W4

BRITISH WOMEN'S HEART AND HEALTH STUDY

FOLLOW-UP QUESTIONNAIRE 2010

Thank you for taking part in the British Women's Heart and Health Study. It would be very helpful if you could complete this questionnaire, which tells us about your health and lifestyle.

Most questions can be answered by simply ticking the appropriate box ☑.
Some questions ask for a date as well, please give this if you can.

All your answers will be strictly confidential, and will only be seen by the research team.

Please complete the form and return it to us with the activity monitor and activity diary in the reply paid envelope 7 days after receipt. No stamp is required.

If you would like a copy of this questionnaire in large print, or have any other difficulties with the questions, please ring Antoinette Amuzu or Christina Gutierrez on 0207 927 2282.

If you are unable to complete the questionnaire yourself but would like to remain in the study we would be happy for you to ask someone to help you complete the questionnaire. If you have asked someone to help you complete this questionnaire please tick here: ☐ 1
Please tell us the relationship of this person to you:_____

THANK YOU FOR YOUR HELP

British Women's Heart and Health Study
London School of Hygiene and Tropical Medicine
Keppel Street, London, WC1E 7HT

Office Use only

Identification label

Your Contact Details

1.1	Your full name:	……..
1.2	Your maiden name (if applicable):	……..
1.3	Your address:	…… …… …… ……
1.4	Your postcode	…….……..
1.5	Your telephone number	(……)…… *area code*
1.6	Your date of birth	……../……./19……. *day/month/year*

Your GP

1.7	Name of your GP:	……...
1.8	GP address:	…… …… …….
1.9	GP postcode:	……

A Contact Person for you

If we are unable to reach you, we would like permission to speak to someone else who may be able to tell us where you are. We will only contact this person if we cannot contact you directly.

1.10	Name of contact person:	…….. *(title, forename, surname)*
1.11	Relationship(friend/child etc):	……
1.12	Address:	…… ……
1.13	Telephone number:	(……..)…….

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Your health at present

2.1 Compared with other women your age, how would you describe your health at present? **Please tick *one***

Excellent ☐ 1 Good ☐ 2 Fair ☐ 3 Poor ☐ 4

Conditions affecting the heart or circulation

Have you ***ever*** been told that you have had any of the following conditions?
Please answer each question, using a tick

		(a) Yes	(a) No	(b) **If yes**, please give the year of most recent diagnosis
3.1	Heart attack (coronary thrombosis or myocardial infarction)	☐ 1	☐ 2	
3.2	Heart failure	☐ 1	☐ 2	
3.3	Angina	☐ 1	☐ 2	
3.4	Other heart trouble	☐ 1	☐ 2	
3.5	Aortic aneurysm	☐ 1	☐ 2	
3.6	Narrowing or hardening of the arteries in the leg (including claudication)	☐ 1	☐ 2	
3.7	High blood pressure	☐ 1	☐ 2	
3.8	High cholesterol	☐ 1	☐ 2	
3.9	Pulmonary Embolism (PE) (blood clot in lung)	☐ 1	☐ 2	
3.10	Deep Vein Thrombosis (DVT) (blood clot in leg)	☐ 1	☐ 2	

Stroke

		(a) Yes	(a) No	(b) **If yes,** please give year of most recent stroke
4.1	Have you ***ever*** been told by the doctor that you have had a stroke?	☐ 1	☐ 2	
	If Yes:			
4.2	Did the symptoms last more than 24 hours?	☐ 1	☐ 2	
4.3	Have you made a complete recovery from your stroke?	☐ 1	☐ 2	
4.4	In the last fortnight did you require help from another person in day-to-day activities?	☐ 1	☐ 2	

Investigations and treatment for heart trouble

Have you ever had any of the **following tests or treatment** for chest pain or heart disease?

