

Adults Questionnaire (People aged 16 and over)

DOCUMENTO PROTEGIDO
INE
POR EL SECRETO ESTADÍSTICO

1. Section identification details

2

Province _____ [][]

Section sort number _____ [][][][] [][]

Local Authority _____ [][][][]

District/section _____ [][][][][][]

Year/quarter/two-week period ____ [][][][] [][] [][]

2. Identification of dwelling and household

Dwelling sort number _____ [][]

Household no. within dwelling _____ [][]

3. Identification of person selected

Name _____

Sort number _____ [][]

Date of Birth [][][][][][][][]

Age _____ [][][][]

4. Is the informant the person selected?

Yes 1 → Q 5.5 (Informant's telephone no.)

No 6

5. Informant's identification

Interviewer: Is the informant a member of the household?

Yes 1 → sort number [][] → Q 5.5

No 6

5.1 Name of the informant _____

5.2 Age _____ [][][][]

5.3 Sex 1 Male 6 Female

5.4 Informant's relationship with adult selected

Spouse or partner ____ 1 Other family member 5

Son/Daughter _____ 2 Social services _____ 6

Father/Mother _____ 3 Volunteers _____ 7

Brother/Sister _____ 4 Others _____ 8

5.5 Informant's telephone no.

[][][][][][][][][][]

6. Date survey conducted

_____ [][][] [][][] [][][][][]

Day Month Year

7. Time survey started

_____ [][] [][]

Hour Minutes

Nature, Characteristics and Purpose

The National Health Survey (ENS 2006) is a nationwide statistical research project designed to obtain data on people's state of health, use of healthcare services, prevention, risk factors, etc.

The importance of these objectives and the public service characteristics of this study have led us to voluntarily request your important and significant contribution.

Legislation

Statistical secret: Any personal data gathered by the statistical service either directly from informants or through administrative sources (Art. 13.1 of the Law on the Public Statistical Function [*Ley de la Función Estadística Pública - LFEP*] of 9 May 1989) shall be subject to protection and deemed to be a statistical secret. All personnel shall be obliged to keep statistical secrets (Art. 17.1 of the LFEP). The statistical services may request data from all Spanish and foreign individuals, as well as legal persons resident in Spain (Art. 10.1 of the LFEP). Any individuals or legal persons that may supply data either under obligation or voluntarily shall have to answer any questions asked in the correct order by the statistical services truthfully, accurately, completely and within the deadline set forth (Art. 10.2 of the LFEP).

(Law 12/1989 on the Public Statistical Function)

Interviewer: Remind the respondent that he/she should be the adult selected, except under the exceptional circumstances listed in the manual.

A. Reproductive work

Interviewer, read to the respondent: "First, I am going to ask you several questions about the care given to household members."

1. Are there any people living in your home who are incapable of caring for themselves like children under the age of 15, people over the age of 74 or people suffering from some kind of disability or limitation?

Yes _____ 1

No _____ 6 → **Q11**

2. Does any child under the age of 15 requiring care live in the home?

Yes _____ 1

No _____ 6 → **Q5**

3. Who is mainly responsible for his/her care?

You alone _____ 01

You sharing it with your partner _____ 02

You sharing it with another person who is not your partner _____ 03

Your partner alone _____ 04

Another household member who is not your partner _____ 05 → **Sort no.**

A person paid to do so _____ 06

Another person who **DOES NOT** live in the home _____ 07

The social services _____ 08

Nobody _____ 09

Other situation _____ 10

→ **Q5**

4. How many hours do you dedicate to his/her care?

1. From Monday to Friday (daily average) __No. of hours

2. Saturdays and Sundays _____No. of hours

5. Does anybody over the age of 74 requiring care live in the home?

Yes _____ 1

No _____ 6 → **Q8**

6. Who is mainly responsible for his/her care?

- You alone _____ 01
- You sharing it with your partner _____ 02
- You sharing it with another person who is not your partner _____ 03
- Your partner alone _____ 04
- Another household member who is not your partner _____ 05
- A person paid to do so _____ 06
- Another person who **DOES NOT** live in the home _____ 07
- The social services _____ 08
- Nobody _____ 09
- Other situation _____ 10

Sort no.

→ Q8

7. How many hours do you dedicate to his/her care?

- 1. From Monday to Friday (daily average) ___ No. of hours
- 2. Saturdays and Sundays _____ No. of hours

8. Is there any person suffering a disability or limitation requiring care?

- Yes _____ 1
- No _____ 6 → Q11

9. Who is mainly responsible for his/her care?

- You alone _____ 01
- You sharing it with your partner _____ 02
- You sharing it with another person who is not your partner _____ 03
- Your partner alone _____ 04
- Another household member who is not your partner _____ 05
- A person paid to do so _____ 06
- Another person who **DOES NOT** live in the home _____ 07
- The social services _____ 08
- Nobody _____ 09
- Other situation _____ 10

Sort no.

→ Q11

10. How many hours do you dedicate to his/her care?

- 1. From Monday to Friday (daily average) ___ No. of hours
 - 2. Saturdays and Sundays _____ No. of hours
-

11. Who is mainly responsible for doing household tasks like washing, cooking, ironing, etc. in your home?

- You alone _____ 01
 - You sharing it with your partner _____ 02
 - You sharing it with another person who is not your partner _____ 03
 - Your partner alone _____ 04
 - Another household member who is not your partner _____ 05
 - A person paid to do so _____ 06
 - Another person who does not live in the home _____ 07
 - The social services _____ 08
 - Nobody _____ 09
 - Other situation _____ 10
- Sort no.

Mark Yes in Q13
- Q13
-

12. How many hours do you dedicate?

- 1. From Monday to Friday (daily average) ___ No. of hours
 - 2. Saturdays and Sundays _____ No. of hours
-

13. Is there anybody in your home paid to do household work (cleaning, cooking, ironing, etc.)?

- Yes _____ 1
 - No _____ 6
-

B. Health status

Interviewer, read to the respondent: *"Now I am going to ask you several questions about your health status."*

14. Would you say your health has been very good, good, fair, bad or very bad in the last twelve months?

- Very good _____ 1
 - Good _____ 2
 - Fair _____ 3
 - Bad _____ 4
 - Very bad _____ 5
-

15. I will now read you a list of diseases or health problems. Are you suffering or have you ever suffered any of them?

Interviewer: Read the illnesses listed below to the respondent one by one and mark the relevant response. Should he/she answer "Yes" to any of the options in 15.a, ask questions 15.b, 15.c and 15.d. If the respondent is male, directly mark **NO** for option 27 of 15.a and, if the respondent is female, directly mark **NO** for option 26 of 15.a.

