

MRC National Survey of Health and Development

Postal Questionnaire 2025

(Version: 14/01/2025)

This questionnaire is to find out how you are physically and mentally. We also ask about what support you access and what medications you take.

When completing the questionnaire please use a pen to put a “x” in the box next to the answer you want to give.

Next to some of the answer options are arrows (→) with instructions, such as “Go to Question 4”. They tell you which question to answer next (and which ones may be irrelevant). If there are no special instructions, just answer the next question.

As always, answering these questions is voluntary and you can skip over any questions that you cannot or would prefer not to answer.

Please enter the date you completed the questionnaire:

Day Month 2025

1. Who is filling out this questionnaire? **proxy25x**

- Study member (alone) ⁽¹⁾ → Go to Question 4
- Study member with assistance or someone else completing on behalf of study member ⁽²⁾

2. What is the relationship of the person answering the questions to the study member?

- Spouse/partner ⁽¹⁾ Other ⁽⁴⁾ Specify **proxyrel25x_txt__**
- Son/daughter ⁽²⁾
- Friend ⁽³⁾ **proxyrel25x**

3. What is the reason they are answering the questions?

- Preference ⁽¹⁾ **proxyreas25x** Physical health problems ⁽²⁾

Memory/thinking problems (3)

Other (4) Specify __
proxyreas25x_txt_

Paid and Voluntary Work

4. Have you retired from your main occupation, even if you are now doing other paid work.

Yes (1)

No (0)

ret25x

5. Are you currently in paid or voluntary work?

Yes (1)

No (0) → Go to Question 7

jobvol25x

6. How many hours a week (to the nearest hour) do you usually work in a paid and/or voluntary job, including regular overtime? Please include voluntary work within the community and don't include personal care for someone you are living with (this will be covered later).

If you do not do any paid work or voluntary work please enter "0" in the boxes below.

Paid work

Voluntary work

Number of hours per week

jobpwrkhr25x

jobvolhr25x

Health

7. How is your health in general?

Excellent (1)

Very good (2)

Good (3)

Fair (4)

Poor (5)

ghi25x

8. In the past 12 months, have you had delirium (worsening in your thinking, concentration or memory due to acute illness)?

Yes ⁽¹⁾

No ⁽⁰⁾

delir1225x

9. **Since the age of 60 years**, have you ever been told by a doctor that you have any of the following medical conditions? If yes, what year were you diagnosed?

Please only include conditions or events diagnosed by a doctor.

	Yes (1)	No (0)	Year of diagnosis
COPD (chronic obstructive pulmonary disease)	<input type="text" value="copd25x"/>		<input type="text" value="copdy25x"/>
Emphysema	<input type="text" value="emph25x"/>		<input type="text" value="emphy25x"/>
Angina	<input type="text" value="danq25x"/>		<input type="text" value="danqy25x"/>
Heart attack (myocardial infarct/coronary thrombosis)	<input type="text" value="dhara25x"/>		<input type="text" value="dharay25x"/>
Heart failure	<input type="text" value="harf25x"/>		<input type="text" value="harfy25x"/>
High blood pressure (hypertension)	<input type="text" value="dbpp125x"/>		<input type="text" value="dbpp1y25x"/>
Orthostatic or postural hypotension (blood pressure too low when you stand up)	<input type="text" value="dbpp225x"/>		<input type="text" value="dbpp2y25x"/>
Stroke	<input type="text" value="dstr25x"/>		<input type="text" value="dstry25x"/>
Diabetes	<input type="text" value="diab25x"/>		<input type="text" value="diaby25x"/>
Atrial fibrillation	<input type="text" value="afib25x"/>		<input type="text" value="afiby25x"/>
Osteoporosis	<input type="text" value="ostpo25x"/>		<input type="text" value="ostopy25x"/>
Osteoarthritis	<input type="text" value="osteo25x"/>		<input type="text" value="osteoy25x"/>
Eye trouble which requires treatment:			
Cataracts	<input type="text" value="eyec25x"/>		<input type="text" value="eyecy25x"/>
Glaucoma	<input type="text" value="eyeq25x"/>		<input type="text" value="eyeqy25x"/>
Age-related macular degeneration	<input type="text" value="eyemd25x"/>		<input type="text" value="eyemdy25x"/>
Parkinson's Disease	<input type="text" value="parkin25x"/>		<input type="text" value="parkiny25x"/>
Cognitive impairment:			
Vascular dementia	<input type="text" value="coqimp625x"/>		<input type="text" value="coqimp6y25x"/>
Alzheimer's disease	<input type="text" value="coqimp225x"/>		<input type="text" value="coqimp2y25x"/>
Mild cognitive impairment	<input type="text" value="coqimp325x"/>		<input type="text" value="coqimp3y25x"/>
Other - Please specify:	<input type="text" value="coqimpoth25x"/>		<input type="text" value="coqimpothy25x"/>
<input type="text" value="coqimpoth25x_txt"/>			

