

Survey Respondent ID Number

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An Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing (IDS - TILDA)

Pre-Interview Questionnaire

Intellectual Disability Supplement to TILDA,
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Office use only

Researcher ID Number:

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Date Received (V2):

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Instructions for filling out this questionnaire

Please complete this questionnaire before your interview.

1. How to complete the questionnaire

Tick a box like this

OR

Write a number in a box like this

Sometimes you will find an instruction telling you which question to answer next like this:

Yes	<input type="checkbox"/>	1	(Go to Question 13)
No	<input type="checkbox"/>	5	(Go to Question 15)

If there are no instructions just answer the next question.

2. What to do if you need support

If you need any support filling in the questionnaire ask a family member, key worker or friend **who has known you at least 6 months** to help.

If you need any further support, or if you need the questionnaire in a different format (for example in large print or Braille) or language, please contact the research team by phoning us on 01 - 8963186 or 01 - 8963187 or email us at dstotilda@tcd.ie

3. How to return the questionnaire

Please bring the completed questionnaire to your interview.

All your answers will remain private.

Thank you for taking part in this study.

Section 1: Personal details



Question 1: Are you male or female?

Tick one box only

Male	<input type="checkbox"/>	1
Female	<input type="checkbox"/>	2

Question 2: What is your date of birth?

(e.g. 01/03/66) / /

Don't know 98

Question 3: Are you ...?

Tick one box only

Single (never married)	<input type="checkbox"/>	1
Living with a partner as if married	<input type="checkbox"/>	2
With a partner but not living with him/her	<input type="checkbox"/>	3
Married	<input type="checkbox"/>	4
Separated	<input type="checkbox"/>	5
Divorced	<input type="checkbox"/>	6
Widowed	<input type="checkbox"/>	7
Don't know	<input type="checkbox"/>	98

Question 4: Do you have any children?

Tick one box only

Yes	<input type="checkbox"/> 1
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 5: What is your level of intellectual disability?

Tick one box only

Not verified	<input type="checkbox"/> 1
Mild	<input type="checkbox"/> 2
Moderate	<input type="checkbox"/> 3
Severe	<input type="checkbox"/> 4
Profound	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 6: What is the cause of your intellectual disability?

Tick one box only

Down syndrome	<input type="checkbox"/> 1
Cause of intellectual disability unknown	<input type="checkbox"/> 2

Other (please tell us)

<input type="checkbox"/> 95

Don't know	<input type="checkbox"/> 98
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Question 7: What is the highest level of education you have completed?

Tick one box only

Some primary (not complete)	<input type="checkbox"/> 1
Primary or equivalent	<input type="checkbox"/> 2
Intermediate/junior/group certificate or equivalent	<input type="checkbox"/> 3
Leaving certificate or equivalent	<input type="checkbox"/> 4
Diploma/certificate	<input type="checkbox"/> 5
Primary degree	<input type="checkbox"/> 6
Postgraduate/higher degree	<input type="checkbox"/> 7
Other (please tell us)	
<input type="checkbox"/>	<input type="checkbox"/> 95
<hr/>	
Don't know	<input type="checkbox"/> 98
None	<input type="checkbox"/> 96

Question 8: How long have you lived in your current place of residence?

year(s) month(s)

Don't know 98

Section 2: Height and weight



Question 9: What is your height without shoes?

Feet Inches
(e.g. 5) (e.g. 5)

Or

Inches
(e.g. 65)

Or

Centimetres (cms)
(e.g. 165)

Don't know ₉₈

Question 10: What is your weight without clothes?

Stones Pounds
(e.g. 10) (e.g. 2)

Or

Pounds
(e.g. 142)

Or

Kilos
(e.g. 64.4)

Don't know ₉₈

Section 3: Eyesight



Question 11: Has a doctor ever told you that you have age related macular degeneration?

Tick one box only

Yes	<input type="checkbox"/> 1
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 12: Has a doctor ever told you that you have glaucoma?

Tick one box only

Yes	<input type="checkbox"/> 1
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 13: Has a doctor ever told you that you have cataracts?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 14)
No	<input type="checkbox"/> 5	(Go to Question 15)
Don't know	<input type="checkbox"/> 98	(Go to Question 15)

Question 14: Have you had cataract surgery?

Tick one box only

Yes, in one eye	<input type="checkbox"/>	1
Yes, in both eyes	<input type="checkbox"/>	2
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 15: Has a doctor ever told you that you have any other eye diseases?

Tick one box only

Yes	<input type="checkbox"/>	1	(Go to Question 16)
No	<input type="checkbox"/>	5	(Go to Question 17)
Don't know	<input type="checkbox"/>	98	(Go to Question 17)

Question 16: What other eye diseases has the doctor told you that you have?

Please tell us

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Section 4: Heart disease



Question 17: Has a doctor ever told you that you have any of the following conditions?

Tick all that apply

High cholesterol	<input type="checkbox"/> ₁	(Go to Question 18)
A heart murmur	<input type="checkbox"/> ₁	(Go to Question 19)
An abnormal heart rhythm	<input type="checkbox"/> ₁	(Go to Question 19)
None of these	<input type="checkbox"/> ₁	(Go to Question 19)
Don't know	<input type="checkbox"/> ₁	(Go to Question 19)

Question 18: Are you taking any tablets or pills for high cholesterol?

