1. **Your current weight?**

POUNDS

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
	7	7
	8	8
	9	9

2. **Is this your correct date of birth?**

◯ Yes
◯ No → If No, please write correct date. MONTH / DAY / YEAR

3. **Do you currently smoke cigarettes?**

◯ Yes → **How many per day?** ◯ 1–4 ◯ 5–14 ◯ 15–24 ◯ 25–34 ◯ 35–44 ◯ 45+
◯ No

4. **Have you had your uterus removed?**

◯ No ◯ Yes → **Date of surgery:** ◯ Before June 1, 2014 ◯ After June 1, 2014

5. **Have you ever had either of your ovaries surgically removed?**

◯ No ◯ Yes → **a) How many ovaries do you have remaining?** ◯ None ◯ One

6. **Since June 2014, have you used prescription female hormones? (Not including over-the-counter/herbal/soy preparations.)**

◯ Yes →
◯ No

a) How many months did you use hormones since June 2014?
◯ 1–4 months ◯ 5–9 ◯ 10–14 ◯ 15–19 ◯ 20–25 ◯ 26-30 ◯ 31-35 ◯ 36+ months

b) Are you *currently* using them (within the last month)? ◯ Yes ◯ No **If No, skip to question 7.**

c) Mark the type(s) of hormones you are *CURRENTLY* using:
◯ Prempro ◯ Oral estrogen (e.g., Premarin, Estrace, etc.) ◯ Patch estrogen ◯ Vaginal estrogen
◯ Estrogen gels, creams, or sprays on skin ◯ Other estrogen (specify in box below)
◯ Oral progesterone (e.g., Provera/MPA) ◯ Micronized progesterone (e.g., Prometrium)
◯ Vaginal progesterone ◯ Other progesterone (specify in box below)

Other hormones *CURRENTLY* used (e.g., Tri-est), Specify:

7. **Do you usually use a cane, walker or wheelchair/scooter? *(Mark all that apply.)***

◯ No ◯ Cane ◯ Walker ◯ Wheelchair/scooter ◯ Unable to walk

8. **Number of times you have fallen to the ground in the past year:**

◯ None ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 or more

9. **How many natural teeth do you currently have (with or without crowns)?**

◯ None ◯ 1–10 ◯ 11–16 ◯ 17–24 ◯ 25–32

10. **Have you *ever* been diagnosed with periodontal bone loss?** ◯ No ◯ Mild ◯ Moderate/Severe

11. **Have you *ever* had any of these clinician-diagnosed illnesses?**

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"

		YEAR OF FIRST DIAGNOSIS							
		2003 or BEFORE	2004–2005	2006–2007	2008–2009	2010–2011	2012–2013	2014–2015	2016+
Asthma, Dr. diagnosed	Y	◯	◯	◯	◯	◯	◯	◯	◯
Emphysema or Chronic bronchitis, Dr. Dx	Y	◯	◯	◯	◯	◯	◯	◯	◯
Sleep apnea, confirmed by sleep study or Dr. diagnosis	Y	◯	◯	◯	◯	◯	◯	◯	◯
Hayfever (allergic rhinitis)	Y	◯	◯	◯	◯	◯	◯	◯	◯
Eczema (atopic dermatitis)	Y	◯	◯	◯	◯	◯	◯	◯	◯
Dysplastic nevus (atypical mole)	Y	◯	◯	◯	◯	◯	◯	◯	◯

3/8" PERF

12. Since June 2014, have you had any of these clinician-diagnosed illnesses?

MARK HERE FOR "YES," LEAVE BLANK FOR "NO"

	Mark	YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 2014	JUNE '14 TO MAY 2016	AFTER JUNE 1 2016	
Breast cancer	(Y)				1
Cancer of the ovary	(Y)				2
Leukemia	(Y)				3
Lymphoma	(Y)				4
Melanoma	(Y)				5
Basal cell skin cancer	(Y)				6
Squamous cell skin cancer	(Y)				7
Colon or rectal polyp (benign)	(Y)				8
Cancer of the colon or rectum	(Y)				9
Other cancer	(Y)				10
Specify site of other cancer: (e.g., uterus, pancreas, lung, etc.)					
Diabetes mellitus	(Y)				11
Elevated cholesterol	(Y)				12
High blood pressure	(Y)				13
Myocardial infarction (heart attack)	(Y)				14
Hospitalized for MI? (N) No (Y) Yes					a
Angina pectoris	(Y)				15
Confirmed by angiogram? (N) No (Y) Yes					a
Coronary bypass, angioplasty, or stent	(Y)				16
Congestive heart failure	(Y)				17
Stroke (CVA)	(Y)				18
TIA (Transient ischemic attack)	(Y)				19
Peripheral artery disease or claudication of legs (not varicose veins)	(Y)				20
Carotid surgery (Endarterectomy)	(Y)				21
Pulmonary embolus or Deep vein thrombosis	(Y)				22
Atrial fibrillation	(Y)				23
ICD-Implantable Cardiac Defibrillator	(Y)				24