	15.a Have you ever suffered any of the following?		If the answer is yes to question 15.a, ask and note down as appropriate					
	YES	NO	15.b Have you suffered it in the last 12 months?		15.c Has a doctor told you that you suffer it?		15.d Are you taking or have you taken medication for this problem in the last 12 months?	
	YES	NO	YES	NO	YES	NO	YES	NO
1. High blood pressure	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
2. Myocardial infarction	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
3. Other heart diseases	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
4. Varicose veins in legs	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
5. Osteoarthritis, arthritis or rheumatism	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
6. Chronic back pain (cervical)	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
7. Chronic back pain (lumbar)	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
8. Chronic allergy	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
9. Asthma	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
10. Chronic bronchitis	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
11. Diabetes	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
12. Stomach or duodenal ulcer	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
13. Urinary incontinence	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
14. High cholesterol levels	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
15. Cataracts	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
16. Chronic skin problems	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
17. Chronic constipation	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
18. Depression, anxiety or other mental disorders	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
19. Embolism	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
20. Migraine or frequent headaches	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
21. Haemorrhoids	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
22. Malignant tumours	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
23. Osteoporosis	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
24. Anemia	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
25. Thyroid problems	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
26. Prostrate problems (only males)	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
27. Menopausal phase problems (only females)	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
Have you suffered any other chronic disease?	<input type="checkbox"/>							
28.	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
29.	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6

Interviewer: If all the responses for column 15.a in Q15 were **NO**, → move on to Module C. If any was **YES**, → continue with Q16.

16. Have any of these illnesses or health problems limited your normal activities in any way during the last twelve months?

Yes _____ 1
 No _____ 6

C. Accidents (last 12 months)

Interviewer, read to the respondent: "I will now ask you if you've suffered any kind of accident, its consequences and treatment in the last twelve months."

17. Have you had any kind of accident including intoxications or burns in the last twelve months?

Yes _____ 1
 No _____ 6 → **Module D**

18. What kind of accident have you had and how many times have you suffered this kind of accident?

	Yes	No. of times	No
1. Fall from a height (step ladder, chair, etc.) _____	<input type="checkbox"/> 1 →	<input type="text"/>	<input type="checkbox"/> 6
2. Fall to the floor _____	<input type="checkbox"/> 1 →	<input type="text"/>	<input type="checkbox"/> 6
3. Burns _____	<input type="checkbox"/> 1 →	<input type="text"/>	<input type="checkbox"/> 6
4. Knocks _____	<input type="checkbox"/> 1 →	<input type="text"/>	<input type="checkbox"/> 6
5. Intoxication (excluding food poisoning) _____	<input type="checkbox"/> 1 →	<input type="text"/>	<input type="checkbox"/> 6
6. Traffic accident as a driver or passenger, suffering physical injuries _____	<input type="checkbox"/> 1 →	<input type="text"/>	<input type="checkbox"/> 6
7. Traffic accident as a pedestrian _____	<input type="checkbox"/> 1 →	<input type="text"/>	<input type="checkbox"/> 6
8. Others _____	<input type="checkbox"/> 1 →	<input type="text"/>	<input type="checkbox"/> 6

19. And specifically referring to the last accident you've had (if you've had several during the last twelve months), where did it happen?

At home, stairs, entrance hall, etc. _____ 1
 In the street or highway and it was a traffic accident _____ 2
 In the street, but it was not a traffic accident _____ 3
 At work _____ 4
 At a place of study _____ 5
 In a sports facility _____ 6
 In a recreational or leisure area _____ 7
 Somewhere else _____ 8

20. Did you consult a healthcare professional, did you go to an emergency centre or were you admitted to hospital as a result of this accident?

Consulted a doctor or nurse _____ 1
 Went to an emergency centre _____ 2
 Was admitted to hospital _____ 3
 No consultation or intervention was necessary _____ 4

21. What effect or injury did this accident have on you?

Interviewer: Mark two responses at most (the ones the respondent considers most important).

1. Contusions, haematomas, sprains, dislocations or surface wounds _____
 2. Fractures or deep wounds _____
 3. Poisoning or intoxication _____
 4. Burns _____
 5. Other effects _____

D. Restriction of activity (last two weeks)

Interviewer, read to the respondent: "I will now ask you some questions about restrictions to you normal activities during the last two weeks. Please think of the time that has passed since _____ (day two weeks ago) until yesterday".

22. Have you had to reduce or limit your normal activities for at least half a day due to one or several pains or symptoms during the last two weeks?

Interviewer: If the time he/she has had to limit his/her normal activities has been less than half a day, note down 01.

Yes _____ 1 → No. of days

No _____ 6

23. Have you had to stay in bed more than half a day for health reasons during the last two weeks? (If you have been hospitalized, also count the days spent in hospital.)

Interviewer: If the time he/she has had to spend in bed has been half a day, note down 01.

Yes _____ 1 → No. of days

No _____ 6

Interviewer: If Q22 = **NO** and Q23 = **NO**, move on to Module E. If he/she has answered **YES** in Q22 or Q23, answer the relevant column(s) marking an "X" in Q 24.a or Q 24.b on the pains or symptoms indicated by the respondent.

24. What were the pains or symptoms that have obliged you to limit or reduce your normal activities and/or stay in bed for at least half a day?

	24.a Normal activity	24.b Stay in bed
01. Pain in bones, back or joints _____	<input type="checkbox"/>	<input type="checkbox"/>
02. Nervousness, depression or difficulty in sleeping _____	<input type="checkbox"/>	<input type="checkbox"/>
03. Throat problems, cough, cold or flu _____	<input type="checkbox"/>	<input type="checkbox"/>
04. Headache _____	<input type="checkbox"/>	<input type="checkbox"/>
05. Contusion, injury or wound _____	<input type="checkbox"/>	<input type="checkbox"/>
06. Earache, otitis _____	<input type="checkbox"/>	<input type="checkbox"/>
07. Diarrhoea or intestinal problems _____	<input type="checkbox"/>	<input type="checkbox"/>
08. Rashes, itchiness or allergies _____	<input type="checkbox"/>	<input type="checkbox"/>
09. Kidney or urinary problems _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Stomach, digestive, liver or gallbladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Fever _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Teeth or gum problems _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Dizziness or dizzy spells _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Pain in the chest _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Swollen ankles _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Breathlessness or breathing difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
17. Tiredness for no apparent reason _____	<input type="checkbox"/>	<input type="checkbox"/>
18. Menstrual pain _____	<input type="checkbox"/>	<input type="checkbox"/>
19. Other pains or symptoms _____	<input type="checkbox"/>	<input type="checkbox"/>

E. Intake of medicines (last two weeks)

Interviewer, read to the respondent: *“Now I am going to ask you about the medicines you have taken in the last two weeks.”*

25. I will now read you a list of medicines. Please tell me which of them you have taken in the last two weeks and which of them were prescribed by the doctor, whether or not you have taken them.

Interviewer: Read the respondent the list of medicines and, for each one of them, ask him/her whether he/she has taken them or not in the last two weeks, and whether or not it was prescribed by a doctor. You should complete the columns “Taken” and “Prescribed” by marking “YES” or “NO” for each of the medicines listed, except for options 21 and 22. If the respondent is male, directly mark “NO” for options 15 and 16 under “Taken” and “Prescribed”.

