

LILACS NZ



# Life and Living in Advanced Age; a Cohort Study in New Zealand

## Te Puāwaitanga o Ngā Tapuwae Kia Ora Tonu

<b>1. CONTACT DETAILS .....</b>	<b>7</b>
<b>2. PERSONAL HISTORY .....</b>	<b>9</b>
ETHNICITY	9
LANGUAGE AND CULTURE	11
RELIGION	12
MODIFIED MINI MENTAL STATE EXAMINATION (3MS)	13
CLOCK DRAWING	15
FAMILY LIFE / CHILDREN	19
EDUCATION / OCCUPATION	21
<b>3. PHYSICAL HEALTH .....</b>	<b>25</b>
SF-12	25
NOTTINGHAM EXTENDED ACTIVITIES OF DAILY LIVING	27
MANCHESTER RESPIRATORY ACTIVITES OF DAILY LIVING	28
<b>4. MEDICAL HISTORY .....</b>	<b>30</b>
MEDICATIONS	30
MEDICAL CONDITIONS	33
SMOKING	33
SLEEP	34
FRACTURES	34
FALLS	36
PAIN	37
<b>5. NUTRITION .....</b>	<b>39</b>
TEETH	39
SCREEN II (14 items)	39
ALCOHOL CONSUMPTION	42
<b>6. MENTAL HEALTH .....</b>	<b>43</b>
GERIATRIC DEPRESSION SCALE (15-items)	43
<b>7. LIFE SKILLS .....</b>	<b>44</b>
LIFE SATISFACTION	44
COPING	44
PERCEIVED CONTROL	45
<b>8. SUPPORT NEEDS .....</b>	<b>46</b>
VISITS TO HEALTH PROFESSIONALS	46
HEARING/VISION	47
SOCIAL SUPPORT	47
<b>9. PHYSICAL PERFORMANCE MEASURES .....</b>	<b>50</b>
SHORT PHYSICAL PERFORMANCE BATTERY	50
<b>10. HOUSING AND ENVIRONMENT .....</b>	<b>53</b>
RESIDENTIAL ENVIRONMENT	54
NEIGHBOURHOOD	56

PHYSICAL ENVIRONMENT	57
<b>11 EVERYDAY INTERESTS AND ACTIVITIES.....</b>	<b>58</b>
TRANSPORT	61
ROLES	62
TECHNOLOGY	63
<b>12. FINANCIAL SITUATION .....</b>	<b>64</b>
STANDARD OF LIVING	65
FOOD SECURITY	65
<b>13. RESPECT.....</b>	<b>67</b>
<b>14. OVERALL VIEWS ABOUT GROWING OLDER .....</b>	<b>68</b>
<b>THANK YOU .....</b>	<b>69</b>



# Visit record form

Interview No.  Date: (dd mm yyyy)   .   .

Start Time: (24 hour time)      
 Finish Time: (24 hour time)

Who provided the responses to this questionnaire?   
 1 = Participant      2 = Family member      3 = Other .....

Reason for proxy completing questionnaire .....

If a proxy completed the questionnaire, who answered most of the questions?   
 1 = Participant told proxy the answers      2 = Proxy used their own judgement

Place of interview:   
 1 = Residence      2 = Health centre      3 = Other .....

Language used to answer questions:   
 1 = English      2 = Te reo Māori/ bilingual      3 = Other .....

Humidity   .  %  
 Temperature   .  °C      Time taken (24 hour time)

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Humidity   .  %

Temperature   .  °C      Time taken (24 hour time)

# Life and Living in Advanced Age; a Cohort Study in New Zealand

## Te Puāwaitanga o Ngā Tapuwae Kia Ora Tonu



*Get NHI from GP clinic if not known*

NHI No:

Interviewer: .....

Date: (dd /mm /yyyy)  /  /

***Must get date of birth and ensure eligibility before starting interview***

Date of birth? (dd /mm /yyyy)  /  /

## 1. Contact Details

Name .....  
Address .....  
..... Phone .....

Could we please have the name and address of two people we could contact if we couldn't get hold of you (if, for example, you had moved or were away)?

Name .....  
Address .....  
..... Phone .....  
Relationship .....

***Different household for second contact if possible***

Name .....  
Address .....  
..... Phone .....  
Relationship .....



Site:

Interviewer: .....

## 2. Personal History

AA1. I'd like to check that I have the details of your GP correct please tell me your GP's name and address:

GP Name .....  
 GP Practice .....  
 .....  
 ..... Phone .....

AA2. Gender 1 = Male 2 = Female

AA3. Who do you live with most of the time?

- 1 = alone 2 = with spouse/partner only
- 3 = with spouse and child/other relative 4 = with spouse and non relatives
- 5 = with child (not spouse)
- 6 = with other(s) not spouse or children Who? .....

AA3a. <u>If not living alone</u> , how many people, including you, are currently living in your residence/ household?	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
OR		
AA3b. <u>If living alone</u> , how long have you lived alone	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>

AA4. What best describes your home?

- 1 = private dwelling, stand alone house 2 = private unit or apartment - independent
- 3 = unit or apartment on site with family dwelling
- 4 = retirement village - villa or own unit 5 = rest home
- 6 = private hospital (own or shared room) 7 = marae or iwi based housing
- 8 = other.....

### ETHNICITY

AB1. What country were you born in?

- 1 = New Zealand (*Go to AB2*) 2 = Australia 3 = England 4 = Scotland
- 5 = China (People's Republic of) 6 = South Africa 7 = Samoa 8 = Cook Islands
- 9 = Other (print the present name of the country) .....

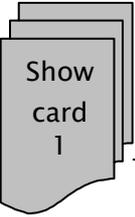
AB1a. If not born in New Zealand, when did you first arrive to live in New Zealand?

Month		Year			
<i>(if known e.g. 11)</i>		<i>(e.g. 1945)</i>			

**AB2. Which ethnic group(s) do you belong to?**

(read all options and mark answers with 0 = No 1 = Yes)

New Zealand European	<input type="checkbox"/>	Maori	<input type="checkbox"/>	Samoan	<input type="checkbox"/>
Cook Island Māori	<input type="checkbox"/>	Tongan	<input type="checkbox"/>	Niuean	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Other European	<input type="checkbox"/>
Other, such as Japanese, Tokelauan (state) .....					



**AB3. How much do you disagree or agree with this statement:**

I have a strong sense of belonging to my own ethnic group(s)

Strongly disagree	Disagree	Neutral	Agree	Strongly agree	<input type="checkbox"/>
0	1	2	3	4	

**AB4. Do you have any Maori ancestors?** 0 = No (Go to AB5) 1 = Yes

AB4a. Was your birth Mother born Maori? 0 = No 1 = Yes

AB4b. For the most part did she live as Maori? 0 = No 1 = Yes

AB4c. Was your birth father born Maori? 0 = No 1 = Yes

AB4d. For the most part did he live as Maori? 0 = No 1 = Yes

AB4e. Was your father's mother born Maori? 0 = No 1 = Yes

AB4f. For the most part did she live as Maori? 0 = No 1 = Yes

AB4g. Was your father's father born Maori? 0 = No 1 = Yes

AB4h. For the most part did he live as Maori? 0 = No 1 = Yes

AB4i. Was your mother's mother born Maori? 0 = No 1 = Yes

AB4j. For the most part did she live as Maori? 0 = No 1 = Yes

AB4k. Was your mother's father born Maori? 0 = No 1 = Yes

AB4l. For the most part did he live as Maori? 0 = No 1 = Yes

**AB5. Have you ever been to a Marae?** 0 = No (Go to AB6) 1 = Yes

**AB5a. If yes how often over the last 12 months**

Once	A few times	Several times	More than once a month	<input type="checkbox"/>
1	2	3	4	

This question considers your contacts with people:

**AB6. In general, would you say that your contacts are with**

Mainly Māori	Some Māori	Few Māori	No Māori	<input type="checkbox"/>
1	2	3	4	



**AC3a. Where do you speak Māori/other language?**

0 = No 1 = Yes

Don't speak it

On the marae

In my community

At home

In meetings or at work (includes volunteer work )

Don't speak it anywhere

Other.....

**AC3b. Do you seek out opportunities to listen to Māori/other language?**

0 = No (Go to AC4) 1 = Yes

**AC3c. If yes, how often do you seek out opportunities to listen to Māori/other language?**

every day	every week	every month	occasionally	
1	2	3	4	<input type="checkbox"/>

All to answer

Show card 2

	Not at all	A little	Moderately	Very	Extremely	
<b>AC4. How important is your language and culture to your wellbeing?</b>	1	2	3	4	5	<input type="checkbox"/>
<b>AC5. Thinking about the values that you have, how important are your values to your wellbeing?</b>	1	2	3	4	5	<input type="checkbox"/>

**RELIGION**

**AD1. What is your religion/denomination? (Select up to three)**

a.   
 b.   
 c.

0 = No religion

1 = Anglican

2 = Catholic

3 = Presbyterian

4 = Methodist

5 = Ratana

6 = Ringatu

7 = Destiny

8 = Paimarire

9 = Mormon/Latter Day Saints

21 = Hindu

22 = Muslim

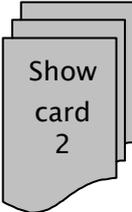
23 = Jewish

24 = Other religion/denomination.....

30 = Object to answering this question

**AD2. How important is faith to your wellbeing?**

Not at all	A little	Moderately	Very	Extremely	
0	1	2	3	4	



**MODIFIED MINI MENTAL STATE EXAMINATION (3MS)**

I'd like to ask some questions that measure your attention, memory and ability to understand instructions. Some of the questions will be easy; others may be more difficult.

*Interviewer: Even if a proxy is in attendance, remember to ask this section of the participant themselves. Remind them they do not have to answer all the questions. Use the next page to help answer AE12, AE13, AE14 and the Clock Drawing Test*

**AE1. When were you born?  
Where were you born?**

Year	/1
Month	/1
Day	/1
Town	/1
Province/Region	/1

*(Score 1 point for each correct answer)*

**AE2. I would like to test your memory. I am going to say 3 words. Repeat them after I have said all three. Now keep those words in mind. I'm going to ask you to say them again in a few minutes.**

shirt	/1
brown	/1
honesty	/1

*(When repeating back, allow up to 6 tries to remember, score 1 point for each correct answer)*

**AE3. Please count from 1 to 5. Now count backwards from 5 to 1.**

/2
----

*(Accurate – score 2; 1 or 2 errors – score 1)*

**AE4. Please spell the word 'WORLD' backwards.**

D	/1
L	/1
R	/1
O	/1
W	/1

*(Give only one chance, score 1 point for each letter in correct order)*

**SUB SCORE**

/15
-----

**AE5. Please repeat back the three words I asked you to remember.**

shirt	/3
brown	/3
honesty	/3

*(For each word: spontaneous recall – score 3, prompt – score 2, multiple choice – score 1)*

**AE6. What year is this?** (Accurate = 8, miss by 1 = 4, miss by 2-5 = 2) Year   
**What season is it?** (Accurate or within 1 month = 1) Season   
**What month is it?** (Accurate or within 5 days = 2, miss by 1 month = 1) Month   
**What is the date?** (Accurate = 3, miss by 1-2 days = 2, miss by 3-5 days = 1) Date   
**What day of the week is it?** (Accurate = 1) Day

**SUB SCORE**

**AE7. Where are we now?** (Or what room are we in?) (Accurate - score 1) Room   
**What region are we in?** (Accurate - score 2) Province/Region   
**What district is this?** (Accurate - score 1) District   
**What city (town) is this?** (Accurate - score 1) City

**AE8. What is this?** pencil   
*(Point to the item or body part. Score 1 for each correct answer, approximate answers such as 'pen', 'arm', 'hand' are not acceptable)* watch   
 shoulder   
 elbow   
 knuckle

**SUB SCORE**

**AE9. You have thirty seconds to answer this next question. Naming as many as you can, what animals have 4 legs?**   
*(1 point each. Discontinue after 30 seconds)*  
 .....  
 .....  
 .....

