carma–2–osteo

OSTEOPOROSIS SUBSTUDY

Cross-Sectional & Longitudinal Assessment of Bone Health in HIV Positive Women

CaMos for CaRMA 2013 Questionnaire

AFFIX STUDY CODE
LABEL HERE

CaRMA

CaMos
Canadian Multicentre Osteoporosis Study
Étude Canadienne multicentrique sur l'ostéoporose

Respondent ID # _____

Site Location _____

INTERVIEWER ID # **NAME**

LOCATION OF INTERVIEW ☐ HOSPITAL ☐ HOME ☐ OTHER

DATE OF INTERVIEW _____ / _____ / _____ (Day / Month / Year) **TIME BEGAN** HRS MIN

TIME ENDED HRS MIN

	D E X A	BLOOD	URINE	X-RAY
CLINICAL ASSESSMENT	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A

RESULTS TO BE SENT TO PHYSICIAN ☐ YES ☐ NO **FOLLOW UP** ☐ YES ☐ NO

CAMOS DATA ENTRY DATE _____ / _____ / _____ (Day / Month / Year)

COMMENTS:

Now I'd like to ask you a general question about yourself

[CO – 1.10] **1.** Do you live alone? ☐ Yes ☐ No

☐ Do you live with another adult (who is at home with you)? ☐ Yes ☐ No

Now we'll review your past health.

[CO – 2.] **2. MEDICAL HISTORY**

2.1. Has a doctor ever told you that you have any of the following conditions (have you ever been diagnosed with…)? If YES, at what age was the diagnosis made? Have you started a treatment for this condition?

	DIAGNOSIS				TREATMENT			
	YES	NO	DK	Age	YES	NO	DK	N/A
Osteoporosis								
Rheumatoid Arthritis								
Osteoarthritis								
Thyroid disease: 1 = Hyperthyroidism 2 = Hypothyroidism								
Liver disease (Hep A / Hep B / other)								
Scoliosis								
Eating Disorder								
Breast Cancer								
Uterine Cancer								
Inflammatory Bowel Disease (colitis, ulcerative colitis, Crohn's disease)								
Kidney Stones								
Hypertension								
Heart Attack								
Stroke TIA (Transient Ischemic Attack)								
Neuromuscular Disease 1 = Parkinson's 2 = Multiple Sclerosis 3 = Other								
Diabetes Age 1 = Insulin Dependent 2 = Non Insulin Dependent								
Kidney Disease								
Phlebitis, thrombophlebitis								
Paget's Disease of Bone								
[JLP added] Polycystic Ovary Syndrome								
Lung Disease 1 = Asthma 2 = Emphysema 3 = Bronchitis								

[C3 – 2.2] **2.2.** Have you **ever** been diagnosed with cancer other than breast or uterine?

☐ Yes ☐ No

↓

When were you diagnosed? _____ (month / year)

[C3 – 2.3] **2.3.** Have you **ever** had an organ transplant?

☐ Yes ☐ No

↓

When did you have the organ transplant? _____ (month / year)

[CO – 2.3] **2.4.** In the past, have you had any of the following surgeries? How old were you?

	YES	NO	AGE
Parathyroid			
Thyroid			
Stomach			
Intestine			
Gall Bladder			

[JLP added] **2.5.** Have you fallen in the past year?

☐ Yes ☐ No → Go to question 3.1

↓

How many times? _____

[CO – 2.5] **2.6.** Have you fallen in the past month?

☐ Yes ☐ No → Go to question 3.1

↓

How many times? _____

[CO – 2.4] **2.6.** Have you fallen in the past week?

☐ Yes ☐ No → Go to question 3.1

↓

How many times? _____

Now I would like to ask you about any medications you may have taken.

[C3 – 3] **3. DRUGS AND MEDICATIONS**

[C10 – 3 .1] **3.1.** Have you ever taken any of the following medications regularly or daily for more than one month? If YES, for approximately how many months total have you taken it?

