#### Dear HUNT participant

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Thank you for taking part in this health study. We ask that you complete this questionnaire. Though some of the questions are similar to questions you have previously answered, it is important that you answer all the questions. The information will be used in research and preventative health care. Researchers will only have access to anonymous information; this means that the information cannot be traced back to the individual participants.

Please complete the questionnaire and send it in as soon as pos	
Date completed 20	Vigorous physical activity sweat, out of breath
Housing and Friends Who do you live with? (One or more Xs) No one	How many hours in total are you in front of a computer screen? (Write 0 if you don't use a computer) Work hours Leisure hours
Parents	
Spouse/partner	How many hours do you watch TV/video/DVD daily? Less than 1 hour 4-6 hours
Other people over 18 years old	1-3 hours
Other people under 18 years old Number of people under 18	Culture/Life Philosophy
Are there any pets in your home?	How often <u>in the last 6 months</u> have you been to:
No Yes, Yes, Yes, other cat dog animals w/ fur/birds	(One X per line) More than 1-3 x 1-6 x Never 3 x /mo. /mo /6 mos.
Do you have friends that can Yes No	Museum/art exhibition
help you when you need them?	Concert, theatre, film
Do you have friends that you can Yes No	Church/chapel
speak to confidentially?	Sports event
Your Surroundings (neighbourhood/group of farms) I feel a strong sense of community with the people who live here (One X) Strongly Somewhat Not sure Somewhat Strongly	How many times in the last 6 months have you participated in the following: (One X per line) More 1x 1-3x 1-5x Never than /week /mo. /6 1x mos.
agree disagree disagree	Association or club and an analysis of the second s
We do not trust each other here (One X)         Strongly       Somewhat       Not sure       Somewhat       Strongly         agree       agree       disagree       disagree         Image: Image	theatre  Image: Constraint of the atree    Parish work  Image: Constraint of the atree    Outdoor activities  Image: Constraint of the atree    Dance  Image: Constraint of the atree
People like living here (One X)	Worked out, sports
Strongly     Somewhat     Not sure     Somewhat     Strongly       agree     agree     disagree     disagree       Image: Image interval int	Which life philosophy is most like yours? (One X only)       Christian       Atheistic
Physical Activity	Humanistic Other
How much of your leisure time have you been physically active in the last year? Weekly average for the year. Commute counts as leisure time. Hours a week	When something bad happens in my life, I think that it happened for a purpose.         No       Yes       Don't know
None Less 1-2 3	
Low physical activity no than 1 sweat, not out of breath	I seek God's help when I need strength and solace. Never Sometimes Often

Personality
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Describe yourself as you <u>normally</u> are:	Maa	No
Are you a life of the party type person?	Yes	
Are you mostly quiet and reserved when you are around other people?		
Do you like meeting new people?		
Do you like to have a lot of life and excitement around you?		
Are you a relatively lively person?		
Do you usually take the first step to make new friends?		
Are you often worried?		
Are your feelings easily hurt?		
Do you often feel that you lose interest?		
Do you have nervous problems?		
Do you often feel tired and		
indifferent/unmotivated without reason? Do you worry that terrible things might happen?		

## Headaches

Have you had headaches	in the last year?
If No, skip to Respiratory	Tract
If Yes, what type of heada Migraine Oth	ache? er headache
Average number of days Less than 1 day 1-6 day	
What is the average stren Mild (does not affect activity	
Moderate (affects activity)	
Strong (hinders activity)	
How long does the heada Less than 4 hours	che usually last? ] 1-3 days 🗌
4 hours – 1 day	More than 3 days
Are the headaches usuall accompanied by:	
) Throbbing/thumping pain	One X per line) Yes No
Pressing pain	
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Pain on one side of the head (right or left)		
Worsening with physical activity		
Nausea and/or vomiting		
Hypersensitivity to light and/or noise		
Before or during the headache, have you had temporary: (One X per line) Visual disturbances	Yes	No
(zigzag lines, flickering/flashing light, fogged vision) Numbness in half of your face or hand		
Write the number of days you have been absent from work or school in the last month because of headaches		days
Respiratory Tract		
Do you cough daily in periods of the year?	Yes	No
Do you usually bring up phlegm when coughing?		
Have you had a cough with phlegm for periods of <u>at least 3 months</u> during each of the last two years?		
Do you have or have you had hayfever or nasal allergies? If Yes:		
Have you had hayfever/allergy symptoms in the last <u>12 months?</u>		
In the <u>last 12 months</u> have you woken during the night because you were short of breath?		
Auscles and Joints		
In the last year, have you had pain or stif muscles or joints that has lasted at least consecutive months?		in
Yes 🔄 If No, skip	No to que:	stion 30
f Yes, Vhere have you had this pain or stiffness Neck	(One or	more Xs)
Shoulders		
Upper back		
Elbows		
Lower back		
Wrists/hands		
Hips		
Knees		

