Health in the West Midlands:

The Hill Study

Version 1.1,dated 10-Oct-2017

IRAS no: 233714

Sponsor code no: RG-0255-17

The aim of this questionnaire is to find out about your health and how it impacts on activities of daily life. The answers you give in the questionnaire will be treated in the **strictest confidence.**

Please answer even if you have no problems with your health.

Please answer all of the questions unless the instructions ask you to do something else.

Please write in **BLACK PEN** and **BLOCK CAPITALS** where appropriate.

Most of the questions can be answered by putting a cross in a box like this:

For example: *How confident are you at completing forms by yourself?* ☒

Not confident										Very confident
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐

When you have finished please check that you have answered all of the questions and then return the questionnaire in the pre-paid envelope enclosed. You do not need a stamp. Please return the completed questionnaire within the next three weeks.

More details about this study are available in the Participant Information Sheet enclosed.

If you would like further information about this study, please contact the Hill Study co-ordinator on 01782 734721.

Thank you for your help with this research study.

SECTION A: YOUR GENERAL HEALTH

PART 1

We are interested in your general health. Under each heading, please cross the ONE box that best describes your health **TODAY**

a. MOBILITY

I have no problems in walking about..... ☐

I have slight problems in walking about..... ☐

I have moderate problems in walking about..... ☐

I have severe problems in walking about..... ☐

I am unable to walk about..... ☐

b. SELF-CARE

I have no problems washing or dressing myself..... ☐

I have slight problems washing or dressing myself..... ☐

I have moderate problems washing or dressing myself..... ☐

I have severe problems washing or dressing myself..... ☐

I am unable to wash or dress myself..... ☐

c. USUAL ACTIVITIES (e.*g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities..... ☐

I have slight problems doing my usual activities..... ☐

I have moderate problems doing my usual activities..... ☐

I have severe problems doing my usual activities..... ☐

I am unable to do my usual activities..... ☐

d. PAIN / DISCOMFORT

I have no pain or discomfort..... ☐

I have slight pain or discomfort..... ☐

I have moderate pain or discomfort..... ☐

I have severe pain or discomfort..... ☐

I have extreme pain or discomfort..... ☐

e. ANXIETY / DEPRESSION

I am not anxious or depressed..... ☐

I am slightly anxious or depressed..... ☐

I am moderately anxious or depressed..... ☐

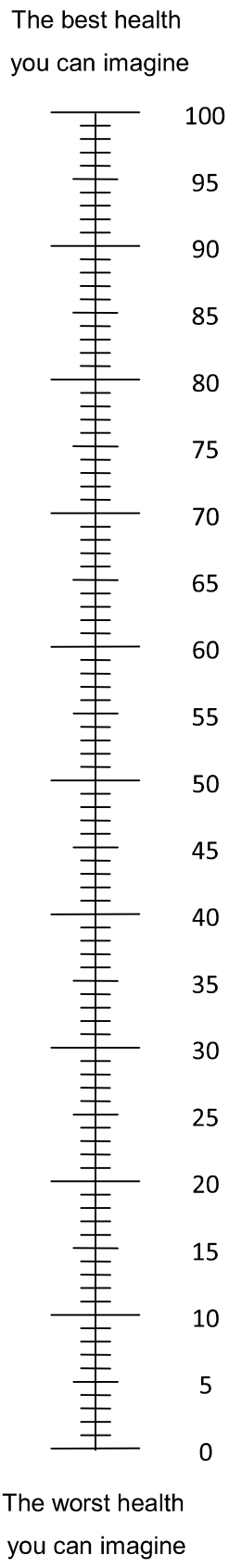
I am severely anxious or depressed..... ☐

I am extremely anxious or depressed..... ☐

We would like to know how good or bad your health is TODAY.

- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐☐☐



PART 2

These questions are about PAIN. Please complete each of the following questions **even if you have not suffered pain.**

	Never	Some days	Most days	Every day
1. In the **past 6 months,** how often did you have pain?	☐	☐	☐	☐
2. Over the **past 6 months**, how often did pain limit your life or work activities?	☐	☐	☐	☐

These questions are about **HOW OFTEN** you have had pain in different parts of the body in the **last 6 months.** Please complete each of the following questions even if you have not suffered pain in any of these areas.