		Total # of months taken	
Seizure Pills (*Phenobarbital, Dilantin®, etc*)	□ 1 Yes →		□ 2 No
Thyroid Hormones (*Synthroid®, Eltroxin®, Levo-T®, etc*)	□ 1 Yes →		□ 2 No
Tamoxifen (*Novaldex®, Tamone®, Tamoplex®, etc*)	□ 1 Yes →		□ 2 No
Alendronate (*Fosamax®*)	□ 1 Yes →		□ 2 No
Calcitonin (*Calimar®, Caltine®, Miacalcin nasal spray*)	□ 1 Yes →		□ 2 No
Clodronate (*Bonefos®, Ostac®*) *i.v./p.o.*	□ 1 Yes →		□ 2 No
Etidronate (*Didronel®, Didrocal®*)	□ 1 Yes →		□ 2 No
Fluoride (*Fluotic®*)	□ 1 Yes →		□ 2 No
Raloxifene *(Evista®*)	□ 1 Yes →		□ 2 No
Risedronate (*Actonel®*)	□ 1 Yes →		□ 2 No
Ibandronate (*Bondronate®, Boniva®*) *i.v./p.o.*	□ 1 Yes →		□ 2 No
Pamidronate (*Aredia®*) *i.v.*	□ 1 Yes →		□ 2 No
Parathormone or PTH (*Forteo®*)	□ 1 Yes →		□ 2 No
Diuretics – Thiazide/Other	□ 1 Yes →		□ 2 No
Laxatives	□ 1 Yes →		□ 2 No
Testosterone			
Andriol (*testosterone undecanoate*)	□ 1 Yes →		□ 2 No
Androgel (*testosterone gel*)	□ 1 Yes →		□ 2 No
Delatestryl (*testerone enanthate*)	□ 1 Yes →		□ 2 No
Depo Testosterone (*testosterone cypionate*)	□ 1 Yes →		□ 2 No
Testoderm (*testosterone patch*)	□ 1 Yes →		□ 2 No
Climacteron	□ 1 Yes →		□ 2 No
Cortisone/Prednisone			
Inhaled	□ 1 Yes →		□ 2 No
Oral	□ 1 Yes →		□ 2 No
Injection		*# of injections*	
Intravenous	□ 1 Yes →		□ 2 No
Intramuscular, subcutaneous	□ 1 Yes →		□ 2 No
[C16 – 3.1] → Denosumab (*Prolia*)	□ 1 Yes →		□ 2 No
[C16 – 3.1] → Zoledronic Acid (*Aclasta*)	□ 1 Yes →		□ 2 No

[CO – 3.2] **3.2.** Current medications and / or self-administered supplements taken on a regular basis.

☐ answered in CARMA-CORE

NAME	DOSE	FREQUENCY	DURATION

Now I would like to know about any broken bones you may have had

[CO – 4] **4. FRACTURES**

4.1. Have you **ever** fractured any bones?

[CO – 4.1]

☐ Yes ☐ No → Go to 5.1

↓

Complete the table below. *(Refer to picture of body skeleton if necessary)*
Use the following trauma codes to indicate how it happened.

1 = severe trauma
2 = minimal trauma
3 = other disease

(See manual for definitions)

INCIDENT(S)	TRAUMA CODE	AGE (YEARS)	BONE SITE										OTHER					
			BACK		RIBS		PELVIS		FOREARM /WRIST		HIP		BONE SITE		BONE SITE		BONE SITE	
			#	x	#	x	#	x	#	x	#	x	#	x	#	x	#	x
1																		
2																		
3																		
4																		
5																		
6																		

# = fracture
x = x-ray

[C3 – 4] **4.1.1.** In the **past year** have you fractured any bones?

☐ Yes ☐ No → Go to question 5.1

↓

How many times have you fractured a bone in the last year? _____

[C3 – 4.1] **4.1.2.** INCIDENT # _____

[C3 – 4.2] **4.2.** Which bone was broken?

☐ Back
☐ Forearm / Wrist
☐ Hip
☐ Ribs
☐ Pelvis
☐ Other

[C3 – 4.2.1] **4.2.1.** Have you been told your fracture is osteoporosis related?