**SUB SCORE**

**AE10. In what way are an arm and a leg alike?** e.g. Body part, limb   
**In what way are laughing and crying alike?** e.g. feeling, emotion   
**In what way are eating and sleeping alike?** e.g. essential for life

*(Accurate - score 2 each example, less correct - score 1 for each)*

**AE11. Please repeat the following - "no ifs, ands or buts"** correct   
*Allow only 1 trial*

*Write "Close your eyes" on a piece of paper large enough for the respondent to see clearly*

**AE12. Please read this and do what it says.**   
*(Obeys without prompt - score 3, prompt - score 2, can read aloud and obey - score 1)*

AE13. Please write a sentence – it can say anything you like.

/5

*The sentence must contain a subject, a verb and be sensible. Correct grammar and punctuation are not necessary. Prompts permitted if necessary. Score 5 for a complete sentence.*

SUB SCORE  /19

AE14. Please copy this drawing exactly as it is. (*Ignore tremor and rotation*)

/10

- *For each figure: approximately equal sides = 4, 5 unequal sides = 3, other enclosed figure = 2, 2 or more lines = 1)*
- *4 corner enclosure: 4 corners = 2, not 4 corners = 1 or 0*

*Hold out a piece of paper (use the blank side of diagram page) to the participant.*

R hand  /1

AE15. Take this paper in your right hand, fold it in half, and hand it back to me

fold  /1

floor  /1

AE16. What three words did I ask you to remember earlier?

shirt  /3

brown  /3

honesty  /3

*(Spontaneous recall = 3, prompt = 2, multiple choice = 1)*

SUB SCORE  /22

TOTAL 3MS SCORE  /100

**CLOCK DRAWING**

AE17. Please imagine this circle is a clock. I would like you to place the numbers in the correct position then place the hands to indicate a time of ‘ten past eleven’

0 = No errors

1 = minor spacing errors

2 = other errors

Comments .....

.....

.....

***For participants who score ...72/100 or less on the 3MS, and a proxy is not already helping with the questionnaire:***

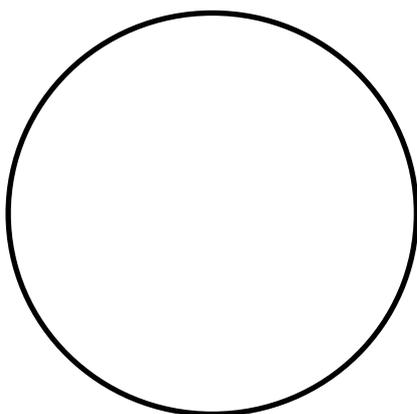
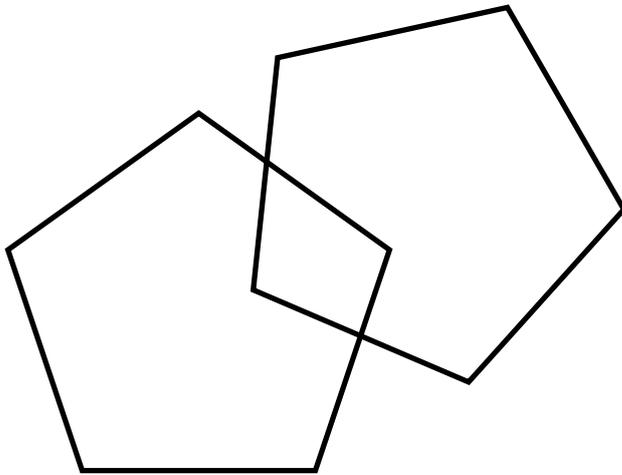
- 1. Go straight to Physical Performance Measures p. 49*
- 2. Find out who might be able to help answer the questions*
- 3. Contact Project Coordinator to discuss the need for a proxy*



*Tear along dotted line*

Please write a sentence about anything.

.....  
.....  
.....  
.....





**FAMILY LIFE / CHILDREN**

The next questions are about your upbringing, your family and your ancestry.

**AF1. Who raised you?**

- 1 = Parent(s)                      2 = Grand parent(s)                      3 = Aunt /Uncle                      4 = Brother/sister
- 5 = Other relative                      6 = Non-relative                      7 = Community
- 8 = Foster home/ orphanage                      9 = Other .....

**Ask Maori only**

**AF2. Are you whangai?**

0 = No    1 = Yes

*All to answer*

**AF3. Are you adopted?**

0 = No    1 = Yes

**AF4. How old was your birth mother when she died?**

Age

**AF5. How old was your birth father when he died?**

Age

I would now like to ask about your brothers, sisters and children. For each member of your family I would like to ask:

- Whether they are alive or dead
- If alive, what age they are now
- Or if they have died, how old they were when they died

Don't worry if you can't remember exact ages, it doesn't matter if you get it wrong by a few years.

The first few questions are about your brothers and sisters. Please include any brothers and sisters who grew up with you in the same household, whether they were full brothers and sisters, half brothers and sisters, adopted or fostered.

**AF6. How many brothers currently living do you have?**

**AF7. How many brothers have died?**

**AF8. How many sisters currently living do you have?**

**AF9. How many sisters have died?**

#	Their Age	<input type="text"/>				
#	Ages died	<input type="text"/>				
#	Their Age	<input type="text"/>				
#	Ages died	<input type="text"/>				

The next questions ask about your children, grandchildren and great-grandchildren. They may have been born and raised by yourself or others; you may have adopted them or they could be step children.

**AF10. Have you ever had children?**

0 = No **(Go to AF16)**    1 = Yes

**AF11. How many sons currently living do you have?**

**AF12. How many sons have died**

**AF13. How many daughters currently living do you have?**

**AF14. How many daughters have died?**

#	Their Age	<input type="text"/>				
#	Ages died	<input type="text"/>				
#	Their Age	<input type="text"/>				
#	Ages died	<input type="text"/>				

AF15. Are there any other children you completely lost contact with? 0 = No 1 = Yes   
 AF15a. How many?

AF16. Do you have grandchildren? 0 = No 1 = Yes   
 AF16a. How many grandchildren do you have?

AF17. Do you have great grandchildren? 0 = No 1 = Yes   
 AF17a. How many great grandchildren do you have?

AF18. Do you have great great grandchildren? 0 = No 1 = Yes   
 AF18a. How many great great grandchildren do you have?

*If AF16, AF17 and AF18 are 'No' Go to AF20*

AF19. How do you currently contribute to the development of your grandchildren or great grandchildren? 0 = No 1 = Yes

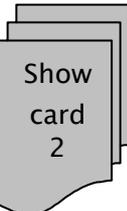
<i>Financial contributions</i>	<input type="checkbox"/>
<i>Occasional support</i>	<input type="checkbox"/>
<i>Shared parenting</i>	<input type="checkbox"/>
<i>I am raising grandchildren as a parent</i>	<input type="checkbox"/>
<i>I teach them my first language</i>	<input type="checkbox"/>
<i>Emotional support/Love</i>	<input type="checkbox"/>
<i>Other .....</i>	<input type="checkbox"/>

AF20. How far away in distance does your nearest: (record one for each line)

	Same house / within 1 ½ km	1 ½ - 8 km	8 - 25 ½ km	25 ½ - 80 km	80+ km/ overseas	Not applicable or none living	
a. Child live?	1	2	3	4	5	6	<input type="checkbox"/>
b. Brother or sister live?	1	2	3	4	5	6	<input type="checkbox"/>
c. Relative live? (not including your spouse/child/siblings)	1	2	3	4	5	6	<input type="checkbox"/>

AF21. How important is your whanau/family to your wellbeing?

Not at all	A little	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>



AF22. What is your current marital status?

I have never been married/partnered <i>(Go to AG1)</i>	Married/ partnered <i>(Go to AF22a)</i>	Widow/Widower <i>(Go to AF22b)</i>	Separated <i>(Go to AF22c)</i>	Divorced <i>(Go to AF22c)</i>	
1	2	3	4	5	<input type="checkbox"/>

AF22a. If married/ partnered, how many years have you been married?    
*(Go to AF24)*

OR

AF22b. If widowed, how many years have you been widowed?

OR

AF22c. If separated/divorced, how many years have you been separated/divorced?

AF23. How long were you married/living together before being widowed/divorced/separated? *(Go to AF25)* Years

AF24. Have you had any relationships prior to the current relationship you have just described?   
 0 = No *(Go to AF26)* 1 = Yes

**AF25.** We are interested in your previous significant relationships if you have had any. You have told me about your current relationship status. Now I would like to ask you about any previous relationships you have had in your life. I will ask you to give me the year a relationship began and when it ended and then how it ended. Its alright if you cannot remember the exact years, just do your best to estimate. *(If they cannot recall the exact years, but they can recall the number of years please make note of that in the comments section, just make sure that they have either the dates or the total number of years).*

Year Beginning	Year Ended	Total Number of Years	Result (Separated, Widowed, Divorced)

**AF26.** How important have your marriage(s)/partnership(s) been to your wellbeing?

Not at all	A little	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**EDUCATION / OCCUPATION**

The next questions ask about your education and the work you've done, both paid and unpaid.

AG1. How old were you when you started school? Years

AG2. How old were you when you left school?

Years

AG3. What is your highest education level?

Primary school or no schooling <i>(Go to AG5)</i>	secondary school, no qualification <i>(Go to AG5)</i>	secondary school qualification <i>(Go to AG5)</i>	trade, occupational <i>(Go to AG5)</i>	tertiary qualification
0	1	2	3	4 <input type="text"/>

AG4. For how many years were you in full time higher education?

Years

AG5. What was your MAIN lifetime occupation? .....

*(Answer should be very specific, for example nurse, teacher, main occupation is what your work was for the most years, paid or unpaid)*

*If never married/partnered go to AG7*

AG6. What was your spouse's/partner's MAIN lifetime occupation? *(Answer for the partner married to for the longest time)* .....

*(Answer should be very specific, for example nurse, teacher)*

AG7. Are you in paid work now?

0 = No *(Go to AG8)*    1 = Yes

AG7a. What work do you do now? .....

AG7b. How are you paid?

Formal - wages/ casual contract/meeting fees

Informal - cash in hand, koha, vouchers, gifts

Other

AG8. Have you retired from paid work at any time?

0 = No *(Go to AG9)*    1 = Yes

AG8a. What age did you first retire?

AG8b. What was the MAIN reason you retired?

1 = Eligible for national superannuation

2 = Poor health

3 = Family responsibilities

4 = Redundancy

5 = Community responsibilities

6 = Compulsory

7 = Other .....

AG9. Do you do any unpaid/voluntary work outside the household now?

0 = No *(Go to AG10)*    1 = Yes

AG9a. What work do you do? .....

*If NOT in either paid or unpaid work now go to AG12*

**AG10. During the past 7 days, did you work for pay or as a volunteer?**

Neither <i>(Go to AG11)</i>	Yes, for pay	Yes, as a volunteer	Yes, both for pay and as a volunteer	
1	2	3	4	<input type="checkbox"/>

**AG10a. How many hours per week did you work for pay or as a volunteer?**

a. Hours per WEEK worked for pay

b. Hours per WEEK worked as a volunteer

TOTAL hours per WEEK

**AG10b. Which of the following categories best describes the amount of physical activity required on your job/volunteer work?**

*(answer this for the job you do spend most hours doing)*

1 = Mainly sitting with slight arm movements. (E.g. office worker, watchmaker, seated, assembly worker, bus driver).

2 = Sitting or standing with some walking. (E.g. cashier, general office worker).

3 = Walking, with some handling of materials weighing less than 50 pounds/20kg. (E.g. postie, waiter / waitress).

4 = Walking and heavy manual work often requiring handling of materials weighing over 50 pounds/20kg. (E.g. forestry, farm or general labourer).