Tick one box only

Yes	<input type="checkbox"/> ₁
No	<input type="checkbox"/> ₅
Don't know	<input type="checkbox"/> ₉₈

High blood pressure

Question 19: Has a doctor ever told you that you have high blood pressure or hypertension?

Tick one box only

Yes	<input type="checkbox"/> ₁	(Go to Question 20)
No	<input type="checkbox"/> ₅	(Go to Question 21)
Don't know	<input type="checkbox"/> ₉₈	(Go to Question 21)

Question 20: About how old were you when you were first told by a doctor that you had high blood pressure?

I was years old

Don't know ₉₈

Angina

Question 21: Has a doctor ever told you that you have angina?

Tick one box only

Yes	<input type="text"/> ₁	(Go to Question 22)
No	<input type="text"/> ₅	(Go to Question 24)
Don't know	<input type="text"/> ₉₈	(Go to Question 24)

Question 22: About how old were you when you were first told by a doctor that you had angina?

I was years old

Don't know ₉₈

Question 23: Are you limiting your usual activities because of your angina?

Tick one box only

Yes	<input type="text"/> ₁
No	<input type="text"/> ₅
Don't know	<input type="text"/> ₉₈

Heart attack including MI or coronary thrombosis

Question 24: Has a doctor ever told you that you have had a heart attack (including myocardial infarction {MI} or coronary thrombosis)?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 25)
No	<input type="checkbox"/> 5	(Go to Question 28)
Don't know	<input type="checkbox"/> 98	(Go to Question 28)

Question 25: About how old were you when you were first told by a doctor that you had a heart attack (including myocardial infarction {MI} or coronary thrombosis)?

I was years old

Don't know 98

Question 26: In what month/year was your most recent heart attack?

(e.g. 03/2008) /

Don't know 98

Question 27: About how many heart attacks has the doctor said you have had?

I have had heart attack(s)

Don't know 98

Question 28: Have you ever had an angioplasty or stent?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 29)
No	<input type="checkbox"/> 5	(Go to Question 30)
Don't know	<input type="checkbox"/> 98	(Go to Question 30)

Question 29: What month/year was your last angioplasty or stent?

(e.g. 03/2008) /

Don't know 98

Question 30: Have you ever had open heart surgery?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 31)
No	<input type="checkbox"/> 5	(Go to Question 32)
Don't know	<input type="checkbox"/> 98	(Go to Question 32)

Question 31: What month/year was your last open heart surgery?

(e.g. 03/2008) /

Don't know 98

Congestive heart failure

Question 32: Has a doctor ever told you that you have congestive heart failure?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 33)
No	<input type="checkbox"/> 5	(Go to Question 34)
Don't know	<input type="checkbox"/> 98	(Go to Question 34)

Question 33: About how old were you when you were first told by a doctor that you had congestive heart failure?

I was years old

Don't know 98

Diabetes or high blood sugar

Question 34: Has a doctor ever told you that you have diabetes or high blood sugar?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 35)
No	<input type="checkbox"/> 5	(Go to Question 40)
Don't know	<input type="checkbox"/> 98	(Go to Question 40)

Question 35: About how old were you when you were first told by a doctor that you had diabetes or high blood sugar?

I was years old

Don't know ₉₈

Question 36: What type of diabetes do you have?

Tick one box only

Type 1 (formerly called insulin dependent diabetes)	<input type="checkbox"/>	1
Type 2 (formerly called non-insulin dependent diabetes)	<input type="checkbox"/>	2
Don't know	<input type="checkbox"/>	98

Question 37: Are you currently taking any tablets, pills or other medication that you swallow for diabetes?

Tick one box only

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 38: Do you currently inject insulin for diabetes?

Tick one box only

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 39: Has a doctor ever told you that you have any of the following conditions related to your diabetes?

Tick all that apply

Leg ulcers	<input type="checkbox"/>	1
Protein in your urine	<input type="checkbox"/>	1
Lack of feeling and tingling in your legs and feet due to nerve damage	<input type="checkbox"/>	1
Damage to the back of your eye	<input type="checkbox"/>	1
Damage to your kidneys	<input type="checkbox"/>	1
No, none of these	<input type="checkbox"/>	1
Don't know	<input type="checkbox"/>	1

Stroke

Question 40: Has a doctor ever told you that you have had a stroke?

Tick one box only

Yes	<input type="checkbox"/>	1	(Go to Question 41)
No	<input type="checkbox"/>	5	(Go to Question 44)
Don't know	<input type="checkbox"/>	98	(Go to Question 44)

Question 41: About how old were you when you were first told by a doctor that you had a stroke?

I was years old

Don't know 98

Question 42: How many strokes have you had?

I have had stroke(s)

Don't know 98

Question 43: In what year was your most recent stroke?

(e.g. 2008)

Don't know

₉₈

Ministroke or TIA (Transient Ischemic Attack)

Question 44: Has a doctor ever told you that you have had a ministroke or TIA?

Tick one box only

Yes	<input type="text"/> ₁	(Go to Question 45)
No	<input type="text"/> ₅	(Go to Question 48)
Don't know	<input type="text"/> ₉₈	(Go to Question 48)

Question 45: About how old were you when you were first told by a doctor that you had a TIA or ministroke?

