

# BLUE MOUNTAINS EYE STUDY

## 10-year Examinations

### Visual Function, General Health and Food Questionnaire

ID Number

Name \_\_\_\_\_

Questionnaire completed on / /

**We appreciate the time you take to fill in this questionnaire. It will give us important information about your vision and will allow us to assess the impact of visual problems on your general health. It will also enable us to assess whether there is any impact of your diet on the development of eye disease, hearing loss and on your general health.**

The questions are divided into 4 sections:

- I. Vision**
- II. Hearing**
- III. General Health**
- IV. Food, Smell, Taste and Dental Questionnaire**

The first section asks you about problems involving your vision and your impressions about your vision. The second section asks questions about your hearing. In the third section, we ask questions about your general health. For each question, please choose the response that best describes your situation. The last section covers the foods you eat regularly, similar to those asked previously, and some new questions on your sense of smell and taste.

Please take as much time as you need. **All your answers are confidential.** For this survey to improve our knowledge about vision and hearing problems and how they affect your quality of life, we need your answers to be accurate. We are keen to know how your vision and general health has changed over the last 10 years.

#### Instructions

1. In general, we would like you to complete this questionnaire on your own. If you find that you need assistance please feel free to ask our staff and they will assist you. If your spouse/ partner assisted, please indicate this on the front cover.
2. Please answer every question (unless you are asked to skip questions because they don't apply to you).
3. Answer the question by circling the appropriate number.
4. If you are unsure how to answer a question please give the best answer you can and make a comment in the left margin.
5. We would be grateful if you could complete the questionnaire before your appointment and bring this with you for the examination. Otherwise, if you have not been able to complete it, we would be happy for you to return it by mail in a pre-paid envelope we will give you.

#### Statement of Confidentiality

Information that would permit the identification of any person completing this questionnaire will be regarded as strictly confidential. All information provided will be used only for the Eye Study and will not be disclosed or released for any other purpose without your consent.

**Visual Function**  
**National Eye Institute Visual Function Questionnaire**

**Part 1 - General vision**

1. At the present time, would you say your eyesight using both eyes (with glasses if worn) is excellent, good, fair, poor, or very poor or are you completely blind?

(circle one)

- Excellent..... 1
- Good..... 2
- Fair..... 3
- Poor..... 4
- Very poor.....5
- Completely blind..... 6

2. How much of the time do you worry about your eyesight? (circle one)

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

3. How much pain or discomfort have you had in and around your eyes (for example, burning, itching or aching)? Would you say it is: (circle one)

- None..... 1
- Mild..... 2
- Moderate.....3
- Severe, or.....4
- Very severe?..... 5

**Part 2 - Difficulty with Activities**

4. How much difficulty do you have, even with glasses, reading ordinary print in newspapers? Would you say you have: (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or not interested in doing this.....6

5. How much difficulty do you have, even with glasses, doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:

(circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or not interested in doing this.....6

6. Because of your eyesight, even with glasses, how much difficulty do you have finding something on a crowded shelf? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or not interested in doing this.....6

7. How much difficulty do you have, even with glasses, reading street signs or the names of shops? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or not interested in doing this.....6

8. Because of your eyesight, even with glasses, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or not interested in doing this.....6

9. Because of your eyesight, even with glasses, how much difficulty do you have noticing objects off to the side while you are walking along? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or not interested in doing this.....6

10. Because of your eyesight, even with glasses, how much difficulty do you have seeing how people react to things you say? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or not interested in doing this.....6

11. Because of your eyesight, even with glasses, how much difficulty do you have picking out and matching your clothes? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or  
not interested in doing this.....6

12. Because of your eyesight, even with glasses, how much difficulty do you have visiting people in their homes, at parties, or in restaurants? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or  
not interested in doing this.....6

13. Because of your eyesight, even with glasses, how much difficulty do you have going out to see movies, plays, or sports events? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or  
not interested in doing this.....6

14. How much difficulty do you have, even with glasses, reading a large-print book or large print-newspaper or numbers on a telephone? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or  
not interested in doing this.....6

15. How much difficulty do you have, even with glasses, recognising people when they are close to you? (circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or  
not interested in doing this.....6

16. How much difficulty do you have, even with glasses, writing out cheques or filling out forms?

(circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or  
not interested in doing this.....6

17. How much difficulty do you have, even with glasses, watching television?

(circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or  
not interested in doing this.....6

18. Are you currently driving, at least once in a while?

(circle one)

- Yes..... 1     **go to Q21**
- No..... 2

19. **If no:** Have you never driven a car or have you given up driving? (circle one)

- Never drove.....1     **go to Q23**
- Gave up..... 2

If you gave up driving, how many years ago was this? \_\_\_\_\_ years ago

20. **If you gave up driving:** Was that mainly because of your eyesight, mainly for some other reasons, or because of both your eyesight and other reasons? (circle one)

- Mainly eyesight..... 1     **go to Q23**
- Mainly other reasons..... 2     **go to Q23**
- Both eyesight and other reasons.... 3     **go to Q23**

21. **If currently driving:** How much difficulty do you have driving during the daytime in familiar places? Would you say you have: (circle one)

- No difficulty at all..... 1
- A little difficulty..... 2
- Moderate difficulty.....3
- Extreme difficulty.....4

22. How much difficulty do you have driving at night? Would you say you have:

(circle one)

- No difficulty at all.....1
- A little difficulty.....2
- Moderate difficulty.....3
- Extreme difficulty.....4
- Stopped doing this because of your eyesight... 5
- Stopped doing this for other reasons or  
not interested in doing this.....6

### Part 3 – Vision Problems

The next questions are about things affecting your vision. For each one, please circle the number to indicate whether the statement is true for you all, most, some, a little, or none of the time.

