

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



Fifth survey for mid-age women
March 2007

How to complete this survey

This is the fifth “main” survey for mid-age women.
As the purpose of the project is to look at changes over time, some of the questions are the same as those in previous surveys.

Please answer every question you can. If you are unsure about how to answer a question, mark the response for the closest answer to how you feel.

Please write any comments or important information on page 30. We are not able to read comments written elsewhere throughout the survey.

Please read the instructions above each question carefully. Some require you to only answer those options which are applicable to you. Other questions require you to mark one answer on each line.
The questions may also refer to different time periods.

INSTRUCTIONS:

- Use a black/blue biro
- Do not fold or bend this survey
- **Cross the boxes like this:**

In general, would you say your health is:

(Mark one only)

Excellent

Very good

Good You would mark this one if you think your health is good

Fair

Poor

- **Print clearly in the boxes like this:**

What is your postcode?
(PRINT clearly in the boxes)

2 3 0 8

- **Correct mistakes like this:**

When you go to a General Practitioner:

(Mark one on each line)

Do you go to the same place?

Always

Most of the time

Sometimes

Rarely or never

If you make a mistake simply scribble it out and clearly mark the correct answer with a cross

**If you need help to answer any questions, please ring 1800 068 081
(This is a FREECALL number)**

* If you are concerned about any of your health experiences and would like some help, you may like to contact:

- your nearest Women’s Health Centre or Community Health Centre;
- your General Practitioner for advice about who would be the best person in your community for you to talk to.

* If you feel distressed NOW and would like someone to talk to, you could ring Lifeline on 131 114 (local call).

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

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

Q1 In general, would you say your health is:

(Mark one only)

- Excellent
- Very good
- Good
- Fair
- Poor

Q2 Compared to one year ago, how would you rate your health in general now?

(Mark one only)

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same now as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

Q3 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?

(Mark one 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	MODERATE activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Climbing SEVERAL flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Climbing ONE flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Bending, kneeling or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Walking MORE THAN ONE kilometre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Walking HALF a kilometre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Walking 100 metres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The questions on this page and the next one ask about your health
IN THE LAST FOUR WEEKS.

Q4 During the PAST FOUR 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?

(Mark one on each line)

		Yes	No
a	Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b	Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c	Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
d	Had difficulty performing the work or other activities (eg it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>

Q5 During the PAST FOUR 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)?

(Mark one on each line)

		Yes	No
a	Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
b	Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
c	Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

Q6 During the PAST FOUR WEEKS, to what extent have your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your normal social activities with family, friends, neighbours or groups?

(Mark one only)

- Not at all
- Slightly
- Moderately
- Quite a bit
- Extremely

Q7 How much BODILY pain have you had during the PAST FOUR WEEKS?

(Mark one only)

- No bodily pain
- Very mild
- Mild
- Moderate
- Severe
- Very severe

Q8 During the PAST FOUR WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

(Mark one only)

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

Q9 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 FOUR WEEKS:

(Mark one 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Have you felt down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q10 During the PAST FOUR WEEKS, how much of the time have your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting friends, relatives, etc)?

(Mark one only)

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

Q11 How TRUE or FALSE is EACH of the following statements for you?

(Mark one 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

women's health *is about using health services*

Q12 How many times have you consulted the following people for YOUR OWN HEALTH in the LAST TWELVE MONTHS?

(Mark one on each line)

	None	Once or twice	3 or 4 times	5 or 6 times	7-12 times	13-24 times	25 or more times
a A family doctor or another General Practitioner (GP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b A hospital doctor (eg in outpatients or casualty)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c A specialist doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q13 Have you consulted the following people for YOUR OWN HEALTH in the LAST TWELVE MONTHS?

(Mark one on each line)

	Yes	No
a Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>
b Counsellor / Psychologist / Social worker	<input type="checkbox"/>	<input type="checkbox"/>
c A community nurse, practice nurse, or nurse practitioner	<input type="checkbox"/>	<input type="checkbox"/>
d Optician / Optometrist	<input type="checkbox"/>	<input type="checkbox"/>
e Dietitian	<input type="checkbox"/>	<input type="checkbox"/>
f Podiatrist	<input type="checkbox"/>	<input type="checkbox"/>
g Massage therapist	<input type="checkbox"/>	<input type="checkbox"/>
h Naturopath / Herbalist	<input type="checkbox"/>	<input type="checkbox"/>
i Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>
j Osteopath	<input type="checkbox"/>	<input type="checkbox"/>
k Acupuncturist	<input type="checkbox"/>	<input type="checkbox"/>
l Other alternative health practitioner (eg aromatherapist, homeopath, reflexologist, iridologist)	<input type="checkbox"/>	<input type="checkbox"/>

Q14 How often have you used the following therapies for YOUR OWN HEALTH in the LAST TWELVE MONTHS?

(Mark one on each line)

	Never	Rarely	Sometimes	Often
a Vitamins / Minerals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Yoga or meditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Herbal medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Aromatherapy oils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e Chinese medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Prayer or spiritual healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g Other alternative therapies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q15 When you go to a General Practitioner:

(Mark one on each line)

	Always	Most of the time	Sometimes	Rarely or never
a Do you go to the same place?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Do you usually see the same doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q16 How would you rate the cost to you of your LAST visit to a General Practitioner?

(Mark one only)

- No cost to me
- Good
- Fair
- Poor
- Don't know

Q17 Do you have a Health Care Card?

This is a card that entitles you to discounts and assistance with medical expenses.
This is not the same as a Medicare card.

(Mark one only)

- Yes
- No

Q18a Do you have private health insurance for HOSPITAL COVER?

(Mark one only)

- Yes
- No – I am covered by Veterans' Affairs
- No – because I can't afford the cost
- No – because I don't think you get value for money
- No – because I don't think I need it
- No – other reason

Q18b Do you have private health insurance for ANCILLARY services (eg dental, physiotherapy)?