I was years old

Don't know ₉₈

Question 46: How many TIAs or ministrokes have you had?

I have had TIA(s) or ministroke(s)

Don't know ₉₈

Question 47: In what year was your most recent TIA or ministroke?

(e.g. 2008)

Don't know

₉₈

Any other heart trouble

Question 48: Has a doctor ever told you that you have any other heart trouble?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 49)
No	<input type="checkbox"/> 5	(Go to Question 51)
Don't know	<input type="checkbox"/> 98	(Go to Question 51)

Question 49: What other heart trouble has the doctor told you that you have?

Please tell us

Question 50: About how old were you when you were first told by a doctor that you had any other heart trouble?

I was years old

Don't know 98

Section 5: Other chronic conditions



Question 51: Has a doctor ever told you that you have any of the following conditions?

Tick all that apply

Asthma	<input type="checkbox"/>	1
Stomach ulcers	<input type="checkbox"/>	1
Varicose ulcers (an ulcer due to varicose veins)	<input type="checkbox"/>	1
Cirrhosis, or serious liver damage	<input type="checkbox"/>	1
Chronic constipation	<input type="checkbox"/>	1
Coeliac disease	<input type="checkbox"/>	1
Phenylketonuria (PKU)	<input type="checkbox"/>	1
Thyroid disease (Hypo/Hyperthyroidism)	<input type="checkbox"/>	1
Gastroesophageal reflux disease	<input type="checkbox"/>	1
Osteoporosis, sometimes called thin or brittle bones	<input type="checkbox"/>	1
Multiple sclerosis	<input type="checkbox"/>	1
Cerebral palsy	<input type="checkbox"/>	1
Scoliosis	<input type="checkbox"/>	1
Muscular dystrophy	<input type="checkbox"/>	1
Spina bifida	<input type="checkbox"/>	1
None of these	<input type="checkbox"/>	1
Don't know	<input type="checkbox"/>	1

Question 52: Has a doctor ever told you that you have any other chronic conditions?

Tick one box only

Yes	<input type="checkbox"/>	1	(Go to Question 53)
No	<input type="checkbox"/>	5	(Go to Question 54)
Don't know	<input type="checkbox"/>	98	(Go to Question 54)

Question 53: What other chronic conditions has the doctor told you that you have?

Please tell us

Chronic lung disease

Question 54: Has a doctor ever told you that you have chronic lung disease such as chronic bronchitis or emphysema?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 55)
No	<input type="checkbox"/> 5	(Go to Question 57)
Don't know	<input type="checkbox"/> 98	(Go to Question 57)

Question 55: Are you receiving oxygen for your lung condition?

Tick one box only

Yes	<input type="checkbox"/> 1
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 56: Does your lung condition (breathing difficulty) limit your usual activities, such as household chores, work, social or leisure activities?

Tick one box only

Yes	<input type="checkbox"/> 1
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Arthritis

Question 57: Has a doctor ever told you that you have arthritis (including osteoarthritis, or rheumatism)?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 58)
No	<input type="checkbox"/> 5	(Go to Question 62)
Don't know	<input type="checkbox"/> 98	(Go to Question 62)

Question 58: Which type or types of arthritis do you have?

Tick all that apply

Osteoarthritis	<input type="checkbox"/> 1
Rheumatoid arthritis	<input type="checkbox"/> 1
Some other kind of arthritis	<input type="checkbox"/> 1
Don't know	<input type="checkbox"/> 1

Question 59: About how old were you when you were first told by a doctor that you had arthritis?

I was years old

Don't know 98

Question 60: Does your arthritis make it difficult for you to do your usual activities, such as household chores, work, social or leisure activities?

Tick one box only

Often/Always	<input type="checkbox"/>	1
Sometimes	<input type="checkbox"/>	2
Never	<input type="checkbox"/>	3
Don't know	<input type="checkbox"/>	98

Question 61: Does your arthritis make it difficult for you to sleep at night?

Tick one box only

Often/Always	<input type="checkbox"/>	1
Sometimes	<input type="checkbox"/>	2
Never	<input type="checkbox"/>	3
Don't know	<input type="checkbox"/>	98

Cancer

Question 62: Has a doctor ever told you that you have cancer or a malignant tumour (including leukaemia or lymphoma but excluding minor skin cancers)?

Tick one box only

Yes	<input type="checkbox"/>	1	(Go to Question 63)
No	<input type="checkbox"/>	5	(Go to Question 70)
Don't know	<input type="checkbox"/>	98	(Go to Question 70)

Question 63: About how old were you when you were first told by a doctor that you had cancer or a malignant tumour?

I was years old

Don't know 98

Question 64: In which organ or part of the body have you/had you cancer?