(circle one number on each line)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
23. <u>Do you accomplish less than you would like because of your vision?</u>	1	2	3	4	5
24. <u>Are you limited in how long you can work or do other activities because of your vision?</u>	1	2	3	4	5
25. How much does pain or discomfort <u>in or around your eyes</u> , for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:	1	2	3	4	5

For each of the following statements, please circle the number to indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.

(circle one number on each line)

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
26. I <u>stay home most of the time</u> because of my eyesight...	1	2	3	4	5
27. I feel <u>frustrated</u> a lot of the time because of my eyesight.....	1	2	3	4	5
28. I have <u>much less control</u> over what I do, because of my eyesight.....	1	2	3	4	5
29. Because of my eyesight, I have to <u>rely too much on what other people tell me..</u>	1	2	3	4	5
30. I <u>need a lot of help</u> from others because of my eyesight.....	1	2	3	4	5
31. I worry about <u>doing things that will embarrass myself or others</u> , because of my eyesight	1	2	3	4	5



## Part 2: Tinnitus and Dizziness

12. Have you experienced any prolonged ringing or buzzing in your ears or head within the past year...that is, lasting for 5 minutes or longer? (circle one)

None.....	1 <b>go to Q26</b>	Often.....	3
Occasional.....	2	Unsure.....	4

13. We call this **tinnitus**. When is tinnitus present?

All the time.....	1	Only occasionally.....	3
Often.....	2	Unsure.....	4

14. Where do you hear your tinnitus?

Right ear.....	1	In the head.....	4
Left ear.....	2	Unsure.....	5
Both ears.....	3		

15. When you hear tinnitus, which word best describes the sound you usually hear?

crackling (static).....	1	roaring.....	5
ringing.....	2	other.....	6
buzzing.....	3	<b>specify</b> .....	
pulsating.....	4	unsure.....	7

16. Do you hear your tinnitus:

during the day when it is quiet.....	1	only at night.....	4
during the day above other noises .....	2	unsure.....	5
day and night.....	3		

17. Does the tinnitus keep you awake at night?

very often.....	1	never.....	4
often.....	2	unsure.....	5
occasionally.....	3		

18. How annoying is your tinnitus?

extremely annoying.....	1	not annoying at all.....	4
very annoying.....	2	unsure.....	5
mildly annoying.....	3		

19. Does your tinnitus get you down at times?

very often.....	1	never.....	4
often.....	2	unsure.....	5
occasionally.....	3		

20. What treatment have you tried for your tinnitus?

none.....	1	(multiple responses accepted)	
medications.....	2	acupuncture.....	5
hearing aids.....	3	relaxation therapy.....	6
tinnitus masker.....	4	music therapy.....	7
		tinnitus retraining therapy....	8

21. Which of those treatments was most helpful?

medications.....	1	(multiple responses accepted)	
hearing aids.....	2	relaxation therapy.....	5
tinnitus masker.....	3	music therapy.....	6
acupuncture.....	4	tinnitus retraining therapy....	7

Please provide any other comments about your tinnitus below...

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22. Have you sought help or spoken to any professional about your tinnitus?

- yes..... 1
- no.....2
- don't know..... 3

23. Which of the following have you contacted?

- family doctor..... 1
- ENT doctor.....2
- Audiologist.....3

(multiple responses accepted)

- hearing service/ hearing aid provider..... 4
- unsure.....5
- self help group (e.g. BHA,ATA,SHHH)..6

24. Have you received *treatment or support services for your tinnitus* from any of the following in the past 5 years? (multiple responses accepted)

- family doctor..... 1
- ENT doctor.....2
- Audiologist.....3

- hearing service/ hearing aid provider..... 4
- unsure.....5
- self help group (e.g. BHA,ATA,SHHH)..6

25. What is the name of professionals or services you have visited because of tinnitus?

- Name 1 ..... How long ago? \_\_\_\_\_ years
- Name 2 ..... How long ago? \_\_\_\_\_ years

26. Have you experienced any dizziness or unsteadiness in the past year?

- yes..... 1
- no.....2
- don't know..... 3

27. How would you describe the sensation?

- Rotational/spinning..... 1
- Lightheadedness..... 2

- don't know..... 3
- other..... 4

Please describe the feeling of your dizziness....

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28. Is this spinning sensation apparently linked with any of the following? (multiple responses accepted)

- nausea/vomiting..... 1
- when turning over in bed..... 2
- Fullness in the ears..... 3

- change in hearing.....4
- change in or onset of tinnitus..... 5
- don't know..... 6

29. How long does the dizziness sensation last?

- A few minutes..... 1
- A few hours..... 2
- A day..... 3

(multiple responses accepted)

- A few days..... 4
- Other *specify below*..... 5
- Don't know..... 6

Duration of your dizziness (if "Other") \_\_\_\_\_

## General Health

### Short-Form 36 questionnaire

1. In general, would you say your health is: (circle one)
- 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)
- 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 than one year ago..... 4
- Much worse now than one year ago..... 5

3. The following questions are about activities you might do doing a typical day.  
Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

Activities	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. <b>Vigorous activities</b> , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. <b>Moderate activities</b> , 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 <b>several</b> flights of stairs	1	2	3
e. Climbing <b>one</b> flight of stairs	1	2	3
f. Bending, kneeling or stooping	1	2	3
g. Walking <b>more than one kilometre</b>	1	2	3
h. Walking <b>half a kilometre</b>	1	2	3
i. Walking <b>100 metres</b>	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 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 <b>amount of time</b> you spent on work or other activities	1	2
b. <b>Accomplished less</b> than you would like	1	2
c. Were limited in the <b>kind</b> of work and other activities	1	2
d. Had <b>difficulty</b> 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)

- 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)

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

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one)

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

9. These questions are about how you feel and how things have been with you during the past 4 weeks. 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 very nervous?	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 happy?	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)

- 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 most 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

# Activities of daily living

## OARS Multidimensional Functional Assessment Questionnaire

We are interested to know about some of your activities of daily living, things that we all need to do as part of our daily lives. We would like to know if you can do these activities without any help at all, or if you need some help to do them, or if you can't do them at all.