Please answer each question. If yes, please complete as much information as possible

		(a)		(b) If yes, what year	(c) Where?	
		Yes	No		NHS	Private
5.1	An exercise ECG (treadmill) test	☐ 1	☐ 2		☐ 1	☐ 2
5.2	Angiogram or x-ray of your coronary arteries (a dye of the arteries)	☐ 1	☐ 2		☐ 1	☐ 2
5.3	Angioplasty of the coronary arteries (balloon treatment for angina)	☐ 1	☐ 2		☐ 1	☐ 2
5.4	Coronary artery bypass graft ('CABG' or 'CABBAGE') operation	☐ 1	☐ 2		☐ 1	☐ 2
5.5	An admission to hospital with chest pain, angina or heart attack	☐ 1	☐ 2		☐ 1	☐ 2
5.6	A GP referral to a hospital to see a heart specialist	☐ 1	☐ 2		☐ 1	☐ 2
5.7	A GP referral to a chest pain clinic	☐ 1	☐ 2		☐ 1	☐ 2
5.8	An echocardiogram or ultrasound of the chest	☐ 1	☐ 2		☐ 1	☐ 2
	Other tests, investigations or operations on the heart, arteries or veins If yes, please give details below:			Year		
5.9	_____			_____		
5.10	_____			_____		
5.11	_____			_____		

Cancer

		(a)		(b) **If yes,** what type of cancer?	(c) Year diagnosed?
		Yes	No		
6.1	Have you ***ever*** been told by a doctor that you have cancer?	☐ 1	☐ 2		
6.2	*Please list all types of cancer*				
6.3					
6.4					

Conditions of the joints and bones

		(a) Yes	No	(b) Year diagnosed?
7.1	Have you ever been told by a doctor that you have osteoporosis?	☐ 1	☐ 2	
7.2	Have you ever been told by a doctor that you have arthritis?	☐ 1	☐ 2	

Falls and fractures

		Yes	No	
8.1	Have you had a fall in the last 12 months?	☐ 1	☐ 2	**If yes**, go to 8.2 **If no**, go to 8.4

If Yes:

8.2 How many times have you fallen in the last 12 months? _____ times

8.3 Did you seek medical attention? ☐ 1 ☐ 2

		(a) Yes	No	(b) Year of last fracture
8.4	Have you ever fractured your hip?	☐ 1	☐ 2	
8.5	Have you ever fractured your wrist?	☐ 1	☐ 2	

Breathlessness

		Yes	No	Never do this	Unable to walk
9.1	Do you get short of breath walking with other people of your own age on level ground?	☐ 1	☐ 2	☐ 3	☐ 4
9.2	On walking uphill or stairs do you get more breathless than people of your own age?	☐ 1	☐ 2	☐ 3	☐ 4
9.3	Do you ever have to stop walking because of breathlessness?	☐ 1	☐ 2	☐ 3	☐ 4

Chest pain

		Yes	No	Never do this	Unable to walk
10.1	Do you ever have any pain or discomfort in your chest?	☐ 1	☐ 2		
	If yes, is this chest pain produced when you…				
10.2	… walk at an ordinary pace on level ground?	☐ 1	☐ 2	☐ 3	☐ 4
10.3	… walk uphill or hurry?	☐ 1	☐ 2	☐ 3	☐ 4

Diabetes

		Yes	No	
11.1	Have you ever been told that you have diabetes?	☐ 1	☐ 2	**If yes**, go to 11.2 **If no,** go to 12.1

11.2 **If yes:** What year was this first diagnosed? _____

How is your Diabetes controlled? (please tick all that apply)

11.3 Diet ☐ 1 11.4 Tablets ☐ 2 11.5 Insulin ☐ 3

Sight and Hearing

		Yes	No	
12.1	Can you see well enough to recognise a friend across a room, with glasses if used?	☐ 1	☐ 2	**If yes,** go to 12.3 **If no,** go to 12.2
12.2	**If no,** can you see well enough to recognise a friend across a table, with glasses if used?	☐ 1	☐ 2	
12.3	Is your hearing good enough to follow a TV programme at a volume others find acceptable, with a hearing aid if necessary?	☐ 1	☐ 2	**If yes,** go to 12.5 **If no,** go to 12.4
12.4	**If no,** can you follow a TV programme with the volume turned up, with a hearing aid if necessary?	☐ 1	☐ 2	

12.5 **If you own a hearing aid,** how often do you wear it?

