

# LONGITUDINAL STUDY OF AGING OF DANISH TWINS

## FEBRUARY - MARCH 1995

SERIAL NO.:	
Personal identification number	
Name	
Address	
Interviewer code (The same interviewer must not interview A and B in a pair of twins).	
Name of interviewer	
Date of interview	

Result codes of interviews during visit:

- 01 ☐ Interview conducted
- 02 ☐ Interview partly conducted
- 03 ☐ Refusal, no interests, no time, appointment not kept
- 04 ☐ Illness
- 05 ☐ Senility/dementia
- 06 ☐ At hospital
- 07 ☐ Travelling
- 08 ☐ Not at home
- 09 ☐ Moved away
- 10 ☐ Cannot be interviewed due to handicap
- 11 ☐ Other matters

**If 04 - 10, relatives or nursing staff must be interviewed.**

*I will now start by asking you about your cohabitation.*

1. How many people live in your house apart from yourself?

# \_\_\_\_\_

**If the twin is living alone, proceed to question 3. If the twin is not living alone, proceed to question 2.**

2. Who are these?

- a. ☐ Spouse
- b. ☐ Common law wife/husband
- c. ☐ Twin
- d. ☐ Other sisters/brothers
- e. ☐ Child/Children
- f. ☐ Parents
- g. ☐ Other relatives
- h. ☐ Close friend/friends
- i. ☐ Nursing home
- j. ☐ Sheltered accomodation
- k. ☐ Others

**Proceed to question 6.**

3. For how many years have you lived by yourself?

# \_\_\_\_\_

4. With whom did you live together before?

- 1. ☐ Spouse
- 2. ☐ Common law wife/husband
- 3. ☐ Twin
- 4. ☐ Other sisters/brothers
- 5. ☐ Child/children
- 6. ☐ Parents
- 7. ☐ Other relatives
- 8. ☐ Close friend/friends
- 9. ☐ Others

5. Why did you stop living together?

- 1. ☐ Death of common law wife/husband
- 2. ☐ Common law wife/husband moved to nursing home or institution
- 3. ☐ Divorce
- 4. ☐ Disagreement
- 5. ☐ Cohabitant went into another relationship
- 6. ☐ Other matters

*I will now ask you about your health.*

6. Do you think that your health is generally?	1. <input type="checkbox"/> Excellent 2. <input type="checkbox"/> Good 3. <input type="checkbox"/> Acceptable 4. <input type="checkbox"/> Poor 5. <input type="checkbox"/> Very poor
7. Compared with other people at your age how do you consider your health?	1. <input type="checkbox"/> Better 2. <input type="checkbox"/> Like most people 3. <input type="checkbox"/> Poorer
8. Do you feel well enough to do what you like?	1. <input type="checkbox"/> Yes, always 2. <input type="checkbox"/> Yes, nearly always 3. <input type="checkbox"/> Yes, now and then 4. <input type="checkbox"/> No, hardly ever 5. <input type="checkbox"/> No, never
9. Are you happy and satisfied with your life at present?	1. <input type="checkbox"/> Yes, always 2. <input type="checkbox"/> Yes, nearly always 3. <input type="checkbox"/> Yes, now and then 4. <input type="checkbox"/> No, hardly ever 5. <input type="checkbox"/> No, never
<b>Did a doctor ever tell you that you had any of the following diseases:</b>	
10a. Diabetes?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10b. Osteoarthritis?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10c. Rheumatoid arthritis?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10d. Gout (podagra)?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10e. Osteoporosis?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10f. Chronic bronchitis?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10g. Tuberculosis?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

10h. Asthma?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10i. Cataract?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10j. Glaucoma?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10k. Sclerosis in your eye?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10l. Thrombosis in your eye?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10m. Meningitis?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10n. Inflammation of the brain?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10o. Parkinson's disease?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10p. Epilepsy?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10q. Migraine?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10r. Cancer?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10s. Stroke?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10t. Heart attack?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10u. Angina pectoris?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10v. Irregular heart rhythm?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

10w. Treatment for hypertension with medicine bought on prescription?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10x. Other heart problems?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10y. Wet lungs?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10z. Bad blood circulation in your legs?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10æ. Gallstone?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10ø. Jaundice?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10â. Treatment for gastric ulcer with medicine bought on prescription?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10aa. Kidney's disease?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10bb. Kidney stones?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10cc. Increased metabolism?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10dd. Decreased metabolism?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
10ee. Slipped disc?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

***Did you ever experience:***

11a. Paralysis of arms or legs?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
11b. Chronic leg sore?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
11c. Amputation of leg, part of leg or foot?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
11d. A fracture of the femur/neck of femur?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
11e. A fracture of the spine?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
12. On how many occasions did you fracture a bone after the age of 40? (excluding toes and fingers)	# _____
13. Did you ever hit your head so seriously that you had nausea or threw up afterwards? (without getting unconscious)?	0. <input type="checkbox"/> No, never 1. <input type="checkbox"/> Once 2. <input type="checkbox"/> Twice 3. <input type="checkbox"/> Three times or more
Did you ever hit your head so seriously that you got unconscious?	0. <input type="checkbox"/> No, never 1. <input type="checkbox"/> Once 2. <input type="checkbox"/> Twice 3. <input type="checkbox"/> Three times or more
Have you had other diseases than the ones that we already discussed?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 17

