



**THE IRISH LONGITUDINAL
STUDY ON AGEING**

**WAVE 2: SELF-COMPLETION
QUESTIONNAIRE IN CONFIDENCE**

TILDA ID No:

Respondent Initials:

Gender

Female

Male

Interview Date

 / /

Interviewer ID:

A black and white close-up photograph of an elderly woman with a joyful expression, wearing a beret and a patterned scarf. The image is the background for a text overlay.

*Towards making Ireland the best
place in the world to grow old*

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 writing a number in 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 4120**.

THE FOLLOWING QUESTIONS ASK YOU ABOUT YOUR ABILITY TO USE MORE THAN ONE LANGUAGE

1. ARE YOU CURRENTLY FLUENT IN MORE THAN ONE LANGUAGE?

PLEASE TICK ONE BOX

YES IF 'YES' GO TO QUESTION **4**

NO

2. WERE YOU EVER FLUENT IN MORE THAN ONE LANGUAGE?

PLEASE TICK ONE BOX

YES

NO IF 'NO' GO TO QUESTION **6**

3. WHAT AGE DID YOU STOP USING THE SECOND LANGUAGE?

ENTER THE AGE IN YEARS

4. APART FROM ENGLISH, WHICH OTHER LANGUAGES DO/DID YOU SPEAK?

PLEASE TICK ANY BOXES APPROPRIATE TO YOU

Irish

Other European

Other non-European

5. FROM WHAT AGE WERE YOU EXPOSED TO A SECOND LANGUAGE?

PLEASE TICK ONE BOX

From birth

From primary school

From secondary school

From later than secondary

6. THE FOLLOWING QUESTIONS ASK ABOUT HOW YOU NORMALLY BEHAVE. PLEASE INDICATE HOW STRONGLY YOU AGREE OR DISAGREE WITH EACH OF THE FOLLOWING STATEMENTS.

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I am not a worrier.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I like to have a lot of people around me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy concentrating on a fantasy or a daydream and exploring all its possibilities, letting it grow and develop.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I try to be courteous to everyone I meet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I keep my belongings neat and clean.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At times I have felt bitter and resentful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I laugh easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think it's interesting to learn and develop new hobbies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At times I bully or flatter people into doing what I want them to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm pretty good about pacing myself so as to get things done on time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I'm under a great deal of stress, sometimes I feel like I'm going to pieces.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I prefer jobs that let me work alone without being bothered by other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am intrigued by patterns I find in art and nature.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Some people think I'm selfish and egotistical.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**STRONGLY
AGREE**

AGREE

NEUTRAL

DISAGREE

**STRONGLY
DISAGREE**

I often come into situations without being fully prepared.

I rarely feel lonely and blue.

I really enjoy talking to people.

I believe letting students hear controversial speakers can only confuse and mislead them.

If someone starts a fight, I'm ready to fight back.

I try to perform all the tasks assigned to me conscientiously.

I often feel tense and jittery.

I like to be where the action is.

Poetry has little or no effect on me.

I'm better than most people, and I know it.

I have a clear set of goals and work towards them in an orderly fashion.

Sometimes I feel completely worthless.

I shy away from crowds of people.

I would have difficulty just letting my mind wander without control or guidance.

When I've been insulted I just try to forgive and forget.

I waste a lot of time before settling down to work.

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

**STRONGLY
AGREE**

AGREE

NEUTRAL

DISAGREE

**STRONGLY
DISAGREE**

I rarely feel fearful or anxious.

I often feel as if I'm bursting with energy.

I seldom notice the moods or feelings that different environments produce.

I tend to assume the best about people.

I work hard to accomplish my goals.

I often get angry at the way people treat me.

I am a cheerful, high spirited person.

I experience a wide range of emotions and feelings.

Some people think of me as cold and calculating.

When I make a commitment, I can always be counted on to follow through.

Too often, when things go wrong, I get discouraged and feel like giving up.

I don't get much pleasure from chatting with people.

Sometimes when I am reading poetry or looking at a work of art, I feel a chill or a wave of excitement.

I have no sympathy for beggars.

Sometimes I'm not as dependable or reliable as I should be.

I am seldom sad and depressed.

