

Mid 1
Aged 45-49
1996

β

women's health a u s t r a l i a



We want to hear from YOU

YOUR views and experiences are important

Please complete the survey and send it back to us soon!

women's health *is about how you are feeling*

Please answer every question by circling the appropriate number next to your answer. If you are unsure about how to answer a question, please give the closest answer to how you feel.

The questions on the first page ask only about NOW - how your health is NOW and about how your health limits certain activities NOW.

1 In general, would you say your health is
(Circle one number only)

- | | |
|-----------|---|
| Excellent | 1 |
| Very good | 2 |
| Good | 3 |
| Fair | 4 |
| Poor | 5 |

2 Compared to one year ago, how would you rate your health in general now?
(Circle one number only)

- | | |
|---------------------------------------|---|
| Much better now than one year ago | 1 |
| Somewhat better now than one year ago | 2 |
| About the same as one year ago | 3 |
| Somewhat worse now than one year ago | 4 |
| Much worse now than one year ago | 5 |

3 The following questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much? (Circle one number on each line)

	Yes limited a lot	Yes limited a little	No not limited at all
a VIGOROUS activities such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
c Lifting or carrying groceries	1	2	3
d Climbing SEVERAL flights of stairs	1	2	3
e Climbing ONE flight of stairs	1	2	3
f Bending, kneeling or stooping	1	2	3
g Walking MORE THAN ONE kilometre	1	2	3
h Walking HALF a kilometre	1	2	3
i Walking 100 metres	1	2	3
j Bathing or dressing yourself	1	2	3

4 During THE PAST 4 WEEKS, have you had any of the following problems with your work (including your work outside the home and housework) or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?

(Circle one number on each line)

	Yes	No
a Cut down on the amount of time you spent on work or other activities	1	2
b Accomplished less than you would like	1	2
c Were limited in the kind of work or other activities	1	2
d Had difficulty performing the work or other activities (for example it took extra effort)	1	2

5 During the PAST 4 WEEKS, 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)?

(Circle one number on each line)

	Yes	No
a Cut down on the amount of time you spent on work or other activities	1	2
b Accomplished less than you would like	1	2
c Didn't do work or other activities as carefully as usual	1	2

6 During the PAST 4 WEEKS, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups?

(Circle one number only)

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

7 How much BODILY pain have you had during the PAST 4 WEEKS?

(Circle one number only)

No bodily pain	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very severe	6

8 During the past four weeks, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

(Circle one number only)

Not at all	1
A little bit	2
Moderately	3
Quite a bit	4
Extremely	5

9 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
(Circle one number on each line)

		All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a	Did you feel full of life	1	2	3	4	5	6
b	Have you been a very nervous person	1	2	3	4	5	6
c	Have you felt so down in the dumps that nothing could cheer you up	1	2	3	4	5	6
d	Have you felt calm and peaceful	1	2	3	4	5	6
e	Did you have a lot of energy	1	2	3	4	5	6
f	Have you felt down	1	2	3	4	5	6
g	Did you feel worn out	1	2	3	4	5	6
h	Have you been a happy person	1	2	3	4	5	6
i	Did you feel tired	1	2	3	4	5	6

10 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)?
(Circle one number only)

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

11 How TRUE or FALSE is EACH of the following statements for you?
(Circle one number on each line)

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a	I seem to get sick a little easier than other people	1	2	3	4	5
b	I am as healthy as anybody I know	1	2	3	4	5
c	I expect my health to get worse	1	2	3	4	5
d	My health is excellent	1	2	3	4	5

women's health *is about using health services*

12 How many times have you consulted the following people for YOUR OWN HEALTH in the LAST 12 MONTHS?

(Circle one number on each line)

	None	Once or twice	Three or four times	Five or six times	Seven or more times
a Family doctor or another general practitioner	0	1	2	3	4
b A hospital doctor (eg in outpatients or casualty)	0	1	2	3	4
c A specialist doctor	0	1	2	3	4
d An allied health professional (eg optician, dentist, physiotherapist, podiatrist, dietitian, counsellor etc)	0	1	2	3	4
e An "alternative" health practitioner (eg chiropractor, naturopath, acupuncturist, herbalist etc)	0	1	2	3	4

13 Here are some questions about your MOST RECENT VISIT to a general practitioner. How would you rate each of the following?