**AG11. If you haven't worked for pay or as a volunteer in the last week, how many hours in the last month?**

a. Hours per MONTH worked for pay

b. Hours per MONTH worked as a volunteer

TOTAL hours per MONTH

*If no spouse/partner, or if the spouse/partner is not living with the participant Go to AG14*

**AG12. If you have a current spouse/partner that you live with, is your spouse/partner in paid work now?** 0 = No *(Go to AG13)* 1 = Yes

**AG12a. How are they paid?**

Formal - wages/ casual contract/meeting fees

Informal - cash in hand, koha, vouchers, gifts

Other

**AG13. Has your spouse retired from paid work?** 0 = No *(Go to AG14)* 1 = Yes

**AG13a. What age did your spouse first retire?**

**AG13b. What was the MAIN reason they retired?**

- 1 = Eligible for national superannuation
- 2 = Poor health
- 3 = Family responsibilities
- 4 = Redundancy
- 5 = Community responsibilities
- 6 = Compulsory
- 7 = Other .....

**AG14. What are your sources of income?**

(0 = No 1 = Yes)

10 = Don't know	
1 = NZ Superannuation	
2 = Superannuation from other sources e.g. work, overseas schemes	
3 = Other NZ pensions e.g. war pension	
4 = Tribal trust/land	
5 = Inheritance	
6 = Investments	
7 = Salary/wage	
8 = Support from family	
9 = Other financial support .....	

**AG15. Out of these, which is your main source of income?**

(Write the number from the answers above)

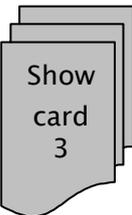
### 3. Physical Health

**SF-12**

These next questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. If you are unsure about how to answer a question, please give the best answer you can.

**BA1. In general, would you say your health is:**

Excellent	Very Good	Good	Fair	Poor	
1	2	3	4	5	<input type="checkbox"/>

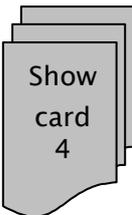


**BA2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

	Yes, limited a lot	Yes, limited a little	No, not limited at all	
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3	<input type="checkbox"/>
b. Climbing several flights of stairs	1	2	3	<input type="checkbox"/>

**BA3. During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	
a. Accomplished less than you would like	1	2	4	5	6	<input type="checkbox"/>
b. Were limited in the kind of work or other activities	1	2	4	5	6	<input type="checkbox"/>



**BA4. During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	
a. Accomplished less than you would like	1	2	4	5	6	<input type="checkbox"/>
b. Did work or activities less carefully than usual	1	2	4	5	6	<input type="checkbox"/>

**BA5** 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**.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	
a. Have you felt calm and peaceful?	1	2	4	5	6	<input type="checkbox"/>
b. Did you have a lot of energy?	1	2	4	5	6	<input type="checkbox"/>
c. Have you felt downhearted and depressed?	1	2	4	5	6	<input type="checkbox"/>

**BA6.** During the **PAST 4 WEEKS**, how much did **PAIN** interfere with your normal work (including both work outside the home and housework)?

Not at all	Slightly	Moderately	Quite a bit	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**BA7.** During the **PAST 4 WEEKS**, how much of the time has your **PHYSICAL HEALTH OR EMOTIONAL PROBLEMS** interfered with your social activities (like visiting with friends, relatives, etc)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time	
1	2	3	4	5	<input type="checkbox"/>

Show card 4

The next questions ask about conditions you have had for 6 months or more

**BB1.** Does a **HEALTH PROBLEM**, or a condition you have (lasting **SIX MONTHS** or more) cause you difficulty with, or stop you doing:

0 = No 1 = Yes

- Everyday activities that people your age can usually do
- Communicating, mixing with others or socialising
- Any other activity that people your age can usually do
- No difficulty with any of these

**BB2.** Do you have any **DISABILITY** or **HANDICAP** that is long-term (lasting six months or more)?

0 = No 1 = Yes

**BB3.** In general, compared with other people your age, would you say your health is:

Excellent	Very Good	Good	Fair	Poor	
1	2	3	4	5	<input type="checkbox"/>

Show card 3

**NOTTINGHAM EXTENDED ACTIVITIES OF DAILY LIVING**

The next questions ask about a few more common everyday activities. For each question please tell me whether you do the activity on your own, on your own with difficulty, with help from someone else, or whether you don't do the activity at all. We are interested in whether you actually **DONE** the activity in the last few weeks, not whether you **CAN** do it.

*Interviewer: ask all the questions first. Then go back to all activities the person said they have help to do. For each activity they said they have help to do, find out who helps.*

Help received from....

Scoring:

0 = No

1 = with help ->

2 = on my own; on my own with difficulty

Someone in the same household	Family outside the household	Others
-------------------------------------	------------------------------------	--------

		Someone in the same household	Family outside the household	Others
<b>BC1. Mobility</b>				
a. Do you walk around outside?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you climb stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you get in and out of the car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you walk over uneven ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you cross roads?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Do you travel on public transport?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BC2. In the kitchen</b>				
a. Do you manage to feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you manage to make yourself a hot drink?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you take hot drinks from one room to another?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you do the washing up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you make yourself a hot snack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BC3. Domestic tasks</b>				
a. Do you manage your own money when you are out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you wash small items of clothing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you do your own housework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you do your own shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you do a full clothes wash?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BC4. Leisure activities</b>				
a. Do you read newspapers or books?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you use the telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you write letters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you go out socially?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you manage your own garden?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Do you drive a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BC5. Other</b>				
a. Do you manage your personal care for instance brushing your teeth and hair, washing your hands and face?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you manage to go to the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you get in/out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you shower/bath yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you dress yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Now I'd like to know about household activities you've done over the last 7 days

**BC6. During the past 7 days, did you engage in any of the following activities?** (Please answer Yes or No for each item).

0 = No 1 = Yes

- a. Any light housework, such as dusting or washing dishes
- b. Heavy housework or chores, such as vacuuming, scrubbing floors, washing windows or carrying wood
- c. Home repairs like painting, wall papering, electrical work etc.
- d. Lawn work or yard care, including snow or leaf removal, wood chopping, etc.
- e. Outdoor gardening
- f. Caring for another person, such as children, dependent spouse or another adult.

**MANCHESTER RESPIRATORY ACTIVITES OF DAILY LIVING**

The next questions are about activities you may have trouble with due to your breathing. They are designed to give us a better idea of how breathing problems affect you in your daily life. Over the last 2 weeks, For each question please tell me whether you do the activity on your own, on your own with difficulty, with help from someone else, or whether you don't do the activity at all.

Help received from....

Scoring:

0 = No

1 = with help

2 = on my own; on my own with difficulty

Someone in the same household    Family outside the household    Others

**BD1. Manchester**

<b>a. Do you bend over from standing?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. Do you lift something off a shelf which is above your shoulder height?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>c. Do you do general housework?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>d. Do you wash and dry yourself?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>e. Do you have a bath?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**BD2. Do you have to eat more slowly than you would like?**

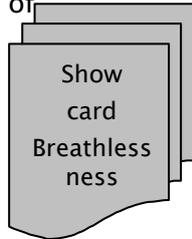
Much more slowly	Quite a lot more slowly	A little more slowly	Not at all more slowly	<input type="checkbox"/>
0	1	2	3	

**BD3. Does your breathing keep you awake at night?**

Most of the night	For 1-2 hours	For up to ½ hour	Not at all	<input type="checkbox"/>
0	1	2	3	

I'm going to ask you a question about breathlessness. I ask it now because we want you to rate how breathless you are feeling while you are relaxed. I will also ask you about your perception of exertion later while you are doing some physical activity.

Please look at this rating scale; we want you to use this scale from 6 to 20, where 6 means 'no breathlessness at all' and 20 means 'maximal breathlessness'. Look at the scale and the expressions and then give a number.



**BD4. Thinking of your breathlessness right now, how would you rate your feeling of breathlessness?**

## 4. Medical History

In this section I would like to find out about things to do with medication and your medical history.

### MEDICATIONS

The first questions are about medications and non-prescribed products you might use as well as any health problems you may have. Remember that any question you are not happy to answer, you may leave.

**Interviewer:**

Ask the following questions and record all medications and health products, whether they are prescribed or not, in the table to the right. Include inhalers, suppositories, creams, eye drops etc. You may need to prompt the participant about these more unusual products. Ask if you can look at the medication packets and fill in as much information as you can. See the procedure manual for further guidance on completing this section.

CA1. Do you currently take any medications prescribed by the doctor? 0 = No (Go to CA3) 1 = Yes

CA2. At times do you forget to take your prescription medications?

All the time	Often	Sometimes	Never	<input type="checkbox"/>
1	2	3	4	

CA3. Do you currently take any over the counter medicines that are not prescribed? 0 = No 1 = Yes

CA4. Do you currently take any nutritional supplements? 0 = No 1 = Yes

CA5. Do you take any “natural” or “herbal” products or traditional medicines? 0 = No 1 = Yes

CA6. Do you take any Rongoa Māori medicines? 0 = No 1 = Yes   
*Go to Medication Table*

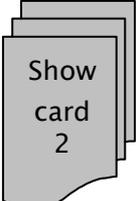
CA6a. Where do you get Rongoa Maori from?

I buy it	I gather it	I make it	I am given it	Other	<input type="checkbox"/>
1	2	3	4	5	

Specify other .....

CA6b. How important is the use of Rongoa Maori to you?

Not at all	A little	Moderately	Very	Extremely	<input type="checkbox"/>
1	2	3	4	5	



<p style="text-align: center;"><b>MEDICATION TABLE</b></p> <p><i>List prescription medications first leave a line, then over the counter medications</i></p> <p style="text-align: center;">Generic name</p>	Strength	As required / PRN? 0 = No, 1 = Yes	Dose				*Other Frequency	**How do you get this medication	What is this for?	Reason for variation between script and taken
			Breakfast	Lunch	Dinner	Bedtime				
			As labelled							
			As taken							
			As labelled							
			As taken							
			As labelled							
			As taken							
			As labelled							
			As taken							
			As labelled							
			As taken							
			As labelled							
			As taken							
			As labelled							
			As taken							

**FREQUENCIES:** 1xDay code under breakfast; 2xDay code breakfast and dinner; 3xDay code breakfast, lunch and dinner  
**\*Other frequency:** D = day M = month Y = year (use the most relevant denominator and add a number to identify how often in a D, M or Y e.g. 5D = 5 times a day)  
**\*\* Codes for "How do you get this medication"** 1 = prescription 2 = bought, no script 3 = other

			As labelled								
			As taken								
			As labelled								
			As taken								
			As labelled								
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\*\* Codes for "How do you get this medication" 1 = prescription 2 = bought, no script 3 = other

CA7. Do you use any aids to help you take your prescribed medication?

0 = No (*skip to CB1*) 1 = Yes

CA7a. What type of aid do you use?

0 = No 1 = Yes

Blister pack

Weekly medication boxes

Yellow card

Other .....

.....

**MEDICAL CONDITIONS**

Now I'm going to ask you some questions about cardiovascular disease

CB1. Have you ever been told by a doctor that you have had:

CB2. Age of onset

CB3. Were you ever in hospital for this?

0 = No 1 = Yes 2 = Don't Know

0 = No 1 = Yes

	0 = No	1 = Yes	2 = Don't Know		0 = No	1 = Yes
a. Heart attack/myocardial infarction						
b. Angina						
c. Stroke						
d. Transient Ischemic Attack / mini stroke						
e. High blood pressure						
f. Atrial fibrillation or irregular heartbeat						
g. Congestive heart failure						
h. Intermittent claudication (pain in calves when walking), peripheral vascular disease						
i. Rheumatic fever						
j. Other heart or circulatory problem						

Specify .....

CB4. Did your father or your brothers have CVD (Myocardial infarction, angina, ischemic stroke, transient ischemic attack) before the age of 55 years?