PLEASE TICK ONE BOX PER LINE WHICH BEST SHOWS HOW YOU FEEL ABOUT EACH STATEMENT	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
My life is fast-paced.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have little interest in speculating on the nature of the universe or the human condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I generally try to be thoughtful and considerate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am a productive person who always gets the job done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often feel helpless and want someone else to solve my problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am a very active person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a lot of intellectual curiosity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I don't like people I let them know it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I never seem to be able to get organised.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At times I have been so ashamed I just want to hide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would rather go my own way than be a leader of others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often enjoy playing with theories or abstract ideas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If necessary, I am willing to manipulate people to get what I want.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I strive for excellence in everything I do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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7. 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"/>

8. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel left out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel isolated from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel in tune with the people around you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel lonely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. DID YOU VOTE IN THE LAST GENERAL ELECTION?

PLEASE TICK ONE BOX

YES

NO

10. DO YOU HAVE A HUSBAND, WIFE OR PARTNER WITH WHOM YOU LIVE?

PLEASE TICK ONE BOX

YES

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

11. WE WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR SPOUSE OR PARTNER.

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"/>

12. HOW CLOSE IS YOUR RELATIONSHIP WITH YOUR SPOUSE OR PARTNER?

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"/>

13. DO YOU HAVE ANY CHILDREN?

PLEASE TICK ONE BOX

YES	<input type="checkbox"/>
NO	<input type="checkbox"/> IF 'NO' GO TO QUESTION 15

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

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"/>

15. 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 **17**

16. 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"/>
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"/>

17. 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 often 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"/>

18. 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

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

PLEASE TICK ONE BOX

- YES
- NO IF 'NO' GO TO QUESTION **21**

20. 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

21. WE WOULD LIKE TO ASK SOME QUESTIONS ABOUT HOW CONCERNED YOU ARE ABOUT THE POSSIBILITY OF FALLING. FOR EACH OF THE FOLLOWING ACTIVITIES, PLEASE INDICATE HOW CONCERNED YOU ARE THAT YOU MIGHT FALL IF YOU DID THIS ACTIVITY.

IF YOU CURRENTLY DON'T DO THE ACTIVITY (E.G. IF SOMEONE DOES YOUR SHOPPING FOR YOU), PLEASE ANSWER TO SHOW WHETHER YOU THINK YOU WOULD BE CONCERNED ABOUT FALLING IF YOU DID THE ACTIVITY.

PLEASE TICK ONE BOX PER LINE	NOT AT ALL CONCERNED 1	SOMEWHAT CONCERNED 2	FAIRLY CONCERNED 3	VERY CONCERNED 4
Cleaning the house (e.g. sweep, vacuum, dust).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting dressed or undressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing simple meals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking a bath or shower.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to the shop.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in or out of a chair.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going up or down stairs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking around in the neighbourhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching for something above your head or on the ground.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to answer the telephone before it stops ringing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on a slippery surface (e.g. wet or icy).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visiting a friend or relative.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking in a place with crowds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking on an uneven surface (e.g. rocky ground, poorly maintained pavement).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking up or down a slope.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going out to a social event (e.g. religious service, family gathering, or club meeting).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt that things were going your way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. 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

	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 can do the things that I want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family responsibilities prevent me from doing what I want to do.	<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 the things that I do.	<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"/>
On balance, I look back on my life with a sense of happiness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel full of energy these days.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I choose to do things that I have never done before.	<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"/>
I feel that the future looks good for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**24. HAVE YOU EVER HAD AN ALCOHOLIC DRINK
E.G. GLASS OF WINE, GLASS OF BEER ETC?**

PLEASE TICK ONE BOX

YES

NO IF 'NO' GO TO QUESTION **36**

**25. HAVE YOU HAD AN ALCOHOLIC DRINK OF ANY KIND
IN THE LAST 12 MONTHS?**

PLEASE TICK ONE BOX

YES

NO IF 'NO' GO TO QUESTION **36**

**26. DURING THE LAST 12 MONTHS, HOW OFTEN HAVE YOU DRUNK
ANY ALCOHOLIC BEVERAGES, 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

**27. 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

28. ON THE DAYS THAT YOU DRINK, ABOUT HOW MANY DRINKS DO YOU HAVE?

PLEASE TICK ALL
THAT APPLY TO YOU

LESS
THAN 1

1-2

3-4

5-6

7-8

8+

Full pint of
beer/ cider/
lager



½ pint
or glass
of beer/cider
/lager



Large can/
bottle of
beer/cider/
lager



Small can/
bottle of
beer/cider/
lager



Small glass
of wine
(125mls)



