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

WAVE 2 PRE-INTERVIEW QUESTIONNAIRE: CONFIDENTIAL

IDS-TILDA ID Number: W 2

Gender: Male 1 Female 2

Interview Date: D D / M M / Y Y

Interviewer ID Number: I D S
IDS-TILDA

Working to Make Ireland the Best Place to Grow Old

IDS-TILDA would like to convey to the reader that no part of this protocol may be replicated reproduced or copied in any form without the explicit permission of the principle investigator of IDS-TILDA ©
INSTRUCTIONS

This questionnaire is part of WAVE 2 of The Intellectual Disability Supplement to TILDA. Thank you for taking part in this study. Your answers are very important to us to help ensure the needs of people with an intellectual disability are met as they grow older.

WHAT TO DO IF YOU NEED HELP.

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

HOW TO FILL IN THE QUESTIONNAIRE.

Please answer the questions by:

Ticking a box like this

Or writing a number in a box like this

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

YES

NO IF ‘NO’ GO TO QUESTION

HOW TO RETURN THIS QUESTIONNAIRE

Please give the questionnaire to the interviewer on the day of your interview. If you have any questions about the questionnaire, please call us at 01 8963186 or 01 8963187.
THE FOLLOWING QUESTIONS WILL UPDATE OUR RECORDS SINCE YOUR LAST INTERVIEW.

What is your date of birth? [ ] [ ] [ ] [ ] [ ]

Are you ...?

PLEASE TICK ONE BOX

- Single [ ]
- Living with a partner as if married [ ]
- With a partner but not living with him/her [ ]
- Married [ ]
- Separated [ ]
- Divorced [ ]
- Widowed [ ]
- Don’t know [ ]

Have you moved home/residence since your last interview?

PLEASE TICK ONE BOX

- YES [ ]
- NO [ ]

If you have moved do you currently pay rent for your home/residence?

PLEASE TICK ONE BOX

- YES [ ]
- NO [ ]
- Don’t Know [ ]

PLEASE TELL US ANY OTHER INFORMATION
If you live in rented accommodation which of the following best describes your rental situation?

PLEASE TICK ONE THAT APPLIES

Type of Rental Situation

Social Housing e.g. County council or Housing association [1]

Private Landlord [2]

Rented from my Service Provider [3]

None of the above [4]

If none of the above, Please tell us your rental situation:

Please tell us if it is adapted or not adapted to meet your needs

Adapted [1]

Not Adapted [2]

Don’t Know [98]

Do you have an individual tenancy agreement?

PLEASE TICK ONE BOX

YES [1]

NO [5]

Don’t Know [98]
WE WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR HEALTH TO SEE IF THERE HAVE BEEN ANY CHANGES SINCE YOUR LAST INTERVIEW.

**EYE HEALTH**

1. Has the doctor ever told you that you have age related macular degeneration?

**PLEASE TICK ONE BOX**

- YES
- NO
- Don’t Know

2. Has a doctor ever told you that you have glaucoma?

**PLEASE TICK ONE BOX**

- YES
- NO
- Don’t Know

3. Has a doctor ever told you that you have cataracts?

**PLEASE TICK ONE BOX**

- YES
- NO
- Don’t Know
4. Have you had cataract surgery?

<table>
<thead>
<tr>
<th>PLEASE TICK ONE BOX</th>
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</thead>
<tbody>
<tr>
<td>YES, in one eye</td>
</tr>
<tr>
<td>YES, in both eyes</td>
</tr>
<tr>
<td>NO</td>
</tr>
<tr>
<td>Don’t Know</td>
</tr>
</tbody>
</table>

5. Has a doctor ever told you that you have any other eye diseases?

<table>
<thead>
<tr>
<th>PLEASE TICK ONE BOX</th>
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</thead>
<tbody>
<tr>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
</tr>
<tr>
<td>Don’t Know</td>
</tr>
</tbody>
</table>

6. Please tell us what other eye diseases the doctor has told you that you have?

- [ ]

**HEART HEALTH**

7. Has the doctor ever told you that you have any of these conditions?

**TICK ALL THAT APPLY**

- High cholesterol □  GO TO QUESTION 8
- A heart murmur □  GO TO QUESTION 9
- An abnormal heart rhythm □  GO TO QUESTION 9
- None of these □  GO TO QUESTION 9
- Don’t know □  GO TO QUESTION 9
8. Are you taking any tablets or pills for high cholesterol?

PLEASE TICK ONE BOX
YES [ ]
NO [ ]
Don’t Know [ ]

9. Has a doctor ever told you that you have high blood pressure or hypertension?

PLEASE TICK ONE BOX
YES [ ] GO TO QUESTION 10
NO [ ] GO TO QUESTION 11
Don’t Know [ ] GO TO QUESTION 11

10. About how old were you when you were first told by the doctor that you had high blood pressure?

I was [ ] years old.

Don’t know [ ]

11. Has a doctor ever told you that you have angina?

PLEASE TICK ONE BOX
YES [ ] GO TO QUESTION 12
NO [ ] GO TO QUESTION 14
Don’t Know [ ] GO TO QUESTION 14

12. About how old were you when you were first told by a doctor that you had angina?

I was [ ] years old.

Don’t Know [ ]
13. Do you limit your usual activities because of your angina?

PLEASE TICK ONE BOX
YES [ ]
NO [ ]
Don’t Know [ ]

14. Has the doctor ever told you that you have had a heart attack (including myocardial infarction [MI] or coronary thrombosis)?

PLEASE TICK ONE BOX
YES [ ] GO TO QUESTION 15
NO [ ] GO TO QUESTION 18
Don’t Know [ ] GO TO QUESTION 18

15. About how old were you when you were first told by a doctor that you had a heart attack (including myocardial infarction [MI] or coronary thrombosis)?

