HUNT 2 Questionnaire 2

Women aged 70 and over

Page 1

Thank you for taking part in this study!
We ask that you complete this questionnaire as well. The information will be used in research for preventive health care. Some of the questions are similar to questions you answered on the questionnaire that you completed at home and took with you when you attended the health examination. It is important that you answer all the questions on this questionnaire. The completed questionnaire should be returned in the enclosed pre-stamped envelope.
All information will be treated in strict confidence.

Yours sincerely,
Health Services in Nord-Trøndelag
The Norwegian Institute of Public Health
The National Health Screening Service

If you do not wish to answer the questionnaire, put an X here and return the form. As a result, you will not receive a reminder.

COMPLETION

Date of completion of the questionnaire: ___/___ 19___

GROWING UP

What town did you living in when you were 1 year old?
If you were not living in Norway, give the **country** instead of the town.

HOUSING

What type of housing do you live in? *One X only*
Single-family house/villa
Farm
Flat in block or terraced block of flats
Terraced house/2-4 family housing
Senior welfare housing /senior citizens' housing/ serviced accommodation
Nursing home/ retirement home
Other accommodations

How large is your home? <Square metres ____>
Are there fitted carpets in the living room? <yes, no>
Are there fitted carpets in your bedroom? <yes, no>
Is there a cat in the home? <yes, no>
Is there a dog in the home <yes, no>
Are there other animals with fur or birds in the home? <yes, no>

Who do you live with? *One or more Xs*
Spouse/partner
Children/children-in-law
Live alone
Sister/brother
Other family/relatives

Other

ILLNESS IN THE FAMILY

Put an X for the relatives who have or have had any of the following illnesses. If none of your relatives has had a particular disease, put an X in the box for Nobody on that line. *Possibly several Xs on each line.* <Mother, Father, Brother, Sister, Child, Nobody>
Stroke or cerebral haemorrhage
Heart attack before age of 60
Asthma
Allergy
Cancer
High blood pressure
Mental health problems
Osteoporosis
Diabetes
Age when he/she got diabetes Years old ____

Do you have hay fever or nasal allergies? <yes, no>

MARITAL STATUS

What is your marital status?
Married
Widow
Divorced/separated
Have never been married

USE OF HEALTH SERVICES

During the last 12 months, have you visited any of the following: <yes, no>
One X for each line
General practitioner (community doctor, private doctor, intern)
Company physician
Doctor at hospital (without being hospitalized)
Another doctor
Physiotherapist
Chiropractor
Homoeopath
Other treatment provider (naturopath, reflexologist, laying on of hands, healer, psychic, etc.)

HOSPITAL

Have you been hospitalized during the last 5 years? <yes, no>

If YES, answer in regards to the last time that you were hospitalized:
Do you think that you were discharged from the hospital too soon, at the right time, or too late?
Too soon
At the right time
Too late

Where did you go when you were discharged?
Home
Convalescent home
Nursing home

Did you receive sufficient help and follow-up after you were discharged? <yes, no>

HOME HELP

Do you have home care? <yes, no>
Private
Community

If you have COMMUNITY home care,
Do you receive enough community home care services or do you need more?
Yes, I have enough
No, I need more

If you do NOT have community home care,
Do you need community home care services? <yes, no>

Page 2

HOME NURSING CARE

Do you receive home nursing care services? <yes, no>

If YES,
Do you have enough home nursing care or do you need more?
Yes, I have enough
No, I need more

NURSING HOME

Have you been admitted to a nursing home during the last 12 months?
No
Yes, I was in one for a time
Yes, I live in one permanently

If NO, skip over the next two questions

If YES,
Where were you BEFORE you were admitted to the nursing home last time?
Living in own home
In hospital
Elsewhere

If you have been in a nursing home FOR A PERIOD during the last 12 months,
Was your stay in the nursing home an appropriate length of time?
It was too short
It was the right length of time
It was too long

COMMUNITY HELP

Overall, are you satisfied with the help you receive from your community?
Very satisfied
Fairly satisfied
Fairly dissatisfied
Very dissatisfied
I don’t receive any help, but should have it

I don’t receive any help, and don’t need it

DIET

How many meals do you usually eat a day (dinner and meals with bread)? Number ____

