days)**. Don't take too long over you replies, **your immediate answer is best**.

1. I feel tense or 'wound up':
   - ☐ Most of the time
   - ☐ A lot of the time
   - ☐ From time to time, occasionally
   - ☐ Not at all

2. I still enjoy the things I used to enjoy:
   - ☐ Definitely as much
   - ☐ Not quite so much
   - ☐ Only a little
   - ☐ Hardly at all

3. I get a sort of frightened feeling as if something awful is about to happen:
   - ☐ Very definitely and quite badly
   - ☐ Yes, but not too badly
   - ☐ A little, but it doesn't worry me
   - ☐ Not at all

4. I can laugh and see the funny side of things:
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

5. Worrying thoughts go through my mind:
   - ☐ A great deal of the time
   - ☐ A lot of the time
   - ☐ From time to time, but not too often
   - ☐ Only occasionally

6. I feel cheerful:
   - ☐ Not at all
   - ☐ Not often
   - ☐ Sometimes
   - ☐ Most of the time

7. I can sit at ease and feel relaxed:
   - ☐ Definitely
   - ☐ Usually
   - ☐ Not often
   - ☐ Not at all

8. I feel as if I am slowed down:
   - ☐ Nearly all the time
   - ☐ Very often
   - ☐ Sometimes
   - ☐ Not at all

9. I get a sort of frightened feeling like 'butterflies' in the stomach:
   - ☐ Not at all
   - ☐ Occasionally
   - ☐ Quite often
   - ☐ Very often
10. I have lost interest in my appearance:
   - ☐ Definitely
   - ☐ I don't take as much care as I should
   - ☐ I may not take quite as much care
   - ☐ I take just as much care as ever
11. I feel restless as if I have to be on the move:
   - ☐ Very much indeed
   - ☐ Quite a lot
   - ☐ Not very much
   - ☐ Not at all
12. I look forward with enjoyment to things:
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all
13. I get sudden feelings of panic:
   - ☐ Very often indeed
   - ☐ Quite often
   - ☐ Not very often
   - ☐ Not at all
14. I can enjoy a good book or radio or TV programme:
   - ☐ Very often indeed
   - ☐ Quite often
   - ☐ Not very often
   - ☐ Not at all

Section E: Memory

Please read the following statements about different sorts of memories and select <u>one</u> response that is most appropriate to how you feel.

1. Do you feel you have any problems with your memory?
   - ☐ Yes
   - ☐ No

2. I find myself asking again and again what day of the week it is:
   - ☐ Never happens
   - ☐ Has happened once or twice
   - ☐ Happens occasionally
   - ☐ Happens all the time
   - ☐ Don't know

3. I find myself repeating the same story/message again and again:
   - ☐ Never happens
   - ☐ Has happened once or twice
   - ☐ Happens occasionally
   - ☐ Happens all the time
   - ☐ Don't know

4. I forget that family members or friends have died:
   - ☐ Never happens
   - ☐ Has happened once or twice
   - ☐ Happens occasionally
   - ☐ Happens all the time
   - ☐ Don't know

5. I forget what month or the year it is:
   - ☐ Never happens
   - ☐ Has happened once or twice
   - ☐ Happens occasionally
   - ☐ Happens all the time
   - ☐ Don't know

6. I can do something again and again, not realising I have done it before:
   - ☐ Never happens
   - ☐ Has happened once or twice
   - ☐ Happens occasionally
   - ☐ Happens all the time
   - ☐ Don't know

7. I have great difficulty in finding my way around places that I once knew well:
   - ☐ No change
   - ☐ A little worse
   - ☐ Somewhat worse
   - ☐ Very much worse
   - ☐ Don't know

8. I have problems in knowing where things are kept in the house:
   - ☐ No change
   - ☐ A little worse
   - ☐ Somewhat worse
   - ☐ Very much worse
   - ☐ Don't know

9. I have great difficulty in remembering what I have read:
   - ☐ No change
   - ☐ A little worse
   - ☐ Somewhat worse
   - ☐ Very much worse
   - ☐ Don't know

10. I have great difficulty in following a TV programme:
    - ☐ No change
    - ☐ A little worse
    - ☐ Somewhat worse
    - ☐ Very much worse
    - ☐ Don't know

11. My memory difficulties have a major impact on my ability to do everyday things I was once able to do easily:
    - ☐ No
    - ☐ To a slight extent
    - ☐ To some degree
    - ☐ A great deal
    - ☐ Don't know

Section F: Sleep

Please carefully read the following statements and respond as requested. Your answers should indicate the most accurate reply for the majority of days and nights in the past month (i.e. past 30 days).