I was [ ] years old.
Don’t know [ ]

16. In what month and year was your most recent heart attack?

(For example.......... 0 9 / 2 0 1 1)

[ ] / [ ]

Don’t know [ ]

17. About how many heart attacks has the doctor said you have had?

I have had [ ] heart attacks
Don’t Know [ ]
18. Have you ever had an angioplasty or stent?

PLEASE TICK ONE BOX
YES ☐  GO TO QUESTION  19
NO ☐ 5 GO TO QUESTION  20
Don’t Know ☐ 98 GO TO QUESTION  20

19. In what month and year was your last angioplasty or stent?

(For example........... 0 9 / 2 0 1 1

☐ ☐ / ☐ ☐ ☐ ☐

Don’t know ☐ 98

20. Have you ever had open heart surgery?

PLEASE TICK ONE BOX
YES ☐ 1 GO TO QUESTION  21
NO ☐ 5 GO TO QUESTION  22
Don’t Know ☐ 98 GO TO QUESTION  22

21. In what month and year was your last open heart surgery?

(For example........... 0 9 / 2 0 1 1

☐ ☐ / ☐ ☐ ☐ ☐

Don’t know ☐ 98
22. Has the doctor ever told you that you have congestive heart failure?

**PLEASE TICK ONE BOX**

YES \[\square\] \[\text{GO TO QUESTION 23}\]

NO \[\square\] \[\text{GO TO QUESTION 24}\]

Don’t Know \[\square\] \[\text{GO TO QUESTION 24}\]

23. About how old were you when you were first told by a doctor that you had congestive heart failure?

I was \(\square\) \(\square\) years old.

Don’t know \[\square\]

24. Have you ever had education on how best to take care of/manage your heart health?

**PLEASE TICK ONE BOX**

YES \[\square\]

NO \[\square\]

Don’t Know \[\square\]

25. Have you ever had education on healthy eating/nutrition?

**PLEASE TICK ONE BOX**

YES \[\square\]

NO \[\square\]

Don’t Know \[\square\]

26. Has the doctor ever told you that you have diabetes or high blood sugar?

**PLEASE TICK ONE BOX**

YES \[\square\] \[\text{GO TO QUESTION 27}\]

NO \[\square\] \[\text{GO TO QUESTION 34}\]

Don’t Know \[\square\] \[\text{GO TO QUESTION 34}\]
27. About how old were you when you were first told by a doctor that you had diabetes or high blood sugar?

I was __________ years old.

Don’t know __________

28. What type of diabetes do you have?

Type 1 (formerly called insulin-dependent diabetes) __________

Type 2 (formerly called non-insulin dependent diabetes) __________

Don’t know __________

29. How often do you have your blood glucose levels checked?

TICK ONE BOX ONLY

Before meals __________

Daily __________

Weekly __________

Monthly __________

Never __________

Don’t know __________

29. How often do you have your blood glucose levels checked?

TICK ONE BOX ONLY

Before meals __________

Daily __________

Weekly __________

Monthly __________

Never __________

Don’t know __________

Other Please tell us __________

30. Are you currently taking any tablets, pills or other medication that you swallow for diabetes?

PLEASE TICK ONE BOX

YES __________

NO __________

Don’t Know __________

Don’t know __________
31. Do you currently inject insulin for diabetes?

PLEASE TICK ONE BOX

YES
NO
Don't Know

32. Has the doctor ever told you that you have any of the following conditions related to your diabetes?

TICK ALL THAT APPLY

Leg ulcer
Protein in your urine
Lack of feeling and tingling in your legs and feet due to nerve damage
Damage to the back of your eye
Damage to your kidneys
No, none of these
Don't know

33. Have you ever had education on how best to take care of/manage your diabetes?

PLEASE TICK ONE BOX

YES
NO
Don't Know

34. Has the doctor ever told you that you have had a stroke?

PLEASE TICK ONE BOX

YES 1 GO TO QUESTION 35
NO 5 GO TO QUESTION 38
Don't Know 98 GO TO QUESTION 38
35. About how old were you when you were first told by a doctor that you had a stroke?

I was __________ years old.

Don't know __________

36. About how many strokes has the doctor said you have had?

I have had __________ strokes.

Don't Know __________

37. In what year was your most recent stroke?

(For example 2011) ____________

Don't know __________

38 Has the doctor ever told you that you have had a ministroke or TIA?

PLEASE TICK ONE BOX

YES __________ GO TO QUESTION 39

NO __________ GO TO QUESTION 42

Don't Know __________ GO TO QUESTION 42

39. About how old were you when you were first told by a doctor that you had a ministroke or TIA?

I was __________ years old.

Don't know __________

40. About how many ministrokes or TIAS has the doctor said you have had?

I have had __________ strokes.

Don't know __________
41. In what year was your most recent ministroke or TIA?

(For example 2011) □ □ □ □

Don't know □

42. Has the doctor ever told you that you have any other heart trouble?

PLEASE TICK ONE BOX

YES □ 1 GO TO QUESTION 43

NO □ 5 GO TO QUESTION 45

Don’t Know □

43. Please tell us what other heart trouble has the doctor told you that you have?

44. About how old were you when you were first told by a doctor that you had any other heart trouble?

I was □ □ years old.

Don't know □
### Other Health Conditions

45. Has the doctor ever told you that you have any of the following chronic conditions? **PLEASE TICK ALL THAT APPLY**

- **Asthma**
- **Stomach ulcers**
- **Varicose ulcers (an ulcer due to varicose veins)**
- **Cirrhosis, or serious liver damage**
- **Constipation**
- **Coeliac disease**
- **Phenylketonuria (PKU)**
- **Hypothyroidism**
- **Hyperthyroidism**
- **Gastroesophageal reflux disease (like heartburn)**
- **Osteoporosis, sometimes called thin or brittle bones**
- **Multiple sclerosis**
- **Cerebral palsy**
- **Scoliosis**
- **Muscular dystrophy**
- **Spina bifida**
- **None of these**
- **Don’t know**
46. Has the doctor ever told you that you have any other chronic conditions?

