Form 161 – Supplemental Questionnaire

Ver. 1

Please use a pencil or black pen only to complete this form.

1. Think about the walking you do inside and outside the home. How often do you walk inside or outside the home for more than 10 minutes without stopping? **Mark only one.**

- ○0 Rarely or never → **Go to Question 2.**
- ○1 1 to 3 times each month
- ○2 1 time each week
- ○3 2 to 3 times each week
- ○4 4 to 6 times each week
- ○5 7 or more times each week

→ **Go to Question 1.1 below.**

When you walk inside or outside the home for more than 10 minutes without stopping,

1.1. For how many minutes do you usually walk?

- ○1 Less than 20 minutes
- ○2 20 to 39 minutes
- ○3 40 to 59 minutes
- ○4 1 hour or more

1.2. What is your usual speed?

- ○2 Casual strolling or walking (less than 2 miles an hour)
- ○3 Average or normal (2-3 miles an hour)
- ○4 Fairly fast (3-4 miles an hour)
- ○5 Very fast (more than 4 miles an hour)
- ○9 Don't know

2. During a usual day and night, about how many hours do you spend sitting? Be sure to include the time you spend sitting at work, sitting at the table eating, driving or riding in a car or bus, and sitting up watching TV or talking. **Mark only one.**

Less than 4 hours	4-5 hours	6-7 hours	8-9 hours	10-11 hours	12-13 hours	14-15 hours	16 or more hours
○1	○2	○3	○4	○5	○6	○7	○8

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3. Which of the following best describes the home where you are **currently** living? **Mark only one home type.**

A detached, single-family home with:

- ○1 A full or partial basement
- ○2 No basement, but with a crawl space below ground level
- ○3 No areas below ground level (e.g., a crawl space or concrete slab at ground level)

A multi-unit building of rooms, apartments, condos, or townhomes with:

- ○4 One or more floors of **your** home at or below ground level
- ○5 All floors of **your** home above ground level (on the second floor or higher)
- ○6 Don't know how the floors of **your** home relate to ground level

Another type of home:

- ○7 A mobile home or trailer
- ○8 Other

4. Which of these statements are true in the home where you are **currently** living?

	Yes	No	Don't know
4.1. Natural gas is used most for cooking (Note: liquid propane, LP & bottled gas are *not* natural gas)	○1	○0	○9
4.2. Most of the water comes from a well	○1	○0	○9
4.3. The air has been tested for radon	○1	○0	○9

Go to Question 5.

4.4. Was the radon level ever high enough for you or someone else to do anything to lower it?

- ○1 Level was low
- ○2 Level was high, nothing was done
- ○3 Level was high, something was done → When? Month: __ __ Year: __ __ __ __
- ○9 Don't know test result or don't know if anything was done

5. In general, how healthy is your overall diet? Would you say:

Excellent	Very Good	Good	Fair	Poor
○1	○2	○3	○4	○5

6. How many full meals do you eat each day?

Fewer than one	One	Two	Three	More than three
○1	○2	○3	○4	○5

7. I drink the following amount of beverages (water, tea, coffee, Boost, Ensure, juice, regular or diet soda, and other drinks) **each day**: (Note: One cup = 8 fluid ounces)

- ○1 Less than four cups (32 fluid ounces) per day
- ○2 Four cups (32 fluid ounces) to less than eight cups (64 fluid ounces) per day
- ○3 Eight cups (64 fluid ounces) or more per day

	Yes	No
8. I eat alone most of the time.	○1	○0
9. I have tooth or mouth problems that make it hard for me to eat.	○1	○0
10. I have problems with swallowing that make it hard for me to eat.	○1	○0
11. I have difficulty smelling odors, including smelling my food.	○1	○0
12. I have difficulty tasting flavors, including tasting my food.	○1	○0
13. I don't always have enough money to buy the food I need.	○1	○0
14. I take pleasure in my food and eating.	○1	○0
15. I enjoy eating with others.	○1	○0

16. Which statement best describes your hearing **without** a hearing aid, personal sound amplifier, or other listening devices?

Excellent	Good	A little trouble	Moderate trouble	A lot of trouble	Deaf	Don't know
○1	○2	○3	○4	○5	○6	○9

17. Do you regularly wear a hearing aid or other listening device? ○1 Yes ○0 No → **Go to Question 19.**

18. Which statement best describes your hearing **with** your listening device?

Excellent	Good	A little trouble	Moderate trouble	A lot of trouble	Deaf	Don't know
○1	○2	○3	○4	○5	○6	○9

19. At the present time, would you say that your eyesight, with glasses or contacts if you wear them, is:

Excellent	Good	Fair	Poor	Very Poor	Don't know
○1	○2	○3	○4	○5	○9

20. The next questions ask about companionship.	Hardly ever	Some of the time	Often
20.1. How often do you feel that you lack companionship?	○1	○2	○3
20.2. How often do you feel left out?	○1	○2	○3
20.3. How often do you feel isolated from others?	○1	○2	○3

Questions 21-26 ask about your feelings during the past week. For each of the statements, indicate the choice that tells how often you felt this way.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
21. You felt depressed (blue or down)	○1	○2	○3	○4
22. Your sleep was restless	○1	○2	○3	○4
23. You enjoyed life	○1	○2	○3	○4
24. You had crying spells	○1	○2	○3	○4
25. You felt sad	○1	○2	○3	○4
26. You felt that people disliked you	○1	○2	○3	○4

27. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed, or lost pleasure in things that you usually cared about or enjoyed?
○1 Yes ○0 No

28. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?
○1 Yes ○0 No

28.1. If yes, have you felt depressed or sad much of the time in the past year?
○1 Yes ○0 No

29. Have you taken medication during the past four weeks for:

29.1. High cholesterol, e.g. statins?	○1 Yes	○0 No	○9 Don't know
29.2. High blood pressure or hypertension?	○1 Yes	○0 No	○9 Don't know
29.3. High blood sugar or diabetes?	○1 Yes	○0 No	○9 Don't know
29.4. Blood thinning (*not* including aspirin)?	○1 Yes	○0 No	○9 Don't know
29.5. Trouble sleeping?	○1 Yes	○0 No	○9 Don't know
29.6. Pain management?	○1 Yes	○0 No	○9 Don't know

30. Do you currently take any of the following regularly?

30.1. Calcium supplements	○1 Yes	○0 No	○9 Don't know
30.2. Vitamin D supplements	○1 Yes	○0 No	○9 Don't know
30.3. Multivitamins	○1 Yes	○0 No	○9 Don't know

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