I rarely wear it ☐ 1 I wear it most days ☐ 2 I always wear my hearing aid ☐ 3

Weight measurement

13.1 What is your present weight (in indoor clothes, without shoes)? _____ st _____ lbs

OR _____ kilograms

13.2 If possible, please use scales to weigh yourself. If you have no scales and have made an estimate please tick this box: ☐ 1

Leg pain

Please write in the number that corresponds to your answer in the box provided.

14.1 Do you ever get pain or discomfort in your leg, thighs or buttocks when you walk?

Yes ☐ 1 No ☐ 2 Unable ☐ 3

14.2 Does this pain ever begin when you are standing still or sitting?

Yes ☐ 1 No ☐ 2

14.3 Do you get the pain if you walk uphill or hurry?

Yes ☐ 1 No ☐ 2 Unable ☐ 3

14.4 What happens to the pain if you stand still?

Usually continues more than 10 minutes ☐ 1

OR

Usually disappears in less than 10 minutes ☐ 2

Your diet

15.1 Do you eat any special diet? Yes ☐ 1 No ☐ 2

15.2 ***If Yes***, please specify

☐ 1 Low fat ☐ 2 High fibre ☐ 3 Vegetarian ☐ 4 Diabetic ☐ 5 Slimming/low calorie ☐ 6 Low GI(glycaemic index) ☐ 7 Other

How often do you eat the following foods? (Please tick the appropriate box for each food item)

	1	2	3	4	5	6
	More than once a day	Once a day	Most days	One or two days a week	Less than once a week	Never
15.3 Fresh fruit summer						
15.4 Fresh fruit winter						
15.5 Salads in summer						
15.6 Salads in winter						
15.7 Green vegetables						
15.8 Fish (all kinds)						
15.9 Poultry (eg. chicken, turkey)						
15.10 Red meat (eg. beef, pork, ham, bacon)						
15.11 Processed meat (eg. burgers, sausages, pies, pasties, pate)						
15.12 Dairy foods (eg. cheese, yoghurts, milk)						
15.13 Cereals and pulses (eg. lentils, beans)						

Your Overall Health Today

By placing a tick in ONE box in EACH group below, please indicate which statement best describes your own health state today.

*Please tick **one** per question*

		Yes	No
16.1	Are you basically satisfied with life?	☐ 1	☐ 1
16.2	Have you dropped many of your activities and interests?	☐ 2	☐ 2
16.3	Do you feel happy most of the time?	☐ 3	☐ 3
16.4	Do you prefer to stay at home, rather than going out and doing new things?	☐ 4	☐ 4

Smoking

17.1 Do you smoke cigarettes at present? Yes ☐ 1 No ☐ 2

If you currently smoke:

17.2 How many cigarettes do you smoke a day? _____ cigarettes/ day

Drinking Alcohol

17.3 At present, how often do you drink alcohol?

Daily/most days ☐ 1 Once or twice a week ☐ 2 Once or twice a month ☐ 3

Special occasions only ☐ 4 Never ☐ 5

If you currently drink:

17.4 Think back carefully over the last seven days. For each day, write in the number of alcoholic drinks you drank:

1) The **number** of pints of beer, lager, shandy, cider, stout etc.
2) The **number** of single glasses of spirits such as whisky, vodka, gin, rum (drunk with or without mixers), and pre-mixed bottled drinks.
3) The **number** of single glasses of wine, sherry, martini, port etc.