Yes
(1) No
(0)

Year of diagnosis

Other diagnoses - Please specify:

1.
2.
3.

Medication

10. Are you regularly taking any medicines or tablets prescribed by a doctor?

Yes (1)

No (0)

→ Go to Question 12

11. If you are regularly taking any medicines or tablets prescribed by a doctor, please give details in the table below. Please include any eye drops, creams, or inhalers.

Use one row for each prescribed medication.

	Name of Medication	Strength (eg 500mg)	Frequency taken (eg once a day / when needed)
1	<input type="text" value="med_name25x_01"/>	<input type="text" value="med_strength25x_01"/>	<input type="text" value="med_freq25x_01"/>
2	<input type="text" value="med_name25x_02"/>	<input type="text" value="med_strength25x_02"/>	<input type="text" value="med_freq25x_02"/>
3	<input type="text" value="med_name25x_03"/>	<input type="text" value="med_strength25x_03"/>	<input type="text" value="med_freq25x_03"/>
4	<input type="text" value="med_name25x_04"/>	<input type="text" value="med_strength25x_04"/>	<input type="text" value="med_freq25x_04"/>
5	<input type="text" value="med_name25x_05"/>	<input type="text" value="med_strength25x_05"/>	<input type="text" value="med_freq25x_05"/>
6	<input type="text" value="med_name25x_06"/>	<input type="text" value="med_strength25x_06"/>	<input type="text" value="med_freq25x_06"/>
7	<input type="text" value="med_name25x_07"/>	<input type="text" value="med_strength25x_07"/>	<input type="text" value="med_freq25x_07"/>
8	<input type="text" value="med_name25x_08"/>	<input type="text" value="med_strength25x_08"/>	<input type="text" value="med_freq25x_08"/>
9	<input type="text" value="med_name25x_09"/>	<input type="text" value="med_strength25x_09"/>	<input type="text" value="med_freq25x_09"/>
10	<input type="text" value="med_name25x_10"/>	<input type="text" value="med_strength25x_10"/>	<input type="text" value="med_freq25x_10"/>
11	<input type="text" value="med_name25x_11"/>	<input type="text" value="med_strength25x_11"/>	<input type="text" value="med_freq25x_11"/>
12	<input type="text" value="med_name25x_12"/>	<input type="text" value="med_strength25x_12"/>	<input type="text" value="med_freq25x_12"/>
13	<input type="text" value="med_name25x_13"/>	<input type="text" value="med_strength25x_13"/>	<input type="text" value="med_freq25x_13"/>

14	med_name25x_14	med_strength25x_14	med_freq25x_14
15	med_name25x_15	med_strength25x_15	med_freq25x_15

12. Do you regularly take junior aspirin / low dosage aspirin that is NOT prescribed?

Yes ⁽¹⁾

No ⁽⁰⁾

mednas25x

Falls

13. In the past 12 months have you had any fall including a slip or trip in which you lost your balance and landed on the ground?

Yes ⁽¹⁾

No ⁽⁰⁾ → Go to Question 16

fallen25x

14. If 'Yes', how many times have you fallen in the past 12 months?

falln25x

15. On how many of these occasions have you injured yourself badly enough to seek medical attention? (If never, please write "0").

dfalln25x

Performing tasks

16. Have you had difficulty with the following in the last 12 months?

Please put an "x" in one box for each line.

