



## INSTRUCTIONS

This questionnaire is a part of The Irish Longitudinal Study on Ageing (TILDA). We greatly value your participation in our study, and we hope that you will find this questionnaire interesting to complete. Your answers are extremely important to us. Please remember that your participation is voluntary and that you may skip over any questions that you would prefer not to answer.

## HOW TO FILL IN THIS QUESTIONNAIRE

Please answer the questions by:

Ticking a box like this

Or circling an answer like this 1 2  4 5

Sometimes you will find an instruction telling you which questions to answer next, like this

YES

NO  IF 'NO' GO TO QUESTION

## HOW TO RETURN THIS QUESTIONNAIRE

**Please give the questionnaire to the interviewer or post it back in the prepaid envelope provided.**

**If you have any questions about the questionnaire, please feel free to call us at 01 896 2509.**



**1. WE WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT PARTICIPATION IN SOCIAL ACTIVITIES. HOW OFTEN, IF AT ALL, DO YOU DO ANY OF THE FOLLOWING ACTIVITIES?**

PLEASE TICK ONE BOX PER LINE	DAILY/ ALMOST DAILY	ONCE A WEEK OR MORE	TWICE A MONTH OR MORE	ABOUT ONCE A MONTH	EVERY FEW MONTHS	ABOUT ONCE OR TWICE A YEAR	LESS THAN ONCE A YEAR	NEVER
Watch television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Go out to films, plays and concerts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attend classes and lectures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel for pleasure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work in the garden, or your home, or on a car.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read books or magazines for pleasure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Listen to music, radio.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spend time on hobbies or creative activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play cards, bingo, games in general.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Go to the pub.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat out of the house.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participate in sport activities or exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visit to or from family or friends, either in person or talking on the phone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do voluntary work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2. ARE YOU A MEMBER OF ANY OF THESE ORGANISATIONS, CLUBS OR SOCIETIES?**

**PLEASE TICK ONE BOX PER LINE**

**YES**

**NO**

Political Party, trade union or environmental groups

Tenants groups, resident groups, neighbourhood watch

Church or other religious groups

Charitable associations

Education, arts or music groups or evening classes

Social clubs

Sports clubs, GAA or gym exercise classes

Any other organisations, clubs or societies

**3. THE NEXT QUESTIONS ARE ABOUT HOW YOU FEEL ABOUT DIFFERENT ASPECTS OF YOUR LIFE. FOR EACH ONE, PLEASE SAY HOW OFTEN YOU FEEL THAT WAY.**

**PLEASE TICK ONE BOX PER LINE**

**OFTEN**

**SOME OF THE  
TIME**

**HARDLY EVER  
OR NEVER**

How often do you feel you lack companionship?

How often do you feel left out?

How often do you feel isolated from others?

How often do you feel in tune with the people around you?

How often do you feel lonely?

**4. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR SPOUSE OR PARTNER WITH WHOM YOU LIVE.**

**IF YOU DO NOT HAVE A HUSBAND, WIFE OR PARTNER WITH WHOM YOU LIVE, PLEASE GO TO QUESTION 6**

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT	A LOT	SOME	A LITTLE	NOT AT ALL
How much does he/she really understand the way you feel about things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you rely on him/her if you have a serious problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much can you open up to him/her if you need to talk about your worries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does he/she make too many demands on you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does he/she criticise you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does he/she let you down when you are counting on him/her?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does he/she get on your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. HOW CLOSE IS YOUR RELATIONSHIP WITH YOUR SPOUSE OR PARTNER WITH WHOM YOU LIVE?**

PLEASE TICK ONE BOX

Very close	<input type="checkbox"/>
Quite close	<input type="checkbox"/>
Not very close	<input type="checkbox"/>
Not at all close	<input type="checkbox"/>

**6. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR CHILDREN.**

**IF YOU DO NOT HAVE CHILDREN, PLEASE GO TO QUESTION 7**

**PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT**

**A LOT**

**SOME**

**A LITTLE**

**NOT AT ALL**

How much do they really understand the way you feel about things?

How much can you rely on them if you have a serious problem?

How much can you open up to them if you need to talk about your worries?