	1) Pints of beer, lager, shandy	2) Single glasses of spirits	3) Single glasses of wine
a) Monday			
b) Tuesday			
c) Wednesday			
d) Thursday			
e) Friday			
f) Saturday			
g) Sunday			

Care

18.1 Does anyone look after you because of long-term physical or mental ill-health, disability, or problems related to old age? Yes ☐ 1 No ☐ 2

18.2 If yes, please use the table below to record:

	1) Tick all who help look after you	2) How many hours did they spend looking after you last week?
a) Spouse/ Partner		
b) Siblings		
c) Children		
d) Grand-children		
e) Other relatives		
f) Friends or neighbours		
g) Home help		
h) Care worker		
i) Nurse		
j) Other (Please specify _____)		

Medications and Treatments

		Yes	No	
19.1	Do you take any regular medication?	☐ 1	☐ 2	**If no**, go to 20.1

19.2 **If yes**, which medication are you taking?

N.B. Please include prescribed tablets, painkillers, medicines, inhalers, sprays, injections AND medications, vitamins and minerals that you buy yourself

	Name of Medication (Please copy name in full from container) **(a)**	**Amount, and how often** (please copy from container) **(b)**	**Reason for taking (c)**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

If you need more space, please continue on a separate sheet of paper

Disability

20.1 Do you have any difficulties getting about outdoors? *(please tick one box only)*

No difficulty ☐ 1 Slight ☐ 2 Moderate ☐ 3

Severe ☐ 4 Unable to do alone/at all ☐ 5

20.2

Thinking about the last seven days, on which days, if any, did you go out of your house?

Monday ☐ 1 Tuesday ☐ 2 Wednesday ☐ 3 Thursday ☐ 4

Friday ☐ 5 Saturday ☐ 6 Sunday ☐ 7 I did not go out of the house in the last seven days ☐ 8

		Yes	No
20.3	Do you have any long-standing illness, disability or infirmity? *(`long-standing' means anything which has troubled you over a period of time or is likely to do so)*	☐ 1	☐ 2
20.4	Do you receive a disability or other allowance for this?	☐ 1	☐ 2

Do you currently use any aids or appliances to help with day to day activities?

		Yes	No
20.5	Walking stick	☐ 1	☐ 2
20.6	Walking frame	☐ 1	☐ 2
20.7	Wheelchair	☐ 1	☐ 2
20.8	Toilet raised seat	☐ 1	☐ 2
20.9	Bath board/shower	☐ 1	☐ 2
20.10	Extra rails in bathroom	☐ 1	☐ 2
20.11	Stair Lift	☐ 1	☐ 2

Limitations in activities (please answer each question)

Do you currently have difficulty carrying out any of the following activities?

		Yes, I have difficulty	**No**, I have no difficulty
21.1	Going up or down stairs	☐ 1	☐ 2
21.2	Bending down	☐ 1	☐ 2
21.3	Straightening up	☐ 1	☐ 2
21.4	Keeping your balance	☐ 1	☐ 2
21.5	Going out of the house	☐ 1	☐ 2
21.6	Walking 400 yards	☐ 1	☐ 2

Is your present state of health causing problems with any of the following?

		Yes, it is causing problems	**No**, it is not causing problems	Not Applicable
21.7	Family relationships	☐ 1	☐ 2	☐ 3
21.8	Household chores	☐ 1	☐ 2	☐ 3
21.9	Social life	☐ 1	☐ 2	☐ 3
21.10	Sex life	☐ 1	☐ 2	☐ 3
21.11	Interests and hobbies	☐ 1	☐ 2	☐ 3
21.12	Holidays and outings	☐ 1	☐ 2	☐ 3
21.13	Job (paid or voluntary)	☐ 1	☐ 2	☐ 3

Physical Activity

22.1 Which of the following forms of transport do you use most often? *Please tick one box only*

☐ 1 Car ☐ 2 Public transport ☐ 3 Cycle ☐ 4 Walk ☐ 5 Not applicable

22.2 Do you make regular journeys everyday or most days either walking or cycling?

☐ 1 No ☐ 2 I walk ☐ 3 I cycle ☐ 4 Both

22.3 Which of the following best describes your walking pace?

☐ 1 Slow ☐ 2 Steady average ☐ 3 Fairly brisk ☐ 4 Fast (at least 4miles/hr)

22.4 Do you take physical activity (e.g. running, swimming, dancing, golf, tennis, squash, jogging, bowls)?

☐ 1 No ☐ 2 Occasionally (less than monthly) ☐ 3 Frequently (more than monthly)

If you take part in these physical activities frequently, (once a month or more):
How many times on average do you take part in these activities?