	Taken		Prescribed	
	Yes	No	Yes	No
01. Cold, flu, throat and bronchial tubes medicines _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
02. Painkillers _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
03. Medicines to reduce fever _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
04. Pick-me-ups like vitamins, minerals and tonics _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
05. Laxatives _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
06. Antibiotics _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
07. Tranquilizers, relaxants, sleeping pills _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
08. Allergy medicines _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
09. Diarrhoea medicines _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
10. Rheumatism medicines _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
11. Heart medicines _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
12. Blood pressure medicines _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
13. Medicines for the stomach and/or digestive problems _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
14. Antidepressants, stimulants _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
15. Contraceptive pills (only females) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
16. Menopausal hormones (only females) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
17. Medicines to lose weight _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
18. Medicines to lower cholesterol levels _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
19. Diabetes medicines _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
20. Other medicines _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6	<input type="checkbox"/> 1	<input type="checkbox"/> 6
21. Homeopathic products _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6		
22. Alternative medicine products _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6		

F. Mental health and occupational stress

26. Now we would like to know your overall state of health during the last few weeks. Please answer all the questions, indicating the response that to your mind best applies to you. Remember you should only respond about recent or current problems, not about problems you may have had in the past. It is important that you try to answer all the questions.

Interviewer, read to the respondent: "I am going to hand you a sheet containing questions about the frequency you have felt or have found yourself in the situation described by each question. When I ask you, answer by only saying the number of the response. Bear in mind that the responses are not the same for all the questions." (Hand over card Ad-1. Read each question and record the response number given by the respondent).

Lately:

- | | | | | | | | | |
|---|--------------------|----------------------------|-------------------------|----------------------------|------------------------|----------------------------|-----------------------------|----------------------------|
| 1. Have you been able to concentrate on what you were doing? _____ | Better than usual | <input type="checkbox"/> 0 | Same as usual | <input type="checkbox"/> 1 | Less than usual | <input type="checkbox"/> 2 | Much less than usual | <input type="checkbox"/> 3 |
| 2. Have you lost much sleep over worries? _____ | Not at all | <input type="checkbox"/> 0 | No more than usual | <input type="checkbox"/> 1 | Rather more than usual | <input type="checkbox"/> 2 | Much more than usual | <input type="checkbox"/> 3 |
| 3. Have you felt you were playing a useful part in things? | More so than usual | <input type="checkbox"/> 0 | Same as usual | <input type="checkbox"/> 1 | Less useful than usual | <input type="checkbox"/> 2 | Much less useful than usual | <input type="checkbox"/> 3 |
| 4. Have you felt capable of making decisions about things? _ | More so than usual | <input type="checkbox"/> 0 | Same as usual | <input type="checkbox"/> 1 | Less useful than usual | <input type="checkbox"/> 2 | Much less useful than usual | <input type="checkbox"/> 3 |
| 5. Have you felt constantly under strain? _____ | Not at all | <input type="checkbox"/> 0 | No more than usual | <input type="checkbox"/> 1 | Rather more than usual | <input type="checkbox"/> 2 | Much more than usual | <input type="checkbox"/> 3 |
| 6. Have you felt you could not overcome your difficulties? | Not at all | <input type="checkbox"/> 0 | No more than usual | <input type="checkbox"/> 1 | Rather more than usual | <input type="checkbox"/> 2 | Much more than usual | <input type="checkbox"/> 3 |
| 7. Have you been able to enjoy your normal day-to-day activities? _____ | More so than usual | <input type="checkbox"/> 0 | Same as usual | <input type="checkbox"/> 1 | Less useful than usual | <input type="checkbox"/> 2 | Much less useful than usual | <input type="checkbox"/> 3 |
| 8. Have you been able to face up to your problems? | More so than usual | <input type="checkbox"/> 0 | Same as usual | <input type="checkbox"/> 1 | Less useful than usual | <input type="checkbox"/> 2 | Much less useful than usual | <input type="checkbox"/> 3 |
| 9. Have you been feeling unhappy and depressed? _____ | Not at all | <input type="checkbox"/> 0 | No more than usual | <input type="checkbox"/> 1 | Rather more than usual | <input type="checkbox"/> 2 | Much more than usual | <input type="checkbox"/> 3 |
| 10. Have you been losing confidence in yourself? _____ | Not at all | <input type="checkbox"/> 0 | No more than usual | <input type="checkbox"/> 1 | Rather more than usual | <input type="checkbox"/> 2 | Much more than usual | <input type="checkbox"/> 3 |
| 11. Have you thinking of as a worthless person? _____ | Not at all | <input type="checkbox"/> 0 | No more than usual | <input type="checkbox"/> 1 | Rather more than usual | <input type="checkbox"/> 2 | Much more than usual | <input type="checkbox"/> 3 |
| 12. Have you been reasonably happy all things considered? | More so than usual | <input type="checkbox"/> 0 | About the same as usual | <input type="checkbox"/> 1 | Less so than usual | <input type="checkbox"/> 2 | Much less than usual | <input type="checkbox"/> 3 |

Interviewer: Has the respondent been working or on leave for three months or more as of last week? (See question 2 of Module C.1 of the household questionnaire).

Yes _____ 1

No _____ 6 → **Module G**

Interviewer, read to the respondent: "Work has an influence on people's well-being. The following questions are aimed at getting to know the conditions under which you do your work."

27. Taking into account the conditions under which you do your work, state how you would rate your job's overall level of stress on a scale from 1 (not stressful at all) to 7 (very stressful).

1 2 3 4 5 6 7

28. Taking into account your job's characteristics, state to what extent you consider your job to be satisfying on a scale of 1 (not satisfying at all) to 7 (very satisfying).

1 2 3 4 5 6 7

G. Use of healthcare services

Interviewer, read to the respondent: "I will now ask you some questions about the use you make of the different healthcare services."

G 1. Medical consultations

Interviewer, read to the respondent: "To start off with, I would like to know about the medical consultations you have had."

29. How long has it been since the last time you had a medical consultation (in person or by telephone) for any kind of problem, pain or illness you have suffered?

Do not include stomatology consultations, visits to the dentist, diagnostic tests like X-rays, analyses, etc., or any consultations during hospitalizations.

Four weeks ago or less _____ 1

More than four weeks ago and less than a year ago _____ 2 → No. of months

One year or more ago _____ 3 → No. of years

Has never been to the doctor _____ 4

→ **Q38**

30. How many times have you seen a family doctor in the last four weeks for any kind of problem, pain or illness you have suffered?

No. of times _____

Doesn't know/Can't remember _____

Doesn't answer _____

31. How many times have you consulted a specialist in the last four weeks for any kind of problem, pain or illness you have suffered?

No. of times _____

Doesn't know/Can't remember _____

Doesn't answer _____

32. What was the specialization of the last doctor you consulted in the last four weeks?

Interviewer: Do not read the reply options. Only mark what the respondent responds without prompting.