MARK HERE FOR "YES," LEAVE BLANK FOR "NO"

	Mark	YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 2014	JUNE '14 TO MAY 2016	AFTER JUNE 1 2016	12
Osteoporosis	(Y)				25
Hip fracture	(Y)				26
Vertebral (spine) fracture	(Y)				27
Hyperparathyroidism	(Y)				28
Glaucoma	(Y)				29
Macular degeneration of retina	(Y)				30
Cataract extraction	(Y)				31
Parkinson's disease	(Y)				32
Lou Gehrig's disease/ Amyotrophic Lat Sclerosis	(Y)				33
Alzheimer's or other type of dementia (e.g., vascular, FTD, Lewy Body)	(Y)				34
Kidney stones	(Y)				35
Ulcerative colitis or Crohn's or microscopic colitis	(Y)				36
Gastric/duodenal ulcer	(Y)				37
Barrett's esophagus	(Y)				38
Celiac disease	(Y)				39
Cholecystectomy	(Y)				40
Rheumatoid Arthritis or Systemic Lupus (SLE)	(Y)				41
Gout	(Y)				42
Depression, clinician diagnosed	(Y)				43
Fatty liver disease and/or cirrhosis	(Y)				44
Chronic hepatitis (B or C)	(Y)				45
Other major illness or surgery since June 2014	(Y)				46

Please specify: Date:

(e.g., hip replacement, GERD, etc.)

3/8" PERF

13. In the past two years, have you been diagnosed with an episode of:

a) Diverticulitis of the colon that required antibiotics and/or hospitalization?

◯ No ◯ Yes ➡ **Surgery for diverticulitis?** ◯ No ◯ Yes

b) Diverticular bleeding that required blood transfusion and/or hospitalization?

◯ No ◯ Yes ➡ **Surgery for diverticular bleeding?** ◯ No ◯ Yes

c) Diverticulosis of the colon without diverticulitis or diverticular bleeding?

◯ No ◯ Yes

14. In the past two years, have you had gastrointestinal bleeding that required hospitalization or a blood transfusion?

◯ Yes ➡ **Site(s):** ◯ Esophagus ◯ Stomach ◯ Duodenum ◯ Colon/Rectum ◯ Other ◯ Site(s) unknown
◯ No

15. In the past two years have you had . . .
(If yes, mark all that apply)

	No	Yes, for Screening	Yes, for Symptoms
A physical exam?	Ⓝ	Ⓨ	Ⓨ
Exam by eye doctor?	Ⓝ	Ⓨ	Ⓨ
Mammogram?	Ⓝ	Ⓨ	Ⓨ
Fasting blood sugar?	Ⓝ	Ⓨ	Ⓨ

Upper endoscopy?	Ⓝ No	Ⓨ Yes
(Virtual) CT Colonoscopy?	Ⓝ No	Ⓨ Yes
Colonoscopy?	Ⓝ No	Ⓨ Yes
Sigmoidoscopy?	Ⓝ No	Ⓨ Yes

Initial reason(s) you had this Colonoscopy or Sigmoidoscopy?

◯ Visible blood ◯ Occult fecal blood
◯ Diarrhea/constipation ◯ Fecal or stool DNA testing
◯ Barium enema ◯ Family history of colon cancer
◯ Prior polyps ◯ Follow-up of (virtual) CT colonoscopy
◯ Abdominal pain ◯ Asymptomatic or routine screening

C 0 1 2 3 4 5 6 7 8 9 (×3) I 0 1 2 3 4 5 6 7 8 9 (×3)

16. What is your marital status?

◯ Married ◯ Widowed ◯ Domestic Partnership ◯ Separated ◯ Divorced ◯ Never married

17. Your living arrangement: *(Mark all that apply.)*

◯ Alone ◯ With spouse or partner ◯ With other family ◯ With other people ◯ With pet(s)