(Circle one number on each line)

	Excellent	Very Good	Good	Fair	Poor
a The convenience of the location of the surgery	1	2	3	4	5
b The length of time you waited in the waiting room	1	2	3	4	5
c The personal manner (courtesy, respect, sensitivity, friendliness) of the doctor	1	2	3	4	5
d The doctor's explanation of your problem and treatment	1	2	3	4	5
e The doctor's interest in how you felt about having the tests or treatment	1	2	3	4	5
f Your opportunity to ask all the questions you wanted to	1	2	3	4	5
g The amount of time you spent with the doctor	1	2	3	4	5
h The cost of your visit	1	2	3	4	5
i The visit overall	1	2	3	4	5

14 In general do you prefer to see a female doctor?

(Circle one number only)

Yes always	Yes, but only for certain things	No	Don't care
1	2	3	4

15 Have you ever been told by a doctor that you have:

(Circle one number on each line)

		Yes	No
a	Diabetes (high blood sugar)	1	2
b	Heart disease	1	2
c	Hypertension (high blood pressure)	1	2
d	Stroke	1	2
e	Thrombosis (a blood clot)	1	2
f	Low iron level	1	2
g	Asthma	1	2
h	Bronchitis/emphysema	1	2
i	Osteoporosis	1	2
j	Breast cancer	1	2
k	Cervical cancer	1	2
l	Lung cancer	1	2
m	Bowel cancer	1	2
n	Skin cancer	1	2
o	Other major illness <i>(Please specify on line)</i>	1	2

16 Have you EVER had any of the following operations?

(Circle one number on each line)

		Yes	No
a	Hysterectomy	1	2
b	Both ovaries removed	1	2
c	Repair of prolapsed vagina, bladder or bowel	1	2
d	Endometrial ablation	1	2
e	Mastectomy (removal of one or both breasts)	1	2
f	Lumpectomy (removal of lump from breast)	1	2
g	Breast biopsy (taking a sample of breast tissue for sampling)	1	2
h	Cholecystectomy (gall bladder removed)	1	2
i	Any cosmetic surgery (eg for face, breasts, fat removal etc)	1	2
j	Other surgery or procedure <i>(Please specify on line)</i>	1	2

17 This question is about health care

(Circle one number on each line)

		Yes	No
a	Have you been admitted to hospital in the LAST 12 MONTHS?	1	2
b	Do you have private hospital insurance?	1	2
c	Do you have private health insurance for ancillary services (eg dental, physiotherapy etc)?	1	2

18 During the PAST 4 WEEKS, how many different types of medication (eg tablets/medicine) have you used which were:

(Circle one number on each line)

		None	One	Two	Three	Four or more
a	Prescribed by a doctor	0	1	2	3	4
b	Bought without a prescription at the chemist, supermarket or health food shop	0	1	2	3	4

19 During the PAST 4 WEEKS have you taken any medications:

(Circle one number on each line)

		Yes	No
a	For your nerves (eg valium, serapax, ducene etc)	1	2
b	To help you sleep (eg normison, mogadon etc)	1	2
c	For any chronic (long-term) illness	1	2

20 Are you CURRENTLY taking the oral contraceptive pill for any reason?

(Circle one number only)

Yes	No
1	2

21 For how many years in total have you EVER taken the oral contraceptive pill?

(Circle one number only)

Never used	1
Less than one year	2
1 - 4 years	3
5 - 10 years	4
11 - 20 years	5
More than 20 years	6