□ Yes □ No ☐ Don't know

4.3. How did it happen?

☐ (1) Fell out of bed or off a chair
☐ (2) Fell climbing a chair or ladder

☐ (3) Fell on stairs

☐ (4) Motor vehicle accident

☐ (5) Sporting injury *(i.e. skiing, playing hockey, cycling, running, jogging, etc)*

☐ (6) Slipped or tripped in home *(on carpet, wet floor, getting in/out of bath, etc)*

☐ (7) Slipped or tripped and fell outside the home other than sporting *(on ice, on the curb, etc)*

☐ (8) Heavy object fell or struck body causing the fracture

☐ (9) Bone(s) broke with no fall or injury

☐ (10) Other – Specify: _____

[JLP added] **FRACTURE VERIFICATION**

[C3 – 4.4] **4.4.** What was the date of the fracture? _____ month _____ year ☐ Don't know

[C3 – 4.5.1] **4.5.1.** Were x-rays of the fracture taken?

☐ Yes ☐ No → Go to question 4.6

[C3 – 4.5.2] **4.5.2.** What was the date of the x-ray? _____ month _____ year ☐ Don't know

[C3 – 4.5.3] **4.5.3.** At what clinic/hospital were the x-rays done? _____ ☐ Don't know

[C3 – 4.6.4] **4.6.** Was the fracture treated? ☐ Yes → Go to question 4.6.1

☐ No → Go to question 4.7

4.6.1. Where was the fracture treated? ☐ In hospital → Go to question 4.6.2

☐ In physician office → Go to question 4.6.3

☐ In home → Go to question 4.6.4

4.6.2. IN HOSPITAL Date: ___ (month) _____ (year)

☐ In emergency clinic OR ☐ In – patient

Hospital name: _____ Length of stay: _____ (days)

Treating doctor: _____

Treatment received: ☐ Surgery ☐ Cast ☐ Other → specify _____

Where did you go when you left the hospital *(Pick one from the list)*

☐ Home

☐ Rehabilitation centre → What was the name? _____

→ How long did you stay? _____ (days)

☐ Convalescent home → What was the name? _____

→ How long did you stay? _____ (days)

☐ Other → specify _____

***** Please repeat the section above for each fracture if more than one *****

In this section I would like to ask you questions that will help us understand how women's hormones relate to bone structure. We ask everyone these questions.

[CO – 5] **5. REPRODUCTIVE HISTORY**

[CO – 5.1] **5.1.** Before menopause, have you ever gone 3 months or more without a menstrual period? *(not including pregnancy or during breastfeeding)*

☐ Yes ☐ No → Go to 5.2

☐ answered in CARMA-ENDO

↓

5.1.1. What was the longest single period of time (months) without a menstrual flow?

_____

5.1.2. If you count all the periods you have missed throughout your menstruating years, how many months would that be? _____ Months

(this question asks for the cumulative time) ☐ Don't know [JLP added]

[CO – 5.2] **5.2.** Have your menstrual periods stopped for more than one year? *(No period one year or more after last menstruation)*

☐ answered in CARMA-CORE

☐ Yes ☐ No → Go to 5.3

↓

At what age? _____ Years

[JLP added] **5.2.1.** For what reason do you think your periods stopped for more than one year?

_____

☐ answered in CARMA-CORE

[C3 – 5.10] **5.3.** Do you or did you ever take **estrogen** for menopause **or for any other reason**?

☐ Yes, currently ☐ No → Go to 5.4

☐ Yes, but not now

☐ answered in CARMA-ENDO

↓

What type(s)?

(Interviewers to show Ogen®, Estrace, CES, Premarin® pills, colours and doses and Estraderm®, Vivelle, Estracomb®, Climara® patches, sizes and doses)

☐ Pill

Pill N°	Number of days/months	Age started	Age stopped	Total # of months taken

If # 25 → specify: (1) _____ specify: (2) _____

☐ Patch

Patch N°	Number of days/months	Age started	Age stopped	Total # of months taken

If # 25 → specify: (1) _____ specify: (2) _____

☐ Injection
How many times / year? _
How many years? _____
What dose? _____ (ml)

☐ Vaginal cream
How many times/week? _ /week
Amount – applicator: ☐ full ☐ ¼ full ☐ ½ full ☐ little bit on my finger

[JLP added] ☐ Vaginal ring (*Estring*®)

[JLP added] ☐ Vagifem dose _____ → *note that there are TWO now*

How many times a week? _____

[C3 – 5.11] **5.4.** Do you or did you ever take Provera® (medroxyprogesterone acetate) for menopause **or for any other reason**?

