HUNT 3 QUESTIONNAIRE 3 - CORONAR

LIFESTYLE ADVICE

Has a doctor given you any of the following advice for your illness? *(Put an X for each question)*

	Yes	No	Don't remember
Lose weight	☐	☐	☐
Smoke less	☐	☐	☐
Quit smoking	☐	☐	☐
Excercise more	☐	☐	☐
Eat less sugar	☐	☐	☐
Eat less fat	☐	☐	☐
Use less salt on food	☐	☐	☐
A less hectic life (reduce stress)	☐	☐	☐

If Yes:

How important do you think this advice is for you?

Not important ☐ A little important ☐ Important ☐ Very important ☐

To what extent do you follow this kind of advice?

Not so much ☐ Somewhat ☐ Much ☐ Very much ☐

HIGH BLOOD PRESSURE

How many times have you been to a doctor/nurse to have your blood pressure checked in the last 12 months? ☐ Number of times

Who measures your blood pressure at these visits? *(One or more Xs)*

Doctor ☐ Nurse/ Medical secretary ☐

Have you used a 24 hour blood pressure monitor? Yes ☐ No ☐

Have you measured your blood pressure at home (yourself)? Yes ☐ No ☐

Have you ever been examined at the hospital because of high blood pressure? Yes ☐ No ☐

Have you taken or do you take medication for high blood pressure? Yes ☐ No ☐

If Yes,

About how old were you when you started taking this type of medicine? ______ years old

If you take medicine for high blood pressure, have you felt unwell/ had side effects from this medicine? Yes ☐ No ☐

If Yes,

How bothersome have the side effects/unwellness been in the last week?

Very bothersome ☐ A little bothersome ☐

Quite bothersome ☐ Not bothersome ☐

How important do you think blood pressure medicine actually is for you?

Not important ☐ A little important ☐ Important ☐ Very important ☐

If you no longer take medicine for high blood pressure, why did you stop? *(One or more Xs)*

The doctor decided I should stop ☐

The medicine bothered me ☐

I thought the medicine wasn't necessary ☐

I was afraid the medicine was harmful ☐

KIDNEY DISEASE

Has it been proven that you have protein in your urine (proteinuria) over a long period of time (at least 1 year)? Yes ☐ No ☐

If Yes,

How old were you when this was proven the first time? ☐ years old

Has it been proven that you have blood in your urine over a long period of time (at least 1 year)? Yes ☐ No ☐

If Yes,

How old were you when this was proven the first time? ☐ years old

About how many times have you had urinary tract infections (bladder infection/ kidney infection) in the last 2 years? ______ Number of times

Has a doctor told you that you have kidney failure (weak kidneys, poor kidney function)? Yes ☐ No ☐

HEART DISEASE

Have you had a heart attack? Yes ☐ No ☐

If Yes,

How many times have you had a heart attack? ☐ Number of times

Do you have or have you had angina pectoris? Yes ☐ No ☐

If Yes,

How many times a week have you noticed this type of pain in the last month?

With exertion ☐ times/week

When you were not active during the day ☐ times/week

During the night ☐ times/week

Have you ever had other treatment than tablets for angina pectoris? Yes ☐ No ☐

If Yes:

Have you had heart surgery (bypass)? Yes ☐ No ☐

Have you had coronary angioplasty/stent placement? Yes ☐ No ☐

Has a doctor said that you have atrial fibrillation? Yes ☐ No ☐

Has a doctor said that you have heart failure (weak heart muscle, water in lungs, swollen legs)? Yes ☐ No ☐

If you have had coronary disease, how does this affect your activity level*? (Put one X)*

No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation or dyspnoea (shortness of breath). ☐

Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation or dyspnoea (shortness of breath). ☐

Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation or dyspnoea (shortness of breath). ☐

Unable to carry out any type of physical activity without discomfort. Symptoms of cardiac insufficiency (shortness of breath, chest pains) at rest. If any physical activity is undertaken, discomfort is increased. ☐

STROKE/CEREBRAL HAEMORRHAGE

Have you ever had a stroke (cerebral thrombus or embolism or cerebral haemorrhage)? Yes ☐ No ☐

If Yes:

How many times have you had a stroke?

1 time ☐ 3-4 times ☐

2 times ☐ 5 times or more ☐

Were you admitted to hospital in connection with the last stroke you had? Yes ☐ No ☐

Have you completely recuperated after your last stroke? Yes ☐ No ☐

If you have had a stroke, how does it affect your <u>functioning level and your ability to do normal, daily tasks</u>? Normal, daily tasks means, for example, eating, dressing and going to the bathroom. *(Put an X by the function level that best describes yours)*

No symptoms at all ☐

No significant disability despite symptoms; able to carry out all usual duties and activities ☐

Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance ☐

Moderate disability; requiring some help, but able to walk without assistance ☐

Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance ☐

Severe disability; bedridden, incontinent and requiring constant nursing care and attention ☐

Return the questionnaire in the enclosed, stamped envelope. ***Thank you for your participation in HUNT 3.***