3. On how many days in the **last 6 months** have you had.....?
(For each pain, please put a cross in one box)

	Never	Some days	Most days	Every day
a. Headache.....	☐	☐	☐	☐
b. Neck pain.....	☐	☐	☐	☐
c. Shoulder pain.....	☐	☐	☐	☐
d. Hand / wrist pain.....	☐	☐	☐	☐
e. Chest pain.....	☐	☐	☐	☐
f. Stomach pain.....	☐	☐	☐	☐
g. Back pain.....	☐	☐	☐	☐
h. Hip pain.....	☐	☐	☐	☐
i. Knee pain	☐	☐	☐	☐
j. Foot / ankle pain.....	☐	☐	☐	☐

These next questions are about pain in the PAST 2 WEEKS.

4. In the **past 2 weeks, on average, how intense were each of these pains** rated on a 0-10 scale where 0 is "no pain" and 10 is "pain as bad as could be"? (That is, your usual pain at times you were experiencing pain.)
For each pain, please put a cross in one box. For pains that do not apply to you please put a cross in box 0 to indicate No Pain.

	No pain										**Pain as bad as could be**
	0	1	2	3	4	5	6	7	8	9	10
a. Headache	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. Neck pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Shoulder pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
d. Hand / wrist pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
e. Chest pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
f. Stomach pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
g. Back pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
h. Hip pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
i. Knee pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
j. Foot / ankle pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

These questions are about any **joint, back, neck, bone and muscle symptoms** such as aches, pains and / or stiffness that you may have. Please complete each of the following questions **even if you have not suffered pain in any of these areas.**

For each question **cross (X) one box** to indicate which statement best describes you **over the last 2 weeks.**

5. Pain / stiffness during the **day**
How severe was your usual joint or muscle pain and / or stiffness overall during the **day** in the last 2 weeks?

Not at all	Slightly	Moderately	Fairly severe	Very severe
☐	☐	☐	☐	☐

6. Pain / stiffness during the **night**
How severe was your usual joint or muscle pain and / or stiffness overall during the **night** in the last 2 weeks?

Not at all	Slightly	Moderately	Fairly severe	Very severe
☐	☐	☐	☐	☐

7. Walking
How much have your symptoms interfered with your ability to walk in the last 2 weeks?

Not at all	Slightly	Moderately	Severely	Unable to walk
☐	☐	☐	☐	☐

8. Washing / Dressing
How much have your symptoms interfered with your ability to wash or dress yourself in the last 2 weeks?

Not at all	Slightly	Moderately	Severely	Unable to wash or dress myself
☐	☐	☐	☐	☐

9. Physical activity levels
How much has it been a problem for you to do physical activities (e.g. going for a walk or jogging) to the level you want because of your joint or muscle symptoms in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Unable to do physical activities
☐	☐	☐	☐	☐

10. Work / daily routine
How much have your joint or muscle symptoms interfered with your work or daily routine in the last 2 weeks (including work & jobs around the house)?

Not at all	Slightly	Moderately	Severely	Extremely
☐	☐	☐	☐	☐

11. Social activities and hobbies

How much have your joint or muscle symptoms interfered with your social activities and hobbies in the last 2 weeks due to joint pain?

Not at all	Slightly	Moderately	Severely	Extremely
☐	☐	☐	☐	☐

12. Needing help

How often have you needed help from others (including family, friends or carers) because of your joint or muscle symptoms in the last 2 weeks?

Not at all	Rarely	Sometimes	Frequently	All the time
☐	☐	☐	☐	☐

13. Sleep

How often have you had trouble with either falling asleep or staying asleep because of your joint or muscle symptoms in the last 2 weeks?

Not at all	Rarely	Sometimes	Frequently	Every night
☐	☐	☐	☐	☐

14. Fatigue or low energy

How much fatigue or low energy have you felt in the last 2 weeks?

