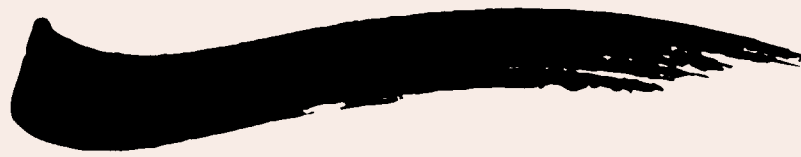


women's  
health  
*australia*



*Third Survey for  
Women over 70*

# How to complete this survey

This is the third “main” survey for women aged over 70. The project looks at changes over time, and some of the questions are the same as those in previous surveys.

## INSTRUCTIONS

- Use a black/blue pen or pencil, preferably 2B
- Erase or correct mistakes
- Please do not fold or bend this survey

Mark the oval like this: 

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 read the instructions above each question very carefully. Some require you to answer only 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.

**Please write any comments or important information on page 22 only.**  
**We are not able to read comments written throughout the survey.**

**Example 1:** In general, would you say your health is:  
(Mark one oval only)

- Excellent   
Very good   
Good  ← You would mark this oval if you think  
Fair  your health is good  
Poor

**Example 2:** What is your postcode?  
(PRINT clearly in the boxes)

2	3	0	8
---	---	---	---

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

# women's health is about using health services

1. In the LAST 3 YEARS have you been diagnosed with or treated for:  
(Mark all that apply)

		Yes
a	High blood pressure (hypertension)	<input type="radio"/>
b	Arthritis (including osteoarthritis, rheumatoid arthritis)	<input type="radio"/>
c	Osteoporosis	<input type="radio"/>
d	Angina	<input type="radio"/>
e	Heart attack	<input type="radio"/>
f	Other heart problems	<input type="radio"/>
g	Diabetes (high blood sugar)	<input type="radio"/>
h	Asthma	<input type="radio"/>
i	Bronchitis / Emphysema	<input type="radio"/>
j	Stroke	<input type="radio"/>
k	Low iron level (Iron deficiency or anaemia)	<input type="radio"/>
l	Skin cancer	<input type="radio"/>
m	Other cancer	<input type="radio"/>
n	Depression	<input type="radio"/>
o	Anxiety / Nervous disorder	<input type="radio"/>
p	Alzheimer's Disease or Dementia	<input type="radio"/>
q	None of these conditions	<input type="radio"/>

**If there are other illnesses or conditions that you would like to tell us about, there is space on page 22.**

2. In the LAST 3 YEARS have you had any of the following operations or procedures? (Mark all that apply)

		Yes
a	Eye surgery	<input type="radio"/>
b	Skin surgery (eg. skin cancer or sun spots removed)	<input type="radio"/>
c	Endoscopy (gastroscopy, colonoscopy, sigmoidoscopy)	<input type="radio"/>
d	Knee surgery or arthroscopy	<input type="radio"/>
e	Hip surgery	<input type="radio"/>
f	Heart surgery (heart bypass, angioplasty, angiography)	<input type="radio"/>
g	Repair of prolapsed vagina, bladder or bowel	<input type="radio"/>
h	Other surgery	<input type="radio"/>
i	None of these operations or procedures	<input type="radio"/>

**If there are other operations or procedures that you would like to tell us about, there is space on page 22.**

3. How many times have you consulted a family doctor or another general practitioner in the LAST 12 MONTHS? (Mark one only)

- None
- 1 or 2 times
- 3 or 4 times
- 5-8 times
- 9-12 times
- 13-15 times
- 16-19 times
- 20 or more times

4. Have you consulted any of the following people for YOUR OWN HEALTH in the LAST 12 MONTHS? (Mark all that apply)

		Yes
a	A hospital doctor (eg. in outpatients or casualty)	<input type="radio"/>
b	A specialist doctor	<input type="radio"/>
c	An optician	<input type="radio"/>
d	A dentist	<input type="radio"/>
e	A physiotherapist	<input type="radio"/>
f	A podiatrist or chiropodist	<input type="radio"/>
g	An "alternative" health practitioner (eg. herbalist, chiropractor, naturopath, acupuncturist, etc)	<input type="radio"/>
h	None of these people	<input type="radio"/>