☐ answered in CARMA-ENDO

☐ Yes, currently ☐ No → Go to 5.5

☐ Yes, but not now

↓

What type(s)? *(Interviewers to show Provera® pills, colours and doses)*

☐ Pill

Pill N°	Number of days/months	Age started	Age stopped	Total # of months taken

If # 25 → specify: (1) _____ specify: (2) _____

☐ Injection
DepoProvera
How many times / year? _____
How many years? _____
What dose? _____ (ml)

[C3 – 5.12] **5.5.** Have you ever taken Prometrium® for menopause **or for any other reason**?

☐ Yes, currently ☐ No → Go to 5.6

☐ Yes, but not now

↓

What type(s)? *(Interviewers to show Progesterone pills, colours and doses)*

☐ Pill

☐ answered in CARMA-ENDO

Pill N°	Number of days/months	Age started	Age stopped	Total # of months taken

[C3 – 5.13] **5.6.** Have you ever been sufficiently bothered by severe acne, unwanted face or body hair to consult a physician for treatment? ☐ Yes ☐ No

↓

At what age? _____ Years

☐ answered in CARMA-ENDO

[CO – 5.7] **5.7.** Have you ever used birth control pills or oral contraceptives?

☐ Yes ☐ No → Go to 5.9

→ Go to 5.8 *(If periods have stopped permanently through natural/surgical menopause)*

☐ answered in CARMA-ENDO

At what age did you start? _____years *(approximately)*

For approximately how long did you use birth control pills?

_____years _____months

Are you still using birth control pills?

☐ Yes ☐ No

↓ ☐ At what age did you stop using birth control pills? _____ Yrs

Go to 5.8

[C5 – 5.6] **5.8.** ***If respondent have ever used birth control pills***

(*consult the participant's information summary sheet or question 5.7 above)*

☐ answered in CARMA-ENDO

Which of the following was the main reason for which you **FIRST** used birth control pills?

☐ 1 Contraception: to prevent pregnancy

☐ 2 To treat premenstrual symptoms

☐ 3 To treat heavy menstrual flow or abnormal bleeding

☐ 4 To treat severe menstrual cramps (*dysmenorrheal*)

☐ 5 To treat irregular or infrequent cramps

☐ 6 To treat acne or unwanted facial or body hair

☐7 N/A

[C3 – 5.5] **5.9.** Have you ever been diagnosed with or treated for infertility, or tried for 2 or more years and been unable to get pregnant?

☐ answered in CARMA-ENDO

☐ Yes ☐ No

↓

What was the reason?

☐ Hormone or ovulation problem

☐ Tubal blockage or abdominal pain

☐ Problem with your partner's fertility

☐ Other, specify _____

[C3 – 5.20] **5.10.** *Night sweats are hot flushes which occur during sleep*.
How often **in the last two weeks**, have you experienced hot flushes during the time when you were sleeping?

☐ answered in CARMA-ENDO

☐ Never → Go to question 6.1

☐ Once or twice

☐ Three to five times

☐ More than five times but less than every night

☐ Once a night

☐ More than once most nights

[C3 – 5.21] **5.11.** If you have experienced any night sweats or night time hot flushes **in the last two weeks**, please grade their usual severity: *(Circle one number)*

☐ answered in CARMA-ENDO

mild warm feeling 1
moderate hot feeling, sweat or flush 2
moderately severe hot feeling often with sweating on half of your body ... 3
a major hot feeling often with sweating on most of your body 4

[JLP added] **5.14.** Do they (night sweats or night time hot flashes) come any <u>particular</u> time in your menstrual cycle?

☐ answered in CARMA-ENDO

☐ Yes ☐ No

↓

When _____

6. FAMILY HISTORY

[C3 – 7.2] **6.1.** Did the following ever occur in your biological parents?

