PLEASE USE PENCIL!

1. What is your current weight?

POUNDS

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
	7	7
	8	8
1	9	9

2. Is this your correct date of birth? ➡

○ Yes
○ No ➡ **If No, please write correct date.** MONTH / DAY / YEAR

3. Do you currently smoke cigarettes? (exclude pipe or cigars)

○ No ○ Yes ➡ **How many/day?** ○ 1–4 ○ 5–14 ○ 15–24 ○ 25 or more/day

4. In the past two years, have you had a PSA test for prostate cancer?

○ No ○ Yes, for symptoms ○ Yes, for routine screening

If Yes, what was your PSA level?

○ <2 ○ 2–2.9 ○ 3–3.9 ○ 4–5.9 ○ 6–7.9 ○ 8–9.9 ○ 10–14.9
○ 15+ ○ Elevated, unknown ○ Normal, unknown ○ Don't know

5. During the past two years did you unintentionally lose weight (e.g., due to illness, stress, or depression)?

○ No ○ Yes ➡ **Number of pounds?** ○ <5 lbs. ○ 5–9 lbs. ○ 10–14 lbs. ○ 15–19 lbs. ○ 20+ lbs.

6. Do you care for any of the following animals? *(Mark all that apply)*

○ Dog ○ Cat ○ Rabbit ○ Parrot/other bird ○ Horse ○ Farm animals ○ Others animals ○ No animals

7. In the past two years have you had . . . *(If yes, mark all that apply)*

	No	Yes, for Screening	Yes, for Symptoms
A physical exam?	(N)	(Y)	(Y)
Exam by eye doctor?	(N)	(Y)	(Y)
Prostate biopsy?	(N)	(Y)	(Y)
Fasting blood sugar?	(N)	(Y)	(Y)

Upper endoscopy (EGD)? (N) No (Y) Yes

Cologuard (fecal DNA)? (N) No (Y) Yes

Fecal occult blood or immunochemical (FIT) test (N) No (Y) Yes

Colonoscopy? (N) No (Y) Yes

Sigmoidoscopy? (N) No (Y) Yes

Initial reason(s) you had this colonoscopy or sigmoidoscopy?

○ Visible blood ○ Diarrhea/constipation
○ Fecal blood test ○ Fecal or stool DNA testing (e.g., Cologuard)
○ Barium enema ○ Family history of colon cancer
○ Abdominal pain ○ Follow-up of (virtual) CT colonoscopy
○ Prior polyps or prior cancer ○ Asymptomatic or routine screening

8. In the past two years, have you had gastrointestinal bleeding that required hospitalization or a blood transfusion?

○ No ○ Yes ➡ **What was the site of bleeding?**
○ Esophagus ○ Stomach ○ Duodenum
○ Colon/Rectum ○ Other ○ Site(s) unknown

9. In the past two years, have you had an episode of:

a) **Diverticulitis (NOT diverticulosis) diagnosed by a clinician?**

○ Yes ➡ **If Yes, did you...** ○ Require hospitalization? ○ Require surgery? ○ Have an abscess?
○ No ○ Require antibiotics? ○ Have a CT scan? ○ Have more than one episode?

b) **Diverticular bleeding that required blood transfusion and/or hospitalization?** ○ No ○ Yes

c) **Diverticulosis of the colon WITHOUT diverticulitis or diverticular bleeding?** ○ No ○ Yes

10. How often do you use a laxative (such as softeners, fiber supplements, or suppositories)?

○ Never ○ Less than once/month ○ 1–3 times/month ○ Once/week
○ 2–3 times/week ○ 4–5 times/week ○ Daily ○ 2+ times/day

11. How frequently do you have a bowel movement?

○ More than twice a day ○ Twice a day ○ Daily ○ Every other day ○ Every 3–4 days ○ Every 5 days or less

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12. Since January 1, 2022, have you had any of these clinician-diagnosed illnesses?