How much do they make too many demands on you?

How much do they criticise you?

How much do they let you down when you are counting on them?

How much do they get on your nerves?

**7. APART FROM YOUR SPOUSE/PARTNER AND CHILDREN (IF ANY), DO YOU HAVE ANY OTHER FAMILY MEMBERS (SUCH AS BROTHERS, SISTERS, PARENTS, COUSINS, ETC.)?**

**PLEASE TICK ONE BOX**

YES

NO

IF 'NO' GO TO QUESTION 9

## 8. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT THESE FAMILY MEMBERS.

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT

A LOT      SOME      A LITTLE      NOT AT ALL

How much do they really understand the way you feel about things?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much can you rely on them if you have a serious problem?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much can you open up to them if you need to talk about your worries?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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How much do they make too many demands on you?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much do they criticise you?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much do they let you down when you are counting on them?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much do they get on your nerves?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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## 9. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR FRIENDS.

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT

A LOT      SOME      A LITTLE      NOT AT ALL

How much do they really understand the way you feel about things?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much can you rely on them if you have a serious problem?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much can you open up to them if you need to talk about your worries?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much do they make too many demands on you?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much do they criticise you?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much do they let you down when you are counting on them?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

How much do they get on your nerves?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------





**10. FOR SOME PEOPLE, SEX IS A VERY IMPORTANT PART OF THEIR LIVES AND FOR OTHERS, IT IS NOT VERY IMPORTANT AT ALL. HOW IMPORTANT A PART OF YOUR LIFE WOULD YOU SAY THAT SEX IS?**

**PLEASE TICK ONE BOX**

- Extremely important
- Very important
- Moderately important
- Somewhat important
- Not at all important

**11. ARE YOU CURRENTLY SEXUALLY ACTIVE (WITHIN THE LAST 12 MONTHS?)**

**PLEASE TICK ONE BOX**

- YES
- NO  IF 'NO' GO TO QUESTION **13**

**12. HOW OFTEN DO YOU ENGAGE IN SEXUAL ACTIVITY?**

**PLEASE TICK ONE BOX**

- Every day
- Once or twice a week
- Once or twice a month
- Every few months
- Once or twice a year



**13. THE NEXT QUESTION IS RELATED TO YOUR SEXUAL ORIENTATION. THIS DESCRIBES WHO YOU ARE SEXUALLY AND EMOTIONALLY ATTRACTED TO.**

**PLEASE TICK ONE BOX**

I am only attracted to people of the opposite sex

I am only attracted to people of the same sex

I am attracted to both men and women

I am not sexually attracted to men or women

**14. THE NEXT FOUR QUESTIONS ARE ABOUT HOW YOU HAVE FELT IN THE PAST MONTH.**

PLEASE TICK ONE BOX PER LINE

HARDLY EVER    ALMOST NEVER    SOMETIMES    FAIRLY OFTEN    VERY OFTEN

In the last month, how often have you felt that you were unable to control the important things in your life?

In the last month, how often have you felt confident about your ability to handle your personal problems?

In the last month, how often have you felt that things were going your way?

In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

**15. BELOW IS A LIST OF PROBLEMS AND COMPLAINTS THAT ARE EXPERIENCED IN RESPONSE TO STRESSFUL LIFE EVENTS. PLEASE PUT A TICK IN THE APPROPRIATE BOX TO INDICATE HOW MUCH YOU HAVE BEEN BOTHERED BY THAT PROBLEM IN THE PAST MONTH. FOR THESE QUESTIONS, THE RESPONSE OPTIONS ARE “NOT AT ALL”, “A LITTLE BIT”, “MODERATELY”, “QUITE A BIT” OR “EXTREMELY”.**

PLEASE TICK ONE BOX PER LINE

NOT AT ALL    A LITTLE BIT    MODERATELY    QUITE A BIT    EXTREMELY

Repeated, disturbing memories, thoughts or images of a stressful experience from the past?

Feeling very upset when something reminded you of a stressful experience from the past?

Avoided activities or situations because they reminded you of a stressful experience from the past?

Feeling distant or cut off from other people?