16. If yes, which?

16a. \_\_\_\_\_

16b. \_\_\_\_\_

16c. \_\_\_\_\_

16d. \_\_\_\_\_

16e. \_\_\_\_\_

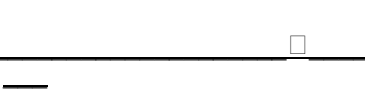
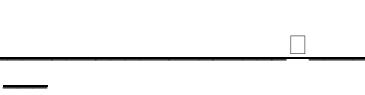
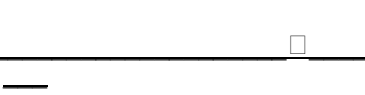
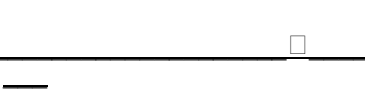
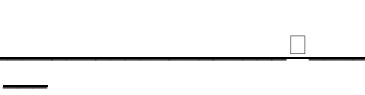
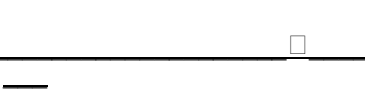
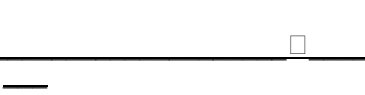
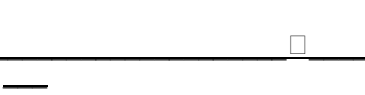
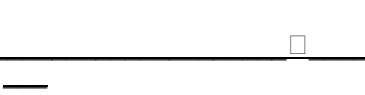
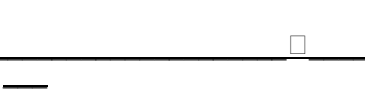
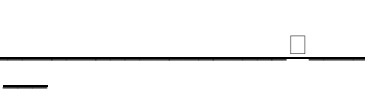
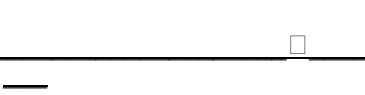
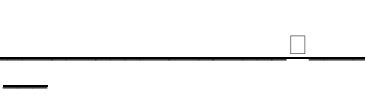
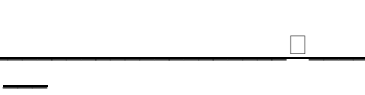
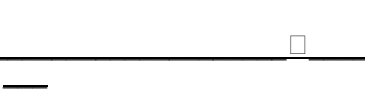
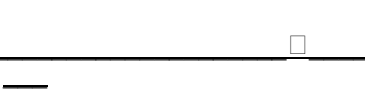
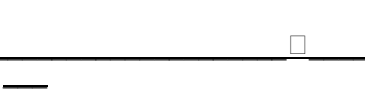
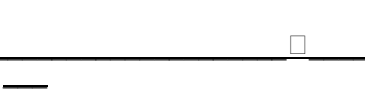
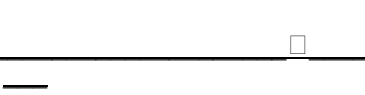
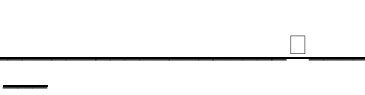
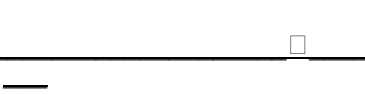
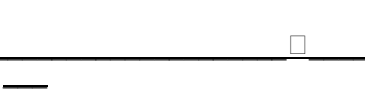
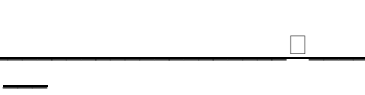
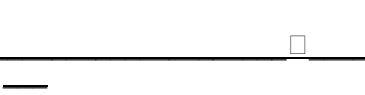
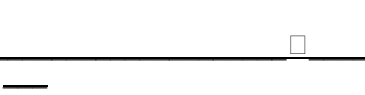
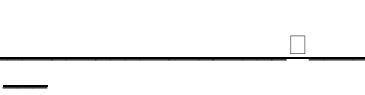
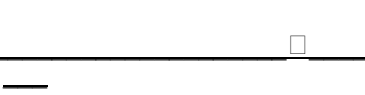
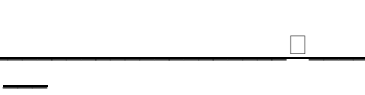
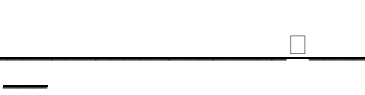
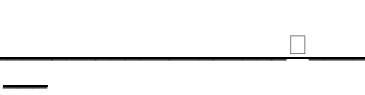
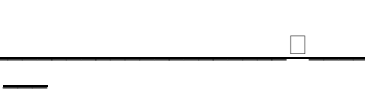
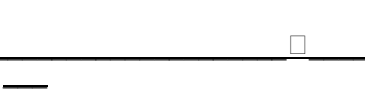
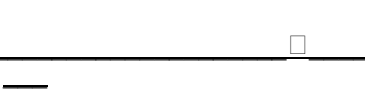
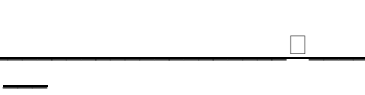
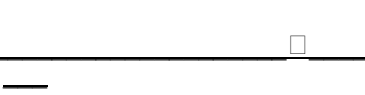
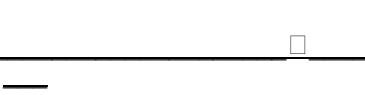
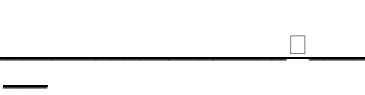
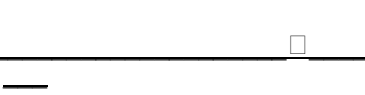
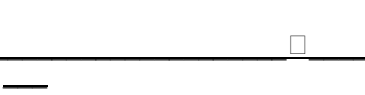
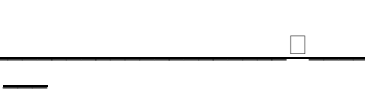
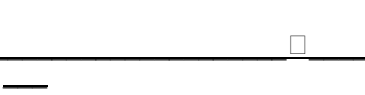
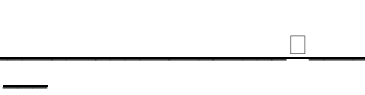
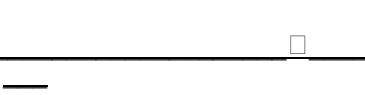
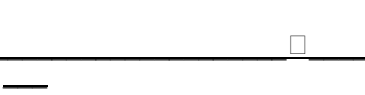
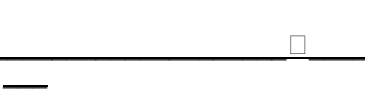
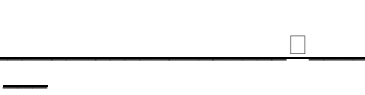
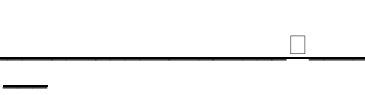
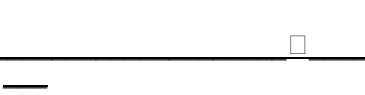
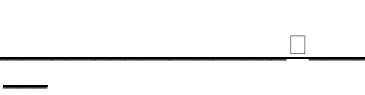
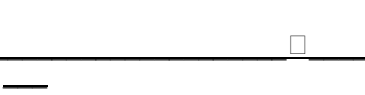
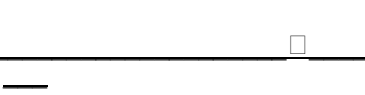
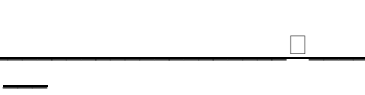
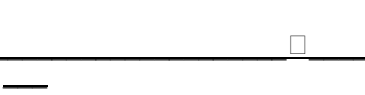
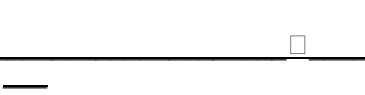
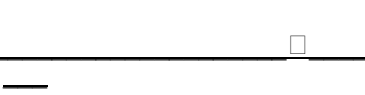
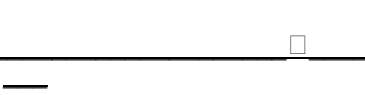
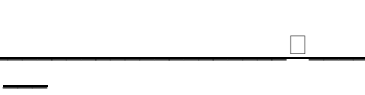
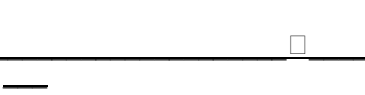
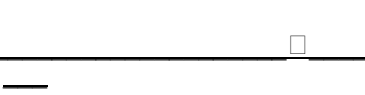
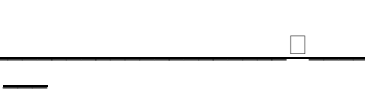
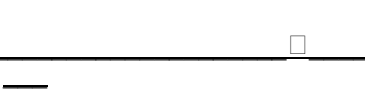
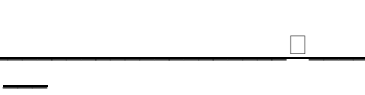
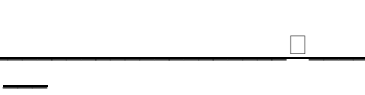
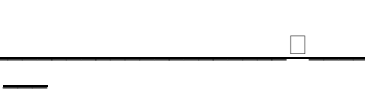
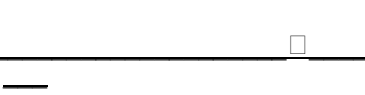
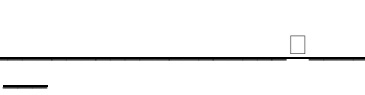
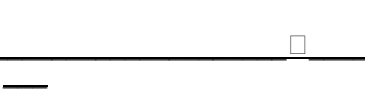
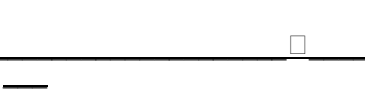
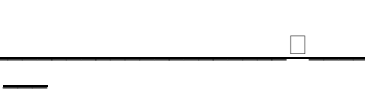
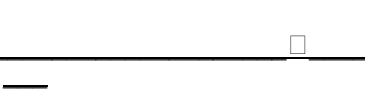
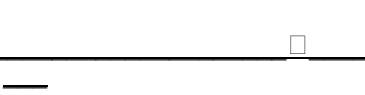
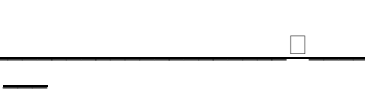
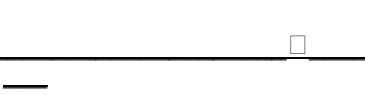
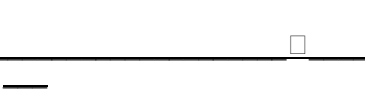
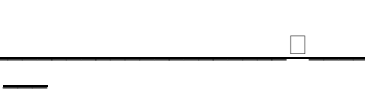
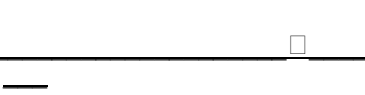
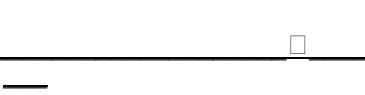
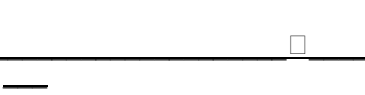
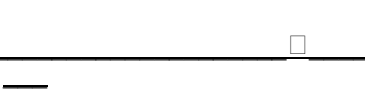
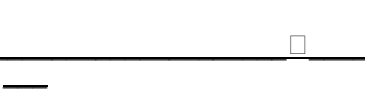
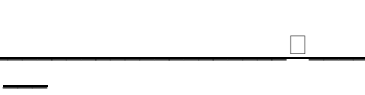
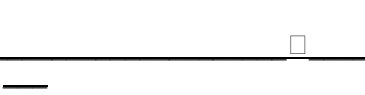
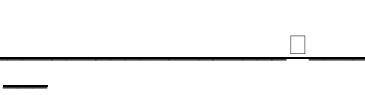
17. Within the last month, did you suffer from:	
a. Dizziness	1. <input type="checkbox"/> Yes      2. <input type="checkbox"/> No
b. Fainting fits	1. <input type="checkbox"/> Yes      2. <input type="checkbox"/> No
c. Pains or stiffness in neck or shoulder	1. <input type="checkbox"/> Yes      2. <input type="checkbox"/> No
d. Back pains, lumbago	1. <input type="checkbox"/> Yes      2. <input type="checkbox"/> No