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Ankles/feet	<u>12 months:</u>	
Have you had this Yes No	Nausea	A little Muc
pain/stiffness on both the right and left side of your body?	Heartburn/acid regurgitation	
	Diarrhoea	
Does this pain/stiffness hinder your daily activities? Yes No	Constipation	
Work	Alternating constipation and	пп
Leisure	Bloating	
Have you had back surgery? Yes No		
If Yes, Type of back surgery Prolapse/sciatica surgery Fixation Other	How You Feel         Read each item below and place an X next         that comes closest to how you have been f         past week (only one X per item). Do not ta         over your replies; your immediate reaction         will probably be more accurate than a long	feeling <b>in the</b> ake too long to each item
Metabolism	response. I feel tense or 'wound up' Not From time to A lot of at time, the	Most of the time
Has it ever been verified       first time         that you have/have had:       Yes       No         Hypothyroidism (too low	Definitely as much Only a little	
If Yes: Did you take Neo-Mercazole? Have you had radioiodine treatment? Abdomen	Very definitely and A little, but it	-
Have you had stomach pain or discomfort <u>in the last</u> <u>12 months</u> ? Yes, Yes, a little No, never If No, skip to question 3-	I can laugh and see the funny side of thi As much as I Definitely not so always could much now Not quite so much Not at all now	ings
If Yes: Is it localized in the upper stomach?	A great deal of the Not too often time	
In the last 3 months, have you had this as often as 1 day a week for at least 3 weeks?	A lot of the time Very little	
Is the pain/discomfort relieved by having a bowel movement?	Never     Sometimes       Not often     Most of the time	
Is the pain/discomfort related to more frequent or less frequent bowel movements than normal?	I can sit at ease and feel relaxed Definitely Not often	
Is the pain/discomfort related to the stool	Usually Dot at all	
Do you have this pain/discomfort after	I feel as if I'm slowed down Nearly all the time Sometimes	
To what degree have you had the following in the last	Very often Not at all	
F	3	-

Much

I get a sort of frigh the stomach	tened	feeling like 'butterflie	s' in
Not at all		Quite often	
Occasionally		Very often	
I have lost interest Definitely I don't take as much care as I should	in my	appearance I may not take quite as much care I take just as much care as ever	
I feel restless as if Very much indeed Quite a lot	I have	<b>to be on the move</b> Not very much Not at all	
I look forward with As much as I ever did Rather less than I used to	enjoy	ment to things Definitely less than I used to Hardly at all	
I get sudden feelin Very often indeed Quite often	gs of	<b>panic</b> Not very often Not at all	
I can enjoy a good programme Often Sometimes	book	<b>or radio or TV</b> Not often Very seldom	

#### Sleep

How often in the last 3 months have you:				
	Seldom /never	Some- times	Several x week	
Snored loudly (bothersome)				
Stopped breathing when you were sleeping (Sleep apnoea)				
Had difficulty falling asleep at night				
Woken up repeatedly during the night				
Woken too early and couldn't get back to sleep				
Felt sleepy during the day				
Sweat while sleeping (night- time)				
Woken with a headache				
Felt an uncomfortable or pins and needles feeling in your legs				

#### Alcohol

If you do not drink alcohol, skip to question 54.

No

Yes

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Have you ever felt that you should reduce your alcohol intake?

Have other people ever criticised your use of alcohol?

Have you ever felt bad or guilty because of your use of alcohol?

Have you ever had a drink first thing in the morning as a pick-me-up or to calm your nerves or to cure a hangover?

#### Diet

#### How many pieces of bread do you usually eat? Put an X for each type of bread 2-3 pr 0-4 pr 5-7 pr 4-5 pr 6 week day or more week day pr day White bread $\square$ Π Wholemeal/ $\square$ П medium ground Multigrain $\Box$ $\Box$ wholemeal/ coarsely ground

#### How often do you normally eat these meals?

(One X for each meal)

(One x for each	Seldom/ never	1-2 x a week	3-4 x a week	5-6 x a week	Every- day
Breakfast					
Lunch					
Warm dinner					
Supper/ evening snack					
Other meal					
Midnight snack (24.00- 06.00)					
What type of f each line)	at do yo	u most o	often use?	(One X	for
,	Butter		Soft/light margarine		Don't use
On bread		marg. i			
For cooking					

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Dental	Health	
- ontai		

Have you been to the last <u>12 months</u>		Yes 🗌 No	
How would you	say your denta	al health is?	
Very bad		Good	
Bad		Very good	
OK			
Is good dental h	ealth importar	it to you?	
Very much		A little	
Much		Svært lite	
Somewhat			