22.5 Summer _____ Times / month

22.6 Winter _____ Times / month

In a **typical week** during the **past year**, how many hours did you spend each week in the following activities? *Please write 0 if you did not do this activity.*

Walking for leisure	22.7	Summer _____	Hours per week
	22.8	Winter _____	Hours per week
Cycling, including to work and leisure	22.9	Summer _____	Hours per week
	22.10	Winter _____	Hours per week
Gardening, light e.g. pruning, watering	22.11	Summer _____	Hours per week
	22.12	Winter _____	Hours per week
Gardening, heavy e.g. digging, mowing	22.13	Summer _____	Hours per week
	22.14	Winter _____	Hours per week
Physical exercise e.g. fitness, swimming, aerobics	22.15	Summer _____	Hours per week
	22.16	Winter _____	Hours per week
DIY e.g. on house or car	22.17	Summer _____	Hours per week
	22.18	Winter _____	Hours per week

Household activities, light (e.g. cooking, washing up)

22.19 Summer _____ Hours per week

22.20 Winter _____ Hours per week

Household activities, heavy (e.g. hoovering, windows)

22.21 Summer _____ Hours per week

22.22 Winter _____ Hours per week

22.23 In a **typical week** in the **last year**, did you do any of these activities vigorously enough to cause breathlessness, sweating or a faster heartbeat?

☐1 Yes ☐2 No

22.24 **If yes,** for how many minutes each week did you perform vigorous activity? _____ Mins per week

22.25 How many flights of stairs do you climb in a typical day? _____ Flights per day

22.26 Compared with your activity level four years ago, are you doing:

☐1 More ☐2 Same ☐3 Less

22.27 If less, please give a reason: _____ ☐ office code

22.28 Compared with other women your age, are you:

☐1	☐2	☐3	☐4	☐5
Much more active	More active	Similar	Less active	Much less active

22.29 On a normal day, how many hours do you spend sitting quietly or lying down? (excluding your night-time sleep) _____ Hours per week

22.30 In a typical day, how many hours do you spend watching TV? (Include time spent watching videos and DVDs) _____ Hours per week

	Yes	No
22.31 Do you own a dog at the moment?	☐1	☐2
22.32 Do you regularly walk a dog at the moment?	☐1	☐2

Attention

In the last 30 days how much difficultly did you have in: *Please tick one box only*

	None (1)	Mild (2)	Moderate (3)	Severe (4)	Extreme (5)	Cannot do (6)
23.1 Concentrating on doing something for 10 minutes?						
23.2 Learning a new task, for example, learning how to get to a new place?						

Activities of daily life

We need to understand difficulties that people may have with various activities because of their health, emotional or physical problems. Do you have any difficulty with any of the following activities