- 22 Are you CURRENTLY on hormone replacement therapy (HRT)?**
(Circle one number only)
- | | | | |
|------------|----------|-----------|----------|
| Yes | 1 | No | 2 |
|------------|----------|-----------|----------|
-
- 23 For how many years in total have you EVER used hormone replacement therapy?**
(Circle one number only)
- | | |
|--------------------|---|
| Never used | 1 |
| Less than one year | 2 |
| 1 - 4 years | 3 |
| 5 - 10 years | 4 |
| More than 10 years | 5 |
-
- 24 When did you have your last Pap test?**
A Pap Smear Test (Pap test) is a routine test carried out by a doctor or nurse during an internal (vaginal) examination.
(Circle one number only)
- | | | |
|---------------------------------------|---|----------------------------|
| I have never had a Pap test | 1 | If never go to question 26 |
| 2 years ago or less | 2 | |
| More than 2 but less than 5 years ago | 3 | |
| 5 or more years ago | 4 | |
| Not sure | 5 | |
-
- 25 Have you EVER had an abnormal Pap test?**
(Circle one number only)
- | | |
|----------------------------|---|
| No | 1 |
| Yes, in the last 5 years | 2 |
| Yes, more than 5 years ago | 3 |
-
- 26 When did you last have a mammogram?**
A mammogram is an X-ray of the breasts by a machine that squashes the breast while the picture is taken.
(Circle one number only)
- | | | |
|---------------------------------------|---|----------------------------|
| I have never had a mammogram | 1 | If never go to question 28 |
| 2 years ago or less | 2 | |
| More than 2 but less than 5 years ago | 3 | |
| 5 or more years ago | 4 | |
| Not sure | 5 | |
-
- 27 Have you EVER had an abnormal mammogram?**
(Circle one number only)
- | | |
|----------------------------|---|
| No | 1 |
| Yes, in the last 5 years | 2 |
| Yes, more than 5 years ago | 3 |

28 Are you currently pregnant?
(Circle one number only)

Yes	No	Don't know
1	2	3

29 How many times have you:
(Circle one number on each line)

Never	Once	Twice	Three times	Four or more times
--------------	-------------	--------------	--------------------	---------------------------

a	Been pregnant	0	1	2	3	4
b	Had a miscarriage	0	1	2	3	4
c	Had a termination	0	1	2	3	4
d	Given birth to a child	0	1	2	3	4

30 What sort of contraception do you use now?
(Circle one number only)

Don't need to use any (pregnant, no periods, no sex or had a hysterectomy)	1
Choose not to use any	2
Oral contraceptive pill	3
Tubal ligation (tubes tied)	4
Vasectomy (partner)	5
Condoms	6
Other (Please specify on line)	7

31 Have you had:
(Circle one number on each line)

a	A period or menstrual bleeding in the last 12 months
b	A period or menstrual bleeding in the last 3 months

Yes	No
1	2
1	2

If no go to question 34

32 Compared with 12 months ago, are your periods:
(Circle one number only)

Less frequent	1
About the same	2
More frequent	3
Changeable	4

33 Compared with 12 months ago, is your menstrual flow:
(Circle one number only)

Lighter	1
About the same	2
Heavier	3
Changeable each month	4

women's health *is about coping with common problems*

34 a In the Last 12 MONTHS have you had any of the following:

(Circle one number on each line, here)

b If you have had any of these problems, were you satisfied with the health services available to help you deal with this problem?

(Circle one number on each line)

	Never	Rarely	Sometimes	Often	Yes	No	Not Applicable
a Allergies, hayfever, sinusitis	1	2	3	4	1	2	3
b Breathing difficulty	1	2	3	4	1	2	3
c Indigestion/heartburn	1	2	3	4	1	2	3
d Chest pain	1	2	3	4	1	2	3
e Headaches/migraines	1	2	3	4	1	2	3
f Constant tiredness	1	2	3	4	1	2	3
g Stiff or painful joints	1	2	3	4	1	2	3
h Back pain	1	2	3	4	1	2	3
i A broken bone (fracture)	1	2	3	4	1	2	3
j Urine that burns or stings	1	2	3	4	1	2	3
k Leaking urine	1	2	3	4	1	2	3
l Constipation	1	2	3	4	1	2	3
m Haemorrhoids (piles)	1	2	3	4	1	2	3
n Other bowel problems	1	2	3	4	1	2	3
o Vaginal discharge or irritation	1	2	3	4	1	2	3
p Premenstrual tension	1	2	3	4	1	2	3
q Irregular monthly periods	1	2	3	4	1	2	3
r Heavy periods	1	2	3	4	1	2	3
s Severe period pain	1	2	3	4	1	2	3
t Hot flushes	1	2	3	4	1	2	3
u Night sweats	1	2	3	4	1	2	3
v Skin problems	1	2	3	4	1	2	3
w Eyesight problems	1	2	3	4	1	2	3
x Hearing problems	1	2	3	4	1	2	3
y Difficulty sleeping	1	2	3	4	1	2	3

