# Health Among Men Study

- 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
   - [ ] Impotence
   - [ ] Hemorrhoids
   - [ ] Migraine
   - [ ] Joint pain
   - [ ] Rheumatoid arthritis
   - [ ] Gastritis
   - [ ] Parkinson’s disease
   - [ ] Psoriasis
   - [ ] Eczema
   - [ ] Atopic eczema (as a child)
   - [ ] Kidney stones
   - [ ] Gallstones
   - [ ] Migraine
   - [ ] Joint pain
   - [ ] Rheumatoid arthritis
   - [ ] Gastritis
   - [ ] Parkinson’s disease
   - [ ] Psoriasis
   - [ ] Eczema
   - [ ] Atopic eczema (as a child)
   - [ ] Kidney stones
   - [ ] Gallstones

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

7. **What is your view of life?**
   - [ ] Very positive
   - [ ] Positive
   - [ ] Negative
   - [ ] Very negative

## DENTAL HEALTH

8. **Do you have...**
   - [ ] all of your teeth (not including wisdom teeth)?
   - [ ] pulled out / lost teeth (besides wisdom teeth) in adulthood?
   - [ ] whole or partial dentures (not including bridge or implant)?
   - [ ] bleeding of the gums when you brush your teeth?
   - [ ] periodontal disease / periodontitis?
   - [ ] problems with dry mouth?
   - [ ] problems chewing?

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*HLSA18M*
ACHES AND PAINS

9. 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]

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

11. In your life, have you ever undergone one 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

12. 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] → table / week during ___ ___ years
   - Alvedon, Panodil, Reliv, Citodon [No] [Yes] → table / week during ___ ___ years
   - Ipren, Diklofenak, Voltaren, Ibumetin, Naproxen [No] [Yes] → table / week during ___ ___ years

13. 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 [ ]

SIGHT, HEARING AND BALANCE

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

15. Do you use glasses? [No] [Yes] → At what age did you start wearing glasses?
   - before 30 [ ]
   - 30-40 [ ]
   - 40-50 [ ]
   - 50-60 [ ]
   - 60-70 [ ]
   - 70-80 [ ]
   - after 80 [ ]

16. 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 [ ]

17. 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 [ ]

18. 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 [ ]

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

SLEEP HABITS

20. How much sleep do you need per day? ___ ___ hours
   How long do you sleep per night on average? ___ ___ hours

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

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

23. 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>
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<tr>
<td>Repeatedly waking up with</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>difficulty falling asleep</td>
<td></td>
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<tr>
<td>Premature awakening</td>
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<tr>
<td>Disturbed / restless sleep</td>
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<tr>
<td>Sleep apnea / apnea</td>
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<tr>
<td>Disturbing snoring</td>
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</table>

24. 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.
### TOILET HABITS

**25.** These questions concern urination over the past month

- How often have you felt like you cannot empty your bladder?
- How many times do you visit the toilet within 2 hours of going?
- How often is your urine intermittent instead of continuous?
- How often is it hard to hold it in when you need to urinate?
- How often do you have a weak urinary stream?
- How often must you apply pressure to urinate?

**26.** How often do you usually urinate at night?

**27.** Have you had a urinary tract infection / urinary retention?

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

**29.** Do you have a bowel movement every day? Yes / No

**30.** Do you have a bowel movement several times a day? Yes / No

**31.** How often do you experience difficulty with bowel movements?

**32.** Do you / have you had fecal leakage? Yes / No

### YOUR FAMILY’S HEALTH

**33.** Have any of your parents or siblings had:

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

**34.** What age did your parents live to?

<table>
<thead>
<tr>
<th>Mother was</th>
<th>Father was</th>
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<tbody>
<tr>
<td>[ ] years old</td>
<td>[ ] years old</td>
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</tbody>
</table>

**35.** 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)

<table>
<thead>
<tr>
<th>In private life</th>
<th>At work</th>
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<tbody>
<tr>
<td>[ ]</td>
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</table>

**36.** How often do you feel very strong anger?

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

<table>
<thead>
<tr>
<th>Question</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>
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<tr>
<td>I have felt calm and relaxed</td>
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<tr>
<td>I have felt energetic, active and enterprising</td>
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<td>On waking, I felt fresh and rested</td>
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<tr>
<td>I have felt happy or satisfied and pleased with my personal life</td>
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<tr>
<td>I have felt sad and down</td>
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<tr>
<td>I am satisfied with my life</td>
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<tr>
<td>I live the kind of life I want to live</td>
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<tr>
<td>I have felt that life is full of interesting things</td>
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</tbody>
</table>

### FAMILY, FRIENDS AND ACQUAINTANCES

<table>
<thead>
<tr>
<th>Question</th>
<th>None</th>
<th>1-2</th>
<th>3-5</th>
<th>6-10</th>
<th>11-15</th>
<th>More than 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>38. How many people, with the same interests as you, do you know and have contact with? Both at work and in your leisure time.</td>
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<td>39. 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.</td>
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<td>40. How many friends 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.</td>
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<td>41. How many are there, in your family or among your friends who you can talk openly with?</td>
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<td>42. 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?</td>
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<td>43. 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?</td>
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### OTHER ISSUES

<table>
<thead>
<tr>
<th>Question</th>
<th>Full-time</th>
<th>Part-time</th>
<th>Not working</th>
<th>Disability</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>44. What is your current employment?</td>
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<td>45. Where do you live now?</td>
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<tr>
<td>46. Do you have pets (e.g. dog or cat) at home?</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>47. Are you active in a club?</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

If you have been helped by someone to complete the survey? Yes/No

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: [ ] Y  [ ] Y  [ ] M  [ ] M  [ ] D  [ ] D   Signature: ___________________________

Many thanks for your participation!