

Pages 1 and 2 contain confidential information that is not collected by the Coordinating Center.





# Family

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5 Do you have any children who are still living?

Yes     No    *FFCHILD*



a. How many living children do you have? *FFCHILDS*

1    2    3    4    5    6    7    8    9    10 or more

b. How many of your children do you see at least once a month?

None    1-2    3-5    6 or more   *SNKIDMO*

c. How many of your living children are sons? *FFSONNUM*

None    1    2    3    4 or more



d. How many of your sons live within 50 miles of your home? *FFSON50*

None live within 50 miles of my home    1    2    3    4 or more

e. How many of your living children are daughters?

None    1    2    3    4 or more   *FFDAUNUM*



f. How many of your daughters live within 50 miles of your home?

None live within 50 miles of my home    1    2    3    4 or more

*FFDAU50*

6 Apart from your children, how many relatives do you have with whom you feel close? *SNRELAT*

None    1-2    3-5    6-9    10 or more

7 How many close relatives do you see at least once a month? *SNRELMO*

None    1-2    3-5    6-9    10 or more

8 How many close friends do you have? *SNFRIEND*

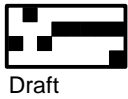
None    1-2    3-5    6-9    10 or more

9 How many close friends do you see at least once a month? *SNFRIMO*

None    1-2    3-5    6-9    10 or more

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# Lifestyle

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① Is there one special person you know that you feel very close to; someone you feel you can share confidences and feelings with?

Yes  No *SNCLOSE*

How often do you see or talk with this person?

<sup>1</sup>Daily  <sup>2</sup>Weekly  <sup>3</sup>Monthly  <sup>4</sup>Several times per year  <sup>5</sup>Less than once a year

*SNCLNUM*

② How many hours each week do you participate in any groups such as social or work group, church-connected group, self-help group, charity, public service or community group?

*SNGROUP*  
 None <sup>0</sup>  1-2 hours per week <sup>1</sup>  3-5 hours per week <sup>2</sup>  6-10 hours per week <sup>3</sup>  11-15 hours per week <sup>4</sup>  16 or more hours per week <sup>5</sup>

③ How often do you go to religious meetings or services?

*SNRELG*  
 Never or almost never <sup>0</sup>  1-3 times per month <sup>2</sup>  Once per week <sup>3</sup>  More than 1 time per week <sup>4</sup>

④ During the last 12 months, have you, because of illness or injury, cut down on the things that you usually do, such as going to work or working around the house?

Yes  No *MHREST*

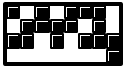
a. During the past 12 months, how many days did you cut down on the things that you usually do, because of illness or injury?

days *MHRESTD*

b. During the past 12 months, of the number of days that you cut down on the things you usually do, for how many days did you stay in bed for more than half the day, because of illness or injury? (Include any days you spent in bed at home, in a nursing facility or as an overnight hospital patient.)

days *MHRESTBD*





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# Lifestyle

**QL1ICOMP**

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5 Compared to other people your own age, how would you rate your overall health?

**QLCOMP**

- 1 Excellent  2 Good  3 Fair  4 Poor  5 Very poor  
*QLHEALTH* for my age      for my age      for my age      for my age      for my age

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- |   | Yes, limited<br>a lot                      | Yes, limited<br>a little | No, not limited<br>at all |
|---|--|--------------------------|---------------------------|
| 6 Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf? | <i>QLMODLIM</i><br><input type="radio"/> 1 | <input type="radio"/> 2  | <input type="radio"/> 3   |
| 7 Climbing several flights of stairs?   | <input type="radio"/> 1                    | <input type="radio"/> 2  | <input type="radio"/> 3   |

8 During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities because of your physical health?

- a. Accomplished less than you would like *QLACCOM*  Yes  No  
 b. Were limited in the **kind** of work or other activities *QLKIND*  Yes  No

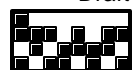
9 During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities because of any emotional problems (such as feeling depressed or anxious)?

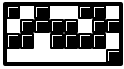
- a. Accomplished less than you would like *QLACCLV*  Yes  No  
 b. Didn't do work or other activities as **carefully** as usual  Yes  No  
*QLCARE*

10 During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- 0 Not at all     1 A little bit     2 Moderately     3 Quite a bit     4 Extremely  
*QLPAIN*

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**11** These questions are about how you feel and how things have been with you during the past 4 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 4 weeks . . .

a. Have you felt calm and peaceful?

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

*QLCALMI*

b. Did you have a lot of energy?

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

*QLENERGI*

c. Have you felt downhearted and blue?

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

*QLBLUEI*

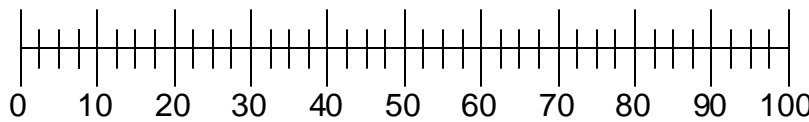
**12** During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

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

*QLSOCIAL*

**13** On a scale of 0 to 100, where 0 represents the worst health you can imagine and 100 represents the best health you can imagine, please rate your health during the past 4 weeks with a number between 0 and 100 and write this number in the boxes below.