# Use of Non-Prescription Medicine How often have you taken non-prescription medicine for the following problems in <u>the last month</u>:

• •	Seldom/	1-3 x a	4-6 x a	Daily
Heartburn/ acid regurgitation Constipation	never		week	
Headache				
Pain in muscles/joints				
Have you taken any of prescription medicine week in the last month Paracetamol, Paracet, F	es <u>at leas</u> t <u>h</u> ?	<u>t once a</u>	Yes	No
Pinex, Perfalgan Albyl E (500 mg), Aspiri	n, Globoid,	Dispril		
lbuprofen, lbux, lbuprox	, Ibumetin,	Brufen		
Naproxen, Naprosyn, Le	edox			
Other				

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## How You Feel Now Do you feel, for the most part, strong and fit or tired and worn out?

Very strong and fit	
Strong and fit	
Somewhat strong and fit	
Somewhat in between	
Somewhat tired and worn out	
Tired and worn out	
Very tired and worn out	

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#### Additional Section Men 20-29 Employment

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Is your work so physically demanding that you are often physically worn out after a day's work? (Only one X)

Yes, nearly always		Seldom				
Quite often		Never, or almost never				
Does your work require so much concentration and attention that you often feel worn out after a day's work? (Only one X)						
Yes, nearly always	Í 🗌	Seldom				
Quite often		Never, or almost never				
All things considered, how much do you enjoy your						

## work? (Only one X)

A great deal	Not much	
A fair amount	Not at all	

#### Your Feelings in the Last 14 Days

In the last two weeks, have you: (One X for each line)

	No	A little	A good amount	Very much
Been continuously afraid and anxious				
Felt tense and restless				
Felt hopelessness when you think about the future				
Felt down and sad				
Worried too much about various things				

#### Life Events

# Have you experienced any of the following in the last 10 years? (Put an X for each question)

	No	Yes	
		Last 12 mos.	Earlier
Had problems at work or school?			
Had financial problems?			
Had problems or conflicts with family or friends?			
Had big problems in your love life?			
Been seriously ill or injured?			
Have those nearest you been seriously ill or injured?			
+			

#### Eating Habits

Below are listed things that concern your eating habits. Put an X in the boxes according to how they apply to you. (Put an X for each line)

When I first begin eating,	Never	Seldom	Often	Always
it is difficult to stop.				
I spend too much time thinking about food.				
I feel that food controls my life.				
l cut my food into small pieces.				
I take longer than others to eat my meals.				
Older people think I'm too thin.				
I feel that others pressure me to eat.				
I vomit after I have eaten.				

#### Gambling

Have you ever felt the need to gamble with continuously increasing amounts of money?

Have you ever had to lie to people who are important to you about how much you lost gambling?

No

Yes

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Additional Section Women 20-29 Pregnancy and Birth Control	Do you leak urine when you cou sneeze, laugh or lift something	
Not including pregnancies or post-natal periods, have you ever not menstruated for at least 6 months? Yes No	When you leak urine is it accom by a sudden and strong urge to urinate?	
If Yes.	How do you feel about having u	ırinary
How many times? times	incontinence?	at problem
Including all pregnancies, how many times have you been times pregnant?	A slight problem A very A moderate problem	y great problem
Have you ever tried for more Yes No have you ever tried for more Yes No have the secone	Employment	
pregnant?	Is your work so physically dema	
If Yes,	often physically worn out after a one X)	a day's work? (Only
How old were you the first time you	Yes, nearly always Seldom	
had problems becoming pregnant? yrs old	Quite often	or almost never
Do you use/take or have you used/taken:		
Now Before, Never but not now	Does your work require so muc attention that you often feel wo	
Birth control pills	work? (Only one X)	_
Birth control patch	Yes, nearly always Seldom	
Other hormone birth control (Injection, vaginal ring, implant,		or almost never
	All things considered, how muc work? (Only one X)	
If you have taken birth control pills: How old were you when you first began taking them?	<b>3</b>	much
How many years in total have you taken birth control		
pills?	Your Feelings in the Last 14 Day	-
Less 1-3 4-10 over 10	In the last two weeks, have you	: (One X for each line)
than 1 yr yrs yrs yrs yrs	No /	A little A good Very amount much
Urinary Tract	Been continuously	
Do vou unintentionally leak urine? Yes  No	afraid and anxious	
	Felt hopelessness	
If No, skip to question 72	when you think about the future	
How often do you leak urine?	Felt down and sad	
Less than once a One or more times	Worried too much	
month a week One or more times a Every day/night month	about various things	
How much urine usually leaks each time? Drops Small Quite a lot amount		

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#### Life Events

Have you experienced any of the following in the last 10 years? (Put an X for each question)

	No	Yes	
		Last 12 mos.	Earlier
Had problems at work or school?			
Had financial problems?			
Had problems or conflicts with family or friends?			
Had big problems in your love life?			
Been seriously ill or injured?			
Have those nearest you been seriously ill or injured?			