(Mark one only)

- Yes
- No – I am covered by Veterans' Affairs
- No – because I can't afford the cost
- No – because I don't think you get value for money
- No – because I don't think I need it
- No - because the services are not available where I live
- No – other reason

Q19 Have you been admitted to hospital in the LAST TWELVE MONTHS?

(Mark one only)

- No
- Yes, day only
- Yes, spent at least one night

Q20 When did you last have:

(Mark one on each line)

		In the last 2 years	2-5 years ago	More than 5 years ago	Never	Don't know
a	A Pap test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	A mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q21 Have you EVER had an abnormal result from: (Mark one on each line)

		Yes	No	Don't know
a	A Pap test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	A mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q22 In the PAST THREE YEARS, have you: (Mark all that apply on each line)

		Doctor	Nurse	Other	Not checked
a	Had your blood pressure checked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Had your cholesterol checked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Had your blood sugar level checked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Had your skin checked (eg spots, lesions, moles)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q23 In the PAST THREE YEARS, have you: (Mark one on each line)

		Yes	No
a	Had your breasts examined by a doctor or nurse?	<input type="checkbox"/>	<input type="checkbox"/>
b	Carried out <i>regular monthly</i> breast self examination?	<input type="checkbox"/>	<input type="checkbox"/>
c	Had a bone density test?	<input type="checkbox"/>	<input type="checkbox"/>
d	Had a test for bowel cancer?	<input type="checkbox"/>	<input type="checkbox"/>
e	Had a reminder from your general practice to have a screening test (eg blood pressure, cholesterol, blood sugar, skin)?	<input type="checkbox"/>	<input type="checkbox"/>

Q24 In the PAST THREE YEARS, have you received advice/information about lifestyle changes from any of these sources? (Mark one on each line)

		Yes	No
a	A doctor	<input type="checkbox"/>	<input type="checkbox"/>
b	A nurse	<input type="checkbox"/>	<input type="checkbox"/>
c	Other health professional (eg physiotherapist, naturopath)	<input type="checkbox"/>	<input type="checkbox"/>
d	Program or organisation (eg weight loss program, gym, self help group)	<input type="checkbox"/>	<input type="checkbox"/>
e	Books, magazines	<input type="checkbox"/>	<input type="checkbox"/>
f	The internet	<input type="checkbox"/>	<input type="checkbox"/>
g	Television	<input type="checkbox"/>	<input type="checkbox"/>
h	Radio	<input type="checkbox"/>	<input type="checkbox"/>
i	Family or friends	<input type="checkbox"/>	<input type="checkbox"/>
j	Private health fund	<input type="checkbox"/>	<input type="checkbox"/>

Q25 Are you CURRENTLY taking: (Mark one on each line)

		Yes	No
a	The oral contraceptive pill?	<input type="checkbox"/>	<input type="checkbox"/>
b	Hormone Replacement Therapy (HRT)?	<input type="checkbox"/>	<input type="checkbox"/>

Q26 Have you: (Mark one on each line)

		Yes	No
a	Had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>
b	Had a period or menstrual bleeding in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
c	Had a period or menstrual bleeding in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, go to Q29

If No, go to Q28

Q27 Compared with twelve months ago, are your periods: (Mark one only)

- Less frequent
- About the same
- More frequent
- Changeable

Q28 If you have reached menopause, at what age did your periods completely stop?

(Please write the age in the box) years

Not applicable

Q29

Have you ever had Gestational Diabetes (diabetes during pregnancy)?

(Mark *one only*)

Yes

No

Q30

Thinking about your own health care, how would you rate the following:

(Mark *one on each line*)

		Excellent	Very good	Good	Fair	Poor	Don't know
a	Access to medical specialists if you need them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Access to a hospital if you need it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Access to medical care in an emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Access to after-hours medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Access to a GP who bulk bills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Access to a female GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Hours when a GP is available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Number of GPs you have to choose from	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Ease of seeing the GP of your choice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	How long you wait to get a GP appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k	The outcomes of your medical care (<i>how much you are helped</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l	Ease of obtaining a mammogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m	Ease of obtaining a Pap test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n	Access to a counselling service if you need it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q31

In the LAST TWELVE MONTHS have you consulted a dentist? (Mark *one only*)

No, I did not need to see a dentist

No, because there was no dentist available locally

No, I could not get there because of travel difficulties

No, because it would cost more than I could afford

No, I did not go to the dentist because of another reason

Yes, I saw a dentist

Q32

How would you rate the overall condition of your teeth, dentures or gums?

(Mark *one only*)

Excellent

Very good

Good

Fair

Poor

Q33

There are 16 teeth, including wisdom teeth in the upper jaw. How many teeth do you have remaining in your UPPER jaw?

(Please write number in boxes)

Q34

There are 16 teeth, including wisdom teeth in the lower jaw. How many teeth do you have remaining in your LOWER jaw?

(Please write number in boxes)

Q35 Do you wear a denture or false teeth in your upper jaw? (Mark one only)

Yes

No

Q36 Do you wear a denture or false teeth in your lower jaw? (Mark one only)

Yes

No

Q37 In the **LAST TWELVE MONTHS** have you: (Mark all that apply)

Yes

a Slipped, tripped or stumbled?

b Had a fall to the ground?

c Been injured as a result of a fall?

d Needed to seek medical attention for an injury from a fall?

e Had any other injury from an accident at your home?

f Broken or fractured any bone/s?

g None of the above

Q38 In the **PAST THREE YEARS**, have you been diagnosed or treated for: (Mark all that apply)

**Yes, in
the past
3 years**

a Diabetes (*high blood sugar*)

b Impaired glucose tolerance

c Osteoarthritis

d Rheumatoid arthritis

e Other arthritis

f Heart disease (*including heart attack, angina*)

g Hypertension (*high blood pressure*)

h Stroke

i Low iron level (*iron deficiency or anaemia*)

j Asthma

k Bronchitis / emphysema

l Osteoporosis

m Breast cancer

n Cervical cancer

o Skin cancer (*including melanoma*)

p Other cancer (*please specify on page 30*)

q Depression

r Anxiety / nervous disorder

s Other psychiatric disorder

t Chronic Fatigue Syndrome

u Sexually transmitted infection (*eg genital herpes or warts, chlamydia*)

v Other major illness or disability (*please specify on page 30*)

w None of these conditions

Q39 Compared to when you were in your twenties, how good are you at:

(Mark one on each line)

		Much better now	Somewhat better now	About the same	Somewhat worse now	Much worse now
a	Remembering the name of a person just introduced to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Recalling telephone numbers or other numbers that you use on a daily or weekly basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Recalling where you put objects (<i>such as keys</i>) in your home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Remembering specific facts from a newspaper or magazine article you have just finished reading?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Remembering the item(s) you intend to buy when you arrive at the shops?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	In general, how would you describe your memory compared to when you were in your twenties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q40 In the PAST THREE YEARS, have you had any of the following operations or procedures

(Mark all that apply)

		Yes, in the past 3 years
a	Both ovaries removed	<input type="checkbox"/>
b	Repair of prolapsed vagina, bladder or bowel?	<input type="checkbox"/>
c	Endometrial ablation (<i>removal of the lining of the uterus</i>)	<input type="checkbox"/>
d	Joint replacement (<i>eg hip, knee</i>)	<input type="checkbox"/>
e	Mastectomy (<i>removal of one or both breasts</i>)	<input type="checkbox"/>
f	Lumpectomy (<i>removal of lump from breasts</i>)	<input type="checkbox"/>
g	Removal of skin cancer	<input type="checkbox"/>
h	Any cancer surgery (<i>other than skin or breast</i>)	<input type="checkbox"/>
i	Chemotherapy or radiotherapy for any cancer	<input type="checkbox"/>
j	Breast biopsy (<i>taking a sample of breast tissue</i>)	<input type="checkbox"/>
k	Hysteroscopy (<i>investigative procedure to examine the uterus</i>)	<input type="checkbox"/>
l	Cholecystectomy (<i>gall bladder removed</i>)	<input type="checkbox"/>
m	Gastroscopy / colonoscopy	<input type="checkbox"/>
n	None of these	<input type="checkbox"/>

Q41 Do you have any of these sleeping problems?

(Mark *all that apply*)

		Yes
a	Waking up in the early hours of the morning	<input type="checkbox"/>
b	Lying awake for most of the night	<input type="checkbox"/>
c	Taking a long time to get to sleep	<input type="checkbox"/>
d	Worry keeping you awake at night	<input type="checkbox"/>
e	Sleeping badly at night	<input type="checkbox"/>
f	None of these problems	<input type="checkbox"/>

Q42 In the PAST FOUR WEEKS, have you taken any:

(Mark *one on each line*)

		Yes	No	
a	Medications prescribed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	If No to both, go to Q44
b	Medications / vitamins / supplements or herbal therapies bought without a prescription at the chemist, supermarket or health food shop?	<input type="checkbox"/>	<input type="checkbox"/>	

Q43 Please write down the names of all your medications, vitamins, supplements or herbal therapies. Where possible, copy names from the packets. (Please write in block letters)

Q44 In the **LAST 12 MONTHS**, have you had any of the following:
 (Mark one on each line in column A.
 For all that apply also answer column B.)

		A				B
		Never	Rarely	Some-times	Often	For the problems you had, DID you seek help? Mark here if you DID seek help
a	Allergies, hayfever, sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Breathing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Indigestion / heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Headaches / migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Severe tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Stiff or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Urine that burns or stings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	Haemorrhoids (<i>piles</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k	Other bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l	Vaginal discharge or irritation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m	Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o	Eyesight problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p	Leaking urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q	Mouth, teeth or gum problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r	Avoided eating some foods because of problems with your teeth, mouth or dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s	Toothache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w	Episodes of intense anxiety (<i>eg panic attacks</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x	Palpitations (<i>feeling that your heart is racing or fluttering in your chest</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q45 In the **PAST WEEK**, have you been feeling that life isn't worth living? (Mark one only)

- Yes
 No

Q46 In the **PAST 6 MONTHS**, have you **EVER** deliberately hurt yourself or done anything that you knew might have harmed or even killed you? (Mark one only)

- Yes
 No

If you answered YES to either of the last 2 questions, you might like to talk to someone about how you are feeling. You could ring Lifeline on 131114 (local call).

women's health *is about coping with stress*

Q47 Over the **LAST TWELVE MONTHS**, how stressed have you felt about the following areas of your life: *(Mark one on each line)*

		Not applicable	Not at all stressed	Somewhat stressed	Moderately stressed	Very stressed	Extremely stressed
a	Own health		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Health of family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Work / Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Living arrangements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Money		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Relationship with parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Relationship with partner / spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Relationship with children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	Relationship with other family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q48 How much do you agree or disagree with each of the following statements?

(Mark one on each line)

		Disagree strongly	Disagree	Disagree slightly	Agree slightly	Agree	Agree strongly
a	At home, I feel I have control over what happens in most situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	I feel that what happens in my life is often determined by factors beyond my control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Over the next 5-10 years I expect to have more positive than negative experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	I often have the feeling that I am being treated unfairly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	In the past 10 years my life has been full of changes without my knowing what will happen next	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	I gave up trying to make big improvements or changes in my life a long time ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q49 Thinking about your current approach to life, please indicate how much you think each statement describes you:

(Mark one on each line)

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
a	In uncertain times, I usually expect the best	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	If something can go wrong for me, it will	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	I'm always optimistic about my future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	I hardly ever expect things to go my way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	I rarely count on good things happening to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Overall, I expect more good things to happen to me than bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q50 What is your Postcode?

a What is your RESIDENTIAL postcode?
(where you live)

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b What is the postcode of your POSTAL ADDRESS?
(if different from residential)

--	--	--	--

Q51 Which of the following events have you experienced?