- Family doctor _____ 01
 - Allergology _____ 02
 - Digestive Apparatus _____ 03
 - Cardiology _____ 04
 - General and digestive surgery _____ 05
 - Cardiovascular surgery _____ 06
 - Vascular surgery _____ 07
 - Dermatology _____ 08
 - Endocrinology and nutrition _____ 09
 - Geriatrics _____ 10
 - Gynaecology-Obstetrics _____ 11
 - Internal medicine _____ 12
 - Nephrology _____ 13
 - Pneumology _____ 14
 - Neurosurgery _____ 15
 - Neurology _____ 16
 - Ophthalmology _____ 17
 - Oncology _____ 18
 - Ear, Mouth and Throat Medicine _____ 19
 - Psychiatry _____ 20
 - Rehabilitation _____ 21
 - Rheumatology _____ 22
 - Orthopaedics _____ 23
 - Urology _____ 24
 - Other specialization _____ 25
-

33. Where did your last consultation in the last four weeks take place?

- Health Centre/Doctor's Surgery _____ 01
 - Outpatients Clinic/Medical specialities centre _____ 02
 - Hospital external surgery _____ 03
 - Non-hospital emergency service _____ 04
 - Hospital emergency room _____ 05
 - Private doctor's surgery _____ 06
 - Mutual society doctor's surgery _____ 07
 - Company or place of work _____ 08
 - Respondent's home _____ 09
 - Telephone consultation _____ 10
 - Other place _____ 11
-

→ **Q37**

34. What was the main reason for this last consultation?

- To diagnose an illness or health problem _____ 1
 - An accident or aggression _____ 2
 - Check-up _____ 3
 - Only to get a prescription _____ 4
 - Doctor's note for sick leave, confirmation or end of illness _____ 5
 - Other reasons _____ 6
- Q36
-

35. How long did you take since you began to feel ill or felt you had some kind of health problem until you requested a medical appointment this last time?

- 1. Months _____
 - 2. Days _____
 - 3. Hours _____
 - Doesn't know/Can't remember _____
 - Doesn't answer _____
-

36. How much time passed since you requested an appointment and saw the doctor this last time?

- 1. Months _____
 - 2. Days _____
 - 3. Hours _____
 - Doesn't know/Can't remember _____
 - Doesn't answer _____
-

37. Was the doctor you saw during this last consultation from:

- The National Health Service (Social Security) _____ 1
 - A mutual society _____ 2
 - A private practice _____ 3
 - Others (doctor on a retainer fee, company doctor, etc.) _____ 4
-

38. Have you had any kind of non-urgent tests like x-rays, ecographies, analyses, etc. done in the last four weeks?

- Yes _____ 1
 - No _____ 6 → Q40
-

39. Which of the following tests have you undergone and how long did it take to do them from when you requested an appointment?

	Yes <input type="checkbox"/>	Time from appointment		Doesn't know/ Can't remember <input type="checkbox"/>	Doesn't answer <input type="checkbox"/>
		Months <input type="text"/>	Days <input type="text"/>		
1. X-rays _____ _____	No <input type="checkbox"/>				
2. CAT scan _____ _____	No <input type="checkbox"/>				
3. Ecography _____ _____	No <input type="checkbox"/>				
4. Magnetic resonance _____ _____	No <input type="checkbox"/>				
5. Analysis _____ _____	No <input type="checkbox"/>				
6. Other/s _____ _____	No <input type="checkbox"/>				

40. Have you consulted any of the following professionals in the last four weeks?

Interviewer: If the respondent is male, mark "NO" for option 3.

	Yes <input type="checkbox"/>	No. of times <input type="text"/>	Doesn't know/ Can't remember <input type="checkbox"/>	Doesn't answer <input type="checkbox"/>
1. Nurse _____ _____	No <input type="checkbox"/>			
2. Physiotherapist _____ _____	No <input type="checkbox"/>			
3. Midwife (only women) _____ _____	No <input type="checkbox"/>			

G 2. Need for medical assistance in the last 12 months

41. Have you needed medical assistance at any time in the last 12 months and not received it?

Yes _____ 1

No _____ 6 → **Module G 3**

42. What was the main reason for not receiving that assistance?

Interviewer: You should not read the response alternatives to the respondent but mark the one he/she provides without prompting, as long as it coincides with any of the alternatives included in options 1 to 9. If the response does not coincide with any of these options, mark alternative 10, "Other reason".

- 1. Could not get appointment _____ 01
- 2. Could not leave work _____ 02
- 3. Was too expensive/didn't have money _____ 03
- 4. Did not have means of transport _____ 04
- 5. Was too nervous/too frightened _____ 05
- 6. Insurance did not cover it _____ 06
- 7. Did not have insurance _____ 07
- 8. Had to wait too long _____ 08
- 9. Could not due to family obligations _____ 09
- 10. Other reason _____ 10

G 3. Health insurance

43. Could you now tell me which of the following modalities of (public and/or private) health insurance you are a holder or beneficiary of?

Interviewer: Mark two responses at most, the ones the respondent considers most important.

- 1. Social Security _____
- 2. Social Security's collaborating companies _____
- 3. State mutual insurance companies (MUFACE, ISFAS, etc.) linked to the Social Security _____
- 4. State mutual insurance companies (MUFACE, ISFAS, etc.) linked to a private health insurance _____
- 5. Private health insurance taken out individually (SANITAS, ASISA, Professional Colleges, etc.) _____
- 6. Private health insurance taken out by the company _____
- 7. Does not have health insurance, always uses private doctors _____
- 8. Other situations _____

G 4. Visits to stomatology, the dentist and dental hygienist

Interviewer, read to the respondent: *"I will now ask you some questions about your dental health."*

44. How long has it been since you went to the dentist, stomatologist or dental hygienist for a check-up, advice or treatment for dental or mouth problems?

- Three months ago or less _____ 1 → No. of times in the last three months
- More than 3 months ago and less than 12 months ago _ 2 → No. of months
- A year or more ago _____ 3 → No. of years
- Has never been _____ 4 → **Q 47**

45. Which of the following kinds of assistance did you receive the last time you went?

	Yes	No
01. Check-up _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
02. Cleaning of mouth _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
03. Fillings, root canal treatment _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
04. Tooth extraction _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
05. Crowns, bridges and other kinds of prostheses _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
06. Gum disease treatment _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
07. Orthodontics _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
08. Fluoride treatment _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
09. Other kind of assistance _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6

46. The dentist, stomatologist or dental hygienist you visited the last time was from:

The National Health Service (Social Security) _____ 1

A local authority _____ 2

A mutual society _____ 3

A private surgery _____ 4

Others (on a retainer fee, etc.) _____ 5

47. What state are your teeth in?

	Yes	No
1. Has cavities _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
2. Some teeth have been extracted _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
3. Some teeth have been filled _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
4. Gums bleed when brushed or spontaneously _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
5. Teeth move _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
6. Has crowns, bridges, other kinds of prostheses or dentures _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
7. Is missing teeth which have not been replaced by prostheses _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
8. Has or keeps all of his/her natural teeth _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6

G 5. Hospitalizations (last 12 months)

Interviewer: Read to the respondent: "The following questions are about your possible admissions to hospital."

