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

IDFUTIME

VIAGE1
VIAGE1RG

Family

Draft

VIQDATE
I1FUTIME

VIMISS0 VIMISS05
VMISS10 VMISS50

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Administration: ○ MAIL 1 ○ TELE 2 ○ OTHER 3
VIQTYPE

1 Is your natural mother still living?

○ Yes ○ No FFMOM

Does your mother live within 50 miles of your home?
FFMOM50 ○ Yes ○ No

How old was your mother when she died?
FFMOMDIE
☐☐☐ years old

2 Is your natural father still living?

○ Yes ○ No FFDAD

Does your father live within 50 miles of your home?
FFDAD50 ○ Yes ○ No

How old was your father when he died?
FFDADDIE
☐☐☐ years old

Please tell us about your natural brothers and sisters. By natural brothers and sisters, we mean those who are related to you by blood. Please do not include step-brothers or step-sisters.

3 Do you have any living natural brothers?

○ Yes ○ No FFBRON

a. How many living, natural brothers do you have?

○ 1 ○ 2 ○ 3 ○ 4 or more FFBRONUM

b. How many of your natural brothers live within 50 miles of your home?

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

FFBRO50

4 Do you have any living natural sisters?

○ Yes ○ No FFSISN

a. How many living, natural sisters do you have?

○ 1 ○ 2 ○ 3 ○ 4 or more FFSISNUM

b. How many of your natural sisters live within 50 miles of your home?

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

FFSIS50

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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 *0* ○ 1-2 *1* ○ 3-5 *2* ○ 6 or more *3* *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*

0 ○ None *1* ○ 1-2 *2* ○ 3-5 *3* ○ 6-9 *4* ○ 10 or more

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

0 ○ None *1* ○ 1-2 *2* ○ 3-5 *3* ○ 6-9 *4* ○ 10 or more

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

0 ○ None *1* ○ 1-2 *2* ○ 3-5 *3* ○ 6-9 *4* ○ 10 or more

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

0 ○ None *1* ○ 1-2 *2* ○ 3-5 *3* ○ 6-9 *4* ○ 10 or more

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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?

○ Daily *1* ○ Weekly *2* ○ Monthly *3* ○ Several times per year *4* ○ Less than once a year *5*

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?**

○ None *0*
○ 1-2 hours per week *1*
○ 3-5 hours per week *2*
○ 6-10 hours per week *3*
○ 11-15 hours per week *4*
○ 16 or more hours per week *5*

SNGROUP

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

○ Never or almost never *0*
○ Less than once per month *1*
○ 1-3 times per month *2*
○ Once per week *3*
○ More than 1 time per week *4*

SNRELG

4 **During the <u>last 12 months</u>, 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

QLHEALTH

1 ○ Excellent for my age
2 ○ Good for my age
3 ○ Fair for my age
4 ○ Poor for my age
5 ○ Very poor 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 a lot	Yes, limited a little	No, not limited at all
6 Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?	QLMODLIM ○ 1	○ 2	○ 3
7 Climbing several flights of stairs?	QLSEVLIM ○ 1	○ 2	○ 3

---

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

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 <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities because of any <u>emotional problems</u> (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 <u>past 4 weeks</u>, 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

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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 <u>past 4 weeks . . .</u>

a. Have you felt calm and peaceful?

QLCALMI	4 ○ All of the time	3 ○ Most of the time	2 ○ Some of the time	1 ○ A little of the time	0 ○ None of the time

b. Did you have a lot of energy?

QLENERGI	4 ○ All of the time	3 ○ Most of the time	2 ○ Some of the time	1 ○ A little of the time	0 ○ None of the time

c. Have you felt downhearted and blue?

QLBLUEI	4 ○ All of the time	3 ○ Most of the time	2 ○ Some of the time	1 ○ A little of the time	0 ○ None of the time

(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.)?

4 ○ All of the time	3 ○ Most of the time	2 ○ Some of the time	1 ○ A little of the time	0 ○ 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 <u>past 4 weeks</u> with a number between 0 and 100 and write this number in the boxes below.

Worst Imaginable Health

0 10 20 30 40 50 60 70 80 90 100

Best Imaginable Health

Your rating: ☐☐☐ QLEQRATE

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

1 ○ Excellent 2 ○ Very good 3 ○ Good 4 ○ Fair 5 ○ Poor

QLEQOVER

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Lifestyle

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These questions ask you how you are feeling <u>today</u>. Please indicate which statement best describes your own health state today.