1. Can you use the telephone (circle one)
  - Without help, including looking up numbers and dialling..... 2
  - With some help (can answer phone or dial operator in an emergency, but need a special phone or help in getting the number or dialling)..... 1
  - Or are you completely unable to use the telephone..... 0
  
2. Can you get to places out of walking distance (circle one)
  - Without help (can travel alone on buses, taxis, or drive your own car)..... 2
  - With some help (need someone to help you or go with you when travelling) or ..... 1
  - Are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?..... 0
  
3. Can you go shopping for groceries or clothes (if you have transportation) (circle one)
  - Without help (taking care of all shopping needs yourself, assuming you had transportation)..... 2
  - With some help (need someone to go with you on all shopping trips)..... 1
  - Or are you completely unable to do any shopping?..... 0
  
4. Can you prepare your own meals (circle one)
  - Without help (plan and cook full meals yourself)..... 2
  - With some help (can prepare some things but unable to cook full meals yourself)..... 1
  - Or are you completely unable to prepare any meals?..... 0
  
5. Can you do your housework (circle one)
  - Without help (can you scrub floors, etc),..... 2
  - With some help (can do light housework but need help with heavy work),..... 1
  - Or are you completely unable to do any housework?..... 0
  
6. Can you take your own medications (circle one)
  - Without help (in the right doses at the right time),..... 2
  - With some help (able to take medications if someone prepares it for you and/or reminds you to take it)..... 1
  - Or are you completely unable to take your medication?..... 0
  
7. Can you handle your own money (circle one)
  - Without help (write cheques, pay bills, etc),..... 2
  - With some help (manage day-to-day purchases but need help with managing your chequebook and paying your bills)..... 1
  - Or are you completely unable to handle money?..... 0

8. Can you eat (circle one)  
Without help (able to feed yourself completely)..... 2  
With some help (need help with cutting, etc)..... 1  
Or are you completely unable to feed yourself?.....0

9. Can you dress and undress yourself (circle one)  
Without help (able to pick out clothes, dress and undress yourself)..... 2  
With some help..... 1  
Or are you completely unable to dress and undress yourself?.....0

10. Can you take care of your own appearance, for example combing your hair and (for men) shaving (circle one)  
Without help..... 2  
With some help..... 1  
Or are you completely unable to maintain your appearance yourself?..... 0

11. Can you walk (circle one)  
Without help (except for cane)..... 2  
With some help from a person or with the use of a walker,  
or crutches, etc.....1  
Or are you completely unable to walk?..... 0

12. Can you get in and out of bed (circle one)  
Without any help or aids,.....2  
With some help (either from a person or with the aid of some device)..... 1  
Or are you totally dependent on someone else to lift you?.....0

13. Can you take a bath or shower (circle one)  
Without help..... 2  
With some help (need help getting in and out of the tub,  
or need special attachments on the tub)..... 1  
Or are you completely unable to bathe yourself?..... 0

14. Do you ever have trouble getting to the bathroom on time? (circle one)  
No.....2  
Yes..... 0  
Have a colostomy or catheter..... 1

If yes, how often do you wet or soil yourself (either day or night)? (circle one)  
Once or twice a week..... 1  
Three times a week or more.....0

15. Is there someone who helps you with such things as shopping, housework, bathing, dressing, and getting around? (circle one)  
No.....2  
Yes..... 0

If yes, who is your major helper? Name: \_\_\_\_\_  
relationship \_\_\_\_\_ /code

Who else helps you? Name: \_\_\_\_\_  
relationship \_\_\_\_\_ /code

# Emotions

## Centre for Epidemiologic Studies Depression Scale

The following questions are a list of the ways you might have felt lately and are designed to assess whether you have been depressed. Please indicate how often you felt this way in the **past week**.

During the **past week**:

(circle one number on each line)

	Rarely or none of the time  ( < 1day)	Some or a little of the time  (1-2 days)	Occasionally or a moderate amount of time  (3-4 days)	Most or all of the time  (5-7 days)
1. I was bothered by things that usually don't bother me	0	1	2	3
2. I had trouble keeping my mind on what I was doing	0	1	2	3
3. I felt depressed	0	1	2	3
4. I felt that everything I did was an effort	0	1	2	3
5. I felt hopeful about the future	0	1	2	3
6. I felt fearful	0	1	2	3
7. My sleep was restless	0	1	2	3
8. I was happy	0	1	2	3
9. I felt lonely	0	1	2	3
10. I could not get "going"	0	1	2	3

## Exercise

1. In the last 2 weeks did you walk for recreation or exercise for at least 10 minutes continuously?

(circle one)

Yes.....1

No.....2

Don't know.....3

**go to Q2**

If **yes**, how many times in the last 2 weeks? \_\_\_\_\_ times

If **yes**, how long would you estimate that you spent walking in total for the last 2 weeks?  
\_\_\_\_\_ hours \_\_\_\_\_ minutes

2. In the past 2 weeks did you do any vigorous activity or exercise which made you breathe harder or puff and pant? (e.g. carrying loads, heavy gardening, chopping wood, labouring - at home, during work or anywhere else) (circle one)

Yes.....1

No.....2

Don't know.....3

**go to Q3**

If **yes**, how many times in the last 2 weeks? \_\_\_\_\_ times

If **yes**, how long would you estimate that you spent doing vigorous activity in the last 2 weeks?  
\_\_\_\_\_ hours \_\_\_\_\_ minutes

3. In the past 2 weeks, did you do any other leisure time physical activities that you haven't already mentioned? (e.g. more moderate activities such as lawn bowls, gardening)

(circle one)

Yes.....1

No.....2

Don't know.....3

**go to Q4**

If **yes**, how many times in the last 2 weeks? \_\_\_\_\_ times

If **yes**, how long would you estimate that you spent doing these leisure-time activities in the last 2 weeks?  
\_\_\_\_\_ hours \_\_\_\_\_ minutes

4. Are you able to walk a kilometre without help?

(circle one)

Yes.....1

No.....2

Don't know.....3

5. Are you able to walk up and down one flight of stairs without help?

(circle one)

Yes.....1

No.....2

Don't know.....3

## Smell and Taste

We are interested to learn how the senses of smell and taste change as people grow older. We have a few questions to ask you regarding these senses and things that can affect them.