0 = No 1 = Yes 3 = Don't Know

CB5. Did you mother or your sisters have CVD (Myocardial infarction, angina, ischemic stroke, transient ischemic attack) before the age of 65 years?

0 = No 1 = Yes 3 = Don't know

**SMOKING**

I'd like to ask you some questions about smoking

CC1. Do you smoke or have you ever smoked cigarettes?

0 = never a smoker (*Go to CC2*) 1 = current 2 = past (stopped more than 12months ago)

CC1a. If you smoke (or if you have ever smoked) cigarettes what age did you start smoking?

CC1b. If you have stopped at what age did you stop smoking?

CC1c. On average, how many cigarettes do you smoke (or did you used to smoke) per day? One pack is 20 cigarettes

CC2. Have you ever smoked a pipe or cigars regularly? 0 = No (Go to CC3) 1 = Yes

CC2a. If yes, approximate number of years? Years

CC3. Have you ever lived or worked in close proximity to a smoker for a period of 1 year or more? 0 = No (Go to CD1) 1 = Yes

CC3a. If yes, Approximate number of years? Years

**SLEEP**

CD1. Do you have trouble with your sleeping (on at least 3 nights per week) such that it interferes with your activities the following day (e.g. un-refreshed in the morning, fatigue, poor concentration or irritability)? 0 = No (Go to CD3) 1 = Yes

CD2. Do you have any of these sleeping problems? (read all options)

(0 = No 1 = Yes)

- Waking up in the early hours of the morning
- Lying awake for most of the night
- Taking a long time to get to sleep
- Worry keeping you awake at night
- Sleep walking/ sleep talking
- Snoring
- Getting up at night to go to the toilet

On average, how many times a night .....

Other sleeping problem .....

CD3. How much trouble did you have with sleeping when you were young?

None at all	A little	Some	A lot	
0	1	2	3	<input type="checkbox"/>

**FRACTURES**

CE1. Has a Doctor ever said that you had a broken or fractured bone? 0 = No (Go to CE2) 1 = Yes

**CE1a. Please tell me the names of all the bones you have broken and your age when you broke that bone**

Broken Bone	Age when Broken	Broken Bone	Age when Broken

**CE2. Did your birth MOTHER ever break or fracture her hip?**

No	Yes	Not that I know of	Don't know	<input type="checkbox"/>
0	1	2	3	

**CE2a. What age was your birth mother when she broke her hip?** Years

**CE3. Did your birth FATHER ever break or fracture his hip?**

No	Yes	Not that I know of	Don't know	<input type="checkbox"/>
0	1	2	3	

**CE3a. What age was your birth father when he broke his hip?** Years

**CE4. How tall were you without shoes on at about age 25? If you don't remember exactly give your best estimate.**

Feet  Inches

OR Metres 1.

**CE5. What was your usual weight at about age 25 (at a time you were not pregnant)? If you don't remember exactly, give your best estimate.**

*(1 stone = 14 pounds (lb), 1 pound = 16 ounces (oz))*

Pounds    oz

OR Kg    .

OR Stones    lbs

**CE6. Have you ever been told by a doctor that you have had osteoporosis?**

0 = No 1 = Yes

**CE7. Have you ever been told by a doctor that you have had arthritis, rheumatism or trouble with your joints?**

Rheumatoid arthritis

Osteoarthritis

Other joint trouble.....

(0 = No 1 = Yes)

**FALLS**

The next questions are about falls

**CF1. How many times have you fallen in the past 12 months?**

None (Go to CF2)	One	Two or three	Four or more	
0	1	2	3	<input type="checkbox"/>

**CF1a. Have you sought medical attention because of a fall in the last 12 months?**

0 = No 1 = Yes

**CF1b. When you fell during the last 12 months?** 0 = No 1 = Yes

a. Did you have a fracture

b. Did you have some other kind of injury (please describe)

.....  
c. Were you admitted to hospital?

**CF2. How confident are you that you can do all your daily activities without falling?**

Not at all confident	Quite confident	Completely confident	
0	1	2	<input type="checkbox"/>

I want to ask you about any bladder and bowel problems you might have

**CF3. Do you have a problem with losing control of urine when you don't want to?**

0 = No (Go to CF4) 1 = Yes

**CF3a. How much of a problem would you say you have with losing control of urine?**

Severe problem	Moderate problem	Mild problem	No problem	
1	2	3	4	<input type="checkbox"/>

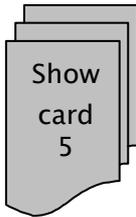
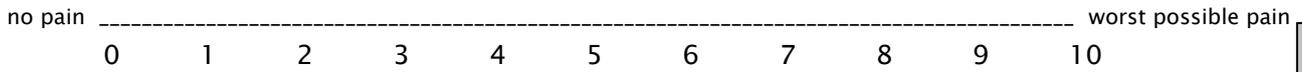
**CF4. Do you have a problem with losing control of your bowels when you don't want to?**

0 = No 1 = Yes

**PAIN**

I'd like to ask a few questions about pain now. I'm going to ask for some detail about each area that you have pain in. Use the following scale to determine the level of pain.

**Example**



**Do you have any pain now? Where is it?** (Interviewer: Use the scale and map supplied to code all pain mentioned by area and write each area in the table below)

Area	CG1	CG2	CG3	CG4	CG5
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					

*Interviewer - ask these questions about each area before you go on to the next*

**CG1. What is your pain RIGHT NOW?**

**CG2. What is your TYPICAL or AVERAGE pain?**

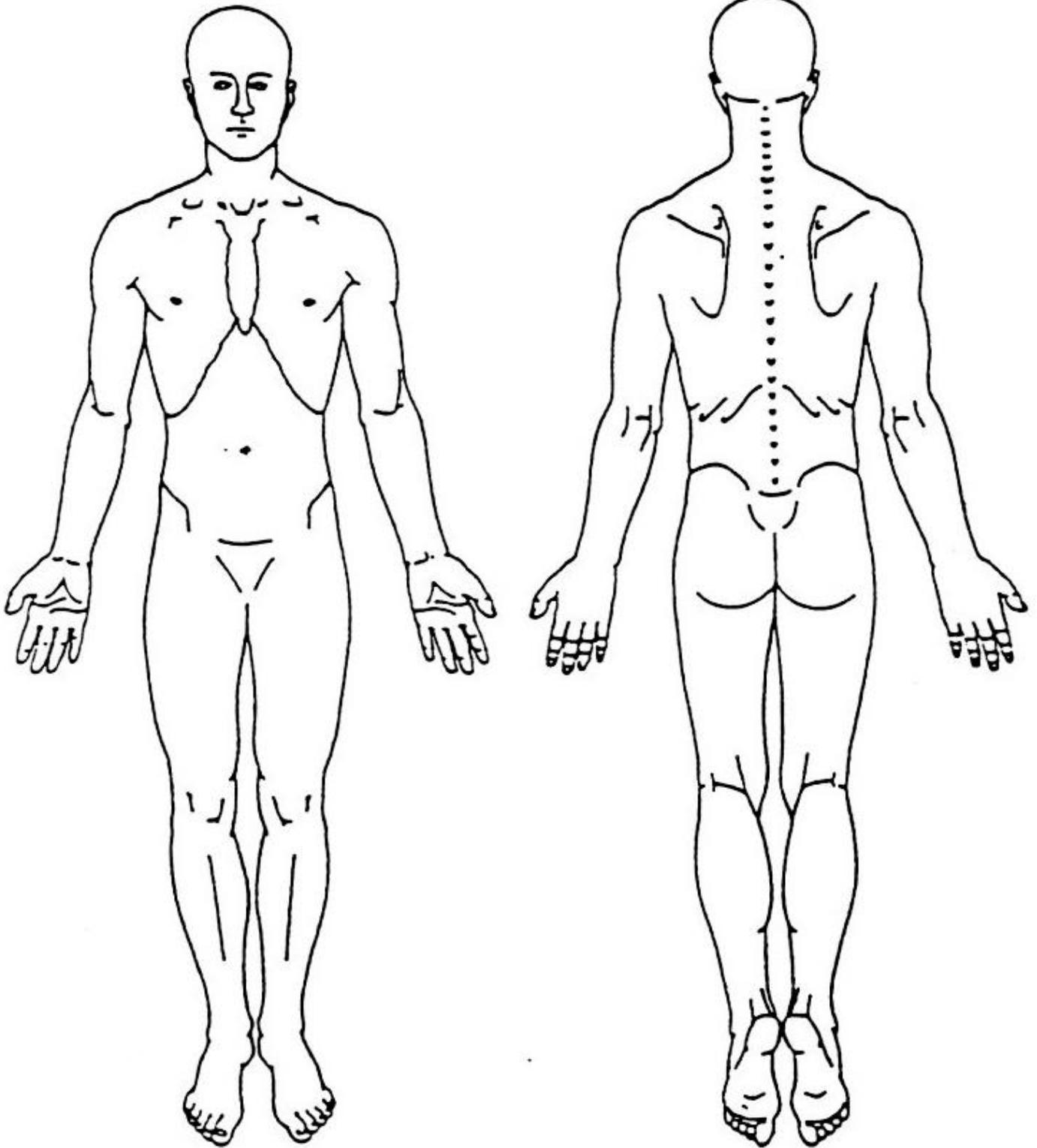
**CG3. What is your pain level AT ITS BEST (How close to '0' does your pain get at its best)?**

**CG4. What is your pain level AT ITS WORST (How close to '10' does your pain get at its worst)?**

**CG5. How many days over the last month have you had this pain?**

**Are there any other areas you sometimes have pain but do not have pain right now?** Interviewer, code these and ask each question as above

Ask participant to shade or circle the location of each area of pain. Place letter of area (a - h) beside shading or circle.



## 5. Nutrition

The next section of questions is about your consumption of food and drink. First I'd like to ask you about your teeth.

### TEETH

**DA1. Do you wear dentures?**

Not at all <i>(Go to DB1)</i>	Upper	Lower	Full mouth	Partial only	
0	1	2	3	4	<input type="checkbox"/>

**DA1a. How many years have you worn dentures**

Years

### SCREEN II (14 items)

I'm now going to ask you some questions about your eating habits. I want to find out about your normal eating habits – so we'll talk about a TYPICAL day. There are no right or wrong answers to any of these questions

**DB1. Has your weight changed in the past 6 months?**

No, my weight has stayed within a few kilos <i>(Go to DB2)</i>	Yes	I don't know how much I weigh or if my weight has changed <i>(Go to DB2)</i>	
0	1	2	<input type="checkbox"/>

**DB1a. How much has it changed?**

More than 5kg	I gained 2½ – 5kg	About 2-2½ kg	More than 5kg	I lost 2½ – 5kg	About 2-2½ kg	
1	2	3	4	5	6	<input type="checkbox"/>

**DB2. Have you been trying to change your weight in the past 6 months?**

No	Yes	No, but it changed anyway	
0	1	2	<input type="checkbox"/>

**DB3. Do you think your weight is...**

More than it should be	Just right	Less than it should be	
1	2	3	<input type="checkbox"/>

**DB4. Do you skip meals?**

Never or rarely	Sometimes	Often	Almost every day	
1	2	3	4	<input type="checkbox"/>

**DB5. Do you limit or avoid certain foods?**

I eat most foods	I limit some foods and I am managing fine	I limit some foods and I am finding it difficult to manage	
1	2	3	<input type="checkbox"/>

**DB6. How would you describe your appetite?**

Very good	Good	Fair	Poor	
1	2	3	4	<input type="checkbox"/>

**DB7. How many pieces or servings of fruit and vegetables do you eat in a day?**

*Can be canned, fresh, frozen or juice. A handful is a serving, count each vegetable as a separate serving.*

Five or more	Four	Three	Two	Less than two	
1	2	3	4	5	<input type="checkbox"/>

**DB8. How often do you eat meat, eggs, fish, poultry or meat alternatives?**

*Meat alternatives are dried peas, beans, lentils, nuts, peanut butter or tofu.*

Two or more times a day	One to two times a day	Once a day	Less than once a day	
1	2	3	4	<input type="checkbox"/>

**DB9. How often do you have milk products?**

*Includes fluid milk, cooking with milk, milk puddings, ice cream, cheese, yoghurt and milk alternatives like soy beverages.*

Three or more times a day	Two to three times a day	One to two times a day	Usually once a day	Less than once a day	
1	2	3	4	5	<input type="checkbox"/>

**DB10. How much fluid do you drink in a day?**

*Includes: water tea, coffee, herbal drinks, juice, and soft-drinks but not alcohol*

Eight or more cups	Five to seven cups	Three to four cups	About two cups	Less than two cups	
1	2	3	4	5	<input type="checkbox"/>

*Use blank pages at end of questionnaire to work out typical daily intake*

**DB10a. Do you cough, choke or have pain when swallowing food or fluids?**

Never	Rarely	Sometimes	Often or always	
1	2	3	4	<input type="checkbox"/>

**DB11. Do you suffer from dry mouth or reduced salivation?**

0 = No 1 = Yes

**DB12. Is biting or chewing food difficult for you?**

Never (Go to DB13)	Rarely	Sometimes	Often or always
--------------------	--------	-----------	-----------------

4	3	1	0	<input type="checkbox"/>
<b>DB12a. If yes, why is chewing difficult? (Main reason first)</b>				
Pain in mouth (other than gums or teeth)	Gum disease	Teeth sore	Dentures don't fit	Other
1	2	3	4	5

Specify other .....