48. Have you had to be admitted to hospital as a patient for at least a night in the last twelve months?

Yes _____ 1

No _____ 6 → **Q57**

49. How many times have you been hospitalized in the last twelve months?

No. of times

50. Concerning the last time you were admitted to hospital in the last twelve months, how many days were you in hospital?

No. of days (at least 1 day)

51. Also regarding this last admission to hospital, what was the reason for your admission?

- Surgical operation _____ 1
 - Medical diagnostic study _____ 2
 - Medical treatment without surgical operation _____ 3
 - Birth (including caesarean section) _____ 4 → **Q54**
 - Other reasons _____ 5
-

52. Were you on the waiting list for this reason?

- Yes _____ 1
 - No _____ 6 → **Q54**
-

53. How much time did you spend on the waiting list from when you were told you had to be admitted to hospital?

Interviewer: If the time spent on the waiting list was less than one month, note down "00".

- No. of months _____
 - Doesn't know/Can't remember _____
 - Doesn't answer _____
-

54. Concerning the last time you were admitted to hospital, how were you admitted?

- Through the emergency service _____ 1
 - Ordinary admission (not through emergency) _____ 2
-

55. Who incurred the costs of your hospitalization?

- National Health Service (Social Security) _____ 1
 - Obligatory mutual society (MUFACE, ISFAS, etc.) _____ 2
 - Private health insurance company _____ 3
 - Incurred by respondent or his/her household _____ 4
 - Incurred by other people, bodies or institutions _____ 5
 - Doesn't know/Can't remember _____ 8
 - Doesn't answer _____ 9
-

56. Were you given a discharge report or was it sent to your home when you were discharged from hospital?

Yes _____ 1

No _____ 6

Doesn't know/Can't remember - 8

Doesn't answer _____ 9

57. Have you been admitted to hospital for an operation, treatment or test for the day, that is to say, staying in the hospital for part of or all day without having to spend a night there during the last twelve months?

(Include admissions in bed or wheelchair. Do not include stays in emergency room or when under observation.)

Yes _____ 1

No _____ 6 → **Module G 6**

58. What was the reason for the last time you had to be admitted to hospital for the day?

A treatment _____ 1

A surgical operation _____ 2 → **Module G 6**

Other reasons _____ 3 → **Module G 6**

59. How many times have you had to go to hospital for the day to receive this treatment?

No. of times _____

Doesn't know/Can't remember

Doesn't answer _____

G 6. Emergency services (last 12 months)

Interviewer, read to the informant: *"To end this section, I am going to ask you some questions about your possible use of emergency services."*

60. Have you had to use any kind of emergency service for some problem or illness in the last twelve months?

Yes _____ 1

No _____ 6 → **Module H**

61. How many times have you had to use an emergency service in the last twelve months?

No. of times _____

Doesn't know/Can't remember

Doesn't answer _____

62. Where were you attended the last time?

	Yes	No
1. Where he/she was at the time (home, place of work, etc.) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
2. In a mobile unit _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
3. At an emergency centre or service _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6

63. The last time you used an emergency service, how much time passed between the time you began to notice you were ill or felt you had some kind of health problem and when you requested assistance?

1. Days _____

2. Hours _____

3. Minutes _____

Doesn't know/Can't remember

Doesn't answer _____

64. How much time passed from when you requested assistance to when you were attended the last time you used an emergency service?

Interviewer: If the assistance was immediate, note down "00" for hours and minutes.

1. Hours _____

2. Minutes _____

Doesn't know/Can't remember

Doesn't answer _____

65. What kind of service did you use the last time you used an emergency service in the last twelve months?

National Health Service hospital (Social Security) _____	<input type="checkbox"/> 1	→ Module H
National Health Service non-hospital emergency service (Social Security) _____	<input type="checkbox"/> 2	
National Health Service non-hospital centre (Health Centre, etc.) _____	<input type="checkbox"/> 3	
Private emergency service _____	<input type="checkbox"/> 4	
Private nursing home, hospital or clinic _____	<input type="checkbox"/> 5	
Local authority neighbourhood clinic or emergency service _____	<input type="checkbox"/> 6	
Other kind of service _____	<input type="checkbox"/> 7	

66. Why did you go to an emergency service?

Because the doctor ordered it _____ 1

Because his/her family or other people considered it necessary _____ 2

H. Lifestyle habits

Interviewer, read to the respondent: "The following questions are on lifestyle habits related to health."

H 1. Tobacco Consumption

Interviewer, read to the respondent: "To start off with, I will ask you some questions about tobacco consumption."

67. Can you tell me if you currently smoke?

- Yes, smokes daily _____ 1 → **Q68**
Smokes, but not daily _____ 2 → **Q71**
Does not currently smoke, but used to smoke _____ 3 → **Q75**
Does not smoke and has never smoked regularly _____ 4 → **Q79**

FOR PEOPLE WHO SMOKE DAILY

68. What kind of tobacco do you smoke and how much do you smoke a day on average?

1. Number of cigarettes _____
2. Number of pipes _____
3. Number of cigars _____

69. At what age did you start smoking?

Age in years _____

70. Would you say you smoke more, less than or the same as two years ago?

- More _____ 1
Less _____ 2
The same _____ 3
- **Module H 2**

FOR PEOPLE WHO SMOKE, BUT NOT DAILY

71. How often do you usually smoke?

- At least three or four times a week _____ 1
Once or twice a week _____ 2
Less frequently _____ 3

72. On days you smoke, what kind of tobacco do you smoke and how much do you smoke on average?

1. Number of cigarettes _____
2. Number of pipes _____
3. Number of cigars _____

73. At what age did you start smoking?

Age in years _____

74. Would you say you smoke more, less than or the same as two years ago?

More _____ 1
Less _____ 2
The same _____ 3

→ Q79

FOR PEOPLE WHO DO NOT CURRENTLY SMOKE, BUT USED TO SMOKE BEFORE

75. At what age did you start smoking?

Age in years _____

76. How long ago did you give up smoking?

1. Years _____
2. Months _____

77. What were the two main reasons that led you to this decision?

Interviewer: Two options at most can be marked.

- 1. A doctor advised it _____
 - 2. Did not feel good due to tobacco _____
 - 3. His/Her worries about the harmful effects of tobacco increased (health risk) _____
 - 4. Pregnancy _____
 - 5. Felt that his/her overall psychic and/or physical performance was being reduced _____
 - 6. Decided on his/her own, out of his/her volition _____
 - 7. Other reasons (specify) _____
-

78. What kind of tobacco did you smoke and how much did you smoke a day on average?

1. Number of cigarettes _____
2. Number of pipes _____
3. Number of cigars _____

79. How much time do you usually spend on average in environments filled with tobacco smoke outside your home or place of work?

Interviewer: Mark the appropriate response code for each question.

	No time	Less than 1 hour	From 1 to 4 hours	More than 4 hours
1. From Monday to Friday	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. From Friday to Sunday	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

80. Does anybody in your home smoke regularly?

Yes _____ 1 → No. of people

No _____ 6

H 2. Consumption of alcoholic drinks

81. I would now like to ask you some questions about your consumption of alcoholic drinks, in other words, any kind of drink containing alcohol independently of its alcohol content. Have you had any alcoholic drinks in the last two weeks?