#### Eating Habits

Below are listed things that concern your eating habits. Put an X in the boxes according to how they apply to you. (Put an X for each line)

When I first begin eating, it is difficult to stop.	Never	Seldom	Often	Always
I spend too much time thinking about food.				
I feel that food controls my life.				
I cut my food into small pieces.				
I take longer than others to eat my meals.				
Older people think I'm too thin.				
I feel that others pressure me to eat.				
I vomit after I have eaten.				

#### Gambling

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Have you ever felt the need to gamble
with continuously increasing amounts
of money?

Have you ever had to lie to people who are important to you about how much you lost gambling? No

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Yes

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#### Additional Section Men 30-69 Evaluating Your Job

Answer if you are or have been employed.

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Respond to the following statements/questions about where you work.

<b>There is a go</b> Strongly agree Disagree	ood collegiality	<b>at work.</b> Agree Strongly disagree	
<b>My co-worke</b> Strongly agree Disagree	ers are there fo	r me (support me). Agree Strongly disagree	
<b>I get along w</b> Strongly agree Disagree	vell with my co	-workers. Agree Strongly disagree	
<b>Are you bull</b> Yes, often No, seldom	ied/ harassed a	<b>at work?</b> Yes, sometimes No, could say never	
<b>Does your jo</b> Yes, often No, seldom	b require you	to work very fast? Yes, sometimes No, could say never	
Yes, often No, seldom		to work very hard? Yes, sometimes No, could say never great a work effort?	
Yes, often No, seldom		Yes, sometimes No, could say never	
<b>Does your jo</b> Yes, often No, seldom	b require crea	<b>tivity?</b> Yes, sometimes No, could say never	
<b>Do you have</b> <b>to carry out</b> Yes, often No, seldom		<b>/ to decide for you</b> Yes, sometime No, could say neve	es 🗌
	the possibility be done in you	<b>/ to decide for you</b> u <b>r work?</b> Yes, sometime	

		I
No, seldom No, could say	never	
Is your work so physically demanding the often physically worn out after a long day Yes, nearly Seldom always		
Quite often Never, or almost ne	ever	
Leg Pain		
Do you have ulcer(s) on your toes, foot ankle that will not heal?	Yes	No
Do you have pain in one or both legs when you walk?		
If Yes,		
Where does it hurt the most? Foot Leg Thigh	Hip	
Does the pain go away if you stand still a while?	Yes	No
Do you have pain in your legs when you are resting?		
<i>If Yes:</i> Is the pain worse when you lay in bed?		
Do you have less pain if you have your legs lower, such as over the edge of the bed?		
Have you had pain in your legs continuously for <u>more than 14 days</u> ?		
Have you taken pain relievers because of pain in your legs?		
Vision		
Do you have any of the following eye conditions?	Yes	No
Cataract		
Glaucoma (raised eye pressure)		
Age-Related Macular Degeneration (retinal calcification)		
Memory		
Do you have problems with your memory No, none Yes, some Yes,		

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Has your memo	r <b>y changed</b> Yes, som	-	<b>u were you</b> Yes, a lot	nger?				
Do you have tro	uble	Never	Sometimes	Often				
remembering: Things that happen minutes ago? Other peoples' nam								
Dates?								
To do something yo planned to do? Things that happen days ago?								
Things that happen ago? Enough to be able	-							
along in a conversa								
Urinary Tract How often do yo 1-4 times	]		11 times	<b>y?</b> 				
How many times do you get up during the night to urinate? None 1 2 3 4 or 5 or more								
If you get up due problem for you Not a problem				a				
Somewhat of a problem		lt's a v	roblem [ very big [ vroblem					
Do you feel a su that is difficult to Never	o suppress	? -	-	te				
Monthly	] 360	eral times	Daily					
<u>Over the past month</u> , how often have you had a sensation of not emptying your bladder completely after you finish urinating?								
Never	] 1 out of 3 times		2 out of 3 times					
1 out of 5 times	] 1 out of 2 times		Almost always					
Over the past m urinate again les urinating?								
Never	] 1 out of 3 times		2 out of 3 times					
1 out of 5	1 out of 2 times		Almost always					

Over the past month, how often have you found you stopped and started again several times when

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#### you urinated?

