• Use a black or blue ball-point pen.
• If you want to change your answer, completely fill the incorrect box and mark the correct box.
• If needed, you can complete the questionnaire with another person.

Personal ID number 19 [ ] [ ] [ ] [ ] - [ ] [ ] [ ]

YOUR HEALTH

1. How are you currently feeling in general? Very Good Good OK Bad Very Bad
   - How is your health?
   - How is your memory?
   - How is your physical condition?
   - How is your appetite?
   - How is your mood?
   - How is your energy?

2. Have you or have you had any of the following conditions?
   - High blood pressure
   - High cholesterol
   - Angina
   - Intermittent claudication
   - Heart failure
   - Dizziness
   - Tinnitus
   - Osteoporosis
   - Allergy
   - Asthma
   - COPD (chronic lung disease)
   - Chronic bronchitis
   - Hay fever
   - Pollen allergy
   - Endometriosis
   - Severe menopausal symptoms
   - Atopic eczema (as a child)
   - Kidney stones
   - Gallstones
   - Rheumatoid arthritis
   - Gastritis
   - Parkinson’s disease
   - Ulcerative colitis
   - IBS / irritable bowel
   - Crohn’s disease
   - Depression
   - Eczema
   - Glaucoma

3. Do you have diabetes? No [ ] Yes, it was detected at [ ] years of age. The treatment I use now is Insulin [ ] Tablets [ ] Dietary advice

4. If you do not take blood pressure medicine, has your blood pressure been checked in the last 3 years? No [ ] Yes, it has been checked and [ ] it was too low [ ] it was normal [ ] it was mildly elevated [ ] it was markedly elevated

5. What are your body measurements? Enter only whole numbers
   - Height [ ] cm
   - Weight [ ] kg
   - Waist [ ] cm
   - Hip [ ] cm

6. At what age did you enter menopause? At the age of [ ]

7. How many doctor visits have you had in the past 12 months? [ ] visits

8. What is your view of life? Very positive [ ] Positive [ ] Negative [ ] Very negative [ ]

DENTAL HEALTH

9. Do you have…
   - all of your teeth (not including wisdom teeth)? No [ ] Yes [ ]
   - pulled out / lost teeth (besides wisdom teeth) in adulthood? No [ ] Yes [ ]
   - whole or partial dentures (not including bridge or implant)? No [ ] Yes [ ]
   - bleeding of the gums when you brush your teeth? No [ ] Yes [ ]
   - periodontal disease / periodontitis? No [ ] Yes [ ]
   - problems with dry mouth? No [ ] Yes [ ]
   - problems chewing? No [ ] Yes [ ]
ACHES AND PAINS

10. During the past 12 months have you had at work, or during chores at home, pain in:
   - the back [ ] No [ ] Yes
   - the shoulders [ ] No [ ] Yes
   - the neck [ ] No [ ] Yes

11. During the past 12 months have you had pain for 3 months or longer in:
   - knee / knees [ ] No [ ] Yes
   - hips [ ] No [ ] Yes

12. Have you had any of the following operations?
   - Torn cartilage [ ] No [ ] Yes
   - Ligament damage in the knee [ ] No [ ] Yes
   - Artificial joint in the knee [ ] No [ ] Yes
   - Artificial joint in the hip [ ] No [ ] Yes

MEDICINES

13. Do you regularly or intermittently use any of the following medicines?
   - Cortisone in tablet form or inhalation [ ] No [ ] Yes → total over [ ] years
   - Magnecyl, Bamyl, Treo, Aspirin, Albyl, Trombyl [ ] No [ ] Yes
     tablets/week during [ ] less than 10 years [ ] 10-20 years
     [ ] more than 20 years
   - Alvedon, Panodil, Reliv, Citodon [ ] No [ ] Yes
     tablets/week during [ ] less than 10 years [ ] 10-20 years
     [ ] more than 20 years
   - Ipren, Diklofenak, Voltaren, Ibumetin, Naproxen [ ] No [ ] Yes
     tablets/week during [ ] less than 10 years [ ] 10-20 years
     [ ] more than 20 years