*I want to make a list of all the medicine you take on a regular basis, such as medicine on prescription, without prescription, and natural medicine.*

18. **NAME:**

**INDICATION:**

**FREQUENCY:**

19.	Did you take Asperin or other mild analgesics for longer periods? (apart from Paracetamol/Panodil/Pinex)	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 21
20.	For how many years did you take Asperin or other mild analgesics at least once a week?	# _____
20a.	On an average, how many pills did you take a week during these years?	# _____
21.	Did you for longer periods take medicine for gastric acid or gastric ulcer?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, skip question 22
22.	App. how many years have you had a weekly consumption of medicine for gastric acid or gastric ulcer?	# _____

**If the respondent is - Male** - proceed to question 23.  
**If the respondent is - Female** - proceed to question 33.

*Now, I want to ask, if you have any problems with urination. The questions concern the last month.*

23.	How often have you had to get up during the night in order to urinate?	1. <input type="checkbox"/> Not at all 2. <input type="checkbox"/> Once every 8th hour 3. <input type="checkbox"/> Once every 4th hour 4. <input type="checkbox"/> Once every 2nd hour 5. <input type="checkbox"/> At least once every hour
24.	How often have you had to push to begin urination?	1. <input type="checkbox"/> Not at all 2. <input type="checkbox"/> Less than 1 time in 5 3. <input type="checkbox"/> Less than half the time 4. <input type="checkbox"/> About half the time 5. <input type="checkbox"/> More than half the time 6. <input type="checkbox"/> Almost always
25.	How often have you had a sensation of not emptying your bladder completely after you finished urinating?	1. <input type="checkbox"/> Not at all 2. <input type="checkbox"/> Less than 1 time in 5 3. <input type="checkbox"/> Less than half the time 4. <input type="checkbox"/> About half the time 5. <input type="checkbox"/> More than half the time 6. <input type="checkbox"/> Almost always
26.	How often have you had to urinate again less than two hours after you finished urinating?	1. <input type="checkbox"/> Not at all 2. <input type="checkbox"/> Less than 1 time in 5 3. <input type="checkbox"/> Less than half the time 4. <input type="checkbox"/> About half the time 5. <input type="checkbox"/> More than half the time 6. <input type="checkbox"/> Almost always

27. How often have you found you stopped and started several times when you urinated?	1. <input type="checkbox"/> Not at all 2. <input type="checkbox"/> Less than 1 time in 5 3. <input type="checkbox"/> Less than half the time 4. <input type="checkbox"/> About half the time 5. <input type="checkbox"/> More than half the time 6. <input type="checkbox"/> Almost always
28. How often did you find it hard to postpone a urination?	1. <input type="checkbox"/> Never 2. <input type="checkbox"/> Less than 1 time in 5 3. <input type="checkbox"/> Less than half the time 4. <input type="checkbox"/> About half the time 5. <input type="checkbox"/> More than half the time 6. <input type="checkbox"/> Almost always
29. How often have you had a weak urinary stream?	1. <input type="checkbox"/> Never 2. <input type="checkbox"/> Less than 1 time in 5 3. <input type="checkbox"/> Less than half the time 4. <input type="checkbox"/> About half the time 5. <input type="checkbox"/> More than half the time 6. <input type="checkbox"/> Almost always
30. Did you <u>ever</u> get hormone treatment due to diseases in the prostate?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
31. Did you ever undergo an operation due to prostata disease?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 40
32. At which hospital and when? Go to question 40.	Year: _____ Hospital: _____

*I will now ask you some questions about your periods and urination.*

33. At what age did you experience menopause?	_____ Years
34. Did you receive hormone treatment in connection with your menopause?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
35. Did you receive hormone treatment in other connections (e.g. prevention against osteoporosis)?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
36. Have you ever had your uterus or ovaries removed?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
36a. At which hospital and when:	Year: _____ Hospital: _____

*Many women are finding it hard to restrain themselves from urination. The following questions are about this problem. The questions about urination concern the last month.*