Tick all that apply

Lung	<input type="checkbox"/>	1
Breast	<input type="checkbox"/>	1
Colon or rectum	<input type="checkbox"/>	1
Stomach	<input type="checkbox"/>	1
Oesophagus	<input type="checkbox"/>	1
Prostate	<input type="checkbox"/>	1
Bladder	<input type="checkbox"/>	1
Liver	<input type="checkbox"/>	1
Brain	<input type="checkbox"/>	1
Ovary	<input type="checkbox"/>	1
Cervix	<input type="checkbox"/>	1
Endometrium	<input type="checkbox"/>	1
Thyroid	<input type="checkbox"/>	1
Kidney	<input type="checkbox"/>	1
Testicle	<input type="checkbox"/>	1
Pancreas	<input type="checkbox"/>	1
Malignant melanoma (skin)	<input type="checkbox"/>	1
Non-malignant melanoma	<input type="checkbox"/>	1
Oral cavity	<input type="checkbox"/>	1
Larynx	<input type="checkbox"/>	1
Other pharynx	<input type="checkbox"/>	1
Non-Hodgkin Lymphoma	<input type="checkbox"/>	1
Leukaemia	<input type="checkbox"/>	1
Other organ	<input type="checkbox"/>	1
Don't know	<input type="checkbox"/>	1

Question 65: Have you received any treatment for your cancer?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 66)
No	<input type="checkbox"/> 5	(Go to Question 70)
Don't know	<input type="checkbox"/> 98	(Go to Question 70)

Question 66: What sort of treatments have you received for your cancer?

Tick all that apply

Chemotherapy	<input type="checkbox"/> 1
Medication	<input type="checkbox"/> 1
Surgery	<input type="checkbox"/> 1
Radiotherapy/X-Ray	<input type="checkbox"/> 1
Treatment of symptoms (pain, nausea, rashes)	<input type="checkbox"/> 1
None of these	<input type="checkbox"/> 1
Don't know	<input type="checkbox"/> 1

Question 67: Have you had other sorts of treatment for your cancer?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 68)
No	<input type="checkbox"/> 5	(Go to Question 70)
Don't know	<input type="checkbox"/> 98	(Go to Question 70)

Question 68: What other sort of treatments have you received for your cancer?

Please tell us

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Question 69: Since treatment has the cancer gotten better, or is it about the same or worse?

Tick one box only

Better	<input type="checkbox"/>	1
About the same	<input type="checkbox"/>	2
Worse	<input type="checkbox"/>	3
Don't know	<input type="checkbox"/>	98

Parkinson's disease

Question 70: Has a doctor ever told you that you have Parkinson's disease?

Tick one box only

Yes	<input type="checkbox"/>	1	(Go to Question 71)
No	<input type="checkbox"/>	5	(Go to Question 72)
Don't know	<input type="checkbox"/>	98	(Go to Question 72)

Question 71: About how old were you when you were first told by a doctor that you had Parkinson's disease?

I was years old

Don't know 98

Emotional, nervous or psychiatric conditions

Question 72: Has a doctor ever told you that you have an emotional, nervous or psychiatric condition?

Tick one box only

Yes	<input type="checkbox"/> ₁	(Go to Question 73)
No	<input type="checkbox"/> ₅	(Go to Question 81)
Don't know	<input type="checkbox"/> ₉₈	(Go to Question 81)

Question 73: About how old were you when you were first told by a doctor that you have an emotional, nervous or psychiatric condition?

I was years old

Don't know ₉₈

Question 74: What type of emotional, nervous or psychiatric condition(s) do you have?

Tick all that apply

Hallucinations	<input type="checkbox"/> ₁
Anxiety	<input type="checkbox"/> ₁
Depression	<input type="checkbox"/> ₁
Emotional problems	<input type="checkbox"/> ₁
Schizophrenia	<input type="checkbox"/> ₁
Psychosis	<input type="checkbox"/> ₁
Mood swings	<input type="checkbox"/> ₁
Manic depression	<input type="checkbox"/> ₁
None of these	<input type="checkbox"/> ₁
Don't know	<input type="checkbox"/> ₁

Question 75: Do you have other emotional, nervous or psychiatric condition(s)?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 76)
No	<input type="checkbox"/> 5	(Go to Question 77)
Don't know	<input type="checkbox"/> 98	(Go to Question 77)

Question 76: What emotional, nervous or psychiatric condition(s) do you have?

Please tell us

Don't know 98

Question 77: Do you now get psychiatric treatment for your condition(s), such as attending a psychiatrist?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 78)
No	<input type="checkbox"/> 5	(Go to Question 79)
Don't know	<input type="checkbox"/> 98	(Go to Question 79)

Question 78: Who gives you psychiatric treatment for your condition(s)?

Tick <u>all that apply</u>		Please tell us the address where you see this person (this is required to calculate the distance you have to travel)
Psychiatrist	<input type="checkbox"/> ₁	
General Practitioner	<input type="checkbox"/> ₁	
Other (please tell us)	<input type="checkbox"/> ₁	

Don't know ₁

Question 79: Do you now get psychological treatment for your condition(s), such as counselling or behaviour support?

Tick one box only

Yes	<input type="checkbox"/> ₁	(Go to Question 80)
No	<input type="checkbox"/> ₅	(Go to Question 81)
Don't know	<input type="checkbox"/> ₉₈	(Go to Question 81)

Question 80: Who gives you psychological treatment for your condition(s)?

Tick <u>all that apply</u>		Please tell us the address where you see this person (this is required to calculate the distance you have to travel)
Psychologist	<input type="checkbox"/> ₁	
Counsellor	<input type="checkbox"/> ₁	
Clinical Nurse Specialist	<input type="checkbox"/> ₁	
Other (please tell us)	<input type="checkbox"/> ₁	

Don't know ₁

Alzheimer's disease

Question 81: Has a doctor ever told you that you have Alzheimer's disease?