**PLEASE TICK ONE BOX**

**YES**  
GO TO QUESTION 47

**NO**  
GO TO QUESTION 48

**Don’t Know**  
GO TO QUESTION 48

47. Please tell us what other chronic conditions the doctor told you that you have?

48. Has the doctor ever told you that you have chronic lung disease such as chronic bronchitis or emphysema?

**PLEASE TICK ONE BOX**

**YES**  
GO TO QUESTION 49

**NO**  
GO TO QUESTION 51

**Don’t Know**  
GO TO QUESTION 51

49. Are your receiving oxygen for your lung condition?

**PLEASE TICK ONE BOX**

**YES**

**NO**

**Don’t Know**
50. Does your lung condition (breathing difficulty) limit your usual activities, such as household chores, work, social or leisure activities?

PLEASE TICK ONE BOX
YES ☐
NO ☐
Don’t Know ☐

ARTHRITIS

51. Has the doctor ever told you that you have arthritis (including osteoarthritis, or rheumatism)?

PLEASE TICK ONE BOX
YES ☐ GO TO QUESTION 52
NO ☐ GO TO QUESTION 58
Don’t Know ☐ GO TO QUESTION 58

52. What type or types of arthritis do you have?

PLEASE TICK ALL THAT APPLY
Osteoarthritis ☐
Rheumatoid arthritis ☐
Some other kind ☐
Don’t know ☐
53. About how old were you when you were first told by a doctor that you had arthritis?

I was [ ] [ ] years old.

Don’t know [ ]

98

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

PLEASE TICK ONE BOX

Often/Always [ ]

Sometimes [ ]

Never [ ]

Don’t Know [ ]

55. Does the arthritis limit your social and leisure activities?

PLEASE TICK ONE BOX

Often/Always [ ]

Sometimes [ ]

Never [ ]

Don’t Know [ ]

56. Does your arthritis make it difficult for you to sleep at night?

PLEASE TICK ONE BOX

Often/Always [ ]

Sometimes [ ]

Never [ ]

Don’t Know [ ]
57. Have you ever had education on how best to take care of/manage your bone health?

PLEASE TICK ONE BOX
YES □
NO □
Don’t Know □

58. Has the doctor ever told you that you have cancer or a malignant tumour (including leukaemia or lymphoma but excluding minor skin cancers)?

PLEASE TICK ONE BOX
YES □ GO TO QUESTION 59
NO □ GO TO QUESTION 67
Don’t Know □ GO TO QUESTION 67

59. About how old were you when you were first told by a doctor that you had cancer or a malignant tumour?

I was □ □ years old.
Don’t know □

60. In which organ or part/s of the body have you or had you cancer?

PLEASE TICK ALL THAT APPLY
Lung □
Breast □
Colon or rectum □
Stomach □
<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oesophagus</td>
<td>1</td>
</tr>
<tr>
<td>Prostate</td>
<td>1</td>
</tr>
<tr>
<td>Bladder</td>
<td>1</td>
</tr>
<tr>
<td>Liver</td>
<td>1</td>
</tr>
<tr>
<td>Brain</td>
<td>1</td>
</tr>
<tr>
<td>Ovary</td>
<td>1</td>
</tr>
<tr>
<td>Cervix</td>
<td>1</td>
</tr>
<tr>
<td>Endometrium</td>
<td>1</td>
</tr>
<tr>
<td>Thyroid</td>
<td>1</td>
</tr>
<tr>
<td>Kidney</td>
<td>1</td>
</tr>
<tr>
<td>Testicle</td>
<td>1</td>
</tr>
<tr>
<td>Pancreas</td>
<td>1</td>
</tr>
<tr>
<td>Malignant melanoma (skin)</td>
<td>1</td>
</tr>
<tr>
<td>Non-malignant melanoma</td>
<td>1</td>
</tr>
<tr>
<td>Oral cavity</td>
<td>1</td>
</tr>
<tr>
<td>Larynx</td>
<td>1</td>
</tr>
<tr>
<td>Other Pharynx</td>
<td>1</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>1</td>
</tr>
<tr>
<td>Leukaemia</td>
<td>1</td>
</tr>
<tr>
<td>Other organ</td>
<td>1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
</tr>
</tbody>
</table>
61. Have you received any treatment for your cancer?

PLEASE TICK ONE BOX

<table>
<thead>
<tr>
<th>Answer</th>
<th>Box Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td>NO</td>
<td>5</td>
</tr>
<tr>
<td>Don't Know</td>
<td>98</td>
</tr>
</tbody>
</table>

GO TO QUESTION 62

62. What sort of treatment have you received for your cancer?

PLEASE TICK ALL THAT APPLY

- Chemotherapy [ ]
- Medication [ ]
- Surgery [ ]
- Radiotherapy/ X-ray [ ]
- Treatment of symptoms [ ] (pain, nausea, rashes)
- Biopsy [ ]
- None of these [ ]
- Don't know [ ]

63. Have you had other sorts of treatment for your cancer?

PLEASE TICK ONE BOX

<table>
<thead>
<tr>
<th>Answer</th>
<th>Box Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td>NO</td>
<td>5</td>
</tr>
<tr>
<td>Don't Know</td>
<td>98</td>
</tr>
</tbody>
</table>

GO TO QUESTION 64
64. Please tell us what other sort of treatments have you received from your cancer?

65. Since treatment has the cancer gotten better, or is it about the same or worse?

PLEASE TICK ONE BOX
Better □ 1 GO TO QUESTION 67
About the same □ 2 GO TO QUESTION 67
Worse □ 3 GO TO QUESTION 67
Don’t Know □ 98 GO TO QUESTION 67

66. Why have you not received treatment? Please tell us,
67. Has the doctor ever told you that you have Parkinson’s disease?