Not at all	Slight	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

15. Emotional well-being

How much have you felt anxious or low in your mood because of your joint or muscle symptoms in the last 2 weeks?

Not at all	Slightly	Moderately	Severely	Extremely
☐	☐	☐	☐	☐

16. Understanding of your condition and any current treatment

Thinking about your joint or muscle symptoms, how well do you feel you understand your condition and any current treatment (including your diagnosis and medication)?

Completely	Very well	Moderately	Slightly	Not at all
☐	☐	☐	☐	☐

17. Confidence in being able to manage your symptoms

How confident have you felt in being able to manage your joint or muscle symptoms by yourself in the last 2 weeks (e.g. medication, changing lifestyle)?

Extremely	Very	Moderately	Slightly	Not at all
☐	☐	☐	☐	☐

18. Overall impact

How much have your joint or muscle symptoms bothered you overall in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐

19. Physical activity levels

In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your heart rate? *This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places, but should not include housework or physical activity that is part of your job.*

None	1 day	2 days	3 days	4 days	5 days	6 days	7 days
☐	☐	☐	☐	☐	☐	☐	☐

20. Previous injury and family history	Yes	No	Not sure
a. Have you ever **injured your hip(s) or knee(s)** badly enough to see a doctor about it?	☐	☐	☐
b. Have either or both of your biological parents **broken their hip?**	☐	☐	☐
c. Do you have any blood relatives (father, mother, brother, sister) who have had a **hip replacement** or a **knee replacement?**	☐	☐	☐

PART 3

These questions are about how you may manage your pain.

1. In the **last month,** have you **bought** any of the following **medicines for your pain** from the pharmacy or supermarket **that were not prescribed by a doctor.**
(*Please cross one box for each)*

	Yes	No
a. Paracetamol.....	☐	☐
b. Anti-inflammatory tablets (e.g. Ibuprofen, Naproxen).....	☐	☐
c. Co-codamol	☐	☐
d. Glucosamine / Chrondroitin sulphate.....	☐	☐
e. Anti-inflammatory creams, gels, rub-ons, sprays (e.g. Emugel, Feldene, Ibuleve, Movelat, Traxam).....	☐	☐

2. In the **last 6 months,** have you seen any of these health care professionals **for your pains.**

	Yes	No
a. Consultant / hospital specialist.....	☐	☐
b. Physiotherapist.....	☐	☐
c. Hospital nurse.....	☐	☐
d. Chiropractor OR Osteopath.....	☐	☐
e. Acupuncturist.....	☐	☐
f. Other (please specify below).....	☐	☐

.....

PART 4

We would like to know if you have any other health problems.
For each question, **please put a cross in one box.**

	Yes	No	Not sure
1. Do you have high blood pressure?	☐	☐	☐
2. Have you received blood pressure treatment?	☐	☐	☐
3. Do you suffer from diabetes?	☐	☐	☐
4. Do you have a chronic kidney disease?	☐	☐	☐
5. Have you suffered from atrial fibrillation?	☐	☐	☐
6. Do you have rheumatoid arthritis?	☐	☐	☐
7. Have you ever suffered from cardiovascular disease?	☐	☐	☐
8. Does a close relative under 60 suffer from cardiovascular disease?	☐	☐	☐
9. Have you been diagnosed / told by a doctor that you have osteoarthritis ('wear and tear' arthritis)?	☐	☐	☐

10. Please respond by putting a **cross in one box for** each of the following statements.

	Never	Rarely	Sometimes	Usually	Always
a. I have trouble doing all of my regular leisure activities with others	☐	☐	☐	☐	☐
b. I have trouble doing all of the family activities that I want to do	☐	☐	☐	☐	☐
c. I have trouble doing all of my usual work (include work at home)	☐	☐	☐	☐	☐
d. I have trouble doing all of the activities with friends that I want to do	☐	☐	☐	☐	☐

11. Please respond by putting a **cross in one box for** each question.

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
a. Are you able to do chores such as vacuuming and gardening?	☐	☐	☐	☐	☐
b. Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
c. Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
d. Are you able to get out and about or go shopping?	☐	☐	☐	☐	☐
e. Are you able to open jars that have never been opened?	☐	☐	☐	☐	☐