		No difficulty	Some difficulty	Can do only with someone else's help	Never do it
24.1	Using public transport on your own	☐ 1	☐ 2	☐ 3	☐ 4
24.2	Driving a car on your own	☐ 1	☐ 2	☐ 3	☐ 4
24.3	Crossing a road	☐ 1	☐ 2	☐ 3	☐ 4
24.4	Getting up from a chair after sitting for a long period	☐ 1	☐ 2	☐ 3	☐ 4
24.5	Reaching or extending your arms above shoulder level	☐ 1	☐ 2	☐ 3	☐ 4
24.6	Pulling or pushing large objects like a living room chair	☐ 1	☐ 2	☐ 3	☐ 4
24.7	Lifting or carrying weights over 10 pounds, like a heavy bag of groceries	☐ 1	☐ 2	☐ 3	☐ 4
24.8	Gripping with your hands, such as opening a jam jar	☐ 1	☐ 2	☐ 3	☐ 4
24.9	Threading a needle	☐ 1	☐ 2	☐ 3	☐ 4
24.10	Cutting your toe nails	☐ 1	☐ 2	☐ 3	☐ 4
24.11	Dressing, including putting on shoes and socks	☐ 1	☐ 2	☐ 3	☐ 4
24.12	Walking across a room	☐ 1	☐ 2	☐ 3	☐ 4
24.13	Bathing or showering	☐ 1	☐ 2	☐ 3	☐ 4
24.14	Eating, including cutting up your food	☐ 1	☐ 2	☐ 3	☐ 4
24.15	Getting in and out of bed	☐ 1	☐ 2	☐ 3	☐ 4
24.16	Using the toilet, including getting up and down	☐ 1	☐ 2	☐ 3	☐ 4
24.17	Preparing a hot meal	☐ 1	☐ 2	☐ 3	☐ 4
24.18	Shopping for groceries	☐ 1	☐ 2	☐ 3	☐ 4
24.19	Making telephone calls by yourself	☐ 1	☐ 2	☐ 3	☐ 4
24.20	Taking medications by yourself	☐ 1	☐ 2	☐ 3	☐ 4
24.21	Doing light housework, such as washing up	☐ 1	☐ 2	☐ 3	☐ 4
24.22	Doing work around the house or garden	☐ 1	☐ 2	☐ 3	☐ 4
24.23	Managing money, paying bills or keeping track of expenses	☐ 1	☐ 2	☐ 3	☐ 4

Feelings towards exercise (Exercise could be going for a walk, doing particular sports, gardening or DIY).

25.1 Please indicate how confident you are that you could exercise (or walk) for **20 minutes three times a week** in each of the following cases: *Tick **one** box for each statement.*

	Not confident									Confident Very
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
a) The weather was bothering you	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b) You were bored by the program or activity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c) You felt pain when exercising	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
d) You had to exercise alone	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
e) You did not enjoy it	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
f) You were too busy with other activities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
g) You felt tired	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
h) You felt stressed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
i) You felt depressed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

25.2 How much do you agree with the following statements about exercise (going out for a walk or doing sports)? *Tick **one** box for each question.*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a) Makes me feel better physically	☐1	☐2	☐3	☐4	☐5
b) Makes my mood better in general	☐1	☐2	☐3	☐4	☐5
c) Helps me feel less tired	☐1	☐2	☐3	☐4	☐5
d) Makes my muscles stronger	☐1	☐2	☐3	☐4	☐5
e) Is an activity I enjoy doing	☐1	☐2	☐3	☐4	☐5
f) Gives me a sense of personal accomplishment	☐1	☐2	☐3	☐4	☐5
g) Makes me more alert mentally	☐1	☐2	☐3	☐4	☐5
h) Improves my endurance in performing daily activities	☐1	☐2	☐3	☐4	☐5
i) Helps to strengthen my bones	☐1	☐2	☐3	☐4	☐5

Present circumstances

26.1 At present who do you live with?

☐ 1 Alone
☐ 2 With husband or partner
☐ 3 With other family members
☐ 4 Residential Care Home
☐ 5 With other people? Please describe their relationship to you:

Where you live

The next questions ask about *your* local area. We want to know how you feel about the place that you live, and what it is like to live there.

27.1 Would you say that this is an area you enjoy living in? ☐ 1 Yes ☐ 2 No

Please rate the following things in your local area and neighbourhood: *Please tick **one** box on each line*

		Very Good	Good	Average	Poor	Very Poor
27.2	Social and leisure activities for people of your age (eg. social clubs, pubs, bingo, churches)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
27.3	Facilities for people of your age (eg. shopping, banking, post office, etc.)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
27.4	Your local health service (e.g. Your GP or the local hospital)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
27.5	Local public transport to places where you want to get to	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
27.6	Your local area for having somewhere nice to go for a walk	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In the area you live in, how safe do you feel when...