PLEASE TICK ONE BOX

YES                                        □  GO TO QUESTION 68
NO                                         □  GO TO QUESTION 69
Don’t Know                                 □  GO TO QUESTION 69

68. About how old were you when you were first told by a doctor that you had Parkinson’s disease?

I was □ □ years old.

Don’t know                                  □ 98

69. Has the doctor ever told you that you have an emotional, nervous or psychiatric condition?

PLEASE TICK ONE BOX

YES                                        □ 1  GO TO QUESTION 70
NO                                         □ 5  GO TO QUESTION 75
Don’t Know                                 □ 98 GO TO QUESTION 75
70. What type of emotional, nervous or psychiatric condition(s) do you have?

PLEASE TICK ALL THAT APPLY

- Hallucinations
- Anxiety
- Depression
- Emotional problems
- Schizophrenia
- Psychosis
- Mood swings
- Manic depression
- None of these
- Don’t know
- Other

If Other, Please tell us

71. Do you now get psychiatric treatment for your condition(s) such as attending a psychiatrist?

PLEASE TICK ONE BOX

- YES
- NO
- Don’t Know

GO TO QUESTION 72
GO TO QUESTION 73
GO TO QUESTION 73
72. Who gives you psychiatric treatment for your conditions?

<table>
<thead>
<tr>
<th>PLEASE TICK ALL THAT APPLY</th>
<th>Please tell us the address where you see this person (this is required to calculate the distance you have to travel).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td></td>
</tr>
<tr>
<td>Other (please tell us)</td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PLEASE TICK ONE BOX</th>
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</thead>
<tbody>
<tr>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td>GO TO QUESTION 74</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>5</td>
</tr>
<tr>
<td>GO TO QUESTION 75</td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
<tr>
<td>GO TO QUESTION 75</td>
<td></td>
</tr>
</tbody>
</table>

74. Who gives you psychological treatment for your condition(s)?

<table>
<thead>
<tr>
<th>PLEASE TICK ALL THAT APPLY</th>
<th>Please tell us the address where you see this person (this is required to calculate the distance you have to travel).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist</td>
<td></td>
</tr>
<tr>
<td>Counsellor</td>
<td></td>
</tr>
<tr>
<td>Clinical Nurse Specialist (CNS)</td>
<td></td>
</tr>
<tr>
<td>Other (please tell us)</td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td></td>
</tr>
</tbody>
</table>
75. Do you ever become annoyed, frustrated, or angry when things don’t work out the way you want them?

PLEASE TICK ONE BOX

YES  

NO  

Don’t Know

76. If Yes, what do you do

PLEASE TICK ALL THAT APPLY

- Do nothing/don’t react
- Scream
- Throw things
- Hit out
- Self injure
- Other

If Other, Please tell us
77. Has a doctor ever told you that you have Alzheimer’s disease?

PLEASE TICK ONE BOX
YES □ Go to Question 78
NO □ Go to Question 79
Don’t Know □ Go to Question 79

78. About how old were you when you were first told by a doctor that you had Alzheimer’s disease?

I was □□ years old
Don’t know □ 98

79. Has the doctor ever told you that you have dementia, organic brain syndrome or senility?

PLEASE TICK ONE BOX
YES □ Go to Question 80
NO □ Go to Question 81
Don’t Know □ 98 Go to Question 81

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

I was □□ years old
Don’t know □ 98
81. Has the doctor ever told you that you have epilepsy?

PLEASE TICK ONE BOX

YES [ ] GO TO QUESTION 82
NO [ ] GO TO QUESTION 93
Don’t Know [ ] GO TO QUESTION 93

82. About how old were you when you were first told by a doctor that you had epilepsy?

I was [ ] [ ] years old.

Don’t know [ ]

83. What type of epilepsy do you have?

TICK ALL THAT APPLY

Tonic-clonic seizures [ ]
Tonic seizures [ ]
Atonic seizures [ ]
Clonic seizures [ ]
Myoclonic seizures [ ]
Absence seizures [ ]
Simple partial seizures [ ]
Complex partial seizures [ ]
Don’t know [ ]
84. Do/Did you attend an Epilepsy clinic or see a specialist?

PLEASE TICK ONE BOX
YES

NO

Don't Know

85. When did you last have your epilepsy reviewed (e.g. medication or seizure activity)?

Last 12 months

Last 2 years

More than 2 years ago

Never

I used to have epilepsy, I don’t have seizures or take medication anymore

Don't know

86. Who reviewed your epilepsy?

PLEASE TICK ALL THAT APPLY
General Practitioner

Psychiatrist

Neurologist

CNS

Don't Know

Other

If Other, Please tell us
87. Does your epilepsy limit any of the following…?
PLEASE TICK ALL THAT APPLY
Household chores
Work
Social Activities
Sports Activities
Driving
Going out alone
None of the above
Other

If Other, Please tell us

88. Are any of the following medication prescribed for you to use in an emergency (rescue medication)

PLEASE TICK ALL THAT APPLY
Epistatus (Buccal Midazolam)
Frisium (Clobazam)
Stesolid (Rectal Diazepam)
Clonazapam (Rivotril)
Lorazepam (Ativan)
None
Don’t Know
Other

If Other, Please tell us
89. Have you used any of the emergency medications (rescue medication) in the last 12 months, if so please tell us?

**Emergency Medication**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epistatus (Buccal Midazolam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frisium (Clobazam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stesolid (Rectal Diazepam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clonazapam (Rivotril)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Other, Please tell us

90. Do you keep a record of your seizures?

**PLEASE TICK ONE BOX**

<table>
<thead>
<tr>
<th>Option</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 91. How often have you had a seizure in the past two years?

