



**THE 45  
AND UP  
STUDY**

# 45 and Up Study Questionnaire for Women

Research to improve health and wellbeing

The *45 and Up Study* relies on the willingness of people in New South Wales to share information about their lives and experiences, to provide knowledge that will help people live healthy and fulfilling lives for as long as possible. Participation is completely voluntary, and you are free to withdraw from the Study at any time. To take part, please read the participant information leaflet, then complete the questionnaire and consent form and return them in the envelope provided. We very much hope you will be able to take part.

**Any questions or comments?** Please call the Study helpline: **1300 45 11 45** or go to **www.45andUp.org.au**

Auspiced by



In collaboration with



NSW HEALTH



**Your answers and experiences are important to us.**

To help us read your answers, please write as clearly as possible using a **BLACK** or **BLUE** pen, and be sure to complete the questionnaire as shown:

Please put a cross in the appropriate box(es)  Yes  No

OR put numbers in the appropriate box, e.g. 21st June 1945

2 1 / 0 6 / 1 9 4 5 age 6 2

## General questions about you

1. What is your date of birth?   /   / 1 9

2. What is today's date?   /   / 2 0

3. How tall are you without shoes?  cm OR  feet  inches  
(please give to the nearest cm or inch)

4. About how much do you weigh?  kg OR  stone  lbs

5. What is the highest qualification you have completed?

(please put a cross in the most appropriate box)

- no school certificate or other qualifications  
 school or intermediate certificate (or equivalent)  
 higher school or leaving certificate (or equivalent)  
 trade/apprenticeship (e.g. hairdresser, chef)  
 certificate/diploma (e.g. child care, technician)  
 university degree or higher

6. Are you of Aboriginal or Torres Strait Islander origin?

(you can cross more than one box)

- No  Yes, Aboriginal  Yes, Torres Strait Islander

7. In which country were you born?

- Australia ▶ please go to question 9  
 UK  Ireland  Italy  China  
 Greece  New Zealand  Germany  Lebanon  
 Philippines  Netherlands  Vietnam  Malta  
 Poland  other (please specify) \_\_\_\_\_

8. What year did you first come to live in Australia for one year or more? (e.g. 1970)

9. What is your ancestry? (please cross up to 2 boxes)

- Australian  English  Irish  Chinese  
 Italian  Greek  Scottish  German  
 Lebanese  Dutch  Maltese  Polish  
 Filipino  Indian  Croatian  Vietnamese  
 other (please specify) \_\_\_\_\_

10. Do you speak a language other than English at home?

- Yes  No

11. Have you ever been a regular smoker?

- Yes ▼  No ▶ If No – please go to question 12

How old were you when you started smoking regularly?   years old

Are you a regular smoker now?  Yes  No

If No – how old were you when you stopped smoking regularly?   years old

About how much do you/did you smoke on average each day?  
(If you are an ex-smoker, how much did you smoke on average when you smoked?)

cigarettes per day   pipes and cigars per day

12. About how many alcoholic drinks do you have each week?

one drink = a glass of wine, middy of beer or nip of spirits  
(put "0" if you do not drink, or have less than one drink each week)

number of alcoholic drinks each week

13. On how many days each week do you usually drink alcohol?

days each week

#### 14. What best describes your current situation?

(you can cross more than one box)

- single       married       de facto/living with a partner  
 widowed       divorced       separated

#### 15. What best describes your current housing? (please cross one box)

- house       flat, unit, apartment       house on farm  
 hostel for the aged       mobile home       other  
 nursing home       retirement village, self care unit

#### 16. How many TIMES did you do each of these activities LAST WEEK?

##### Walking briskly

(for recreation or exercise or to get to or from places)

times in the last week

 

##### Moderate physical activities

(like social tennis, golf, gentle swimming, vigorous gardening or work around the house)

 

##### Vigorous leisure activities

(that made you breathe harder or puff and pant, like aerobics, vigorous sport, cycling, swimming, running)

 

#### 17. If you add up all the time you spent doing each activity LAST WEEK, how much time did you spend ALTOGETHER doing each type of activity?