12. Thinking back over the **past 4 weeks,** did you....?
(Please put a cross in one box on each line)

	Not at all	**On some nights**	**On most nights**
a. Have trouble falling asleep.....	☐	☐	☐
b. Wake up several times per night.....	☐	☐	☐
c. Have trouble staying asleep.....	☐	☐	☐
d. Wake up after your usual amount of sleep feeling tired and worn out.....	☐	☐	☐

13. In the past 7 days.....
(Please put a cross in one box on each line)

	Not at all	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
a. My mind has been as sharp as usual.....	☐	☐	☐	☐	☐
b. My memory has been as good as usual.....	☐	☐	☐	☐	☐
c. My thinking has been as fast as usual.....	☐	☐	☐	☐	☐
d. I have been able to keep track of what I am doing, even if I am interrupted.....	☐	☐	☐	☐	☐

14. Do you have any of the following? **(Cross all the boxes that apply)**

☐ Home computer (including laptops)

☐ Tablet computer

☐ Smartphone

☐ Mobile phone

☐ None of the above (Please go to question 17).

	Yes	**No**
15. Do you have health apps on your phone, tablet or computer?.....	☐	☐

	Yes	**No**
16. In the previous month, have you searched the internet for information to improve your health (for example, used www.nhs.uk or NHS choices)?	☐	☐

17. These are questions about how it is for you to find, understand and use information related to health, illness and medical care and support you may receive from others.
Place a cross in the box on each line that best matches your answer.

How easy / difficult is it for you to....	Very easy	Easy	Difficult	Very difficult
a. Judge when you need to get a second opinion from another doctor?	☐	☐	☐	☐
b. Use information the doctor gives you to make decisions about your illness?	☐	☐	☐	☐
c. Find information on how to manage mental health problems such as stress and depression?	☐	☐	☐	☐
d. Judge if the information on health risks in the media is reliable (e.g. from TV or internet)?	☐	☐	☐	☐
e. Find out about activities that are good for your mental well-being (e.g. meditation, exercise and walking)?	☐	☐	☐	☐
f. Understand information in the media on how to get healthier (e.g. from the internet, daily or weekly magazines)?	☐	☐	☐	☐

	Never	Rarely	Sometimes	Often	Always
g. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	☐	☐	☐	☐	☐
h. I have someone who will listen to me when I need to talk	☐	☐	☐	☐	☐
i. I have someone to confide in or talk to about myself or my problems	☐	☐	☐	☐	☐
j. I have someone who makes me feel appreciated	☐	☐	☐	☐	☐
k. I have someone to talk with when I have a bad day	☐	☐	☐	☐	☐

PART 5

The following questions are about how you feel at the moment. Please read each item and put a cross in the box of the reply that comes closest to how you have been feeling **in the past week.** Don't take too long over your replies: your immediate reaction to each item will usually be more accurate than a long thought out response.

1. I feel tense or 'wound up':

Most of the time	A lot of the time	From time to time, occasionally	Not at all
☐	☐	☐	☐

2. I still enjoy the things I used to enjoy:

Definitely as much	Not quite as much	Only a little	Hardly at all
☐	☐	☐	☐

3. I get a sort of frightened feeling as if something awful is about to happen:

Very definitely and quite badly	Yes, but not too badly	A little, but it doesn't worry me	Not at all
☐	☐	☐	☐

4. I can laugh and see the funny side of things:

As much as I always could	Not quite so much now	Definitely not so much now	Not at all
☐	☐	☐	☐

5. Worrying thoughts go through my mind:

A great deal of the time	A lot of the time	Not too often	Very little
☐	☐	☐	☐

6. I feel cheerful:

Never	Not often	Sometimes	Most of the time
☐	☐	☐	☐

7. I can sit at ease and feel relaxed:

Definitely	Usually	Not often	Not at all
☐	☐	☐	☐

8. I feel as if I am slowed down:

Nearly all the time	Very often	Sometimes	Not at all
☐	☐	☐	☐

9. I get a sort of frightened feeling like 'butterflies' in my stomach:

Not at all	Occasionally	Quite often	Very often
☐	☐	☐	☐

10. I have lost interest in my appearance:

Definitely	I don't take as much care as I should	I may not take quite as much care	I take just as much care as ever
☐	☐	☐	☐