Tick one box only

Yes	<input type="checkbox"/> ₁	(Go to Question 82)
No	<input type="checkbox"/> ₅	(Go to Question 83)
Don't know	<input type="checkbox"/> ₉₈	(Go to Question 83)

Question 82: About how old were you when you were first told by a doctor that you had Alzheimer's disease?

I was years old

Don't know ₉₈

Dementia, organic brain syndrome or senility

Question 83: Has a doctor ever told you that you have dementia, organic brain syndrome or senility?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 84)
No	<input type="checkbox"/> 5	(Go to Question 85)
Don't know	<input type="checkbox"/> 98	(Go to Question 85)

Question 84: About how old were you when you were first told by a doctor that you had dementia, organic brain injury or senility?

I was years old

Don't know 98

Serious memory impairment

Question 85: Has a doctor ever told you that you have serious memory impairment?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 86)
No	<input type="checkbox"/> 5	(Go to Question 87)
Don't know	<input type="checkbox"/> 98	(Go to Question 87)

Question 86: About how old were you when you were first told by a doctor that you had serious memory impairment?

I was years old

Don't know 98

Question 87: Has a doctor ever told you that you have epilepsy?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 88)
No	<input type="checkbox"/> 5	(Go to Question 96)
Don't know	<input type="checkbox"/> 98	(Go to Question 96)

Question 88: What type of epilepsy do you have?

Tick all that apply

Tonic-clonic seizures	<input type="checkbox"/> 1
Tonic seizures	<input type="checkbox"/> 1
Atonic seizures	<input type="checkbox"/> 1
Clonic seizures	<input type="checkbox"/> 1
Myoclonic seizures	<input type="checkbox"/> 1
Absence seizures	<input type="checkbox"/> 1
Simple partial seizures	<input type="checkbox"/> 1
Complex partial seizures	<input type="checkbox"/> 1
Don't know	<input type="checkbox"/> 1

Question 89: Do/Did you attend an Epilepsy clinic or see a specialist?

Tick one box only

Yes	<input type="checkbox"/> 1
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 90: When did you last have your epilepsy reviewed (e.g. medication, seizure activity)?

Tick one box only

Last 12 months	<input type="checkbox"/> ₁	(Go to Question 91)
Last 2 years	<input type="checkbox"/> ₂	(Go to Question 91)
More than 2 years ago	<input type="checkbox"/> ₃	(Go to Question 91)
Never	<input type="checkbox"/> ₄	(Go to Question 96)
I used to have epilepsy, I don't have seizures or take medication anymore	<input type="checkbox"/> ₉₄	(Go to Question 96)
Don't know	<input type="checkbox"/> ₉₈	(Go to Question 96)

Question 91: Who reviewed your epilepsy?

Tick all that apply

General Practitioner	<input type="checkbox"/> ₁
Psychiatrist	<input type="checkbox"/> ₁
Neurologist	<input type="checkbox"/> ₁
None of these	<input type="checkbox"/> ₁
Don't know	<input type="checkbox"/> ₁

Question 92: Has anyone else reviewed your epilepsy?

Tick one box only

Yes	<input type="checkbox"/> ₁	(Go to Question 93)
No	<input type="checkbox"/> ₅	(Go to Question 94)
Don't know	<input type="checkbox"/> ₉₈	(Go to Question 94)

Question 93: Who else has reviewed your epilepsy?

Please tell us

Don't know 98

Question 94: Do you keep a record of your seizures?

Tick one box only

Yes	<input type="checkbox"/> 1
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 95: How often have you had a seizure in the past two years?

Tick one box only

Have not had a seizure in 2 years	<input type="checkbox"/> 1
Daily	<input type="checkbox"/> 2
Weekly (but not daily)	<input type="checkbox"/> 3
More than once a month (but not weekly)	<input type="checkbox"/> 4
Less than once a month	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Section 6: Medical tests



Question 96: Have you had a flu injection?

Tick one box only

Yes, within the last 2 years	<input type="checkbox"/>	1
Yes, over 2 years ago	<input type="checkbox"/>	2
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 97: Have you had the Hepatitis B vaccine?

Tick one box only

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 98: Have you ever had a blood test for cholesterol?

Tick one box only

Yes, within the last 2 years	<input type="checkbox"/>	1
Yes, over 2 years ago	<input type="checkbox"/>	2
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 99: Have you ever had your blood pressure measured?

Tick one box only

Yes, within the last 2 years	<input type="checkbox"/>	1
Yes, over 2 years ago	<input type="checkbox"/>	2
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 100: Have you ever had a thyroid function test?

Tick one box only

Yes, within the last 2 years	<input type="checkbox"/> 1
Yes, over 2 years ago	<input type="checkbox"/> 2
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 101: Have you ever had a blood glucose test (sugar test)?

Tick one box only

Yes, within the last 2 years	<input type="checkbox"/> 1
Yes, over 2 years ago	<input type="checkbox"/> 2
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Other Screening Tests

Question 101a: Have you ever been screened or assessed for memory impairment/dementia?