**DB13. Do you use commercial meal replacements or supplements? (protein shakes, energy bars, Complan, Ensure)**

Never or rarely	Sometimes	Often or always	<input type="checkbox"/>
1	2	3	

**DB14. Do you eat one or more meals a day with someone?**

Never or rarely	Sometimes	Often	Almost always	<input type="checkbox"/>
1	2	3	4	

**DB15. Who usually prepares your meals?**

I do	I share my cooking with someone else	Someone else cooks most of my meals	<input type="checkbox"/>
1	2	3	

**DB16. Which statement best describes meal preparation for you?**

I enjoy cooking most of my meals	I sometimes find cooking a chore	I usually find cooking a chore	I'm satisfied with the quality of food prepared by others	I'm not satisfied with the quality of food prepared by others	<input type="checkbox"/>
1	2	3	4	5	

**DB17. Do you have any problems getting your groceries?**

*Can be poor health or disability, limited income, lack of transportation, weather conditions, or finding someone to shop*

Never or rarely	Sometimes	Often	Always	<input type="checkbox"/>
1	2	3	4	

Now I'd like to ask you about special food that you may not eat every day

**DB18. Are there special foods that are important to you for practicing your culture?**    0 = No *(Go to DE1)*    1 = Yes   

**DB18a. What are these?**

.....  
 .....

**DB1 8b. How important are these special foods to you?**

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**DB1 8c. How available are these special foods when you want them?**

Always	Most of the time	Sometimes	Not very often	None of the time	
1	2	3	5	6	<input type="checkbox"/>

**DB1 8d. If available none of the time, why not?**

- 1 = unavailable in my area
- 2 = source of food is polluted
- 3 = food is restricted or illegal
- 4 = I'm physically unable to get it
- 5 = no-one is able to provide it
- 6 = unable to eat it for health reasons
- 7 = it is too expensive
- 9 = Other .....
- reason .....

**ALCOHOL CONSUMPTION**

**DE1. How often do you have a drink containing alcohol?**

Never (Go to EA1)	Monthly or less	Two to four times a MONTH	Two to three times a WEEK	Four or more times a WEEK	
0	1	2	3	4	<input type="checkbox"/>

**DE1a. How many drinks containing alcohol do you have on a typical occasion when drinking?**

One or two	Three or four	Five or six	Seven to nine	Ten or more	
1	2	3	4	5	<input type="checkbox"/>

**DE1b. How often do you have six or more drinks on one occasion?**

Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
0	1	2	3	4	<input type="checkbox"/>

**DE1c. Do you ever feel the need to cut down on your drinking alcohol?**

0 = No 1 = Yes

## 6. Mental Health

### GERIATRIC DEPRESSION SCALE (15-items)

*If being interviewed via proxy go to FA1* The next questions are from a scale used in many studies and are about how you have been feeling lately. Please choose the best answer to describe how you have felt over the past WEEK.

*Scoring: 0 = No 1 = Yes*

EA1. Are you basically satisfied with your life?	
EA2. Have you dropped many of your activities and interests?	
EA3. Do you feel that your life is empty?	
EA4. Do you often get bored?	
EA5. Are you in good spirits most of the time?	
EA6. Are you afraid that something bad is going to happen to you?	
EA7. Do you feel happy most of the time?	
EA8. Do you often feel helpless?	
EA9. Do you prefer to stay at home, rather than going out and doing new things?	
EA10. Do you feel you have more problems with memory than most?	
EA11. Do you think it is wonderful to be alive now?	
EA12. Do you feel pretty worthless the way you are now?	
EA13. Do you feel full of energy?	
EA14. Do you feel that your situation is hopeless?	
EA15. Do you think that most people are better off than you are?	

EA16. Have you ever been told by a doctor that you have had depression?   
 0 = No 1 = Yes

EA16a. What age were you then? Age in years

## 7. Life Skills

*If being interviewed via proxy go to FD1*

### LIFE SATISFACTION

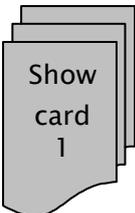
**FA1. All things considered, how satisfied are you with your life as a whole these days**

Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied	
1	2	3	4	5	<input type="checkbox"/>

**FA2. How would you rate your quality of life?**

Very poor	Poor	Neither good nor poor	Good	Very good	
1	2	3	4	5	<input type="checkbox"/>

### COPING



	Not at all	Somewhat	Moderately	Very	Extremely	
<b>FB1. In general, thinking about life overall, how well do you cope?</b>	1	2	3	4	5	<input type="checkbox"/>
<b>FB2. Thinking about times of loss, how well do you cope?</b>	1	2	3	4	5	<input type="checkbox"/>
<b>FB3. Thinking about times of financial hardship, how well do you cope?</b>	1	2	3	4	5	<input type="checkbox"/>
<b>FB4. Thinking about ongoing health problems, how well do you cope?</b>	1	2	3	4	5	<input type="checkbox"/>
<b>FB5. Thinking about times of trouble for your family and friends, how well do you cope?</b>	1	2	3	4	5	<input type="checkbox"/>

**PERCEIVED CONTROL**

We are interested in how much control you feel you have over your circumstances. Please answer the following questions by saying how much you agree with each statement. Do you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
FC1. I have little control over the things that happen to me	1	2	3	4	5	<input type="checkbox"/>
FC2. There is really no way I can solve some of the problems that I have	1	2	3	4	5	<input type="checkbox"/>
FC3. There is little I can do to change many of the important things in my life	1	2	3	4	5	<input type="checkbox"/>
FC4. I often feel helpless in dealing with the problems in life	1	2	3	4	5	<input type="checkbox"/>
FC5. Sometimes I feel that I am being 'pushed around' in life	1	2	3	4	5	<input type="checkbox"/>
FC6. What happens to me in the future mostly depends on me	1	2	3	4	5	<input type="checkbox"/>
FC7. I can do just about anything I really set my mind to do	1	2	3	4	5	<input type="checkbox"/>

These next two questions ask about major health events you may have experienced

**FD1. Have you ever had a major injury or health event that has affected you in the long term?**

0 = No *(go to FD2)* 1 = Yes

FD1a. What was it?

.....  
 .....  
 .....

Age at event


**FD2. Have you ever had a major psychological stress event that has affected you in the long term?**

0 = No *(Go to GA1)* 1 = Yes

*If needing prompt (For example the unexpected death of a family member, abuse, bankruptcy)*

FD2a. What was it?

.....  
 .....  
 .....

Age at event


## 8. Support needs

### VISITS TO HEALTH PROFESSIONALS

Thank you for answering the questions about medical conditions. I'd now like to ask you about visits to health professionals. Try to remember back to any visits you've had over the last year.

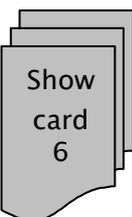
**GA1. If you have any health problems, which one would you most like to be fixed?**

.....  
*(if no problems Go to GA2)*

**GA1a. Is a health professional helping/trying to help you with this problem?**

0 = No 1 = Yes

**GA2. In the last year have you visited, or had a visit from, any of the following health professionals? How many times in the last 12 months?**



	Not at all	About once a year	About every 6 months	About every 3 months	About every month	About every week	Don't know	
a. General practitioner	0	1	2	3	4	5	6	
b. Hospital based doctor or private specialist	0	1	2	3	4	5	6	
c. After hours medical clinic	0	1	2	3	4	5	6	
d. Practice nurse	0	1	2	3	4	5	6	
e. Pharmacist/chemist	0	1	2	3	4	5	6	
f. Dentist	0	1	2	3	4	5	6	
g. Podiatrist - feet	0	1	2	3	4	5	6	
h. Audiologist - ears/hearing	0	1	2	3	4	5	6	
i. Optometrist - eyes glasses	0	1	2	3	4	5	6	
j. District Nurse	0	1	2	3	4	5	6	
k. Physiotherapist	0	1	2	3	4	5	6	
l. Occupational Therapist	0	1	2	3	4	5	6	
m. Dietician	0	1	2	3	4	5	6	
n. Social worker	0	1	2	3	4	5	6	
o. Alternative health professional e.g. Naturopath/ Homeopath	0	1	2	3	4	5	6	
p. Tohunga / Maori healer	0	1	2	3	4	5	6	
q. Other health professional. Specify .....	0	1	2	3	4	5	6	

**GA3. In general how happy are you with the current government policy on health services for older people**

Very unhappy	Mainly unhappy	Neither unhappy nor happy	Mainly happy	Very happy	
1	2	3	4	5	

**HEARING/VISION**

I'd like to ask a couple of questions about your hearing and your eyesight now.

**GB1. How much does your hearing interfere with normal day-to-day functioning?**

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**GB2. Do you have a hearing aid?**

0 = No *(Go to GB3)* 1 = Yes

**GB2a. How often do you use it?**

None of the time	Some of the time	Most of the time	All of the time	
0	1	2	3	<input type="checkbox"/>

**GB3. Does your eyesight interfere with normal day-to-day functioning?**

0 = No 1 = Yes

**GB4. Have you ever been told by a doctor or optician that you have had:**

*(0 = No 1 = Yes 2 = Don't Know)*

Cataract

Age related macular degeneration

Glaucoma

Diabetic eye disease

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

**SOCIAL SUPPORT**

Now I'd like to ask you some questions about your social network and social relationships.