How many days a week do you have a warm dinner? Number ____

What kind of bread (bought or homemade) do you usually eat? *No more than two Xs*
The bread type is most like… <White, White multigrain (finely ground), Wholemeal (medium ground), Multigrain wholemeal (coarsely ground), Crispbread>

What kind of fat is usually used in your household?
One X for cooking and one X for bread <For cooking, On bread>
Do not use butter or margarine
Dairy butter
Hard margarine
Soft margarine
Butter/margarine blend
Low fat margarine
Oils

REST AND RELAXATION

How many hours do you usually spend lying down during a 24 hour period?
Night-time sleep, Number of hours ____

Afternoon rest, Number of hours ____

How many hours do you usually spend sitting down during a 24 hour period?
Work, mealtimes, TV, car, etc., Number of hours ____

Have you had problems falling asleep in the last month? *One X only*
Almost every night
Often
Sometimes
Never

During the last month, have you ever woken too early and not been able to get back to sleep?
One X only
Almost every night
Often
Sometimes
Never

USE OF MEDICINES

During the last 12 months, have you taken any medicines daily or almost daily? <yes, no>

If YES:
Indicate for how many months you used the following medicines:
Put 0 if you have not used these medicines. No. of months ____
Analgesics (pain relief medicine)
Sleep medicine
Sedatives
Medicine for depression

Allergy medicine
Asthma medicine
Heart medicine (not blood pressure medicine)
Other medicine
Dietary supplements:
Iron tablets
Vitamin supplements
Cod liver oil/fish oil

How often have you taken tranquilizers/sedatives or sleep medication in the last month?
Daily
Weekly, but not every day
Not as often as every week
Never

FRIENDS

How many good friends do you have? Number ____
Count those with whom you can talk confidentially and who can give you good help when you need it. Do not include those with whom you live, but include other relatives.

Do you feel that you have enough good friends? <yes, no>

Page 3

How often do you usually participate in social activities such as a sewing club, senior citizens' community centre, political association, religious or other groups?
Never, or only a few times a year
1-2 times a month
About once a week
More than once a week

MOOD AND WELLBEING

One X for each line

How have you have felt in the last month:
<Never, Sometimes, Quite often, Mostly>
in a good mood
in a bad mood

Are you quick to understand that something is funny?
Very slow
Quite slow
Quite quick
Very quick

Do you agree that there is something irresponsible about people who constantly try to be funny?
No, not at all
To some extent
Quite agree
Yes, absolutely

Are you a cheerful person?
No, not at all
To some extent

Quite cheerful
Yes, absolutely

MUSCULOSKELETAL CONDITIONS

Have you had discomfort (pain, aching) in your muscles/limbs in the last month? <yes, no>

If YES,
Where did you have the discomfort (one or more Xs) **and for about how many days altogether were you troubled?** Number of days ____
Discomfort/pain (put an X):
Neck
Shoulders/upper arms
Upper back
Elbows
Lower back
Wrists/hands
Hips
Knees
Ankles/feet

If there are several Xs, put a **ring** around the X for **the area that bothered you the most**.

Did the discomfort (pain, aching) hinder you in carrying out your everyday activities in the last month? <yes, no>

HEADACHES

Have you had headaches in the last 12 months?
Yes, in attacks (migraines)
Yes, other types of headaches
No
Number of headaches in the last 12 months ____

If NO, go to URINE INCONTINENCE

About how many days per month do you have a headache?
Less than 7 days
7 to 14 days
More than 14 days

How long do the headaches last each time?
Less than 4 hours
4 hours - 3 days
More than 3 days

How often is the headache characterised by or accompanied by:
One X for each line <Seldom or never, Now and again, Often>
Throbbing, thumping pain
Pressing pain
Pain on one side of the head, always the same side
Pain on one side of the head, alternating left and right sides
Pain in entire head
Nausea
Hypersensitivity to light and/or noise
Worsening with physical activity

Visual disturbance before onset of headache

How many tablets/suppositories of these medicines have you used altogether in the last month?
Put 0 of you have not used any of these medicines
Cafergot
Anervan
Imigran

URINARY INCONTINENCE

Do you unintentionally leak urine at least twice a month? <yes, no>

If NO, go to MENSTRUATION AND MENOPAUSE

How often do you leak urine?
Less than once a month
One or more times a month
One or more times a week
Everyday and/or night

