

Participant sticker

The ADDITION Study:

a study about screening for diabetes

ISRCTN No. 99175498

General Questionnaire

Please try to answer all the questions

**If you have any queries, please ask one of the staff
Your answers will be treated as confidential and
will only be used for medical research**

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Section A. General questionnaire.

A1. Are you taking any tablets or medicines at the moment? Yes [] No []

A2. What are they and what are they for?

For eg: BENDROFLUAZIDE 2.5mg/day Blood Pressure

Are you taking regular vitamins? Yes [] No []

If yes..... *which one?* _____

A3. During the course of last year, on average how many times a week did you eat the following foods?

Food Type	Times/week	Portion size
Vegetables (not including potatoes)	<input type="checkbox"/> <input type="checkbox"/>	medium serving
Salads	<input type="checkbox"/> <input type="checkbox"/>	medium serving
Fruit and fruit products (not including fruit juice)	<input type="checkbox"/> <input type="checkbox"/>	medium serving or 1 fruit
Fish and fish products	<input type="checkbox"/> <input type="checkbox"/>	medium serving
Meat, meat products and meat dishes (including bacon, ham and chicken)	<input type="checkbox"/> <input type="checkbox"/>	medium serving

A4. Have you taken any vitamins, minerals, fish oils, fibre or other food supplements during the past year?

If yes, please complete the table below. If you have taken more than 5 types of supplement please put the most frequently consumed brands first.

Vitamin supplements Name and Brand Please list full name, Brand and strength	Dose Please State Number of pills, capsules or teaspoons consumed	Average frequency Tick one box per line to show how often on average you consumed supplements									
		Never Or less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day	
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	

For women only

A5. Are you on a special diet at the moment?

Yes [] No []

If yes..... What type of diet is it?

Is there any special reason why you are on it?

Please specify

A6. Has a doctor ever told you that you have any of the following?

	Yes	No	Age first Diagnosed	If treated in which hospital
High blood cholesterol (hyperlipidaemia)	[]	[]	[] yrs	[]
High blood pressure (hypertension)	[]	[]	[] yrs	[]
Angina	[]	[]	[] yrs	[]
Heart Attack (myocardial infarction)	[]	[]	[] yrs	[]
Stroke	[]	[]	[] yrs	[]
Cardiac arrhythmia/ palpitations/ irregular heartbeat	[]	[]	[] yrs	[]

Please give details.....

Have you ever had an operation for coronary arteriosclerosis (balloon dilation of the coronary arteries or by-graft)?

Yes [] No []

A7. To which of these groups do you consider you belong?

White []

Black, Caribbean []

Black, African []

Black, other []

Please give details.....

Indian []

Pakistani []

Bangladeshi []

Chinese []

Other []

Please give details.....

Section B**Alcoholic drinks and smoking.****Smoking****B1. Do you smoke?**

Yes, daily []

Yes, occasionally (less than one cigarette, cigar or pipe a day) []

No, I have never smoked []

No, but previously I was a smoker. I quit in – year

If your answer is No, please go to B2

If Yes

B1b. How much do you smoke a day on average?

No. cigarettes a day []

No. cheroots a day []

No. cigars a day []

No. grams tobacco in a week []

Alcoholic Drinks**B2. How many units of alcohol do you consume in an average week?**

1 unit is equivalent to: $\frac{1}{2}$ pint of beer
 1 glass of wine
 1 single measure of spirits

Units per week

Beer _____

Wine _____

Spirits _____

Section C. Occupation.

C1. What is your current work status ?

In work - full time ie more than 30 hours per week	[]
part time work ie less than 30 hours per week	[]
keeping house	[]
wholly retired from work	[]
waiting to start a new job already obtained	[]
unemployed and looking for work	[]
out of work as temporarily sick	[]
permanently sick or disabled	[]

other, please specify _____

C2. Please could you give us some details about your present/or last job.

What is (was) the name or title of your job ?

What kind of work do (did) you do in your job ?

What training or qualifications are (were) needed for your job ?

Are (were) you working..... as an employee []
as self-employed []

Do (did) you supervise or have management responsibility for the work of other people ?

No	[]
Yes 1-24 people	[]
Yes 25 or more people	[]

C3. Do you have a partner?

Yes [] No []

If your answer is No, please go to C4

If yes

C3a. What kind of work does (did) s/he do in his/her job?

C3b. What training or qualifications are (were) needed for his/her job ?

C3c. Is (was) s/he working..... as an employee []
as self-employed []

C3d. Does (did) s/he supervise or have management responsibility for the work of other people?

No []
Yes; 1-24 people []
Yes; 25 or more people []

C4. At what age did you finish full time education? _____ years

Yes [] No []

Do you own or rent your home?

Own it/buying it Yes [] No []

Rent it Yes [] No []

C6a. What is your legal marital status?

Married []
Unmarried []
Divorced/Separated []
Widow/Widower []

C6b. Have you ever cohabited with someone without being married?

I am cohabiting with someone now []
I have cohabited with someone in the past []
I have never cohabited with someone []

Section D

Please take a few minutes to answer the questions below about the feeling in your legs and feet. Check yes or no based on how you usually feel.

	No	Yes
1. Are your legs and /or feet numb?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever have any burning pain in your legs and/or feet?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your feet sensitive to touch?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you get muscle cramps in your legs and/or feet?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you ever have any prickling feelings in your legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does it hurt when the bedcovers touch your skin?	<input type="checkbox"/>	<input type="checkbox"/>
7. When you get into the tub or shower, are you able to tell the hot water from the cold water?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had an open sore on your foot?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has your doctor ever told you that you have diabetic neuropathy?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel weak all over most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are your symptoms worse at night?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do your legs hurt when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you able to sense your feet when you walk?	<input type="checkbox"/>	<input type="checkbox"/>
14. Is the skin on your feet so dry that it cracks open?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had an amputation?	<input type="checkbox"/>	<input type="checkbox"/>

Total _____/15pts

Section E

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives.