	FATHER			MOTHER		
	YES	NO	DK	YES	NO	DK
Height loss						
Stooping						
Hip fracture						
Wrist fracture						

In this section I will ask you about diet, exercise programs and eating attitudes.

7. PHYSICAL CHARACTERISTICS

[CO – 8.1] **7.1.** What was your **greatest** adult height?

_____ feet _____ inches OR _____ cm ☐ do not know

[JLP added] **7.2.** What was your **greatest** adult waist circumference? (*when not pregnant)*

_____ inches OR _____ cm ☐ do not know ☐ declined

[CO – 8.3] **7.3.** What was your **greatest** adult weight? *(when not pregnant)*

_____ lbs OR _____ kg ☐ do not know

[CO – 8.4] **7.4.** What was your **lowest** adult weight? *(18 years or older)*

_____ lbs OR _____ kg ☐ do not know

[C3 – 8.6] **7.5.** How much did you weigh when you were 18 years old?
Give your best estimate including a range if you can't be specific.

_____ lbs OR _____ kg ☐ do not know

[CO – 8.6] **7.6.** Have you ever lost more than 10 lbs? *(Other than after childbirth, i.e. one year postpartum.)*

☐ Yes ☐ No

↓

Did you regain the lost weight?

☐ Yes ☐ No → How much did you lose? ____lbs OR _____ kg

↓

In your lifetime:

How many times have you lost and regained 10-20 lbs (6-10 kg)? _____

How many times have you lost and regained over 20 lbs (over 10 kg)? _____

Now I will ask you in detail about the foods you eat

[C16 – 10] **8. FOOD INTAKE**

[C16 – 10.1] **8.1.** How often (on the average) have you eaten the following items **during the last 12 months**?

Food		Never	Servings per Month	Servings per Week	Servings per Day	Serving Size	
Milk to drink - (incl. milk flavoured with powder e.g. chocolate)	Not fortified with calcium	(1)	(2)	(3)	(4)	□ 125 ml □ 250 ml □ 375 ml	(0.5 cup) (1 cup) (1.5 cups)
- (incl. commercial choc. milk fortified with calcium)	Fortified with calcium	(1)	(2)	(3)	(4)	□ 125 ml □ 250 ml □ 375 ml	(0.5 cup) (1 cup) (1.5 cups)
Soy beverages to drink	Not fortified with calcium	(1)	(2)	(3)	(4)	□ 125 ml □ 250 ml □ 375 ml	(0.5 cup) (1 cup) (1.5 cups)
	Fortified with calcium	(1)	(2)	(3)	(4)	□ 125 ml □ 250 ml □ 375 ml	(0.5 cup) (1 cup) (1.5 cups)
Other alternative milk to drink (rice or almond milk)		(1)	(2)	(3)	(4)	□ 125 ml □ 250 ml □ 375 ml	(0.5 cup) (1 cup) (1.5 cups)
Milk in cereal	Not fortified with calcium	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)
	Fortified with calcium	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)

Food		Never	Servings per Month	Servings per Week	Servings per Day	Serving Size	
Soy beverage in cereal	Not fortified with calcium	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)
	Fortified with calcium	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)
Other alternative milk in cereal (rice or almond milk)	Not fortified with calcium	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)
	Fortified with calcium	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)
Milk/cream in tea/coffee		(1)	(2)	(3)	(4)	□ 15 ml □ 30 ml □ 60 ml	(1 tbsp) (2 tbsp) (4 tbsp)
Alternative beverage in tea/coffee (soy, rice or almond beverage)		(1)	(2)	(3)	(4)	□ 15 ml □ 30 ml □ 60 ml	(1 tbsp) (2 tbsp) (4 tbsp)
Milk desserts - (e.g. tapioca, rice pudding)	Not fortified with calcium	(1)	(2)	(3)	(4)	□ 125 ml □ 250 ml	(0.5 cup) (1 cup)
- (fortified only applies for homemade desserts)	Fortified with calcium	(1)	(2)	(3)	(4)	□ 125 ml □ 250 ml	(0.5 cup) (1 cup)
Desserts prepared with alternative milk (soy, rice or almond beverage) - (e.g. tapioca, rice pudding) - (homemade desserts prepared with alternative milk)		(1)	(2)	(3)	(4)	□ 125 ml □ 250 ml	(0.5 cup) (1 cup)