5. Approximately how many days in total have you spent in hospital in the LAST 12 MONTHS? (Mark one only)

- None
- 1-2 days
- 3-7 days
- 8-13 days
- 14 or more days

6. Do you have Veterans' Affairs coverage for health services? (Mark one only)

- |                       |                       |
|-----------------------|-----------------------|
| Yes                   | No                    |
| <input type="radio"/> | <input type="radio"/> |

7. Do you have private health insurance for: (Mark one on each line)

		Yes	No
a	Hospital cover	<input type="radio"/>	<input type="radio"/>
b	Ancillary services (Extras cover eg. physiotherapy or dental)	<input type="radio"/>	<input type="radio"/>

8. During the LAST 4 WEEKS, have you used any medications that were prescribed or recommended by a doctor: (Mark all that apply)

		Yes
a	For high blood pressure (hypertension)	<input type="radio"/>
b	For arthritis	<input type="radio"/>
c	For pain (headaches / backaches, etc)	<input type="radio"/>
d	For heart problems	<input type="radio"/>
e	For asthma or breathing difficulties	<input type="radio"/>
f	For osteoporosis	<input type="radio"/>
g	For nerves / anxiety / worries	<input type="radio"/>
h	To help you sleep	<input type="radio"/>
i	For tiredness / fatigue	<input type="radio"/>
j	For depression	<input type="radio"/>
k	For digestive / bowel problems	<input type="radio"/>
l	For skin problems (eg. allergy or eczema)	<input type="radio"/>
m	For diabetes	<input type="radio"/>
n	For any other chronic (long-term) illness or condition	<input type="radio"/>
o	None of the above	<input type="radio"/>

9. How many different types of medication (eg. tablets or medicine) that were prescribed or recommended by a doctor have you used during the LAST 4 WEEKS? (Mark one only)

- None
- One or two
- Three or four
- Five to eight
- Nine to twelve
- More than twelve

10. Are you CURRENTLY taking Hormone Replacement Therapy (HRT)? (Mark one only)

- | Yes                   | No                    |
|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> |



11. What is your date of birth? (Please write date in boxes)

			19		
Day				Year	

12. Thinking about YOUR OWN HEALTH CARE now, how would you rate the following? (Mark one on each line)

		Excel- lent	Very Good	Good	Fair	Poor	Don't Know
a	Access to medical specialists if you need them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b	Access to a hospital if you need it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c	Access to a GP who bulk bills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d	Hours when a GP is available	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e	Number of GPs you have to choose from	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f	Ease of seeing the GP of your choice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g	Access to a female GP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h	How long you wait to get a GP appointment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i	Access to after-hours medical care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. How would you rate the cost to you of your LAST visit to a general practitioner? (Mark one only)

- No cost to me
- Excellent
- Very good
- Good
- Fair
- Poor

14. Do you have any of these sleeping problems? (Mark all that apply)

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

15. In the LAST 12 MONTHS, have you: (Mark all that apply)

	Yes
a Slipped, tripped, or stumbled? (not including falls to the ground)	<input type="radio"/>
b Had a fall to the ground? (does <i>not</i> include stumbles / trips)	<input type="radio"/>
c Been injured as a result of a fall?	<input type="radio"/>
d Needed to seek medical attention (eg. doctor, hospital) for an injury from a fall?	<input type="radio"/>
e Had any other injury from an accident at your home? (eg. burns, cuts, bruises)	<input type="radio"/>
f Broken or fractured any bone/s?	<input type="radio"/>
g None of these accidents	<input type="radio"/>

16. Do you have: (Mark all that apply)

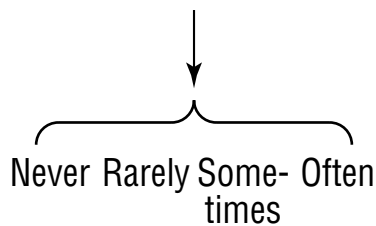
	Yes
a Difficulty seeing newspaper print, even with glasses?	<input type="radio"/>
b Difficulty in hearing a conversation, even with a hearing aid?	<input type="radio"/>
c Difficulty shopping for food?	<input type="radio"/>
d Difficulty in cooking and / or feeding yourself?	<input type="radio"/>
e None of the above	<input type="radio"/>