##### Walking briskly

(for recreation or exercise or to get to or from places)

hours	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>	minutes
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##### Moderate physical activities

(like social tennis, golf, gentle swimming, vigorous gardening or work around the house)

hours	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>	minutes
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##### Vigorous leisure activities

(that made you breathe harder or puff and pant, like aerobics, vigorous sport, cycling, swimming, running)

hours	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>	minutes
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### Questions about your family

#### 18. Have your mother, father, brother(s) or sister(s) ever had:

(blood relatives only; please put a cross in the appropriate box(es))

	mother	father	brother/ sister		mother	father	brother/ sister
heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dementia/Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
severe depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
severe arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hip fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
do not know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

#### 19. How many children have you given birth to?

(please include stillbirths but do not include miscarriages, please write "0" if you have not had any children)

  children

#### How old were you when you gave birth to your FIRST child?

  years old

#### How old were you when you gave birth to your LAST child?

  years old

#### For how many months, in total, have you breastfed?

(please add together all the time you spent breastfeeding all of your children; put "0" if you never breastfed)

  months

### Questions about your health

#### 20. About how many hours a week are you exposed to someone else's tobacco smoke?

hours per week

  at home

hours per week

  in other places  
(e.g. work, going out, cars)

#### 21. Have you ever used the pill or other hormonal contraceptives?

(e.g. the combined pill, mini pill, contraceptive implant or injections)

- Yes  No

#### If Yes, for how long altogether have you used hormonal contraceptives?

(please write '0' if you used them for less than a year in total)

  years

#### If Yes, how old were you when you LAST used hormonal contraceptives?

(please write your current age if you are still using them)

  age

#### Which type of pill or other hormonal contraceptive did you use MOST RECENTLY?

- "the pill", combined pill (e.g. Microgynon, Levlen)  
 progesterone-only pill ("mini pill") (e.g. Micronor, Noriday, Microval)  
 Depo Provera  
 contraceptive implant (e.g. Implanon, Norplant)  
 do not know

#### 22. Have you ever used hormone replacement therapy (HRT)?

- Yes  No

#### If Yes, for how long altogether have you used HRT?

(please write '0' if you used HRT for less than a year in total)

  years

#### Are you currently taking HRT?

- Yes  No

#### If No, at what age did you stop?

  age

#### 23. Have you taken any medications, vitamins or supplements for most of the last 4 weeks, including HRT and the pill?

- Yes  No

#### If Yes, was it:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> fish oil                    | <input type="checkbox"/> glucosamine                         | <input type="checkbox"/> omega 3                        |
| <input type="checkbox"/> paracetamol                 | <input type="checkbox"/> aspirin for the heart               | <input type="checkbox"/> aspirin for other reasons      |
| <input type="checkbox"/> Lipitor                     | <input type="checkbox"/> Avapro, Karvea                      | <input type="checkbox"/> warfarin, Coumadin             |
| <input type="checkbox"/> Pravachol                   | <input type="checkbox"/> Coversyl, Coversyl Plus             | <input type="checkbox"/> Lasix, frusemide               |
| <input type="checkbox"/> Zocor, Lipex                | <input type="checkbox"/> Cardizem, Vasocordol                | <input type="checkbox"/> Micardis                       |
| <input type="checkbox"/> Nexium                      | <input type="checkbox"/> Norvasc                             | <input type="checkbox"/> Fosamax                        |
| <input type="checkbox"/> Somac                       | <input type="checkbox"/> Tritace                             | <input type="checkbox"/> Caltrate                       |
| <input type="checkbox"/> Losec, Acimax<br>omeprazole | <input type="checkbox"/> Noten, Tenormin<br>atenolol         | <input type="checkbox"/> Oroxine<br>thyroxine           |
| <input type="checkbox"/> Ventolin<br>salbutamol      | <input type="checkbox"/> Zyloprim, Progut 300<br>allopurinol | <input type="checkbox"/> Diabex, Diaformin<br>metformin |
| <input type="checkbox"/> Zoloft<br>sertraline        | <input type="checkbox"/> Cipramil<br>citaloprim              | <input type="checkbox"/> Efexor<br>venlafaxine          |

please list any other regular medications or supplements here

**24. Has a doctor EVER told you that you have:**

(If YES, please cross the box and give your age when the condition was first found)

	Yes	Age when condition was first found	
skin cancer (not melanoma)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
melanoma	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
breast cancer	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
other cancer	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
type of cancer (please describe)			
heart disease	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
type of heart disease (please describe)			
high blood pressure – when pregnant	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
high blood pressure – when not pregnant	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
stroke	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
diabetes	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
blood clot (thrombosis)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
asthma	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
hayfever	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
depression	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
anxiety	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
Parkinson's disease	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
none of these	<input type="checkbox"/>		

**25. In the last month have you been treated for:**

(If YES, please cross the box and give your age when the treatment started)