Tick one box only

Yes, within the last 2 years	<input type="checkbox"/> 1
Yes, over 2 years ago	<input type="checkbox"/> 2
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 101b: Have you had a bone density test? (e.g. DEXA Scan)

Tick one box only

Yes, within the last 2 years	<input type="checkbox"/> 1
Yes, over 2 years ago	<input type="checkbox"/> 2
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Women only (Question 102 – Question 109)

Question 102: Have you gone through the menopause? If you are going through the menopause please tick 'Yes'.

Tick one box only

Yes	<input type="checkbox"/> ₁	(Go to Question 103)
No	<input type="checkbox"/> ₅	(Go to Question 107)
Don't know	<input type="checkbox"/> ₉₈	(Go to Question 107)

Question 103: About how old were you when you it started?

I was years old

Don't know ₉₈

Question 104: Since menopause, have you used prescription hormones (e.g. HRT, estrogen etc.)

Tick one box only

Yes, currently taking hormones	<input type="checkbox"/> ₁	(Go to Question 105)
Yes, but no longer taking hormones	<input type="checkbox"/> ₂	(Go to Question 106)
No	<input type="checkbox"/> ₅	(Go to Question 107)
Don't know	<input type="checkbox"/> ₉₈	(Go to Question 107)

Question 105: For how many years have you been taking prescription hormones?

(e.g. 01 years) year(s)

Don't know ₉₈

Question 106: For how many years did you take prescription hormones?

(e.g. 01 years) year(s)

Don't know ₉₈

Question 107: Do you check your breasts for lumps regularly?

Tick one box only

Yes	<input type="checkbox"/> ₁
No	<input type="checkbox"/> ₅
Don't know	<input type="checkbox"/> ₉₈

Question 108: Has your GP checked your breasts for lumps?

Tick one box only

Yes	<input type="checkbox"/> ₁
No	<input type="checkbox"/> ₅
Don't know	<input type="checkbox"/> ₉₈

Question 109: Have you had a mammogram or x-ray of the breast, to search for cancer?

Tick one box only

Yes	<input type="checkbox"/> ₁
No	<input type="checkbox"/> ₅
Don't know	<input type="checkbox"/> ₉₈

Men only (Question 110 – Question 113)

Question 110: Do you check your testicles for lumps regularly?

Tick one box only

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 111: Has your GP checked your testicles for lumps?

Tick one box only

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 112: Have you had an examination of your prostate to screen for cancer?

Tick one box only

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 113: Have you had a blood test to screen for prostate cancer?

Tick one box only

Yes	<input type="checkbox"/>	1
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Section 7: Healthcare utilisation



Question 114: Are you covered by any of the following?

Tick one box only

Full Medical Card or equivalent	<input type="checkbox"/>	1
GP Visit Card	<input type="checkbox"/>	2
Neither of these	<input type="checkbox"/>	96
Don't know	<input type="checkbox"/>	98

Question 115: Do you have private medical insurance cover (VHI etc) in your own name or through another family member?

Tick one box only

Yes, in own name	<input type="checkbox"/>	1
Yes, as the spouse of a subscriber	<input type="checkbox"/>	2
Yes, as the relative of a subscriber	<input type="checkbox"/>	3
No	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 116: In the last year, about how often did you visit your GP or did your GP visit you?

(e.g. 01) Number of visit(s)

Don't know 98

Question 118: In the last year, how many times did you visit a hospital Emergency Department (sometimes called A&E or Accident and Emergency) as a patient?

(e.g. 01) Number of visit(s)

Don't know ₉₈

Question 119: If you attended A & E for treatment in the last year, what was the reason?

I haven't visited A & E in the last year ₁

Tick all that apply

Multiple injuries	<input type="checkbox"/> ₁
Broken or fractured bone(s)	<input type="checkbox"/> ₁
Burn(s)	<input type="checkbox"/> ₁
Dislocation(s)	<input type="checkbox"/> ₁
Sprain or strain(s)	<input type="checkbox"/> ₁
Cut(s) (open wound)	<input type="checkbox"/> ₁
Scrape, bruise, blister(s)	<input type="checkbox"/> ₁
Concussion or other brain injury	<input type="checkbox"/> ₁
Poisoning	<input type="checkbox"/> ₁
Internal injury(s)	<input type="checkbox"/> ₁
Pneumonia	<input type="checkbox"/> ₁
None of these	<input type="checkbox"/> ₁
Don't know	<input type="checkbox"/> ₁

Question 120: Did you attend A & E in the last year for treatment for other reasons?

Tick one box only

Yes	<input type="checkbox"/> ₁	(Go to Question 121)
No	<input type="checkbox"/> ₅	(Go to Question 122)
Don't know	<input type="checkbox"/> ₉₈	(Go to Question 122)

Question 121: For what other reasons did you attend A & E for treatment in the last year?

Please tell us

Question 122: In the last year, about how many visits did you make to a hospital out-patient? (Include all types of consultations, tests, operations, procedures or treatments)

(e.g. 01) Number of visit(s)

Don't know ₉₈

Question 123: In the last year, how many nights did you spend in a general hospital?

(e.g. 01) Total number of night(s)

Don't know ₉₈

Question 124: In the last year, how many nights did you spend in an acute/psychiatric hospital due to mental health problems?