Food		Never	Servings per Month	Servings per Week	Servings per Day	Serving Size	
Cream soups prepared with milk		(1)	(2)	(3)	(4)	□ 125 ml □ 160 ml □ 250 ml	(0.5 cup) (2/3 cup) (1 cup)
Cream soups prepared with alternative milk (Soy, rice or almond beverage)		(1)	(2)	(3)	(4)	□ 125 ml □ 160 ml □ 250 ml	(0.5 cup) (2/3 cup) (1 cup)
Ice cream, ice milk or frozen yogurt		(1)	(2)	(3)	(4)	□ 125 ml □ 250 ml □ 375 ml	(0.5 cup) (1 cup) (1.5 cups)
Yogurt to eat or drink	Not fortified with vitamin D	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 200 ml □ 250 ml	(0.25 cup) (0.5 cup) (0.75 cup) (1 cup)
	Fortified with vitamin D	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 200 ml □ 250 ml	(0.25 cup) (0.5 cup) (0.75 cup) (1 cup)
Hard cheese * (in sandwich or mixed dish including frozen meals)		(1)	(2)	(3)	(4)	□ 15 g □ 30 g □ 60 g	(0.5 oz) (1.0 oz) (2.0 oz)
Soft cheese (brie, camembert, goat)		(1)	(2)	(3)	(4)	□ 15 g □ 30 g □ 60 g	(0.5 oz) (1.0 oz) (2.0 oz)
Orange juice	Fortified with calcium	(1)	(2)	(3)	(4)	□ 125 ml □ 160 ml □ 250 ml	(0.5 cup) (2/3 cup) (1 cup)
	Not fortified with calcium	(1)	(2)	(3)	(4)	□ 125 ml □ 160 ml □ 250 ml	(0.5 cup) (2/3 cup) (1 cup)
Canned salmon or sardines with bones*		(1)	(2)	(3)	(4)	□ 30 g □ 60 g □ 90 g	(1 oz) (2 oz) (3 oz)

Food	Servings per				Serving Size	
	Never	Month	Week	Day		
Broccoli	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)
Dark leafy greens (bok choy, kale, gailan (Chinese broccoli), collards, dandelion greens)	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)
Dried beans or peas (navy, pinto, kidney, chick peas, lentil, etc)	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)
White bread, buns, rolls, bagels, etc	(1)	(2)	(3)	(4)	1 serving =	1 slice ½ bagel ½ pita
Whole wheat bread, buns, rolls, bagels, etc	(1)	(2)	(3)	(4)	1 serving =	1 slice ½ bagel ½ pita
Meal replacement drink (1 serving = 235 ml (8 oz)) (e.g. Ensure, Boost, etc)	(1)	(2)	(3)	(4)	1 serving	
Tofu	(1)	(2)	(3)	(4)	□ 60 ml □ 125 ml □ 250 ml	(0.25 cup) (0.5 cup) (1 cup)
Multivitamin**, vitamin D or cod liver oil ** ask about vit. D content	(1)	(2)	(3)	(4)	□ 400 IU □ 2000 IU □ 800 IU □ _____IU □ 1000 IU	
Calcium supplements or 'TUMS'	(1)	(2)	(3)	(4)	□ 200 mg □ 300 mg □ 500 mg	

Now some questions about the beverages you might choose to drink

BEVERAGES

[C16 – 10.2]

8.2. How many of the following drinks did you consume **in the past 12 months**?

One serving is:

- tea or coffee is 6 oz (180 ml)
- cola is 12 oz – 1 can (355 ml)
- energy drink – 8 oz (235 ml)
- 1 bottle or can of beer or a glass of draft (12 oz)
- 1 straight or mixed drink with (1 – 1 ½ oz) hard liquor
- 1 glass of wine or a wine cooler (4-5 oz)