### Smell Questions:

(Please tick one box)

A. Do you have a normal sense of smell (compared to other people)? Yes ~ No ~ Unsure ~

*If yes, please go to question F*

B. If you don't have a normal sense of smell, please tick the box which most applies to you and write down your age when you first noticed this difference in your sense of smell:

- I have never had a sense of smell ~ *please go to question E*
- I have lost my sense of smell ~ at \_\_\_\_\_ years old
- I have an increased sensitivity to odours ~ at \_\_\_\_\_ years old
- I have a decreased sensitivity to odours ~ at \_\_\_\_\_ years old

C. Was there an illness (other than cold / flu) or an injury around the time you first noticed this difference in your sense of smell?

Yes ~ No ~ Unsure ~

**If yes, please specify what happened** \_\_\_\_\_

D. Did you change medications around this time?

Yes ~ No ~ Unsure ~

**If yes, around this time, did you start a new medicine or stop one? (Please specify)** \_\_\_\_\_

E. Did you see a doctor for this (change or loss)?

Yes ~ No ~ Unsure ~

**If yes, What did the doctor say?** \_\_\_\_\_

**F. Have you ever had a change in your sense of smell, other than when you have had a cold / flu or allergy symptoms?**

Yes ~ No ~ Unsure ~

G. Have you ever smelled an unpleasant, bad, or burning odour when nothing is there?

Yes ~ No ~ Unsure ~

**If yes, currently (within the past year) or not currently? (Please specify)** \_\_\_\_\_

## Taste Questions

A. Do you have a normal sense of taste (compared to other people)? Yes ~ No ~ Unsure ~  
*If yes, please go to question F*

B. If you don't have a normal sense of taste, please tick the box which most applies to you and write down your age when you first noticed this difference in your sense of taste:

I have never had a sense of taste ~ *please go to question E*  
I have lost my sense of taste ~ \_\_\_\_\_ years old  
I have an increased sensitivity to odours ~ \_\_\_\_\_ years old  
I have a decreased sensitivity to odours ~ \_\_\_\_\_ years old

C. Was there an illness (other than cold / flu) or an injury around the time you first noticed this difference in your sense of taste? Yes ~ No ~ Unsure ~  
*If yes, please specify what happened* \_\_\_\_\_

D. Did you change medications around this time? Yes ~ No ~ Unsure ~  
*If yes, around this time, did you start a new medicine or stop one? (Please specify)* \_\_\_\_\_

E. Did you see a doctor for this (change or loss)? Yes ~ No ~ Unsure ~  
*If yes, What did the doctor say?* \_\_\_\_\_

**F. Have you ever had a change in your sense of taste, other than when you have had a cold / flu or allergy symptoms?** Yes ~ No ~ Unsure ~

G. Do foods you eat taste as good as when you were younger? (If you eat the same foods now)? Yes ~ No ~ Unsure ~

H. Do familiar foods have an unpleasant, bad, or unusual taste? Yes ~ No ~ Unsure ~

I. Do you have an unpleasant or bad taste in your mouth that affects the taste of food? Yes ~ No ~ Unsure ~

J. Do you usually have a bad taste in your mouth? Yes ~ No ~ Unsure ~

## Food Questionnaire

WE WOULD LIKE TO ASK YOU WHICH FOODS YOU EAT, AND HOW MUCH YOU EAT OF EACH.

On the next page you will see a list of foods with an amount written next to each food. For each food we would like you to indicate with a tick **how often**, on average, you have eaten the **given amount over the last twelve months**. This may vary from never to four or more times as much as the given amount per day.

To help get you started, here are some examples of what we mean. If you can take a few minutes to work through these examples, you will quickly get the idea.

**EXAMPLE 1:**How often do you drink 250 ml (8oz) of whole milk?

If you drink a 250 ml glass of whole milk every day, on average (including milk you use on cereal, or in tea or coffee), you would place a tick in the 1 per day column, like this:

		Number of times used this amount over last 12 months								
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day
Whole Milk	250 ml (8oz.) glass							T		

If you drink **twice** this amount, that is a total of about **two** 8oz. glasses of whole milk every day, you would place a tick in the 2-3 **per day** column, like this:

Whole Milk	250 ml (8oz.) glass								T	
------------	---------------------	--	--	--	--	--	--	--	---	--

**EXAMPLE 2:** How often do you eat 1/2 cup of green beans?

If you eat 1/2 cup of green beans every 2 weeks, on average, you would place a tick in the **1-3 per month** column, like this:

		Number of times used this amount over last 12 months								
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day
Green Beans	1/2 cup			T						

If you eat 1 cup of green beans a **week**, on average, this is the same as eating 1/2 cup of green beans 2 times a week, so you would place a tick in the **2-4 per week** column, like this:

Green Beans	1/2 cup					T				
-------------	---------	--	--	--	--	---	--	--	--	--

If there are any foods that you never eat, please place a tick in the **NEVER** column. Do not leave it blank.

Q 1 **Now**, please look at the list of foods below. For **each** food listed indicate with a tick how often, on average, you have eaten this food, in the given amount, during the past year. Please try to think carefully about **each** food, and try not to leave any blank lines.