<p>37. Do you experience such an urge to urinate that you do not reach the toilet in time?</p> <p>37a. If yes, how often?</p>	<p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 38</p> <p>1. <input type="checkbox"/> Less than once a week 2. <input type="checkbox"/> One or several times a week, but 3. <input type="checkbox"/> Daily</p>
<p>38. Do you experience a slight leakage of urination when you move around, exert yourself, cough or sneeze?</p> <p>38a. If yes, how often?</p>	<p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 39</p> <p>1. <input type="checkbox"/> Less than once a week 2. <input type="checkbox"/> One or several times a week but not daily 3. <input type="checkbox"/> Daily</p>
<p>39. Do you use sanitary towels due to urination problems?</p> <p>39a. If yes, how often?</p>	<p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 40</p> <p>1. <input type="checkbox"/> Less than once a week 2. <input type="checkbox"/> One or several times a week, but not daily 3. <input type="checkbox"/> Daily</p>
<p>40. Are you able to go to the toilet?</p> <p>40a. Do you get tired?</p>	<p>1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> Yes, with aids 3. <input type="checkbox"/> Yes, with personal assistance 4. <input type="checkbox"/> No, proceed to question 41.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Go to question 42.</p>
<p>41. Do you urinate in the toilet?</p> <p>41a. Do you bowel in the toilet?</p>	<p><input type="checkbox"/> Yes, proceed to question 42 <input type="checkbox"/> Some times <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> Some times <input type="checkbox"/> No</p>
<p>42. Did you experience that you lost control of urination and bowel movements?</p>	<p>1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes, now and then 3. <input type="checkbox"/> Yes, always 4. <input type="checkbox"/> Catheter</p>
<p>43. What is your body weight?</p> <p>43a. Is your weight:</p> <p>43b. How much did you weigh approximately at the age of 25?</p>	<p>kg: _____</p> <p>1. <input type="checkbox"/> According to IP 2. <input type="checkbox"/> Estimated</p> <p>kg: _____</p> <p>Do not remember, however, I weighed</p> <p>1. <input type="checkbox"/> More than now 2. <input type="checkbox"/> Less than now 3. <input type="checkbox"/> Approx. the same 8. <input type="checkbox"/> Do not know</p>

43c. What did your maximum body weight used to be? (excluding pregnancy)	kg: _____
44. How tall are you?	cm: _____
44a. Is your height?	1. <input type="checkbox"/> According to IP 2. <input type="checkbox"/> Estimated
45. Are you right- or lefthanded?	1. <input type="checkbox"/> Right 2. <input type="checkbox"/> Left

*I would like to ask you some questions about your family.*

46. For how many years did you and your twin live together? (from birth until you moved away from each other)	# _____
47. For how many years did you and your twin live together? (all the periods that you lived together)	# _____
48. Who had the highest birth weight?	1. <input type="checkbox"/> You 2. <input type="checkbox"/> Your twin 3. <input type="checkbox"/> Same weight 4. <input type="checkbox"/> Do not know
49. How much did you weigh at birth?	_____ Grammes <input type="checkbox"/> Do not know
49a. How much did your twin brother/sister weigh at birth?	_____ Grammes <input type="checkbox"/> Do not know
49b. Who was born first?	1. <input type="checkbox"/> You 2. <input type="checkbox"/> Your twin 3. <input type="checkbox"/> Do not know
50. Is your twin alive?  If yes,	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 53
50a. How do you consider your health compared to the health of your twin?	1. <input type="checkbox"/> Better 2. <input type="checkbox"/> The same 3. <input type="checkbox"/> Poorer

51. How often do you meet your twin?	1. <input type="checkbox"/> Never 2. <input type="checkbox"/> Seldom 3. <input type="checkbox"/> Monthly (once or twice a month) 4. <input type="checkbox"/> 1-2 times a week 5. <input type="checkbox"/> 3-4 times a week 6. <input type="checkbox"/> Daily 7. <input type="checkbox"/> More than once daily 8. <input type="checkbox"/> Live together
52. How often do you talk with your twin on the phone?	1. <input type="checkbox"/> Never 2. <input type="checkbox"/> Seldom 3. <input type="checkbox"/> Monthly (once or twice a month) 4. <input type="checkbox"/> 1-2 times a week 5. <input type="checkbox"/> 3-4 times a week 6. <input type="checkbox"/> Daily 7. <input type="checkbox"/> More than once daily 8. <input type="checkbox"/> Live together  Go to question 55.
53. How was your twin brother/sister a year before he/her died - For what did he/she need help?  53a. To walk? 53b. To bathe? 53c. To dress? 53d. To eat?	1. <input type="checkbox"/> Yes    2. <input type="checkbox"/> No    8. <input type="checkbox"/> Do not know 1. <input type="checkbox"/> Yes    2. <input type="checkbox"/> No    8. <input type="checkbox"/> Do not know 1. <input type="checkbox"/> Yes    2. <input type="checkbox"/> No    8. <input type="checkbox"/> Do not know 1. <input type="checkbox"/> Yes    2. <input type="checkbox"/> No    8. <input type="checkbox"/> Do not know
54. Did he/she live in a nursing home or sheltered housing before he/she died?  54a. Was your twin brother/sister senile or demented a year before he/she died?  54b. Did your twin brother/sister ever suffer from a serious depression of long duration?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 8. <input type="checkbox"/> Do not know  1. <input type="checkbox"/> Yes, to a high degree 2. <input type="checkbox"/> Yes, to some degree 3. <input type="checkbox"/> Yes, to a slight degree 4. <input type="checkbox"/> No 8. <input type="checkbox"/> Do not know  1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

55. How old did your mother become?	_____years
55a. How old did your father become?	_____years
56. How many children do you have? By children is meant biological children, adopted children, and children who died early in life. I <b>do not</b> think of your spouse's own children, unless they were adopted by you. (This is not a test. You may help IP, if needed)	# _____(biological) # _____(adopted)

If IP has biological children or adopted children, proceed to questions 57.  
If IP does not have any children, proceed to question 59.

57. First, I will ask you some questions about your first biological child and continue with the same questions about the second-oldest child etc. (This is not a test. You may assist IP)

Birthday	Name of Birth (First- and surname)	Native Town	Native Parish	Alive	Date of Death
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

57a. Now, I will ask you some questions about your eldest adopted child and continue with questions about the second-eldest child etc. (This is not a test. You may assist IP)

Birthday	Name of Birth (First- and surname)	Native Town	Native Parish	Alive	Date of Death
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

58. How often do you meet your children?

1. ☐ Never
2. ☐ Seldom
3. ☐ Monthly
4. ☐ Weekly
5. ☐ Daily
6. ☐ More than once daily

59. How often do you meet your family?  
(apart from your children, twin, grandchildren and  
children-in-law)

1. ☐ Never
2. ☐ Seldom
3. ☐ Monthly
4. ☐ Weekly
5. ☐ Daily
6. ☐ More than once daily

*Now, I am going to ask you some questions and to perform some small tests. You may think that they are very simple or very difficult.*

ORIENTATION		SCORE
60a. What day of the week is it today?      1. <input type="checkbox"/> correct      2. <input type="checkbox"/> wrong 60b. What date is it today?      1. <input type="checkbox"/> correct      2. <input type="checkbox"/> wrong 60c. What is the name of this month?      1. <input type="checkbox"/> correct      2. <input type="checkbox"/> wrong 60d. What year do we have?      1. <input type="checkbox"/> correct      2. <input type="checkbox"/> wrong 60e. What time of year is it?      1. <input type="checkbox"/> correct      2. <input type="checkbox"/> wrong March = Winter or Spring      May = Spring or Summer September = Summer or Autumn      November = Autumn or Winter		(5) _____
61a. What is the name of this county?      1. <input type="checkbox"/> correct      2. <input type="checkbox"/> wrong 61b. What is the name of this city?      1. <input type="checkbox"/> correct      2. <input type="checkbox"/> wrong 61c. What is the name of the two closest and biggest streets?      1. <input type="checkbox"/> correct      2. <input type="checkbox"/> wrong 61d. What floor are we on now?      1. <input type="checkbox"/> correct      1. <input type="checkbox"/> wrong 61e. What is the name of this place or the address?      1. <input type="checkbox"/> correct      2. <input type="checkbox"/> wrong		(5) _____
REGISTRATION		SCORE
62. <i>I am now going to test your memory. I will mention three objects.</i>  Mention the following three objects. You must only use one second at maximum to mention each object:  <p style="text-align: center;"><b>apple, table, bicycle.</b></p> Please repeat these three objects.  62a. Note the correct answer and write the total number of correct answers in <u>the first attempt</u> below scores.  <div style="display: flex; align-items: center;"> <input type="checkbox"/> apple  <input type="checkbox"/> table  <input type="checkbox"/> bicycle         </div> <p>If failures or faults occur in first attempt, you must repeat the names of all objects, until the respondent is able to mention all three objects (6 attempts at maximum). Write the number of attempts (write "0", if the repetition of all three objects is correct in first attempt)</p> 62b.                      # _____ (attempts)		(3) _____