(Mark *all that apply*)

A Yes, in the last 12 months **B** Yes, more than 12 months ago

		A Yes, in the last 12 months	B Yes, more than 12 months ago
a	Major personal illness	<input type="checkbox"/>	<input type="checkbox"/>
b	Major personal injury or involvement in a serious accident	<input type="checkbox"/>	<input type="checkbox"/>
c	Major personal achievement	<input type="checkbox"/>	<input type="checkbox"/>
d	Birth of a grandchild	<input type="checkbox"/>	<input type="checkbox"/>
e	Major surgery (not including dental work)	<input type="checkbox"/>	<input type="checkbox"/>
f	Going through menopause	<input type="checkbox"/>	<input type="checkbox"/>
g	Major decline in health of spouse or partner	<input type="checkbox"/>	<input type="checkbox"/>
h	Major decline in health of other close family member or close friend	<input type="checkbox"/>	<input type="checkbox"/>
i	Starting a new, close personal relationship	<input type="checkbox"/>	<input type="checkbox"/>
j	Infidelity of spouse or partner	<input type="checkbox"/>	<input type="checkbox"/>
k	Break-up of a close personal relationship	<input type="checkbox"/>	<input type="checkbox"/>
l	Divorce	<input type="checkbox"/>	<input type="checkbox"/>
m	Major conflict with teenage or older children	<input type="checkbox"/>	<input type="checkbox"/>
n	Child or other family member leaving home (due to marriage, to attend university etc)	<input type="checkbox"/>	<input type="checkbox"/>
o	Death of a spouse or partner	<input type="checkbox"/>	<input type="checkbox"/>
p	Death of a child	<input type="checkbox"/>	<input type="checkbox"/>
q	Death of other close family member	<input type="checkbox"/>	<input type="checkbox"/>
r	Death of close friend	<input type="checkbox"/>	<input type="checkbox"/>
s	Changing your type of work / hours / conditions / responsibilities at work	<input type="checkbox"/>	<input type="checkbox"/>
t	Retirement	<input type="checkbox"/>	<input type="checkbox"/>
u	Your spouse or partner retiring from work	<input type="checkbox"/>	<input type="checkbox"/>
v	Being made redundant	<input type="checkbox"/>	<input type="checkbox"/>
w	Your spouse / partner being made redundant	<input type="checkbox"/>	<input type="checkbox"/>
x	Decreased income	<input type="checkbox"/>	<input type="checkbox"/>
y	Moving house	<input type="checkbox"/>	<input type="checkbox"/>
z	Natural disaster (fire, flood, drought, earthquake etc) or house fire	<input type="checkbox"/>	<input type="checkbox"/>
aa	Major loss or damage to personal property	<input type="checkbox"/>	<input type="checkbox"/>
bb	Being robbed	<input type="checkbox"/>	<input type="checkbox"/>
cc	Being pushed, grabbed, shoved, kicked or hit	<input type="checkbox"/>	<input type="checkbox"/>
dd	Being forced to take part in unwanted sexual activity	<input type="checkbox"/>	<input type="checkbox"/>
ee	Legal troubles or involved in a court case	<input type="checkbox"/>	<input type="checkbox"/>
ff	Family member / close friend being arrested / in gaol	<input type="checkbox"/>	<input type="checkbox"/>
gg	You or a family member involved in problem gambling	<input type="checkbox"/>	<input type="checkbox"/>
hh	None of these events		<input type="checkbox"/>

Q52 Below is a list of the ways you might have felt or behaved. Please indicate how often you have felt this way **DURING THE LAST WEEK**.

(Mark one on each line)

		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 the time (3-4 days)	Most or all of the time (5-7 days)
a	I was bothered by things that don't usually bother me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	I had trouble keeping my mind on what I was doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	I felt depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	I felt that everything I did was an effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	I felt hopeful about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	I felt fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	My sleep was restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	I was happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	I felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	I could not "get going"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k	I felt terrific	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q53 In the past month: (Mark one on each line)

		Yes	No
a	Have you felt keyed up or on edge?	<input type="checkbox"/>	<input type="checkbox"/>
b	Have you been worrying a lot?	<input type="checkbox"/>	<input type="checkbox"/>
c	Have you been irritable?	<input type="checkbox"/>	<input type="checkbox"/>
d	Have you had difficulty relaxing?	<input type="checkbox"/>	<input type="checkbox"/>
e	Have you been sleeping poorly?	<input type="checkbox"/>	<input type="checkbox"/>
f	Have you had headaches or neck aches?	<input type="checkbox"/>	<input type="checkbox"/>
g	Have you had any of the following: trembling, tingling, dizzy spells, sweating, diarrhoea or needing to pass urine more often than normal?	<input type="checkbox"/>	<input type="checkbox"/>
h	Have you been worried about your health?	<input type="checkbox"/>	<input type="checkbox"/>
i	Have you had difficulty falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>

Q54 Do you regularly **NEED** help with daily tasks because of long-term illness, disability or frailty (eg personal care, getting around, preparing meals etc)?

(Mark one only)

Yes
No

The following sections are about other health habits, time use and your relationships.

Often there are no "right" or "wrong" answers – we are interested only in your opinion or feelings.

If you feel uncomfortable about answering a question, just leave it and go on to the next one, but please try to finish the survey if you can.

You may like to take a break now and do the second part later.

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

Q55 a How much do you weigh? (no clothes or shoes)

kg **OR** stones pounds

b How tall are you without shoes?

cm **OR** feet inches

Q56 What is your waist measurement?

Please measure your waist while in your underwear. If possible, get someone to help you take the measurement. Find your navel (belly button) and measure at that level. Be careful not to have the tape too tight. You should be able to slip your little finger under it comfortably. Write the measurement to the **nearest** centimetre (or inch if this is the only measure you have available).

cm **OR** inches

Q57 In the LAST THREE YEARS, have you:

(Mark one on each line)

		Yes	No
a	Lost 5 kg or more on purpose?	<input type="checkbox"/>	<input type="checkbox"/>
b	Lost 5 kg or more for any other reason?	<input type="checkbox"/>	<input type="checkbox"/>
c	Gained 5 kg or more?	<input type="checkbox"/>	<input type="checkbox"/>

Q58 Have you used any of these methods to lose weight or to control your weight or shape in the LAST TWELVE MONTHS?