LEAVE BLANK FOR "NO", MARK HERE FOR "YES"	YEAR OF DIAGNOSIS: Before 2022	2022	2023	2024
Enlarged prostate, treated by drugs, surgery, or laser (Y)	○	○	○	○
Prostate cancer (Y)	○	○	○	○
Kidney cancer (Y)	○	○	○	○
Bladder cancer (Y)	○	○	○	○
Colon or rectal polyp (benign) (Y)	○	○	○	○
Cancer of the colon or rectum (Y)	○	○	○	○
Leukemia or lymphoma (Y)	○	○	○	○
Melanoma (Y)	○	○	○	○
Skin cancer (not melanoma) (Y)	○	○	○	○
Other cancer (Y) — Please specify site and year	○	○	○	○
Diabetes mellitus (Y)	○	○	○	○
Elevated cholesterol (Y)	○	○	○	○
High blood pressure (Y)	○	○	○	○
Myocardial infarction (heart attack) (Y) — Hospitalized for this MI? (N) No (Y) Yes	○	○	○	○
Angina pectoris (Y) — Confirmed by angiogram? (N) No (Y) Yes	○	○	○	○
Coronary bypass, angioplasty, or stent (Y)	○	○	○	○
Congestive heart failure (Y)	○	○	○	○
Stroke (Y)	○	○	○	○
TIA (transient ischemic attack) (Y)	○	○	○	○
Peripheral artery disease or claudication of legs (not varicose veins) (Y)	○	○	○	○
Carotid surgery (endarterectomy) (Y)	○	○	○	○
Pulmonary embolus or deep vein thrombosis (Y)	○	○	○	○
Atrial fibrillation (Y)	○	○	○	○
Gout (Y)	○	○	○	○

12. (continued)

LEAVE BLANK FOR "NO", MARK HERE FOR "YES"	YEAR OF DIAGNOSIS: Before 2022	2022	2023	2024
Osteoarthritis (Y)	○	○	○	○
Osteoporosis (Y)	○	○	○	○
Vertebral (spine) fracture, x-ray confirmed (Y)	○	○	○	○
Hip fracture (Y)	○	○	○	○
Hip replacement (Y)	○	○	○	○
Knee replacement (Y)	○	○	○	○
Depression, clinician-dx (Y)	○	○	○	○
Glaucoma (Y)	○	○	○	○
Macular degeneration of retina (Y)	○	○	○	○
Cataract extraction (Y)	○	○	○	○
Asthma (Y)	○	○	○	○
Emphysema or chronic bronchitis (COPD) (Y)	○	○	○	○
Parkinson's disease (Y)	○	○	○	○
ALS (Amyotrophic Lat. Sclerosis) (Y)	○	○	○	○
Alzheimer's or other type of dementia (Y)	○	○	○	○
Chronic viral hepatitis (B or C) (Y)	○	○	○	○
Kidney stones (Y)	○	○	○	○
Ulcerative colitis or Crohn's or microscopic colitis (Y)	○	○	○	○
Gastric/duodenal ulcer (Y)	○	○	○	○
Barrett's esophagus (Y)	○	○	○	○
Gallbladder removal (Y)	○	○	○	○
Fatty liver disease (Y) — Confirmed by liver biopsy? (N) No (Y) Yes	○	○	○	○
Cirrhosis (Y)	○	○	○	○
Other major illness or surgery since January 2022 (Y)	○	○	○	○

Please specify: **Date:**

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13. Regular Medication *(Mark if used regularly in past 2 years)*

Analgesics

- ○ Acetaminophen (e.g., Tylenol)
  - Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
  - Total tablets per week: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets
- ○ Low dose aspirin (100mg or less/tablet)
  - Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
  - Total tablets per week: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets
- ○ Aspirin or aspirin-containing products (325mg or more/tablet)
  - Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
  - Total tablets per week: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets
- ○ Ibuprofen (e.g., Advil, Motrin, Nuprin)
  - Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
  - Total tablets per week: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets
- ○ Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naprosyn, Celebrex, Clinoril, Relafen)