women's health *is about coping with stress*

35 Over the LAST 12 months, how stressed have you felt about the following areas of your life:
(Circle one number on each line)

		Not Applicable	Not at all Stressed	Somewhat Stressed	Moderately Stressed	Very Stressed	Extremely Stressed
a	Own health	1	2	3	4	5	6
b	Health of other family members	1	2	3	4	5	6
c	Work/Employment	1	2	3	4	5	6
d	Living arrangements	1	2	3	4	5	6
e	Study	1	2	3	4	5	6
f	Money	1	2	3	4	5	6
g	Relationship with parents	1	2	3	4	5	6
h	Relationship with partner/spouse	1	2	3	4	5	6
i	Relationship with children	1	2	3	4	5	6
j	Relationship with other family members	1	2	3	4	5	6
k	Anything else (<i>Please specify on line</i>)	1	2	3	4	5	6

36 When you feel stressed, do you use any of the following methods to reduce stress?
(Circle one number on each line)

		None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
a	Walking, exercise or working out	1	2	3	4	5
b	Music, reading, sleeping, meditation	1	2	3	4	5
c	Talking to a good friend	1	2	3	4	5
d	Writing, drawing or creative activity	1	2	3	4	5
e	Wanting to be alone, watching TV	1	2	3	4	5
f	Throwing things, slamming doors	1	2	3	4	5
g	Smoking, using drugs or alcohol	1	2	3	4	5
h	Eating more or less	1	2	3	4	5

37 In the LAST 12 MONTHS, have you experienced any of the following events?

(Circle one number on each line)

		Yes	No
a	Major personal illness	1	2
b	Major personal injury	1	2
c	Major surgery (not including dental work)	1	2
d	Going through menopause	1	2
e	Major decline in health of spouse or partner	1	2
f	Major decline in health of other close family member or close friend	1	2
g	Starting a new, close personal relationship	1	2
h	Infidelity of spouse or partner	1	2
i	Break-up of a close personal relationship	1	2
j	Divorce	1	2
k	Major conflict with teenage or older children	1	2
l	Child or family member leaving home (due to marriage, to attend college etc)	1	2
m	Death of spouse or partner	1	2
n	Death of child	1	2
o	Death of other close family member	1	2
p	Death of close friend	1	2
q	Changing your type of work/hours/conditions/responsibilities at work	1	2
r	Your spouse or partner ceasing work outside the home	1	2
s	Decreased income	1	2
t	Moving house	1	2
u	Natural disaster (fire, flood, drought, earthquake etc) or house fire	1	2
v	Major loss or damage to personal property	1	2
w	Being robbed	1	2
x	Involvement in a serious accident	1	2
y	Being pushed, grabbed, shoved, kicked or hit	1	2
z	Being forced to take part in unwanted sexual activity	1	2
aa	Legal troubles or involved in a court case	1	2
bb	Family member/close friend being arrested/in gaol	1	2

38 Which of the following best describes your smoking status NOW?
(Circle one number only)

- I have never smoked 1 Go to Q43
- I used to smoke 2 Go to Q39
- I now smoke occasionally 3 Go to Q40a
- I now smoke regularly 4 Go to Q40a