18. Do you live in any of the following special residential settings?

◯ Nursing home ◯ Senior/retirement housing or community exclusively for people age 55+
◯ Assisted living facility ◯ None of the above

19. What is your *current* work status: *(Mark all that apply.)*

◯ Retired ◯ Disabled ◯ Full-time non-nursing employment ◯ Part-time non-nursing employment
◯ Nursing full-time ◯ Nursing part-time ◯ Full-time **volunteer** ◯ Part-time **volunteer**

20. During the last 12 months, how often have you leaked or lost control of your urine?

◯ Never ◯ Less than once/month ◯ Once/month ◯ 2–3 times/month ◯ About once/week ◯ Almost every day

I) When you lose your urine, how much usually leaks?

◯ A few drops ◯ Enough to wet your outerclothing
◯ Enough to wet your underwear ◯ Enough to wet the floor

II) When you lose urine, what is the usual cause?

ⓐ Coughing, sneezing, laughing, or doing physical activity ⓑ A sudden and urgent need to go to the bathroom
ⓒ Both a) and b) equally ⓓ In other circumstances

3/8" PERF

21. Regular Medication *(Mark if used regularly in past 2 years)*

Analgesics

◯ Acetaminophen (e.g., Tylenol)

Days per week:	◯ 1	◯ 2–3	◯ 4–5	◯ 6+ days
Total tablets per week:	◯ 1–2	◯ 3–5	◯ 6–14	◯ 15+ tablets

◯ Low dose aspirin (100 mg or less/tablet)

Days per week:	◯ 1	◯ 2–3	◯ 4–5	◯ 6+ days
Total tablets per week:	◯ 1–2	◯ 3–5	◯ 6–14	◯ 15+ tablets

◯ Aspirin or aspirin-containing products (325mg or more/tablet)

Days per week:	◯ 1	◯ 2–3	◯ 4–5	◯ 6+ days
Total tablets per week:	◯ 1–2	◯ 3–5	◯ 6–14	◯ 15+ tablets

◯ Ibuprofen (e.g., Advil, Motrin, Nuprin)

Days per week:	◯ 1	◯ 2–3	◯ 4–5	◯ 6+ days
Total tablets per week:	◯ 1–2	◯ 3–5	◯ 6–14	◯ 15+ tablets

◯ Celebrex

Days per week:	◯ 1	◯ 2–3	◯ 4–5	◯ 6+ days

◯ Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naproxen, Clinoril, Relafen, Indocin)

Other Regularly Used Medications

◯ Lasix, Bumex, or Demadex

◯ Thiazide diuretic ◯ Potassium

◯ Calcium blocker (e.g., Calan, Procardia, Cardizem, Norvasc)

◯ Beta-blocker (e.g., Lopressor, Tenormin, Corgard, Coreg)

◯ ACE Inhibitors (e.g., Capoten, Vasotec, Zestril)

◯ Angiotensin receptor blocker (e.g., Diovan, Losartan, Avapro)

◯ Other anti-hypertensive (e.g., clonidine, doxazosin)

◯ Coumadin ◯ Plavix ◯ Pradaxa/Xarelto/Eliquis/Savaysa

◯ Prasugrel (Effient) ◯ Digoxin ◯ Antiarrhythmic

"Statin" cholesterol-lowering drug:
◯ Mevacor (lovastatin) ◯ Lipitor (atorvastatin)
◯ Pravachol (pravastatin) ◯ Crestor
◯ Zocor (simvastatin) ◯ Other

◯ Other cholesterol-lowering drug

◯ Steroids taken orally (e.g., Prednisone, Decadron, Medrol)

◯ Insulin ◯ Metformin (glucophage) ◯ Actos

◯ Other oral hypoglycemic medication

◯ Opioid pain medications (e.g., codeine, Percocet, Vicodin, tramadol)

◯ SSRIs (Celexa, Lexapro, Prozac, Paxil, Zoloft, Luvox, fluoxetine, citalopram)

◯ Tricyclics (e.g., amitriptyline, nortriptyline, imipramine)

◯ SNRIs /Other antidepressants (Wellbutrin, Effexor, Remeron, Cymbalta, veniafaxine, bupropion)

◯ Minor tranquilizers (e.g., Valium, alprazolam, lorazepam)

◯ Prilosec, Nexium, Prevacid, Protonix, Aciphex

◯ H2 blocker (e.g., Pepcid, Zantac, Axid, Tagamet)