1. During the past month, when have you usually gone to bed at night? Please give the time in the 24 hour format, e.g. 10:30pm would be 22:30

   _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

   _____

3. During the past month, when have you usually got up in the morning? Please give the time in the 24 hour format, e.g. 10:30pm would be 22:30

   _____

4. During the past month, how many hours and minutes (HH:MM) of actual sleep did you get at night? **This may be different than the number of hours you spend in bed.**

   _____

For each statement, please tick the box with the most accurate reply for the majority of days and nights in the past month.

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

	Not during the past month	Less than once a week	Once a week or twice a week	Three or more times a week	Don't know
Cannot get to sleep within 30 minutes					
Wake up in the middle of the night or early morning					
Have to get up to use the bathroom					
Cannot breathe comfortably					

	Not during the past month	Less than once a week	Once a week or twice a week	Three or more times a week	Don't know
Cough or snore loudly					
Feel too cold					
Feel too hot					
Had bad dreams					
Have pain					

5a. Any other reasons (not listed in the table above), and if so how often?

- ☐ Not during the past month (i.e. no other reason)
- ☐ Less than once a week
- ☐ Once or twice a week
- ☐ Three or more times a week
- ☐ Don't know

5b. Please provide details for any other reason(s) you have trouble sleeping:

_____

_____

6. During the past month how would you rate your sleep quality overall?
   - ☐ Very good
   - ☐ Fairly good
   - ☐ Fairly bad
   - ☐ Very bad
   - ☐ Don't know

7. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?
   - ☐ Not during the past month
   - ☐ Less than once a week
   - ☐ Once or twice a week
   - ☐ Three or more times a week
   - ☐ Don't know

8. 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
   - ☐ Once or twice a week
   - ☐ Three or more times a week
   - ☐ Don't know

9. 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
   - ☐ Don't know

10. Do you have a bed partner or roommate
   - ☐ No bed partner or roommate
   - ☐ Partner in other room
   - ☐ Partner/roommate in same room, but not same bed
   - ☐ Partner in same bed
   - ☐ Don't know

11. How often do you feel tired at the following time

	Most days	Often	Occasionally	Never	Don't know
Morning					
Afternoon					
Evening					

➤ Go to the next page for the next section

Section G: Vigorous, moderate and walking activity

Now we will ask separately about all the vigorous, moderate and walking activities that you did in the last 7 days.

Vigorous activity over the last 7 days

Think about all the **vigorous activities** that you did for at least 10 minutes, i.e. activities that take hard physical effort and make you breathe much harder than normal.

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

   - _____ days per week
   - ☐ No vigorous physical activities

2. How much time did you usually spend doing vigorous physical activities on one of those days?
   Please provide hours AND minutes

   - ☐ _____ hours **and** _____ minutes per day
   - ☐ Don't know/Not sure

Moderate activity over the last 7 days

Now think about all the **moderate activities** that you did for at least 10 minutes, i.e. activities that take moderate physical effort and make you breathe somewhat harder than normal.

3. **During the last 7 days**, on how many days did you do moderate physical activities like carrying light loads, cycling at a regular pace, or doubles tennis? Do not include walking.

   - _____ days per week
   - ☐ No moderate physical activities

4. How much time did you usually spend doing moderate physical activity on one of those days?
   Please provide hours AND minutes

   - ☐ _____ hours **and** _____ minutes per day
   - ☐ Don't know/Not sure

Walking activity over the last 7 days

Now, please think about the time you spent **walking** including at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.

5. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?

   - _____ days per week
   - ☐ No walking

7. How much time did you usually spend walking on one of those days?
Please provide hours AND minutes
- ☐ _____ hours **and** _____ minutes per day
- ☐ Don't know/Not sure

Sedentary behaviour over the last 7 days

Finally, please think about the time you spent sitting including time spent at work, home, and during leisure time, e.g. sitting at a desk, reading, watching television.