**GC1. When you need some extra help, can you count on anyone to help with daily tasks like grocery shopping, cooking, house cleaning, telephoning, give you a ride?**

No	Yes	I don't need help	
0	1	2	<input type="checkbox"/>

**GC2. In the last year who has been most helpful with these daily tasks?**

1 = Spouse

2 = Daughter

3 = Son

4 = Sibling

5 = Other relative

6 = Your neighbours

7 = Co-workers

8 = Church members

9 = Club members

10 = Professionals

11 = Any friend not included in these

12 = No-one

categories

**GC3. Could you have used more help with daily tasks than you received? Would you say...**

A lot	A little help	Some	None at all <i>(received sufficient help)</i>	
1	2	3	4	<input type="checkbox"/>

*If being interviewed via proxy go to GC10*

**GC4. Can you count on anyone to provide you with emotional support?  
(talking over problems or helping you make a difficult decision)**

No	Yes	I don't need help	
0	1	2	<input type="checkbox"/>

**GC5. In the last year who has been most helpful in providing you with emotional support?**

- 1 = Spouse                      2 = Daughter                      3 = Son                      4 = Sibling
- 5 = Other relative            6 = Your neighbours            7 = Co-workers            8 = Church members
- 9 = Club members            10 = Professionals            11 = Any friend not included in these categories
- 12 = No-one

**GC6. Could you have used more emotional support than you received? Would you say...**

A lot	A little help	Some	None at all (received sufficient help)	
1	2	3	4	<input type="checkbox"/>

**GC7. Does it seem that your family and friends (i.e. people who are important to you) understand you?**

None of the time	Hardly ever	Some of the time	Most of the time	All of the time	
1	2	3	4	5	<input type="checkbox"/>

**GC8. How satisfied are you with the kinds of relationships you have with your family?**

Extremely dissatisfied	Very dissatisfied	Somewhat dissatisfied	Satisfied most of the time	Satisfied all of the time	
1	2	3	4	5	<input type="checkbox"/>

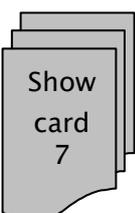
**GC9. How satisfied are you with the kinds of relationships you have with your friends?**

Extremely dissatisfied	Very dissatisfied	Somewhat dissatisfied	Satisfied most of the time	Satisfied all of the time	
1	2	3	4	5	<input type="checkbox"/>

**GC10. Do you receive any regular support service (such as home help)?**

0 = No *(Go to GC12)*    1 = Yes

If living in a rest home or private hospital Go to GC14



**GC11. Do you receive any of the following support services?**

*IF Yes: How often? Who funds this help?*

*(For each service received, ask who the support is received from. Record the frequency in the appropriate column - there may be more than one service provider)*

Type of service	A. Receive 0 = No 1 = Yes	B. Frequency 1 = Several times a day 2 = Once a day 3 = One or more times a week 4 = Less than once a week	C. Support provided by 1 = public system 2 = part of accommodation cost 3 = respondent pays
a. Any meal service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Home Help (cleaning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Home Help (shopping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Home Help (gardening)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Personal Care (bathing/dressing etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**GC12. How often do you currently provide care or assistance for other people?**

Never (Go to GC14)	Occasionally (less than weekly)	Once a week	Two to five times weekly	Daily (six to seven times weekly)	
0	1	2	3	4	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**GC13. Do you give care or assistance for...**

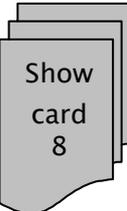
(0 = No 1 = Yes)

Who do you give help to? ... (0=No 1 = Yes)

	Someone in same household	Family other household	Other
a. Financial help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Personal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**GC14. In general how happy are you with the current government policy on social services for older people, including pension**

Very unhappy	Mainly unhappy	Neither unhappy nor happy	Mainly happy	Very happy	
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**BREAK**

You are half way through the questionnaire and the participant may want to take a break. However, if they are willing and there is time you can continue to the end of the questionnaire

# 9. Physical performance measures

## SHORT PHYSICAL PERFORMANCE BATTERY

<i>Reason not attempted or not completed</i>	<i>CODE</i>
Tried but unable	1
Participant could not hold position unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (specify) .....	6
Participant refused	7

Now I'd like to ask you to do some physical performance tests. I will first describe and show each movement to you. Then I'd like you to try to do it. If you cannot do a particular movement or you feel it would be unsafe to try to do it, tell me and we'll move on to the next one. Let me emphasise that I do not want you to try to do any exercise that you feel might be unsafe.

### **BALANCE TEST**

*Instructions: Start with B: Semi-tandem stand. If the person cannot hold the position for 10 seconds, ask them to attempt A: Side-by-side stand. If they manage the semi-tandem stand for 10 seconds, go straight to C: Tandem stand.*

	Attempted 0 = No 1 = Yes	Number of seconds held: □ □ . □ □	Held for 10 sec 0 = No 1 = Yes	If not attempted or failed, enter reason: <i>(Code box above)</i>
<b>A. Side-by-side stand</b> I want you to try to stand with your feet together, side by side, for about 10 seconds.	□	□ □ . □ □	□	□ .....

*If not attempted or not held for 10 seconds, end balance tests and go to gait speed test*

	Attempted 0 = No 1 = Yes	Number of seconds held: □ □ . □ □	Held for 10 sec 0 = No 1 = Yes	If not attempted or failed, enter reason: <i>(Code box above)</i>
<b>B. Semi-Tandem Stand</b> Now I want you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you.	□	□ □ . □ □	□	□ ..... ..... .....

*If not attempted or not held for 10 seconds, end balance tests and go to gait speed test*

	Attempted 0 = No 1 = Yes	Number of seconds held:	Held for 10 sec 0 = No 1 = Yes	If not attempted or failed, enter reason: <i>(Code box above)</i>
<b>C. Tandem Stand</b> Now I want you to try to stand with the heel of one foot in front of and touching the toes of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you.	<input type="checkbox"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/> ..... ..... .....

**GAIT SPEED TEST**

Now I am going to observe how you normally walk. This is our walking course. I want you to walk to the other end of the course at your usual speed, just as if you were walking down the street to go to the store. Walk all the way past the other end of the tape before you stop.

		First walk		Second walk
Test was attempted	0 = No 1 = Yes	<input type="checkbox"/>		<input type="checkbox"/>
Time for 3 metres (min' secs)		<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"/> <input type="text"/>
Aids for walk (1 = None, 2 = Cane, 3 = Other)		<input type="checkbox"/>		<input type="checkbox"/>
If not attempted or failed, enter reason <i>(Code box above)</i>		<input type="checkbox"/> .....		<input type="checkbox"/> .....

*If not attempted or failed, go to chair stand test*

**CHAIR STAND TEST**

Let's do the last movement test. Do you think it would be safe for you to try to stand up from a chair without using your arms?

Remember that I said earlier that I would ask you about your perception of exertion while you are doing physical activity. While doing the chair stand test we want you to rate your perception of exertion, i.e., how heavy and strenuous the exercise feels to you. The perception of exertion depends mainly on the strain and fatigue in your muscles and on your feeling of breathlessness or aches in the chest. Please look at this rating scale; we want you to use this scale from 6 to 20, where 6 means 'no exertion at all' and 20 means 'maximal exertion'.

- 9 corresponds to 'very light' exercise. For a normal, healthy person it is like walking slowly at his or her own pace for some minutes.
- 13 on the scale is 'somewhat hard' exercise, but it still feels OK to continue.
- 17 'very hard' is very strenuous. A healthy person can still go on, but he or she really has to push him- or herself. It feels very heavy, and the person is very tired.
- 19 on the scale is an extremely strenuous exercise level. For most people this is the most strenuous exercise they have ever experienced.



Try to appraise your feeling of exertion as honestly as possible, without thinking about what the actual physical load is. Don't underestimate it, but don't overestimate it either. It's your own feeling of effort and exertion that's important, not how it compares to other people's. What other

people think is not important either. Look at the scale and the expressions and then give a number.

Any questions?

**So let's do the test.** This test measures the strength in your legs. First, fold your arms across your chest and sit so that your feet are on the floor; then stand up keeping your arms folded across your chest.

**(Single)**

Safe to stand without help (0 = No, 1 = Yes)

Results Participant stood without using arms

Participant used arms to stand

Test not completed


*Go to Repeated Chair Stand Test*

*End test*

*End test*

If not attempted or failed, code reason

 .....

*(Code box above)*

Please stand up as QUICKLY as you can 5 times without stopping in between. After standing up each time, sit down and then stand up again. Keep your arms folded across your chest. I'll be timing you with a stopwatch.

**(Repeated)**

Safe to stand five times (0 = No, 1 = Yes)

Time to complete five stands (in seconds)

 . 

If not attempted or failed, code reason

 .....

*(Code box above)*

***Interviewer: ask immediately after completing the chair stand test. If only one stand can be completed ask it after the one stand or if 5 stands are completed, ask after the fifth stand.***

HC1. So, thinking of your feeling of exertion right now, how would you rate your feeling of exertion?

# 10. Housing and Environment

We know that people’s living environments are closely related to their health and well-being so I’d like to ask you some questions about your house, your neighbourhood and the environment you live in.

**IA1. How connected are you to the place you presently live?**

Not at all	Somewhat	Moderately	Very	Extremely	<input type="checkbox"/>
1	2	3	4	5	

**IA2. How connected are you to your neighbourhood?**

Not at all	Somewhat	Moderately	Very	Extremely	<input type="checkbox"/>
1	2	3	4	5	

**IA3. How connected are you to your community?**

Not at all	Somewhat	Moderately	Very	Extremely	<input type="checkbox"/>
1	2	3	4	5	

*If they live in a rest home/private hospital Go to IA7*

**IA4. I’d like to check how this accommodation is owned or rented. Do you...**

- |  |  |
|--|--|
| 1 = Own it outright yourself or with spouse/partner    | 2 = Still pay a mortgage or loan yourself or with spouse/partner |
| 3 = Rent (Private)                                     | 4 = Rent (Public) e.g. State or local council                    |
| 5 = Pay part rent and part mortgage (shared ownership) | 6 = Live here rent free (e.g. relative, friend’s property)       |
| 8 = Lease to occupy                                    |  |
| 7 = Other .....  |  |

**IA5. How many bedrooms are there in your house?**

**IA5a. Are your bedroom, toilet, kitchen and living room on the same level?**

(0 = No, 1 = Yes)

**IA6. APPROXIMATELY how old is your residence?**

Less than 5 years old	Between 5 and 15 years old	Between 16 and 40 years old	More than 40 years old	I don’t know	<input type="checkbox"/>
1	2	3	4	5	

**IA7. How long have you been living in your current RESIDENCE?**

Years  Months

If not moved in the last 2 years *Go to IA10*

IA8. How many other households have you lived in over the past two years?

IA9. Did you move here from outside this NEIGHBOURHOOD? 0 = No 1 = Yes

IA10. How often have you moved in the last 20 years?

None	Once	One to four times	Five to nine times	Ten times or more	
0	1	2	3	4	<input type="checkbox"/>

**RESIDENTIAL ENVIRONMENT**

IB1. Do you currently have one or more of the following pets in your household?

Number of cats       Number of dogs       Number of birds   
 Number of fish       Number of other pets.....

IB2. Generally, how satisfied are you with the warmth of your home in winter?

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	
1	2	3	4	5	<input type="checkbox"/>

*Interviewer to make a note if the participant mentions a discrepancy in the warmth of different rooms in the residence .....*

IB3. Thinking about your current home, how well do you like it?

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

IB4. Thinking about your home, is there anything that causes you problems moving around your house?   
 0 = No (*Go to IB6*) 1 = Yes

IB5. If yes, what are the things that cause you problems moving around your house?

0 = No 1 = Yes

Steps and stairs       Outside paths       Toilet up or down stairs   
 No hand rails       Rugs, mats       Size of room/doorways   
 Objects in the way (e.g., furniture, medical equipment)       Dark areas/inadequate lighting   
 Other .....

IB6. How likely are you to move in the near future?

Not at all	Somewhat	Moderately	Very	Extremely	
------------	----------	------------	------	-----------	--

1	2	3	4	5	
---	---	---	---	---	--

**IB7. How enthusiastic are you about moving in the near future?**

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	

**IB8. Whose choice was it to live in this particular RESIDENCE?**

- 1 = Mine
- 2 = My partner's
- 3 = My partner's and mine
- 4 = Someone else's .....
- 5 = Mine and someone else's .....

**IB9. Please take a look at this list and rank the top 2 reasons you chose this RESIDENCE**

- 1 = Size of home
- 2 = Safety
- 3 = To free up equity
- 4 = Easier maintenance of house and or gardens
- 5 = Aesthetics
- 6 = Change in marital status
- 7 = Work or retirement related
- 8 = Other .....

