The South London Health Study

Departments of General Practice & Primary Care and Public Health Sciences
St George's Hospital Medical School
Cranmer Terrace
London
SW17 0RE

Thank you for filling in this questionnaire.

Please answer each question as best you can.

Please feel free to write comments by any question.

All information will be treated in the strictest confidence.

Please return the completed questionnaire in the freepost envelope provided.

Thank you

If you would like help filling in this questionnaire, please either phone us on the helpline number, 020 8725 2772, or write your phone number in the box below and return the questionnaire in the freepost envelope.

I would like help with the questionnaire

Name……

Phone Number……

Please put a tick in the box next to the most appropriate answer for each question. ✓

Section A - Some questions about yourself

Office use

1 What is your date of birth?

_____ day _____ month _____year

1

2 What sex are you?

Male ☐ Female ☐

2

3 In which country were you born?……

3

4 To which of the following groups do you consider you belong? (please tick one)

White	☐	
Black – Caribbean	☐	
Black – African		☐
Black – Other		☐
Indian	☐	
Pakistani		☐
Bangladeshi	☐	
Chinese		☐
None of these		☐

4

If none of these, how would you describe
the racial or ethnic group to which you belong……

5

Section B - Some general questions about your health

1 How is your health in general?

very good	☐
good	☐
fair	☐
bad	☐
very bad	☐

☐6

2 Do you have any long-standing illness, disability or infirmity? By long-standing, we mean anything that has troubled you over a period of time, or that is likely to affect you over a period of time?

Yes ☐ If Yes, go to next question

☐7

No ☐ If No, go to the next page

3 Do any of these illnesses or disabilities limit your activities in any way?

Yes ☐

No ☐

☐8

Section C - Specific questions about your health

Have you *ever* been told by a doctor or nurse that you have any of these conditions? (Please tick all that apply to you)

		Yes	
1	Angina …….……..	☐	☐9
2	A heart attack ……..……..	☐	☐10
3	Other heart problems……..……..	☐	☐11
4	Stroke……..……..	☐	☐12
5	High blood pressure……..……	☐	☐13
6	Chronic bronchitis……..……	☐	☐14
7	Asthma ……..…….……	☐	☐15
8	Diabetes……..…….……	☐	☐16
9	Epilepsy or fits……..…….……	☐	☐17
10	Arthritis……..……..….	☐	☐18
11	Cancer (apart from skin cancer) ……..….	☐	☐19
12	Depression……..…….……	☐	☐20

13How much physical or bodily pain have you had in the past 4 weeks

None ☐ Very mild or mild ☐ Moderate ☐ Severe or very severe ☐

14In the past four weeks, how much did pain interfere with your normal activities?

☐21

Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit or extremely ☐

15 Is your hearing good enough (with a hearing aid, if you use one) to follow a TV programme at a volume others find acceptable?

Yes ☐ No, only with the volume turned up ☐

No, not even with the volume turned up ☐ ☐22

16 Can you see well enough to recognise a friend across a road ?

Yes, without glasses ☐ Yes, with glasses ☐ No ☐ ☐23

☐24

Section D - Some questions about difficulties you may have

Here are a few things people find difficult to do without help.
Do you or *would* you have difficulty with these activities?

		No Difficulty	Some Difficulty	Unable to do alone	
1	Washing yourself all over	☐	☐	☐	☐ 25
2	Cutting your own toenails	☐	☐	☐	☐ 26
3	Getting on a bus	☐	☐	☐	☐ 27
4	Going up and down stairs	☐	☐	☐	☐ 28
5	Doing heavy housework	☐	☐	☐	☐ 29
6	Shopping & carrying heavy bags	☐	☐	☐	☐ 30
7	Preparing and cooking a hot meal	☐	☐	☐	☐ 31
8	Reaching an overhead shelf	☐	☐	☐	☐ 32
9	Tying a good knot in a piece of string	☐	☐	☐	☐ 33

Section E - Some questions about services you may have used

The following questions ask when you last used a number of health and other services. Please tick one box for each question.

In the last 1 month have you seen

		Yes	No	
1	A GP at his/her surgery…….		☐	☐ 34
2	A GP at your home…….		☐	☐ 35
3	A nurse at the GP surgery…….		☐☐	36
4	A nurse at your home…….	☐		☐ 37
5	A GP or nurse at a walk-in/out-of-hours centre	☐		☐ 38

During the last 12 months have you attended

		Yes	No	
6	Hospital outpatients…….	☐	☐	39
7	A&E (Accident & Emergency \ Casualty) …	☐	☐	40
8	Hospital as a day patient…….	☐	☐	41
9	Hospital as an in-patient…….		☐ ☐	42

During the last 12 months have you seen

		Yes	No	
10	A chiropodist at home/clinic…….	☐	☐	43
11	A dentist…….	☐	☐	44
12	An optician…….	☐	☐	45

Do you currently

		Yes	No	
13	Receive meals on wheels…….	☐	☐	46
14	Attend a day centre…….	☐	☐	47
15	Attend a lunch club…….	☐	☐	48
16	Have a home help / domestic help…….	☐	☐	49

The questions on this page are for women only. Men please go to the next page.

