SERIAL#



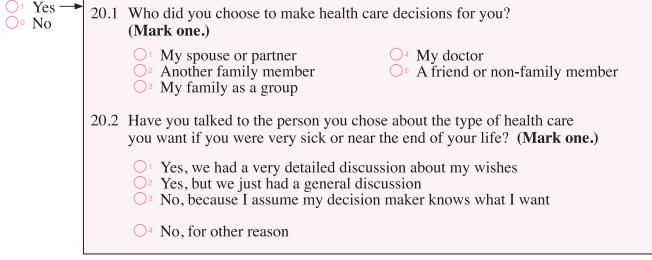
Form 156 - Supplemental Questionnaire

MARKING INSTRUCTIONS CORRECT MARK · Use a Pencil. $\bigcirc \bigcirc \bigcirc \bigcirc$ • Darken the circle completely next to the answer you choose. INCORRECT MARKS • Erase cleanly any marks you wish to change. • Do not make any stray marks on this form. This questionnaire asks about you, your home, your phone and computer use, and your health care. Your answers will help us understand the health of women like you. OFFICE USE ONLY 1. What year was your mother born? 2. What year was your father born? 3. What is your current weight? 0 1-2 5-6 10 or more 4. How many close friends do you have? 5. How many close relatives do you have? 6. As people grow older they sometimes need to make changes to their home so that it is a safer and easier place to live. Please read the list below and mark any changes or additions you have made to your home for yourself or someone else. Be sure to mark all that apply. Railings or banisters O Decreasing clutter O² Grab bars O7 Increasing lighting O³ Indoor or outdoor ramps O⁸ Sink/counter heights O4 Non-slip surfaces Og Other O₅ Tacking down carpets/rugs ○¹º No changes 7. In the last year, did you fall at home? Oo No O1 Yes 8. Do you wear a device around your neck or wrist for O1 Yes \bigcirc No contacting emergency help? Public reporting for this collection of information is estimated to average 8.5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the information needed and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it is displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0414). Do not return the completed form to this address. **AFFIX LABEL BETWEEN LINES Date Received: BAR CODE HERE** OFFICE USE ONLY Reviewed By: | Language: ○ RCR

PLEASE MAKE NO MARKS IN THIS AREA

					No	Yes	Don't know/ Not sure
9. During the past 12 months, have you had a seasonal flu shot?				0	<u></u> 1	<u>2</u>	
10. A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's life and is different from the flu shot.							
Have you ever had a pneumonia shot?					0	<u></u> 1	<u></u> 2
11. Have you had the shingles vaccine (also known as the zoster vaccine)?					0	<u></u> 1	<u></u> 2
12. As an adult, have you had pneumonia diagnosed by a physician?							
01 Yes 00 No	-	12.1 How long	ago was your last	pneumonia	diagnosed	1?	
O² Don't kno Not sure	w/	O1 Less than 6 months O2 6 to 12 months ago O4 Greater than 3 years ago O4 Greater than 3 years ago					
13. Has a health care provider ever told you that you had a urinary tract infection (bladder infection, cystitis, kidney infection, pyelonephritis)?							
01 Yes ——— 00 No	•	13.1 How long	ago was your last	urinary trac	t infection	n?	
O² Don't know/ Not sure		Less than 6 months of to 12 months ago of to 12 months ago of Greater than 3 years ago					
14. Have you ever	had shingle	s?					
O¹ Yes O⁰ No O² Don't know/ Not sure		14.1 How long ago did you have shingles?					
		O¹ Less than 6 months O² 6 to 12 months ago O⁴ Greater than 3 years ago O⁴ Greater than 3 years ago					
15. When was the	last time yo	u saw an eye do	ctor?				
1 year ago 1 1 year ago 1 1 years ago 2 1-2 years ago 4 I do not see an eye doctor							
16. Have you ever	been told by	y an eye doctor	that you have gla	ucoma?			
\bigcirc Yes \longrightarrow 1	6.1 How o	d were you whe	n diagnosed with	glaucoma?			
		45 O ² 45-54		O ₄ 65-74		75-84	O ₆ ≥ 85
	16.2 Has your glaucoma been treated with any of the following? (Mark all that apply.)						
	O¹ Ey	e drops	O² Laser tro	eatment	○³ Ot	her surg	ery

sick to live on your own, being very sick and you cannot speak for yourself, or being near the end of your life and you cannot speak for yourself.



21. Have you made plans for what should happen if you become too sick to live on your own? (Mark one.)

O1 Yes, I have made plans O2 No, I haven't given it much thought O₃ No, I don't have plans but I have thought about it

Thank you. Please take a moment to review any questions you may have missed.

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