	Yes	Age started treatment	
cancer	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
heart attack or angina	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
other heart disease	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
high blood pressure	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
high blood cholesterol	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
blood clotting problems	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
asthma	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
osteoarthritis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
thyroid problems	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
osteoporosis or low bone density	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
depression	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
anxiety	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
none of these	<input type="checkbox"/>		

**26. Are you NOW suffering from any other important illness?**

Yes  No

Please describe this illness and its treatment

**27. Do you regularly need help with daily tasks because of long-term illness or disability?**

(e.g. personal care, getting around, preparing meals)

Yes  No

**28. Does your health now LIMIT YOU in any of the following activities?**

**yes,** limited a lot    **yes,** limited a little    **no,** not limited at all

VIGOROUS activities <i>(e.g. running, strenuous sports)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MODERATE activities <i>(e.g. pushing a vacuum cleaner, playing golf)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lifting or carrying shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
walking one kilometre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
walking half a kilometre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
walking 100 metres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bending, kneeling or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**29. Have you ever had any of the following operations?**

(If YES, please cross the box and give your age when you had the operation; give your age at the **most recent operation** if you have had more than one)

	Yes	Age when had operation	
removal of skin cancer	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
hysterectomy	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
both ovaries removed	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
sterilisation (tubes tied)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
repair of prolapsed womb, bladder or bowel	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
knee replacement	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
hip replacement	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
gallbladder removed	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age
heart or coronary bypass surgery <i>(include stents and balloons)</i>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> age

other (please describe any other operations you have had in the last 10 years, with your age when you had them)

**30. Do you regularly care for a sick or disabled person?**

Yes ▼  No

If Yes, about how much time each week do you usually spend caring for this person?

full time OR   hours/wk

**31. In general, how would you rate your:**

	excellent	very good	good	fair	poor
overall health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
quality of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
eyesight? (with glasses or contact lenses, if you wear them)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
memory?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**32. Do you feel you have a hearing loss?**  Yes  No

**33. How many of your own teeth do you have left?**

None – all of my teeth are missing  1-9 teeth left  
 10-19 teeth left  20 or more teeth left

**34. During the past 12 months, how many times have you fallen to the floor or ground?** (put "0" if you haven't fallen in this time)

times

**35. Have you had a broken/fractured bone in the last 5 years?**

Yes ▼  No

If Yes, which bones were broken?

wrist  arm  hip  ankle  
 rib  finger/toe  other \_\_\_\_\_

How old were you when it happened?   years old  
 (give age at most recent fracture if more than one)

**36. About how many times a week are you usually troubled by leaking urine?**

never  once a week or less  
 2-3 times  4-6 times  every day

**37. Have you been through menopause?**

No  
 Not sure (because hysterectomy, taking HRT, etc.)  
 My periods have become irregular  
 Yes – How old were you when you went through menopause?   years old

**38. Have you ever been for a breast screening mammogram?**

Yes ▼  No

If Yes, what year did you have your last mammogram? (e.g. 2005)

How many times have you been for breast screening altogether?   times

**39. Have you ever been screened for colorectal (bowel) cancer?**

Yes ▼  No

If Yes, please indicate which test(s) you had:

faecal occult blood test (test for blood in the stool/faeces)  
 sigmoidoscopy (a tube is used to examine the lower bowel: this is usually done in a doctor's office without pain relief)  
 colonoscopy (a long tube is used to examine the whole large bowel; you would usually have to have an enema or drink large amounts of special liquid to prepare the bowel for this)

What year did you have the most recent one of these tests? (e.g. 2005)

**Questions about your diet**

**40. About how many times each week do you eat:**

(please count all meals and snacks. put '0' if never eaten or eaten less than once a week) number of times eaten each week

beef, lamb or pork	<input type="text"/>	<input type="text"/>
chicken, turkey or duck	<input type="text"/>	<input type="text"/>
processed meat (include bacon, sausages, salami, devon, burgers, etc)	<input type="text"/>	<input type="text"/>
fish or seafood	<input type="text"/>	<input type="text"/>
cheese	<input type="text"/>	<input type="text"/>

**41. About how many of the following do you usually eat:**

slices or pieces of brown/wholemeal bread each week (also include multigrain, rye bread, etc.)

bowls of breakfast cereal each week

If you eat breakfast cereal is it usually: (please cross)

bran cereal (allbran, branflakes, etc.)  muesli  
 biscuit cereal (weetbix, shredded wheat, etc.)  other (cornflakes, rice bubbles, etc.)  
 oat cereal (porridge, etc.)