◯ Aricept, Exelon, Razadyne ◯ Namenda

◯ Fosamax, Actonel, Boniva, Reclast, or other bisphosphonate

◯ Thyroid hormone (e.g., Synthroid, Levothroid, extract)

◯ Ambien, Sonata, Lunesta or zolpidem

◯ Other prescription sleep medications (e.g., Trazodone, Rozerem)

◯ Over-the-counter sleep medications

◯ Other regular medications (no need to specify)

3/8" PERF

22. Choose the best answer for how you felt the *past month*:

Are you basically satisfied with your life?	◯ Yes	◯ No
Have you dropped many of your activities and interests?	◯ Yes	◯ No
Do you feel that your life is empty?	◯ Yes	◯ No
Do you often get bored?	◯ Yes	◯ No
Are you in good spirits most of the time?	◯ Yes	◯ No
Are you afraid that something bad is going to happen to you?	◯ Yes	◯ No
Do you feel happy most of the time?	◯ Yes	◯ No
Do you often feel helpless?	◯ Yes	◯ No
Do you prefer to stay at home, rather than going out and doing new things?	◯ Yes	◯ No
Do you feel you have more problems with memory than most?	◯ Yes	◯ No
Do you think it is wonderful to be alive now?	◯ Yes	◯ No
Do you feel pretty worthless the way you are now?	◯ Yes	◯ No
Do you feel full of energy?	◯ Yes	◯ No
Do you feel that your situation is hopeless?	◯ Yes	◯ No
Do you think that most people are better off than you are?	◯ Yes	◯ No

23. During the past month, how many hours of actual sleep did you get most nights?

◯ Less than 4 hours ◯ 4 hrs ◯ 5 hrs ◯ 6 hrs ◯ 7 hrs ◯ 8 hrs ◯ 9 hrs ◯ 10 hrs ◯ 11+ hrs

24. During the past month, how would you rate your sleep quality overall?

◯ Very good ◯ Fairly good ◯ Fairly bad ◯ Very bad

25. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

◯ Not during the past month ◯ Less than once a week ◯ 1 or 2 times a week ◯ 3+ times a week

26. Please rate your ability to do the following activities. *(Mark one answer for each row.)*

Are you able to . . .	Without Help	With Some Help	Unable
a. Get to places out of walking distance	◯ Drive car, or travel alone on bus, train, or taxi	◯ Need someone to help you or go with you	◯ Unable to travel except by ambulance, etc.
b. Go shopping for groceries or clothes (assuming you had transportation)	◯ Can shop by yourself, assuming you had transportation	◯ Need someone to help you on all shopping trips	◯ Completely unable to do any shopping
c. Prepare your own meals	◯ Plan and cook full meals yourself	◯ Can prepare some things. Unable to cook full meals	◯ Completely unable to prepare any meals
d. Do your own housework	◯ Can clean floors, bathroom, etc.	◯ Need help with heavy housework & cleaning	◯ Completely unable to do any housework
e. Handle your own money	◯ Write checks, pay bills, etc., by yourself	◯ Can manage day-to-day buying. Need help with checkbook & paying bills	◯ Completely unable to handle money
f. Handle your medications	◯ Able to keep track of and take meds yourself	◯ Need someone to help manage medications	◯ Completely unable to manage medications

3/8" PERF

27. How many hours <u>each week</u> do you participate in any groups such as a social or work group, church-connected group, self-help group, charity, public service or community group?

◯ None ◯ 1 to 2 hours ◯ 3 to 5 hours ◯ 6 to 10 hours ◯ 11 to 15 hours ◯ 16 or more hours

28. How often do you go to religious meetings or services?

◯ More than once a week ◯ Once a week ◯ 1 to 3 times per month
◯ Less than once per month ◯ Never or almost never

29. To what extent is your religion or spirituality involved in understanding or dealing with stressful situations?

◯ Not involved at all ◯ Not very involved ◯ Somewhat involved ◯ Very involved

30. Over the past year, have you had a discussion with any of your healthcare providers about the kind of medical care you would want if you were faced with a serious illness?