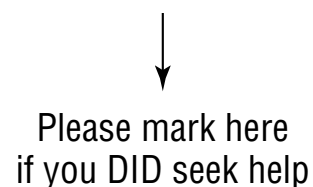
17. In our last survey, we asked about major events you had experienced. This question is about events you may have experienced in the LAST THREE YEARS. (Mark all that apply)

	Yes
a Major personal illness or injury	<input type="radio"/>
b Major surgery (not including dental work)	<input type="radio"/>
c Major decline in health of spouse or partner	<input type="radio"/>
d Death of spouse or partner	<input type="radio"/>
e Major decline in health of other close family member or friend	<input type="radio"/>
f Death of other close family member or friend	<input type="radio"/>
g Death of your child	<input type="radio"/>
h Decreased income	<input type="radio"/>
i Moving house	<input type="radio"/>
j Being robbed	<input type="radio"/>
k Moving into hostel / institution	<input type="radio"/>
l Spouse/partner moving into hostel / institution	<input type="radio"/>
m None of these events	<input type="radio"/>

18. **a** Have you had any of the following problems in the **LAST 12 MONTHS?** (Mark one on each line)

**b** For the problems you had, did you seek help?


  
 Never Rarely Some- Often times


  
 Please mark here if you DID seek help

<b>a</b>	Stiff or painful joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>b</b>	Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>c</b>	Problems with one or both feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>d</b>	Allergies, hay fever, sinusitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>e</b>	Skin problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>f</b>	Breathing difficulty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>g</b>	Indigestion / heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>h</b>	Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>i</b>	Headaches / migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>j</b>	Severe tiredness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>k</b>	Urine that burns or stings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>l</b>	Passing urine more than twice during the night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>m</b>	Needing to rush to the toilet to pass urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>n</b>	Leaking urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>o</b>	Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>p</b>	Haemorrhoids (piles)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>q</b>	Other bowel problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>r</b>	Poor memory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>s</b>	Clumsiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>t</b>	Dizziness, loss of balance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>u</b>	Anxiety / panic attacks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



# women's health is about how you are feeling

**The questions on this page ask only about NOW – how your health is NOW and about how your health limits certain activities NOW.**

19. In general, would you say your health is... *(Mark one only)*

- Excellent
- Very good
- Good
- Fair
- Poor

20. 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 as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

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



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

28. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting friends, relatives, etc)? (Mark one only)

All of the time	<input type="radio"/>
Most of the time	<input type="radio"/>
Some of the time	<input type="radio"/>
A little of the time	<input type="radio"/>
None of the time	<input type="radio"/>

29. 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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b	I am as healthy as anybody I know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c	I expect my health to get worse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d	My health is excellent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

30. Next are some specific questions about your health and how you have been feeling in the PAST MONTH. (Mark one on each line)

		Yes	No
a	Have you felt keyed up or on edge?	<input type="radio"/>	<input type="radio"/>
b	Have you been worrying a lot?	<input type="radio"/>	<input type="radio"/>
c	Have you been irritable?	<input type="radio"/>	<input type="radio"/>
d	Have you had difficulty relaxing?	<input type="radio"/>	<input type="radio"/>
e	Have you been sleeping poorly?	<input type="radio"/>	<input type="radio"/>
f	Have you had headaches or neckaches?	<input type="radio"/>	<input type="radio"/>
g	Have you had any of the following: trembling, tingling, dizzy spells, sweating, diarrhoea or needing to pass urine more often than usual?	<input type="radio"/>	<input type="radio"/>
h	Have you been worried about your health?	<input type="radio"/>	<input type="radio"/>
i	Have you had difficulty falling asleep?	<input type="radio"/>	<input type="radio"/>
j	Have you been lacking energy?	<input type="radio"/>	<input type="radio"/>
k	Have you lost interest in things?	<input type="radio"/>	<input type="radio"/>
l	Have you lost confidence in yourself?	<input type="radio"/>	<input type="radio"/>
m	Have you felt hopeless?	<input type="radio"/>	<input type="radio"/>
n	Have you had difficulty concentrating?	<input type="radio"/>	<input type="radio"/>
o	Have you lost weight (due to poor appetite)?	<input type="radio"/>	<input type="radio"/>
p	Have you been waking early?	<input type="radio"/>	<input type="radio"/>
q	Have you felt slowed down?	<input type="radio"/>	<input type="radio"/>
r	Have you tended to feel worse in the mornings?	<input type="radio"/>	<input type="radio"/>

## **You are half way through! Time for a cuppa?**

The following section asks more questions about your health and your community.