	No difficulty ⁽¹⁾	A little difficulty ⁽²⁾	Some difficulty ⁽³⁾	A great deal of difficulty ⁽⁴⁾
Reading a newspaper? rnew25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognising a friend across the street? recf25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading signs at night? rsnt25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing over the phone? htel25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hearing a normal conversation?
hconv25x

Hearing conversation in a noisy room? hnois25x

17. Do you wear a hearing aid at all?

	Yes, most of the time ⁽¹⁾	Yes, some of the time ⁽²⁾	No ⁽⁰⁾
a. Left ear aidhl25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Right ear aidhr25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. These questions relate to your independence to perform **daily tasks**. Are you able to do the following activities alone or is help required?

Please put an "x" in one box for each line.

	I can do this myself ⁽¹⁾	I can do this myself but with difficulty ⁽²⁾	I need help with this ⁽³⁾	I am unable to manage this ⁽⁴⁾
Feed myself feed25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing (e.g. shower, bath) bath25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming (e.g. brushing teeth, shaving) groom25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing (including buttons, zips) dress25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet use (including managing personal hygiene) wcusec25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stairs (including with aids such as a walking stick) step25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cutting toenails cuttoe25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Are you able to transfer from a bed to a chair and back again independently, or is help required? bed25x

- Independently ⁽¹⁾
- Independently but with difficulty ⁽²⁾
- I need minor help (someone to be with me) ⁽³⁾

- I need major help (people to physically help me), but I can sit unsupported ⁽⁴⁾
- Unable ⁽⁵⁾

20. Are you able to move on level surfaces alone or is help required? **move25x**

- Independently (but may use any aid, e.g. walking stick or frame), can move more than 5 yards ⁽¹⁾
- Independently but with difficulty (including with any aid), can move more than 5 yards ⁽²⁾
- Walk with help of one person (verbal or physical), can move more than 5 yards ⁽³⁾
- Using a wheelchair independently, including corners, can move more than 5 yards ⁽⁴⁾
- Immobile or can move less than 5 yards ⁽⁵⁾

21. The following questions are about **everyday activities**. Please record what you have done in the **last month**. If you have not done an activity in the last month because you are not able to do it, then please put a "x" in "I am unable to manage this". If you have the ability to do it, but have not done it, for example the weather has been too bad for gardening, please put an "x" in "Not applicable".

Please put an "x" in one box for each line.

	I can do this myself ⁽¹⁾	I can do this myself but with difficulty ⁽²⁾	I need help with this ⁽³⁾	I am unable to manage this ⁽⁴⁾	Not applicable ⁽⁰⁾
Walk around outside? iadla25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb stairs? iadlb25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of a car? iadlc25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk over uneven ground? iadld25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cross roads? iadle25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel on public transport? iadlf25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage to feed yourself? iadlg25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	I can do this myself ⁽¹⁾	I can do this myself but with difficulty ⁽²⁾	I need help with this ⁽³⁾	I am unable to manage this ⁽⁴⁾	Not applicable ⁽⁰⁾
Manage to make yourself a hot drink? <i>iadh25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take hot drinks from one room to another? <i>iadli25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do the washing up? <i>iadj25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make yourself a hot snack? <i>iadlk25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage your own money when out? <i>iadll25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wash small items of clothing? <i>iadlm25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your own housework? <i>iadln25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your own shopping? <i>iadlo25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do a full clothes wash? <i>iadlp25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read newspapers or books? <i>iadlq25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use the phone? <i>iadlr25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Write letters? <i>iadls25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Go out socially? <i>iadlt25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage your own garden? <i>iadlu25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive a car? <i>iadlv25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use the internet for shopping? <i>iadlw25x</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Help received

The questions above ask about difficulties you may have with some activities. The next questions are about any help you receive with these activities. Please only think about help you have received because of a physical, mental, emotional or memory problem.

22. Do **you receive help** with any of the daily tasks and everyday activities listed in questions 18 and 21?

Yes ⁽¹⁾
rechelp25x

No ⁽⁰⁾ → Go to Question 25

23. Thinking about a typical week, **who has helped you** with the type of activities listed in questions 18 and 21 and **how many hours have they helped you** with these tasks? Please do not include occasional errands or odd jobs.

Please put an "x" in one box for each line.

