



UPPSALA
UNIVERSITET

Health Among Men Study

- Use a black or blue ball-point pen.
- If you want to change your answer, completely fill the incorrect box and mark the correct box.
- If needed, you can complete the questionnaire with another person.

Personal ID number -

YOUR HEALTH

1. How are you currently feeling in general?
- | | Very Good | Good | OK | Bad | Very Bad |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| How is your health? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How is your memory? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How is your physical condition? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How is your appetite? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How is your mood? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How is your energy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Have you or have you had any of the following conditions?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergy | <input type="checkbox"/> Migraine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Angina | <input type="checkbox"/> COPD (chronic lung disease) | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Gastritis |
| <input type="checkbox"/> Intermittent claudication | <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Hay fever | <input type="checkbox"/> MS (multiple sclerosis) | <input type="checkbox"/> IBS / irritable bowel |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pollen allergy | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Impotence | <input type="checkbox"/> Eczema | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Atopic eczema (as a child) | <input type="checkbox"/> Glaucoma |

3. Do you have diabetes?

- No Yes, it was detected at years of age. The treatment I use now is Insulin
 Tablets
 Dietary advice

4. If you do not take blood pressure medicine, has your blood pressure been checked in the last 3 years?

- No Yes, it has been checked and it was too low it was normal
 it was mildly elevated it was markedly elevated

5. What are your body measurements? *Enter only whole numbers*

Height cm Weight kg Waist cm Hip cm

6. How many doctor visits have you had in the past 12 months? visits

7. What is your view of life? Very positive Positive Negative Very negative

DENTAL HEALTH

8. Do you have...

- | | | | |
|--|-----------------------------|------------------------------|---|
| all of your teeth (not including wisdom teeth)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| pulled out / lost teeth (besides wisdom teeth) in adulthood? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | no. <input type="text"/> <input type="text"/> |
| whole or partial dentures (not including bridge or implant)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| bleeding of the gums when you brush your teeth? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| peridontal disease / periodontitis? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| problems with dry mouth? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| problems chewing? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |

9. During the past 12 months have you had at work, or during chores at home, pain in:
the back No Yes the shoulders No Yes the neck No Yes
10. During the past 12 months have you had pain for 3 months or longer in:
knee / knees No Yes hips No Yes
11. Have you had any of the following operations?
Torn cartilage No Yes artificial joint in the knee No Yes
Ligament damage in the knee No Yes artificial joint in the hip No Yes

MEDICINES

12. Do you regularly or intermittently use any of the following medicines?
Cortisone in tablet form or inhalation No Yes → total over years
- Magnecyl, Bamyl, Treo, No Yes, tablets/week during less than 10 years 10-20 years
Aspirin, Albyl, Trombyl more than 20 years
- Alvedon, Panodil, Reliv, No Yes, tablets/week during less than 10 years 10-20 years
Citodon more than 20 years
- Ipren, Diklofenak, No Yes, tablets/week during less than 10 years 10-20 years
Voltaren, Ibumetin, Naproxen more than 20 years
13. Have you used antibiotics during the last 10 years?
 No
 Yes → less than 1 course a year 1 course/year 2-3 courses/year more than 3 courses/year

SIGHT, HEARING AND BALANCE

14. Have you had cataract surgery? No Yes → When I was years old.
15. Do you use glasses? No Yes → At what age did you start wearing glasses?
 before 30 30-40 40-50 50-60 60-70 70-80 after 80
16. Do you use a hearing aid? No Yes → At which age did you start using a hearing aid?
 before 30 30-40 40-50 50-60 60-70 70-80 after 80
17. Do you have a good sense of taste? Yes No → At which age did you lose your sense of taste?
 before 30 30-40 40-50 50-60 60-70 70-80 after 80
18. Do you have good balance? Yes No → At which age did your balance become impaired?
 before 30 30-40 40-50 50-60 60-70 70-80 after 80
19. Have you had a fall during the past 12 months? No Yes, time(s).

SLEEP HABITS

20. How much sleep do you need per day? hours How long do you sleep per night on average? hours
21. What time do you usually fall asleep? : (time) What time do you usually wake? : (time)
Do you regularly take a nap? No Yes → from : (time) until : (time) per day
22. How do you find that you sleep on the whole?
 Very good Fairly good Neither good nor bad Fairly bad Very bad
23. How often have you had the following symptoms in the past 3 months?
- | | Never | Seldom | Often | Mostly | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Difficulty falling asleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repeatedly waking up with difficulty falling asleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Premature awakening | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Disturbed / restless sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep apnea / apnea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Disturbing snoring | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
24. During your working life, have you had working hours that required you to work at night at least a few times per month?
 No Yes, I did this for years.