Feeling irritable or having angry outbursts?

Difficulty concentrating?

**16. HERE IS A LIST OF STATEMENTS THAT PEOPLE HAVE USED TO DESCRIBE THEIR LIVES OR HOW THEY FEEL. HOW OFTEN DO YOU FEEL LIKE THIS?**

PLEASE TICK ONE BOX PER LINE	OFTEN	SOMETIMES	RARELY	NEVER
My age prevents me from doing the things I would like to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that what happens to me is out of my control.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel free to plan for the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel left out of things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I can please myself in what I can do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My health stops me from doing the things I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortage of money stops me from doing the things that I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I look forward to each day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that my life has meaning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy being in the company of others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel satisfied with the way my life has turned out.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that life is full of opportunities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**17. HERE IS A LIST OF STATEMENTS THAT PEOPLE HAVE USED TO DESCRIBE THEIR LIVES OR HOW THEY FEEL. HOW OFTEN DO YOU FEEL LIKE THIS?**

PLEASE TICK ONE BOX PER LINE	STRONGLY DISAGREE	DISAGREE	DISAGREE SLIGHTLY	AGREE SLIGHTLY	AGREE	STRONGLY AGREE
I enjoy making plans for the future and working to make them a reality.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My daily activities often seem trivial and unimportant to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am an active person in carrying out the plans I set for myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I don't have a good sense of what it is I'm trying to accomplish in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I sometimes feel as if I've done all there is to do in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I live life one day at a time and don't really think about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a sense of direction and purpose in my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**18. HAVE YOU EVER HAD DRINKS CONTAINING ALCOHOL, E.G. GLASS OF WINE, GLASS OF BEER, ETC.?**

PLEASE TICK ONE BOX

YES

NO  IF 'NO' GO TO QUESTION **32**

**19. HAVE YOU HAD DRINKS CONTAINING ALCOHOL OF ANY KIND IN THE LAST 6 MONTHS?**

PLEASE TICK ONE BOX

YES

NO  IF 'NO' GO TO QUESTION **32**



**20. DURING THE LAST 6 MONTHS, HOW OFTEN HAVE YOU HAD DRINKS CONTAINING ALCOHOL, LIKE BEER, CIDER, WINE, SPIRITS OR COCKTAILS?**

PLEASE TICK ONE BOX

Daily

4-6 days a week

2-3 days a week

Once a week

2-3 days a month

Once a month

One or a couple of days per year

GO TO QUESTION **22**

**21. MORE RECENTLY (I.E. IN THE LAST MONTH), WOULD YOU DESCRIBE YOUR CURRENT ALCOHOL INTAKE AS:**

PLEASE TICK ONE BOX

Daily

4-6 days a week

2-3 days a week

Once a week

2-3 days a month

Once a month

**22. FROM THE PICTURES BELOW, PLEASE TICK THE BOX THAT REPRESENTS THE DRINK YOU WOULD BE MOST LIKELY TO DRINK**

PLEASE TICK ONE BOX

Full pint of beer/  
cider/lager




Full pint of stout




1/2 pint or glass  
of stout/beer/  
cider/lager




Large glass of  
wine




Measure of  
spirit




Pre-mixed  
spirit drink (e.g.  
Smirnoff Ice)




**23. THINKING ABOUT YOUR DRINK OF CHOICE, ON AVERAGE, IN THE LAST 6 MONTHS ON THE DAYS THAT YOU DRANK, ABOUT HOW MANY DID YOU HAVE?**

PLEASE TICK ONE BOX

1

5

9

2

6

10

3

7

11 or more

4

8

**24. THINKING ABOUT YOUR DRINK OF CHOICE, DURING THE LAST 6 MONTHS, APPROXIMATELY WHAT WAS THE LARGEST NUMBER OF DRINKS YOU HAD ON ANY ONE DAY?**

PLEASE TICK ONE BOX

1

5

9

2

6

10

3

7

11 or more

4

8



**25. HOW OFTEN IN THE LAST 6 MONTHS WOULD YOU SAY YOU DRANK THE MAXIMUM NUMBER OF DRINKS YOU INDICATED IN THE LAST QUESTION?**