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you urinated?	ſ		
Never	1 out of 3 times	2 av 3 ganger	
1 out of 5 times	1 av 2 ganger	Nesten alltid	
Over the last postpone urin	<u>month</u> , how difficul nation?	t have you fou	und it to
Never	1 out of 3	2 out of 3	
1 out of 5 times	times 1 out of 2 times	Limes Almost alv	vays
Over the past urinary stream	<u>: month,</u> how often l n?	have you had	a weak
Never	1 out of 3	2 out of 3	
1 out of 5 times	1 out of 2 times	times Almost alv	vays
	<u>month</u> , how often legin urination?	have you had	to push
Never	1 out of 3 times	2 out of 3 times	
1 out of 5 times	1 out of 2 times	Almost alv	vays
urine? (If No, skip to qu If Yes:		Yes	a week
How much u Drops	A small amount	each time? Quite a lot	
(You may X se	uations might you le everal answers) gh, sneeze, lift somethi		
When having a	a sudden urge to urinate	e	
Drops at end o	f or after urinating		
Drops all the ti	me, independent of urir	nating	
How do you Not a problem	feel about having u	i <b>rinary inconti</b> A great proble	
A slight problem A moderate problem		very great proble	)m
became inco	re you when you ontinent? nsulted a doctor	Yes	yrs old
			-

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because of urinary incontinence?	them? Very Moderately Hardly intense intense noticable
Additional Section Women 30-69	
Menstruation, Birth Control and Pregnancy	Have you been to a doctor No Yes because of this?
Not including during pregnancy or post-natal period, have you ever not gotten a period for <u>at</u> least 6 months (premenopause)? Yes □ No □	Have you ever taken/used Now Previously Never medicine that contains oestrogen?
If Yes, How many times?	Tablets or patches   Image: Constraint of the sector of the sec
In total, how many times have you been pregnant?	If you have taken/used prescription oestrogen: How old were you when you began?
Have you ever tried for <u>more</u> Yes No than one year to become pregnant?	How old are/were you the last time you took/used it?
If Yes, How old were you the first time you tried to become pregnant?	If you take/use or have taken/used oestrogen tablets or patches, why did you begin? Alleviate menapausal symptoms
Yes No Have you ever received hormone	Prevent osteoporosis Other
If Yes, Have you received this treatment in the last 3 months?	If you have previously taken/used oestrogen tablets or patches, why did you stop? No longer have/had Afraid of side effects symptoms
<b>Do you use/take or have you used/taken:</b> Now Before, Never but not	Experienced bothersome Other Side effects
now	Operations/Radiation Therapy in the Lower Abdomen
Birth control pills	Have you had both ovaries surgically removed?
Birth control patch	No Yes Don't know
(injection, vaginal ring, implant, IUD/coil)	If Yes, How old were you then? yrs old
If you have taken birth control pills: How old were you when you first began taking them?	Have you had your womb surgically removed (hysterectomy)? No
How many years in total have you taken birth control pills? Less 1-3 4-10 Over than 1 yr yrs yrs 10 yrs	If Yes, How old were you then?
Menopause	Have you ever had radiation therapy in your pelvic region?
(If you are premenopausal, skip to 75) Do you have/have you had hot flashes due to menopause? During During Day and Haven't D the day night had any	No Yes Don't know I If Yes, How old were you then? yrs old
If you have had hot flashes, how would you describe	
<b>⊢</b> 1	1 <b>–</b>

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	Have you consulted a doctor Yes No Decause of urinary incontinence?
Urinary Tract	
How often do you usually urinate during the day? 1-4 times 8-11 times	Have you ever been treated for urinary incontinence? (Several Xs possible here) No, I have never had urinary incontinence
5-7 times over 11 times	No, I had urinary incontinence, but became
How many times do you get up during the night	Yes
to urinate? None 1 2 3 4 or more	If Yes, what type of treatment? Operation Medicine
If you get up during the night to urinate, is this a problem for you?	Pelvic floor exercises Other
Not a problem It's a problem	Bowel Movements
Somewhat of a lt's a very big problem problem	Have you had uncontrollable flatulence <u>in the last</u> month?
Do you feel a sudden, compelling urge to urinate that is difficult to suppress?	Never/seldom Weekly Daily
Never Several times a week	Have you leaked stool (faecal incontinence) in the last month?
Monthly Daily	Never/seldom Weekly Daily
Do you unintentionally leak urine? Yes No	If you answered Yes to one of the above questions,
If No, skip to question 84	does faecal incontinence affect your daily life? Never/seldom Weekly Daily
How often do you leak urine?         Less than once a       One or more times         month       a week         One or more times a       Every day/night	Are you able to hold back the stool for 15 minutes after you first feel the urge to evacuate Yes No your bowels?
How much urine usually leaks each time?	Evaluating Your Job
Drops Small Quite a lot amount	Answer if you are or have been employed.
Yes No	Respond to the following statements/questions about where you work.
Do you leak urine when you cough, sneeze, laugh or lift something heavy?	There is a good collegiality at work.
onoozo, haagi or int contorning hoavy.	Strongly Agree
When you leak urine is it accompanied by a sudden and strong urge to urinate?	Disagree Strongly disagree
	My co-workers are there for me (support me).
How do you feel about having urinary incontinence? Not a problem A great problem	Strongly Agree agree Strongly disagree
A slight problem A very great problem	
A moderate problem	I get along well with my co-workers. Strongly Agree
How old were you when you became incontinent?	Disagree Strongly disagree
	Are you bullied/ harassed at work?
+	12 –