◯ No, and I do not intend to do so anytime soon
◯ No, but I have considered doing so
◯ Yes, I have discussed these matters with my healthcare provider

If Yes: **Who initiated this discussion?** ◯ You or your family ◯ Your healthcare provider

31. Have you established any form of advance care planning for yourself in the event of serious illness? *(Mark all that apply and provide most recent date the form was updated.)*

◯ **Health care proxy/durable power of attorney for healthcare**
➡ If yes, year form completed? ◯ before 2005 ◯ 2005–12 ◯ 2013–15 ◯ 2016–present

◯ **Physician or Medical Orders for Life Sustaining Treatment OR other similar forms** (e.g., Do Not Resuscitate (DNR))
➡ If yes, year form completed? ◯ before 2005 ◯ 2005–12 ◯ 2013–15 ◯ 2016–present

◯ **Living will for healthcare**
➡ If yes, year form completed? ◯ before 2005 ◯ 2005–12 ◯ 2013–15 ◯ 2016–present

◯ **Other** ◯ **Not sure** ◯ **None of these**

32. The next set of questions asks about preferences for care during the last months of life. Suppose that you had a very serious illness, and no one knew exactly how long you would live. However, your doctors said <u>you almost certainly would live less than 1 year</u>.

a) In that situation, would you be more concerned that you would receive too little medical treatment or too much medical treatment?
◯ Too little ◯ Too much ◯ Not concerned ◯ Don't know

b) If that illness got worse, where would you like to spend your last days?
◯ In a hospital ◯ In a nursing home ◯ At home ◯ Don't know

c) To deal with that illness, do you think you would want drugs that would make you feel worse all the time but might prolong your life? ◯ Yes ◯ No ◯ Don't know

d) If you reached the point at which you were feeling bad all the time, would you want drugs that would make you feel better, even if they might shorten your life? ◯ Yes ◯ No ◯ Don't know

e) If you needed a respirator to stay alive, would you want to be put on a respirator, if it would extend your life:

1) For one week? ◯ Yes ◯ No ◯ Don't know
2) For one month? ◯ Yes ◯ No ◯ Don't know

33. Do you currently take multi-vitamins?

◯ No ◯ Yes ➡ **a) How many do you take per week?** ◯ 2 or less ◯ 3–5 ◯ 6–9 ◯ 10 or more

34. Aside from multi-vitamins, do you currently take Vitamin D (separately or in calcium supplement)**?**

◯ No ◯ Yes, seasonal only ◯ Yes, most months ➡ If Yes, } Dose per day: ◯ Less than 600 IU ◯ 600 to 900 IU ◯ 1000 to 1500 IU ◯ 2000 IU or more ◯ Don't know

35. How often do you use a laxative (such as softeners, bulking agents, fiber supplements or suppositories)**?**

◯ Never ◯ < Once/month ◯ 1–3 times/month ◯ Once/week
◯ 2–3 times/wk ◯ 4–5 times/wk ◯ Daily ◯ 2+ times/day

36. How frequently do you have a bowel movement?

◯ More than twice a day ◯ Twice a day ◯ Daily ◯ Every other day ◯ Every 3–4 days ◯ Every 5 days or less

3/8" PERF

37. In the past year, have you been bothered by constipation for at least 12 weeks (not necessarily consecutive)?

◯ Yes → **Have you talked with a healthcare provider about your constipation?**
◯ Yes, my primary physician ◯ Yes, a specialist (gastroenterologist) ◯ No

◯ No

Mark any of the following that are usually true for you:
◯ I have rectal symptoms (i.e., painful BMs, incomplete BMs, straining)
◯ I have abdominal pain/bloating that improves with BMs

38. Has anyone noticed that you stop breathing during your sleep?

◯ No ◯ Yes

39. Has your spouse (or sleep partner) ever told you that you appear to "act out your dreams" while sleeping (punched or flailed arms in the air, shouted or screamed), which has occurred at least three times?

◯ No ◯ Yes ◯ I do not have a sleep partner

40. The following items are about activities you might currently do during a typical day. Does your health now limit you in these activities? If so, how much? *(Mark one response on each line.)*

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, like running, lifting heavy objects, strenuous sports	◯	◯	◯
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	◯	◯	◯
Lifting or carrying groceries	◯	◯	◯
Climbing *several* flights of stairs	◯	◯	◯
Climbing *one* flight of stairs	◯	◯	◯
Bending, kneeling, or stooping	◯	◯	◯
Walking *more than a mile*	◯	◯	◯
Walking *several* blocks	◯	◯	◯
Walking *one* block	◯	◯	◯
Bathing or dressing yourself	◯	◯	◯