Yes _____ 1 → **Q84**

No _____ 6

82. Have you had any alcoholic drinks in the last twelve months?

Yes _____ 1 → **Q84**

No _____ 6

83. Have you ever had an alcoholic drink?

Yes _____ 1

No _____ 6 → **Module H3**

84. Concerning the kinds of alcoholic drinks set out below, could you tell me how often and how many glasses do you have?

Interviewer, read to the respondent: *“I am going to hand you a sheet containing responses about how frequently you consume different kinds of alcoholic drinks. When I ask you, answer by only saying the number of the response.”* Hand over card Ad-2. Ask about each kind of drink one by one. For any responses other than “Never”, ask about the number of times and then about the number of glasses each time before moving on to the next kind of drink.

Type of drink	Daily	Weekly	Monthly	At least once a year and less than once a month	Less than once a year	Never
1. Wine or sparkling wine	<input type="checkbox"/> 1 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 2 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 3 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 4 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 5 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 6
2. Beer with alcohol	<input type="checkbox"/> 1 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 2 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 3 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 4 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 5 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 6
3. Aperitifs with alcohol	<input type="checkbox"/> 1 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 2 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 3 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 4 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 5 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 6
4. Cider	<input type="checkbox"/> 1 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 2 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 3 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 4 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 5 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 6
5. Cocktails, brandy or liquors	<input type="checkbox"/> 1 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 2 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 3 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 4 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 5 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 6
6. Whisky	<input type="checkbox"/> 1 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 2 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 3 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 4 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 5 No. of times _____ No. of glasses each time _____	<input type="checkbox"/> 6

85. As regards each of these drinks, do you usually consume them only at the weekend (including Friday afternoons), only during the week or at both times indistinctly?

Interviewer: Directly mark column 0 "Doesn't consume" for any drinks that the interviewer responded that he/she did not consume in the previous question.

	Doesn't consume	Weekends (from Friday afternoons)	During the week (does not include Friday afternoons)	Both indistinctly
1. Wine or sparkling wine _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Beer with alcohol _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Aperitifs with alcohol _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Cider _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Cocktails, brandy or liquors _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Whisky _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

86. At what age did you start drinking alcoholic drinks regularly?

Interviewer: Does not refer to when the respondent took a sip or tried a specific drink, but when he/she started to drink on his/her own.

Age in years _____

H 3. Rest and physical exercise

Interviewer, read to the respondent: "Now I am going to ask you some questions about your rest and physical exercise habits."

87. Could you tell me approximately how many hours you usually sleep a day? Include afternoon nap hours.

No. of hours a day _____

88. Do the hours you sleep allow you to get enough rest?

Yes _____ 1

No _____ 6

89. How many times in the last four weeks...

	Never	A day	Several days	Most days	All days
1. have you had difficulties in falling asleep? _____	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
2. have you woken up several times while sleeping? _____	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
3. have you woken up too early? _____	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

90. Which of the following possibilities best describes your main activity at your place of work, education centre, home (household chores), etc.?

Seated most of the day _____ 1

Standing up most of the day, without moving around a lot or making a great deal of effort _____ 2

Walking, carrying a bit of weight, moving around frequently _____ 3

Doing tasks requiring a great deal of physical effort _____ 4

91. Do you normally do all the physical exercise you would like to do in your free time?

Yes _____ 1 → **Q93**
No _____ 6

92. Why not?

Because my health problems prevent me from doing so _____ 1
Because I prefer to do other kinds of leisure activities (go to the cinema, read a book, watch TV, etc.) _____ 2
Because I haven't got a place to do the physical activities I would like to do _____ 3
Due to lack of time _____ 4
Due to a lack of will power _____ 5
Other reasons _____ 6

93. Do you regularly do any physical activity like walking, doing sport or going to the gym in your free time?

Yes _____ 1
No, I don't normally do physical exercise _____ 6 → **Module H 4**

94. Could you tell me how often you have done the activities set out below for over 20 minutes in the last two weeks?

	No. of times
1. A light physical activity like walking, gardening, easy gym activities, games that require little effort or similar activities _____	_ _
2. A moderate physical activity like riding a bicycle, gymnastics, aerobics, running or swimming _____	_ _
3. An intense physical activity like football, basketball, competitive cycling or swimming, judo karate or similar activities _____	_ _

H 4. Diet

Interviewer: Read to the respondent: *"To end with lifestyle habits, I am going to ask you some questions about your diet."*

95. What do you usually have for breakfast?

	Yes	No
1. Coffee, milk, tea, chocolate, cocoa, yoghurt _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
2. Bread, toast, biscuits, cereals, pastries, etc. _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
3. Fruit and/or fruit juice _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
4. Food like eggs, cheese, ham, etc. _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
5. Other kinds of food _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6
6. Nothing, doesn't usually have breakfast _____	<input type="checkbox"/> 1	<input type="checkbox"/> 6

96. How frequently do you consume the following kinds of food?

Interviewer: Show the respondent card Ad-3 and mark the frequency with which each of the foodstuffs listed is consumed.

	Daily	Three or more times a week, but not daily	Once or twice a week	Less than once a week	Never or hardly ever
01. Fresh fruit _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
02. Meat (chicken, veal, pork, lamb, beef etc.) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
03. Eggs _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
04. Fish _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
05. Pasta, rice, potatoes, etc. _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
06. Bread, cereals, etc. _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
07. Vegetables and garden produce _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
08. Beans _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
09. Cold meats and cold cuts _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. Dairy products (milk, cheese, yoghurt, etc.) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11. Sweets (biscuits, pastries, marmalades, etc.) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
12. Soft drinks with sugar _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

97. Are you currently on a special diet?

Yes _____ 1

No _____ 6 → **Module I**

98. What is the main reason for being on this special diet?

To lose weight _____ 1

To maintain current weight _____ 2

To live in a healthier manner _____ 3

Due to an illness or health problem _____ 4

Due to another reason _____ 5

I. Preventive practices

Interviewer, read to the respondent: *"I will now ask you some questions about the different kinds of preventive practices you do."*

I 1. General preventive practices

99. Have you had an anti-flu vaccination in the last campaign?

Yes _____ 1

No _____ 6 → **Q101**

100. Who directed you to get vaccinated?

- A healthcare professional, due to age _____ 1
 - A healthcare professional, due to illnesses ___ 2
 - A healthcare professional, due to other reasons _____ 3
 - Is vaccinated at work / educational centre ___ 4
 - Requested a vaccination because prefers to be vaccinated ___ 5
 - Others _____ 6
-

101. Now I would like to ask you about your blood pressure. Have you ever had your blood pressure taken by a healthcare professional, excluding pharmacies?