(Mark one on each line)

		Yes	No
a	Commercial weight loss programs (eg <i>Weight Watchers, Lite n' Easy, Sureslim, Jenny Craig</i>)	<input type="checkbox"/>	<input type="checkbox"/>
b	Meal replacements or slimming products (eg <i>OPTIFAST, Herbalife</i>)	<input type="checkbox"/>	<input type="checkbox"/>
c	Exercise	<input type="checkbox"/>	<input type="checkbox"/>
d	Cut down on the size of meals or between meal snacks	<input type="checkbox"/>	<input type="checkbox"/>
e	Cut down on fats (<i>low fat</i>) and / or sugars	<input type="checkbox"/>	<input type="checkbox"/>
f	Low glycaemic index (GI) diet	<input type="checkbox"/>	<input type="checkbox"/>
g	Diet book diets (eg <i>Atkins, Zone, CSIRO diet, Liver Cleansing diet</i>)	<input type="checkbox"/>	<input type="checkbox"/>
h	Laxatives, diuretics or diet pills (eg <i>Xenical, Reductil</i>)	<input type="checkbox"/>	<input type="checkbox"/>
i	Fasting	<input type="checkbox"/>	<input type="checkbox"/>
j	Smoking	<input type="checkbox"/>	<input type="checkbox"/>
k	Other (please specify on page 30)	<input type="checkbox"/>	<input type="checkbox"/>

Q59 How often do you usually drink alcohol?

(Mark one only)

- I have never drunk alcohol in my life
- I never drink alcohol, but I have in the past
- I drink rarely
- Less than once a week
- On 1 or 2 days a week
- On 3 or 4 days a week
- On 5 or 6 days a week
- Every day

Go to Q62

Q60 On a day when you drink alcohol, how many drinks do you usually have?

(Mark one only)

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

Q61 How often do you have five or more drinks of alcohol on one occasion?

(Mark one only)

- Never
- Less than once a month
- About once a month
- About once a week
- More than once a week

Q62 The next question is about your alcohol consumption during different stages of your life. On average, how many drinks did you usually drink PER WEEK in your:

(Mark one on each line)

		No alcohol	1-7 drinks	8-14 drinks	15 or more drinks
a	Late teens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	20s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	30s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	40s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	50s	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q63 How many glasses / cups of non-alcoholic drinks do you usually have each day

(eg juice, tea, coffee, water, milk, etc)?

(Mark one only)

- 0 - 2 glasses
- 3 - 5 glasses
- 6 - 8 glasses
- 9 or more glasses

This section is about your **usual** eating habits over the **LAST TWELVE MONTHS**. Where possible, give only **one answer per question** for the type of food you eat **most often** (if you can't decide which type you have most often, answer for the types you usually eat).

- Q64** How many pieces of **FRESH** fruit do you usually eat per day?
(Count $\frac{1}{2}$ cup diced fruit, berries or grapes as one piece)
- I don't eat fruit
- Less than 1 piece of fruit per day
- 1 piece of fruit per day
- 2 pieces of fruit per day
- 3 pieces of fruit per day
- 4 pieces of fruit per day
- 5 or more pieces of fruit per day

- Q65** How many **DIFFERENT** vegetables do you usually eat per day?
(Count all types, fresh, frozen or tinned)
- Less than 1 vegetable per day
- 1 vegetable per day
- 2 vegetables per day
- 3 vegetables per day
- 4 vegetables per day
- 5 vegetables per day
- 6 or more vegetables per day

- Q66** How many **SERVES** of vegetables do you usually eat each day?
(A serve = half a cup of cooked vegetables or a cup of salad vegetables)
- None
- 1 serve
- 2-3 serves
- 4 serves
- 5 serves or more

- Q67** What type of milk do you usually use?
- a None
- b Full cream milk
- c Reduced fat milk
- d Skim milk
- e Soya milk

- Q68** How much milk do you usually use per day? (Include flavoured milk and milk added to tea, coffee, cereal etc)
- None
- Less than 250ml (1 large cup or mug)
- Between 250ml and 500ml (1-2 cups)
- Between 500ml and 750ml (2-3 cups)
- 750ml (3 cups) or more

- Q69** What type of bread do you usually eat?
- a I don't eat bread
- b High fibre white bread
- c White bread
- d Wholemeal bread
- e Rye bread
- f Multi-grain bread

- Q70** How many slices of bread do you usually eat per day? (Include all types, fresh or toasted and count one bread roll as 2 slices)
- Less than 1 slice per day
- 1 slice per day
- 2 slices per day
- 3 slices per day
- 4 slices per day
- 5-7 slices per day
- 8 or more slices per day

- Q71** Which spread do you usually put on bread?
- a I don't use any fat spread
- b Margarine of any kind
- c Polyunsaturated margarine
- d Monounsaturated margarine
- e Butter and margarine blends
- f Butter

- Q72** On average, how many eggs do you usually eat per week?
- I don't eat eggs
- Less than 1 egg per week
- 1 to 2 eggs per week
- 3 to 5 eggs per week
- 6 or more eggs per week

- Q73** What types of cheese do you usually eat?
- a I don't eat cheese
- b Hard cheeses eg parmesan, romano
- c Firm cheeses eg cheddar, edam
- d Soft cheeses eg camembert, brie
- e Ricotta or cottage cheese
- f Cream cheese
- g Low fat cheese

Q74a Over the LAST 12 MONTHS, on average, how often did you eat the following foods?