PLEASE TICK ONE BOX

Daily or almost daily

Weekly

Monthly

Less than monthly

**26. HAVE YOU EVER FELT THAT YOU SHOULD CUT DOWN ON DRINKING?**

PLEASE TICK ONE BOX

YES

NO

**27. HAVE YOU REDUCED YOUR ALCOHOL INTAKE IN THE LAST 2 YEARS?**

PLEASE TICK ONE BOX

YES

NO  IF 'NO' GO TO QUESTION **29**



**28. WHY DID YOU REDUCE YOUR ALCOHOL INTAKE?**

PLEASE TICK ONE BOX

Personal choice

Doctor's advice

Medication

Illness or ill health

Other reasons (please specify)

**29. HAVE PEOPLE EVER ANNOYED YOU BY CRITICISING YOUR DRINKING?**

PLEASE TICK ONE BOX

YES

NO

**30. HAVE YOU EVER FELT BAD OR GUILTY ABOUT DRINKING?**

PLEASE TICK ONE BOX

YES

NO

**31. HAVE YOU EVER TAKEN A DRINK FIRST THING IN THE MORNING TO STEADY YOUR NERVES OR GET RID OF A HANGOVER?**

PLEASE TICK ONE BOX

YES

NO

**32. WE WOULD NOW LIKE TO ASK SOME QUESTIONS ABOUT HOW MUCH YOU WORRY ABOUT THINGS. PLEASE INDICATE HOW TYPICAL OR CHARACTERISTIC EACH STATEMENT IS OF YOU.**

PLEASE TICK ONE BOX PER LINE	NOT AT ALL TYPICAL		SOMEWHAT TYPICAL		VERY TYPICAL
My worries overwhelm me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many situations make me worry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know I should not worry about things, but I just cannot help it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I am under pressure, I worry a lot.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am always worrying about something.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As soon as I finish one task, I start to worry about everything else I must do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been a worrier all my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been worrying about things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**33. HAVE ANY OF YOUR CLOSE FRIENDS DIED IN THE PAST TWO YEARS?**

PLEASE TICK ONE BOX

YES

NO



**34. WHAT IS THE MAIN WAY IN WHICH YOU HEAT YOUR ACCOMMODATION  
IN THE WINTER (TICK ONE BOX ONLY)**

PLEASE TICK ONE BOX

Central heating

Open fire only

Portable heaters only

Open fire and portable heaters

Closed solid fuel appliance only

Closed solid fuel appliance and portable heaters

**35. COULD YOU TELL ME WHETHER YOU HAVE ANY OF THE FOLLOWING PROBLEMS IN YOUR ACCOMMODATION? IF SO, WOULD YOU SAY THAT THESE ARE A MINOR, MODERATE OR MAJOR PROBLEM FOR THE ACCOMMODATION?**

PLEASE TICK ONE BOX PER LINE  
DO YOU HAVE PROBLEMS WITH...

NO PROBLEM      MINOR PROBLEM      MODERATE PROBLEM      MAJOR PROBLEM

PLEASE TICK ONE BOX PER LINE DO YOU HAVE PROBLEMS WITH...	NO PROBLEM	MINOR PROBLEM	MODERATE PROBLEM	MAJOR PROBLEM
A leaking roof?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaking or moisture getting in through walls?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaking or moisture getting in at doors or windows?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaks from water pipes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising damp?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condensation dampness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General dampness from unknown sources?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mould on walls/ceilings, etc?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corrosion or rot around any external door(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Badly fitting doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corrosion or rot around any window(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaky or draughty windows?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Windows that don't open/close properly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rot in timbers other than windows/doors, such as rot in joists, floor boards, etc?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Structural cracks in internal or external support walls?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subsidence in floors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pests – rats, mice, cockroaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noise from neighbouring houses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in heating your accommodation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other problems (tick level of problem and specify below)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**36. HOW DO YOU FEEL ABOUT YOUR LOCAL AREA, THAT IS EVERYWHERE WITHIN A 20 MINUTE WALK OR ABOUT A KILOMETER OF YOUR HOME?**

THE CLOSER YOUR TICK IS TO A STATEMENT THE MORE STRONGLY YOU AGREE WITH IT.