15 Mobility: *QLEQMOB*

0 ○ I have no problems walking about
1 ○ I have some problems walking about
2 ○ I am confined to bed

16 Self-care: *QLEQCARE*

0 ○ I have no problems with self-care
1 ○ I have some problems washing or dressing myself
2 ○ I am unable to wash or dress myself

17 Usual activities (e.g. work, study, housework, family or leisure activites) *QLEQUSE*

0 ○ I have no problems with performing my usual activites
1 ○ I have some problems with performing my usual activities
2 ○ I am unable to perform my usual activites

18 Pain/discomfort: *QLEQPAIN*

0 ○ I have no pain or discomfort
1 ○ I have moderate pain or discomfort
2 ○ I have extreme pain or discomfort

19 Anxiety/depression: *QLEQANX*

0 ○ I am not anxious or depressed
1 ○ I am moderately anxious or depressed
2 ○ I am extremely anxious or depressed

---

20 What is your current marital status? *GIMSTAT*

1 ○ Married or living in a married-like relationship
4 ○ Divorced
3 ○ Separated
5 ○ Single, never married
2 ○ Widowed →

What is the date of your spouse's death? *SEDOD*

Month	/	Day	/	Year

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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

GILIVES ○ I live with my spouse or partner

GILIVEC ○ I live with my child or children

GILIVEF ○ I live with other family members

GILIVER ○ I live with friend(s) or roommate(s)

○ I live in a nursing home GILIVEH

○ I live in an assisted living center GILIVEN

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

☐☐ years GILIVEYR

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

○ Yes ○ No SEACDENT

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

○ Yes ○ No SEDEATH

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

○ Yes ○ No SESEP

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

○ Yes ○ No SEPET

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

○ Yes ○ No SEHOBBY

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

○ Yes ○ No SEMONEY

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

○ Yes ○ No SEMOVED

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

○ Yes ○ No SEBADGOO

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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: *MHHIPRYR*

Year of hip replacement: *MHHIPLYR*

MHHIPLEFT

MHHIPANY

2 During the <u>past 12 months,</u> 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 ○ 1 *2* ○ 2-3 *3* ○ 4-5 *4* ○ 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?

MHCURWGT 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 → *MHWOTH*

Please specify: _____

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Sleep Habits

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1 **At what time do you usually fall asleep?** SLSLPTM : SLPSTAP 1 ○ A.M. 2 ○ P.M.

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

3 **At what time do you usually wake up?** SLPWAKTM : SLPWTAP 1 ○ A.M. 2 ○ P.M.

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

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

5 **Do you take naps regularly?** SLNAP

○ Yes ○ No ○ I don't know

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

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

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

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

○ Yes ○ No ○ I don't know

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? SLFALLS	○	○	○	○	○	○
b. Wake up during the night and have difficulty getting back to sleep? SLWAKEUP	○	○	○	○	○	○
c. Wake up too early in the morning no matter how many hours of sleep you had? SLUPEAR	○	○	○	○	○	○
d. Feel unrested during the day, no matter how many hours of sleep you had? SLUNREST	○	○	○	○	○	○
e. Feel excessively sleepy during the day? SLEEPY	○	○	○	○	○	○
f. Do not get enough sleep? SLNOTE	○	○	○	○	○	○
g. Take sleeping pills or other medications to help you sleep? SLPILLS	○	○	○	○	○	○
h. Use alcohol to help you sleep? SLALCO	○	○	○	○	○	○

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?

PSEMPTY

0 ○ Not at all 1 ○ Less than 1 time in 5 2 ○ Less than half the time 3 ○ About half the time 4 ○ More than half the time 5 ○ Almost always

2 Over the past month, how often have you had to urinate again less than two hours after you finished urinating?

PSAGAIN

0 ○ Not at all 1 ○ Less than 1 time in 5 2 ○ Less than half the time 3 ○ About half the time 4 ○ More than half the time 5 ○ Almost always

3 Over the past month, how often have you found you stopped and started again several times when you urinated?

PSSTOP

0 ○ Not at all 1 ○ Less than 1 time in 5 2 ○ Less than half the time 3 ○ About half the time 4 ○ More than half the time 5 ○ Almost always

4 Over the past month, how often have you found it difficult to postpone urination?

PSPOST

0 ○ Not at all 1 ○ Less than 1 time in 5 2 ○ Less than half the time 3 ○ About half the time 4 ○ More than half the time 5 ○ Almost always

5 Over the past month, how often have you had a weak urinary stream?

PSWEAK

0 ○ Not at all 1 ○ Less than 1 time in 5 2 ○ Less than half the time 3 ○ About half the time 4 ○ More than half the time 5 ○ Almost always

6 Over the past month, how often have you had to push or strain to begin urination?

PSPUSH

0 ○ Not at all 1 ○ Less than 1 time in 5 2 ○ Less than half the time 3 ○ About half the time 4 ○ More than half the time 5 ○ Almost always

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?

PSUP

○ None ○ 1 time ○ 2 times ○ 3 times ○ 4 times ○ 5 times or more

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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?**

PSQL

○ 0 Delighted ○ 1 Pleased ○ 2 Mostly satisfied ○ 3 Mixed, about equally satisfied and dissatisfied ○ 4 Mostly unsatisfied ○ 5 Unhappy ○ 6 Terrible

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?

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?

TUDRAMT

1 ○ Less than one drink per week
2 ○ 1-2 drinks per week
3 ○ 3-5 drinks per week
4 ○ 6-13 drinks per week
5 ○ 14 or more drinks per week