(Mark one on each line)

		Never	Less than once a week	Once a week or more
a	All Bran	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Sultana Bran™, Fibre Plus™, Branflakes™	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Weet Bix™, Vita Brits™, Weeties™	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Cornflakes, Nutrigrain™, Special K™	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Porridge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Muesli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Pasta or noodles (<i>include lasagne</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Nuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	Peanut butter or peanut paste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k	Vegemite™, Marmite™, Promite™	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l	Tinned or frozen fruit (<i>any kind</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m	Oranges or other citrus fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n	Apples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o	Pears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p	Bananas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q	Watermelon, rockmelon, honey dew etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r	Pineapple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s	Strawberries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t	Apricots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u	Peaches or nectarines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v	Mango or paw paw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w	Avocado	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x	Fruit or vegetable juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y	Potatoes cooked without fat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z	Tomato sauce, tomato paste or dried tomatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
aa	Fresh or tinned tomatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bb	Peppers (capsicum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cc	Lettuce, endive or other salad greens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dd	Cucumber	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ee	Celery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ff	Beetroot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gg	Carrots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hh	Cabbage or brussels sprouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii	Cauliflower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
jj	Broccoli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
kk	Silverbeet or spinach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ll	Peas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mm	Green beans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Never	Less than once a week	Once a week or more
nn	Bean sprouts or alfalfa sprouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oo	Baked beans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pp	Soya beans, soy bean curd or tofu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
qq	Other beans (<i>include chick peas, lentils etc</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
rr	Pumpkin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ss	Onions or leeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tt	Garlic (<i>not garlic tablets</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
uu	Mushrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vv	Zucchini	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q74b Over the LAST 12 MONTHS, on average, how often did you eat the following foods?

(Mark one on each line)

		Never	Less than once a week	Once a week	2-4 times per week	5 or more times per week
a	Cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Ice cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Yoghurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Beef	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Veal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Chicken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Lamb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Pork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Fish, steamed, grilled or baked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	Fish, tinned (<i>salmon, tuna, sardines etc</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q75 How often do you currently smoke cigarettes or any tobacco products?

(Mark one only)

- Daily ← Go to Q76
- At least weekly (but not daily) ← Go to Q77
- Less often than weekly } ← Go to Q78
- Not at all

Q76 If you smoke daily, on average how many cigarettes do you smoke EACH DAY?

PRINT the number in the box

cigarettes per day ← Go to Q80

Q77 If you smoke, but not daily, on average how many cigarettes do you smoke PER WEEK?

PRINT the number in the box

cigarettes per week

Q78 Have you ever smoked DAILY?

(Mark one only)

- Yes
- No ← If No, go to Q80

Q79 At what age did you finally stop smoking DAILY?

PRINT age in the box

years old

Think about all of the time you spend sitting during EACH DAY while at home, at work, while getting from place to place or during your spare time.

Q80 How many hours EACH DAY do you typically spend sitting down while doing things like visiting friends, driving, reading, watching television or working at a desk or computer?

a On a usual **WEEK DAY**

 hours

b On a usual **WEEKEND DAY**

 hours

The next two questions are about the amount of physical activity you did LAST WEEK.

Q81 How many *times* did you do each type of activity **LAST WEEK**?

Only count the number of times when the activity lasted for 10 minutes or more. (If you did **not** do an activity, please write "0" in the box)

a **Walking briskly** (for recreation or exercise, or to get from place to place)

 times

b **Moderate leisure activity** (like social tennis, moderate exercise classes, recreational swimming, dancing)

 times

c **Vigorous leisure activity** (that makes you breathe harder or puff and pant like aerobics, competitive sport, vigorous cycling, running, swimming)

 times

d **Vigorous household or garden chores** (that make you breathe harder or puff and pant)

 times

Q82 If you add up all the times you spent in each activity **LAST WEEK**, how much time did you spend **ALTOGETHER** doing each type of activity?

(If you did **not** do an activity, please write "0" in the box)

a **Walking briskly** (for recreation or exercise, or to get from place to place)

 hours minutes

b **Moderate leisure activity** (like social tennis, moderate exercise classes, recreational swimming, dancing)

 hours minutes

c **Vigorous leisure activity** (that makes you breathe harder or puff and pant like aerobics, competitive sport, vigorous cycling, running, swimming)

 hours minutes

d **Vigorous household or garden chores** (that make you breathe harder or puff and pant)

 hours minutes

Q83 This question asks about your physical activity in your **MAIN** job (this could be paid work, unpaid work, caring etc - whatever you spend most of your "working day" doing). On a usual working day, how often do you do each of the following while you are at work? (Mark one on each line)

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Heavy labour or physically demanding work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

women's health *is about how you spend your time*

Q84 What is your date of birth?

		Day			Month	19			Year
--	--	-----	--	--	-------	----	--	--	------

Q85 In a **USUAL WEEK**, how much time in total do you spend doing the following things?
(Mark one on each line)

		I don't do this activity	1-15 hours	16-24 hours	25-34 hours	35-40 hours	41-48 hours	49 hours or more
a	Full time paid work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Part-time paid work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Casual paid work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Home duties (<i>own / family home</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Work without pay (<i>eg family business</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Looking for work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Unpaid voluntary work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Active leisure (<i>eg walking, exercise, sport</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Passive leisure (<i>eg TV, music, reading, relaxing</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	Studying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q86 Managing time is often difficult. How often do you feel:
(Mark one on each line)

		Every day	A few times a week	About once a week	About once a month	Never
a	That you are rushed, pressured, too busy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	That you have time on your hands that you don't know what to with?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q87 Are you happy with your share of the following tasks and activities?
(Mark one on each line)

		Happy the way it is	Would like other house- hold members to do more	Would prefer another arrangement	Not applicable (don't do this)
a	Domestic work (<i>shopping, cooking, cleaning etc</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Caring for another adult (<i>who is elderly / disabled / sick</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Other household work (<i>gardening, home / car maintenance</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q88 Do you regularly provide (unpaid) care for grandchildren or other people's children?

(Mark *one only*)

- Yes, daily
- Yes, weekly
- Yes, occasionally
- No, never

Q89 Do you regularly provide care or assistance (eg personal care, transport) to any other person because of their long-term illness, disability or frailty?