39 If you used to smoke, how long ago did you give up smoking?
(Circle one number or write years on line)

- Within the last 6 months 77
- 6 - 12 months ago 88
- _____ years ago

Go to question 40b

40a If you NOW smoke, how many cigarettes do you usually smoke in a day?
(Write number on line)

_____ a day

OR

40b If you used to smoke, how many cigarettes did you usually smoke in a day?
(Write number on line)

_____ a day

41 At what age did you start smoking?
(Write years on line)

_____ years

42 Have you ever smoked daily for six months or more?
(Circle one number only)

- | | |
|-----|----|
| Yes | No |
| 1 | 2 |

43 How often do you usually drink alcohol?
(Circle one number only)

- I never drink alcohol 1
- I drink rarely 2
- Less than once a week 3
- On 1 or 2 days a week 4
- On 3 or 4 days a week 5
- On 5 or 6 days a week 6
- Every day 7

If never go to question 46

44 On a day when you drink alcohol, how many drinks do you usually have?
(Circle one number only)

- 1 or 2 drinks per day 1
- 3 or 4 drinks per day 2
- 5 - 8 drinks per day 3
- 9 or more drinks per day 4

45 How often do you have five or more drinks of alcohol on one occasion?
(Circle one number only)

- Never 1
- Less than once a month 2
- About once a month 3
- About once a week 4
- More than once a week 5

women's health *is about healthy weight and shape*

46 How tall are you without shoes? _____ cms OR _____ ft _____ ins

47 How much do you weigh without clothes or shoes? _____ kgs OR _____ stones _____ pounds

48 How much would you LIKE to weigh?
(Circle one number only)

Happy as I am	1
1 - 5 kg more	2
Over 5 kg more	3
1 - 5 kg less	4
6 - 10 kg less	5
Over 10 kg less	6

49 What is the MOST you have EVER weighed? Do not include DURING pregnancies. _____ kgs OR _____ stones _____ pounds

50 What was the reason for your highest weight?
(Circle one number only)

I gained weight on purpose	1
I gained weight as a result of pregnancy	2
I gained weight from over-eating or lack of exercise	3
I gained weight as a result of illness	4
It was my normal weight	5
I don't know why - it just happened	6

51 What is the LEAST you have EVER weighed (since you were 18 years old)? _____ kgs OR _____ stones _____ pounds

52 What was the reason for your lowest weight?
(Circle one number only)

I lost weight on purpose (by dieting or exercise)	1
I did not intend to - it was through illness, worry or stress	2
I was breast feeding	3
It was my normal weight	4
I don't know why - it just happened	5

53 How often have you gone on a diet to lose weight DURING THE LAST YEAR?
(Circle one number only)

Never	1
1-4 times	2
5-10 times	3
More than 10 times	4
I am always on a diet to lose weight	5

54 When you were a child (say age 10) how would you describe your weight?
(Circle one number only)

- Very underweight 1
- Underweight 2
- Slightly underweight 3
- Average 4
- Slightly overweight 5
- Overweight 6
- Very overweight 7
- Don't know 8

55 How would you describe yourself now?
(Circle one number only)

- Very underweight 1
- Underweight 2
- Slightly underweight 3
- Average 4
- Slightly overweight 5
- Overweight 6
- Very overweight 7
- Don't know 8

56 Are you trying to lose weight now?
(Circle one number only)

- Yes 1
- No 2

57 In the last SIX months, have you:
(Circle one number only)

- LOST 5 kg or more *on purpose* 1
- LOST 5 kg or more *without wanting to* 2
- Not lost 5 kg or more 3

58 In the last SIX months, have you:
(Circle one number only)

- GAINED 5 kg or more *on purpose* 1
- GAINED 5 kg or more *without wanting to* 2
- Not gained 5 kg or more 3

59 How often do you eat takeaway food?
(Circle one number only)

- Never 1
- Less than once a month 2
- About once a month 3
- About once a week 4
- More than once a week 5
- Almost every day 6