ATTENTION AND CALCULATION	
<p>63. <i>I will ask you to deduct 7 from 100. Then you must deduct 7 from the number you arrived at and continue to deduct 7 until you are asked to stop.</i> Write the answers. Give one point each time the difference is 7 - even if a former answer was wrong. Maximum score = 5 points.</p> <p>93□   86□   79□   72□   65□</p> <p>If IP "cannot calculate",</p> <p><i>I will ask you to spell "SCHOOL" backwards. (5 letters in Danish: SKOLE)</i></p> <p>L□   O□   O□   H□   C□   S□</p>	<p>_____</p> <p>(5)</p>
RECALL	
<p>64. <i>Please repeat the the three words that I told you to repeat a little while ago.</i></p> <p>Write all the correct answers and write the total number of answers under scores.</p> <p>apple table bicycle</p>	<p>_____</p> <p>(3)</p>

LANGUAGE	SCORE
<p>65. Point at a pencil and then watch and ask what it is (1 point for each correct answer)</p> <p>66. I will now ask you to repeat the following sentence: "No one above, below or next to me". (1 point if repeated in the first attempt)</p> <p>67. Read aloud the text below and hand out a piece of paper to the respondent. Hand out the paper right in the middle of the respondent.</p> <p><i>I will give you a piece of paper. Your must take the paper using your right hand, fold it in the middle using both hands, and place the paper in your lap.</i></p> <p>Do not repeat the instructions and do not offer any help. Note every movement as correct, if it is made in the correct order. Maximum score = 3 points.</p> <p style="padding-left: 100px;">Right hand Folding In the lap</p> <p>68. Ask IP to read card A and to do what it says. (1 point, if the sentence gives meaning) (0 point, if the sentence does not give any meaning)</p> <p>69. Ask the patient to write a sentence according to own choice. (The sentence must contain a subject and a verb and have a meaning. Spelling errors and grammar to be ignored). (1 point, if the sentence gives meaning) (0 point, if the sentence does not give any meaning)</p>	<p>(2) _____</p> <p>(1) _____</p> <p>(3) _____</p> <p>(1) _____</p> <p>(1) _____</p>
<p>70. Ask the patient to draw the figure on Card B. (1 point, if all the sides and angles are correct, and if the figure in the middle is a quadrangle). (0 point, if not)</p> <p style="text-align: center;">0. <input type="checkbox"/> wrong    1. <input type="checkbox"/> correct</p>	<p>(1) _____</p>

71a. Was it possible to carry out the tests?

- ☐ Yes, proceed to question 72  
☐ Yes partly  
☐ No

71b. Why was it not possible to carry out some of the tests?

1. Visually handicapped
2. Hearing-handicapped
3. Paralyzed
4. Do not wish to participate
5. Other reasons

1. ☐
2. ☐
3. ☐
4. ☐
5. ☐

Remarks:

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72. On which date were you born?

\_\_\_\_\_  
Day    Month    Year

73. *Could you please mention as many animals as you can recall. You will get one minute to mention as many as you can. Please start.*

Number of correct answers

-----

## 74. DIGIT SPAN

The two parts of Digit Span - Digits Forward and Digits Backward - are administered separately. Administer Digits Backward even if the twin scores 0 on Digits Forward.

### DIGITS FORWARD

**DIRECTIONS** Start with Item 1. Say,

*I am going to say some numbers. Listen carefully, and when I am through say them right after me.*

The digits should be given at the rate of one per second. Let the pitch of voice drop on the last digit of each trial. Administer both trials of each item, even if the twin passes Trial 1.

**DISCONTINUE** After failure on both trials of any item.

**SCORING** Each item is scored 2, 1, or 0, as follows:

2 points, if the twin passes both tests.  
1 point, if the twin passes only one trial.  
0 point, if the twin fails both trials.

Maximum Score on Digits Forward: 14 points

Item	Trial 1.	Trial 2.	Score
1.	5-8-2	6-9-4	
2.	6-4-3-9	7-2-8-6	
3.	4-2-7-3-1	7-5-8-3-6	
4.	6-1-9-4-7-3	3-9-2-4-8-7	
5.	5-9-1-7-4-2-8	4-1-7-9-2-8-6	
6.	5-8-1-9-2-6-4-7	3-8-2-9-5-1-7-4	
7.	2-7-5-8-6-2-5-8-4	7-1-3-9-4-2-5-6-8	

## 75. DIGITS BACKWARD

### DIRECTIONS

Start with Item 1. Say,

*Now, I am going to say some more numbers, but this time when I stop I want you to say them backwards. For example, if I say 7-1-9, what would you say?*

Pause for the twin to respond.

If the twin responds correctly (9-1-7), say

**That's right,**

and proceed to Item 1. As with Digits Forward, read the digits at the rate of one per second and administer both trials of each item, even if the twin passes Trial 1.

However, if the twin fails the example, say,

**No, you would say 9-1-7. I said 7-1-9, so to say it backwards you would say 9-1-7. Now, try these numbers. Remember, you are to say them backwards. 3-4-8.**

Whether the twin succeeds or fails with the second example (3-4-8), proceed to Item 1. Give no help on this second example or on any of the items that follow.

**DISCONTINUE** After failure on both trials of any item.

### SCORING

Each item is scored 2, 1 or 0, as follows:

- 2 points, if the twin passes both trials.
- 1 point, if the twin passes only one trial.
- 0 point, if the twin fails on both trials.

Maximum Score on Digits Backward: 14 points

Item	Trial 1	Trial 2	Score
1.	2-4	5-8	
2.	6-2-9	4-1-5	
3.	3-2-7-9	4-9-6-8	
4.	1-5-2-8-6	6-1-8-4-3	
5.	5-3-9-4-1-8	7-2-4-8-5-6	
6.	8-1-2-9-3-6-5	4-7-3-9-1-2-8	
7.	9-4-3-7-6-2-5-8	7-2-8-1-9-6-5-3	

Total score for Digit Span Test: Sum of scores on Digits Forward and Digits Backward.

Maximum score: 28 points

## 76. DELAYED RECALL

*I will read aloud 12 words to you. Afterwards, you must try to mention as many of the words as you can recall.*

*As soon as you cannot recall more words, I will read the words aloud to you again, and I will do that four times (all together).*

**COLOUR**

**HOUSE**

**RIVER**

**HEN**

**NOSE**

**GARDENER**

**HAT**

**SCHOOL**

**FIELD**

**PARENTS**

**COFFEE**

**BELL**

Give 1 point for every recalled word (the order is irrelevant)

After 1st reading \_\_\_\_\_ point

After 2nd reading \_\_\_\_\_ point

After 3rd reading \_\_\_\_\_ point

After 4th reading \_\_\_\_\_ point

*In approx. 10 min., I will ask you how many words you can recall.*

*(Read the list of words aloud once. Let IP repeat as many words as he/she remembers. Repeat this, so IP will be tested four times in total)*

*I will ask you additional questions about your ability to perform daily activities. You must answer the questions on the basis of your present abilities today.*

77. Can you get up from a chair and a bed?

1. ☐ Yes

2. ☐ Yes, with aids

3. ☐ Yes, with personal help

4. ☐ No, proceed to question 78

77a. Do you get tired?