11. I feel restless as if I have to be on the move:

Very much indeed	Quite a lot	Not very much	Not at all
☐	☐	☐	☐

12. I look forward with enjoyment to things:

As much as I ever did	Rather less than I used to	Definitely less than I used to	Hardly at all
☐	☐	☐	☐

13. I get sudden feelings of panic:

Very often indeed	Quite often	Not very often	Not at all
☐	☐	☐	☐

14. I can enjoy a good book or radio or television programme:

Often	Sometimes	Not often	Very seldom
☐	☐	☐	☐

SECTION B: LIFESTYLE

1. What is your weight? ☐☐ st ☐☐ lbs or ☐☐☐ kgs

2. What is your height? ☐☐ ft ☐☐ in or ☐☐☐ cms

3. Thinking about your weight, in the past 12 months have you lost more than 10 pounds (4.5kg) **unintentionally** *(*i.e. without dieting or exercise*)?* **(please put a cross in one box only)** Yes ☐ No ☐

4. Pick the description that matches you best **(please put a cross in one box only)**.....

I have never smoked..... ☐

I am a former smoker (last smoked more than 12 months ago)..... ☐

I am a current smoker or I smoked regularly in the last 12 months and I smoke .....

1-5 cigarettes / day..... ☐

6-10 cigarettes / day..... ☐

11-15 cigarettes / day..... ☐

16-20 cigarettes / day..... ☐

More than 20 cigarettes / day..... ☐

	Currently using	**I have in the past**	**Never**
5. Have you ever used e-cigarettes? **(Please put a cross in one box only)**.....	☐	☐	☐

6. Over the past 12 months, what has been your typical exposure to **other people's tobacco smoke? (Please put a cross in one box only)**

Less than 1 hour of exposure per week or no exposure..... ☐

One or more hours of second-hand smoke exposure per week..... ☐

7. About how often do you drink alcohol? ***(Please put a cross in one box only)***

Daily or almost daily	3 or 4 times a week	Once or twice a week	1 to 3 times a month	Special occasions only	Never
☐	☐	☐	☐	☐	☐

↓

Please **go to question 10.**

8. In an **average week** how many.....

	Number
a. **regular** (175ml) glasses of **wine** would you drink? (*there are roughly four regular glasses in an average bottle*)	☐☐
b. pints of **beer** or **cider** would you drink? *(includes bitter, lager, stout, ale, Guinness)*	☐☐
c. **single** measures (25ml) of **spirits or liqueurs** would you drink? (*includes drinks such as whisky, gin, vodka)*	☐☐

9. Compared to 10 years ago, do you drink.....

More nowadays	About the same	Less nowadays	Don't know
☐	☐	☐	☐

10. Please tell us about the food you eat.

	Number
a. How many **portions of fruit** did you eat **yesterday?** (Please include all fruit including fresh, frozen, tinned fruit, stewed fruit or fruit juices and smoothies	☐☐
b. How many **portions of vegetables** did you eat **yesterday?** (Please include fresh, frozen, raw or tinned vegetables, but do not include any potatoes you ate)	☐☐
c. How many **salty foods or snacks** did you eat **yesterday?**	☐☐
d. How many **sugary snacks or drinks** did you eat or drink **yesterday?**	☐☐
e. How many **portions of fish** do you eat in **an average week?**	☐☐
f. How many times do you eat **deep fried foods or snacks or fast foods** in **an average week?**	☐☐

11. Please tell us **the type and amount of physical activity** involved in your work. (**Please cross one box only).**

a. I am not in employment (e.g. retired, retired on health reasons, unemployed, full-time carer etc.)	☐
b. I spend most of my time at work sitting (such as in an office)	☐
c. I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	☐
d. My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery worker, etc.)	☐
e. My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	☐

12. During the **last week,** how many hours did you spend on each of the following?
(Please answer whether you are in employment or not)