41. For each statement, mark the answer that best describes the degree to which you agree or disagree.

	Strongly disagree	Somewhat disagree	Slightly disagree	Slightly agree	Somewhat agree	Strongly agree
I enjoy making plans for the future and working to make them a reality.	◯	◯	◯	◯	◯	◯
My daily activities often seem trivial and unimportant to me.	◯	◯	◯	◯	◯	◯
I am an active person in carrying out the plans I set for myself.	◯	◯	◯	◯	◯	◯
I don't have a good sense of what it is I'm trying to accomplish in life.	◯	◯	◯	◯	◯	◯
I sometimes feel as if I've done all there is to do in life.	◯	◯	◯	◯	◯	◯
I live life one day at a time and don't really think about the future.	◯	◯	◯	◯	◯	◯
I have a sense of direction and purpose in my life.	◯	◯	◯	◯	◯	◯

42. Which best describes your hearing:

◯ Excellent ◯ Good ◯ A little hearing trouble ◯ Moderate hearing trouble ◯ A lot of trouble ◯ Deaf

43. Have you noticed a change in your hearing?

◯ Yes → **At what age did you first notice a change in your hearing?**

◯ No

◯ <40 years ◯ 40–49 ◯ 50–54 ◯ 55–59 ◯ 60–64 ◯ 65–69 ◯ 70–74 ◯ 75+ ◯ Unsure

44. In the past 12 months, have you had ringing, roaring, or buzzing in your ears?

◯ Never ◯ Once per week or less ◯ A few days per week ◯ Almost every day ◯ Daily

a) On the days you hear the sound, how long does it last?
◯ A few seconds ◯ Less than 5 minutes ◯ 5 minutes to an hour ◯ Several hours ◯ All the time

b) Does the sound affect your ability to:
◯ Sleep ◯ Work ◯ Perform other activities ◯ None of these

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45. Since June 2014, have any of the following events occurred?

Event	Yes	No
Death of your spouse	◯ Yes	◯ No
Death of another close family member	◯ Yes	◯ No
Death of a close friend	◯ Yes	◯ No
A significant negative change in your financial, business or work situation	◯ Yes	◯ No
Major conflict or problems in relationships with relatives, friends, or neighbors	◯ Yes	◯ No
A significant negative change in your living conditions	◯ Yes	◯ No

46a. Do you regularly provide care to your disabled or ill spouse/partner?

◯ No ◯ Yes → **Number of hours per week?** ◯ 1–8 hours ◯ 9–20 hrs ◯ 21–35 hrs ◯ 36–72 hrs ◯ 73+ hrs

b. Outside of employment, do you regularly provide care to another disabled or ill person?

◯ No ◯ Yes → **Number of hours per week?** ◯ 1–8 hours ◯ 9–20 hrs ◯ 21–35 hrs ◯ 36–72 hrs ◯ 73+ hrs

47. For each statement, mark the answer that best describes the degree to which you agree or disagree.

Statement	Strongly disagree	Disagree	Slightly disagree	Neutral	Slightly agree	Agree	Strongly agree
I have so much in life to be thankful for.	◯	◯	◯	◯	◯	◯	◯
If I had to list everything that I felt grateful for, it would be a very long list.	◯	◯	◯	◯	◯	◯	◯
When I look at the world, I don't see much to be grateful for.	◯	◯	◯	◯	◯	◯	◯
I am grateful to a wide variety of people.	◯	◯	◯	◯	◯	◯	◯
As I get older I find myself more able to appreciate the people, events and situations that have been part of my life history.	◯	◯	◯	◯	◯	◯	◯
Long amounts of time can go by before I feel grateful to something or someone.	◯	◯	◯	◯	◯	◯	◯

48. Did you need any help from someone else to complete this questionnaire?

◯ No ◯ Yes, I received help from someone else but I provided most of the input
◯ Yes, someone else completed it on my behalf with minimal input from me

If Yes: **I needed help with:** ◯ Vision ◯ Writing ◯ Memory ◯ Other
Who helped? ◯ Spouse/partner ◯ Adult child ◯ Other family ◯ POA

Explain briefly in the space below why your help was needed (e.g., vision, Parkinson's, dementia, etc.). Include your name, address, telephone number or email address, and your relationship to the participant.

49. Please indicate the name of someone at a *DIFFERENT PERMANENT ADDRESS* to whom we might write in the event we are unable to contact you:

Name: ____________________

Address: ____________________

____

Phone or Email: ____________________

2016 ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ 2017 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ 2018 ① ② ③ ④ ⑤ ⑥

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