Questionnaire Number: | | |

Study Number : | | | | |

Town : | | |

Nurse interviewer: | |

Date of interview: | | | | | | | | |
Day Month Year

BRITISH WOMEN'S HEART & HEALTH STUDY

INTERVIEW 1999/2001

Thank you for coming today. I am going to ask you some questions about your health and your medication. I will also ask about your way of life. All the information collected will be treated in ***strict confidence.***

Note: Most questions can be answered simply by filling the box with the correct number(s).

Avoid writing extra information in the margins – please stick to the questions asked!

British Womens' Heart & Health Study
Department of Social Medicine
Canynge Hall
Whiteladies Road
Bristol BS8 2PR

Please ask the following questions and fill in the appropriate number(s) in the box or write the answer in the space provided.

1.0 **Date of birth** What is your date of birth?

DD MM YY

1.1 **Place of birth** Where were you born?

In this town=1 In this county=2 Elsewhere, UK=3 Elsewhere, overseas=4

office use

(specify)______________________________

1.2

2.0 **Conditions affecting the heart or circulation**

Have you ever been told by a doctor that you have or have had any of the following conditions ?

Show card 1

	Yes =1 No = 2		If Yes, no. of years ago
2.1 Heart attack (coronary thrombosis or myocardial infarction)		2.10	
2.2 Heart failure		2.11	
2.3 Angina		2.12	
2.4 Other heart trouble		13	
2.5 High blood pressure		2.14	
2.6 Aortic aneurysm		2.15	
2.7 Narrowing or hardening of the arteries in the leg		2.16	
2.8 Deep vein thrombosis (clot in a deep leg vein)		2.17	
2.9 Pulmonary embolism (clot on the lung)		2.18	

3.0 **Investigations and treatment for heart trouble**

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

If Yes: Please complete as much as possible. If you need more space please use the back page.

		Yes=1 No=2		No. years ago	
3.1	An exercise ECG (treadmill) test	☐	3.7	☐☐	**HOSPITAL NAME / TOWN** ____________ **CONSULTANT** ____________
3.2	Angiogram or X-ray of your coronary arteries (a dye test of the arteries)	☐	3.8	☐☐	**HOSPITAL NAME / TOWN** ____________ **CONSULTANT** ____________
3.3	Angioplasty of coronary arteries (balloon treatment for angina)	☐	3.9	☐☐	**HOSPITAL NAME / TOWN** ____________ **CONSULTANT** ____________
3.4	Coronary artery bypass graft (CABG) operation	☐	3.10	☐☐	**HOSPITAL NAME / TOWN** ____________ **CONSULTANT** ____________
3.5	An admission to hospital with chest pain, angina or heart attack	☐	3.11	☐☐	**HOSPITAL NAME / TOWN** ____________ **CONSULTANT** ____________
3.6	A GP referral to a hospital to see *a* heart specialist *If Yes please specify*	☐	3.12	☐☐	**HOSPITAL NAME / TOWN** ____________ **CONSULTANT** ____________

____

4.0 **Previous stroke**

Yes=1 No=2 No. of years since first diagnosed

4.1 Have you ever had a stroke? ☐ *4.2* ☐☐

If Yes, refering to your first stroke

4.3 Did the stroke symptoms last for more than 24 hours? ☐

4.4 Did you make a complete recovery from your stroke? ☐

4.5 Following this stroke, did you require any help to carry out everyday activities? ☐

4.6 Have you had a further stroke? ☐

No.of years since first diagnosed

4.7 Have you ever been told that you suffer from TIAs (mini-strokes, transient ischaemic attacks)? ☐ 4.8 ☐☐

5.0 **Chest pain**

Yes=1 No =2

5.1 Do you ever have any pain or discomfort in your chest ? ☐

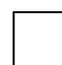
***If No*, go to 6 "Previous chest pain"**

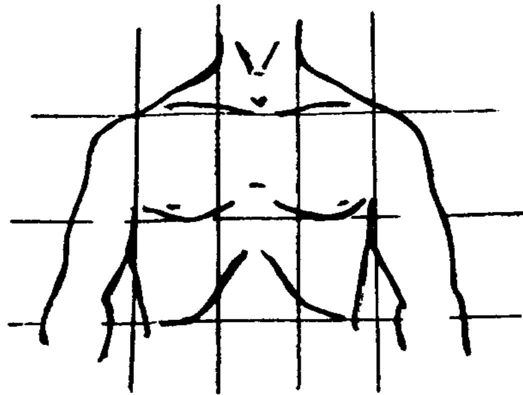
5.2 Do you know the cause of this pain? ☐

