Health Among Women Study

- Use a black or blue ball-point pen
- If you want to change your answer, fill in the wrong box completely and mark the correct box
- If needed, you can fill in the questionnaire with another person.

Personal number 1 9 ____ - ____

YOUR HEALTH

1. How are you currently feeling in general?

	Very Good	Good	Okay	Bad	Very Bad
How is your health?	☐	☐	☐	☐	☐
How is your memory?	☐	☐	☐	☐	☐
How is your physical condition?	☐	☐	☐	☐	☐
How is your appetite?	☐	☐	☐	☐	☐
How is your mood?	☐	☐	☐	☐	☐
How is your energy?	☐	☐	☐	☐	☐

2. Have you or have you had any of the following conditions?

☐ High blood pressure	☐ Allergy	☐ Migraine	☐ Kidney stones
☐ High cholesterol	☐ Asthma	☐ Joint pain	☐ Gallstones
☐ Angina	☐ COPD (chronic lung disease)	☐ Rheumatoid arthritis	☐ Gastritis
☐ Intermittent claudication	☐ Chronic bronchitis	☐ Parkinson's disease	☐ Ulcerative colitis
☐ Heart failure	☐ Hay fever	☐ MS (multiple sclerosis)	☐ IBS / irritable bowel
☐ Dizziness	☐ Pollen allergy	☐ Psoriasis	☐ Crohn's disease
☐ Tinnitus	☐ Endometriosis	☐ Eczema	☐ Depression
☐ Osteoporosis	☐ Severe menopausal symptoms	☐ Atopic eczema (as a child)	☐ Glaucoma

3. Do you have diabetes?

☐ No ☐ Yes, it was detected at _____ years of age. The treatment I use now is ☐ Insulin ☐ Tablets ☐ Dietary advice

4. If you do not take blood pressure medicine, has your blood pressure been checked in the last 3 years?

☐ No ☐ Yes, it has been checked and ☐ it was too low ☐ it was normal ☐ it was mildly elevated ☐ it was markedly elevated

5. What are your body measurements? *Enter only whole numbers*

Height_____ cm Weight _____ kg Waist _____ cm Hip _____ cm

6. At what age did menopause begin? At the age of _____ .

7. How many doctor visits have you had in the past 12 months? _____ visits

8. What is your view of life? ☐ Very positive ☐ Positive ☐ Negative ☐ Very negative

DENTAL HEALTH

9. Do you have…

all of your teeth (not including wisdom teeth)?	☐ No	☐ Yes	
pulled out / lost teeth (in addition to wisdom teeth) in adulthood?	☐ No	☐ Yes	no. ____
whole or partial dentures (not counting bridge or implant)?	☐ No	☐ Yes	
bleeding of the gums when you brush your teeth?	☐ No	☐ Yes	
peridontal disease / periodontitis?	☐ No	☐ Yes	
problems with dry mouth?	☐ No	☐ Yes	
problems with chewing?	☐ No	☐ Yes	

ACHES AND PAINS

10. During the past 12 months have you had at work, or during chores at home, pain in:

the back ☐ No ☐ Yes the shoulders ☐ No ☐ Yes the neck ☐ No ☐ Yes

11. During the past 12 months have you had 3 months or longer of pain in:

the knee / the knees ☐ No ☐ Yes the hips ☐ No ☐ Yes

12. Have you gone through any of the following operations?

Torn cartilage ☐ No ☐ Yes artificial part in the knee ☐ No ☐ Yes

Ligament damage in the knee ☐ No ☐ Yes artificial part in the hip ☐ No ☐ Yes

MEDICINES

13. Do you **regularly** or **intermittently** use any of the following medicines?

Cortisone in tablet form or inhalation ☐ No ☐ Yes→ total over _____ years

Magnecyl, Bamyl, Treo, Aspirin, Albyl, Trombyl ☐ No ☐ Yes, _____ tablets/week during ☐ less than 10 years ☐ 10-20 years ☐ more than 20 years

Alvedon, Panodil, Reliv, Citodon ☐ No ☐ Yes, _____ tablets/week during ☐ less than 10 years ☐ 10-20 years ☐ more than 20 years