Rank 1st	
Rank 2nd	

*If living in a rest home Go to IC1*

**IB10. Have there been any renovations or changes to your current home since you've been living here?**

0 = No 1 = Yes

**IB11. Please look at this list. Tell me what was done and how long ago it was done**

(0 = No 1 = Yes)	Done	0-5 yrs ago	≥ 5 yrs ago
Redecorated	□	□	□
Added or extended rooms	□	□	□
Improved access e.g. rails, ramps, flooring	□	□	□
Improved heating or insulation	□	□	□
Improved bathroom	□	□	□
Outside garden / fencing improvements	□	□	□
Other? (please describe) .....	□	□	□

**IB12. Are there any renovations or changes that you would like to make to your current home?**

0 = No (*Go to IC1*) 1 = Yes

**IB13. What are they?**

(0 = No 1 = Yes)

Redecorate

Add or extend rooms

Improve access

Improve heating or insulation

e.g. rails, ramps, flooring

Improve bathroom

Outside garden / fencing improvements

Other? (please describe) .....

**IB14. What is the MAIN reason that has prevented you from doing this so far?**

(Maximum of 1)

Cost

Availability of help

Council requirements

Not necessary yet

Haven't got around to it

**NEIGHBOURHOOD**

Now I'm going to ask you some questions about the neighbourhood you live in

**IC1. Do you consider your neighbourhood to be ....?**

Central city	Suburban	Semi-rural	Rural	Other	Don't know	
1	2	3	4	5	6	<input type="checkbox"/>

**IC2. Thinking about your current neighbourhood, how well do you like it?**

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**IC3. Take a look at this list. Please name the one thing you like most and the one thing you like least about your current NEIGHBOURHOOD? Give only one choice for like most and like least.**

	Like most	Like least
The land/ the physical environment, parks etc		
Amenities		
Age of housing/architecture		
Diversity / age/ friendliness of people		
Length of time have lived here		
Other.....		

Show card 9

**IC4. Please take a look at this list and rank the top 2 reasons you chose this NEIGHBOURHOOD**

- 1 = To be near or with children
- 2 = To be near or with other relatives or friends
- 3 = Leisure activities
- 4 = Closer to health services or amenities e.g. shops
- 5 = Close to marae
- 6 = Returning to family/whanau land
- 7 = Climate/weather
- 8 = Other .....

Rank 1st

Rank 2nd

Show card 10

**IC5. How difficult is it for you to get to the shops?**

Not at all (Go to IC5b)	Somewhat (Go to IC5a)	Moderately (Go to IC5a)	Very (Go to IC5a)	Extremely (Go to IC5a)	
1	2	3	4	5	<input type="checkbox"/>

**IC5a. Why is it difficult for you to get to the shops? (mark all that apply)**

The footpaths are inadequate <input type="checkbox"/>	I do not feel safe <input type="checkbox"/>
There is no public transport <input type="checkbox"/>	There is public transport but the timetable is inappropriate <input type="checkbox"/>
My health/disability makes walking or catching public transport difficult <input type="checkbox"/>	Other ..... <input type="checkbox"/>

**OR**

**IC5b. Why is it NOT difficult for you to get to the shops? (mark all that apply)**

I can walk comfortably <input type="checkbox"/>	I have my own transport <input type="checkbox"/>
I can use public transport <input type="checkbox"/>	Someone else takes me <input type="checkbox"/>
Other ..... <input type="checkbox"/>	



**PHYSICAL ENVIRONMENT**

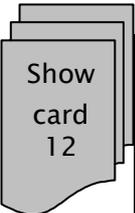
The next questions are about the physical environment, i.e. local parks, lakes, rivers, mountains and nature in general.

**ID1. In what ways are nature and the outdoors important to you? How important is it ...**

	Not at all	Somewhat	Moderately	Very	Extremely	
<b>a For your wellbeing</b>	1	2	3	4	5	
<b>b For recreation?</b>	1	2	3	4	5	
<b>c For your children/grandchildren?</b>	1	2	3	4	5	

# 11 Everyday Interests and Activities

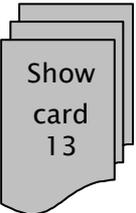
We are interested in activities that you spend time doing. First I want to ask you about activities you have done over the last week, that is since last .....



Over the past 7 days, how often did you....	0 = Never 1 = Seldom (1-2 days) 2 = Sometimes (3-4 days) 3 = Often (5-7 days)	A. What were these activities?	B. On average, how many hours per day did you engage in these activities? 1 = Less than one hour 2 = 1 - 2 hours 3 = 2 - 4 hours 4 = More than 4 hours
...participate in sitting activities such as reading, watching TV or doing handicraft?	<input type="checkbox"/>		<input type="checkbox"/>
...take a walk outside your home or yard for any reason? For example, for fun or exercise, walking to work, walking the dog etc.?	<input type="checkbox"/>		<input type="checkbox"/>
...engage in light sport or recreational activities such as light gardening e.g. using a ride-on mower, bowling, golf with a cart, shuffleboard, fishing from a boat or pier or similar activities?	<input type="checkbox"/>		<input type="checkbox"/>
...engage in moderate sport and recreational activities such as moderate gardening e.g. using a motor mower, double tennis, ballroom dancing, hunting, ice skating, golf without a cart, softball or other similar activities?	<input type="checkbox"/>		<input type="checkbox"/>
...engage in strenuous sport and recreational activities such as heavy gardening e.g. using a hand mower, jogging, swimming, cycling, singles tennis, aerobic dance, skiing or other similar activities?	<input type="checkbox"/>		<input type="checkbox"/>
...do any exercises specifically to increase muscle strength and endurance, such as lifting weights or push ups etc?	<input type="checkbox"/>		<input type="checkbox"/>

**JA7. How often do you speak or do something with:** (tick one on each line)

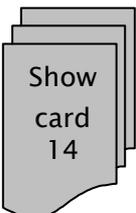
	Daily	2-3 times a week	At least weekly	At least monthly	Less often	Never/ I have none	
a. Any of your children or other relatives?	1	2	3	4	5	6	<input type="checkbox"/>
b. Any friends in your community/neighbourhood?	1	2	3	4	5	6	<input type="checkbox"/>
c. Any of your neighbours?	1	2	3	4	5	6	<input type="checkbox"/>



**Of all the things you do, which three would you say are most important to you?**

*(List the activities in the table below, most important first)*

JA8. Three most important activities	JA9. During the last 4 weeks how often have you ...insert...?				If less than monthly	
	Every day	Every week	Once	Not at all	Occasionally	
A	1	2	3	4	5	<input type="checkbox"/>
B	1	2	3	4	5	<input type="checkbox"/>
C	1	2	3	4	5	<input type="checkbox"/>



**JA10. What kind of interests have you dropped during the last 5 years?**

1 = One or more interests dropped (list below)      2 = No interests dropped (Go to JA11)

.....

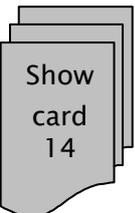
.....

.....

**JA10a. Which of these were reasons for dropping some of your interests?**

*(Code all that apply 0 = No 1 = Yes)*

- Personal capacity; such as reduced strength or energy, limited mobility, vision impairment, hearing impairment, health or other limitation
- Motivation; such as lack of motivation, "it was time to give up", not appropriate or proper to continue
- Time use; such as lack of time, doing it takes longer
- Security; such as not confident about own limits or abilities, fear of doing things outside the home
- Physical environment; such as limited accessibility (e.g. Steps, seating, toilets, parking), or restricted environment (e.g. age limited, car access only)
- Social circumstance; such as caring for other/s, loss of partner or friend, relocation
- Economic conditions; such as restricted finances or cost
- Other .....



**JA11. During the last 4 weeks how often have you ....?**

If less than monthly  
Occasionally

	Every day	Every week	Once	Not at all	Occasionally	
a) Spent time on a hobby (including handcrafts)	1	2	3	4	5	<input type="checkbox"/>
b) Gone to the shops						<input type="checkbox"/>
c) Visited or been visited by family and friends	1	2	3	4	5	<input type="checkbox"/>
d) Gone to the doctor	1	2	3	4	5	<input type="checkbox"/>
e) Taken care of pets?	1	2	3	4	5	<input type="checkbox"/>
f) Attended meetings of any community /neighbourhood or social groups, such as old people's clubs, lectures or anything like that?	1	2	3	4	5	<input type="checkbox"/>
g) Attended any religious meetings?	1	2	3	4	5	<input type="checkbox"/>
h) Been a spectator at a sports event	1	2	3	4	5	<input type="checkbox"/>
i) Gone to an entertainment or arts event (such as concert, theatre or cinema)	1	2	3	4	5	<input type="checkbox"/>
j) Gone to a restaurant, café, pub or bar	1	2	3	4	5	<input type="checkbox"/>
k) Gone to a TAB (betting shop) or casino	1	2	3	4	5	<input type="checkbox"/>
l) Attended a family event	1	2	3	4	5	<input type="checkbox"/>
m) Attended a social occasion (such as a barbeque or hangi)	1	2	3	4	5	<input type="checkbox"/>
n) Gone to the library or museum	1	2	3	4	5	<input type="checkbox"/>
o) Participated in an outdoor activity (such as cycling, walking or gardening)	1	2	3	4	5	<input type="checkbox"/>

**JA12. Thinking of how you spend your time, would you say, "Most days I....."**

Don't have enough to do	Just keep busy enough	Always have more than enough to do	
1	2	3	<input type="checkbox"/>

**JA13. How many hours have you spent outside in the *last 4 weeks*? (add them up as follows)**

How many hours on a week day (average)	Hours	<input type="text"/>
How many hours on the weekend (average)	Hours	<input type="text"/>
<b>TOTAL</b>		<input type="text"/>

**JA14. How much time do you spend by yourself? are you**

Always alone	Often alone	Seldom alone	Never alone	<input type="checkbox"/>
1	2	3	4	

**JA14a. And would you say that you:**

Always feel lonely	Often feel lonely	Sometimes feel lonely	Never feel lonely	<input type="checkbox"/>
1	2	3	4	

**TRANSPORT**

Please remind me whether you drive a car. ***If participant doesn't drive Go to JB3***

**JB1. If yes, how often do you drive yourself in a typical week?** Number of times

**JB2. How far do you go on a typical journey?**

Within 1 ½ km	1 ½ – 8km	8 – 25 ½ km	25 ½ – 80 km	80km or more	<input type="checkbox"/>
1	2	3	4	5	

*If participant currently drives Go to JB4*

**JB3. Have you ever driven a car?** 0 = No (***Go to JB4***) 1 = Yes

**JB3a. When did you stop driving?**

Less than 6 months ago	6-12 months ago	More than 12 months ago	<input type="checkbox"/>
1	2	3	

**JB3b. Why did you stop driving?**

*Interviewer to decide on reason with participant after discussion*

- |                        |                                    |
|------------------------|------------------------------------|
| 1 = Vision             | 2 = Illness or physical disability |
| 3 = Age                | 4 = Loss of confidence             |
| 5 = Others decided     | 6 = Didn't pass driving test       |
| 7 = Other reason ..... |                                    |

**JB4. Do you use private car transport driven by someone else (not taxis)?**

0 = No (***Go to JB6***) 1 = Yes

**JB5. Who is the person who is your most regular driver?**

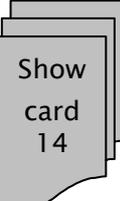
- |                    |                     |  |                    |
|--------------------|---------------------|--|--------------------|
| 1 = Spouse         | 2 = Daughter        | 3 = Son  | 4 = Sibling        |
| 5 = Other relative | 6 = Your neighbours | 7 = Co-workers                                   | 8 = Church members |
| 9 = Club members   | 10 = Paid person    | 11 = Any friend not included in these categories |                    |
| 12 = No-one        |                     |  |                    |

**JB5a. How often does someone else drive you in a typical week?**

Number of times

**JB5b. How far do you go with someone else on a typical journey?**

Within 1 ½ km	1 ½ – 8km	8 – 25 ½ km	25 ½ – 80 km	80km or more	
1	2	3	4	5	<input type="text"/>



**JB6. Have you used public transport in the last 12 months? (e.g. bus)**

0 = No (Go to JB6a)

1 = Yes (Go to JB6b)

**JB6a. Why not?**

- 1 = Don't want to
- 2 = Doesn't go where I want or need to go
- 3 = Hard to get on/off (bus)
- 4 = None available
- 5 = Don't know where or when they go
- 6 = Feels unsafe
- 7 = Bus stops inconvenient to use
- 8 = Never have
- 9 = Can't afford/too expensive
- 10 = Other.....