60 Are you ever afraid to start eating because you think you won't be able to stop?
(Circle one number only)

Yes	1
No	2

61 Do you use any of the following to lose weight?
(Circle one number on each line)

		Yes	No
a	Laxatives	1	2
b	Something to make you vomit	1	2
c	Diuretics (water or fluid pills)	1	2

62 How often do you vomit (throw up) on purpose after eating?
(Circle one number only)

Never	1
Rarely	2
Less than half of the time	3
Half the time	4
More than half the time	5
Most of the time	6
Every time	7

63 In a NORMAL week, how many times do you engage in VIGOROUS exercise lasting for 20 minutes or more? (exercise which makes you breathe harder or puff and pant, such as netball, squash, jogging, aerobics, vigorous swimming, etc.)
(Circle one number only)

Never	1
Once a week	2
Two or three times a week	3
Four, five or six times a week	4
Once every day	5
More than once every day	6

64 In a NORMAL week, how many times do you engage in LESS VIGOROUS exercise which lasts for 20 minutes or more? (exercise which does not make you breathe harder or puff and pant, like walking, gardening, swimming and lawn bowls)
(Circle one number only)

Never	1
Once a week	2
Two or three times a week	3
Four, five or six times a week	4
Once every day	5
More than once every day	6

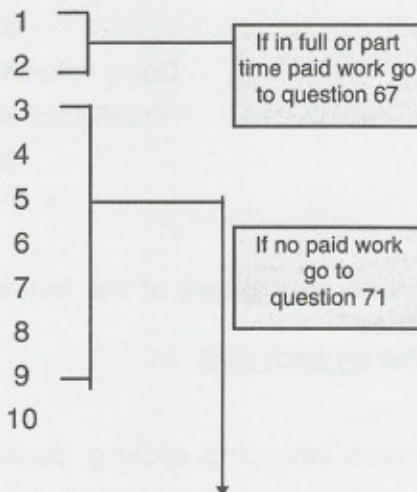
65 In the course of your WORK (paid or unpaid) how many times in a NORMAL week would your work involve exertion for MORE THAN 20 MINUTES WITHOUT STOPPING, that is, exertion which makes you breathe harder and puff or pant?
(Circle one number only)

Never	1
Once a week	2
Two or three times a week	3
Four, five or six times a week	4
Once every day	5
More than once every day	6

women's health *is about juggling time*

66 Which of the following best describes your main current employment status? (Circle one number only)

- 1 In full time paid work
- 2 In part time or casual paid work
- 3 Work without pay (eg in a family business)
- 4 Home duties only - no paid work
- 5 Studying - no paid work
- 6 Unemployed - looking for work
- 7 Unpaid voluntary work
- 8 Retired
- 9 Unable to work due to sickness or injury
- 10 Other (Please specify on line)



67 How many hours do you normally spend in all your PAID jobs each week? (Circle one number only)

- 1 1 - 15 hours
- 2 16 - 24 hours
- 3 25 - 34 hours
- 4 35 - 40 hours
- 5 41 - 48 hours
- 6 49 hours or more

68 Do you normally do paid shift work? (Circle one number only)

- 1 Yes
- 2 No

69 Do you normally do paid work at night? (Circle one number only)

- 1 Yes
- 2 No

70 Is your home your normal ("paid work") work-place? (Circle one number only)

- 1 Yes
- 2 No

71 How often do you feel rushed/pressured/ too busy? (Circle one number only)

- 1 Every day
- 2 A few times a week
- 3 About once a week
- 4 About once a month
- 5 Never

72 Compared to five years ago, do you now feel: (Circle one number only)

- 1 More rushed/pressured/busy
- 2 About the same
- 3 Less rushed/pressured/busy

73 How often do you feel you have time on your hands that you don't know what to do with? (Circle one number only)

- 1 Every day
- 2 A few times a week
- 3 About once a week
- 4 About once a month
- 5 Never

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74 How happy are you with the amount of time you spend in the following aspects of your life? **Happy the way it is** **Would like to do more** **Would like to do less** **Not applicable (Don't do this)**
(Circle one number on each line)

Time spent:

		1	2	3	4
a	In paid work	1	2	3	4
b	In ACTIVE leisure (eg sport, art, drama, music)	1	2	3	4
c	In PASSIVE leisure (eg reading, TV, writing letters)	1	2	3	4
d	Studying	1	2	3	4
e	Doing voluntary work	1	2	3	4
f	In religious activities	1	2	3	4
g	Sleeping	1	2	3	4
h	Alone	1	2	3	4

75 Are you happy with your share of the following tasks and activities?

(Circle one number on each line)

	Happy the way it is	Would like other family members to do more	Would prefer another arrangement	Not applicable (Don't do this)
a Domestic work (shopping, cooking, cleaning etc)	1	2	3	4
b Child care	1	2	3	4
c Caring for another adult (who is elderly/disabled/sick)	1	2	3	4
d Other household work (gardening, home/car maintenance)	1	2	3	4

76 What is/was your main occupation and your partner/spouse's main occupation?

(Circle one number for self and one for partner/spouse)

	Self	Partner/Spouse
No partner/spouse		0
Manager or Administrator (eg personnel manager, managing supervisor)	1	1
Professional (eg teacher, social worker, doctor, artist)	2	2
Para-professional (eg welfare worker, technical officer, registered nurse, police)	3	3
Trade (eg hairdresser, cook, mechanic)	4	4
Administrative assistant (eg secretary, telephonist)	5	5
Sales and personal service worker (eg sales assistant, bar attendant, child care worker, enrolled nurse)	6	6
Machine operator or driver (eg sewing machinist)	7	7
Manual worker (eg labourer, cleaner, kitchenhand)	8	8
Never had a paid job	9	9
Other (Please specify on line)	10	10

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77 Who lives with you?

(Circle one number on each line)

		Yes	No
a	No-one, I live alone	1	2
b	Partner/spouse	1	2
c	Own children	1	2
d	Someone else's children	1	2
e	Parents	1	2
f	Other adult relatives	1	2
g	Other adults who are not family members	1	2

If live alone, go to question 80

IF YOU HAVE NO CHILDREN LIVING WITH YOU, GO TO QUESTION 80

78 If you have children living with you, how many are:

(Circle one number on each line)

		None	One	Two	Three	Four or more
a	Under 5 years	0	1	2	3	4
b	5 - 15 years	0	1	2	3	4
c	16 - 18 years	0	1	2	3	4
d	Over 18 years	0	1	2	3	4

79 Most parents need someone to care for their children when they cannot. How satisfied are you with your child care arrangements for:

(Circle one number on each line)

		Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	Not Applicable
a	Children under 5 years (eg child care centre, occasional care etc)	1	2	3	4	5
b	Children 5 - 15 years (eg before/after school, care when child is sick)	1	2	3	4	5

80 Do you regularly PROVIDE care or assistance (eg personal care, transport) to any other person because of their long-term illness, disability or frailty?

(Circle one number only)

Yes	No
1	2

81 Do you regularly NEED help with daily tasks because of long-term illness, disability or frailty (eg personal care, getting around, preparing meals etc)?
(Circle one number only)

Yes
1

No
2

If no go to question 83

82 How satisfied are you with the help you receive for your own personal care?
(Circle one number only)

Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
1	2	3	4

83 These questions are about getting on with other people:
(Circle one number on each line)

	Yes	No
a Has anyone close to you tried to hurt you or harm you recently?	1	2
b Are you sad or lonely often?	1	2
c Do you feel that nobody wants you around?	1	2
d Does anyone in your family drink a lot of alcohol?	1	2
e Are you afraid of anyone in your family?	1	2
f Do you have enough privacy at home?	1	2
g Have you ever been in a violent relationship with a partner/spouse?	1	2
h Has anyone close to you called you names or put you down or made you feel bad recently?	1	2

84 Other than members of your family how many persons in your local area do you feel you can depend on or feel very close to? *(Circle one number only)*

None	1
1-2 people	2
More than 2 people	3

85 Does it seem that your family and friends (ie people who are important to you) understand you?
(Circle one number only)

Hardly ever	1
Some of the time	2
Most of the time	3

86 Can you talk about your deepest problems with at least some of your family and friends?
(Circle one number only)

Hardly ever	1
Some of the time	2
Most of the time	3

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87 What is your date of birth?