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.

# women's health is about managing day by day

31. How satisfied are you with your physical ability to do what you want to do?  
(Mark one only)

- Completely satisfied
- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied
- Completely dissatisfied

32. Are you in bed or in a chair *most or all* of the day because of your health?  
(Mark one only)

- Yes, every day
- Yes, most days
- Yes, some days
- Yes, occasionally
- No, never

33. Compared with 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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b Recalling telephone numbers or other numbers that you use on a daily or weekly basis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c Recalling where you put objects (such as keys) in your home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d Remembering specific facts from a newspaper or magazine article you have just finished reading?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e Remembering the item(s) you intend to buy when you arrive at the shops?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f In general, how would you describe your memory compared to when you were in your twenties?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

# women's health is about having a healthy lifestyle

These questions are about the amount of physical activity you did **LAST WEEK**

## 34. 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, golf, bowls, 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

## 35. 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, golf, bowls, 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

**Now 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.**

36. 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

37. How often do you usually drink alcohol? *(Mark one only)*

I never drink alcohol

I drink rarely

Less than once a week

1 – 2 days a week

3 – 4 days a week

5 – 6 days a week

Every day

38. On a day when you drink alcohol, how many drinks do you usually have? *(Mark one only)*

I don't drink alcohol

1 or 2 drinks per day

3 or 4 drinks per day

5 to 8 drinks per day

9 or more drinks per day

39. How tall are you without shoes?

 cms

**OR**

 ft  ins

40. How much do you weigh without clothes or shoes?

 kgs

**OR**

 stones pounds

---

*women's health* is about your home and neighbourhood

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

--	--	--	--

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

--	--	--	--

42. Which of the following best describes your housing situation?  
Do you live in... (Mark one only)

- A house
- A flat / unit / apartment / villa / townhouse
- Mobile home / caravan / cabin / houseboat
- Retirement village / self care unit
- Nursing Home
- Hostel
- Other

43. Which of the following are sources of income for you and your spouse or partner (if you have one)? (Mark all that apply)

		Yes
a	Government pension or allowance	<input type="radio"/>
b	Superannuation	<input type="radio"/>
c	Other income	<input type="radio"/>

44. 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



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45. When you travel around your town, does someone have to assist you because of your health? *(Mark one only)*

- Yes, all of the time
- Yes, most of the time
- Yes, some of the time
- Yes, a little of the time
- No, none of the time

46. What is your main (or most common) means of transport? *(Mark one only)*

- Car (you drive)
- Car (someone else drives)
- Taxi
- Bus
- Tram or train
- Other

47. Are you capable of using public transport? *(Mark one only)*

- No, because of my health
- No, for some other reason
- Yes
- Don't know

48. Is public transport available when you need it? *(Mark one only)*

- Yes, all of the time
- Yes, most of the time
- Yes, some of the time
- Yes, a little of the time
- No, none of the time
- Not applicable

---

## women's health is about family and friends

49. What is your PRESENT marital status? (Mark one only)

- Married
- De facto (in a relationship)
- Widowed
- Separated
- Divorced
- Never married

50. If you have ever been widowed, please write date of bereavement in the box below (if widowed more than once, please give all dates).