☐ Yes ☐ No

<p>78. Are you able to walk around in the house?</p>     <p>78a. Do you get tired?</p>	<p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> Yes, with aids</p> <p>3. <input type="checkbox"/> Yes, with personal help</p> <p>4. <input type="checkbox"/> No, proceed to question 88</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>79. Are you able to walk up and down the stairs from one floor to the next without resting?</p>	<p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> Yes, with minor difficulty</p> <p>3. <input type="checkbox"/> Yes, with major difficulty</p> <p>4. <input type="checkbox"/> No, proceed to question 81</p>
<p>80. Are you able to walk up the stairs to the 2nd floor?</p>     <p>80a. Do you get tired?</p>	<p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> Yes, with aids</p> <p>3. <input type="checkbox"/> Yes, with personal help</p> <p>4. <input type="checkbox"/> No, proceed to question 81</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>81. Are you able to get outdoors (e.g. in the garden)?</p>     <p>81a. Do you get tired?</p>	<p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> Yes, with aids</p> <p>3. <input type="checkbox"/> Yes, with personal help</p> <p>4. <input type="checkbox"/> No, proceed to question 88</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>82. Are you able to walk 400 m without resting?</p>	<p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> Yes, with minor difficulty</p> <p>3. <input type="checkbox"/> Yes, with major difficulty</p> <p>4. <input type="checkbox"/> No, proceed to question 88</p>
<p>83. Do you do any kind of <u>light</u> exercise at present (e.g. gardening, short walks or bicycle rides)?</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No, proceed to question 85</p>

<p>83a. How often?</p>	<p>1. <input type="checkbox"/> Every day or almost every day</p> <p>2. <input type="checkbox"/> Several times a week</p> <p>3. <input type="checkbox"/> Approx. one a week</p> <p>4. <input type="checkbox"/> 2-3 times a month</p> <p>5. <input type="checkbox"/> Approx. once a month</p>
<p>84. Do you do any kind of <u>hard</u> exercise (e.g. heavy gardening, long walks or bicycle rides, sports, gymnastics or dances?)</p> <p>84a. How often?</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No, proceed to question 85</p> <p>1. <input type="checkbox"/> Every day or almost every day</p> <p>2. <input type="checkbox"/> Several times a week</p> <p>3. <input type="checkbox"/> Approx. one a week</p> <p>4. <input type="checkbox"/> 2-3 times a month</p> <p>5. <input type="checkbox"/> Approx. once a month</p>
<p>85. Can you go for a walk outdoors in nice weather for 1/2 to 1 hour?</p> <p>85a. Do you get tired?</p>	<p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> Yes, with aids</p> <p>3. <input type="checkbox"/> Yes, with personal help</p> <p>4. <input type="checkbox"/> No, proceed to question 88</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>86. Can you go for a walk in bad weather for 1/2 to 1 hour?</p> <p>86a. Do you get tired?</p>	<p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> Yes, with aids</p> <p>3. <input type="checkbox"/> Yes, with personal help</p> <p>4. <input type="checkbox"/> No, proceed to question 88</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>87. Can you run 100 meter?</p>	<p>1. <input type="checkbox"/> Yes</p> <p>2. <input type="checkbox"/> Yes, with minor difficulty</p>

	3. <input type="checkbox"/> Yes, with major difficulty 4. <input type="checkbox"/> No, not able to
88. Can you carry an object of 5 kilos? (such as a heavy bag of groceries)	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> Yes, with minor difficulty 3. <input type="checkbox"/> Yes, with major difficulty 4. <input type="checkbox"/> No, not able to
89. Can you wash the upper part of your body?  89a. Do you get tired?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> Yes, with aids 3. <input type="checkbox"/> No, proceed to question 90 <input type="checkbox"/> Yes <input type="checkbox"/> No
90. Can you wash the lower part of your body?  90a. Do you get tired?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> Yes, with aids 3. <input type="checkbox"/> No, proceed to question 91 <input type="checkbox"/> Yes <input type="checkbox"/> No
91. Can you wash your hair?  91a. Do you get tired?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 92 3. <input type="checkbox"/> No, proceed to question 92 <input type="checkbox"/> Yes <input type="checkbox"/> No
92. Can you dress the upper part of your body?  92a. Do you get tired?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 93 <input type="checkbox"/> Yes <input type="checkbox"/> No
93. Can you dress the lower part of your body?  93a. Do you get tired?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 94 <input type="checkbox"/> Yes <input type="checkbox"/> No
94. Can you take your socks and shoes on and off?  94a. Do you get tired?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 95 <input type="checkbox"/> Yes <input type="checkbox"/> No

<p>95. Can you comb your hair?</p> <p>95a. Do you get tired?</p>	<p>1. <input type="checkbox"/> Yes  2. <input type="checkbox"/> No, proceed to question 96  3. <input type="checkbox"/> Not relevant, proceed to question 96</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>96. Can you cut your toenails?</p> <p>96a. Do you get tired?</p>	<p>1. <input type="checkbox"/> Yes  2. <input type="checkbox"/> No, proceed to question 97</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>97. Can you cut your fingernails?</p> <p>97a. Do you get tired?</p>	<p>1. <input type="checkbox"/> Yes  2. <input type="checkbox"/> No, proceed to question 98</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>98. Can you chew or bite hard foodstuffs?</p>	<p>1. <input type="checkbox"/> Yes, without difficulty  2. <input type="checkbox"/> Yes, with minor difficulty  3. <input type="checkbox"/> Yes, with major difficulty  4. <input type="checkbox"/> No, not able to</p>
<p>99. How many of your own teeth have you got left?</p>	<p>1. <input type="checkbox"/> 0  2. <input type="checkbox"/> 1-9  3. <input type="checkbox"/> 10-19  4. <input type="checkbox"/> 20 or more  5. <input type="checkbox"/> All teeth</p>
<p>100. Can you eat without help?</p>	<p>1. <input type="checkbox"/> Yes  2. <input type="checkbox"/> Yes, but get help to cut meat or butter a slice of bread  3. <input type="checkbox"/> No, get help to eat</p>
<p>101. Can you read an ordinary newspaper text (with glasses, if they are usually worn)</p>	<p>1. <input type="checkbox"/> Yes, without difficulty  2. <input type="checkbox"/> Yes, with minor difficulty  3. <input type="checkbox"/> Yes, with major difficulty  4. <input type="checkbox"/> No, not able to</p>
<p>102. Do you have a reduced hearing ability?</p> <p>102a. Do you have a hearing aid?</p>	<p>1. <input type="checkbox"/> Yes  2. <input type="checkbox"/> No, proceed to question 102c</p> <p>1. <input type="checkbox"/> Yes  2. <input type="checkbox"/> No, proceed to question 102c</p>

102b. Do you use the hearing aid?

