

These first questions ask about your general health.

1. In general, would you say your health is:
- | | | | | | |
|--|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| | Excellent | Very good | Good | Fair | Poor |
| | <input type="radio"/> ₁ | <input type="radio"/> ₂ | <input type="radio"/> ₃ | <input type="radio"/> ₄ | <input type="radio"/> ₅ |
2. Compared to one year ago, how would you rate your health in general now?
- | | | | | | |
|--|------------------------------------|-------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| | Much better now than 1 year ago | Somewhat better now than 1 year ago | About the same | Somewhat worse now than 1 year ago | Much worse now than 1 year ago |
| | <input type="radio"/> ₁ | <input type="radio"/> ₂ | <input type="radio"/> ₃ | <input type="radio"/> ₄ | <input type="radio"/> ₅ |
3. Overall, how would you rate your quality of life? (Mark one circle below.)

0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worst					Halfway					Best

As bad or worse than being dead

Best quality of life

4. How would you describe (Mark one circle on each line.)
- | | | | | | |
|--|-----------|-----------|---------|------|-----------|
| | Excellent | Very good | Average | Poor | Very poor |
|--|-----------|-----------|---------|------|-----------|
- 4.1 Your hearing? ₁ ₂ ₃ ₄ ₅
- 4.2 The condition of your mouth and teeth? ₁ ₂ ₃ ₄ ₅
- 4.3 Your vision (corrected with glasses or lenses as needed)? ₁ ₂ ₃ ₄ ₅
- 4.4 Your appetite? ₁ ₂ ₃ ₄ ₅
- 4.5 Your balance? ₁ ₂ ₃ ₄ ₅

5. Are you taking a calcium supplement such as Oscal, Viactiv, or Tums?

₀ No ₁ Yes

The next question is about female hormones you got with a doctor's prescription in the last year, even if you are not taking them right now.

6. **In the past year**, did you use any of the following female hormones—ESTROGEN, PROGESTERONE (also called PROGESTIN), or TESTOSTERONE—that were prescribed by a doctor? (These may have been in the form of a pill; skin patch; shot; cream; vaginal ring, pellet, or suppository; or bioidentical compound.)

₀ No ₁ Yes ₉ Don't know

The next questions are about your usual physical activity and exercise.

20. Think about the walking you do outside the home. How often do you walk outside the home **for more than 10 minutes without stopping?** (Mark only one.)

- 0 Rarely or never → Go to Question 21 below.
- 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

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

20.1 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

20.2 What is your usual speed?

- 2 Casual strolling (2 miles per 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

21. Not counting walking outside the home, how often **each week** (7 days) do you usually do the exercises listed below?

21.1 Moderate or strenuous exercise. For example, biking outdoors, using an exercise machine (like a stationary bike or treadmill), aerobics, swimming, folk or popular dancing, jogging, tennis.

- 0 None → Go to the next page.
- 1 1 day per week
- 2 2 days per week
- 3 3 days per week
- 4 4 days per week
- 5 5 or more days per week

21.2 How long do you usually exercise like this at one time?

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

The next questions are about your living conditions.

29. Do you live alone?

- ⁰ Yes ¹ No

29.1 Who lives with you? (Mark all that apply.)

- ¹ I live with my husband or partner
- ² I live with my children
- ³ I live with other relatives
- ⁴ I live with friends
- ⁸ Other (please describe): _____

30. Does the place where you live have special services for older people (such as help with meals, medicines, bathing, or transportation)?

- ⁰ No ¹ Yes

30.1 Are you currently receiving any of these services?

- ⁰ No ¹ Yes


31. In the past year, have you stayed in a nursing home?

- ⁰ No ¹ Yes

Now some questions about your social activities. How often, if at all, do you do any of the following activities? (Mark one circle on each line.)

	At least once a week	Several times a month	Once a month	Rarely or never
32. Eat out of the house	<input type="radio"/> ⁴	<input type="radio"/> ³	<input type="radio"/> ²	<input type="radio"/> ¹
33. Go shopping	<input type="radio"/> ⁴	<input type="radio"/> ³	<input type="radio"/> ²	<input type="radio"/> ¹
34. Go to a cultural event such as a movie, concert, play, or lecture	<input type="radio"/> ⁴	<input type="radio"/> ³	<input type="radio"/> ²	<input type="radio"/> ¹
35. Meet with family or friends who do not live with you	<input type="radio"/> ⁴	<input type="radio"/> ³	<input type="radio"/> ²	<input type="radio"/> ¹
36. Communicate with family or friends by phone or email	<input type="radio"/> ⁴	<input type="radio"/> ³	<input type="radio"/> ²	<input type="radio"/> ¹
37. Go to a church or other religious center	<input type="radio"/> ⁴	<input type="radio"/> ³	<input type="radio"/> ²	<input type="radio"/> ¹

Below are some hard things that sometimes happen to people. Please try to think back over the past year to remember if any of these things happened. Mark the answer that seems best.

Over the past year:	Yes, and it upset me:			
	No	Not too much	Moderately (Medium)	Very much
48. Did your spouse or partner have a serious illness?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
49. Did a close friend or family member die or have a serious illness (other than your spouse or partner)?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
50. Did you have any major problems with money?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
51. Did you have a divorce or break-up with a spouse or partner?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
52. Did a family member or close friend have a divorce or break-up?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
53. Did you have a major conflict with children or grandchildren?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
54. Did you have any major accidents, disasters, mugging, unwanted sexual experiences, robberies, or similar events?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
55. Did you or a family member or close friend lose their job or retire?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
56. Were you physically abused by being hit, slapped, pushed, shoved, punched or threatened with a weapon by a family member or close friend?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
57. Were you verbally abused by being made fun of, severely criticized, told you were a stupid or worthless person, or threatened with harm to yourself, your possessions, or your pets, by a family member or close friend?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
58. Did a pet die?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
59. Did your spouse or partner die? 	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

If you answered yes to Question 59, please mark the answer that best describes how you feel right now about the person who died.