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Yes, often		Yes, sometim	es	
No, seldom		No, could s	ay	
		nev	/er	
Does your io	h require v	ou to work very fa	st?	
Yes, often		Yes, sometim		
No, seldom		No, could s		
Does your jo Yes, often	b require y	ou to work very have Yes, sometime		
No, seldom		No, could s	ay	
		nev	/er	
Does your jo Yes, often	b require to	<b>oo great a work ef</b> Yes, sometim		
No, seldom		No, could s		
,		nev	-	
Does your jo	b require c			
Yes, often		Yes, sometim		
No, seldom		No, could s ne		
Do vou have	the possib	ility to decide for	vours	elf how
to carry out y Yes, often				_
No, seldom		Yes, som No, could say		
,				
Do you have what should		ility to decide for	yours	elf
Yes, often		Yes, some	etimes	
	_			_
Leg Pain				
Do vou have	ulcer(s) or	n your toes, foot	Yes	No
ankle that wi				
	nain in on	e or both legs		
when you wa		e of both legs		
lf Yes,				
Where does			Llin	_
Foot	Leg	] Thigh 🗌	Hip	
			Yes	No
Does the pa a while?	ain go away	if you stand still		
		our legs when		
you are res	ting?			
If Yes:				
	worse when	n you lay in bed?		

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Do you have less pain if you have your legs lower, such as over the edge of the bed?	
Have you had pain in your legs continuously for <u>more than 14 days</u> ?	
Have you taken pain relievers because of pain in your legs?	
Vision	
Do you have any of the following eye conditions? Cataract	Yes No
Glaucoma (raised eye pressure)	
Age-Related Macular Degeneration (retinal calcification)	
Memory	
<b>Do you have problems with your memory</b> No, none Yes, some Yes, a	
Has your memory changed since you were No Yes, some Yes	e younger?
Do you have trouble remembering:       Never       Some remembering:         Things that happened a few minutes ago?	
Are you satisfied with your eating habits? Very satisfied 1 2 3 4 5 6 7	Very disatisfied
Have you eaten to comfort yourself or bec were unhappy? Not at all	ause you Every-
1 2 3 4 5 6 7	day

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Have you felt guilty about eating?								
Not at all	1	2	3	4	5	6	7	Every- day
Have you felt that it was necessary for you to use a strict diet or other eating rituals to control your eating?								
Not at all	1	2	3	4	5	6	7	Every- day
Have you felt that you are too fat?								

	••••	,				••		_
Not at all								Every-
	1	2	3	4	5	6	7	day

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## Additional Section Men 70+

Leg	Pain
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Do you have ulcer(s) on your toes, foot ankle that will not heal?	Yes	No				
Do you have pain in one or both legs when you walk?						
If Yes, Where does it hurt the most? Foot Leg Thigh	Hip					
Does the pain go away if you stand still a while?	Yes	No				
Do you have pain in your legs when you are resting?						
<i>If Yes:</i> Is the pain worse when you lay in bed? Do you have less pain if you have your						
legs lower, such as over the edge of the bed?						
Have you had pain in your legs continuously for <u>more than 14 days</u> ?						
Have you taken pain relievers because 🛛 🗌						
Activities of Daily Life						
Can you do the following daily tasks with help of others?						
Walk around indoors on the same floor	Yes	No				
Go to the toilet	Π					
Wash yourself						
Take a bath or shower						
Dress and undress yourself						
Go to bed and get up						
Eat						
Other Daily Tasks						
Do you have a driver's Yes	No					
<b>Do you still drive a car?</b> Yes	No					
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Can you do the the help of others?	following da	ily tasks	withou	t the	
_			Yes	No	
Prepare warm mea		,			
Do light housework					
Do heavier housew	ork (ex: wash i	floors)			
Wash clothes					
Do the shopping					
Pay bills					
Take medicines					
Go out					
Take the bus					
Memory					
Do you have pro			-	- 4	_
No, none	Yes, some	*	Yes, a l	51	
Has your memo	r <b>y changed s</b> Yes, some		<b>u were</b> Yes, a	-	ger?
Do you have tro remembering: Things that happen minutes ago? Other peoples' nam Dates? To do something yo planned to do? Things that happen days ago? Things that happen ago? Enough to be able along in a conversa	ed a few nes? ou have ed a few ed years to follow	Never	Sometir	nes	
Falls					
Have you fallen yourself <u>in the la</u>		No 🗌	] Ye	es	
lf Yes, Where did it happen?	Indoors		Outdoor	S	
Have you been t <u>year</u> because of fall?				es ]	No
Have you been a <u>the last year</u> bec			<u>in</u> [	]	