1. ☐ Yes, always
2. ☐ Yes, often
3. ☐ Yes, now and then
4. ☐ No

102c. Are you able to hear what is being said during a normal conversation with several persons?  
(with hearing aid, if used)

1. ☐ Yes, without difficulty
2. ☐ Yes, with minor difficulty
3. ☐ Yes, with major difficulty
4. ☐ No

103. Do you normally use some of the following aids:

- a. ☐ Glasses/contact lenses
- b. ☐ Magnifying glass
- c. ☐ Cane
- d. ☐ Crutches
- e. ☐ Walker
- f. ☐ Wheel chair
- g. ☐ Bath chair
- h. ☐ Heightened toilet seat
- i. ☐ Banister
- j. ☐ Handle
- k. ☐ Hanger, Balkan frame
- l. ☐ Special eating tools
- m. ☐ Other aids

Such as \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LAWTON'S IADL				
For the interviewer: For every area, you must mark the best description.				
104. ABILITY TO USE TELEPHONE				
1 <input type="checkbox"/>  Operates telephone on own initiative - looks up and dials numbers, etc.	2 <input type="checkbox"/>  Dials a few well-known numbers.	3 <input type="checkbox"/>  Answers telephone but does not	4 <input type="checkbox"/>  Does not use telephone at all.	5 <input type="checkbox"/>  Not relevant (no phone)
105. SHOPPING				
1 <input type="checkbox"/>  Takes care of all shopping needs independently.	2 <input type="checkbox"/>  Shops independently for small purchases.	3 <input type="checkbox"/>  Needs to be accompanied on any shopping trip.	4 <input type="checkbox"/>  Completely unable to shop.	5 <input type="checkbox"/>  Not relevant (does not need to shop)
106. FOOD PREPARATION				
1 <input type="checkbox"/>  Plans, prepares and serves adequate meals independently.	2 <input type="checkbox"/>  Prepares adequate meals if supplied with ingredients.	3 <input type="checkbox"/>  Heats and serves prepared meals, or prepares small meals.	4 <input type="checkbox"/>  Need to have all meals prepared and served.	5 <input type="checkbox"/>  Not relevant
107. HOUSEKEEPING				
1 <input type="checkbox"/>  Maintains house alone or with occasional assistance (e.g. "heavy work-domestic help").	2 <input type="checkbox"/>  Performs light daily tasks such as dishwashing, bedmaking.	3 <input type="checkbox"/>  Performs light daily tasks but cannot maintain acceptable level of cleanliness.	4 <input type="checkbox"/>  Needs help with all home maintenance tasks. Does not participate in any housekeeping tasks.	5 <input type="checkbox"/>  Not relevant
108. LAUNDRY				
1 <input type="checkbox"/>  Does personal laundry completely.	2 <input type="checkbox"/>  Launders small itemsrinses socks, stockings, etc.	3 <input type="checkbox"/>  All laundry must be done by others.		5 <input type="checkbox"/>  Not relevant

**109. MODE OF TRANSPORTATION**

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Travels independently on public transportation or drives own car.	Arranges own travel via taxi but does not use public transportation.	Travel limited to taxi or automobile with assistance of another.	Travels only with special means of transport or does not travel at all	Not relevant

**110. RESPONSIBILITY FOR OWN MEDICATIONS**

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		5 <input type="checkbox"/>
Is responsible for taking medication in correct dosages at correct time.	Takes responsibility if medication is prepared in advance in separate dosages.	Is not capable of dispensing own medication		Not relevant

**111. ABILITY TO HANDLE FINANCES**

1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		5 <input type="checkbox"/>
Manages financial matter independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income.	Manages day-to-day purchases but needs help with banking, major purchases, etc.	Incapable of handling money.		Not relevant

*I am now going to ask you about your background, your life circumstances and about your general condition.*

112. What type of elementary school education did you receive?	<ol style="list-style-type: none"><li>1. <input type="checkbox"/> Less than 7th grade</li><li>2. <input type="checkbox"/> 7th - 8th grade</li><li>3. <input type="checkbox"/> 9th - 10th grade</li><li>4. <input type="checkbox"/> 11th grade or above</li><li>5. <input type="checkbox"/> Other types</li></ol> <p>If yes, which: _____</p>
113. Did you get any education after elementary school?	<ol style="list-style-type: none"><li>1. <input type="checkbox"/> None</li><li>2. <input type="checkbox"/> Course for semi-skilled workers</li><li>3. <input type="checkbox"/> Course for skilled workers</li><li>4. <input type="checkbox"/> Theoretic education (less than 3 years)</li><li>5. <input type="checkbox"/> Theoretic education (3-4 years)</li><li>6. <input type="checkbox"/> Academic education or similar education (more than 4 years)</li><li>7. <input type="checkbox"/> Other education</li></ol> <p>If yes, which: _____</p>
114. What type of jobs did you have during the greater part of your life?	_____  _____
115. How many subordinates do you have or did you have, when you stopped working?	# _____
116. Are you or have you been married?	<ol style="list-style-type: none"><li>1. <input type="checkbox"/> Never married. If not, proceed to question 121</li><li>2. <input type="checkbox"/> Married</li><li>3. <input type="checkbox"/> Divorced</li><li>4. <input type="checkbox"/> Separated</li><li>5. <input type="checkbox"/> Widower/widow</li></ol>
117. What type of elementary school education did your spouse receive?	<ol style="list-style-type: none"><li>1. <input type="checkbox"/> Less than 7th grade</li><li>2. <input type="checkbox"/> 7th - 8th grade</li><li>3. <input type="checkbox"/> 9th - 10th grade</li><li>4. <input type="checkbox"/> 11th grade or above</li><li>5. <input type="checkbox"/> Other types</li></ol> <p>If yes, which: _____</p>

<p>118. Did your spouse get any education after elementary school?</p>	<ol style="list-style-type: none"> <li>1. <input type="checkbox"/> None</li> <li>2. <input type="checkbox"/> Course for semi-skilled workers</li> <li>3. <input type="checkbox"/> Course for skilled workers</li> <li>4. <input type="checkbox"/> Theoretic education (less than 3 years)</li> <li>5. <input type="checkbox"/> Theoretic education (3-4 years)</li> <li>6. <input type="checkbox"/> Academic education or similar education (more than 4 years)</li> <li>7. <input type="checkbox"/> Other education</li> </ol> <p>If yes, which: _____</p>
<p>119. What type of job did your spouse have in his/her greater part of life?</p>	<p>_____</p> <p>_____</p>
<p>120. How many subordinates did he/she have in this job?</p>	<p># _____</p>
<p>121. Have you lost any relatives or close friends during the last 5 years?</p>	<ol style="list-style-type: none"> <li>1. <input type="checkbox"/> Yes</li> <li>2. <input type="checkbox"/> No, proceed to question 123</li> </ol>
<p>122. Who did you lose?</p>	<ol style="list-style-type: none"> <li>a. <input type="checkbox"/> Spouse/cohabitant</li> <li>b. <input type="checkbox"/> Child/children</li> <li>c. <input type="checkbox"/> Your twin</li> <li>d. <input type="checkbox"/> Brothers/sisters</li> <li>e. <input type="checkbox"/> Other relatives</li> <li>f. <input type="checkbox"/> Close friend(s)</li> </ol>
<p>123. How often do you meet friends or acquaintances?</p>	<ol style="list-style-type: none"> <li>1. <input type="checkbox"/> Never</li> <li>2. <input type="checkbox"/> Seldom</li> <li>3. <input type="checkbox"/> Once or twice a month</li> <li>4. <input type="checkbox"/> Once or twice a week</li> <li>5. <input type="checkbox"/> 3-4 times a week</li> <li>6. <input type="checkbox"/> Daily</li> <li>7. <input type="checkbox"/> More than once a day</li> </ol>
<p>124. If you got ill and needed help for practical problems, could you then expect to get help from friends?</p>	<ol style="list-style-type: none"> <li>1. <input type="checkbox"/> Yes, definitely</li> <li>2. <input type="checkbox"/> Yes, perhaps</li> <li>3. <input type="checkbox"/> No</li> </ol>