Tick one box only

Did not spend any nights	<input type="checkbox"/>	1
1 to 5 nights	<input type="checkbox"/>	2
6 to 10 nights	<input type="checkbox"/>	3
11 to 20 nights	<input type="checkbox"/>	4
More than 20 nights	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 125: In the last year, how much time did you spend in a nursing/convalescent home?

Tick one box only

Did not spend any time	<input type="checkbox"/>	1
One week or less	<input type="checkbox"/>	2
Up to 1 month	<input type="checkbox"/>	3
Up to 2 months	<input type="checkbox"/>	4
Up to 3 months	<input type="checkbox"/>	5
More than 3 months	<input type="checkbox"/>	6
Don't know	<input type="checkbox"/>	98

Question 126: During the last year, was there ever a time when you felt you needed healthcare but you didn't receive it?

Tick one box only

Yes	<input type="checkbox"/>	1	(Go to Question 127)
No	<input type="checkbox"/>	5	(Go to Question 133)
Don't know	<input type="checkbox"/>	98	(Go to Question 133)

Question 127: Thinking of the most recent time, why did you not get healthcare?

Tick all that apply

Healthcare was not offered	<input type="checkbox"/> 1
Not available in the area	<input type="checkbox"/> 1
Not available at the time required (e.g., doctor on holidays, inconvenient hours, difficult to get an appointment)	<input type="checkbox"/> 1
Waiting time too long	<input type="checkbox"/> 1
Felt that the service would not be good	<input type="checkbox"/> 1
Too costly	<input type="checkbox"/> 1
Too busy	<input type="checkbox"/> 1
Didn't get around to it / didn't bother	<input type="checkbox"/> 1
Didn't know where to go	<input type="checkbox"/> 1
Problems with transport	<input type="checkbox"/> 1
Communication/language problems	<input type="checkbox"/> 1
Personal or family responsibilities	<input type="checkbox"/> 1
Fear of healthcare services and/or of treatment.	<input type="checkbox"/> 1
Decided not to seek care	<input type="checkbox"/> 1
Information material not accessible/inadequate communication aids	<input type="checkbox"/> 1
Complaint was not taken seriously enough	<input type="checkbox"/> 1
Negative attitudes of the staff	<input type="checkbox"/> 1
Too embarrassing	<input type="checkbox"/> 1
I was in too much pain	<input type="checkbox"/> 1
I forgot about my appointments	<input type="checkbox"/> 1
None of these	<input type="checkbox"/> 1
Don't know	<input type="checkbox"/> 1

Question 128: Are there other reasons why you did not get healthcare?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 129)
No	<input type="checkbox"/> 5	(Go to Question 133)
Don't know	<input type="checkbox"/> 98	(Go to Question 133)

Question 129: For what other reasons did you not get healthcare?

Please tell us

Question 130: Again, thinking of the most recent time, what was the type of care that was needed?

Tick all that apply

Treatment of a physical health problem (e.g. cancer, cataract surgery)	<input type="checkbox"/> 1
Treatment of an emotional or mental health problem	<input type="checkbox"/> 1
A regular check-up	<input type="checkbox"/> 1
Care of an injury	<input type="checkbox"/> 1
None of these	<input type="checkbox"/> 1
Don't know	<input type="checkbox"/> 1

Question 131: Was another type of care needed?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 132)
No	<input type="checkbox"/> 5	(Go to Question 133)
Don't know	<input type="checkbox"/> 98	(Go to Question 133)

Question 132: What other type of care was needed?

Please tell us

Question 133: In the last year, did you receive any of the following services (exclude any service that you paid for yourself)?

Tick all that apply

General practitioner	<input type="checkbox"/>	1
Public health or community nurse	<input type="checkbox"/>	1
Occupational therapy	<input type="checkbox"/>	1
Chiropody services	<input type="checkbox"/>	1
Physiotherapy services	<input type="checkbox"/>	1
Social work services	<input type="checkbox"/>	1
Psychological/counselling services	<input type="checkbox"/>	1
Home help	<input type="checkbox"/>	1
Personal care attendant	<input type="checkbox"/>	1
Meals-on-Wheels	<input type="checkbox"/>	1
Optician services	<input type="checkbox"/>	1
Dental services	<input type="checkbox"/>	1
Hearing services	<input type="checkbox"/>	1
Dietician services	<input type="checkbox"/>	1
Speech & Language services	<input type="checkbox"/>	1
Day centre services	<input type="checkbox"/>	1
Respite services	<input type="checkbox"/>	1
Residential services	<input type="checkbox"/>	1
Psychiatry services	<input type="checkbox"/>	1
Neurological services	<input type="checkbox"/>	1
Geriatrician services	<input type="checkbox"/>	1
Endocrinology services	<input type="checkbox"/>	1
Dermatological services	<input type="checkbox"/>	1
Palliative care services	<input type="checkbox"/>	1
None of these	<input type="checkbox"/>	1
Don't know	<input type="checkbox"/>	1

Question 134: Are there other services (exclude any service that you paid for yourself) that you received in the last year?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 135)
No	<input type="checkbox"/> 5	(Go to Question 136)
Don't know	<input type="checkbox"/> 98	(Go to Question 136)

Question 135: What other services (exclude any service that you paid for yourself) did you receive in the last year?