**42. Which type of milk do you mostly have?**

whole milk  reduced fat milk  skim milk  
 soy milk  other milk  I don't drink milk

**43. About how many serves of vegetables do you usually eat each day?** A serve is half a cup of cooked vegetables or one cup of salad

(please include potatoes and put "0" if less than one a day)

number of serves of cooked vegetables each day

number of serves of raw vegetables each day (e.g. salad)

I don't eat vegetables

**44. About how many serves of fruit or glasses of fruit juice do you usually have each day?** A serve is 1 medium piece or 2 small pieces or 1 cup of diced or canned fruit pieces (put "0" if you eat less than one serve a day)

number of serves of fruit each day

number of glasses of fruit juice each day

I don't eat fruit

**45. Please put a cross in the box if you NEVER eat:**

red meat  chicken/poultry  pork/ham  dairy products  
 any meat  eggs  sugar  wheat products  
 fish  seafood  cream  cheese

**Questions about time and work**

**46. What is your usual yearly HOUSEHOLD income before tax, from all sources?** (please include benefits, pensions, superannuation, etc)

less than \$5,000 per year  \$30,000-\$39,999 per year  
 \$5,000-\$9,999 per year  \$40,000-\$49,999 per year  
 \$10,000-\$19,999 per year  \$50,000-\$69,999 per year  
 \$20,000-\$29,999 per year  \$70,000 or more per year  
 I would rather not answer this question

**47. What is your current work status?** (you can cross more than one box)

- |   |  |
|---|--|
| <input type="checkbox"/> in full time paid work       | <input type="checkbox"/> self-employed             |
| <input type="checkbox"/> in part time paid work       | <input type="checkbox"/> doing unpaid work         |
| <input type="checkbox"/> completely retired/pensioner | <input type="checkbox"/> studying                  |
| <input type="checkbox"/> partially retired            | <input type="checkbox"/> looking after home/family |
| <input type="checkbox"/> disabled/sick                | <input type="checkbox"/> unemployed                |
| <input type="checkbox"/> other                        |  |

**48. If you are partially or completely retired, how old were you when you retired?**   years old

Why did you retire? (you can cross more than one box)

- |   |   |
|---|---|
| <input type="checkbox"/> reached usual retirement age     | <input type="checkbox"/> lifestyle reasons    |
| <input type="checkbox"/> to care for family member/friend | <input type="checkbox"/> ill health           |
| <input type="checkbox"/> made redundant                   | <input type="checkbox"/> could not find a job |
| <input type="checkbox"/> other                            |   |

**49. About how many HOURS each WEEK do you usually spend doing the following?** (please put "0" if you do not spend any time doing it)

- |   |   |
|---|---|
| hours per week                                      | hours per week  |
| <input type="text"/> <input type="text"/> paid work | <input type="text"/> <input type="text"/> voluntary/unpaid work |

**50. Which of the following do you have?** (excluding Medicare)

- Private health insurance – with extras
- Private health insurance – without extras
- Department of Veterans' Affairs white or gold card
- Health care concession card
- none of these

**51. What best describes the colour of the skin on the inside of your upper arm, that is your skin colour without any tanning?**

- |                                    |                                      |                                |
|------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> very fair | <input type="checkbox"/> light olive | <input type="checkbox"/> brown |
| <input type="checkbox"/> fair      | <input type="checkbox"/> dark olive  | <input type="checkbox"/> black |

**52. What would happen if your skin was repeatedly exposed to bright sunlight during summer without any protection? Would it:**

- |   |   |
|---|---|
| <input type="checkbox"/> Get very tanned?       | <input type="checkbox"/> Get mildly or occasionally tanned? |
| <input type="checkbox"/> Get moderately tanned? | <input type="checkbox"/> Never tan, or only get freckled?   |

**53. About how many hours a DAY would you usually spend outdoors on a weekday and on the weekend?**

- |   |   |
|---|---|
| hours per day                                     | hours per day                                     |
| <input type="text"/> <input type="text"/> weekday | <input type="text"/> <input type="text"/> weekend |

**54. About how many HOURS in each 24 hour DAY do you usually spend doing the following?**

- (please put "0" if you do not spend any time doing it)
- |   |  |
|---|--|
| hours per day   | hours per day                                      |
| <input type="text"/> <input type="text"/> sleeping (including at night & naps)    | <input type="text"/> <input type="text"/> sitting  |
| <input type="text"/> <input type="text"/> watching television or using a computer | <input type="text"/> <input type="text"/> standing |