**PLEASE TICK ONE BOX**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have not had a seizure in 2 years</td>
<td>1</td>
</tr>
<tr>
<td>Daily</td>
<td>2</td>
</tr>
<tr>
<td>Weekly (but not daily)</td>
<td>3</td>
</tr>
<tr>
<td>More than once a month (but not weekly)</td>
<td>4</td>
</tr>
<tr>
<td>Less than once a month</td>
<td>5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
</tbody>
</table>

### 92. Have you ever had education on how best to take care of/manage your epilepsy?

**PLEASE TICK ONE BOX**

<table>
<thead>
<tr>
<th>Response</th>
<th>Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td>NO</td>
<td>5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
</tbody>
</table>
93. Over the past 6 months have you experienced any of the following for at least 25% of defecations and have they been active for 3 months?

**PLEASE TICK ALL THAT APPLY**

Straining

Lumpy or hard stool

Sensation of incomplete evacuation

Sensation of anorectal obstruction/blockage

Manual maneuvers (e.g. digital evacuation, support to the pelvic floor)

Fewer than three defecations per week

Pain during defecation

94. Do you ever have normal or loose stool without the use of laxatives?

**PLEASE TICK ONE BOX**

YES

NO

Don’t Know
95. Have you ever been diagnosed with irritable bowel syndrome?

PLEASE TICK ONE BOX

YES
NO
Don’t Know

96. Have you ever experienced encopresis? By this we mean a small leakage of bowel movements which result in stained underwear

PLEASE TICK ONE BOX

YES
NO
Don’t Know

MEDICAL TESTS AND SCREENING

97. Have you had a flu injection?

PLEASE TICK ONE BOX

YES
NO
Don’t Know
98. Have you had the Hepatitis B vaccine?

**PLEASE TICK ONE BOX**

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
</tbody>
</table>

99. Have you ever had a blood test for cholesterol?

**PLEASE TICK ONE BOX**

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, within the last 2 years</td>
<td>1</td>
</tr>
<tr>
<td>Yes, over 2 years ago</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
</tbody>
</table>

100. Have you ever had your blood pressure measured?

**PLEASE TICK ONE BOX**

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, within the last 2 years</td>
<td>1</td>
</tr>
<tr>
<td>Yes, over 2 years ago</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
</tbody>
</table>

101. Have you ever had a thyroid function test?

**PLEASE TICK ONE BOX**

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, within the last 2 years</td>
<td>1</td>
</tr>
<tr>
<td>Yes, over 2 years ago</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
</tbody>
</table>
102. Have you ever had a blood glucose test (sugar test)?

<table>
<thead>
<tr>
<th>PLEASE TICK ONE BOX</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>YES, within the last 2 years</td>
<td>1</td>
</tr>
<tr>
<td>YES, over 2 years ago</td>
<td>2</td>
</tr>
<tr>
<td>NO</td>
<td>5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
</tbody>
</table>

103. Have you ever been screened or assessed for memory impairment/dementia?

<table>
<thead>
<tr>
<th>PLEASE TICK ONE BOX</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>YES, within the last 2 years</td>
<td>1</td>
</tr>
<tr>
<td>YES, over 2 years ago</td>
<td>2</td>
</tr>
<tr>
<td>NO</td>
<td>5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
</tbody>
</table>

104. Have you had a bone density test? (e.g. DEXA Scan)

<table>
<thead>
<tr>
<th>PLEASE TICK ONE BOX</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>YES, within the last 2 years</td>
<td>1</td>
</tr>
<tr>
<td>YES, over 2 years ago</td>
<td>2</td>
</tr>
<tr>
<td>NO</td>
<td>5</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>98</td>
</tr>
</tbody>
</table>
105. Did your mother or father ever experience any of the following….?

PLEASE TICK ALL THAT APPLY

- Hip fracture
- Colon cancer
- Breast cancer
- Dementia
- Don’t Know

106. Have you ever had any of the following tests?

PLEASE TICK ALL THAT APPLY

- CT Brain Scan
- CT Scan (other than brain) Please tell us ____________________________
- MRI Brain scan
- MRI Scan (Other than brain) Please tell us ____________________________
- EEG
- Don’t Know
**Women Only Questions**

**107.** Have you gone through or are you currently going through the menopause?

**PLEASE TICK ONE BOX**

- YES, gone through the menopause already  
  [ ] 1  GO TO QUESTION 108
- YES, currently going through the menopause  
  [ ] 2  GO TO QUESTION 108
- NO  
  [ ] 5  GO TO QUESTION 112
- Don’t Know  
  [ ] 98  GO TO QUESTION 112

**108.** About how old were you when it started?

I was [ ] [ ] years old?

Don’t know  [ ] 98

**109.** Since menopause have you used prescription hormones (e.g. HRT, estrogen)

**PLEASE TICK ONE BOX**

- YES, currently taking hormones  
  [ ] 1  GO TO QUESTION 110
- YES, but no longer taking hormones  
  [ ] 2  GO TO QUESTION 111
- NO  
  [ ] 5  GO TO QUESTION 112
- Don’t Know  
  [ ] 98  GO TO QUESTION 112

**110.** For how many years have you been taking prescription hormones?

(For example … 0 3 years)

For [ ] [ ] years  GO TO QUESTION 112

Don’t know  [ ] 98  GO TO QUESTION 112
111. For how many years did you take prescription hormones?

(For example ..... 0 3 years)

For           years
Don't know  98

112. Do you check your breasts for lumps regularly?

PLEASE TICK ONE BOX
YES           1
NO            5
Don't Know   98

113. Has the GP or nurse checked your breasts for lumps?

PLEASE TICK ONE BOX
YES           1
NO            5
Don't Know   98

114. Have you had a mammogram or x-ray of the breast, to search for cancer?

PLEASE TICK ONE BOX
YES           1
NO            5
Don't Know   98
115. Do you check your testicles for lumps regularly?