Please tell us

Question 136: Which services were you most satisfied with?

Please tell us

Don't know	<input type="checkbox"/> 98
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Question 137: Which services were you least satisfied with?

Please tell us

Don't know	<input type="checkbox"/>	98
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Question 138: Are there any services that you think you would benefit from that you are not receiving at present?

Tick one box only

Yes	<input type="checkbox"/>	1	(Go to Question 139)
No	<input type="checkbox"/>	5	(Go to Question 142)
Don't know	<input type="checkbox"/>	98	(Go to Question 142)

Question 139: What are these services?

Please tell us

Question 140: Could you tell us the main thing that stops/prevents you from receiving this service or services?

Please tell us

Don't know	<input type="checkbox"/>	98
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Question 141: How would you find out about this service or services?

Please tell us

Don't know	<input type="checkbox"/>	98
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Question 142: In the last year, how many nights did you spend in respite (excluding nights spent in a nursing home)?

Tick one box only

None	<input type="checkbox"/>	1
1 to 5 nights	<input type="checkbox"/>	2
6 to 10 nights	<input type="checkbox"/>	3
11 to 20 nights	<input type="checkbox"/>	4
More than 20 nights	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 143: In the last year, did you receive support from any of the following organisations?

Tick all that apply

The Society of St. Vincent's de Paul	<input type="checkbox"/>	1
The Senior Helpline	<input type="checkbox"/>	1
The Samaritans	<input type="checkbox"/>	1
No support from these organisations	<input type="checkbox"/>	1
Don't know	<input type="checkbox"/>	1

Question 144: In the last year, did you receive support from any other organisations?

Tick one box only

Yes	<input type="checkbox"/>	1	(Go to Question 145)
No	<input type="checkbox"/>	5	(Go to Question 146)
Don't know	<input type="checkbox"/>	98	(Go to Question 146)

Question 145: From what organisations did you receive support from?

Please tell us

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Question 146: Have you ever received any easy to read information leaflets on keeping healthy e.g. diet and exercise?

Tick one box only

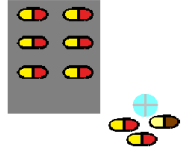
Yes	<input type="checkbox"/> 1
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Question 147: Have you ever received any easy to read information leaflets on healthcare services?

Tick one box only

Yes	<input type="checkbox"/> 1
No	<input type="checkbox"/> 5
Don't know	<input type="checkbox"/> 98

Section 8: Medication



We would like to record all medications that you take on a regular basis, like every day or every week. This will include prescription and non-prescription medications, over-the-counter medicines, vitamins, and herbal and alternative medicines.

Question 148: Please write down all medications you take and how often you take them.

Don't know what medication I am on	<input type="checkbox"/> 1
Don't take any medication	<input type="checkbox"/> 1

Please tick one box only on each line

Name of medication	Daily	Weekly	When required	Don't know
1.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
2.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
3.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
4.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
5.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
6.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
7.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
8.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
9.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
10.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
11.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
12.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
13.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
14.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
15.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
16.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
17.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98
18.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 98

Section 9: Filling out this questionnaire



Question 149: How long did it take you to fill out this questionnaire?

Tick one box only

Less than 30 minutes	<input type="checkbox"/>	1
30 minutes – 1 hour	<input type="checkbox"/>	2
1 – 2 hours	<input type="checkbox"/>	3
2 – 3 hours	<input type="checkbox"/>	4
More than 3 hours	<input type="checkbox"/>	5
Don't know	<input type="checkbox"/>	98

Question 150: In general, did you find it easy to understand the questions?

Tick one box only

Yes	<input type="checkbox"/>	1	(Go to Question 152)
No	<input type="checkbox"/>	5	(Go to Question 151)
Don't know	<input type="checkbox"/>	98	(Go to Question 152)

Question 151: Which questions did you find most difficult to understand?

Example: Question number	1
a) Question number	
b) Question number	
c) Question number	

d) Question number	
e) Question number	
f) Question number	
g) Question number	

Question 152: Do you have other comments about the questionnaire?

Section 10: Support with filling out this questionnaire



Question 153: Has anyone supported you to fill out this questionnaire?

Tick one box only

Yes	<input type="checkbox"/> 1	(Go to Question 154)
No	<input type="checkbox"/> 5	You are now finished. Thank you for your time.

Question 154: Name of the person supporting you:

First name

Surname

Question 155: What is their relationship to you?

Tick one box only

Boyfriend/Girlfriend/Partner	<input type="checkbox"/> 1
Parent	<input type="checkbox"/> 2
Sibling	<input type="checkbox"/> 3
Key worker/Support worker	<input type="checkbox"/> 4
Friend	<input type="checkbox"/> 5

Other (please tell us)

<input type="text"/>	<input type="checkbox"/> 95
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Don't know	<input type="checkbox"/> 98
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Question 156: How long have you known the person supporting you?

Tick one box only

Less than 6 months	<input type="checkbox"/>	1
Between 6 months and a year	<input type="checkbox"/>	2
More than a year	<input type="checkbox"/>	3
Don't know	<input type="checkbox"/>	98

Thank you very much for taking the time to fill in this questionnaire.

Please bring the completed questionnaire to your interview.