14. Have you used antibiotics during the last 10 years? [ ] No
    [ ] Yes → [ ] less than 1 course a year [ ] 1 course/year [ ] 2-3 courses/year [ ] more than 3 courses/year

15. Have you used estrogen supplements? [ ] No, I have never used any type of estrogen
    [ ] Yes, I have taken estrogen supplements for [ ] less than 5 years [ ] 5-10 years [ ] more than 10 years
    For example: [ ] cream / pessaries [ ] tablets [ ] patches

SIGHT, HEARING AND BALANCE

16. Have you had cataract surgery? [ ] No [ ] Yes → When I was [ ] years old.

17. Do you use a hearing aid? [ ] No [ ] Yes → At which age did you start using a hearing aid?
    [ ] before 30 [ ] 30-40 [ ] 40-50 [ ] 50-60 [ ] 60-70 [ ] 70-80 [ ] after 80

18. Do you have a good sense of taste? [ ] Yes [ ] No → At which age did you lose your sense of taste?
    [ ] before 30 [ ] 30-40 [ ] 40-50 [ ] 50-60 [ ] 60-70 [ ] 70-80 [ ] after 80

19. Do you have good balance? [ ] Yes [ ] No → At which age did your balance become impaired?
    [ ] before 30 [ ] 30-40 [ ] 40-50 [ ] 50-60 [ ] 60-70 [ ] 70-80 [ ] after 80

20. Have you had a fall during the past 12 months? [ ] No [ ] Yes, [ ] time(s).

SLEEP HABITS

21. How much sleep do you need per day? [ ] hours
    How long do you sleep per night on average? [ ] hours

22. What time do you usually fall asleep? [ ]::[ ] time (time)
    What time do you usually wake? [ ]::[ ] time (time)
    Do you regularly take a nap? [ ] No [ ] Yes → from [ ]::[ ] time (time) until [ ]::[ ] time (time) per day

23. How do you find that you sleep on the whole?
    [ ] Very good [ ] Fairly good [ ] Neither good nor bad [ ] Fairly bad [ ] Very bad

24. How often have you had the following symptoms in the past 3 months?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Never</th>
<th>Seldom</th>
<th>Often</th>
<th>Mostly</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty falling asleep</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Repeatedly waking up with difficulty falling asleep</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Premature awakening</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Disturbed / restless sleep</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Sleep apnea / apnea</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Disturbing snoring</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

25. During your working life, have you had working hours that required you to work at night at least a few times per month?
    [ ] No [ ] Yes, I did this for [ ] years.
26. These questions concern urination over the past month

- Do you have symptoms from the lower urinary tract?
- Do you think you urinate often?
- Do you have a strong urge to urinate?
- Do you experience urinary leakage when training?
- Is there leakage of urine during physical exertion / when coughing?
- Is there leakage of urine without any activity?
- Does the urine leak in drops?
- Is there leakage of large amounts of urine?
- Do you get up at night to urinate?
- Are you experiencing difficulty in passing urine?
- Does it feel like your bladder does not empty?
- Is there pain when you urinate?
- Do you have symptoms from the lower urinary tract?
- Do you think you urinate often?
- Do you have a strong urge to urinate?
- Do you experience urinary leakage when training?
- Is there leakage of urine during physical exertion / when coughing?
- Is there leakage of urine without any activity?
- Does the urine leak in drops?
- Is there leakage of large amounts of urine?
- Do you get up at night to urinate?
- Are you experiencing difficulty in passing urine?
- Does it feel like your bladder does not empty?
- Is there pain when you urinate?