Beverages				**Servings per**	
		Never	**Month**	**Week**	**Day**
Coffee	Caffeinated	(1)	(2)	(3)	(4)
	Decaffeinated	(1)	(2)	(3)	(4)
Tea	Caffeinated	(1)	(2)	(3)	(4)
	Decaffeinated	(1)	(2)	(3)	(4)
Colas	Caffeinated	(1)	(2)	(3)	(4)
	Decaffeinated	(1)	(2)	(3)	(4)
Energy drink (e.g. Monster, Nos, Red Bull, Rockstar)		(1)	(2)	(3)	(4)
Alcoholic beverages		(1)	(2)	(3)	(4)

In this section I will ask you about your physical activities and exercise.

[CO – 11] **9. PHYSICAL ACTIVITY**

[CO – 11.1] **9.1.** During a typical week in the past 6 months, how much time did you usually spend walking to work or school or while doing errands?

☐ None
☐ Less than 1 hour
☐ Between 1 – 5 hours
☐ Between 6 – 10 hours
☐ Between 11 – 20 hours
☐ More than 20 hours

[CO – 11.2] **9.2.** Which of the following describes the paid work you usually do or what you consider your job? Or if retired or unemployed, which best describes your *(past or longest)* job?

☐ I am usually sitting during the day and do not walk around much
☐ I stand or walk quite a lot during the day but don't lift or carry heavy things
☐ I usually lift or carry light loads or I often have to climb stairs or hills
☐ I do heavy work or have to carry loads
☐ Never employed

[CO – 11.3] **9.3.** Do you currently participate in any regular physical activity or programme *(either on your own or in a formal class)*?

☐ Yes ☐ No
↓
How many times a week? _____
How long per session? _____ hours _____ minutes

[CO – 11.4] **9.4.** On the average, during the last year, how many hours **in a week** did you spend in the following activities?

	Never	**½ - 1 hour**	**2 - 3 hours**	**4 - 6 hours**	**7 - 10 hours**	**11 - 20 hours**	**21 - 30 hours**	**31 + hours**
STRENUOUS SPORTS (such as jogging, bicycling on hills, tennis, racquetball, swimming laps, aerobics)								
VIGOROUS WORK (such as moving heavy furniture, loading or unloading trucks, shoveling, weight lifting or equivalent manual labour)								
MODERATE ACTIVITY (such as housework, brisk walking, golfing, bowling, cycling on level ground, gardening)								

[CO – 11.5] **9.5.** On the average, during the last year, how many hours **in a day** did you spend in the following sitting activities?

	Never	Less than 1 hour	1 – 2 hours	3 – 4 hours	5 – 6 hours	7 – 10 hours	11 hours or more
Sitting in car or bus							
Sitting at work							
Watching TV							
Sitting at meals							
Other sitting activities (such as reading, playing cards, sewing, sitting at the computer for leisure)							

WE ARE INTERESTED IN KNOWING ABOUT YOUR SLEEP

[CO – 11.6] **9.6.** On the average, during the last year, how many hours in a day did you sleep *(include naps)*?

☐ 5 hours or less ☐ 7 hours ☐ 9 hours

☐ 6 hours ☐ 8 hours ☐ 10 hours or more

[C3 – 6.3] **9.6.1.** Have you ever been repeatedly *(many times)* bothered by the following:
(Check each of the items that applies)

Waking early ..... ☐ Yes ☐ No

Night time wakening ..... ☐ Yes ☐ No

Problems falling asleep ..... ☐ Yes ☐ No

Now I want to ask you a question about being in the sunlight

[CO – 12] **10. SUNLIGHT EXPOSURE**

[CO – 12.1] section A only **10.1.** Did you ever expose a considerable part of your body to direct sunlight, *without sunscreen*?