PLEASE TICK ONE BOX
YES [ ]
NO [ ]
Don't Know [ ]

116. Has the GP checked your testicles for lumps?

PLEASE TICK ONE BOX
YES [ ]
NO [ ]
Don't Know [ ]

117. Have you had an examination of your prostate to screen for cancer?

PLEASE TICK ONE BOX
YES [ ]
NO [ ]
Don't Know [ ]

118. Have you had a blood test (PSA) to screen for prostate cancer?

PLEASE TICK ONE BOX
YES [ ]
NO [ ]
Don't Know [ ]
HEALTHCARE UTILISATION

119. Are you covered by any of the following?

**PLEASE TICK ONE BOX**

- Full medical card or equivalent [ ]
- GP visit card [ ]
- Neither of these [ ]
- Don’t Know [ ]

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

**PLEASE TICK ONE BOX**

- Yes, in my own name [ ]
- Yes, as the spouse of a subscriber [ ]
- Yes, as the relative of a subscriber [ ]
- No [ ]
- Don’t Know [ ]

121. In the last year, about how often did you visit your GP or did your GP visit you?

(For example ... 1 1 visits)

- Number of visits [ ] [ ]
- Don’t Know [ ]

98
122. In the last year, how many times did you visit a hospital Emergency Department (sometimes called A&E or Accident and Emergency) as a patient?

(For example ... 0 1 visits)

<table>
<thead>
<tr>
<th>Number of visits</th>
<th>0</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't Know</td>
<td>98</td>
<td></td>
</tr>
</tbody>
</table>

123. If you attended A&E for treatment in the last year, what was the reason?

**PLEASE TICK ALL THAT APPLY**

<table>
<thead>
<tr>
<th>Reason</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not visited A&amp;E in last year</td>
<td>1</td>
</tr>
<tr>
<td>Multiple injuries</td>
<td>1</td>
</tr>
<tr>
<td>Broken or fractured bone(s)</td>
<td>1</td>
</tr>
<tr>
<td>Burn(s)</td>
<td>1</td>
</tr>
<tr>
<td>Dislocation(s)</td>
<td>1</td>
</tr>
<tr>
<td>Sprain or strain(s)</td>
<td>1</td>
</tr>
<tr>
<td>Cut(s) or Open wound</td>
<td>1</td>
</tr>
<tr>
<td>Scrape, bruise, blister(s)</td>
<td>1</td>
</tr>
<tr>
<td>Concussion or other head/brain injury</td>
<td>1</td>
</tr>
<tr>
<td>Poisoning</td>
<td>1</td>
</tr>
<tr>
<td>Internal injuries(s)</td>
<td>1</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1</td>
</tr>
<tr>
<td>Don't know</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

If Other, Please tell us


124. In the last year, about how many visits did you make to a hospital out-patient clinic? Include all types of consultations, tests, operations, procedures or treatment

Number of visits

(For example ... 0 3 visits)

Don’t Know 98

125. In the last year, how many nights did you spend in a general hospital?

(For example ... 0 1 nights)

Total number of nights

Don’t Know 98

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

PLEASE TICK ONE BOX

Did not spend any nights 1
1 to 5 nights 2
6 to 10 nights 3
11 to 20 nights 4
More than 20 nights 5
Don’t know 98
127. the last year, how much time did you spend in a nursing/convalescent home?

Please tick one box

Did not spend any time
One week or less
Up to 1 month
Up to 2 months
Up to 3 months
More than 3 months
Don't know

128. During the last year, was there ever a time when you felt you needed healthcare but you didn’t receive it?

Please tick one box

Yes
No
Don’t Know
129. Thinking of the most recent time, why did you not get healthcare?

**PLEASE TICK ALL THAT APPLY**

<table>
<thead>
<tr>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare was not offered</td>
</tr>
<tr>
<td>Not available in the area</td>
</tr>
<tr>
<td>Not available at the time required</td>
</tr>
<tr>
<td>Waiting time too long</td>
</tr>
<tr>
<td>Felt that the service would not be good</td>
</tr>
<tr>
<td>Too costly</td>
</tr>
<tr>
<td>Too busy</td>
</tr>
<tr>
<td>Didn’t get around to it/didn’t bother</td>
</tr>
<tr>
<td>Didn’t know where to go</td>
</tr>
<tr>
<td>Problems with transport</td>
</tr>
<tr>
<td>Communications/language problems</td>
</tr>
<tr>
<td>Personal or family responsibilities</td>
</tr>
<tr>
<td>Fear of healthcare services and/or of treatment</td>
</tr>
<tr>
<td>Decided not to seek care</td>
</tr>
<tr>
<td>Information material not accessible/inadequate communication aids</td>
</tr>
<tr>
<td>Complaint was not taken seriously enough</td>
</tr>
<tr>
<td>Negative attitudes of the staff</td>
</tr>
<tr>
<td>Too embarrassing</td>
</tr>
<tr>
<td>I was in too much pain</td>
</tr>
<tr>
<td>I forgot about my appointments</td>
</tr>
</tbody>
</table>
130. Again thinking of the most recent time, what was the type of care that was needed?

**PLEASE TICK ALL THAT APPLY**

Treatment of a physical health problem (e.g. cataract surgery)  
Treatment of an emotional or mental health problem  
A regular check-up  
Care of an injury  
Don't know  
Other

If Other, Please tell us
131. In the last year, did you receive any of the following services (exclude any service that you paid for yourself)? **If yes please tell us how satisfied you are with this service**

<table>
<thead>
<tr>
<th>Service</th>
<th>Very Satisfied</th>
<th>Satisfied</th>
<th>Not Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public health or community nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropody services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological/counselling services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care attendant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meals-on-wheels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optician services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietician services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech &amp; Language services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day centre services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Very Satisfied</td>
<td>Satisfied</td>
<td>Not Satisfied</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
<tr>
<td>Neurological services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geriatrician services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrinology services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatological services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative care services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t Know</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Other, Please tell us

132. If you ticked ‘not satisfied’ for any of the above please tell us why you are not satisfied e.g. waiting list too long, cost, access to building is very difficult.

