

This form has questions about your current experiences. Please answer the questions as honestly as you can, using your first thoughts about each question. You should not go back later to "figure out" answers. Please answer the questions on both sides. Your answers will be kept confidential and will never be put with your name in a published report, but they will help us to understand the health of women like you. Thank you for your help.

1. In general, would you say your health is (Mark one box only.)
Excellent Very good Good Fair Poor
[]1 []2 []3 []4 []5

2. Overall, how would you rate your quality of life? (Mark one box below.)

0 1 2 3 4 5 6 7 8 9 10
[] [] [] [] [] [] [] [] [] [] []
Worst Halfway Best

As bad or worse than being dead

Best quality of life

3. Does the place where you live have special services for older people (such as help with meals, medicines, bathing, or transportation)?

[]0 No []1 Yes ->

3.1. Are you currently receiving any of these services?
[]0 No []1 Yes

4. In the past year, have you stayed in a nursing home?

[]0 No []1 Yes

Go to next page. ->

Public reporting for this collection of information is estimated to average 6 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the information needed and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0414). Do not return the completed form to this address.

OFFICE USE ONLY
1. Date Received: [][][][][][]
Month Day Year
2. Reviewed By: [][][][][][]
3. Contact Type:
[] Phone [] Mail [] Other
4. Language:
[] E [] S
[] FCA [] OU1 [] OU2
46999
PLEASE MAKE NO MARKS IN THIS AREA

5. What aid, if any, do you usually use to walk on a level surface? (Mark one.)
- | | | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| I do not
use any aid | I use a
cane | I use
crutches | I use a
walker | I use a
wheelchair |
| <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₄ | <input type="checkbox"/> ₅ |
6. Are you taking a calcium supplement such as Oscal, Viactiv, or Tums?
- ₀ No ₁ Yes

The following are questions about a typical (or usual) day's activities. Does your health now limit you in these activities and, if so, how much? (Mark one box for each question.)

- | | No,
not limited
at all | Yes,
limited
a little | Yes,
limited
a lot |
|---|---------------------------------------|---------------------------------------|---------------------------------------|
| 7. Vigorous activities, such as running, lifting heavy objects, or strenuous sports | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |
| 8. Moderate activities, such as moving a table, vacuuming, bowling, or golfing | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |
| 9. Lifting or carrying groceries | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |
| 10. Climbing several flights of stairs | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |
| 11. Climbing one flight of stairs | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |
| 12. Bending, kneeling, stooping | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |
| 13. Walking more than a mile | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |
| 14. Walking several blocks | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |
| 15. Walking one block | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |
| 16. Bathing or dressing yourself | <input type="checkbox"/> ₃ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₁ |

These next questions ask about how much help (if any) you need to do routine activities for yourself. Help can be defined as getting assistance from another person or using a device. (Mark one box for each question)

- | | I can do this activity: | | |
|--|---------------------------------------|---------------------------------------|--|
| | By
myself | With some
help | Completely
unable to do
this by myself |
| 17. Can you feed yourself? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 18. Can you dress and undress yourself? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 19. Can you get in and out of bed yourself? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 20. Can you take a bath or shower? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 21. Can you do your own grocery shopping? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |
| 22. Can you keep track of and take your medicines? | <input type="checkbox"/> ₁ | <input type="checkbox"/> ₂ | <input type="checkbox"/> ₃ |

FORM: 151 – ACTIVITIES OF DAILY LIFE

Version: 9 – March 30, 2007

Description: 1-page, 2-sided form; scanned at CCC.

When used: Mailed annually to Extension Study participants; mailed routinely with the *Form 33 – Medical History Update*.

Purpose: To record information about the impact of disease events on daily functioning and quality of life in aging participants. There is no expectation that the FCs follow-up on information that a participant marks on this form.

GENERAL INSTRUCTIONS

The form is printed in both English (*Form 151*) and Spanish (*Form 151s*) and both are in mark-sense format. For both forms, follow the instructions on the front of the form for marking the answers.

The CCC places the participant barcode label on the front page of the form and mails it with the annual *Form 33 – Medical History Update* and one-time *Form 134 – Addendum to the Medical History Update* to HT participants two months before the randomization anniversary month.

Participants are asked to mail the completed form back to the CCC together with the *Form 33 – Medical History Update* and the *Form 134 – Addendum to the Medical History Update* in the return envelope provided.