		Number of times used this amount over last 12 months								
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	
Foods	Amount									
Skim milk	250 ml (8oz.) glass									6 _
Low fat milk	250 ml (8oz.) glass									_
Whole milk	250 ml (8oz.) glass									_
Cream e.g. thickened, pouring	1 tblsp.									_
Ice cream	1/2 cup									10 _
Yoghurt, flav/plain	1 small carton									_
Yoghurt, low fat, flav/plain	1 small carton									_
Cottage or ricotta cheese	1/2 cup									_
Other cheese, e.g. Coon	1 slice or 1 oz. serving									_
Margarine, added to food or bread: Exclude use in cooking	1 teasp.									15 _
Butter, added to food or bread: Exclude use in cooking	1 teasp.									_

**Q 2 What form of margarine do you use most often for spreading on bread, adding to vegetables etc? (Exclude use in cooking) (Circle one)**

- |                              |                                |
|------------------------------|--------------------------------|
| 1. Cooking margarine         | 4. Low fat margarine           |
| 2. Table margarine           | 5. Do not use margarine        |
| 3. Polyunsaturated margarine | 6. Other, please specify _____ |

17 \_

What brand do you use most often? \_\_\_\_\_

18 \_ \_

**Q 3 What form of butter do you use most often for spreading on bread, adding to vegetables etc? (Exclude use in cooking) (Circle one)**

- |                         |                             |
|-------------------------|-----------------------------|
| 1. Ordinary butter      | 4. Dairy blend, reduced fat |
| 2. Reduced fat butter   | 5. Do not use butter        |
| 3. Dairy blend, regular |                             |

20 \_

**Q 4a. Do you usually add butter or margarine to your cooked vegetables before you eat them? (Circle one)**

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

21 \_

**Q. 4b. What type of ice cream and other ice confection do you usually use? (Circle one)**

- |                           |                                       |
|---------------------------|---------------------------------------|
| 1. Regular ice cream      | 4. Reduced fat frozen yoghurt         |
| 2. Reduced fat ice cream  | 5. Vitari, sorbet or other fruit ices |
| 3. Regular frozen yoghurt | 6. Other, please specify _____        |

**Q. 4 c. What type of cheese do you usually have?**

1. Cottage / ricotta
2. Traditional types ( cheddar, tasty, processed, Camembert, etc.)
3. Fat modified/ reduced fat types
4. Don't know/ can't say

Q 5  SEASONAL FRUITS Please indicate how often on average you eat these fruits when they are in season.		Number of times used this amount over last 12 months								
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day
Foods	Amount									
Fresh peaches, apricots, plums or nectarines	1									22 _
Fresh grapes	small bunch (about 20)									_
Fresh strawberries	1/2 cup									_
Other fresh berries	1/2 cup									25 _
Fresh cantaloupe or rockmelon	1/4 melon									_
Fresh mangoes	1									_
Fresh paw-paw	1 slice									_
Fresh pineapple	1 slice									_
Watermelon	1 slice									30 _
Avocado	1/2 avocado									_

Q 5		Number of times used this amount over last 12 months									
OTHER FRUITS		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day	
Fresh apple or pear	1										32
Fresh orange	1										-
Fresh grapefruit	1/2										-
Fresh banana	1										35
Prunes	1/2 cup										-
Dried apricots	4 - 5 halves										-
Dried peaches	4 - 5 halves										-
Other dried fruits	1 tblsp.										-
Canned apricots or peaches	1/2 cup										40
Other canned fruit	1/2 cup										-

Q 6  SEASONAL VEGETABLES (Please indicate how often on average you eat these vegetables when they are in season.)		Number of times used this amount over last 12 months								
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day
Foods	Amount									
Broccoli	1/2 cup									
Cauliflower	1/2 cup									
Spinach, Silverbeet, cooked	1/2 cup									
Spring onions, shallots	1 medium									

42 \_  
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 45 \_

Q 6		Number of times used this amount over last 12 months									
OTHER VEGETABLES (fresh, frozen or canned)		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day	
Foods	Amount										
Potato, boiled or mashed	1 medium, 1/2 cup										46 _
Potato, baked	1 medium										_
Hot chips	1 cup										_
Pumpkin, boiled or mashed	1 med. piece, 1/2 cup										_
Pumpkin, baked	1 medium piece										50 _
Sweet potato	1/2 cup										_
Peas	1/2 cup										_
Green beans	1/2 cup										_
Cabbage	1/2 cup										_
Brussel sprouts	3-5 fresh or frozen										55 _
Carrots	1 medium whole or 1/2 cup cooked										_

Q 6		Number of times used this amount over last 12 months								
OTHER VEGETABLES (fresh, frozen or canned) Continued		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day
Foods	Amount									
Sweet corn	1 cob or 1/2 cup frozen or canned									
Eggplant, zucchini or squash	1/2 cup									
Mushrooms	6-7 small									
Tomatoes	1									
Lettuce	2 medium leaves									
Coleslaw	1/2 cup									
Celery	10cm (4 inch) stick									
Bean sprouts	1/2 cup									
Baked beans	1/2 cup									
Soybeans	1/2 cup									
Other beans or lentils	1/2 cup									

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Q 7 MEATS, FISH & EGGS		Number of times used this amount over last 12 months									
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day	
Foods	Amount										
Beef, pork or lamb as main dish e.g. steak, roast	1 small t-bone or 3 slices										68 _
Beef, pork or lamb mixed dish e.g. stew, casserole	1/2 cup										_
Ham, beef, pork or lamb in sandwich	1 slice										70 _
Chicken with skin	1 drumstick or 2 slices										_
Chicken without skin	1 drumstick or 2 slices										_
Sausages	2 thick or 3 thin										_
Hamburger patty or rissole	1										_
Mince in tomato sauce e.g. spaghetti sauce	1 cup										75 _
Other mince meat dishes	1 cup										_
Bacon	2 slices										_