The questions are about the time you spend being physically active in the last 7 days. They include questions about activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Your answers are important. Please answer each question even if you do not consider yourself to be an active person.

In answering the following questions,

- ◆ **vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal.
- ◆ **moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal.

1a During the last 7 days, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling? Think about *only* those physical activities that you did for at least 10 minutes at a time.

_____ days per week

None (Go to question 2a.)

1b How much time in total did you usually spend on one of those days doing vigorous physical activities?

_____ hours _____ minutes

2a Again, think *only* about those physical activities that you did for at least 10 minutes at a time. During the last 7 days, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

_____ days per week

None (Go to question 3a.)

2b How much time in total did you usually spend on one of those days doing moderate physical activities?

_____ hours _____ minutes

3a During the last 7 days, on how many days did you walk for at least 10 minutes at a time? This includes walking at work and at home, walking to travel from place to place, and any other walking that you did solely for recreation, sport, exercise or leisure.

_____ days per week

None (Go to question 4.)

3b How much time in total did you usually spend walking on one of those days?

_____ hours _____ minutes

4 The last question is about the time you spent sitting on weekdays while at work, at home, while doing course work and during leisure time. This includes time spent sitting at a desk, visiting friends, reading travelling on a bus or sitting or lying down to watch television.

During the last 7 days, how much time in total did you usually spend *sitting* on a **week day**?

_____ hours _____ minutes

Section F EuroQol

Please indicate which statements best describe your health state, today, by marking one box in each group with a cross like this: X

1 MOBILITY

I have no problems in walking about

I have some problems in walking about

I am confined to bed

2 SELF CARE

I have no problems with self-care

I have some problems washing and dressing myself

I am unable to wash or dress myself

3 USUAL ACTIVITIES

(eg work, study, housework, family or leisure activities)

I have no problems with performing my usual activities

I have some problems with performing my usual activities

I am unable to perform my usual activities

4 PAIN/DISCOMFORT

I have no pain or discomfort

I have moderate pain or discomfort

I have extreme pain or discomfort

5 ANXIETY/DEPRESSION

I am not anxious or depressed

I am moderately anxious or depressed

I am extremely anxious or depressed

Section G

PATIENT COSTS

This part of the questionnaire asks about the costs of attending the hospital

1. Please circle the number that best describes how you travelled from your home to the hospital. If you used more than one form of transport please indicate the way you travelled for the **main** (longest in terms of distance) part of your journey.

Walked	1
Cycled	2
Bus	3
Train.....	4
Taxi.....	5
Private car.....	6
Motorbike.....	7
Other (please specify).....	8

2. If you travelled by public transport (e.g. bus, train, taxi) for part or the entire journey, what was the cost of the return fare? Please write the cost in the space below.

Put Zero if you did not travel by public transport at all or if you did not pay a fare.

Cost of return fare (£) _____

3. If you travelled by private car or motorbike for part of or the entire journey how many miles did you travel **one way**? Please write the number of miles in the space below.

Put Zero if you did not travel by private car or motorbike at all.

Number of miles_____

If you travelled by private car or motorbike for part of or the entire journey and had to pay parking fees how much did these amount to? Please write the cost in the space below.

Put zero if you did not travel by private car or motorbike at all or did not pay parking fees.

Expenditure on parking fees (£) _____

4. How long did it take to travel from your home to the hospital? Please write the number of hours and minutes in the space below.

Number of _____ hours _____ minutes

5 Did anyone come with you to the hospital? Please circle the appropriate answer below.

Yes (please continue with question 6).....	1
No (go to question 7).....	2

6 Who accompanied you to the hospital? Please circle the number(s) that best describe the person(s) who accompanied you to the hospital? You may circle more than one answer.

Partner/Spouse.....	1
Child/Children under 16 years.....	2
Other relative.....	3
Paid caregiver.....	4
Other (Please specify)	5

7. Did you get someone to look after your child/children or other dependants (if you have any) while you were at the hospital? Please circle the appropriate answer.

Yes	1
No	2
Not applicable (no children or dependants)..	3

Section H

- Many people find a way of using their medicines or pills which suits them.
- This may differ from the instructions on the label or what their doctor has said.
- We would like to ask you a few questions about how you use your medicines or pills.
- Here are some ways in which other people have said they use their medicines.

For each of the statements, please tick the box that best describes how you have used your medicines or pills, in the **last month**.

There are no right or wrong answers. We are interested in your personal views.

QUESTIONS ABOUT USING MEDICINES PRESCRIBED FOR YOU

For each statement, please place a tick in one box	Always	Often	Sometimes	Rarely	Never
I forgot to take my medicines					
I altered the dose of my medicines					
I stopped taking my medicines for a while					
I decided to miss out a dose					
I took less than instructed					

Section I **Self Evaluation Questionnaire**

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the most appropriate number to the right to indicate how you feel right now, at this moment.

There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	Not at all	Somewhat	Moderately	Very much
I feel calm	1	2	3	4
I am tense	1	2	3	4
I feel upset	1	2	3	4
I am relaxed	1	2	3	4
I feel content	1	2	3	4
I am worried	1	2	3	4

Please make sure you answer all the questions.

MANY THANKS FOR YOUR HELP