5.3 *If Yes*, give cause ☐

Angina/heart=1 Indigestion/ulcer=2 Reflux/hernia=3
Respiratory=4 Musculo-skeletal=5
Other= 6 (specify)_____________________________________

5.4 Where do you get this pain or discomfort ? **Show card**
Please mark **X** on the appropriate places





YOUR RIGHT SIDE

YOUR LEFT SIDE

Areas 4, 5 or 8=1 L arm only=2 Other =3

Yes=1 No=2 Unable=3

5.5 When you walk at an ordinary pace on the level does this produce the pain ? ☐

Chest pain (continued)

Yes=1 No=2 Unable=3

5.6 When you walk uphill or hurry does this produce the pain ? ☐

5.7 When you get any pain or discomfort in your chest on walking, what do you do? ☐

Stop=1 Slow down=2 Continue at the same pace =3 Not applic=4

Yes=1 No=2

5.8 Does the pain or discomfort in your chest go away if you stand still ? ☐

5.9 How long does it take to go away ? 10 minutes or less =1
More than 10 minutes =2 ☐

5.10 Overall, is your chest pain becoming:
More frequent =1 Staying about the same=2 Less frequent=3 ☐

6.0 <u>**Previous chest pain**</u>

Yes=1 No=2

6.1 Have you previously had chest pain which has stopped because of an operation? ☐

6.2 *If Yes*, give details:

CABG=1 PTCA=2 Both CABG & PTCA=3 Other=4 ☐

(specify)____

7.0 **Severe chest pain**

Yes=1 No=2

7.1 Have you **ever** had a **severe** pain across the front of your chest lasting for half an hour or more ? [ ]

Yes=1 No=2

7.2 *If Yes,* Did you see a doctor because of this pain? [ ]

7.3 What year did this first happen ? [ ][ ] Y Y

7.4 *If Yes*, what were you told was the cause? [ ]

Heart atttack=1 Angina=2 Other heart trouble=3 Gastro-intestinal=4
Musculo-skeletal=5 Psychological=6 Other=7

(specify)____

8.0 **Other regular treatment**

Yes=1 No=2

8.1 Are you on any other regular treatment from a doctor? [ ]

If Yes, please list any medicines and the reasons for taking them:

Medicine		Reasons for taking		
8.2 ______________	[ ][ ][ ]	______________	8.7	[ ][ ][ ]
8.3 ______________	[ ][ ][ ]	______________	8.8	[ ][ ][ ]
8.4 ______________	[ ][ ][ ]	______________	8.9	[ ][ ][ ]
8.5 ______________	[ ][ ][ ]	______________	8.10	[ ][ ][ ]
8.6 ______________	[ ][ ][ ]	______________	8.11	[ ][ ][ ]

If more medications, please list here:

9.0 **About you.**

Yes=1 Ex-smoker=2 Never =3

9.1 Do you smoke cigarettes currently? ☐

Yes=1 No=2 Never drink=3

9.2 Do you drink alcohol every day? ☐

3+ times / week =1 1-2 times/week=2 Less often=3 Never=4

9.3 Do you take regular exercise? ☐
(eg. keep fit, gardening, brisk walking)

10.0 **Consent to further study**

An important part of this study is to observe the future health of the people taking part. We are therefore seeking your permission to receive specific information related to heart disease and stroke, particularly from records held by your general practitioner and by hospitals. All these details would be treated in absolute confidence by the research team.

Yes=1 No=2

10.1 Do you agree to us following your future health through your health records? ☐

We will arrange to have your blood sample checked for cholesterol and other factors which are important for heart disease risk. The results of these tests will be sent back to your doctor in the next four to five weeks. If any of the results give cause for concern, you will be asked to make an appointment with your doctor.

Yes=1 No=2

10.2 Do you agree to us passing your test results to your doctor? ☐

Part of your blood sample will be frozen and kept for special scientific studies of factors affecting heart disease risk, which may help us to understand how to prevent heart disease in the future. Among the factors we may need to study will be the way in which genetic factors affect heart disease risk.

Yes=1 No=2

10.3 Would you allow us to use your sample in this way? ☐

I agree to allow the Research Team to study my health in accordance with the criteria above. I understand that any details recorded will be treated in complete confidence.

Signed____ Date ______________

Name in block letters ____

Signed for Research Team ____

THANK YOU FOR YOUR HELP IN ANSWERING ALL MY QUESTIONS.
I WILL JUST CHECK WE HAVE COMPLETED THE WHOLE QUESTIONNAIRE.

***CHECK CAREFULLY THAT EACH PAGE HAS BEEN ANSWERED*.**