Data entry at the CCC. Review the form for comments and mark the FCA box in the Office Use Only box as needed. Scan the form.

Item Instructions

Date received	Date received at FC or date completed by phone interview. Located in <i>Official Use Only</i> on page 1. When the CCC mails the form to and receives it back from the participant, this item is left blank and instead the scan date is inserted into WHIX.
Reviewed by	5-digit WHI Extension study employee ID. For forms scanned at the CCC, this item is left blank and instead WHIX inserts the ID of the CCC staff person scanning the form.
Contact type	Mark appropriate box. For forms scanned at the CCC, this item is left blank, and WHIX inserts "2 – Mail" into WHIX.
Visit type	Mark appropriate box. For forms scanned at the CCC, this item is left blank, and WHIX inserts "3 – Annual" into WHIX.
Language	Indication of English (E) or Spanish (S) version of the form. The response to this item is printed on the form.
Field Center Alert (FCA) bubble	Used by CCC to alert the FC that a form has participant comments and the image should be reviewed.
OU1 bubble	Reserved for future use.
OU2 bubble	Reserved for future use.

1. In general, how is your health? Mark one box
2. Overall, rate your quality of life Mark one box, 0 (worse than being dead) to 10 (best quality of life)
3. Does your place have special services for older people? No/Yes
- 3.1 Currently receiving any of these services? No/Yes
4. Stayed in nursing home in past year? No/Yes
5. Do you use aids to walk on level surface? Mark one box (1 – 5)
6. Taking a calcium supplement such as Oscal, Viactiv, or Tums? No/Yes
7. Does your health limit moderate activities? Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
8. Does your health limit lifting or carrying groceries? Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)

9. Does your health limit climbing flights of stairs? Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
10. Does your health limit climbing one flight of stairs? Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
11. Does your health limit bending, kneeling, stooping? Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
12. Does your health limit walking more than a mile? Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
13. Does your health limit walking several blocks? Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
14. Does your health limit walking one block? Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
15. Does your health limit bathing or dressing? Mark one box: No (not limited)/Yes (limited a little)/Yes (limited a lot)
16. Can you feed yourself? Mark one box: By myself/With some help/Completely unable to do by myself
17. Can you dress and undress yourself? Mark one box: By myself/With some help/Completely unable to do by myself
18. Can you get in/out of bed by yourself? Mark one box: By myself/With some help/Completely unable to do by myself
19. Can you bathe or shower by yourself? Mark one box: By myself/With some help/Completely unable to do by myself
20. Can you do your own grocery shopping? Mark one box: By myself/With some help/Completely unable to do by myself
21. Can you keep track and take your medication? Mark one box: By myself/With some help/Completely unable to do by myself

6. ¿Está tomando un suplemento de calcio como Oscal, Viactive o Tums?

- No Sí

A continuación, se incluyen preguntas acerca de las actividades de un día típico (o habitual). ¿Su salud lo limita en estas actividades en la actualidad? En caso afirmativo, ¿en qué medida? (Marque una sola círculo para cada pregunta).

	No, no me limita para nada	Sí, me limita un poco	Sí, me limita mucho
7. Actividades intensas, como correr, levantar objetos pesados o hacer deportes que demanden mucho esfuerzo	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
8. Actividades moderadas, como mover una mesa, pasar la aspiradora o jugar a los bolos o al golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Levantar objetos o cargar las compras	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Subir varios pisos por escalera	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Subir un piso por escalera	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Inclinarsse, arrodillarse, agacharse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Caminar más de una milla	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Caminar varias cuadras	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Caminar una cuadra	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Bañarse o vestirse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Las siguientes preguntas hacen referencia a cuánta ayuda necesita (si la necesita) para hacer las actividades de rutina por sí sola. El término "ayuda" puede definirse como obtener asistencia de otra persona o usar un dispositivo. (Marque una sola círculo para cada pregunta).

Puedo hacer esta actividad:	Por mí misma sin ayuda	Con algo de ayuda	Soy completamente incapaz de hacer esta actividad sola
17. ¿Puede alimentarse sola?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. ¿Puede vestirse o desvestirse sola?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. ¿Puede acostarse y levantarse de la cama sola?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
20. ¿Puede bañarse o ducharse?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. ¿Puede hacer las compras?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
22. ¿Puede llevar un registro de sus medicamentos y tomarlos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>