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caused by a fall? Have you fallen <u>in the last 3 months</u> ?		sensation of not emptying your bladder completely after you finish urinating? Never 1 out of 3 2 out of 1
Do you have problems with your		1 out of 5  1 out of 2    times  3 times    1 out of 5  1 out of 2    times  always
Use of Health Services		<u>Over the past month</u> , how often have you had to urinate again less than 2 hours after you finished
Yes       No         Have you had home care help in the       Image: Care help in the help in thelp in the help in thelp in		urinating?       Never     1 out of 3     2 out of       times     3 times
If Yes, Do you have enough home care help?		1 out of 5 1 out of 2 Almost 1 out of 2 always
Have you received home nursing care		<u>Over the past month</u> , how often have you found you stopped and started again several times when you urinated?
If Yes, Do you receive enough home nursing care?		Never   1 out of 3   2 av 3     times   ganger
Have you been admitted to a nursing home <u>in the last 12 months</u> ?		times alltid
Vision		<u>Over the last month</u> , how difficult have you found it to postpone urination?
Do you have any of the following eyeYesNoconditions?Image: CataractImage: Image: CataractImage: Image: Cataract		Never     1 out of 3 times     2 out of 3 times       1 out of 5 times     1 out of 2 times     Almost always
Glaucoma (raised eye pressure)		Over the past month, how often have you had a weak
Age-Related Macular Degeneration (retinal		urinary stream?       Never     1 out of 3     2 out of 3
Urinary Tract		times times times times
How often do you usually urinate during the day?         1-4 times       8-11 times         5-7 times       More than 11 times		<u>Over the past month,</u> how often have you had to push or strain to begin urination?
		Never 1 out of 3 2 out of 3 times
How many times do you get up during the night to urinate? None 1 2 3 4 or more		1 out of 5 1 out of 2 Almost always times
If you get up during the night to urinate, is this a problem for you?		Do you unintentionally leak       Yes       No         urine?       If No, skip to question about 89
Not a problem     It's a problem       Somewhat of a     It's a very big       problem     problem		If Yes: How often do you leak urine? Less than once a month One or more times a week
Do you feel a sudden, compelling urge to urinate		Several times a month Every day/night
that is difficult to suppress?         Never       Several times a week         Monthly       Daily		How much urine usually leaks each time? Drops Small Quite a lot
Over the past month, how often have you had a		In which situations might you leak urine? (You may X several answers)
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When you cough, sneeze, lift something heavy	
When having a sudden urge to urinate	Π
Drops at end of or after urinating	$\Box$
Drops all the time, independent of urinating	
How do you feel about having urinary incontinen         Not a problem       A great problem         A slight       A very great problem         A moderate       problem	ce?
How old were you when you became incontinent?	sold
Have you consulted a doctor because of urinary incontinence? Yes	lo 🗌

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	Additional	Section	Women	70+
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Additional Section Women 70+ Pregnancy, Children and Hormone Therapy	Operations/Radiation Therapy in the Lower Abdomen		
In total, how many times have you times	Have you had both ovaries surgically removed? No Yes Don't know		
Have you ever tried for <u>more than</u> Yes No O	If Yes, How old were you then? yrs old		
If Yes, How old were you the first time you had problems becoming pregnant?	Have you had your womb surgically removed (hysterectomy)? No Yes Don't know		
Do you have/have you had hot flashes due to menopause? During During During Haven't Haven't had any	If Yes, How old were you then? yrs old Have you ever had radiation therapy in your pelvic region?		
If you have had hot flashes, how would you describe them?	No Yes Don't know		
Very       Moderately       Hardly         intense       noticable         Have you been to a doctor       No       Yes         because of this?	If Yes, How old were you then? yrs old Urinary Tract		
Have you ever taken/used medicine that contains oestrogen?NowPreviouslyNeverTablets or patches (prescribed by a doctor)Image: Control of the second sec	How often do you usually urinate during the day?         1-4 times       8-11 times         5-7 times       over 11 times		
If you have taken/used prescription oestrogen: How old were you when you began?	How many times do you get up during the night to urinate? None 1 2 3 4 or more		
How old are/were you the last time you took/used it? yrs old	If you get up during the night to urinate, is this a problem for you?		
If you take/use or have taken/used oestrogen tablets or patches, why did you begin? Alleviate menapausal symptoms	Somewhat of a lt's a very big problem problem		
Prevent osteoporosis	Do you feel a sudden, compelling urge to urinate that is difficult to suppress? Never Several times a week		
If you have previously taken/used oestrogen tablets         or patches, why did you stop?         No longer have/had       Afraid of side effects         symptoms       effects         Experienced bothersome side effects       Other	Monthly       Daily         Do you unintentionally leak urine?       Yes         If No, skip to question 79       If Yes:         How often do you leak urine?       Image: Compare the second se		
	Less than once a     One or more times       month     a week		