(Write date on line below)

__ __ __ __ 1 9 __ __
Day Month Year

88 How old were you when you left school?

(Please include both full and part time schooling. Circle one number only)

- Still at school 1
- Never attended school 2
- 14 years or under 3
- 15 -16 years 4
- 17 -18 years 5
- 19 years or older 6

89 Are you currently attending an educational institution?

(Circle one number only)

- No 1
- Yes, part-time student 2
- Yes, full-time student 3

90 What is the highest qualification you have completed?

(Circle one number only)

- No formal qualifications 1
- School or Intermediate Certificate (or equivalent) 2
- Higher School or Leaving Certificate (or equivalent) 3
- Trade/apprenticeship (eg Hairdresser, Chef) 4
- Certificate/diploma (eg Child Care, Technician) 5
- University degree 6
- Higher University degree (eg Grad Dip, Masters, PhD) 7

91 Are you of Aboriginal or Torres Strait Islander origin?

(Circle one number only)

- No 1
- Aboriginal 2
- Torres Strait Islander 3

92 In which country were you born?

(Circle one number only)

- Australia 1
- United Kingdom 2
- Italy 3
- Greece 4
- New Zealand 5
- Vietnam 6
- Other (Please specify on line) 7

If Australia go to question 94

93 If you were not born here, when did you first arrive in Australia with the intention of living here for one year or more?

(Circle one number only)

- 1955 or earlier 1
- 1956 - 1965 2
- 1966 - 1985 3
- 1986 - 1990 4
- 1991 or later 5

94 Do you usually speak a language other than English AT HOME? (Circle one number only)

- No, I speak only English at home 1
 - Yes, Italian 2
 - Yes, Greek 3
 - Yes, Cantonese 4
 - Yes, Mandarin 5
 - Yes, German 6
 - Yes, Arabic 7
 - Yes, other 8
- (Please specify on line)

If no go to question 96

95 How well do you speak English?

(Circle one number only)

- Very well 1
- Well 2
- Not well 3
- Not at all 4

96 What is your PRESENT marital status?

(Circle one number only)

- Married 1
- Defacto (opposite sex) 2
- Defacto (same sex) 3
- Separated 4
- Divorced 5
- Widowed 6
- Single 7

97 How do you manage on the income you have available?

(Circle one number only)

- It is impossible 1
- It is difficult all the time 2
- It is difficult some of the time 3
- It is not too bad 4
- It is easy 5

98a Which of the following best describes your housing situation? Do you live in:

(Circle one number only)

- A house 1
 - A flat/unit/apartment 2
 - A caravan/tent/cabin/houseboat 3
 - Other *(Please specify on line)* 4
-

98b In whose name is the ownership/ purchasing agreement/ tenancy agreement?

(Circle one number only)

- Self 1
 - Partner/Spouse 2
 - Partner/Spouse and self together 3
 - Parents or other family members 4
 - Self and others 5
 - Not applicable 6
 - Other *(Please specify on line)* 7
-

99 What is your postcode?

100 In general, are you satisfied with what you have achieved in your life so far in the areas of:

(Circle one number on each line)

		Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
a	Work/career/study	1	2	3	4
b	Family relationships	1	2	3	4
c	Partner/closest personal relationship	1	2	3	4
d	Friendships	1	2	3	4
e	Social activities	1	2	3	4

*Thank you very much for taking the time to complete this survey.
Please fold the survey in half and place it in the reply-paid envelope.*

DON'T FORGET TO ENCLOSE THE CONSENT FORM

as we will need this to contact you again.

You are a valuable contributor to this women's health research.

Don't forget to let us know your new address if you move!

If you have any questions you can contact us by telephoning

1800 068 081 (This is a FREECALL number)

or writing to us at the address below.

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