TOILET HABITS

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25. These questions concern urination over the **past month**

	Never	Less than every 5th visit	Less than half the time	About half of the time	More than half of the time	Almost never
How often have you felt like you cannot empty your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many times do you visit the toilet within 2 hours of going?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is your urine intermittent instead of continuous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is it hard to hold it in when you need to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have a weak urinary stream?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often must you apply pressure to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	1 time	2 times	3 times	4 times	5+
26. How often do you usually urinate at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you had a urinary tract infection / urinary retention?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Very Good	Good	Acceptable	Neither Good/Bad	Fairly Bad	Very Bad	Terrible
28. If you had to live with urination the way it is today how would you feel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. Do you have a bowel movement every day? Yes No, it takes day(s) between occasions

30. Do you have a bowel movement several times a day? Yes No

31. How often do you experience difficulty with bowel movements?
 Never less than 1 time/week 1-6 times/week Always

32. Do you / have you had fecal leakage? No Yes, I have had it before Yes, I have it now

YOUR FAMILY'S HEALTH

	No	Yes, mother	Yes, father	Yes, sibling	Don't know
33. Have any of your parents or siblings had:					
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial infarction before 60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. What age did your parents live to?
 Mother was years old Mother still alive
 Father was years old Father still alive

STRESS

35. By stress, we mean that you feel tense, irritable, nervous, anxious or have difficulty sleeping because of situations at work or in private life (e.g. feelings of sadness or powerlessness)

	In private life	At work
I have never experienced stress	<input type="checkbox"/>	<input type="checkbox"/>
I have experienced a stressful period	<input type="checkbox"/>	<input type="checkbox"/>
I have experienced a stressful period in the past 5 years	<input type="checkbox"/>	<input type="checkbox"/>
I have experienced several periods of stress in the past 5 years	<input type="checkbox"/>	<input type="checkbox"/>
I have experienced constant stress in the past year	<input type="checkbox"/>	<input type="checkbox"/>
I have experienced constant stress in the past 5 years	<input type="checkbox"/>	<input type="checkbox"/>
I have had many long periods of stress in my life	<input type="checkbox"/>	<input type="checkbox"/>

36. How often do you feel very strong anger?
 times per day
 times per week
 seldom never

HOW ARE YOU FEELING?

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	Always / almost all the time	Often / fairly often	Sometimes / Very rarely	Never / almost never
I have felt able to cope with serious problems or major changes in my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt calm and relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt energetic, active and enterprising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On waking, I felt fresh and rested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt happy or satisfied and pleased with my personal life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt sad and down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I live the kind of life I want to live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been eager to get on with the day's work or make new decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt that life is full of interesting things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY, FRIENDS AND ACQUAINTANCES

38. How many people, with the same interests as you, do you know and have contact with? Both at work and in your leisure time.
 No one 1-2 3-5 6-10 11-15 More than 15

39. How many people, that you know well, do you meet or talk with during a normal week? Do not count those that you run into unexpectedly.
 None 1-2 3-5 6-10 11-15 More than 15

40. How many friends do you have that can come to your home anytime and feel at home? They would not care if it was untidy or if you were about to eat. Do not count close relatives.
 None 1-2 3-5 6-10 11-15 More than 15

41. How many are there, in your family or among your friends who you can talk openly with?
 None 1-2 3-5 6-10 11-15 More than 15

42. How many people are there in your environment who you can easily ask for things? People who know you so well that you can borrow tools or kitchen things?
 None 1-2 3-5 6-10 11-15 More than 15

43. Apart from those at home, how many are there that you can turn to if you are in difficulty? Someone who you can easily meet and who you trust and can really help you when you are experiencing difficulties?
 None 1-2 3-5 6-10 11-15 More than 15

OTHER ISSUES

44. What is your current employment?
 Full-time Part-time Not working Disability Retired

45. Where do you live now?
 Home Assisted living facility Nursing home Retirement home
 There are people in the household. I have lived alone for years.

46. Do you have pets (e.g. dog or cat) at home? Yes No

47. Are you active in a club? Yes No

Have you been helped by someone to complete the survey? No Yes

Can we call you if we have any further questions? If so, please enter your telephone number

Daytime phone Evening phone

I have read the attached information letter and want to continue to participate in the study.

Date

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 Signature _____

Y Y M M D D

Many thanks for your participation!