Other Regularly Used Medications

- ○ Thiazide diuretic ○ Lasix
- ○ Calcium channel blocker ○ Beta-blocker
- ○ ACE inhibitors (e.g., lisinopril, enalapril, benazepril)
- ○ Angiotensin receptor blocker (valsartan, losartan, irbesartan)
- ○ Spironolactone ○ Eplerenone ○ Finerenone
- ○ Other anti-hypertensive (e.g., clonidine, doxazosin)
- ○ Warfarin (Coumadin) ○ Pradaxa, Xarelto, Eliquis, Savaysa
- ○ Antiplatelet medication (e.g., Plavix, Effient, Brilinta)
- ○ Digoxin ○ Antiarrhythmic

Lipid-lowering drugs: (Mark all that apply)

- ○ Statin (e.g., atorvastatin, rosuvastatin, simvastatin)
- ○ PCSK9 inhibitor (Praluent, Repatha, Leqvio)
- ○ Ezetimibe (Zetia)
- ○ Other lipid-lowering drugs (e.g., fenofibrate, cholestyramine)

- ○ Insulin
- ○ Metformin (e.g., glucophage)
- ○ SGLT2 inhibitors (e.g., Jardiance, Farxiga, Invokana)
- ○ DPP4 inhibitors (Januvia, Onglyza, Tradjenta, Nesina)
- ○ GLP-1 agonist (e.g., Ozempic, Wegovy, Rybelsus, Victoza, Trulicity)
- ○ GLP-1/GIP agonist (e.g., Mounjaro)
- ○ Over-the-counter weight-loss medications
- ○ Steroids taken orally (e.g., prednisone, Decadron, Medrol)
- ○ Alpha blocker for BPH (e.g., tamsulosin (Flomax), terazosin)
- ○ Prescription memory loss medications (e.g., Aricept, Exelon, Namenda, Namzaric, Aduhelm)
- ○ Over-the-counter memory medications
- ○ Antidepressant medications (e.g., SSRIs, SNRIs, Tricyclics)
- ○ Benzodiazepines (e.g., Valium, alprazolam, lorazepam)
- ○ Prilosec, Nexium, Prevacid, Protonix, Aciphex
- ○ H2 blocker (e.g., Pepcid, Tagamet, Zantac, Axid)
- ○ Potassium-competitive acid blocker (e.g., vonoprazan)
- ○ Fosamax, Actonel, or other bisphosphonate
- ○ ß-agonist inhaler (e.g., albuterol, Ventolin, Maxair)
- ○ Finasteride (Proscar) ○ Propecia ○ Avodart
- ○ Prescription sleep medications (e.g., Ambien, Sonata, Lunesta)
- ○ Melatonin
  - Dose? ○ 1 mg or less ○ 2–5 mg ○ 6–10 mg ○ over 10 mg ○ Unknown (a)
- ○ Over-the-counter sleep medications
- ○ Other regular medications (no need to specify)

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14. Your current marital status: ◯ Married ◯ Divorced/separated ◯ Widowed ◯ Never married

15. Your current living arrangement: *(Mark all that apply)*

◯ Alone ◯ With spouse/partner ◯ With other family ◯ With pet(s) ◯ Other
◯ Assisted living ◯ Nursing home ◯ Senior/retirement housing or community for people age 55+

16. Do you have difficulty with your balance? ◯ No ◯ Occasionally ◯ Often

17. Do you usually use a cane, walker, or wheelchair/scooter? *(Mark all that apply)*

◯ No ◯ Cane ◯ Walker ◯ Wheelchair/scooter ◯ Unable to walk

18. What is your usual walking pace outdoors?

◯ Unable to walk ◯ Easy, casual (less than 2 mph)
◯ Normal, average (2-2.9 mph) ◯ Brisk pace (3-3.9 mph) ◯ Very brisk/striding (4 mph or faster)