PLEASE STATE WHICH SERVICE YOU ARE REFERRING TO
133. In the last year, where did you receive any of the following services (exclude any service that you paid for yourself)? Tell us if you attended the health service in the community or in the service provider/service setting.

**PLEASE TICK ALL THAT APPLY**

<table>
<thead>
<tr>
<th>Service Provider Setting</th>
<th>Community Setting /Mainstream</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>1</td>
</tr>
<tr>
<td>Public health or community nurse</td>
<td>1</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>1</td>
</tr>
<tr>
<td>Chiropody services</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapy services</td>
<td>1</td>
</tr>
<tr>
<td>Social work services</td>
<td>1</td>
</tr>
<tr>
<td>Psychological/counselling services</td>
<td>1</td>
</tr>
<tr>
<td>Home help</td>
<td>1</td>
</tr>
<tr>
<td>Personal care attendant</td>
<td>1</td>
</tr>
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<td>Meals-on-wheels</td>
<td>1</td>
</tr>
<tr>
<td>Optician services</td>
<td>1</td>
</tr>
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<td>Dental services</td>
<td>1</td>
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<td>Speech &amp; Language services</td>
<td>1</td>
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<tr>
<td>Day centre services</td>
<td>1</td>
</tr>
<tr>
<td>Respite services</td>
<td>1</td>
</tr>
<tr>
<td>Service</td>
<td>Community Setting /Mainstream Services</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Residential services</td>
<td>1</td>
</tr>
<tr>
<td>Neurological services</td>
<td>1</td>
</tr>
<tr>
<td>Geriatrician services</td>
<td>1</td>
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<tr>
<td>Endocrinology services</td>
<td>1</td>
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<tr>
<td>Dermatological services</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatry services</td>
<td>1</td>
</tr>
<tr>
<td>Palliative care services</td>
<td>1</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

If Other, Please tell us

**134. Are there any services that you think you would benefit from that you are not receiving at present?**

**PLEASE TICK ONE BOX**

- **YES** □ GO TO QUESTION 135
- **NO** □ GO TO QUESTION 138
- **Don’t Know** □ GO TO QUESTION 138
135. Please tell us which services you think you would benefit from that you are not receiving at present?

**PLEASE TICK ALL THAT APPLY**

<table>
<thead>
<tr>
<th>Service</th>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
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<td>Occupational therapy</td>
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<td>Psychological/counselling services</td>
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<td>Home help</td>
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<td>Personal care attendant</td>
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<td>Residential services</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Geriatrician services 1
Endocrinology services 1
Dermatological services 1
Psychiatry services 1
Palliative care services 1
Don’t Know 1
Other 1

If Other, Please tell us

136. Do you know how to access this service?

PLEASE TICK ONE BOX
YES 1
NO 5
Don’t Know 98

137. Please tell us the main thing that stops/prevents you from receiving this service or services?

Don’t Know 98
138. In the last year how many nights did you spend in respite (excluding nights spent in a nursing home)?

PLEASE TICK ONE

Did not spend any nights
1
1 to 5 nights
2
6 to 10 nights
3
11 to 20 nights
4
More than 20 nights
5
Don’t know
98

139. Have you ever received any easy to read information leaflets on any of the following….?

PLEASE TICK ALL THAT APPLY

Bone Health
1
GO TO QUESTION 140
Heart Health
1
GO TO QUESTION 140
Epilepsy
1
GO TO QUESTION 140
Diabetes
1
GO TO QUESTION 140
Exercise
1
GO TO QUESTION 140
Nutrition/Healthy Eating
1
GO TO QUESTION 140
Constipation
1
GO TO QUESTION 140
None of the above
1
GO TO QUESTION 141
Don’t Know
1
GO TO QUESTION 141
140. Please tell us who you received easy to read information from...

**TICK ALL THAT APPLY**

<table>
<thead>
<tr>
<th></th>
<th>Specialist</th>
<th>GP</th>
<th>Pharmacist</th>
<th>Public Health Nurse</th>
<th>RNID</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Health</td>
<td></td>
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<td>Heart Health</td>
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<td>Nutrition/Healthy</td>
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<td>Constipation</td>
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</tr>
</tbody>
</table>

If Other, please tell us

141. Have you ever received any easy to read information leaflets about your medication?

**PLEASE TICK ONE BOX**

- YES  \[ \]  GO TO QUESTION 142
- NO  \[ \]  GO TO QUESTION 143
- Don’t Know  \[ \]  GO TO QUESTION 143
142. If Yes, from whom