Ipren, Diklofenak, Voltaren, Ibumetin, Naproxen ☐ No ☐ Yes, _____ tablets/week during ☐ less than 10 years ☐ 10-20 years ☐ more than 20 years

14. Have you used anitbiotics during the last 10 years? ☐ No

☐ Yes→ ☐less than 1 course a year ☐1 course/year ☐2-3 courses/year ☐ more than 3 courses/year

15.Have you used estrogen supplements? ☐ No, I have never used any type of estrogen

☐ Yes, I have taken estrogen supplements for ☐ less than 5 years ☐ 5-10 years ☐ more than 10 years

Such as: ☐ cream / pessaries ☐ tablets ☐ patches

SIGHT, HEARING AND BALANCE

16. Have you had cataract surgery? ☐ No ☐ Yes→ When I was _____ years old.

17. Do you use a hearing aid? ☐ No ☐ Yes→ At which age did you start using a hearing aid?

☐ before 30 ☐30-40 ☐40-50 ☐50-60 ☐60-70 ☐70-80 ☐ after 80

18. Do you have a good sense of taste? ☐ Yes ☐ No → At which age did you lose your sense of taste?

☐ before 30 ☐30-40 ☐40-50 ☐50-60 ☐60-70 ☐70-80 ☐ after 80

19. Do you have good balance? ☐ Yes ☐ No → At which age did your balance become impaired?

☐before 30 ☐30-40 ☐40-50 ☐50-60 ☐60-70 ☐70-80 ☐ after 80

20. Have you fallen during the past 12 months? ☐ No ☐ Yes, _____ time(s).

SLEEP HABITS

21. How much sleep do you need per day? _____ hours How long do you sleep per night on average? _____ hours

22. What time do you usually fall asleep? ___:___ (time) What time do you usually wake? ___:___ (time)

Do you regularly take a nap? ☐ No ☐ Yes→ from ___:___ (time) until ___:___ (time) per day

23. How do you find that you sleep on the whole?

☐ Very good ☐ Fairly good ☐ Neither good nor bad ☐ Fairly bad ☐ Very bad

24. How often have you had the following symptoms in the past 3 months?

	Never	Seldom	Often	Mostly	Always
Difficulty falling asleep	☐	☐	☐	☐	☐
Repeated awakenings with difficulty falling asleep	☐	☐	☐	☐	☐
Premature awakening	☐	☐	☐	☐	☐
Disturbed / restless sleep	☐	☐	☐	☐	☐
Sleep apnea / apnea	☐	☐	☐	☐	☐
Disturbing snoring	☐	☐	☐	☐	☐

25. Have you had working hours that required you to occasionally work at night?

☐ No ☐ Yes, I did this for _____ years.

TOILET HABITS

26. These questions concern urination over the **past month**

	Not at all	A little	Moderately	Much
Are you experiencing symptoms from the lower urinary tract?	☐	☐	☐	☐
Do you think you urinate often?	☐	☐	☐	☐
Do you have a strong urge to urinate?	☐	☐	☐	☐
Are you experiencing urinary leakage?	☐	☐	☐	☐
Is there leakage of urine at physical exertion / cough?	☐	☐	☐	☐
Is there leakage of urine without any activity?	☐	☐	☐	☐
Does the urine leak in drops?	☐	☐	☐	☐
Is there leakage of large amounts of urine?	☐	☐	☐	☐
Do you get up at night to urinate?	☐	☐	☐	☐
Are you experiencing difficulty in passing urine?	☐	☐	☐	☐
Does it feel like your bladder does not empty?	☐	☐	☐	☐
Is there pain when you urinate?	☐	☐	☐	☐

	Never	1 time	2 times	3 times	4 times	5+
27. How often do you usually urinate at night?	☐	☐	☐	☐	☐	☐
28. Have you had a urinary tract infection / urinary retention?	☐	☐	☐	☐	☐	☐

	Very Good	Good	Accept-able	Neither Good/Bad	Fairly Bad	Very Bad	Terrible
29. If you had to live with urination the way it is today how would you feel?	☐	☐	☐	☐	☐	☐	☐