19. DURING THE PAST YEAR, what was your average time PER WEEK spent at each of the following recreational activities?

	TIME PER WEEK									
	Zero	1-4 Min.	5-19 Min.	20-59 Min.	One Hour	1-1.5 Hrs.	2-3 Hrs.	4-6 Hrs.	7-10 Hrs.	11+ Hrs.
Walking for exercise or walking for transportation or errands	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Jogging (slower than 10 minutes/mile)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Running (10 minutes/mile or faster)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Bicycling: **stationary exercise bike** Intensity: ◯ Low ◯ Medium ◯ High	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Bicycling: **outside, separated from traffic (e.g., bike path)** Intensity: ◯ Low ◯ Medium ◯ High	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Bicycling: **outside on road** Intensity: ◯ Low ◯ Medium ◯ High	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pickleball, tennis, squash, or racquetball Racquet sport intensity: ◯ Low ◯ Medium ◯ High	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Lap swimming Swimming intensity: ◯ Low ◯ Medium ◯ High	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other aerobic exercise (e.g., aerobic dance, ski or stair machine, etc.)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Lower intensity exercise (e.g., yoga, stretching, toning)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other vigorous activities (e.g., lawn mowing)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Weight training or resistance exercises (include free weights or resistance machines) — Arm weights	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Weight training or resistance exercises (include free weights or resistance machines) — Leg weights	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

20. DURING THE PAST YEAR, on average, how many <u>HOURS PER WEEK</u> did you spend:

	TIME PER WEEK								
	Zero Hrs.	One Hour	2-5 Hrs.	6-10 Hrs.	11-20 Hrs.	21-40 Hrs.	41-60 Hrs.	61-90 Hrs.	Over 90 Hrs.
Standing or walking around at work or away from home?	◯	◯	◯	◯	◯	◯	◯	◯	◯
Standing or walking around at home?	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting at work or away from home or while driving?	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting at home while watching TV/DVD/movies?	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other sitting at home (e.g., reading, meal times, at desk)?	◯	◯	◯	◯	◯	◯	◯	◯	◯

21. **Do you have difficulty climbing a flight of stairs or walking eight blocks due to a physical impairment?** ○ No ○ Yes 21

22. **How many flights of stairs (not steps) do you climb daily? (Do not include time spent on stair or exercise machines.)** 22

○ No flights ○ 1–2 flights ○ 3–4 flights ○ 5–9 flights ○ 10–14 flights ○ 15 or more flights

23. **In the past year, did you have a fall where you fell all the way to the ground?** 23

○ No ○ Yes → **a) How many falls did you have?** ○ 1–2 ○ 3–4 ○ 5–10 ○ >10 a

b) Did you have a fall with an injury? *(i.e., a bruise, a cut, a swollen joint or a fracture.)* b

○ No ○ Yes

24. **Has your spouse (or sleep partner) ever told you that you appear to "act out your dreams" while sleeping (punched or flailed arms in the air, shouted or screamed), on three or more occasions?** 24

○ No ○ Yes ○ I do not have a sleep partner

25. **Do you have any problems with your sense of smell, such as not being able to smell things or things not smelling the way they are supposed to for at least 3 months? (Do not include COVID-related changes to sense of smell.)** 25

○ No ○ Yes → **Which problem do you have?** ○ Loss of smell ○ Things don't smell right ○ Don't know a

26. **In the last year, how often have you had heartburn or acid-reflux?** 26

○ None in the past year ○ Less than once/month ○ About once/month ○ About once/week ○ Several times/week ○ Daily

27. **In the past year, have you been bothered by constipation or diarrhea for at least 12 weeks (not necessarily consecutive)?** 27

○ No
○ Yes, diarrhea
○ Yes, constipation

→ **If Yes, were your bowel movements associated with abdominal pain?** a

○ No ○ Yes

28. **Have you ever had any of the following:** *(Mark all that apply)* 28

Leave blank for "NO", mark here for "YES"		Before 2004	2004-2007	2008-2011	2012-2017	2018-2019	2020-2021	2022	2023	2024+
Shingles	Y →	○	○	○	○	○	○	○	○	○
Vaccine for shingles	Y →	○	○	○	○	○	○	○	○	○
Influenza Vaccine	Y →	○	○	○	○	○	○	○	○	○
Bariatric Surgery	Y →	○	○	○	○	○	○	○	○	○
Syncope (transient loss of consciousness/fainting)	Y →	○	○	○	○	○	○	○	○	○

If syncope within the past two years, did this cause an injury? ○ No ○ Yes a

29. **Have you ever been diagnosed with COVID-19 or tested positive for COVID-19?** 29

