HUNT 2 Questionnaire 2

Men 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
The Health Service in Nord-Trøndelag
The Norwegian Institute for 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___

CHILDHOOD

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

HOUSING

What type of housing do you live in? *Only one X*
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 your 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
Widower
Divorced/separated
Have never been married

USE OF HEALTH SERVICES

During the last 12 months, have you visited any of the following: <yes, no>
Put X in one box on 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? Up to 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? *Only one X*
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?
Only one X
Almost every night
Often
Sometimes
Never

USE OF MEDICINE

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 confidentially talk and who can help you when are in need.
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 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 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 URINARY TRACT AND PROSTATE PROBLEMS

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:
Put an X in one box on 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 TRACT AND PROSTATE PROBLEMS

One X on each line

Have you ever been told by a doctor that you have: <yes, no>
An enlarged prostate
Prostate cancer

Have you had any of the following procedures done: <yes, no>
Vasectomy
A tissue sample (biopsy) of the prostate taken
Prostatectomy (prostate removal - whole or partial)

The next questions apply to the last month
One X for each question

How often have you had the feeling that your bladder is not completely empty after you have finished urinating?
Never
About 1 out of 5 times
About 1 out of 3 times
About every other time
About 2 out of 3 times
Almost always

How often have you had to urinate again less than 2 hours after urinating?
Never
About 1 out of 5 times
About 1 out of 3 times
About every other time
About 2 out of 3 times
Almost always

How often have you had to stop and start several times when urinating?
Never
About 1 out of 5 times
About 1 out of 3 times
About every other time
About 2 out of 3 times
Almost always

How often has been difficult to hold back when you felt the need to urinate?
Never
About 1 out of 5 times
About 1 out of 3 times
About every other time
About 2 out of 3 times
Almost always

How often have you had a weak urine flow?
Never
About 1 out of 5 times
About 1 out of 3 times
About every other time
About 2 out of 3 times
Almost always

Page 4

How often have you had to push or press to start urinating?
Never
About 1 out of 5 times
About 1 out of 3 times
About every other time
About 2 out of 3 times
Almost always

How many times do you usually get up during the night to urinate?
Never
Once
Twice
Thrice
4 times
5 times or more

If you had to live the rest of your life with the urination problems that you have now, how would you feel about it?
Very satisfied
Satisfied
Mostly satisfied
Mixed feelings
Mostly dissatisfied
Dissatisfied
Very dissatisfied

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 on 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 all events 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? X one box on 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 on 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 helps you most often? *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!