	No help (1)	Less than one hour (2)	1-4 hours (3)	5-9 hours (4)	10-19 hours (5)	20-49 hours (6)	50+ hours (7)
Husband/Wife/Partner whohelpua25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children whohelpub25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandchildren whohelpuc25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling whohelpud25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other relative whohelpue25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends or neighbours whohelpuf25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home care worker/ home help/ personal assistant whohelpug25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A member of the reablement / intermediate care staff team whohelpuh25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary helper whohelpui25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warden / Sheltered housing manager whohelpuj25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleaner whohelpuk25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Council's handyman whohelpul25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Member of staff at the care/nursing home whohelpum25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other - please specify whohelpuo25x <u>whohelpuo25x_txt</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. Do you live in a care home?

Yes (1)

No (0)

carehome25x

Help given

25. Do **you provide help to others**, with any of the activities listed in questions 18 and 21?

Yes ⁽¹⁾

No ⁽⁰⁾ → Go to Question 27

provhelp25x

26. Thinking about a typical week, **who have you helped** with the type of activities listed in questions 18 and 21 and **how many hours have you helped others** with these tasks? Please do not include occasional errands or odd jobs.

	No help (1)	Less than one hour (2)	1-4 hours (3)	5-9 hours (4)	10-19 hours (5)	20-49 hours (6)	50+ hours (7)
Husband/Wife/Partner provhelpa25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children provhelpb25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandchild provhelpc25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings provhelpd25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other relative provhelpe25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friend or neighbours provhelpf25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other - please specify provhelpo25x __ provhelpo25x_txt _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Household

27. How many people in total live in your household, and who are they?

	Number
Husband/Wife/Cohabiting Partner hhnumwh25x_1	<input type="text"/> <input type="text"/>
Children hhnumwh25x_2	<input type="text"/> <input type="text"/>
Grandchild hhnumwh25x_3	<input type="text"/> <input type="text"/>
Sibling hhnumwh25x_4	<input type="text"/> <input type="text"/>
Other relative hhnumwh25x_5	<input type="text"/> <input type="text"/>
Friend / unrelated sharer hhnumwh25x_6	<input type="text"/> <input type="text"/>
Other, please specify hhnumwh25x_7 _____ hhnumwh25x_8_txt	<input type="text"/> <input type="text"/>

Mental Health

28. How is your mental health in general?

Excellent (1)

Very good (2)

Good (3) mhi25x

Fair (4)

Poor (5)

29. Over the last 2 weeks how often have you been bothered by the following problems?

Put an "x" in one box for each line.

	Not at all (1)	Several days (2)	More than half the days (3)	Nearly every day (4)
Feeling nervous, anxious or on edge gad2phq25x_1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not been able to stop or control worrying gad2phq25x_2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Little interest or pleasure in doing things gad2phq25x_3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless gad2phq25x_4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. Overall, how satisfied are you with your life nowadays, where 0 means 'not at all' and 10 means 'completely'?

We appreciate 0-10 scales can be difficult to answer. Please pick the figure which is most likely to be true to how you feel now.

Please put an "x" in one box.

Not at all satisfied

Completely satisfied

0 1 2 3 4 5 6 7 8 9 10

satis25x

31. The following statements are about different aspects of your life.

Please put an "x" in one box for each line to indicate how often you feel that way.

	Hardly ever (1)	Some of the time (2)	Often (3)
How often do you feel that you lack companionship? nocomp25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel left out? leftout25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel isolated from others? isolate25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Please select the answer that best describes your experience of each over the **last two weeks**.

Please put an "x" in one box for each line.

	None of the time (1)	Rarely (2)	Some of the time (3)	Often (4)	All of the time (5)
I've been feeling optimistic about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been dealing with problems well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling close to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been able to make up my own mind about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 33.** Below are some questions about changes you may have noticed in your thinking, memory, or daily abilities. Please answer each question as honestly as you can. If you're unsure about an answer, choose the option that feels closest to your experience.

For each question, select:

- **Yes** – If you have noticed a change in yourself.
- **No** – If there has been no change.

Please put an "x" in one box for each line.