Q 7		Number of times used this amount over last 12 months								
MEATS, FISH & EGGS (continued)		Never	Less than 1 per month	1-3 per month	1 per week	2-3 per week	5-6 per week	1 per day	2-3 per day	4+ per day
Foods	Amount									
Liver	100 g (4 oz.)									
Meat pie	1									
Sausage roll	1									
Processed meats e.g. Devon, Chicken roll	1 piece or slice									
Frankfurt, saveloy	1 large or 3 small									
Boiled or poached egg	1									
Fried egg	1									
Scrambled egg or omelette	1									
Tuna canned in oil	1/2 cup									
Tuna, salmon canned in water	1/2 cup									
Sardines	1/2 cup									
Other fish (e.g. fried, baked)	1 small fillet									
Other seafood e.g. prawns, crabs scallops as a main dish	1/2 cup									

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80 —  
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85 —  
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90 —

Q 8 BREAD, CEREALS, STARCHES		Number of times used this amount over last 12 months								
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day
Foods	Amount									
Cold breakfast cereal	1 cup									91 _
Cooked oatmeal	1 cup									_
White bread or toast	1 slice									_
Wholemeal/mixed grain bread or toast	1 slice									_
Scone, pikelet	1 scone, 3 pikelets									95 _
Brown rice	1 cup (cooked)									_
White rice	1 cup (cooked)									_
Pasta e.g. spaghetti, noodles, etc.	1 cup									_
Crispbread, cracker, etc.	1									_

**Q9** What kind of breakfast cereal do you use most often (e.g. Uncle Toby's Toasted Muesli, Kellogg's Corn Flakes)  
Please specify type(s) and brand(s):

1. \_\_\_\_\_

100 \_\_

2. \_\_\_\_\_

102 \_\_

Q 10a		Number of times used this amount over last 12 months									
BEVERAGES		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day	
Amount											
Orange juice	1 small glass										104 _
Pineapple juice	1 small glass										_
Grape juice	1 small glass										_
Tomato juice	1 small glass										_
Carrot juice	1 small glass										_
Other juice	1 small glass										_
Low calorie cola e.g. Diet Coke	1 can										110 _
Other low calorie soft drink e.g. Diet Solo	1 can										_
Coke, Pepsi or other cola	1 can										_
Other soft drink, e.g. Lemonade	1 can										_
Cordial	1 glass										_
Coffee	1 cup										115 _
Decaf Coffee	1 cup										_
Tea (not herbal teas)	1 cup										_
Herbal tea	1 cup										_

Q 10a		Number of times used this amount over last 12 months								
BEVERAGES WITH ALCOHOL		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day
Amount										
Beer (ordinary or heavy)	1 stubbie, can									
Beer (low alcohol)	1 stubbie, can									
Red Wine	1 wine glass									
White Wine or Champagne	1 wine glass									
Sherry or Port	1/2 wine glass									
Spirits (e.g. whiskey, gin)	1 drink or nip									

119 \_

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**Q.10 b. What type(s) and brand(s) of fruit juice do you use?**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Q 11  SWEETS, BAKED GOODS & SNACKS		Number of times used this amount over last 12 months									
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4+ per day	
Foods	Amount										
Custard	1/2 cup										125 _
Cake	1 slice										_
Tart or pie	1 slice										_
Pastry, Pavlova, Cheesecake, etc	1 slice										_
Sweet roll, bun	1										_
Plain sweet biscuits, commercial	1										130 _
Fancy biscuits, commercial, e.g. chocolate coated	1										_
Chocolate	1										_
Lollies	3-5										_
Jam, marmalade, syrup or honey	1 tblsp.										_
Peanut paste	1 tblsp.										135 _
Vegemite or Marmite	1 teasp.										_
Nuts	1 tblsp.										_
Potato chips (crisps), corn chips, twisties etc.	1 small bag										_

Q 11		Number of times used this amount over last 12 months							
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day
OTHER FOODS	Amount								
Pizza	2 slices								
Olives/gherkins/pickled vegs	1/3 cup								
Cream soup	1 cup								
Oil and vinegar dressing, e.g. French	1 tbsp.								
Mayonnaise or other creamy salad dressing	1 tbsp.								

139 \_  
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**Q 12 Are there any other foods not listed above that you usually eat at least once per week?**

Other foods that you usually use at least once per week	Usual serving size	Average use per week
(a)		
(b)		
(c)		

144 \_ \_ \_  
 -  
 148 \_ \_ \_  
 -  
 152 \_ \_ \_  
 -

**Q 13 How many teaspoons of sugar altogether do you add to your food and drink each day? (Include sugar added to your tea, coffee, cereal, fruit etc.)**

Total \_\_\_\_\_ teasp

156 \_ \_

**Q 14 What do you do with the visible fat on your meat? (Circle one)**

- 1. Eat most of it
- 2. Eat some of it
- 3. Eat as little as possible
- 4. Don't eat meat

158 \_

**Q 15 What type of cooking oil is used most often in your home? (e.g. Bertolli olive oil, Meadow Lea sunflower oil)**

Please specify type and brand \_\_\_\_\_

159 \_

**Q 16 What kind of fat is used most often in your home for frying or roasting meat or vegetables?**

- |                              |                          |
|------------------------------|--------------------------|
| 1. Butter                    | 5. Table margarine       |
| 2. Lard                      | 6. Vegetable oil         |
| 3. Cooking margarine         | 7. Other, please specify |
| 4. Polyunsaturated margarine | _____                    |
| /polyunsat. table margarine  | 8. None                  |

160 \_

**Q 17 How often do you eat food that is fried at home? (Include any foods cooked in a pan or on a hot plate e.g. pan frying or dry frying) (Circle one)**

- |                            |                            |
|----------------------------|----------------------------|
| 1. Less than once per week | 4. Daily                   |
| 2. 1 - 3 times per week    | 5. 2 or more times per day |
| 3. 4 - 6 times per week    |                            |

161 \_

**Q 18 How often do you eat take-away that is fried food e.g. Chips, battered foods, chicken fried fish? (Circle one)**

- |                          |                         |
|--------------------------|-------------------------|
| 1. Less than once a week | 3. 4 - 6 times per week |
| 2. 1 - 3 times per week  | 4. Daily                |