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One or more times a Every day/night	Leg Pain	
Month        How much urine usually leaks each time?       Drops     Small       Quite a lot	Do you have ulcer(s) on your toes, foot [ ankle that will not heal?	´es No
amount	Do you have pain in one or both legs [ when you walk?	
Yes       No         Do you leak urine when you cough,          sneeze, laugh or lift something heavy?	If Yes, Where does it hurt the most? FootLegThighHi	р 🗌
When you leak urine is it accompanied by a sudden and strong urge to urinate?	Y Does the pain go away if you stand still  [ a while?	′es No
How do you feel about having urinary incontinence? Not a problem A great problem	Do you have pain in your legs when [ you are resting?	
A slight problem A very great problem	If Yes:	
A moderate problem	Is the pain worse when you lay in bed? Do you have less pain if you have your legs lower, such as over the edge of	
became incontinent?       yrs old         Have you consulted a doctor       Yes       No         because of urinary incontinence?       Yes       No	the bed? Have you had pain in your legs [ continuously for <u>more than 14 days</u> ?	
Have you ever been treated for urinary incontinence? (Several Xs possible here) No, I have never had urinary incontinence	Have you taken pain relievers because [ of pain in your legs?	
No, I had urinary incontinence, but became better on its own Yes	Activities of Daily Life	
If Yes, what type of treatment? Operation Medicine	Can you do the following daily tasks without help of others?	
Pelvic floor exercises Other	Yes Walk around indoors on the same floor	s No
Bowel Movements	Go to the toilet	
	Wash yourself	
Have you had uncontrollable flatulence in the last month?	Take a bath or shower	
Never/seldom Weekly Daily	Dress and undress yourself	
Have you leaked stool (faecal incontinence) in the last month?	Go to bed and get up	
Never/seldom Weekly Daily	Other Daily Tasks	
If you answered Yes to one of the above questions, does faecal incontinence affect your daily life? Never/seldom Weekly Daily	Do you have a driver's Yes No licence? If Yes,	
Are you able to hold back the	Do you still drive?YesNo	
stool for 15 minutes after you first feel the urge to evacuate Yes No your bowels?	Can you do the following daily tasks without help of others? Yes	t <b>the</b> No
<b>–</b> 19		-

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Prepare warm meals	
Do light housework (ex: wash dishes)	
Do heavier housework (ex: wash floors)	
Wash clothes	
Do the shopping	
Pay bills	
Take medicines	
Go out	
Take the bus	

## Memory

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Do you hay No, none	ve proble	<b>ems with y</b> Yes, some		<b>mory?</b> Yes, a lot	
Has your n No	nemory o	<b>hanged s</b> Yes, some		<b>u were you</b> Yes, a lot	nger?
Do you have remembering Things that he minutes ago Other people	i <b>ng:</b> happened a ?	a few	Never	Sometimes	Often
Dates?					
To do somet planned to d Things that h days ago? Things that h ago? Enough to be along in a co	o? happened a happened y e able to fo	a few years bllow			
Falls					
Have you f yourself in		-	10	Yes	
lf Yes, Where did happen?	it	Indoors		Outdoors	
Yes       No         Have you been to a doctor in the last       Image: Comparison of the last         year because of an injury caused by a fall?				No	
Have you k the last yes caused by	<u>ar</u> becau		•	<u>in</u>	
Have you f	allen <u>in t</u>	he last 3 r	months	?	
Do you hay balance?	ve proble	ems with y	our		
Use of Hea	Ith Servi	ces			

Have you had home care help <u>in the</u> last 12 months?	Yes	No
<i>If Yes,</i> Do you have enough home care help?		
Have you received home nursing care in the last 12 months?		
If Yes, Do you receive enough home nursing care?		
Have you been admitted to a nursing home in the last 12 months?		
Vision		
Do you have any of the following eye conditions?	Yes	No
Cataract		
Glaucoma (raised eye pressure)		
Age-Related Macular Degeneration (retinal calcification)		

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