1 Have you ever had an X-ray screening test for breast cancer (mammogram)?

Yes, in the last three years ☐
Yes, four or five years ago ☐
Yes, more than five years ago ☐
Yes, but I cannot recall when ☐
No, never ☐
Not sure ☐

☐50

2 Have you ever had a cervical smear test, where a sample of cells is taken from the neck of your womb?

Yes, in the last three years ☐
Yes, four or five years ago ☐
Yes, more than five years ago ☐
Yes, but I cannot recall when ☐
No, never ☐
Not sure ☐

☐51

Section F - Some questions about you and your family

1 Who do you live with?
(Please tick all the boxes that apply to you)

I live alone ☐
I live with my husband / wife / partner ☐
I live with a younger generation relative ☐
I live with an older or same generation relative ☐
I live in sheltered accomodation for older people ☐

☐52
☐53
☐54
☐55
☐56
☐57

Other ☐

If other, please describe …….

2 If you live alone, how long have you done so?

less than 1 year ☐ more than 1 year ☐ not applicable ☐

3 What is your current marital status? (please tick one)

Married (or living with someone as husband & wife)	☐	Go to next page
Widowed	☐	Go to question **4**
Divorced or Separated	☐	Go to question **5**
Single	☐	Go to next page Other ☐

If other, please describe……. Go to next page

4 If you are widowed, how long ago did your husband or wife die?

Less than one year ago ☐ More than one year ago ☐

(Please go to next page)

5 If you are divorced or separated, how long ago did you divorce / separate from your husband or wife?

Less than one year ago ☐ More than one year ago ☐

Section G - Some questions about where you live

If you are living in sheltered accommodation for older people please go straight to the next page

1 Do you or the people you live with, own or rent your home?

Own (with or without a mortgage) ☐

Rent from council or housing association ☐ ☐62

Rent - privately ☐

Other ☐

Other, please describe…….

☐63

2 Does your home have any form of central heating, including electric storage heaters?

Yes ☐ No ☐

3 Does your home have a telephone? (this includes mobile or shared phones for which you or others in your home pay the bill)

Yes ☐ No ☐

4 How many cars or vans are normally available for use by you and the others in your home?

None ☐
One ☐
Two or more ☐

Section H - Some questions about your education and employment

1 At what age did you finish your continuous full-time education at school, college or university?

14 or under ☐
15 ☐
16 ☐
17 ☐ 67
18 ☐
19 or over ☐

2 Are you currently (tick as many as apply)

Retired from paid employment ☐
A housewife / A retired housewife ☐ 68
In paid employment and working more than 30 hours a week ☐ 69
In paid employment and working less than 30 hours a week ☐ 70
Unemployed / Seeking work ☐ 71
Other ☐ 72
If other, please describe…… 73

3 If you are retired, or not working, at what age did you stop paid work

_____ Years

or

I have never been in paid employment ☐ 74

4 What was your last main job?

75

5 What was your husband's or wife's last main job?

76

Section I - Some questions about your income

1 Which of the following best describes the total income of *everyone in your home* before tax? (include earnings, benefits and pensions)

Per Week or **Per Year**

80

Nil		Nil	☐
Less than £60	or	Less than £3000	☐
£60 to £119	or	£3000 to £5,999	☐
£120 to £199	or	£6,000 to £9,999	☐
£200 to £299	or	£10,000 to £14,999	☐
£300 to £479	or	£15,000 to 24,999	☐
£480 or more	or	£25,000 or more	☐
Don't Know			☐

2 Do you or your spouse receive an occupational pension from former employer(s)

Yes ☐
No ☐
Don't Know ☐

3 Do you have private health insurance?

Yes ☐
No ☐
Don't Know ☐

4 Do you have to cut back spending or borrow money to pay your electricity, gas, telephone or council tax bills?

Always ☐
Often ☐
Occasionally ☐
Never ☐

Section J - Some questions on how you feel

The next questions ask about your feelings and mood.
Choose the answer for how you felt over the last week.

Please answer all the questions.

		Yes	No	
1	Are you basically satisfied with your life?……	☐	☐	☐84
2	Have you dropped many activities and interests?……	☐	☐	
3	Do you feel your life is empty?……	☐	☐	☐85
4	Do you often get bored?……	☐	☐	☐86
5	Are you in good spirits most of the time?……	☐	☐	
6	Are you afraid that something bad is going to happen to you?	☐	☐	☐87
7	Do you feel happy most of the time?……	☐	☐	☐88
8	Do you often feel helpless?……	☐	☐	☐89
9	Do you prefer to stay at home at night rather than going out and doing new things?……..	☐	☐	☐90
10	Do you feel that you have more problems with your memory than most? ……	☐	☐	☐91
11	Do you think it is wonderful to be alive now?……	☐	☐	
12	Do you feel pretty worthless the way you are now?……	☐	☐	☐92
13	Do you feel full of energy?……	☐	☐	☐93
14	Do you feel that your situation is hopeless?……	☐	☐	☐94
15	Do you think that most people are better off than you are?…….	☐	☐	☐95
				☐96
				☐97
				☐98
				☐☐99

The next few questions also ask about how you feel.
Please tick one option for each question.