○ No ○ Yes →

a) Number of times you have had COVID-19? ○ One ○ Two ○ Three ○ Four or more a

b) Were you ever hospitalized for COVID-19? ○ Yes ○ No b

c) Have you experienced any long-term COVID-19 symptoms (lasting for more than 4 weeks)? c

○ No ○ Yes → **Which of the following long-term COVID-19 symptoms have you experienced?**

○ Fatigue	○ Confusion, disorientation, "brain fog"	○ Headache
○ Shortness of breath or difficulty breathing	○ Memory issues	○ Intermittent fever
○ Persistent cough	○ Depression, anxiety, changes in mood	○ Mouth or tongue ulcers
○ Muscle, joint or chest pain	○ Heart palpitations	○ Tinnitus
○ Smell and taste problems	○ Rash, blisters or welts anywhere on body	○ Other symptoms

30. **Regarding your eating habits during the past year. . .** 30

	Never/ Rarely	Sometimes	Often	Usually/ Always
While I eat, I'm fully aware of the smells and taste of my food (e.g., temperature, texture, etc.).	○	○	○	○
I stop eating when I'm full, even if my plate is not empty yet.	○	○	○	○
I eat anything I want, whenever I want.	○	○	○	○
When I eat, I do something else on the side (e.g., read, watch TV, drive, work, be on the phone).	○	○	○	○
I try to make food and beverage choices that are good for the environment.	○	○	○	○
When I start eating, I just can't seem to stop.	○	○	○	○

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31. During the past three months, how would you rate your ability (without treatment) to have and maintain an erection good enough for intercourse?

◯ Very Poor ◯ Poor ◯ Fair ◯ Good ◯ Very Good ◯ Not Applicable

32. On average, how many ejaculations do you have per month?

◯ None ◯ 1–3/month ◯ 4–7 ◯ 8–12 ◯ 13–20 ◯ 20+/month

33. Please answer Yes or No for each of the following questions about your memory:

Have you recently experienced any change in your ability to remember things?	◯ Yes	◯ No
Do you have more trouble than usual remembering recent events?	◯ Yes	◯ No
Do you have more trouble than usual remembering a short list of items, such as a shopping list?	◯ Yes	◯ No
Do you have trouble remembering things from one second to the next?	◯ Yes	◯ No
Do you have difficulty in understanding or following spoken instructions?	◯ Yes	◯ No
Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory?	◯ Yes	◯ No
Do you have trouble finding your way around familiar streets?	◯ Yes	◯ No

34. How do the following statements describe you?

	Never or Very Rarely True	Rarely True	Sometimes True	Often True	Very Often or Always True
When I take a shower or a bath, I stay alert to the sensations of water on my body.	◯	◯	◯	◯	◯
I'm good at finding words to describe my feelings.	◯	◯	◯	◯	◯
I don't pay attention to what I'm doing because I'm daydreaming, worrying or otherwise distracted.	◯	◯	◯	◯	◯
I believe some of my thoughts are abnormal or bad and I shouldn't think that way.	◯	◯	◯	◯	◯
When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.	◯	◯	◯	◯	◯
I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.	◯	◯	◯	◯	◯
I have trouble thinking of the right words to express how I feel about things.	◯	◯	◯	◯	◯
I do jobs or tasks automatically without being aware of what I'm doing.	◯	◯	◯	◯	◯
I do think my emotions are bad or inappropriate and I shouldn't feel them.	◯	◯	◯	◯	◯
When I have distressing thoughts or images, I am able to just notice them without reacting.	◯	◯	◯	◯	◯
I pay attention to sensations, such as the wind in my hair or sun on my face.	◯	◯	◯	◯	◯
Even when I'm feeling terribly upset, I can find a way to put it into words.	◯	◯	◯	◯	◯
I find myself doing things without paying attention.	◯	◯	◯	◯	◯
I tell myself I shouldn't be feeling the way I'm feeling.	◯	◯	◯	◯	◯
When I have distressing thoughts or images, I just notice them and let them go.	◯	◯	◯	◯	◯

35. Thinking about people close to you who have died, please answer the following questions with respect to the one person whose loss was the most distressing to you.

a) What was this person's relationship to you?