27. How often do you usually urinate at night?

28. Have you had a urinary tract infection / urinary retention?

29. If you had to live with urination the way it is today how would you feel?

30. Do you have a bowel movement every day? [ ] Yes [ ] No, it takes [ ] day(s) between times

31. Do you have a bowel movement several times a day? [ ] Yes [ ] No

32. How often do you experience difficulty with bowel movements?

33. Do you / have you had fecal leakage? [ ] No [ ] Yes, I have had it before [ ] Yes, I have it now

YOUR FAMILY’S HEALTH

34. Have any of your parents or siblings had:

- Breast cancer
- Prostate cancer
- Colon cancer
- Other cancer
- Rheumatoid arthritis
- Psoriasis
- Diabetes
- High blood pressure
- Myocardial infarction before 60

35. What age did your parents live to?

- Mother was [ ] years old [ ] Mother still alive
- Father was [ ] years old [ ] Father still alive

STRESS

36. By stress, we mean that you feel tense, irritable, nervous, anxious or have difficulty sleeping because of situations at work or in private life (e.g. feelings of sadness or powerlessness)

- In private life
- At work

I have never experienced stress
I have experienced a stressful period
I have experienced a stressful period in the past 5 years
I have experienced several periods of stress in the past 5 years
I have experienced constant stress in the past year
I have experienced constant stress in the past 5 years
I have had many long periods of stress in my life

37. How often do you feel very strong anger?

[ ] times per day [ ] times per week [ ] seldom [ ] never
### HOW ARE YOU FEELING?

#### 38. How have you felt during the last week?

<table>
<thead>
<tr>
<th></th>
<th>Always / almost all the time</th>
<th>Often / fairly often</th>
<th>Sometimes / Very rarely</th>
<th>Never / almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have felt able to cope with serious problems or major changes in my life</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I have felt calm and relaxed</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I have felt energetic, active and enterprising</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>On waking, I felt fresh and rested</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I have felt happy or satisfied and pleased with my personal life</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I have felt sad and down</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I am satisfied with my life</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I live the kind of life I want to live</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I have been eager to get on with the day’s work or make new decisions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I have felt that life is full of interesting things</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### FAMILY, FRIENDS AND ACQUAINTANCES

#### 39. How many people, with the same interests as you, do you know and have contact with? Both at work and in your leisure time

- ☐ No one
- ☐ 1-2
- ☐ 3-5
- ☐ 6-10
- ☐ 11-15
- ☐ More than 15

#### 40. How many people, that you know well, do you meet or talk with during a normal week? Do not count those that you run into unexpectedly.

- ☐ None
- ☐ 1-2
- ☐ 3-5
- ☐ 6-10
- ☐ 11-15
- ☐ More than 15

#### 41. How many do you have that can come to your home anytime and feel at home? They would not care if it was untidy or if you were about to eat. Do not count close relatives.

- ☐ None
- ☐ 1-2
- ☐ 3-5
- ☐ 6-10
- ☐ 11-15
- ☐ More than 15

#### 42. How many are there, in your family or among your friends who you can talk openly with?

- ☐ None
- ☐ 1-2
- ☐ 3-5
- ☐ 6-10
- ☐ 11-15
- ☐ More than 15

#### 43. How many people are there in your environment who you can easily ask for things? People who know you so well that you can borrow tools or kitchen things?

- ☐ None
- ☐ 1-2
- ☐ 3-5
- ☐ 6-10
- ☐ 11-15
- ☐ More than 15

#### 44. Apart from those at home, how many are there that you can turn to if you are in difficulty? Someone who you can easily meet and who you trust and can really help you when you are experiencing difficulties?

- ☐ None
- ☐ 1-2
- ☐ 3-5
- ☐ 6-10
- ☐ 11-15
- ☐ More than 15

### OTHER ISSUES

#### 45. What is your current employment?

- ☐ Full-time
- ☐ Part-time
- ☐ Not working
- ☐ Disability
- ☐ Retired

#### 46. Where do you live now?

- ☐ Home
- ☐ Assisted living facility
- ☐ Nursing home
- ☐ Retirement home

- There are ☐ people in the household.

- I have lived alone for ☐ years.

#### 47. Do you have pets (e.g. dog or cat) at home?

- ☐ Yes
- ☐ No

#### 48. Are you active in a club?

- ☐ Yes
- ☐ No

---

**Have you been helped by someone to complete the survey?**  ☐ No  ☐ Yes

*Can we call you if we have any further questions? If so, please enter your telephone number*

- **Daytime phone**
- **Evening phone**

---

*I have read the attached information letter and want to continue to participate in the study.*

**Date**

**Signature**

---

**Many thanks for your participation!**

(HLSA18K)