30. Do you have a bowel movement every day? ☐ Yes ☐ No, it takes _____ day(s) between times

31. Do you have a bowel movement several times a day? ☐ Yes ☐ No

32. How often do you experience difficulty with bowel movements?

☐ Never ☐ less than 1 time/week ☐ 1-6 times/week ☐ Always

33. Do you / have you had fecal leakage? ☐ No ☐ Yes, I have had it before ☐ Yes, I have it now

YOUR FAMILY'S HEALTH

34. Have any of your parents or siblings had:

	No	Yes, mother	Yes, father	Yes, sibling	Don't know
Breast cancer	☐	☐		☐	☐
Prostate cancer	☐		☐	☐	☐
Colon cancer	☐	☐	☐	☐	☐
Other cancer	☐	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Myocardial infarction before 60	☐	☐	☐	☐	☐

35. What age did your parents live to?

Mother was _____ years old ☐ Mother still alive Father was _____ years old ☐ Father still alive

STRESS

36. With stress, we mean that you feel tense, irritable, nervous, anxious or have difficulty sleeping because of situations at work or in private life (e.g. feelings of sadness or powerlessness)

	In private life	At work
I have never experienced stress	☐	☐
I have experienced a stressful period	☐	☐
I have experienced a stressful period in the past 5 years	☐	☐
I have experienced several periods of stress in the past 5 years	☐	☐
I have experienced constant stress in the past year	☐	☐
I have experienced constant stress in the past 5 years	☐	☐
I have had many long periods of stress in my life	☐	☐

37. How often do you feel very strong anger?

_____ times per day _____ times per week ☐ seldom ☐ never

HOW ARE YOU FEELING?

38. How have you felt during the last week?	Always / almost all the time	Often / fairly often	Sometimes / Very rarely	Never / almost never
I felt that I could cope with serious problems or major changes in my life	☐	☐	☐	☐
I have felt calm and relaxed	☐	☐	☐	☐
I have felt energetic, active and enterprising	☐	☐	☐	☐
When I woke up, I felt fresh and rested	☐	☐	☐	☐
I have felt happy or satisfied and pleased with my personal life	☐	☐	☐	☐
I have felt sad and down	☐	☐	☐	☐
I am satisfied with my life	☐	☐	☐	☐
I live the kind of life I want to live	☐	☐	☐	☐
I have been eager to address the day's work or make new decisions	☐	☐	☐	☐
I have felt that life is full of interesting things	☐	☐	☐	☐

FAMILY, FRIENDS AND ACQUAINTANCES

39. How many people, with the same interests as you, do you know and have contact with? Both at work and in spare time

☐ No one ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-15 ☐ More than 15

40. How many people, that you know well, do you meet or talk with during a normal week? Do not count those that you run into unexpectedly.

☐ None ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-15 ☐ More than 15

41. How many friends do you have that can come to your home anytime and feel at home? They would not care if it was untidy or if you were about to eat. Do not count close relatives.

☐ None ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-15 ☐ More than 15

42. How many are there, in your family or among your friends who you can talk openly with?

☐ None ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-15 ☐ More than 15

43. How many people are there in your environment who you can easily ask for things? People who know you so well that you can borrow tools or kitchen things?

☐ None ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-15 ☐ More than 15

44. Apart from those at home, how many are there that you can turn to if you are in difficulty? Someone who you can easily meet and who you trust and can really help you when you are experiencing difficulties?

☐ None ☐ 1-2 ☐ 3-5 ☐ 6-10 ☐ 11-15 ☐ More than 15

OTHER ISSUES

45. What is your current employment?

☐ Full-time ☐ Part-time ☐ Not working ☐ Disability ☐ Retired

46. Where do you live now?

☐ Home ☐ Assisted living facility ☐ Nursing home ☐ Retirement home

There are_____ people in the household. I have lived alone for _____ years.

47. Do you have pets (e.g. dog or cat) at home? ☐ Yes ☐ No

48. Are you active in any club? ☐ Yes ☐ No

Did you have help from someone to complete the survey? ☐ No ☐ Yes

Can we call you if we need anything further? If so, please fill in your telephone number

Daytime phone _____ *Evening phone* _____

I have read the attached information letter and want to continue to participate in the study.

Date _____ *Signature* _____

Many thanks for your participation!