◯ Spouse/partner ◯ Child ◯ Sibling ◯ Close Friend or relative ◯ Parent ◯ Other (specify) _____

b) Approximately when did this person die?

◯ Before 2010 ◯ 2010–2015 ◯ 2016–2019 ◯ 2020 ◯ 2021 ◯ 2022 ◯ 2023 ◯ 2024+

c) Have you continued to have strong feelings that won't go away of wanting the person back even though you know it's not possible?

◯ Yes ◯ Sometimes ◯ No

d) Have thoughts of your deceased loved one continued to be on your mind so much that it makes it hard to think about or care about other things?

◯ Yes ◯ Sometimes ◯ No

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36. **In general, would you say your health is:** 36

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

37. **Compared to one year ago, how would you rate your health in general now?** 37

◯ Much better now than one year ago ◯ Somewhat better now than one year ago ◯ About the same
◯ Somewhat worse than one year ago ◯ Much worse than one year ago

38. **The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?** *(Mark one response on each line.)* 38

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
Vigorous activities, such as running, lifting heavy objects, strenuous sports	◯	◯	◯
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	◯	◯	◯
Lifting or carrying groceries	◯	◯	◯
Climbing *several* flights of stairs	◯	◯	◯
Climbing *one* flight of stairs	◯	◯	◯
Bending, kneeling, or stooping	◯	◯	◯
Walking *more than one mile*	◯	◯	◯
Walking *several blocks*	◯	◯	◯
Walking *one block*	◯	◯	◯
Bathing or dressing yourself	◯	◯	◯
Getting in and out of a bed or chair	◯	◯	◯

39. **During the *past four weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your *physical health*?** 39

a) Cut down the amount of time you spent on work or other activities ◯ Yes ◯ No
b) Accomplished less than you would like ◯ Yes ◯ No
c) Were limited in the kind of work or other activities ◯ Yes ◯ No
d) Had difficulty performing the work or other activities (for example, it took extra effort) ◯ Yes ◯ No

40. **During the *past four weeks*, have you had any of the following problems with your work or other regular daily activities as a result of any *emotional problems* (such as feeling depressed or anxious)?** ***(Mark one response on each line.)*** 40

a) Cut down the amount of time you spent on work or other activities ◯ Yes ◯ No
b) Accomplished less than you would like ◯ Yes ◯ No
c) Didn't do work or other activities as carefully as usual ◯ Yes ◯ No

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41. **During the *past four weeks*, to what extent have your emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?** 41

◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely

42. **How much *bodily pain* have you had during the *past four weeks*?** 42

◯ None ◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ Very severe

43. **During the *past four weeks*, how much did *bodily pain* interfere with your normal work (including both work outside the home and housework)?** 43

◯ Not at all ◯ A little bit ◯ Moderately ◯ Quite a bit ◯ Extremely

44. **These questions are about how you feel and how things have been with you *during the past four weeks.* For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the *past four weeks...*** 44

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
Did you feel full of pep?	◯	◯	◯	◯	◯	◯
Have you been a very nervous person?	◯	◯	◯	◯	◯	◯
Have you felt so down in the dumps nothing could cheer you up?	◯	◯	◯	◯	◯	◯
Have you felt calm and peaceful?	◯	◯	◯	◯	◯	◯
Did you have a lot of energy?	◯	◯	◯	◯	◯	◯
Have you felt downhearted and blue?	◯	◯	◯	◯	◯	◯
Did you feel worn out?	◯	◯	◯	◯	◯	◯
Have you been a happy person?	◯	◯	◯	◯	◯	◯
Did you feel tired?	◯	◯	◯	◯	◯	◯

45. **During the *past four weeks*, how much of the time have your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?** 45

◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

46. **Please choose the answer that best describes how true or false each of the following statements is for you.** 46

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
I seem to get sick a little easier than other people.	◯	◯	◯	◯	◯
I am as healthy as anybody I know.	◯	◯	◯	◯	◯
I expect my health to get worse.	◯	◯	◯	◯	◯
My health is excellent.	◯	◯	◯	◯	◯