	Yes ⁽¹⁾	No ⁽⁰⁾
Do you feel like you are having more trouble remembering things than you used to? cogsymp_1_25x	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it harder to keep track of appointments, tasks, or events than before? cogsymp_2_25x	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel like it takes more effort to learn new things now? cogsymp_3_25x	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed that you have difficulty handling money, such as paying bills or managing finances? cogsymp_4_25x	<input type="checkbox"/>	<input type="checkbox"/>
Do you find yourself having trouble making decisions or planning things out? cogsymp_5_25x	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed changes in your ability to do household chores or hobbies you used to do regularly? cogsymp_6_25x	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel like you are forgetting how to do things that you used to do easily? cogsymp_7_25x	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any problems with finding the right words when speaking or writing? cogsymp_8_25x	<input type="checkbox"/>	<input type="checkbox"/>

Access to healthcare

34. Have you wanted to use any of the following services in the last 6 months and if so, how long did you have to wait between first trying to get an appointment and getting an appointment or receiving care (personal care)?

Please put an "x" in one box for each line.

	Less than 2 weeks (1)	From 2 weeks to 6 months (2)	Over 6 months (3)	Did not want to use service (4)
GP healthcare25x_01	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentist healthcare25x_02	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiroprapist or podiatrist healthcare25x_03	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise classes including yoga, Pilates, gym healthcare25x_04	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational therapist or physiotherapist healthcare25x_05	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community nurse healthcare25x_06	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital nurse healthcare25x_07	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counselling healthcare25x_08	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other mental health care services healthcare25x_09	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal care (e.g. bathing, showering, dressing, toileting) healthcare25x_11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other - please specify healthcare25x_11 healthcare25x_11_txt__	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Financial questions

We know that financial circumstances can have a significant impact on many aspects of life including health and well-being. We would therefore like to ask you about your household's financial circumstances.

35. How well would you say your household is managing financially at the moment?

Please put an "x" in one option. [finman25x](#)

Best

Living
comfortably (1)

Doing alright
(2)

Just about
getting by (3)

Finding it quite
difficult (4)

Finding it very
difficult (5)

Prefer not
to say (6)

36. Does your household have to go without things you really needed because you were short of money? **gowout25x**

- No ⁽⁰⁾
- Yes, sometimes ⁽¹⁾
- Yes, often ⁽²⁾
- Prefer not to say ⁽³⁾

37. Are you receiving the following?

- Attendance Allowance ⁽¹⁾ **allowance25x_1**
- Carer's Allowance ⁽²⁾ **allowance25x_2**
- Pension Credit ⁽³⁾ **allowance25x_3**
- Council Tax Reduction ⁽⁴⁾ **allowance25x_4**
- State Pension ⁽⁵⁾ **allowance25x_5**
- Housing Benefit ⁽⁶⁾ **allowance25x_6**
- Winter Fuel Payment ⁽⁷⁾ **allowance25x_7**
- Cold Weather Payments ⁽⁸⁾ **allowance25x_8**
- None of these ⁽⁹⁾ **allowance25x_9**
- Prefer not to say ⁽¹⁰⁾ **allowance25x_10**

38. Do you have lasting power of attorney (LPA) in place for?

		Yes ⁽¹⁾	No ⁽⁰⁾
lpa125x	Health and care	<input type="checkbox"/>	<input type="checkbox"/>
lpa225x	Financial decisions	<input type="checkbox"/>	<input type="checkbox"/>

Social activities

39. How often have you taken part in each of the following activities in the **last 12 months**? If you do not take part in the activity, please put an "x" in "Never". *Please put an "x" in one box for each line.*

	Weekly or more often (1)	Fortnightly (2)	Monthly (3)	Less often (4)	Never (5)
Church-related group or religious activities chchr25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports groups, e.g. golf, cycle, dancing, or walking clubs sptr25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational groups, e.g. chess, bridge; U3A; book club or writing group; art, music or craft based group rgr25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support groups – bereavement or patient support groups suppg25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Civic-political group, e.g. political party club, residents association, Chamber of Commerce, local government, school-based group lgr25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary groups, e.g. Lions or Rotary club or charity work adecr25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social activities with friends or family, e.g. meeting up for coffee, dinner; or going out shopping, cinema, theatre with others or attending football or other sporting events sparr25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Online social networking, e.g. Facebook, WhatsApp, Skype, online social events socnet25x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other social activities, <i>please specify</i> othersoc125x, othersoc225x, othersoc325x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

othersoc125x_txt, othersoc225x_txt, othersoc325x_txt

40. We would welcome any comments about any of your own experiences that have not been covered by the questions:

_____ **comment25x**

Thank you for your help