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

- a No one, I live alone
- b Spouse or partner
- c Own children
- d Other family members
- e Non-family members

52. Do you have any pets in your household? (Mark all that apply)

- a No pet
- b Dog
- c Cat
- d Bird
- e Other

53. Can you talk about your deepest problems with at least some of your family and friends? (Mark one only)

- Hardly ever
- Some of the time
- Most of the time

54. How many people in your local area do you feel you can depend on or feel very close to (other than members of your family)? (Mark one only)

- None
- 1 – 2 people
- More than 2 people

55. How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together? (Mark one only)

None	1	2	3	4	5	6	7 or more
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

56. How many times did you talk to someone (friends, relatives or others) on the telephone in the past week (either they called you, or you called them)? (Mark one only)

None	1	2	3	4	5	6	7 or more
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

57. About how often did you go to meetings of clubs, religious meetings, or other groups that you belong to in the past week? (Mark one only)

None	1	2	3	4	5	6	7 or more
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

58. Do you do any volunteer work for any community or social organisations? (eg. fundraising, community welfare, church activities, organising groups or classes) (Mark one only)

Every day	Every week	Every month	Less than once a month	Not at all
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

59. Do you regularly provide (unpaid) care for grandchildren or other people's children? (Mark one only)

Yes, daily	Yes, weekly	Yes, occasionally	No, never
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

60. 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 all that apply)

a	Yes, for someone who lives with me	<input type="radio"/>
b	Yes, for someone who lives elsewhere	<input type="radio"/>
c	No, I do not provide care	<input type="radio"/>

61. 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

62. The following question is about assistance you receive from others:  
 (Mark one on each line)

	Yes	No	I don't need this help
a Do people help you to do odd jobs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b Do people give you information or advice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c Do people help you if you call upon them to do so unexpectedly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d Do people help you, for example, when you are sick, when you have transport problems or when you need them to accompany you somewhere?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

63. These questions are about getting on with other people:  
 (Mark all that apply)

	Yes
a Are you sad or lonely often?	<input type="radio"/>
b Do you feel uncomfortable with anyone in your family?	<input type="radio"/>
c Can you take your own medication and get around by yourself?	<input type="radio"/>
d Do you feel that nobody wants you around?	<input type="radio"/>
e Does someone in your family make you stay in bed or tell you you're sick when you know you're not?	<input type="radio"/>
f Has anyone forced you to do things you didn't want to do?	<input type="radio"/>
g Has anyone taken things that belong to you without your OK?	<input type="radio"/>
h Do you trust most of the people in your family?	<input type="radio"/>
i Do you have enough privacy at home?	<input type="radio"/>
j Has anyone close to you tried to hurt you or harm you recently?	<input type="radio"/>
k Has anyone close to you called you names or put you down or made you feel bad recently?	<input type="radio"/>
l Are you afraid of anyone in your family?	<input type="radio"/>
m None of the above	<input type="radio"/>

64. Which of the following groups have you sought advice or help from in the LAST 6 MONTHS? (Mark all that apply)

		Yes
a	Food services (eg. Meals on Wheels)	<input type="radio"/>
b	Nursing or community health services	<input type="radio"/>
c	Respite services (in home, day centre, or inpatient)	<input type="radio"/>
d	Homemaking services (eg. home care service, laundry service)	<input type="radio"/>
e	Home maintenance services (eg. odd jobs, gardening)	<input type="radio"/>
f	Counselling or other mental health services	<input type="radio"/>
g	Ambulance service	<input type="radio"/>
h	Social groups (eg. CWA, Senior Citizen's Centre, craft or exercise groups, church groups)	<input type="radio"/>
i	Support and advisory groups (eg. Arthritis Foundation, Pensioner Advisory Service, Older Women's Network)	<input type="radio"/>
j	None of these groups	<input type="radio"/>

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

65. Your relationship to participant:

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

66. When you filled in this survey for the participant, which of the following applied? (Mark one only)

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

67. What was the MAIN reason why the participant did not fill in the survey herself? (Please describe)

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# Consent

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

**Signature:**

**Date:**

Please sign above and send the completed survey back to us in the envelope supplied as soon as possible. We will detach the consent form and store it in a separate locked room.

## Help us keep in touch!

We plan to survey women in your age group again in three years' time. Sometimes we lose touch with participants. It would be helpful if you could give us details of a relative or friend who will be able to help us find you.

**Name:**

**Address:**

**Postcode:**

**Phone:  
(home)**

**Relationship  
to you:**

**Name:**

**Address:**

**Postcode:**

**Phone:  
(home)**

**Relationship  
to you:**

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

*You are a valuable contributor to  
women's health research*

If you have any questions you can contact us by telephoning

**1800 068 081**

(FREECALL)

or writing to us at the address below.

women's  
health  
*australia*



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