	None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
a. Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.	☐	☐	☐	☐
b. Cycling, including cycling to work and during leisure time	☐	☐	☐	☐
c. Walking, including walk to work, shopping, for pleasure etc.	☐	☐	☐	☐
d. Housework / Childcare	☐	☐	☐	☐
e. Gardening / DIY	☐	☐	☐	☐

13. Below is a list of ways you might have **felt or behaved** - please tell us how often you have felt this way during the **past 7 days** including **today** (Please cross one box per question only)

	Rarely or none of the time (less than one day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)	Most or all of the time (5-7 days)
a. I felt that everything I did was an effort	☐	☐	☐	☐
b. I could not get "going"	☐	☐	☐	☐

14. How would you describe your **usual walking pace?** ***(Please cross one box only)***

Slow pace (i.e. less than 3 mph)	Steady average pace	Brisk pace	Fast pace (i.e. over 4 mph)
☐	☐	☐	☐

15. Have you had **any falls** in the **past 12 months?**
(Please put a cross in one box only)

☐ No falls ☐ One fall ☐ More than one fall

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SECTION C: ABOUT YOU AND YOUR CIRCUMSTANCES

This section contains general questions about yourself and your circumstances. Please follow the instructions and answer ALL of the questions relevant to you.

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

(For example - if you were born on the 5th of June 1936, this would be entered as 05/06/36)

2. Are you: Female ☐ Male ☐

3. What is your ethnic group?
(Please put a cross in one box only)

☐ White ☐ Black-Caribbean ☐ Black-African

☐ Black-Other ☐ Indian ☐ Pakistani

☐ Bangladeshi ☐ Chinese

☐ Other (please specify).....

4. How old were you when you left school? ☐☐ years old

	Yes	No
5. Did you go on from school to full-time education or university?	☐	☐

6. Do you have any of the following qualifications? ***(Cross all boxes that apply)***

a) O Levels / GCSEs (or equivalents) ☐ b) A Levels (or equivalents) ☐

c) Vocational training certificate(s) (e.g. City and Guilds, NVQ) ☐ d) University degree(s) or HND ☐

e) Higher professional qualifications (e.g. in accountancy, law, etc.) ☐

7. What is your current marital status?
(Please put a cross in one box only)

Married	Separated	Divorced	Widowed	Cohabiting	Single
☐	☐	☐	☐	☐	☐

8. Thinking about the cost of living as it affects you, which of these descriptions best describes your situation. ***(Please put a cross in one box only)***

Find it a strain to get by from week to week	Have to be careful with money	Able to manage without much difficulty	Quite comfortably off
☐	☐	☐	☐

9. How often have you felt work or home life stress in the last year?

Never	Some periods	Several periods of stress	Permanent stress
☐	☐	☐	☐

10. Use the following scale to put a cross in the box for each statement to indicate how much you disagree or agree with each of the statements.
(Please put a cross in one box only on each line)

	Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
a. I tend to bounce back quickly after hard times	☐	☐	☐	☐	☐
b. I have a hard time making it through stressful events	☐	☐	☐	☐	☐
c. It does not take me long to recover from a stressful event	☐	☐	☐	☐	☐
d. It is hard for me to snap back when something bad happens	☐	☐	☐	☐	☐
e. I usually come through difficult times with little trouble	☐	☐	☐	☐	☐
f. I tend to take a long time to get over set-backs in my life	☐	☐	☐	☐	☐

11. What is your current employment status?
(Please put a cross in one box only)

In paid employment or self-employed	Unable to work because of sickness or disability	Retired	Unemployed / seeking work	Looking after home and / or family	Doing unpaid or voluntary work	Full or part-time student	Other
☐	☐	☐	☐	☐	☐	☐	☐

12. If you are **working** what is your job title?
(examples - factory worker, welder, office worker, lawyer)

13. If you provided a job title in the question above please state in which field of employment this is
(examples - manufacturing, civil service, health care)

14. If you are **not working** or **retired** what job have you done for **most** of your working life?
(examples - factory worker, welder, office worker, lawyer)