		Very Safe	Fairly Safe	A bit unsafe	Very unsafe	Never go out alone during this time of day
27.7	Walking alone during the daytime	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
27.8	Walking alone after dark	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In your neighbourhood, how much of a problem are the following?

*Please tick **one** box on each line*

		Not a problem	Minor problem	Serious problem
27.9	The speed of traffic?	☐ 1	☐ 2	☐ 3
27.10	The volume of traffic?	☐ 1	☐ 2	☐ 3
27.11	Noise (e.g. neighbours, traffic, etc)	☐ 1	☐ 2	☐ 3
27.12	The amount of crime?	☐ 1	☐ 2	☐ 3
27.13	The quality of air you breathe?	☐ 1	☐ 2	☐ 3
27.14	Rubbish or litter lying around?	☐ 1	☐ 2	☐ 3
27.15	Graffiti or vandalism?	☐ 1	☐ 2	☐ 3
27.16	Uneven or dangerous pavements?	☐ 1	☐ 2	☐ 3

27.17 Do you think your neighbourhood has lots of green space? (gardens, trees, park or countryside) ☐ 1 Yes ☐ 2 No

27.18 Do you do most of your regular shopping at shops within easy walking distance (less than 15 minutes) of your home?

☐ 1 Yes ☐ 2 No ☐ 3 Someone else shops for me

27.19 How do you mostly go shopping?

☐ 1 Walking ☐ 2 By Bus ☐ 3 Using other public transport ☐ 4 By Taxi

☐ 5 Using own car ☐ 6 My friend or relative drives me ☐ 7 I do not go shopping

Friends and Family

The next few questions see how often you have contact with friends or family

*Please tick **one** box on each line*

		None	One	Two	Three or four	Five to eight	Nine or more
28.1	How many relatives do you see or hear from at least once a month?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
28.2	How many relatives do you feel close to such that you could call on them for help?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
28.3	How many relatives do you feel at ease with that you can talk about private or personal matters with?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Considering all your friends including those who live in your neighbourhood…

		None	One	Two	Three or four	Five to eight	Nine or more
28.4	How many of your friends do you see or hear from at least once a month?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
28.5	How many friends do you feel close to such that you could call on them for help?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
28.6	How many friends do you feel at ease with that you can talk about private or personal matters?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

28.7 How many of these friends and/or relatives live within a 15-20 minute walk or 5-10 minute drive of your home, if any?
Please write the number in the box provided: ☐☐

Consent - please complete and sign

Thank you for completing this questionnaire. You completed a consent form at the time of the first survey in 1999-2000. To allow us to continue our work we now need you to complete and sign an updated consent form.

The British Women's Heart and Health Study is run by the University of London in collaboration with the University of Bristol. Both universities fulfil their duties under the Data Protection Act.

Please read the statement carefully and **tick the box** to show that you agree. You must tick the box to remain this study.

Consent for continued access to medical records:

We need to follow your health over time. To do this properly, we will need to send questionnaires to you in the future. We also need to obtain routine information about your health and medical care from National Health Service and related organisations and from your medical records, particularly for conditions of the heart and circulation, diabetes, cancer and other disabling conditions and medical problems. You may not have any of these conditions, but that information is just as important for us.

We are therefore seeking your permission to allow us to do this.

Do you agree to allow us to follow your future health through questionnaires, medical records and routine information from the agencies related to the National Health Service? ☐ 1 Yes ☐ 2 No

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Please sign and date below:

Signature:_____ Date:_____

Would like to participate in a repeated measure of this study in which we will contact you to take part in this study again in the next six (6) months? ☐ 1 Yes ☐ 2 No

If you change your mind in the future or wish to withdraw from the study you are free to do so at any time. If you have any questions about this form or our work, please call Ms Antoinette Amuzu or Christina Gutierrez (Research Coordinators) on 020 7927 2282.

Thank you for completing the questionnaire.

Please return it to us in the envelope provided. Please check that you have used the activity monitor for the entire specified time and have included it, along with the activity diary and questionnaire in the return envelope. No stamp is needed.