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UPPSALA UNIVERSITET

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 1 9 ☐☐☐☐☐☐ - ☐☐☐☐

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	☐ Allergy	☐ Migraine	☐ Kidney stones
☐ High cholesterol	☐ Asthma	☐ Joint pain	☐ Gallstones
☐ Angina	☐ COPD (chronic lung disease)	☐ Rheumatoid arthritis	☐ Gastritis
☐ Intermittent claudication	☐ Chronic bronchitis	☐ Parkinson's disease	☐ Ulcerative colitis
☐ Heart failure	☐ Hay fever	☐ MS (multiple sclerosis)	☐ IBS / irritable bowel
☐ Dizziness	☐ Pollen allergy	☐ Psoriasis	☐ Crohn's disease
☐ Tinnitus	☐ Impotence	☐ Eczema	☐ Depression
☐ Osteoporosis	☐ Hemorrhoids	☐ Atopic eczema (as a child)	☐ 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. 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)?	☐ No	☐ Yes	
pulled out / lost teeth (besides wisdom teeth) in adulthood?	☐ No	☐ Yes	no. ☐☐
whole or partial dentures (not including bridge or implant)?	☐ No	☐ Yes	
bleeding of the gums when you brush your teeth?	☐ No	☐ Yes	
peridontal disease / periodontitis?	☐ No	☐ Yes	
problems with dry mouth?	☐ No	☐ Yes	
problems chewing?	☐ No	☐ Yes	

ACHES AND PAINS

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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 artificial joint in the knee ☐ No ☐ Yes

Ligament damage 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, ☐☐☐ 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

13. Have you used anitbiotics 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?

	Never	Seldom	Often	Mostly	Always
Difficulty falling asleep	☐	☐	☐	☐	☐
Repeatedly waking up with difficulty falling asleep	☐	☐	☐	☐	☐
Premature awakening	☐	☐	☐	☐	☐
Disturbed / restless sleep	☐	☐	☐	☐	☐
Sleep apnea / apnea	☐	☐	☐	☐	☐
Disturbing snoring	☐	☐	☐	☐	☐

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

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

	Never	Less than every 5th visit	Less than half the time	About half of the time	More than half of the time	Almost never
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?	☐	☐	☐	☐	☐	☐

	Never	1 time	2 times	3 times	4 times	5+
26. How often do you usually urinate at night?	☐	☐	☐	☐	☐	☐
27. Have you had a urinary tract infection / urinary retention?	☐	☐	☐	☐	☐	☐

	Very Good	Good	Accept-able	Neither Good/Bad	Fairly Bad	Very Bad	Terrible
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, it takes ☐☐ day(s) between occations

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

31. How often do you experience difficulty with bowel movements?
☐ Never ☐ less than 1 time/week ☐ 1-6 times/week ☐ Always

32. Do you / have you had fecal leakage? ☐ No ☐ Yes, I have had it before ☐ Yes, I have it now

YOUR FAMILY'S HEALTH

33. Have any of your parents or siblings had:	No	Yes, mother	Yes, father	Yes, sibling	Don't know
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?
Mother was ☐☐☐ years old ☐ Mother still alive Father was ☐☐☐ years old ☐ Father still alive

STRESS

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)

	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	☐	☐

36. How often do you feel very strong anger?
☐☐ times per day ☐☐ times per week ☐ seldom ☐ never

HOW ARE YOU FEELING?

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37. How have you felt during the last week?

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

FAMILY, FRIENDS AND ACQUAINTANCES

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.

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

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.

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

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.

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

41. 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

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?

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

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?

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

OTHER ISSUES

44. What is your current employment?

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

45. 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.

46. Do you have pets (e.g. dog or cat) at home? ☐ Yes ☐ No

47. 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* _____

Y Y M M D D

Many thanks for your participation!