16 In the past month have you felt so fidgety or restless that you couldn't sit still?

Yes ☐
No ☐

☐100

17 How often, if at all, have you worried in the past month?

Never ☐
Some days ☐
Most days ☐
All the time ☐

☐101

18 In general, would you describe yourself as a worrier?

Yes ☐
No ☐

☐102

19 Do you take anything (including sedative tablets or alcohol) to help you relax?

Yes ☐
No ☐

☐103

Section K - Questions about contact with relatives, friends and neighbours

1 Apart from people that you live with, about how often do you see any of your children or other relatives?

- Daily ☐
- Weekly ☐
- Monthly ☐
- Less often than once a month ☐
- Never ☐

☐104

2 About how often do you see any of your friends?

- Daily ☐
- Weekly ☐
- Monthly ☐
- Less often than once a month ☐
- Never ☐

☐105

3 Apart from relatives or friends, about how often do you see any of your neighbours to chat to?

- Daily ☐
- Weekly ☐
- Monthly ☐
- Less often than once a month ☐
- Never ☐

☐106

4 About how often do you speak on the telephone to relatives, friends or neighbours?

- Daily ☐
- Weekly ☐
- Monthly ☐
- Less often than once a month ☐
- Never ☐

☐107

5 Do you feel you see your relatives as much as you would like?

- No, I see them too little ☐
- No, I see them too much ☐
- Yes, I see them enough ☐

6 Do you feel you see your friends as much as you would like?

- No, I see them too little ☐
- No, I see them too much ☐
- Yes, I see them enough ☐

☐109

☐110

7 Overall are you satisfied with the help and support that you can get from your close friends?

Yes, I am satisfied ☐
No, I am not satisfied ☐
I am not sure ☐

8 Do you have someone with whom you would discuss a very personal and serious problem?

Yes ☐
No ☐

9 Do you experience conflict, upset or bother in any of your relationships with close friends or relatives?

Yes ☐
No ☐

10 How often have you attended a religious service or place of worship in the past month?

Once a week or more ☐
Once or twice in the past month ☐
Not at all in the past month ☐

11 How much time do you usually spend alone?

I'm alone all the time ☐
I'm often alone ☐
I'm seldom alone ☐
I'm never alone ☐

12 Do you feel lonely?

All the time ☐
Often ☐
Sometimes ☐
Never ☐

Section L – Some questions about your attitudes to health

For each of the statements below, please choose the response which best describes how you feel

1 Physical diseases are part of the destiny of old people.

I agree ☐ I'm not sure ☐ I disagree ☐ ☐116

☐

2 Physical diseases in old age can be prevented by a healthy life-style.

I agree ☐ I'm not sure ☐ I disagree ☐

3 Physical diseases in old age cannot be avoided by regular medical visits.

I agree ☐ I'm not sure ☐ I disagree ☐

4 My health depends mainly on myself.

I agree ☐ I'm not sure ☐ I disagree ☐

5 Health is a gift.

I agree ☐ I'm not sure ☐ I disagree ☐

6 Being in good health even in old age is no problem with modern medicine.

I agree ☐ I'm not sure ☐ I disagree ☐

Section M- Some questions about smoking and drinking

1 Have you ever smoked?

Yes ☐ No ☐ ☐122

2 Do you currently smoke?

Yes ☐ Please go to question **3** ☐123

No ☐ Please go to question **5**

3 About how many cigarettes a day do you usually smoke? ☐124

None ☐ _____ Cigarettes each day ☐☐125

4 **Do you currently smoke a pipe?** Yes ☐ No ☐ ☐126

cigars? Yes ☐ No ☐

5 If you used to smoke in the past, when did you give up? ☐127

Less than 1 year ago ☐ 1-5 years ago ☐

 ☐128

6-10 years ago ☐ more than 10 years ago ☐

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6 About how often do you have an alcoholic drink of any kind?

Every day or almost every day ☐
Three or four days a week ☐
Once or twice a week ☐
Once or twice a month ☐
Less than once a month ☐
Not at all in the last 12 months ☐

7 *One drink is half a pint of beer / cider, a single whisky, gin etc or one glass of wine or sherry* **…**

How many alcoholic drinks do you have during the average week? Drinks

Please now read and sign the consent form on the next page

This page is for any other comments you may have on your health or this questionnaire

Consent Form

As part of this study, we would like to link the information that you have provided in this questionnaire to records that are kept by your general practitioner. We need your permission to do this. As this is an important part of the study, we would greatly value your agreement to do this.

The confidentiality of any information from this questionnaire and medical records will be maintained by the researchers in the Departments of General Practice & Primary Care and Public Health Sciences at St George's Hospital Medical School. This information will not be disclosed to others or presented in any form that allows you to be identified.

If you agree to us looking at your general practice records, please sign below.

Signature_____

Name_____

Date_____

If you do not wish us to access your general practice records, please tick the box below.

☐ I do not agree to you accessing my general practice records as part of this study

Thank you for your help

We will detach this page from the questionnaire to ensure confidentiality