Large glass
of wine
(250mls)



Bottle of wine



Measure
of spirit



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



29. IN THE LAST 12 MONTHS, WHAT IS THE MAXIMUM NUMBER OF DRINKS YOU HAVE HAD ON ANY ONE OCCASION?

PLEASE TICK ALL THAT APPLY TO YOU	LESS THAN 1	1-2	3-4	5-6	7-8	8+
Full pint of beer/ cider/ lager 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
½ pint or glass of beer/cider/ lager 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Large can/ bottle of beer/cider/ lager 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Small can/ bottle of beer/cider/ lager 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Small glass of wine (125mls) 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Large glass of wine (250mls) 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bottle of wine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measure of spirit 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-mixed spirit drink (e.g. Smirnoff Ice) 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

PLEASE TICK ONE BOX

YES

NO

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

PLEASE TICK ONE BOX

YES

NO IF 'NO' GO TO QUESTION **33**

32. 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)

33. HAVE PEOPLE EVER ANNOYED YOU BY CRITICISING YOUR DRINKING?

PLEASE TICK ONE BOX

YES

NO

34. HAVE YOU EVER FELT BAD OR GUILTY ABOUT DRINKING?

PLEASE TICK ONE BOX

YES

NO

35. 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

36. FOR EACH OF THE FOLLOWING EVENTS, PLEASE INDICATE WHETHER THE EVENT OCCURRED AT ANY POINT IN THE LAST TWO YEARS. IF THE EVENT DID HAPPEN, PLEASE INDICATE THE YEAR IN WHICH IT HAPPENED MOST RECENTLY.

PLEASE TICK ONE BOX PER LINE

USE 4 DIGITS FOR THE YEAR, I.E. 2010, 2011 or 2012

	YES	NO	IF 'YES', WHAT YEAR?
Have you been in a major fire, flood or other natural disaster?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Has your spouse, partner, or child been addicted to drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Were you the victim of a serious physical attack or assault in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Did you have a life-threatening illness or accident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Did your spouse, partner, or a child of yours have a life-threatening illness or accident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Has a child of yours died?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

37. PLEASE CIRCLE THE ONE NUMBER THAT BEST DESCRIBES HOW TYPICAL OR CHARACTERISTIC EACH ITEM IS OF YOU

PLEASE CIRCLE ONE NUMBER PER LINE

NOT AT ALL TYPICAL SOMEWHAT TYPICAL VERY TYPICAL

1 2 3 4 5
|-----|-----|-----|-----|

My worries overwhelm me.

1 2 3 4 5
|-----|-----|-----|-----|

Many situations make me worry.

1 2 3 4 5
|-----|-----|-----|-----|

I know I should not worry about things, but I just cannot help it.

1 2 3 4 5
|-----|-----|-----|-----|

When I am under pressure, I worry a lot.

1 2 3 4 5
|-----|-----|-----|-----|

I am always worrying about something.

1 2 3 4 5
|-----|-----|-----|-----|

As soon as I finish one task, I start to worry about everything else I must do.

1 2 3 4 5
|-----|-----|-----|-----|

I have been a worrier all my life.

1 2 3 4 5
|-----|-----|-----|-----|

I have been worrying about things.

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

PLEASE TICK ONE BOX

YES

NO

39. 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

40. 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
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 door 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, please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. 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 in this
area after dark.

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.

This 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.

42. IF THERE IS ANYTHING YOU WOULD LIKE TO TELL US, PLEASE WRITE IN THE SPACE BELOW. FEEL FREE TO WRITE ON THE NEXT PAGE OR TO ADD A PAGE IF THIS SPACE IS INSUFFICIENT. WE SHALL BE VERY INTERESTED TO READ WHAT YOU HAVE TO SAY.

A large, empty rectangular box with a thin black border, intended for the respondent to write their answers to question 42. The box occupies most of the page's vertical space below the question text.

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 ENVELOPE PROVIDED. ALL YOUR ANSWERS WILL REMAIN CONFIDENTIAL.

NOTES

NOTES

TILDA, Chemistry Extension Building (Lincoln Gate),
Trinity College, Dublin 2, Ireland.

General Enquires: +353 1 896 4120

Health Assessment Related Enquires: +353 1 896 4120

Email: tilda@tcd.ie

www.tilda.ie

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