How much urine usually leaks each time?
Drops or not much
Small amount
Quite a lot

Do you leak urine when you cough, sneeze, laugh or lift something heavy? <yes, no>

When you leak urine is it accompanied by a sudden and strong urge to urinate? <yes, no>

Have you consulted a doctor because of urinary incontinence? <yes, no>

How do you feel about having urinary incontinence? *One X only*
Not a problem
A slight problem
A moderate problem
A great problem
A very great problem

MENSTRUATION AND MENOPAUSE

How old were you when you stopped menstruating? Years old ____

HORMONE TREATMENT

Not including contraceptive pills
Have you ever taken medicines that contain oestrogen? Common names of such medicines are Cyclabil, Estraderm, Kliogest, Oversterin, Progynova, Trisekvens
Tablets or patches <Now, Previously, Never>
Cream or suppositories <Now, Previously, Never>

If YES,
How old were you the first time that you were prescribed oestrogen, and for about how many years did you use oestrogen?
(Your age/Number of years)
Tablets or patches <Now, Previously, Never>

Cream or suppositories <Now, Previously, Never>

If you are currently using oestrogen, what is the name of the product? _____

Page 4

OPERATIONS IN THE LOWER ABDOMEN

Have you had both ovaries removed? <Yes, No, Don't know>

If you had both ovaries removed, how old were you at the time of the surgery? Years old ____

Have you had your womb removed (hysterectomy)? <Yes, No, Don't know>

If you had a hysterectomy, how old were you at the time of the surgery? Years old ____

PREGNANCY, BIRTHS AND BREASTFEEDING

How many times altogether have you been pregnant?
*Include **all** pregnancies: miscarriages and abortions as well as births (including stillbirths)* Times ____

How many children have you had? No. of children ____

Fill in below for each child (the first 7) information on year of birth, the approximate number of months you breastfed each child and the number of months you did not menstruate after the birth (also write this information for stillbirths and for children who died later in life)

Child	Year of birth	Number of months breastfed	Number of months without a period
1			
2			
3			
4			
5			
6			
7			

HOW YOU SEE YOURSELF

People see themselves in different ways. For each statement, put an X to indicate how much or how little you agree with it. *One X for each line*
<Strongly agree, Agree, Disagree, Strongly disagree>
I have a positive opinion of myself.
I feel really useless at times.
I feel that I do not have much to be proud of.
I feel that I am a valuable person, at least equal to others.

Do you feel that you have a meaningful life? <yes, no>

Do you feel that you live life to its fullest? <yes, no>

HOW YOU FEEL

Put an X in the box by the answer that best describes your feelings **last week**. *One X only*

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

On the whole, do you feel calm and good?
Almost all the time
Often
Sometimes
Never

Would you say you are usually cheerful or downhearted?
Very downhearted
Downhearted
Somewhat downhearted
Some of both
Somewhat cheerful
Cheerful
Very cheerful

ACTIVITIES OF DAILY LIFE

Can you do the following daily tasks without the help of others? One X for each line <Yes, With some help, No>
Walk around indoors on the same floor
Go to the toilet
Wash yourself
Take a bath or shower
Dress and undress yourself
Go to bed and get up
Eat

If you need help to do any of these things, for about how long have you had help? *One X only*
Less than 3 months
3 - 6 months
6 months - 1 year
1 - 5 years
More than 5 years

If you need help with one or more of these tasks, who most often helps you? *One X only*
Spouse/partner
Children/children-in-law
Sister/brother
Other family/relative
Other

OTHER DAILY TASKS

Can you do the following daily tasks without the help of others? One X for each line <Yes, With some help, No>
Prepare warm meals
Do light housework (e.g. wash dishes)
Do heavier housework (e.g. wash floor)
Wash clothes
Pay bills
Take medicines
Go out
Do the shopping

Take the bus

If you need help to do any of these things, for about how long have you had help? *One X only*
Less than 3 months
3 - 6 months
6 months - 1 year
1 - 5 years
More than 5 years

If you need help with one or more of these daily tasks, who is it who most often helps you?
One X only
Spouse/partner
Children/children-in-law
Sister/brother
Other family/relative
Other

Place the completed questionnaire in the enclosed reply envelope and post it as soon as possible!
The postage is paid.

Many thanks for your help!