**55. How many TIMES in the LAST WEEK did you:** times in the last week

- (please put "0" if you did not spend any time doing it)
- |   |   |
|---|---|
| spend time with friends or family who do not live with you?                     | <input type="text"/> <input type="text"/> |
| talk to someone (friends, relatives or others) on the telephone?                | <input type="text"/> <input type="text"/> |
| go to meetings of social clubs, religious groups or other groups you belong to? | <input type="text"/> <input type="text"/> |

**56. How many people outside your home, but within one hour of travel, do you feel you can depend on or feel very close to?**   people

**57. During the past 4 weeks, about how often did you feel:**

- |  | none of the time         | a little of the time     | some of the time         | most of the time         | all of the time          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| tired out for no good reason?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| nervous?                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| so nervous that nothing could calm you down? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| hopeless?                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| restless or fidgety?                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| so restless that you could not sit still?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| depressed?                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| that everything was an effort?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| so sad that nothing could cheer you up?      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| worthless?                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**58. During the past 4 weeks, have you had any of the following problems with your work or daily activities because of any emotional problems (such as being depressed or anxious)?**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| cut down on the amount of time you spent on work or other activities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| achieved less than you would have liked to                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| did work or other activities less carefully than usual               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Thank you very much for filling in the questionnaire

Don't forget to sign the consent form overleaf 

Are your name and address correct on the front of this questionnaire?  Yes  No

If INCORRECT, give details below.

Surname:

Given name(s):

Postal address:

Town or Suburb:

State or Territory:  Postcode:

## Consent form



Research to improve health and wellbeing

The *45 and Up Study* relies on the willingness of people in New South Wales to share information about their lives and experiences and to have their health followed over time. By signing this form you are agreeing to take part in the *45 and Up Study* and for the Study team to follow your health over time. Participation is completely voluntary, and you are free to ask questions or to withdraw from the Study at any time, by calling the Study helpline on 1300 45 11 45. More information on the Study can be found at [www.45andup.org.au](http://www.45andup.org.au)

### I agree to have my health followed over time through:

**the 45 and Up Study team following health and other records relating to me**, including NSW hospital records, cancer records, death records and other health-related records, as outlined in the Study leaflet: *The 45 and Up Study: Information for participants*;

**Medicare Australia** releasing to the 45 and Up Study my enrolment details, including Medicare number, and information concerning services provided to me under Medicare, the Department of Veterans' Affairs, the Pharmaceutical Benefits Scheme and the Repatriation Pharmaceutical Benefits Scheme, including past information, until the end of the Study or for the duration of my involvement in the Study;

**being contacted in the future** to provide information on changes to my health and lifestyle. I may also be asked to provide further information including questionnaire responses or biological samples; my participation in any of these would be completely voluntary.

I have been provided with information about the 45 and Up Study including how it will gather, store, use and disclose information about me, in the Study leaflet. I have been given an opportunity to ask questions and have been fully informed about the Study.

### I give my consent on the understanding that:

**my information will only be used for the purposes outlined in the Study leaflet** entitled *The 45 and Up Study: Information for participants*, of which I have a copy;

**my information will be kept strictly confidential** and will be used for health research only;

**reports and publications from the Study will be based on de-identified information** and will not identify any individual taking part;

**my participation in this Study is entirely voluntary** and my consent will continue to be valid following death or disablement unless withdrawn by my next of kin or other person responsible. I am free to withdraw from the Study at any time by calling the **Study helpline on 1300 45 11 45**;

**my decision on whether or not to take part** in the Study or in any additional research will not disadvantage me or affect my future health care in any way.

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date today: 

day	month	year
<input type="text"/>	<input type="text"/>	<input type="text"/>

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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## Extra contact details

It would be very helpful and reduce Study costs if we could contact you in future by email. If you are happy for us to do this, please write your email address here:

Email address: \_\_\_\_\_

Sometimes we find that people have moved when we try to contact them again. It would be very helpful if you could give us your mobile phone number and/or the contact details of someone close to you (such as a relative or friend) who would be happy for us to contact them if we are unable to reach you. We would only get in touch with that person if we were unable to contact you directly and we would need to tell them our reason for contacting you. Please leave this section blank if you do not wish to provide these extra contact details.

Your home phone number: (  )  Your mobile phone number:

Full name of contact person: \_\_\_\_\_

Phone number of contact person: (  )

If you have any questions about the Study, please ring the Study helpline on **1300 45 11 45** (toll free). You can also write to or send your questionnaire (no stamp required) directly to:

**Associate Professor Emily Banks, Scientific Director,  
The 45 and Up Study, Reply paid 5289, Sydney NSW 2001.**

**Thank you very much for taking part**