PLEASE TICK ONE BOX EACH LINE

I really feel part of this area.        I feel that I don't belong in this area.

Vandalism and graffiti are a big problem in this area.        There is no problem with vandalism and graffiti in this area.

I often feel lonely living in this area.        I have never felt lonely living in this area.

Most people in this area can be trusted.        Most people in this area can't be trusted.

People would be afraid to walk alone after dark in this area.        People feel safe walking alone after dark in this area.

Most people in this area are friendly.        Most people in this area are unfriendly.

People in this area will take advantage of you.        People in this area will always treat you fairly.

This area is kept very clean.        The area is always full of litter and rubbish.

If you were in trouble, there are lots of people in this area who would help you.        If you were in trouble, there is nobody in this area who would help you.

**37. DID YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS DURING YOUR CHILDHOOD (THAT IS FROM WHEN YOU WERE BORN UP TO AND INCLUDING AGE 15)?**

PLEASE TICK ONE BOX PER LINE

	YES	NO
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Allergies other than asthma (e.g. food intolerance, hayfever)	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory problems other than asthma (e.g. bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>
Chronic ear problems	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, fits or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Emotional, nervous or psychiatric problem	<input type="checkbox"/>	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Childhood diabetes or high blood sugar	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Leukaemia or lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or malignant tumour (excluding minor skin cancers)	<input type="checkbox"/>	<input type="checkbox"/>

### 38. THINK OF THIS LADDER AS REPRESENTING WHERE PEOPLE STAND IN OUR SOCIETY.

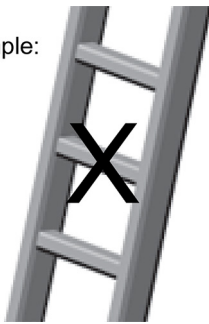
At the top of the ladder are the people who are the best off - those who have the most money, most education and best jobs.

At the bottom are the people who are the worst off - those who have the least money, least education and the worst jobs or no jobs.

The higher up you are on this ladder, the closer you are to the people at the very top and the lower you are, the closer you are to the people at the very bottom.

Please mark a cross on the rung of the ladder where you would place yourself.

Example:



**39. THINKING ABOUT THE FOOD THAT YOU EAT, WE WOULD LIKE YOU TO TELL US HOW OFTEN YOU USUALLY EAT THE FOLLOWING FOODS.**

**FOR EACH FOOD, THERE IS AN AMOUNT SHOWN, EITHER WHAT WE THINK IS A “MEDIUM SERVING” OR A COMMON HOUSEHOLD UNIT SUCH AS A SLICE OR TEASPOON. PLEASE PUT A TICK IN THE BOX TO INDICATE HOW OFTEN, ON AVERAGE, YOU HAVE EATEN THE SPECIFIED AMOUNT OF EACH FOOD (TO THE NEAREST WHOLE NUMBER) DURING THE PAST YEAR, I.E. FROM WHEN YOU RECEIVE THIS QUESTIONNAIRE TO THE SAME MONTH THE PREVIOUS YEAR.**

**Examples:**

The following are examples on how to estimate how often and how much bread and potatoes you ate over the past year. Please estimate your food intake for all foodstuffs in the same way.

Potatoes: If you ate a medium serving of potatoes 3 times per week over the past year, put a tick in the box “2-4 per week”. If you think you usually ate more or less than a medium serving, please try to estimate which box suits best.

**EXAMPLE 1:**

**AVERAGE USE LAST YEAR**

Potatoes, Rice, Pasta (medium serving)	Never/less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Potatoes, including boiled, mashed, baked potatoes, but excluding roast potatoes, chips or potato products (e.g. waffles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For white bread, a medium serving is one medium-sized slice. Therefore if you usually ate 1 medium slice 4 or 5 times per day, then you should put a tick in the column headed “4-5 per day”. If you ate 2 medium slices 4-5 times per day, then you should put a tick in the column “6+ per day”.