162 \_

**Q 19 Do you take vitamin pills (or liquid)? (Circle One)**

1. Yes                      2. No

157 \_

**If YES, do you regularly (in most weeks) take any of the vitamins listed below?**

1. Yes                      2. No

158 \_

**If YES, please look at the bottle to help answer the following:**

<b>Name of Vitamin</b>	<b>Brand Name</b>	<b>Used for how many years</b>	<b>No. of pills, capsules or teaspoons per day</b>	<b>Strength in mg or other units - see bottles</b>
<b>Multi-vitamin</b>				
<b>Vitamin A retinol</b>				
<b>Beta - carotene</b>				
<b>Vitamin C</b>				
<b>Vitamin E</b>				

159 \_ \_ \_ \_

165 \_ \_ \_ \_

175 \_ \_ \_ \_

185 \_ \_ \_ \_

195 \_ \_ \_ \_

**Q 20 Do you take other dietary supplements or minerals? (Circle one)**

1. Yes                      2. No

205 \_

**If YES, please specify for each supplement, the type, number or amount taken and how often taken.**

Name of Supplement or Mineral	Brand Name	Used for how many years	Amount taken per day	If applicable - strength in mg or other units
(a)				
(b)				
(c)				
(d)				
(e)				

206 \_ \_ \_ \_

216 \_ \_ \_ \_

226 \_ \_ \_ \_

236 \_ \_ \_ \_

246 \_ \_ \_ \_

Q. 21. These are more detailed questions about meat		Number of times used this amount over last 12 months									
		Never	Less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day		4+ per day
Foods	Amount										
Beef or veal as main dish eg steak or roast	1 small t-bone or 3 slices										250 _
Pork or ham as main dish eg chops or roast	3 slices										_
Lamb as main dish eg chops or roast	3 slices										252 _
Beef or veal mixed dish e.g. stew, casserole, stir fry	1/2 cup										_
Pork or ham mixed dish e.g. stew, casserole, stir fry	1/2 cup										254 _
Lamb mixed dish e.g. stew, casserole, stir fry	1/2 cup										_
Ham or pork in sandwich	1 slice										256 _
Beef or veal in sandwich	1 slice										_
Lamb in sandwich	1 slice										258 _

**Q.22** For each of the following types of food I would like you to tell me about how often you usually eat the food at this time of year. For example, over the last 3 months have you eaten a particular food, once a day, twice a week, three times a month - whatever is easier. Think about all the food you eat - both at home and away from home.

**A. How often do you eat fried food with a batter or breadcrumb coating?**

- |                    |                                 |
|--------------------|---------------------------------|
| 1. _____ per day   | 4. _____ rarely or never        |
| 2. _____ per week  | 5. _____ don't know / can't say |
| 3. _____ per month |                                 |

**B. How often do you eat meat products such as sausages, frankfurters, belgium, devon, salami, meat pies, bacon or ham?**

- |                    |                                 |
|--------------------|---------------------------------|
| 1. _____ per day   | 4. _____ rarely or never        |
| 2. _____ per week  | 5. _____ don't know / can't say |
| 3. _____ per month |                                 |

**C. How often do you eat chips, french fries, wedges, fried potatoes or crisps?**

- |                    |                                 |
|--------------------|---------------------------------|
| 1. _____ per day   | 4. _____ rarely or never        |
| 2. _____ per week  | 5. _____ don't know / can't say |
| 3. _____ per month |                                 |

**D. How is your meat usually cooked?**

- |  |                                      |
|--|--------------------------------------|
| 1. fried                                 | 4. grilled/roasted without added fat |
| 2. stewed/casserole                      | 5. Rarely or never eat meat          |
| 3. grilled/roasted with added fat or oil | 6. Don't know/can't say              |

**E. What type of milk do you usually have?**

- |  |                                |
|--|--------------------------------|
| 1. regular milk (whole or full cream milk) | 6. Shape                       |
| 2. Life full cream                         | 7. Skim milk                   |
| 3. Lite white                              | 8. Other, please specify _____ |
| 4. Farmer's best                           | 9. Don't have milk             |
| 5. Life reduced fat                        | 10. Don't know/can't say       |

**F. Which one of the following best describes your usual way of eating?**

- |                             |   |
|-----------------------------|---|
| 1. no special way of eating | 4. diabetic diet                                      |
| 2. vegetarian               | 5. fat modified diet to lower blood fat (cholesterol) |
| 3. weight reduction diet    | 6. Other, please specify _____                        |

**Q. 23. How many serves of vegetables do you usually eat each day?  
(a 'serve' = ½ cup of cooked vegetables or 1 cup of salad vegetables)**

1. \_\_\_\_\_ serves per day (0,1,2,3, etc)
2. don't eat vegetables

**Q.24 How many serves of fruit do you usually eat each day?  
(a 'serve' = 1 medium piece or 2 small pieces of fruit or 1 cup of diced pieces)**

1. \_\_\_\_\_ serves per day (0,1,2,3, etc)
2. don't eat fruit

**Q.25 How many slices of bread do you usually eat each day?  
(A slice of bread is equal to 1 small bread roll or 1 bagel or ½ a large bread roll or ½ bread muffin or 1 scone or ½ a pita bread)**

1. \_\_\_\_\_ slices per day (0,1,2,3, etc)
2. don't eat bread
3. don't know

**Q.26 How many cups of cooked pasta, rice, noodles, or other cooked cereals do you usually eat each week? (Not including cooked breakfast cereals). I am asking you about per week here!**

1. \_\_\_\_\_ cups per day (0,½, 1,1½,2,2½,3, etc)
2. don't eat these foods
3. don't know

**Q.27 How many cups of breakfast cereal do you usually eat each day?  
(One cup is equal to 2 weetbix or ½ cup of cooked porridge or ⅓ of a cup of muesli or ½ cup of allbran)**

1. \_\_\_\_\_ cups per day (0,½, 1,1½,2,2½,3, etc)
2. don't eat breakfast cereals
3. don't know

**Q. 28 a. In the last 5 years, have you changed your eating habits in any way?**

1. Yes                      2. No

If YES, how?