(Mark *one on each line*)

- | | | Yes | No | |
|----------|---------------------------------|--------------------------|--------------------------|----------------------------|
| a | For someone who lives with you | <input type="checkbox"/> | <input type="checkbox"/> | } If No to both, go to Q93 |
| b | For someone who lives elsewhere | <input type="checkbox"/> | <input type="checkbox"/> | |

Q90 How many people with long-term illness, disability or frailty do you regularly provide care for?

(Mark *one only*)

- One person
- Two people
- More than two people

Q91 How often in total do you provide this care or assistance?

(Mark *one only*)

- Every day
- Several times a week
- Once a week
- Once every few weeks
- Less often

Q92 How much time do you usually spend providing such care or assistance on each occasion?

(Mark *one only*)

- All day and night
- All day
- All night
- Several hours
- About an hour

women's health *is about the kinds of work you do and your plans for the future*

Q93 Do you normally do any of the following kinds of paid work?
(Mark all that apply)

		Yes
a	Paid shift work	<input type="checkbox"/>
b	Paid work at night	<input type="checkbox"/>
c	Paid work from home	<input type="checkbox"/>
d	Self employment	<input type="checkbox"/>
e	Paid work in more than one job	<input type="checkbox"/>
f	Casual paid work	<input type="checkbox"/>
g	Paid work involving none of the above	<input type="checkbox"/>
h	I don't do any paid work	<input type="checkbox"/>

Q94 We would like to know YOUR and YOUR PARTNER'S main occupation NOW:
(Mark one in each column)

	A self	B partner
Manager or administrator (eg magistrate, farm manager, media producer, school principal)	<input type="checkbox"/>	<input type="checkbox"/>
Professional (eg registered nurse, allied health professional, teacher, artist)	<input type="checkbox"/>	<input type="checkbox"/>
Associate professional (eg office manager, branch manager, shop manager, retail buyer, youth worker, police officer)	<input type="checkbox"/>	<input type="checkbox"/>
Tradesperson or related worker (eg cook, dressmaker, hairdresser, gardener, florist)	<input type="checkbox"/>	<input type="checkbox"/>
Advanced clerical or service worker (eg credit officer, radio despatcher, personal assistant, flight attendant, law clerk)	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate clerical, sales or service worker (eg accounts clerk, checkout supervisor, data entry operator, child care worker, nursing assistant, hospitality worker)	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate production or transport worker (eg machine operator, bus driver)	<input type="checkbox"/>	<input type="checkbox"/>
Elementary clerical, sales or service worker (eg filing / mail clerk, parking inspector, sales assistant, telemarketer, housekeeper)	<input type="checkbox"/>	<input type="checkbox"/>
Labourer or related worker (eg cleaner, factory worker, kitchen hand, fast food cook)	<input type="checkbox"/>	<input type="checkbox"/>
No paid job	<input type="checkbox"/>	<input type="checkbox"/>
Don't know or no partner		<input type="checkbox"/>

Q95 How do you manage on the income you have available?
(Mark one only)

- It is impossible
- It is difficult all the time
- It is difficult some of the time
- It is not too bad
- It is easy

Q96 Are there people who do NOT live with you who are dependent on your household income?
(Mark one only)

- No
- Yes, one
- Yes, more than one

Q97 Women's employment patterns have changed a lot over recent years. We are keen to learn how women see retirement in their own lives. Please indicate the following description that best fits your life now. If you want to add more please write this on page 30.

(Mark *one only*)

- I am not retired at all
- I am partially retired
- I am completely retired from paid work
- I gave up paid work over 20 years ago
- I have never been in paid work

Q98 When did you retire or give up work completely?

(Print year in the box)

--	--	--	--

Not applicable

Q99 At what age do you expect to retire (completely) from the paid workforce?

(Print age, in whole years, in the box)

--	--

- Do not expect to ever retire
- Have already retired
- Don't know

Q100 You have said when you expect to retire, but if you had the choice, at what age would you like to retire (completely) from the paid workforce?

(Print age, in whole years, in the box)

--	--

- Do not expect to ever retire
- Have already retired
- Don't know

Q101a What are your **CURRENT** sources of income?

(Mark *all that apply*)

Yes

a	Age pension / Service pension / Widow's pension / War Widow's pension	<input type="checkbox"/>
b	Other government pension or allowance	<input type="checkbox"/>
c	Lump sum superannuation payout	<input type="checkbox"/>
d	A pension or annuity purchased with superannuation or some other funds	<input type="checkbox"/>
e	Income from savings and investments (<i>such as shares and property</i>)	<input type="checkbox"/>
f	Income from a business	<input type="checkbox"/>
g	Income or pension from your spouse / partner	<input type="checkbox"/>
h	Financial support from family	<input type="checkbox"/>
i	Spouse / partner's superannuation	<input type="checkbox"/>
j	Wage or salary	<input type="checkbox"/>
k	Other sources	<input type="checkbox"/>

Q101b When you are OVER 65 what will be your sources of income?

(Mark all that apply)

		Yes
a	Age pension / Service pension / Widow's pension / War Widow's pension	<input type="checkbox"/>
b	Other government pension or allowance	<input type="checkbox"/>
c	Lump sum superannuation payout	<input type="checkbox"/>
d	A pension or annuity purchased with superannuation or some other funds	<input type="checkbox"/>
e	Income from savings and investments (<i>such as shares and property</i>)	<input type="checkbox"/>
f	Income from a business	<input type="checkbox"/>
g	Income or pension from your spouse / partner	<input type="checkbox"/>
h	Financial support from family	<input type="checkbox"/>
i	Spouse / partner's superannuation	<input type="checkbox"/>
j	Wage or salary	<input type="checkbox"/>
k	Other sources	<input type="checkbox"/>

Q102 Have you begun to think about your life in retirement? In particular, have you made any plans for the following aspects of your life?

(Mark one on each line)

		Not at all	Thought about it	Made some plans	Have firm plans
a	To be socially active with friends or family or the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	To be mentally active (<i>eg join a group, do word or number puzzles</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	To be physically active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	To be financially secure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	To be in some kind of paid, unpaid or voluntary work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	To be in housing that meets your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q103 When you are 65 how do you expect to manage on your available income?