- Yes _____ 1
 - No _____ 6
 - Doesn't know/Can't remember _____ 8
 - Doesn't answer _____ 9
- } → **Q103**
-

102. When was the last time you had your blood pressure taken?

- Less than 3 months ago _____ 1
 - Between 3 and 5 months ago _____ 2
 - Between 6 months and 1 year ago _____ 3
 - Between 1 and 3 years ago _____ 4
 - More than 3 years ago _____ 5
 - Doesn't know/Can't remember _____ 8
 - Doesn't answer _____ 9
-

103. The following questions refer to cholesterol levels. Have you ever had your cholesterol levels measured due to a medical indication, excluding in pharmacies?

- Yes _____ 1
 - No _____ 6
 - Doesn't know/Can't remember _____ 8
 - Doesn't answer _____ 9
- } → **Module 1 2**
-

104. When was the last time your cholesterol levels were measured?

- Less than 3 months ago _____ 1
 - Between 3 and 5 months ago _____ 2
 - Between 6 months and 1 year ago _____ 3
 - Between 1 year and 3 years ago _____ 4
 - More than 3 years ago _____ 5
 - Doesn't know/Can't remember _____ 8
 - Doesn't answer _____ 9
-

I 2. Dental hygiene

105. Now I am going to ask you about your dental hygiene. How often do you usually brush your teeth?

Interviewer: Mark the responses given by the respondent without prompting.

- More than three times a day _____ 01
Three times a day _____ 02
In the morning and at night _____ 03
In the morning and after lunch _____ 04
After lunch and at night _____ 05
Once a day in the morning _____ 06
Once a day after lunch _____ 07
Once a day at night _____ 08
Occasionally, not every day _____ 09
Never _____ 10
Other _____ 11
-

I 3. Female preventive practices

Interviewer: Is the person selected female?

Yes _____ 1

No _____ 6

Module I 4

106. Have you ever had a gynaecology consultation?

Yes _____ 1

No _____ 6 → **Q109**

107. When was the last gynaecology visit you had for any reason other than reasons having to do with pregnancy or giving birth?

Less than 6 months ago _____ 1

Between 6 months and 1 year ago _____ 2

Between 1 year and 3 years ago _____ 3

More than 3 years ago _____ 4

Has never gone for reasons other than pregnancy or giving birth _____ 5 → **Q109**

Doesn't know/Can't remember _____ 8

Doesn't answer _____ 9

108. Could you tell me the reason for your last visit (not related to pregnancy or giving birth)?

A gynaecological problem (illness, discomfort, etc.) _____ 1

Orientation / family planning _____ 2

Regular check-up _____ 3

Other reasons _____ 4

109. Have you ever had a mammography (breast x-ray)?

- Yes _____ 1
No _____ 6
Doesn't know/Can't remember _____ 8 → **Q114**
Doesn't answer _____ 9
-

110. In what year was your first mammography done?

- Year (2000, 2004, etc.) →
Doesn't know/Can't remember _____
Doesn't answer _____
-

111. When was the last mammography done?

- Year (2000, 2004, etc.) →
Doesn't know/Can't remember _____
Doesn't answer _____
-

112. Which of the following were the main reasons for having this last mammography done?

Interviewer: Mark two responses at most (the ones the respondent considers most important).

1. Because you noticed you had some kind of breast problem _____
 2. Because your general practitioner noticed you had some kind of breast problem during an examination _____
 3. Because your general practitioner suggested it without you having any problem _____
 4. Because your gynaecologist suggested it without you having any problem _____
 5. Because your gynaecologist noticed you had some kind of breast problem during an examination _____
 6. Because other women in your family have had or have breast cancer _____
 7. Because your regional or local authority made an appointment for you for a breast cancer screening programme _____
 8. Due to another reason _____
-

113. How frequently have you had other mammographies done after the first time?

- At least once a year _____ 1
Every 2 years _____ 2
Every 3 years _____ 3
Approximately once every 5 years _____ 4
Once every more than 5 years _____ 5
Never _____ 6
-

114. Have you ever had a vaginal cytology (cell sample) done?

Yes _____ 1
No _____ 6 → **Module I4**

115. In what year was your last vaginal cytology done?

Year (2000, 2004, etc.) →
Doesn't know/Can't remember ___
Doesn't answer _____

116. What was the reason for having this last vaginal cytology done?

Because you suffered discomfort _____ 1
Because it was recommended by the general practitioner's surgery _____ 2
Because you went to the gynaecology surgery _____ 3
Because your regional or local authority made an appointment for you for a cancer screening programme _____ 4
Due to another medical reason _____ 5
Due to any other kind of reasons (non-medical) _____ 6

117. How frequently have you had other cytologies done after the first time?

At least once a year _____ 1
Every 2 years _____ 2
Every 3 years _____ 3
Approximately once every 5 years _____ 4
Once every more than 5 years _____ 5
Never _____ 6

I 4. Road safety preventive practices

Interviewer, read to the respondent: *"The following questions are about the measures you take to prevent injuries caused by traffic accidents."*

118. Do you usually fasten your seat belt when you drive ...

	Always	Almost always	Hardly ever	Never	Never drives
1. ... in the city?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. ... on highways?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

119. Do you usually fasten your seat belt when you ride a car as a passenger...

	Always	Almost always	Hardly ever	Never	Is never a passenger
1. ... in the city?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. ... on highways?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

120. Do you usually put on a helmet when you ride a motorbike...

	Always	Almost always	Hardly ever	Never	Not applicable
1. ... in the city?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. ... on highways?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

121. Do you usually put on a helmet when you ride a bicycle...

	Always	Almost always	Hardly ever	Never	Not applicable
1. ... in the city?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. ... on highways?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

J. Aggressions

To be filled in by the interviewer: Due to the sensitive subject matter of the following items, you should request the permission of the adult selected to ask them.

Is the respondent being accompanied at the moment of answering these questions?

Yes _____ 1 No _____ 6

122. Would you be willing to answer some questions about whether you have suffered any kind of aggression or abuse?

Yes _____ 1

No _____ 6 → **Module K**

Interviewer: Hand over card Ad-4 on aggressions and abuse. If the respondent does not know how to read, ask: "May I read you the questions out aloud?"

Yes _____ 1 No _____ 6 → **Module K**

123. Have you suffered any kind of aggression or abuse over the last year?

Yes _____ 1

No _____ 6 → **Module K**

124. As regards the aggression or abuse you have suffered (if you have suffered several over the last 12 months refer to the last), where did it take place?

- In a place of leisure _____ 1
 - At work or in an educational centre _____ 2
 - In the street _____ 3
 - At home _____ 4
 - In the building where I live _____ 5
 - In a sports facility _____ 6
 - Other places _____ 7
-

125. Who was/were the person/people who have attacked or abused you?

Interviewer: Mark all the responses indicated by the respondent.

- 1. A stranger (male) _____
 - 2. A stranger (female) _____
 - 3. His/her partner _____
 - 4. A woman he/she knows (other than his/her partner) _
 - 5. A man he/she knows (other than his/her partner) ____
-

K. Discrimination

Interviewer, read to the respondent: *"I would like to ask you some questions about discrimination."*

126. Have you experienced discrimination, been prevented from doing something, bothered or made to feel inferior due to your sex, ethnic origin, country of origin, level of studies, social class, sexual preferences or religion over the last year?