Worst  
Imaginable  
Health



Best  
Imaginable  
Health

Your rating:

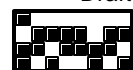
*QLEQRATE*

**14** Taking all things into consideration, how would you rate the overall quality of your life?

Excellent     Very good     Good     Fair     Poor

*QLEQOVER*

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# Life Events

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1 Please tell us about your current living arrangement. Mark all that apply to you.

- GILIVEA*  I live alone *GILIVER*  live with friend(s) or roommate(s)  
*GILIVES*  I live with my spouse or partner  I live in a nursing home *GILIVEH*  
*GILIVEC*  I live with my child or children  I live in an assisted living center  
*GILIVEF*  I live with other family members *GILIVEN*

2 How long have you lived in this current living arrangement?

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 years *GILIVEYR*

3 a. Within the past 12 months, has your spouse or partner been seriously ill or had a serious accident? *SEACDENT*

Yes  No

b. Within the past 12 months, have you lost any other close relative or very close friend through death? *SEDEATH*

Yes  No

c. Within the past 12 months, have you been separated from a child, close friend or relative whom you depend on for help? *SESEP*

Yes  No

d. Within the past 12 months, did you lose a pet? *SEPET*

Yes  No

e. Within the past 12 months, have you given up a hobby or activity that is important to you? *SEHOBBY*

Yes  No

f. Within the past 12 months, have you experienced serious financial trouble? *SEMONEY*

Yes  No

g. Within the past 12 months, have you moved or changed residences? *SEMOVED*

Yes  No

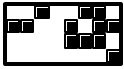
h. Within the past 12 months, did anything else happen to you, either good or bad, that was very important to you? *SEBADGOO*

Yes  No

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# Medical History

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① Have you ever had hip replacement surgery where all or part of your hip joint was replaced?

Yes, right hip       Yes, left hip       No       I don't know

*MHHIPRGT*

Year of hip replacement:

<i>MHHIPRYR</i>			
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Year of hip replacement:

<i>MHHIPLYR</i>			
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*MHHIPLEFT*

*MHHIPANY*

② During the past 12 months, have you fallen and landed on the floor or ground, or fallen and hit an object like a table or chair?

Yes     No      *MHFALL*

a. How many times have you fallen in the past 12 months?

1     2-3     4-5     6 or more    *MHFALLTM*

b. Which of the following injuries did you have? (Mark all that apply)

*MHFRACT*  I broke or fractured a bone     I had a bruise or bleeding    *MHBRUISE*

*MHHEAD*  I hit or injured my head     I had some other kind of injury    *MHOTHER*

*MHSPRAIN*  I had a sprain or a strain     I did not have any injuries from a fall in the past 12 months    *MHNOINJR*

③ What is your current weight?

<i>MHCURWGT</i>			
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pounds

④ During the past 12 months, have you been trying to lose weight?

Yes     No      *MHWTLOSS*

a. By what means were you trying to lose weight? (Mark all that apply)

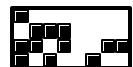
*MHWDIET*  Diet       Diet pills    *MHWPILL*

*MHWEXE*  Exercise     Other → 

Please specify:
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*MHWOTH*

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# Sleep Habits

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① At what time do you usually fall asleep?

SL	SLP	TM	
----	-----	----	--

A.M. *SLPSTAP*  
 P.M.

② How many minutes does it usually take you to fall asleep?

SLP	SLPM	minutes
-----	------	---------

③ At what time do you usually wake up?

SLP	WAK	TM	
-----	-----	----	--

A.M. *SLPWTAP*  
 P.M.

④ How many hours of actual sleep do you usually get each night?

- 1 Less than 4 hours
- 2 4 to 5 hours
- 3 5 to 6 hours
- 4 6 to 7 hours
- 5 7 to 8 hours
- 6 8 to 9 hours
- 7 9 to 10 hours
- 8 More than 10 hours

*SLSLPHR*

⑤ Do you take naps regularly?

Yes  No  I don't know *SLNAP*

a. How many days per week do you usually nap? 

SLNAPDY
---------

 days

b. On average, how many hours do you nap each time?

- 1 Less than 1 hour
- 2 At least 1 hour but no more than 2 hours
- 3 More than 2 hours

*SLNAPHR*

⑥ Have you ever snored (now or anytime in the past)?