(Mark one only)

- It will be impossible
- It will be difficult all of the time
- It will be difficult some of the time
- It will not be too bad
- It will be easy

women's health *is about you and your life*

Q104 These questions are about getting on with other people:

(Mark one on each line)

		Yes	No
a	Are you sad or lonely often?	<input type="checkbox"/>	<input type="checkbox"/>
b	Do you feel uncomfortable with anyone in your family?	<input type="checkbox"/>	<input type="checkbox"/>
c	Can you take your own medication and get around by yourself?	<input type="checkbox"/>	<input type="checkbox"/>
d	Do you feel that nobody wants you around?	<input type="checkbox"/>	<input type="checkbox"/>
e	Does someone in your family make you stay in bed or tell you you're sick when you know you are not?	<input type="checkbox"/>	<input type="checkbox"/>
f	Has anyone forced you to do things you didn't want to do?	<input type="checkbox"/>	<input type="checkbox"/>
g	Has anyone taken things that belong to you without your OK?	<input type="checkbox"/>	<input type="checkbox"/>
h	Do you trust most of the people in your family?	<input type="checkbox"/>	<input type="checkbox"/>
i	Do you have enough privacy at home?	<input type="checkbox"/>	<input type="checkbox"/>
j	Has anyone close to you tried to hurt or harm you recently?	<input type="checkbox"/>	<input type="checkbox"/>
k	Has anyone close to you called you names or put you down or made you feel bad recently?	<input type="checkbox"/>	<input type="checkbox"/>
l	Are you afraid of anyone in your family?	<input type="checkbox"/>	<input type="checkbox"/>
m	Does anyone in your family drink a lot of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
n	Have you ever been in a violent relationship with a partner / spouse?	<input type="checkbox"/>	<input type="checkbox"/>

Q105 If you have ever lived with a violent partner or spouse, in which years did you experience violence?

(Mark all that apply)

a	I have never lived with a violent partner or spouse	<input type="checkbox"/>
b	Before 1996	<input type="checkbox"/>
c	1996-1998	<input type="checkbox"/>
d	1999-2001	<input type="checkbox"/>
e	2002-2004	<input type="checkbox"/>
f	2005-now	<input type="checkbox"/>

Q106 What is your present marital status?

(Mark one only)

Married (<i>registered</i>)	<input type="checkbox"/>
De facto relationship (<i>opposite sex</i>)	<input type="checkbox"/>
De facto relationship (<i>same sex</i>)	<input type="checkbox"/>
Separated	<input type="checkbox"/>
Divorced	<input type="checkbox"/>
Widowed	<input type="checkbox"/>
Never married	<input type="checkbox"/>

Q107 How many people live with you now?
(Mark all that apply)

			One	Two	Three or more
a	No one, I live alone	<input type="checkbox"/>			
b	Partner or spouse	<input type="checkbox"/>			
c	Children under 16 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Children 16-18 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Children over 18 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Your parents or in-laws	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Other adult relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Other adults (<i>not family members</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q108 People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it?

(Mark one 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	Someone to help you if you are confined to bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Someone you can count on to listen to you when you need to talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Someone to give you good advice about a crisis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Someone to take you to the doctor if you need it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Someone who shows you love and affection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Someone to have a good time with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Someone to give you information to help you understand a situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h	Someone to confide in or talk to about yourself or your problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Someone who hugs you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j	Someone to get together with for relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k	Someone to prepare your meals if you are unable to do it yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l	Someone whose advice you really want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m	Someone to do things with to help you get your mind off things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n	Someone to help with daily chores if you are sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o	Someone to share your most private worries and fears with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p	Someone to turn to for suggestions about how to deal with a personal problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q	Someone to do something enjoyable with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r	Someone who understands your problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s	Someone to love and make you feel wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q109 Are you a twin?

(Mark one only)

- Yes - identical
- Yes - not identical (*fraternal*)
- No

Q110 In general, are you satisfied with what you have achieved in your life so far in the areas of:

(Mark one on each line)

		Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
a	Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	Career	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c	Study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d	Family relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e	Partner / closest personal relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f	Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g	Social activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you filled in this survey for the participant, please answer the next three questions.

Q111 Your relationship to participant: (Mark one only)

- Family member
- Professional health worker (*eg nurse*)
- Other (*eg friend*)

Q112 When you filled in this survey for the participant, which of the following applied?

(Mark one only)

- The participant told me what answers she wanted
- The participant was unable to tell me what answers she wanted and I used my own judgement

Q113 What was the MAIN reason why the participant did not fill in the survey herself?

(Please describe)

Have we missed anything?
If there is ANYTHING else you would like to tell us about changes in your health (especially in the last three years) please write on the lines below.

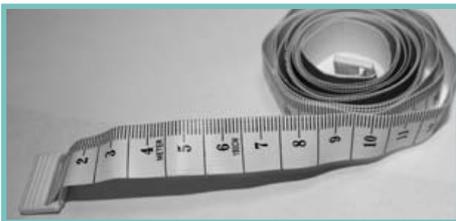
Consent

Mid 5 2007

I consent to the researchers 'matching' the information provided in this survey with that provided in previous surveys so that any changes in my health can be noted.

Signature: _____ Date: _____

What is your maiden name? _____



Have you remembered to measure your waist?
Page 17 Question 56

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Help us keep in touch!

Sometimes we lose touch with our participants. It would be helpful if you could give us your mobile phone number and email address.

Mobile

Email

It would also be helpful if you could give us details of a relative or friend who will be able to help us find you.

Name

Address

P'Code

Phone (home) ()

Relationship to you

Name

Address

P'Code

Phone (home) ()

Relationship to you

***Thank you for taking the time to
complete this survey.***

***If you have any questions you can contact us
by telephoning
1800 068 081 (freecall).***

***Don't forget to sign the consent
and post this back to us!***



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



***Fifth survey for
mid - age women
March 2007***



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