**EXAMPLE 2:**

**AVERAGE USE LAST YEAR**

Cereals and Breads (one bowl or one slice)	Never/less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
White bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>



**PLEASE ESTIMATE YOUR AVERAGE FOOD USE AS BEST YOU CAN. PLEASE ANSWER EVERY QUESTION, DO NOT LEAVE ANY LINES BLANK.**

	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
<b>Meat and meat alternatives (medium serving)</b>									
Beef or lamb including roast, steak stew, mince	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pork including roast, chops, slices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ham, bacon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken or turkey portion including breast, thigh, leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken products including chicken nuggets or breaded chicken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fresh fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish, including breaded, battered, or fish fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Processed meat including meat pies, pasties, sausage rolls, burgers, sausages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lentils, tofu, soya meat, vegeburger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cereals and Breads (one bowl or one slice)</b>									
White bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brown bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Porridge, readybrek	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High fibre cereal e.g. Weetabix, all bran branflakes, bran buds, muesli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other cereal e.g. cornflakes, rice crispies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
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### Potatoes, Rice, Pasta (medium serving)

Potatoes, including boiled, mashed, baked potatoes, but excluding roast potatoes, chips or potato products e.g. waffles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chips, roast potatoes, and potato products, e.g. potato waffles, smiles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pasta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Dairy Products and Fats

Yoghurt (carton)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheese including cheddar, cheese slices, soft cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs (one) including boiled, scrambled, poached, fried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cream (tablespoon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salad dressings (tablespoon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Butter (teaspoon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low fat spread (teaspoon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol lowering spread e.g. Benecol, Flora pro-active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Fruit and Vegetables

Fruit including fresh, frozen, dried, tinned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Green vegetables, including cabbage, broccoli, peas, green beans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Orange/Yellow vegetables, including carrots, turnips, cauliflower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salad or other vegetables, including leeks, onions, garlic, sweet peppers, mushrooms, sweetcorn, tomatoes, beetroot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Sweets and snacks**

Plain biscuits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate biscuits, including wrapped chocolate biscuits, e.g. Twix, Kit-Kat, Penguin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confectionary, including sweets and chocolate bars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cakes, buns, desserts, e.g. cheesecakes, apple tart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Savoury snacks, e.g. crisps, tortilla chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Soups, sauces, spreads**

Vegetable soup (homemade/carton)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetable soup (packet, cup-a-soup)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sauces e.g. white sauce, cheese sauce, gravy (tablespoon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marmite, bovril	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jam, marmalade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Drinks**

Water (glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Tea (cup)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee (cup)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocoa, hot chocolate (cup)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Horlicks, Ovaltine (cup)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wine (glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beer (half pint)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirits (single measure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Calorie or Diet Fizzy drinks (glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fizzy drinks (glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pure fruit juice (glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit squash, diluted orange (glass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## 40. WHAT TYPE OF MILK DO YOU USE MOST OFTEN?

PLEASE TICK ONE BOX

- None      IF 'NONE' GO TO QUESTION **42**
- Whole/full fat
- Low fat
- Skimmed
- Super/fortified
- Soya
- Other

## 41. HOW MUCH MILK DO YOU USE EACH DAY?

PLEASE TICK ONE BOX

- Less than half a pint
- 250ml (half pint)
- 568ml (1 pint)
- One litre
- More than one litre



**42. PLEASE FILL IN THE DATE ON WHICH YOU COMPLETED YOUR BOOKLET.**

D	D	/	M	M	/	Y	Y
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**43. IF THERE IS ANYTHING YOU WOULD LIKE TO TELL US, PLEASE WRITE IN THE SPACE BELOW. FEEL FREE TO ADD A PAGE IF THIS SPACE IS INSUFFICIENT.**

**WE SHALL BE VERY INTERESTED TO READ WHAT YOU HAVE TO SAY.**

**THANK YOU VERY MUCH FOR TAKING THE TIME TO ANSWER OUR QUESTIONS. PLEASE GIVE THE QUESTIONNAIRE TO THE INTERVIEWER OR POST IT BACK IN THE PREPAID ENVELOPE PROVIDED. ALL YOUR ANSWERS WILL REMAIN CONFIDENTIAL.**