47. Which of the following best represents how you think of yourself? 47
◯ Gay ◯ Straight, that is, not gay. ◯ Bisexual

48. Which best describes your hearing (without a hearing aid)? 48
◯ Excellent ◯ Good ◯ A little trouble hearing ◯ Moderate hearing trouble ◯ A lot of trouble hearing ◯ Deaf

49. Do you wear a hearing aid? 49
◯ Yes, All the time ◯ Yes, Most the time ◯ Yes, Occasionally ◯ No, Never

50. In the past 12 months, have you had ringing, roaring, or buzzing in your ears or head? 50
◯ Never ◯ <Once/week ◯ About once/week ◯ Several times/week ◯ Almost every day ◯ Every day

a) If so, when did this first begin? a
◯ Within the past year ◯ 1–2 years ago ◯ 3–5 years ago ◯ 6–10 years ago ◯ >10 years ago

b) On the days you hear the sound, how long does it last? b
◯ A few seconds ◯ Less than 5 minutes ◯ 5 minutes to an hour ◯ Several hours ◯ All the time

c) Does the sound affect your ability to: c ◯ Sleep ◯ Work ◯ Concentrate ◯ Perform other activities ◯ None of these

51. Which best describes your eyesight using both eyes (with glasses or contact lenses, if you wear them)? 51
◯ Excellent ◯ Good ◯ Fair ◯ Poor ◯ Very Poor ◯ Completely blind

52. Outside of your employment, do you provide regular care to any of the following? *(Mark one response on each line. For people to whom you do not provide regular care, mark "Zero hours")* 52

	HOURS PER WEEK					
	Zero Hrs.	1-8 Hrs.	9-20 Hrs.	21-35 Hrs.	36-72 Hrs.	73+ Hrs.
Your grandchildren	◯	◯	◯	◯	◯	◯
Disabled or ill spouse/partner	◯	◯	◯	◯	◯	◯
Disabled or ill adult child	◯	◯	◯	◯	◯	◯
Disabled or ill other person	◯	◯	◯	◯	◯	◯

53. How often do you go to religious meetings or services? 53
◯ More than once a week ◯ Once a week ◯ 1 to 3 times per month ◯ Less than once per month ◯ Never or almost never

54. How many hours <u>each week</u> do you participate in any groups such as social or work group, church-connected group, self-help group, charity, public service or community group? 54
◯ None ◯ 1 to 2 hours ◯ 3 to 5 hours ◯ 6 to 10 hours ◯ 11 to 15 hours ◯ 16 or more hours

55. How many living children (include stepchildren) do you have? 55
Daughters ◯ None ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 or more
Sons ◯ None ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 or more

56. How many of your children do you see at least once a month? 56
◯ None ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 or more

57. Apart from your children, how many relatives do you have with whom you feel close? 57
◯ None ◯ 1 to 2 ◯ 3 to 5 ◯ 6 to 9 ◯ 10 or more

58. Apart from your children, how many close relatives do you see at least once a month? 58
◯ None ◯ 1 to 2 ◯ 3 to 5 ◯ 6 to 9 ◯ 10 or more

59. How many close friends do you have? 59
◯ None ◯ 1 to 2 ◯ 3 to 5 ◯ 6 to 9 ◯ 10 or more

60. How many of these friends do you see at least once a month? 60
◯ None ◯ 1 to 2 ◯ 3 to 5 ◯ 6 to 9 ◯ 10 or more

61. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with? 61
◯ Yes → **a) How often do you see or talk to this person?** a
◯ No ◯ Daily ◯ Weekly ◯ Monthly ◯ Several times/year ◯ Once/year or less

62. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)? 62
◯ None of the time ◯ A little of the time ◯ Some of the time ◯ Most of the time ◯ All of the time

63. Did you (the participant) have help with filling out this questionnaire? 63
◯ No (I filled it out alone) ◯ Yes (Someone helped me)

64. Please indicate the name of someone at a DIFFERENT PERMANENT ADDRESS to whom we might write in the event we are unable to contact you: 64

Name: _____ Email: _____

Address: _____ Relationship: _____

_____ Phone #: _____

Thank you! Please return to: HPFS, 677 Huntington Ave. Boston, MA 02115

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1 2 3 4 5 6 7 8 9 10 24 11 25 12 26

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