15. If you provided a job title in the question above please state in which field of employment this was
(examples - manufacturing, civil service, health care)

16. Do you look after, or give any help or support to family members, friends, neighbours or others because of either:- **long-term physical or mental ill-health / disability? problems related to old age?**
Do not count anything you do as part of paid employment

No	Yes, 1-19 hours a week	Yes, 20-49 hours a week	Yes, 50 or more hours a week
☐	☐	☐	☐

These questions are about **your current work.** If you are not working, please **go to SECTION D.**

17. How would you best describe your **typical working week i**n the **last 12 months?**

Working full-time (30 hours or more per week)	Working part-time (29 hours or less per week)
☐	☐

18. How satisfied are you with your employment?

Very satisfied	Satisfied	No opinion	Not very satisfied	Not at all satisfied
☐	☐	☐	☐	☐

19. During the past seven days, how many hours did you miss from work because of your health problems? *Include hours you missed on sick days, times you went in late, left early, etc., because of your health problems.*

☐☐ hours

20. During the past seven days, how many hours did you miss from work because of any other reason, such as vacation, holidays, time off to participate in this study?

☐☐ hours

21. During the past seven days, how many hours did you actually work?

☐☐ hours

22. During the past seven days, how much did your health problems affect your productivity **while you were working?**

Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If health problems affected your work only a little, choose a low number. Choose a high number if health problems affected your work a great deal
(Please put a cross in one box only)

Consider only how much health problems affected productivity while you were working

	0	1	2	3	4	5	6	7	8	9	10	
Health problems had no effect on my work	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	**Health problems completely prevented me from working**

23. Please describe your work experiences **in the past month.** These experiences may be affected by many environmental as well as personal factors, and may change from time to time. For each of the following statements, please cross one of the following responses to show your agreement or disagreement with this statement in describing *your* work experiences **in the past month.**

	Strongly disagree	Somewhat disagree	Uncertain	Agree	Somewhat agree
a. Because of problems with my health, the stresses of my job were much harder to handle.	☐	☐	☐	☐	☐
b. Despite having problems with my health, I was able to finish hard tasks in my work.	☐	☐	☐	☐	☐
c. A health problem distracted me from taking pleasure in my work.	☐	☐	☐	☐	☐
d. I felt hopeless about finishing certain work tasks, due to problems with my health.	☐	☐	☐	☐	☐
e. At work, I was able to focus on achieving my goals despite health problems.	☐	☐	☐	☐	☐
f. Despite having health problems, I felt energetic enough to complete all my work.	☐	☐	☐	☐	☐

24. When you have difficulties at work, how often do you get help and support from your colleagues, supervisor or manager?
(Please put a cross in one box only)

Often	Sometimes	Rarely / never	Not applicable (work alone)
☐	☐	☐	☐

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Data Entry	Quality Checked

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SECTION D: CONTINUING TO HELP WITH THIS STUDY

Thank you very much for completing this questionnaire.

Please ensure that you have read the enclosed Participant Information Sheet (**version 1.1 dated 10-Oct-2017)** that explains about the study.

By completing and returning this questionnaire, you confirm that you have read and understood the Participant Information Sheet and are willing to take part in the study.

You can withdraw from the study at any time, and this will not affect the care you receive in any way.

Consent form

As well as completing this questionnaire, we would like your permission to review your medical records held by your GP. More details on this can be found in the Participant Information Sheet.

Please read and complete the following consent form, and then sign below.
Please answer each statement by putting a cross in the box on each line.

	Yes	No
I give my permission for my medical records to be reviewed for this study.....	☐	☐
I am happy to be contacted about future research studies (this does not mean that you must take part in future - you are just agreeing to be contacted again).....	☐	☐

Signed: ..... Date: .....

Please print your name and address:

Title: ..... Forename: ..... Surname: .....

Address: .....

..... Town/City: .....

County: ..... Postcode: .....

Even if you would prefer us not to review your medical records the answers you have given in this questionnaire will still be very important to us.

Please return your questionnaire in the pre-paid envelope provided (no stamp needed)
Thank you for your help with this research study

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Logged 1	DB Logged