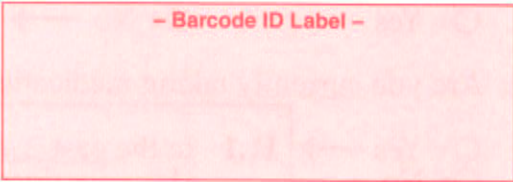




# Form 159 - Supplemental Questionnaire 2018

Ver. 1

This questionnaire has questions about your experiences. Please answer each question as honestly as you can. No one will see your answers except for the scientists and staff at WHI. (Use a pencil or blue or black pen only.)



1. Over the past year, my physical activity level has:

- 1 Increased a lot
- 2 Increased somewhat
- 3 Not changed; remained about the same
- 4 Decreased somewhat
- 5 Decreased a lot

These questions are about your sleep habits. Please mark one of the answers for each of the following questions. Choose the answer that best describes how often you experienced the situation in the past 4 weeks.

2. Did you have trouble falling asleep?

No, not in past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 times a week	Yes, 5 or more times a week
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- 1
- 2
- 3
- 4
- 5

3. Did you wake up several times at night?

- 1
- 2
- 3
- 4
- 5

4. Did you wake up earlier than you planned to?

- 1
- 2
- 3
- 4
- 5

5. Did you have trouble getting back to sleep after you woke up too early?

- 1
- 2
- 3
- 4
- 5

6. Overall, was your typical night's sleep during the past 4 weeks:

Very sound or restful	Sound or restful	Average quality	Restless	Very restless
<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1

7. Over the past 2 weeks, how many times did you have **swelling** in your feet, ankles or legs when you woke up in the morning?

- 1 Every morning
- 2 3 or more times a week, but not every day
- 3 1-2 times a week
- 4 Less than once a week
- 5 Never over the past 2 weeks

8. Over the past 2 weeks, on average, how many times has **fatigue** limited your ability to do what you want?

- 1 Several times per day
- 2 At least once a day
- 3 3 or more times a week, but not every day
- 4 1-2 times a week
- 5 Less than once a week
- 6 Never over the past 2 weeks

9. Over the past 2 weeks, on average, how many times has **shortness of breath** limited your ability to do what you wanted?

- 1 All of the time
- 2 Several times per day
- 3 At least once a day
- 4 3 or more times a week, but not every day
- 5 1-2 times a week
- 6 Less than once a week
- 7 Never over the past 2 weeks

PLEASE MAKE NO MARKS IN THIS AREA



001501

10. Have you ever taken medication for blood pressure?  
 Yes  No → Go to Question 12.

11. Are you currently taking medication for blood pressure?

Yes →  
 No

	No	Yes
11.1 In the past 2 years:		
Has your dose increased?	<input type="radio"/>	<input type="radio"/>
Has your dose decreased?	<input type="radio"/>	<input type="radio"/>
Have you started a new medication for blood pressure?	<input type="radio"/>	<input type="radio"/>
Was your medication for blood pressure stopped?	<input type="radio"/>	<input type="radio"/>

12. Have you ever taken medication for cholesterol?  
 Yes  No → Go to Question 14.

13. Are you currently taking medication for cholesterol?

Yes →  
 No

	No	Yes
13.1 In the past 2 years:		
Has your dose increased?	<input type="radio"/>	<input type="radio"/>
Has your dose decreased?	<input type="radio"/>	<input type="radio"/>
Have you started a new medication for cholesterol?	<input type="radio"/>	<input type="radio"/>
Was your medication for cholesterol stopped?	<input type="radio"/>	<input type="radio"/>

14. What is your current weight?    pounds

14.1 Have you lost more than 10 pounds in the past 2 years?

No  Yes →

Were you trying to lose weight?	<input type="radio"/> No	<input type="radio"/> Yes
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14.2 Have you gained more than 10 pounds in the past 2 years?

No  Yes →

Were you trying to gain weight?	<input type="radio"/> No	<input type="radio"/> Yes
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15. When was the last time you saw an eye doctor?

Less than  
12 months ago

12-24  
months ago

More than  
24 months ago

I do not see  
an eye doctor

16. Have you ever been told by an eye doctor that you have age-related macular degeneration?

Yes →  
 No

16.1 How old were you when you were diagnosed with macular degeneration?

Age in years

17. Please think about your current level of well-being. When you think about well-being, think about your physical health, your emotional health, any challenges you are experiencing, the people in your life, and the opportunities or resources you have available to you. How would you describe your current level of well-being?

Excellent  Very good  Good  Fair  Poor  Very poor

Thank you for taking the time to complete this questionnaire.