8. During the last 7 days, how much time did you spend sitting on a week day?
Please provide hours AND minutes
- ☐ _____ hours **and** _____ minutes per day
- ☐ Don't know/Not sure

➤ Go to the next page for the next section

Section H: COVID-19

The following questions will ask whether you contracted COVID-19 and any symptoms you experienced.

1. Do you think that you have or have had COVID-19?
   - ☐ Yes, confirmed by a positive test
   - ☐ Yes, but not tested / was not confirmed by a positive test
   - ☐ Don't know
   - ☐ No

   ➤ Skip to question 2

1a. If yes, approximately, when were you tested positive for COVID-19/think you had COVID-19?

If you were infected more than once, list the month and year of all occurrences. For each occurrence indicate whether it was confirmed by a positive test or not by ticking **Confirmed** or **Not confirmed:**

	Month	Year	Confirmed by a positive test	Not confirmed
1st COVID occurrence				
2nd COVID occurrence				
3rd COVID occurrence				
4th COVID occurrence				

1b. Did you experience any COVID-19 or LONG COVID symptoms?

- ☐ Yes
- ☐ No

1c. Which symptoms did you experience while you were infected with COVID-19 (i.e., within 1 month of the diagnosis)? **Tick all that apply:**

- ☐ High temperature or shivering (chills)
- ☐ New, continuous cough – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours
- ☐ Loss or change to your sense of smell or taste
- ☐ Shortness of breath
- ☐ Feeling tired or exhausted
- ☐ Aching body Headache
- ☐ Sore throat
- ☐ Blocked or runny nose
- ☐ Loss of appetite
- ☐ Diarrhoea
- ☐ Feeling sick or being sick
- ☐ Other symptom(s) detail:

_____

_____

1d. Have you been hospitalised due to COVID-19?

- ☐ Yes
- ☐ No ➤ Skip to question 1f

1e. If yes, when were you **hospitalised** due to COVID-19? **Please list the month and year of each hospitalisation:**

	Month	Year
1st COVID occurrence		
2nd COVID occurrence		
3rd COVID occurrence		
4th COVID occurrence		

1f. Do you think that you have or have had LONG COVID?

- ☐ Yes, confirmed by a doctor
- ☐ Yes, my own suspicions
- ☐ Don't know
- ☐ No

➤ Skip to question 2

1g. Which LONG COVID-19 symptoms did you experience (i.e., symptoms that lasted more than 1 month of the diagnosis)? **Tick all that apply:**

- ☐ Extreme tiredness (fatigue)
- ☐ Shortness of breath
- ☐ Chest pain or tightness
- ☐ Problems with memory and concentration ("brain fog")
- ☐ Difficulty sleeping (insomnia)
- ☐ Heart palpitations
- ☐ Dizziness
- ☐ Pins and needles
- ☐ Joint pain
- ☐ Depression and anxiety
- ☐ Tinnitus, earaches
- ☐ Feeling sick, diarrhoea, stomach aches, loss of appetite
- ☐ A high temperature, cough, headaches, sore throat, changes to sense of smell or taste
- ☐ Rashes
- ☐ Other symptom(s) detail: Other symptom(s) detail:

_____

_____

_____

2. Were you vaccinated against COVID-19?
   - ☐ Yes
   - ☐ No ➤ Skip to question 5

3. How many doses of vaccination for COVID-19 did you have?
   - ☐ 1
   - ☐ 2
   - ☐ 3
   - ☐ More than 3

4. Approximately, when did you receive your COVID-19 vaccination(s)? **Please list the dates (MM and YYYY) of all occurrences:**

	Month	Year
1st COVID vaccination		
2nd COVID vaccination		
3rd COVID vaccination		
4th COVID vaccination		

5. Has anyone in your immediate family been hospitalised due to COVID?
   - ☐ Yes
   - ☐ No

6. Does anyone your immediate family suffer, or have suffered, from LONG COVID?
   - ☐ Yes
   - ☐ No

Thank you for your time!

Feel free to write any comments about filling this questionnaire below:

_____

_____

_____

_____

_____