PLEASE TICK ALL THAT APPLY

General Practitioner

Pharmacist

Public Health Nurse

RNID

Don’t Know

Other

If Other, Please tell us

143. In the last year did you receive support from any of the following organisations?

PLEASE TICK ALL THAT APPLY

The Society of St. Vincent de Paul

The Senior Helpline

The Samaritans

No support from these organisations

Don’t Know

Support from other excluding your service provider

If Other, Please tell us
144. MEDICATIONS

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

**PLEASE WRITE DOWN ALL MEDICATIONS/TABLETS YOU TAKE AND HOW OFTEN YOU TAKE THEM, PLEASE USE ONE LINE PER MEDICATION**

Don’t know what medication I take, record by proxy

Don’t take any medication

### Examples of medication completion form:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage Strength</th>
<th>Frequency</th>
<th>Route</th>
<th>Date First Prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilim Chrono</td>
<td>200mgs</td>
<td>Twice a day (BD)</td>
<td>Orally(PO)</td>
<td>Sept 2009</td>
</tr>
<tr>
<td>One touch ultra test strip (blood glucose)</td>
<td>1 strip</td>
<td>Before meals</td>
<td>-</td>
<td>June 2010</td>
</tr>
<tr>
<td>Neo-cytamen Injection (hydroxycobalamin)</td>
<td>1000micrograms</td>
<td>Monthly</td>
<td>IM</td>
<td>Nov 2010</td>
</tr>
<tr>
<td>Xalatan eye drops</td>
<td>2 drops (left eye)</td>
<td>Nocte (At night)</td>
<td>Instill</td>
<td>June 2010</td>
</tr>
<tr>
<td>Emulsifying Ointment</td>
<td>PRN</td>
<td>Topically</td>
<td></td>
<td>Jan 2009</td>
</tr>
<tr>
<td>Vegepa (Omega fishoil)</td>
<td>2 daily</td>
<td>PO</td>
<td></td>
<td>June 2005</td>
</tr>
<tr>
<td>Ensure Plus</td>
<td>1 daily</td>
<td>PO</td>
<td></td>
<td>Oct 2007</td>
</tr>
<tr>
<td>Name of Medication</td>
<td>Dosage Strength</td>
<td>Frequency</td>
<td>Route</td>
<td>Date Prescribed</td>
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<tr>
<td>Name of Medication</td>
<td>Dosage Strength</td>
<td>Frequency</td>
<td>Route</td>
<td>Date Prescribed</td>
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</tbody>
</table>
145. **BLOOD TESTS**

We would like to record all the blood tests you have had in the last year. This will help us build a picture of the changes older people experience over time. Please tell us the results of your most recent blood tests.

[Please indicate if bloods are *fasting* or *random*]

Did not get any blood tests in the last year

GO TO QUESTION 146

<table>
<thead>
<tr>
<th>BLOOD TEST</th>
<th>DATE</th>
<th>RESULT</th>
<th>Fasting&lt;sub&gt;1&lt;/sub&gt; / Not Fasting&lt;sub&gt;5&lt;/sub&gt; (If Applicable)&lt;sub&gt;888&lt;/sub&gt;</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXAMPLE:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium</td>
<td>14/3/2012</td>
<td>6.1mg</td>
<td></td>
<td>(Normal range 8.2 - 10.6 mg/dL)</td>
</tr>
<tr>
<td>FBC Red blood cells</td>
<td></td>
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<tr>
<td>FBC White blood cells</td>
<td></td>
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<tr>
<td>FBC Haemoglobin</td>
<td></td>
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<tr>
<td>FBC Platelets</td>
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<tr>
<td>ESR</td>
<td></td>
<td></td>
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<tr>
<td>HbA1C</td>
<td></td>
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<tr>
<td><strong>BLOOD GLUCOSE</strong></td>
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<tr>
<td>U&amp;E</td>
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<tr>
<td>B&lt;sub&gt;12&lt;/sub&gt;</td>
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</tr>
<tr>
<td>BLOOD TEST</td>
<td>DATE</td>
<td>RESULT</td>
<td>Fasting&lt;sub&gt;1&lt;/sub&gt; / Not Fasting&lt;sub&gt;5&lt;/sub&gt; (If Applicable)&lt;sup&gt;888&lt;/sup&gt;</td>
<td>Normal Range</td>
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<tr>
<td>FOLATE</td>
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<tr>
<td>LFTs</td>
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<tr>
<td>SERUM CHOLESTEROL</td>
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<tr>
<td>LIPID PROFILE</td>
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<tr>
<td>VIT D (25-hydroxyvitamin D/1,25-hydroxyvitamin D)</td>
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<tr>
<td>HEP SCREEN (A)</td>
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<tr>
<td>HEP SCREEN (B)</td>
<td></td>
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<tr>
<td>HEP SCREEN (C)</td>
<td></td>
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<tr>
<td>TFTs</td>
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<tr>
<td>CALCIUM</td>
<td></td>
<td></td>
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<tr>
<td>PSA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>BLOOD TEST</td>
<td>DATE</td>
<td>RESULT</td>
<td>Fasting₁ /Not Fasting₅ (If Applicable)</td>
<td>Normal Range</td>
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</tbody>
</table>
146. How long did it take you to fill out this questionnaire?

PLEASE TICK ONE BOX

Less than 30 minutes [ ]
30 minutes – 1 hour [ ]
1 – 2 hours [ ]
2 – 3 hours [ ]
More than 3 hours [ ]
Don’t know [ ]

147. In general, did you find it easy to understand the questions?

PLEASE TICK ONE BOX

YES [ ] GO TO QUESTION 149
NO [ ] GO TO QUESTION 148
Don’t Know [ ] GO TO QUESTION 149

148. Please tell us which questions did you find most difficult to understand?
149. Please tell us if you have any other comments about the questionnaire?

150. Has anyone supported you to fill out this questionnaire?

PLEASE TICK ONE BOX

YES [ ] GO TO QUESTION 151

NO [ ] YOU ARE NOW FINISHED THANK YOU FOR YOUR TIME

151. Name of the person supporting you

First name ___________________________ Surname ___________________________

152. Is this the same person who gave you support in the first interview?

PLEASE TICK ONE BOX

YES [ ]

NO [ ]
153. What is their relationship to you?

1. Boyfriend/Girlfriend/Partner
2. Parent
3. Sibling
4. Key worker/ Support worker
5. Friend
95. Other

If Other, Please tell us

154. How long do you know the person supporting you?

PLEASE TICK ONE BOX

1. Less than 6 months
2. Between 6 months and a year
3. More than a year
98. Don’t Know

THANK YOU VERY MUCH FOR TAKING THE TIME TO FILL IN THIS QUESTIONNAIRE. PLEASE BRING IT WITH YOU TO YOUR INTERVIEW AND GIVE IT TO THE INTERVIEWER
The Intellectual Disability Supplement to TILDA
The University of Dublin, Trinity College,
School of Nursing & Midwifery,
24 D’Olier Street, Dublin 2.

General Inquiries: 01-8963187
Email: idstilda@tcd.ie

www.idstilda.tcd.ie

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