**JB6b. How often do you use public transport in a typical week?**

Number of times

**JB7. Have you used other forms of transport in the last 12 months? e.g. taxi, minivan, subsidised bus etc.**

0 = No 1 = Yes



**JB8. In general how happy are you with the current government policy on transport options for older people**

Very unhappy	Mainly unhappy	Neither unhappy nor happy	Mainly happy	Very happy	
1	2	3	4	5	<input type="text"/>

**ROLES**

Now I'm going to ask you some questions about more specific roles you may have.

**JC1. Do you have a specific role in your family/whanau/hapu?**

0 = No (Go to JC2) 1 = Yes

**JC1a. How satisfied are you with your role(s) in your family/whanau/hapu?**

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**JC2. Do you have a specific role in your local community/ neighbourhood?**

0 = No *(Go to JC3 if Maori else JD1)* 1 = Yes

**JC2a. How satisfied are you with your role(s) in your local community/neighbourhood?**

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**Ask Maori participants only**

**JC3. Do you have a specific role in your tribal/marae activities?**

0 = No *(Go to JC4)* 1 = Yes

**JC3a. How satisfied are you with the role(s) in your tribal/marae activities?**

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**JC4. Do you have a specific role in other Maori organisations in wider society?**

0 = No *(Go to JD1)* 1 = Yes

**JC4a. How satisfied are you with the role(s) in other Maori organisations in wider society?**

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**TECHNOLOGY**

Now I'm going to ask you some questions about your use of modern technology

**JD1. How comfortable are you with new technology, mobile phones and computers?**

Very uncomfortable	Mainly uncomfortable	Neither uncomfortable nor comfortable	Mainly comfortable	Very comfortable	
1	2	3	4	5	<input type="checkbox"/>

**JD2. Do you use the Internet?**

0 = No 1 = Yes

**JD3. Do you use a mobile phone?**

0 = No 1 = Yes

**JD4. Do you watch Sky television?**

0 = No 1 = Yes

## 12. Financial Situation

The next couple of questions will ask you about your income and how you manage your money. I will not ask you how MUCH money you have. Remember that any information you give to us will be treated in strictest confidence.

(0 = No 1 = Yes)

<b>KA1. Do you have a SuperGold Card?</b>	<input type="checkbox"/>
<b>KA2. Do you have a Community Services Card?</b>	<input type="checkbox"/>
<b>KA3. Do you have a High User Health Card?</b>	<input type="checkbox"/>
<b>KA4. Do you have a Total Mobility Card?</b>	<input type="checkbox"/>
<b>KA5. Do you have private Health Insurance?</b>	<input type="checkbox"/>

**KA6. Thinking of your money situation right now, would you say:**

I can't make ends meet 1	I have just enough to get along on 2	I am comfortable 3	<input type="checkbox"/>
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**KA7. Thinking of your money situation in the future, would you say, I expect that:**

I will not have enough to make ends meet 1	I will have just enough to get along on 2	I will be comfortable 3	<input type="checkbox"/>
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**KA8. Thinking of your money situation before you left home, that is growing up, including your adolescence, would you say:**

We couldn't make ends meet 1	We had just enough to get along on (Go to KA9) 2	We were comfortable (Go to KA9) 3	<input type="checkbox"/>
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**KA8a. What effect did this have for you?**

Very negative 1	Mainly negative 2	Neither negative nor positive 3	Mainly positive 4	Very positive 5	<input type="checkbox"/>
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**KA9. In general how happy are you with the current government policy on the economy**

Very unhappy 1	Mainly unhappy 2	Neither unhappy nor happy 3	Mainly happy 4	Very happy 5	<input type="checkbox"/>
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### STANDARD OF LIVING

Now I am going to ask you about some things some people do to help keep costs down.

In the last 12 months, have you done any of these things? Have you

	Not at all	A little	A lot	
KB1. Gone without fresh fruit and vegetables to help keep costs down?	1	2	3	<input type="checkbox"/>
KB2. Continued wearing clothing that was worn out because you couldn't afford a replacement?	1	2	3	<input type="checkbox"/>
KB3. Put off buying clothes for as long as possible to help keep down costs?	1	2	3	<input type="checkbox"/>
KB4. Stayed in bed longer to save on heating costs?	1	2	3	<input type="checkbox"/>
KB5. Postponed or put off visits to the doctor to help keep down costs?	1	2	3	<input type="checkbox"/>
KB6. NOT picked up a prescription to help keep down costs?	1	2	3	<input type="checkbox"/>
KB7. Spent less time on hobbies than you would like to help keep down costs?	1	2	3	<input type="checkbox"/>
KB8. Done without or cut back on trips to the shops or other local places to help keep down costs?	1	2	3	<input type="checkbox"/>

KB9. Generally, how would you rate your material standard of living? Would you say that it is:

High	Fairly high	Medium	Fairly low	Low	
1	2	3	4	5	<input type="checkbox"/>

KB10. Generally, how satisfied are you with your current material standard of living?

Would you say you were:

Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	
1	2	3	4	5	<input type="checkbox"/>

### FOOD SECURITY

I now want to ask you some questions about particular foods you choose. We are interested in whether you feel you always have sufficient resources to have the food you need for yourself and the people you live with.

First of all, we know that some people can't afford to eat properly and we are interested in whether you think you eat properly. It's what you think eating properly is – not what I or anyone else thinks.

KC1. I/we can afford to eat properly. Is this true ...

Always (Go to KC4)	Sometimes	Never	Don't know	
1	2	3	4	<input type="checkbox"/>

How often have the following statements been true for you (or your household) over the past year? Have they been true often, sometimes, never or you don't know?

	Often	Sometimes	Never	Don't know	
KC2. I/we eat less because of lack of money	1	2	3	4	<input type="checkbox"/>
KC3. The variety of foods I am (we are) able to eat is limited by lack of money	1	2	3	4	<input type="checkbox"/>

KC4. Before you left home, would you say there was a time when you or your family did not have enough food?

0 = No (*Go to LA1*) 1 = Yes

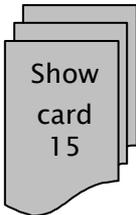
KC4a. If yes, what effect did this have for you?

Very negative	Mainly negative	Neither negative nor positive	Mainly positive	Very positive	
1	2	3	4	5	<input type="checkbox"/>

# 13. Respect

We are almost finished now. There are just a few more questions I'd like to ask you. First, we are interested in how you give and are shown respect

**LA1. Thinking of how things are for you in general, how much respect do you feel you are shown by:**



	None at all	Some	A moderate amount	A lot	A very great deal	N/A	
a. Young people in general?	1	2	3	4	5	6	<input type="checkbox"/>
b. Younger members of your family/ whanau?	1	2	3	4	5	6	<input type="checkbox"/>
d. Your brothers, sisters and cousins currently?	1	2	3	4	5	6	<input type="checkbox"/>
f. Your community/ neighbourhood?	1	2	3	4	5	6	<input type="checkbox"/>
g. Wider society?	1	2	3	4	5	6	<input type="checkbox"/>

Now I would like to ask about discrimination in New Zealand

**LA2. Have you ever been the victim of an ethnically motivated attack (verbal or physical abuse to the person or property) in New Zealand?** *(0 = No 1 = Yes)*

Verbal within the past 12 months       Verbal more than 12 months ago   
 Physical within the past 12 months       Physical more than 12 months ago

**LA3. Have you ever been treated unfairly (e.g. treated differently, kept waiting) by a health professional (e.g. doctor, nurse, dentist etc.) because of your ethnicity in New Zealand?**

*(0 = No 1 = Yes)*  
 Within the past 12 months       More than 12 months ago

**LA4. Have you ever been treated unfairly by a service agency (e.g. WINZ) because of your ethnicity in New Zealand?**

*(0 = No 1 = Yes)*  
 Within the past 12 months       More than 12 months ago

**LA5. Have you ever been treated unfairly when renting or buying housing because of your ethnicity in New Zealand?**

0 = No 1 = Yes

**LA6. Have you ever been treated unfairly because of a disability you have in New Zealand?**

0 = No 1 = Yes

**LA7. Have you ever been treated unfairly because of your age in New Zealand?**

0 = No 1 = Yes

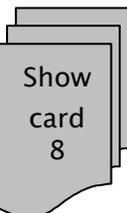
**Maori only to ask the next two questions**

**LA9. How often are you spoken down to as a Maori?**

More than daily	Daily	Twice a week to weekly	Weekly to monthly	Occasionally	Never	
1	2	3	4	5	6	<input type="checkbox"/>

**LA10. How much has colonisation affected the way you live your life today?**

Not at all	A little	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>



**LA11. In general how happy are you with the current government policy on race relations**

Very unhappy	Mainly unhappy	Neither unhappy nor happy	Mainly happy	Very happy	
1	2	3	4	5	<input type="checkbox"/>

I'd like to talk a bit more about your plans for the end of your life

**LB1. How important is it for you to have a plan for the end of your life?**

Not at all	A little	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

**LB2. Which one of these statements would you say is most true for you? I have...**

- 1 = Written down my wishes (e.g. in a living will not a legal will about assets)
- 2 = Talked with someone about my plans for the end of my life
- 3 = Thought about making plans for the end of my life but not acted on or recorded them
- 4 = Done nothing about planning for the end of my life

## 14. Overall Views about growing older

The final questions I want to ask you are about your overall views about growing older and what you have thought about this questionnaire.

**MA2. On the whole has growing older been a positive or negative experience for you?**

Very positive	Mainly positive	Neither positive nor negative	Mainly negative	Very negative	
1	2	3	4	5	<input type="checkbox"/>

**MA1. How much do you agree or disagree with the statement “There is a lot you can do to keep healthy in old age? “**

Strongly agree	Agree	Unsure	Disagree	Strongly disagree	Don't know	
1	2	3	4	5	6	<input type="checkbox"/>

**Are there any areas of your well being that we haven't covered in this questionnaire?**

.....

.....

.....

.....

## THANK YOU

Thank you for being part of this study. The information you have shared is much appreciated and is very important as it will help us find out how life is now for older New Zealanders.

We invite you to stay involved in the study so that we can find out what is important to ongoing wellbeing. That means we would like to talk to you again in the future. Involvement would include completing another questionnaire (shorter than this one) and a few physical assessments. is that okay with you?

Are you willing to be in the longitudinal study, possibly every year for ten years?

Are you willing to be contacted for sub-studies related to the LILAC study?

0 = No 1 = Yes

***Interviewer to answer the following***

How well do you rate the...	Very poor	Poor	Neither good nor poor	Good	Very good	
Reliability of the respondent's responses?	1	2	3	4	5	
Participant's understanding of the questions	1	2	3	4	5	
Participant's level of interest?	1	2	3	4	5	
Participant's level of stamina	1	2	3	4	5	

***Please check that all pages are included in the envelope before delivery to Auckland***

<i>Please tick</i>	<input type="checkbox"/>	Informed Consent completed and enclosed
	<input type="checkbox"/>	Visit record page completed and enclosed
	<input type="checkbox"/>	Picture Page (3MSE) completed and enclosed
	<input type="checkbox"/>	Extra medication page enclosed <i>(or state N/A)</i>
	<input type="checkbox"/>	Physical Assessment record sheet completed and enclosed
	<input type="checkbox"/>	Incident Report enclosed (if used)

Signed by:.....

Name: ..... (Project Coordinator)

Date: ...../...../.....

COMMENTS