- Yes _____ 1
 - No _____ 6 → **Module L**
-

127. For each of the following situations, indicate if you have felt you were being discriminated against, the reasons and the frequency.

Interviewer, tell the respondent: "Now I will hand you a sheet with the responses to some questions about the frequency with which you may have suffered discrimination. When I ask you, answer by only saying the number of the response." Hand over card Ad-5. Ask about each situation one by one and, in the event of a positive response, ask the respondent about the frequency of that kind of discrimination for each kind of cause.

Have you felt discriminated against in any of the following situations?

Due to which of the following causes did you feel discriminated against?

		A. Due to sex?	B. Due to ethnicity or country of origin	C. Due to level of studies or social class?	D. Due to sexual preferences?	E. Due to religion?
1. Looking for work	Yes <input type="checkbox"/> 1 →	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1
	No <input type="checkbox"/> 6 ↓	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2
2. At work	Yes <input type="checkbox"/> 1 →	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3
	No <input type="checkbox"/> 6 ↓	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4
3. At home (by your partner)	Yes <input type="checkbox"/> 1 →	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1
	No <input type="checkbox"/> 6 ↓	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2
4. At home (by someone other than your partner)	Yes <input type="checkbox"/> 1 →	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3
	No <input type="checkbox"/> 6 ↓	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4
5. When receiving healthcare	Yes <input type="checkbox"/> 1 →	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1	Never <input type="checkbox"/> 1
	No <input type="checkbox"/> 6 ↓	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2	Sometimes <input type="checkbox"/> 2
6. In a public place (including the street)	Yes <input type="checkbox"/> 1 →	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3	Many times <input type="checkbox"/> 3
	No <input type="checkbox"/> 6 ↓	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4	Constantly <input type="checkbox"/> 4

L. Physical and sensory characteristics

Interviewer, read to the respondent: *"The following questions refer to your physical and sensory characteristics."*

L 1. Physical characteristics

Interviewer: If the subject of the interview is a pregnant woman, she should indicate how much she weighed before the pregnancy started.

128. Could you tell me approximately how much you weigh without clothing or shoes?

Weight in Kg →

Doesn't know/Can't remember _

Doesn't answer _____

129. And how tall are you without shoes?

Height in cm. →

Doesn't know/Can't remember _

Doesn't answer _____

130. In relation to your height, would you say your weight is:

Quite a bit more than normal _____ 1

Somewhat more than normal _____ 2

Normal _____ 3

Less than normal _____ 4

L 2 Hearing and visual characteristics

131. Can you hear a television programme at a volume others consider normal? *(If the respondent uses a hearing aid, consider that the question refers to any situations in which he/she is wearing the hearing aid.)*

Yes _____ 1 → **Q133**

No _____ 6

132. Can you hear it if the volume is turned up?

Yes _____ 1

No _____ 6

133. Can you see well enough to recognize a person at a distance of four metres or across the street? *(If the respondent wears glasses or contact lenses, consider that the question refers to situations in which he/she is using glasses or contact lenses.)*

Yes _____ 1 → **Module M**

No _____ 6

134. Could you recognize them at a distance of one metre?

Yes _____ 1
 No _____ 6

M. Emotional support and the family's role

Interviewer, read to the respondent: "Lastly, I am going to ask you a few questions about the emotional support you receive and about your opinion on the family's role."

135. Interviewer, tell the respondent: "I will hand you a sheet containing different situations of emotional and personal support that tend to occur in daily life. There are a series of responses beside each situation. Please read each situation and tell me one by one the number of the response that best reflects the situation." Hand over card Ad-6 and then say: "Tell me the number of your response for situation 1 please". Then mark the number and proceed in the same way until you have finished with all the situations.

	Much less than I would wish	Less than I would wish	Neither much nor little	Almost as much as I would wish	As much as I would wish
1. My friends and family visit me _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. I receive help in matters having to do with my house	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. I receive praise and recognition when I do my work well _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. I can count on people who are worried about what happens to me _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. I receive love and affection _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
6. I have the possibility of talking to someone about my problems at work or at home _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
7. I have the possibility of talking to someone about my personal and family problems _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. I have the possibility of talking to someone about my economic problems _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9.- I receive invitations to enjoy myself and go out with other people _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. I receive useful advice whenever something important happens in my life _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11. I receive help when I'm ill in bed _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

136. I will now read you a series of questions about your family situation, in other words, about your relationships with the members of your family with whom you are in closer contact.

Please tell me the response that best fits in with your personal situation and think of the same people to respond to all the questions (Read the response alternatives).

	Hardly ever	Sometimes	Almost always
1. Are you satisfied with the support you receive from your family when you have a problem?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
2. Do you talk among yourselves about the problems you have at home? _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
3. Are important decisions at home taken jointly? _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
4. Are you satisfied with the time you spend together with your family? _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
5. Do you feel that your family loves you? _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2

N. Limitations to performing every day activities

137. For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do?

- Severely limited _____ 1
Limited, but not severely _____ 2
Not limited at all _____ 3 → **Q139**
-

138. What kind of problem is the cause that limited you from doing the activities people usually do?

- Physical _____ 1
Mental _____ 2
Both _____ 3
-

139. Interviewer: Is the subject selected 65 years old or more?

- Yes _____ 1 No _____ 6 → **Q141**

140. Interviewer, read to the respondent: *“I am going to ask you some questions about everyday activities of any person’s daily life (preparing breakfast, cooking food, doing the washing up, etc.). I am not going to ask you whether you know how to do them, but rather if you are able to do them without the help of another person, with the help of another person, or if you cannot do them at all in your current situation.”*

	I can do it without help	I can do it with help	I cannot do it at all
1. Use the telephone (look for a number and dial) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Buy food, clothing, etc. _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Catch the bus, underground, taxi, etc. _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Prepare your own breakfast _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Cook your own food _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Take medicines (remembering the dosage and the time they should be taken) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Administer your own money (paying bills, dealing with the bank, signing cheques, etc.) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. Cut a slice of bread _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. Wash the dishes _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
10. Make the bed _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
11. Change the bed linen _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
12. Wash delicate clothes by hand _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
13. Use the washing machine _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
14. Clean the house (mopping the floor, sweeping, etc.) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
15. Clean a floor stain crouching down _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
16. Eat (cutting food and/or taking it to your mouth) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
17. Dress and undress, and choose what clothing to wear	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
18. Comb yourself, shave, etc. _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
19. Walk (without or without a walking stick) _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
20. Get out of and get into bed _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
21. Cut your toenails _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
22. Sew a button _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
23. Wash your face and body from the waist up	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
24. Take a shower or bath _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
25. Walk up ten steps _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
26. Walk non-stop for an hour _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
27. Remain alone all night _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

141. Time survey ended

_ _	_ _
Hour	Minutes

Interviewer: Proceed to fill in the children questionnaire if there are any child living in the household.