Yes  No  I don't know *SLSNORE*

How often do you snore now? *SLOFTSNO*

- 0 Do not snore anymore
- 1 Rarely (less than 1 night a week)
- 2 Sometimes (1 or 2 nights a week)
- 3 Frequently (3 to 5 nights a week)
- 4 Always or almost always (6 or 7 nights/week)
- 8 I don't know

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# Sleep Habits

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7) Indicate how often you experienced each of the following during the last 12 months:

	Never 1	Rarely (Once a month) 2	Sometimes (2-4 times a month) 3	Often (5-15 times a month) 4	Almost always (16-30 times a month) 5	Don't know 6
a. Have trouble falling asleep? <i>SLFALLS</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Wake up during the night and have difficulty getting back to sleep? <i>SLWAKEUP</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Wake up too early in the morning no matter how many hours of sleep you had? <i>SLUPEAR</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feel unrested during the day, no matter how many hours of sleep you had? <i>SLUNREST</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Feel excessively sleepy during the day? <i>SLEEPY</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Do not get enough sleep? <i>SLNOTE</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Take sleeping pills or other medications to help you sleep? <i>SLPILLS</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Use alcohol to help you sleep? <i>SLALCO</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8) Has a doctor or other health care provider ever told you that you had or have:

- a. Sleep apnea?  Yes  No *SLSA* *SLSAT*
- ↓
- Are you currently being treated for this condition by a doctor?  Yes  No
- b. Insomnia?  Yes  No *SLINSOM* *SLINSOMT*
- ↓
- Are you currently being treated for this condition by a doctor?  Yes  No
- c. Restless legs?  Yes  No *SLRESTL* *SLRESTLT*
- ↓
- Are you currently being treated for this condition by a doctor?  Yes  No

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# Prostate Health

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**PSSCORE**

**PSSCOR1I**

- ① Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?  
 Not at all    Less than 1 time in 5    Less than half the time    About half the time    More than half the time    Almost always  
**PSEEMPTY**
- ② Over the past month, how often have you had to urinate again less than two hours after you finished urinating?  
 Not at all    Less than 1 time in 5    Less than half the time    About half the time    More than half the time    Almost always  
**PSAGAIN**
- ③ Over the past month, how often have you found you stopped and started again several times when you urinated?  
 Not at all    Less than 1 time in 5    Less than half the time    About half the time    More than half the time    Almost always  
**PSSTOP**
- ④ Over the past month, how often have you found it difficult to postpone urination?  
 Not at all    Less than 1 time in 5    Less than half the time    About half the time    More than half the time    Almost always  
**PSPOST**
- ⑤ Over the past month, how often have you had a weak urinary stream?  
 Not at all    Less than 1 time in 5    Less than half the time    About half the time    More than half the time    Almost always  
**PSWEAK**
- ⑥ Over the past month, how often have you had to push or strain to begin urination?  
 Not at all    Less than 1 time in 5    Less than half the time    About half the time    More than half the time    Almost always  
**PSPUSH**
- ⑦ Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?  
 None    1 time    2 times    3 times    4 times    5 times or more  
**PSUP**

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# Prostate Health

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8 If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?

- Delighted  Pleased  Mostly satisfied  Mixed, about equally satisfied and dissatisfied  Mostly unsatisfied  Unhappy  Terrible
- PSQL*

9 A digital rectal exam is an exam in which a doctor, nurse, or other health professional places a gloved finger into the rectum to feel the size, shape, and hardness of the prostate gland. Have you ever had a digital rectal exam?

*PSDREEE*  Yes  No  I don't know

In the past two years, has a doctor or other health care provider checked your prostate by a digital rectal exam?

Yes  No *PSDRELV*

10 Has a doctor or other health care provider told you that you have or had an enlarged prostate, also known as benign prostatic hyperplasia (BPH)? This means an enlarged prostate that is NOT due to cancer

Yes  No *PSBPH*

a. Treatments for BPH usually are to improve urinary symptoms and flow. Have you ever had treatment for BPH?

Yes  No *PSBPHT1*

b. What type of treatment have you received? (Mark all that apply)

*PSTSURG1*  Surgery (laser surgery or transurethral resection of the prostate, sometimes called TURP or roto-rooter)

*PSTMEDS*  Prescription Medications

*PSTOTH*  Other

11 Has a doctor or other health care provider told you that you had or have prostatitis (inflammation or infection of the prostate)?

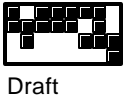
Yes  No *MHPROST*

Are you currently being treated for this condition by a doctor?

Yes  No *MHPROSTT*

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# Tobacco & Alcohol

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① Do you smoke cigarettes now?

Yes     No    *TUSMKNOW*

About how many cigarettes do you smoke per day?

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*TUSMKCGN*  
cigarettes

② Do you currently smoke a pipe or cigars regularly?

Yes     No    *TUPIPEC*

About how much do you smoke?

--	--

*TUCPIAMT*  
pipes or cigars per week.

③ In the past 12 months, have you had at least 12 drinks of any kind of alcoholic beverage?

Yes     No     I don't know    *TU12DRIN*

On average, how many alcoholic drinks do you consume per week?

1  Less than one drink per week

2  1-2 drinks per week

3  3-5 drinks per week    *TUDRAMT*

4  6-13 drinks per week

5  14 or more drinks per week