A. During the past 12 months?

☐ never
☐ seldom
☐ regularly
☐ often

*Now I would like to ask you how your health has been on the average, **over the past week**. I will ask you about different areas of general health. For some of the questions, I want you to tell me which statement most closely describes how you felt.*

[CO – 13] **11. TORRANCE HEALTH UTILITIES INDEX**

INTERVIEWER ADMINISTERED VERSION

11.1. Are you able to see well enough without glasses or contact lenses to read ordinary newsprint?

☐ Yes → Go to 11.3 ☐ No

11.2. If not, which of the following describes your **usual** ability to see well enough to read ordinary newsprint? Are you:

A Able to see well enough but with glasses or contact lenses.
B Unable to see well enough even with glasses or contact lenses.
C Unable to see at all.

11.3. Are you able to see well enough without glasses or contact lenses to recognize a friend on the other side of the street?

☐ Yes → Go to 12 ☐ No

11.4. If not, which one of the following best describes your **usual** ability to see well enough to recognize a friend on the other side of the street? Are you:

A Able to see well enough but with glasses or contact lenses.
B Unable to see well enough even with glasses or contact lenses.
C Unable to see at all.

[CO – 14] **12. RAND HEALTH SCIENCE PROGRAM (SF-36)**

12.1. In general, would you say your health is: *(Circle one number)*

Excellent 1
Very good 2
Good 3
Fair 4
Poor 5

12.2. Compared to one year ago, how would you rate your health in general now?

(Circle one number)

Much better than one year ago 1
Somewhat better now than one year ago 2
About the same 3
Somewhat worse now than one year ago 4
Much worse now than one year ago 5

12.3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? *(Circle one number on each line)*

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.	1	2	3
Moderate activities, such as moving a table, vacuuming, bowling or playing golf.	1	2	3
Lifting or carrying groceries.	1	2	3
Climbing several flights of stairs.	1	2	3
Climbing one flight of stairs.	1	2	3
Bending, kneeling or stooping.	1	2	3
Walking more than one mile.	1	2	3
Walking several blocks.	1	2	3
Walking one block.	1	2	3
Bathing or dressing yourself.	1	2	3

12.4. During the past 4 weeks, have you had any of the following problems with your work or regular daily activities as a result of your physical health?

(Circle one number on each line)

	YES	NO
Cut down the amount of time you spent on work or other activities.	1	2
Accomplished less than you would have liked.	1	2
Were limited in the kind of work or other activities.	1	2
Had difficulty performing the work or other activities (for example, it took extra effort).	1	2

12.5. During the past 4 weeks, have you had any of the following problems with your work or regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? *(Circle one number on each line)*

	YES	NO
Cut down the amount of time you spent on work or other activities.	1	2
Accomplished less than you would have liked.	1	2
Didn't do work or other activities as carefully as usual.	1	2

12.6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

(Circle one number)

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

12.7. How much bodily pain have you had **during the past 4 weeks**? *(Circle one number)*

None 1
Very mild 2
Mild 3
Moderate 4
Severe 5
Very severe 6

12.8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? *(Circle one number)*

Not a bit 1
A little bit 2
Moderately 3
Quite a bit 4
Extremely 5

12.9. 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 past 4 weeks… *(Circle one number on each line)*

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of pep?	1	2	3	4	5	6
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Do you have a lot of energy?	1	2	3	4	5	6
Have you felt downhearted and blue?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired?	1	2	3	4	5	6

12.10. How TRUE or FALSE is **each** of the following statements for you?

(Circle one number on each line)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
I seem to get sick a little easier than other people.	1	2	3	4	5
I am as healthy as anybody I know.	1	2	3	4	5
I expect my health to get worse.	1	2	3	4	5
My health is excellent.	1	2	3	4	5

INTERVIEWER'S ASSESSMENT

As an interview my assessment of the process and the respondent was:

(Circle one number on each line)

	Not at all	Not much	Moderate	Somewhat	A great deal
The respondent appeared or seemed interested in the research	1	2	3	4	5
The respondent seemed to cooperate with me	1	2	3	4	5
I believe that the respondent understood the questions	1	2	3	4	5
I believe that the respondent listened well	1	2	3	4	5
I perceived that the respondent was restless or wanted to hurry the process	1	2	3	4	5
The respondent expressed feelings of tiredness during the interview	1	2	3	4	5

The respondent required assistance with the Rand SF-36?

☐ Yes ☐ No

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Time finished _____ hrs _____ min