	Never	Rarely	Sometimes	Often	Always
59.1 I feel myself longing or yearning for my spouse or partner who died—I miss them so much it's hard to care about anything else.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
59.2 I think about this person so much that it's hard for me to do the things I normally do.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

Below is a list of symptoms women sometimes have as they become older or after menopause. For each item, mark the one circle that best describes how bothersome the symptom was **over the past year**.
Be sure to mark one circle on each line.

If you did not have the problem, please mark the circle under “symptom did not occur.”
If you had the symptom, use the following key to indicate how bothersome it was:

Mild = symptom did not interfere with usual activities
 Moderate = symptom interfered somewhat with usual activities
 Severe = symptom was so bothersome that usual activities could not be performed

	Symptom did not occur	Symptom occurred and was:		
		Mild	Moderate	Severe
60. Night sweats	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
61. General aches or pains	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
62. Breast tenderness	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
63. Hot flashes	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
64. Mood swings	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
65. Irritability	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
66. Feeling tired	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
67. Forgetfulness	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
68. Skin dryness or scaling	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
69. Headaches or migraines	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
70. Difficulty concentrating	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
71. Joint pain or stiffness	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
72. Uncontrolled leaking of urine	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
73. Uncontrolled leaking of feces	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
74. Vaginal or genital irritation or itching	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
75. Vaginal or genital dryness	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
76. Other (<i>Specify</i>): _____	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃

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During the past 4 weeks, how intensively did you suffer from the following?

	Not at all	Symptom occurred and was:		
		Mild	Moderate	Severe
77. Cold hands or feet	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
78. Feeling too warm	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
79. Perspiring (without exercise)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
80. "Gooseflesh" or shivering	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
81. Generally uncomfortable with the temperature	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

In the past 4 weeks, how often have you felt:

	Never	Almost never	Sometimes	Fairly often	Very often
82. That you were unable to control the important things in your life?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
83. Confident about your ability to handle your personal problems?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
84. That things were going your way?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
85. That difficulties were piling up so high that you could not overcome them?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

In general...

	Strongly disagree	Disagree somewhat	Disagree slightly	Agree slightly	Agree somewhat	Agree strongly
86. I tend to bounce back quickly after hard times.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
87. It does not take me long to recover from a stressful event.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
88. I have a hard time making it through stressful events.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6

PLEASE MAKE NO MARKS IN THIS AREA



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The next questions are about your sleep habits and experiences. Pick the answer that best describes how often you experienced the situation in the past 4 weeks.

	No, not in past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 times a week	Yes, 5 or more times a week
89. Did you take any kind of medication or alcohol at bedtime to help you sleep?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
90. Did you fall asleep during quiet activities like reading, watching TV, or riding in a car?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
91. Did you nap during the day?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
92. Did you have trouble falling asleep?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
93. Did you wake up several times at night?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
94. Did you wake up earlier than you planned to?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
95. Did you have trouble getting back to sleep after you woke up too early?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

96. Overall, was your typical night's sleep during the past 4 weeks:

Very sound or restful	Sound or restful	Average quality	Restless	Very restless
<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1

97. About how many hours of sleep did you get on a typical night during the past 4 weeks?

5 or less hours	6 hours	7 hours	8 hours	9 hours	10 or more hours
<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6



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115. **During the past 4 weeks**, how much bodily pain have you had?

None Very mild Mild Moderate (Medium) Severe

₀ ₂ ₃ ₄ ₅

116. **During the past 4 weeks**, how much did pain interfere with your normal work (both outside your home and at home)?

Not at all A little bit Moderate (Medium) Quite a bit Extremely (A lot)

₁ ₂ ₃ ₄ ₅

Questions 117-122 ask about your feelings during the **past week**. For each of the statements, please 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)
117. You felt depressed (blue or down)	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
118. Your sleep was restless	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
119. You enjoyed life	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
120. You had crying spells	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
121. You felt sad	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃
122. You felt that people disliked you	<input type="radio"/> ₀	<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃

123. **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?

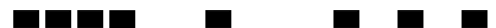
₀ No ₁ Yes

124. Have you had **2 years** or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

₀ No ₁ Yes →

124.1 If yes, have you felt depressed or sad much of the time in the past year?

₀ No ₁ Yes



How true have the following been for you **in the past week**?

	Not at all	A little bit	Somewhat	Quite a bit	Very much
138. Some people wander aimlessly through life, but I am not one of them.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
139. I sometimes feel as if I've done all there is to do in life.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
140. I felt peaceful.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
141. I had a reason for living.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
142. My life has been productive.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
143. I had trouble feeling peace of mind.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
144. I felt a sense of purpose in my life.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
145. I was able to reach down deep into myself for comfort.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
146. I felt a sense of harmony within myself.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
147. My life lacked meaning and purpose.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
148. I found comfort in my faith or spiritual beliefs.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
149. I found strength in my faith or spiritual beliefs.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
150. I am always hopeful about my future.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

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The last questions are about emotions you may have been feeling. Please mark one circle on each line.

Mark the answer that best corresponds to how much you agree with each statement.

	Strongly disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
151. In most ways my life is close to my ideal.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
152. The conditions of my life are excellent.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
153. I am satisfied with my life.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
154. So far I have gotten the important things I want in life.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
155. If I could live my life over, I would change almost nothing.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

Please take a few minutes to review this form for any questions you may have missed.

Thank you for taking the time to complete this questionnaire

PLEASE MAKE NO MARKS IN THIS AREA



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