**Q.28 b. Over the past 5 years, would you say you have increased, decreased, or not changed the amount you eat of the following foods and nutrients. (Please tick)**

<b>Food</b>	<b>Increased</b>	<b>Decreased</b>	<b>Not Changed</b>	<b>Don't Eat</b>
Salt				
Starches (eg, cereals, pasta, rice, bread, grains)				
Fibre				
Fruit				
Vegetables				
Total fat				
Saturated fats (eg fat in meat, milk, cheese, butter)				
Polyunsaturated fats (eg vegetable oils, polyunsaturated margarine)				
Monounsaturated fats (eg olive oil, canola oil or canola margarine)				
Cholesterol				
Alcohol				
Energy (kilojoules or calories)				

**Q. 28c. Do you think you will make any changes to your eating habits during the next five years?**

1. Yes                      2. No

If **YES**, what changes? \_\_\_\_\_

**Q.29 How would you rate the amount you eat of each of these foods and nutrients? (Please tick)**

<b>Food</b>	<b>Too much</b>	<b>About right</b>	<b>Too little</b>	<b>Don't Eat</b>
Salt				
Starches (eg, cereals, pasta, rice, bread, grains)				
Fibre				
Fruit				
Vegetables				
Total fat				
Saturated fats (eg fat in meat, milk, cheese, butter)				
Polyunsaturated fats (eg vegetable oils, polyunsaturated margarine)				
Monounsaturated fats (eg olive oil, canola oil or canola margarine)				
Cholesterol				
Alcohol				
Energy (kilojoules or calories)				

**The next nine questions are about your body weight.**

**30. Do you consider yourself to be**

1. Acceptable weight
2. Underweight
3. Overweight

**31. How tall are you without shoes?**

\_\_\_\_\_centimetres

**OR**

\_\_\_\_\_ feet \_\_\_\_\_ inches

**32. How much do you weigh without clothes or shoes?**

\_\_\_\_\_kilograms

**OR**

\_\_\_\_\_stones \_\_\_\_\_pounds

**33. Compared to the same time last year, has your weight:**

1. Increased
2. Decreased
3. Stayed the same
4. Don't know

**34. If your weight has changed, what do you think were the reasons for this weight change?**

---

---

**35. Have you tried to lose weight in the past 12 months?**

1. Yes
2. No
3. Not sure

**36. If you have tried to lose weight in the past 12 months, which weight loss methods have you used?  
(You can mark more than one response)**

- |                              |   |
|------------------------------|---|
| 1. I dieted                  | 5. I used meal replacements   |
| 2. I exercised               | 6. I used diet supplements  |
| 3. I used organised programs | 7. I used over-the-counter pharmaceutical products<br>Eg. Diet pills or appetite suppressants |
| 4. I used vitamins           | 8. I had surgery, eg. Liposuction   |

**If you circled 3, please specify program type**

---

**If you circled 4, 5, 6 or 7, please specify type and brand:**

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**37. Which one of the following statements best describes you at the moment?**

1. I am actively doing things to try to **gain** weight at the moment
2. I am actively doing things to **avoid gaining** weight at the moment
3. I am actively doing things to try to **lose** weight at the moment
4. I am **not doing anything** in particular for my weight at the moment

### Q 38. Dental Questions

A. When was the last time you saw the dentist? \_\_\_\_\_ months \_\_\_\_\_ years ago

(Please tick one box only per question)

B. Are you missing any lower teeth (other than wisdom teeth)?

Yes ~ No ~ Unsure ~

If yes, are all of your lower teeth missing?

Yes ~ No ~ Unsure ~

C. Are you missing any upper teeth (other than wisdom teeth)?

Yes ~ No ~ Unsure ~

If yes, are all of your upper teeth missing?

Yes ~ No ~ Unsure ~

*If you responded "no" to both questions B and C please go to question G*

D. Do you wear dentures or bridges that are removable?

Yes ~ No ~ Unsure ~

(Please tick)

If yes, are they upper dentures/ bridges ~ \_\_\_\_\_ age of first use  
lower dentures/ bridges ~ \_\_\_\_\_ age of first use

E. Do you have permanent bridges or dental implants?

Yes ~ No ~ Unsure ~

If yes, are they upper bridges/ implants? ~ \_\_\_\_\_ age of first use  
lower bridges/ implants? ~ \_\_\_\_\_ age of first use

F. Have you ever had an adult tooth extracted (other than a wisdom tooth)?

Yes ~ No ~ Unsure ~

If yes, how many teeth were extracted? \_\_\_\_\_ extracted

G. Are any of your teeth (or teeth on your dentures) broken?

Yes ~ No ~ Unsure ~

H. Do you ever have difficulty eating solid foods because of problems with your mouth or teeth?

Yes ~ No ~ Unsure ~

I. Do you ever find that you cannot eat some things you really enjoy because of problems with your mouth?

Yes ~ No ~ Unsure ~

J. What specific kinds of foods can't you eat? \_\_\_\_\_

K. Have you ever been told you have a periodontal problem?

Yes ~ No ~ Unsure ~

### **Q39. Cholesterol and weight**

- |   |       |      |          |
|---|-------|------|----------|
| A. Have you been told that your cholesterol is high?                        | Yes ~ | No ~ | Unsure ~ |
| B. Are you on a special diet to lower your cholesterol?                     | Yes ~ | No ~ | Unsure ~ |
| C. In the past year, have you lost more than 5 kilograms (and kept it off)? | Yes ~ | No ~ | Unsure ~ |
| D. Are you on a special diet to lose weight?                                | Yes ~ | No ~ | Unsure ~ |

**Thank you very much for your kind co-operation**

**We know that completing this questionnaire has required a lot of your valuable time and effort.**

**We greatly appreciate your contribution towards our vision and hearing research program and**

**look forward to meeting you at the Examinations.**