125.	How often do you get visits from a visiting nurse?	1. <input type="checkbox"/> At nursing home 2. <input type="checkbox"/> Daily 3. <input type="checkbox"/> 2 - 3 times a week 4. <input type="checkbox"/> Weekly 5. <input type="checkbox"/> More seldom 6. <input type="checkbox"/> Never
126.	How often do you get visits from a home care service?	1. <input type="checkbox"/> At nursing home 2. <input type="checkbox"/> Daily 3. <input type="checkbox"/> 2 - 3 times a week 4. <input type="checkbox"/> Weekly 5. <input type="checkbox"/> More seldom 6. <input type="checkbox"/> Never
126a.	How often do you get private cleaning assistance?	1. <input type="checkbox"/> At nursing home 2. <input type="checkbox"/> Daily 3. <input type="checkbox"/> 2 - 3 times a week 4. <input type="checkbox"/> Weekly 5. <input type="checkbox"/> More seldom 6. <input type="checkbox"/> Never
127.	Do you have a calling device installed in your home?	1. <input type="checkbox"/> Yes, on body 2. <input type="checkbox"/> Yes, in home 3. <input type="checkbox"/> No
128.	Do you participate in joint activities (e.g. bingo, sewing club, lectures, etc.)	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

## 129. DELAYED RECALL

*I will now ask you to recall as many of those 12 words that we talked about earlier on. (do not read aloud the words)*

**COLOUR**

**HOUSE**

**RIVER**

**HEN**

**NOSE**

**GARDENER**

**HAT**

**SCHOOL**

**FIELD**

**PARENTS**

**COFFEE**

**BELL**

Give one point for every word remembered.

# \_\_\_\_\_ (correct answers)

*Now, I will ask you about your state of mind.*

130.	Have you ever been so sad that you had to consult a doctor, who told you that you were suffering from a depression?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 135
131.	How many times have you been depressed for more than 3 weeks?	# _____ (depressions)
132.	At what age did you suffer from your first depression?	Age at first episode _____
132a.	At what age did you suffer from your last depression?	Age at last episode _____
133.	Do you get medical treatment for depression?	1. <input type="checkbox"/> At present 2. <input type="checkbox"/> Previously 3. <input type="checkbox"/> No treatment
134.	Have you ever received shock therapy or convulsive treatments for depression?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No  If yes, # _____ (treatments in total)

*Now, I will ask you about your present state of mind compared to your state of mind a half to one year ago.*

135. Do you wake up early in the morning without being able to fall asleep again?	1. <input type="checkbox"/> Most nights 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
136. Do you have an extraordinarily long sleep?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
137. Do you have less appetite or are you often more hungry than usually?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
138. Within the last 6 months have you lost or gained weight to a substantial degree?	1. <input type="checkbox"/> Major change 2. <input type="checkbox"/> Some change 3. <input type="checkbox"/> No
139. Do you find it more difficult to cope with things than before?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
140. Do you find it more difficult to make decisions than you used to?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
141. Have you lost pleasure or interest in doing things you usually cared about or enjoyed?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
142. Do you find you have lost energy recently and is it harder to get things done?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
143. Have you preferred to be more on your own recently?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
144. Do you find it more difficult to concentrate than usually?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
145. Do you speak more slowly than usually?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
146. Do you sometimes feel that you think more slowly than usually?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No

147.	How often do you feel happy?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> Never or hardly ever
148.	Do you feel lonely lately?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
149.	Do you feel tense and do you worry more than usually about matters of minor importance?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
150.	Do you consider yourself a nervous person?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
151.	Have you ever had an emotional or nervous illness requiring treatment?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 152
151a.	If yes, how many episodes?	# _____
152.	Do you feel sad, depressed or miserable?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No, proceed to question 160
153.	For how many months have you felt like this?	# _____
154.	Is there any reason why you have become depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No, proceed to question 156
155.	What is the reason for this?	a. <input type="checkbox"/> Near relative has died b. <input type="checkbox"/> Close friends have died c. <input type="checkbox"/> Own illness d. <input type="checkbox"/> Illness within close family e. <input type="checkbox"/> Friend's illness f. <input type="checkbox"/> Financial problems g. <input type="checkbox"/> Other reason,  <b>If yes, which:</b> _____
156.	Is this feeling different from a usual feeling of sadness?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
157.	When you feel depressed, is there anything which is able to cheer you up?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
158.	Is there a special time of day, when you feel most depressed?	1. <input type="checkbox"/> Yes, in the morning 2. <input type="checkbox"/> Yes, other time of day 3. <input type="checkbox"/> No
159.	Do you feel that other people are to be blamed for your unhappiness?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

160.	Do you feel worthless, or do you blame yourself for mistakes that you have made a long time ago?	1. <input type="checkbox"/> Most of the time 2. <input type="checkbox"/> Some times 3. <input type="checkbox"/> No
161.	How do you feel about your own future?	1. <input type="checkbox"/> Optimistic 2. <input type="checkbox"/> Neutral 3. <input type="checkbox"/> Pessimistic
162.	Do you sometimes feel that life is not worth living?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 164
163.	Have you ever been so depressed that you thought about ending life?(suicide)	1. <input type="checkbox"/> Attempt(s) of suicide 2. <input type="checkbox"/> Have considered suicide often 3. <input type="checkbox"/> Have considered suicide sometimes 4. <input type="checkbox"/> No

*I am now going to ask you about your habits.*

164.	Do you smoke?	1. <input type="checkbox"/> Yes, more than 1 cigarette, cigar or 1 pipe of tobacco a day Proceed to question 166 2. <input type="checkbox"/> Yes, but less than 1 cigarette, cigar or one pipe of tobacco a day. Proceed to question 166 3. <input type="checkbox"/> No
165.	Being a non-smoker, have you smoked previously?	1. <input type="checkbox"/> Yes, more than 1 cigarette, cigar or 1 pipe of tobacco a day 2. <input type="checkbox"/> Yes, but less than 1 cigarette, cigar or 1 pipe of tobacco a day 3. <input type="checkbox"/> No, proceed to question 170
165a.	If yes, when did you stop?	Year _____
166.	Do you inhale now or did you inhale at the time you were smoking?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
167.	How much do you smoke or did you usually smoke a day on average?  (state number and what types)	a. _____ filtertipped cigarettes (daily) b. _____ cigarettes without filtertip (daily) c. _____ cheroots (daily) d. _____ cigars (daily) e. _____ tobacco (how many pipes a week)
168.	What is the greatest number of cigarettes, etc. that you have smoked daily during one year?	a. _____ filtertipped cigarettes (daily) b. _____ cigarettes without filtertip (daily) c. _____ cheroots (daily) d. _____ cigars (daily) e. _____ tobacco (how many pipes a week)

169.	How many years have you smoked on a regular basis?	# of years _____
170.	Do you ever drink alcohol?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 172
171.	If yes, how much do you drink per week?	1. <input type="checkbox"/> < 1 drink per week 2. <input type="checkbox"/> 1-5 drinks per week 3. <input type="checkbox"/> 6-10 drinks per week 4. <input type="checkbox"/> 11-20 drinks a week 5. <input type="checkbox"/> > 20 drinks per week
172.	How is your present consumption of alcohol compared to your previous consumption?	1. <input type="checkbox"/> Bigger than before 2. <input type="checkbox"/> The same now as earlier on 3. <input type="checkbox"/> Less now than earlier on
173.	Have you ever had a daily alcohol use of more than 3 drinks for a longer period?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No, proceed to question 174.
173a.	For how many months or years?	# _____ (months)      # _____ (years)
173b.	How many drinks on average per week?	# _____

174.	May we look at your hospital record after this interview?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
<b>IF ON FUNEN</b>		
175.	May we also look at your pharmacy record?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
<i>For all respondents</i>		
176.	Finally, I want to thank you for participating in the investigation. May we contact you again in the future?	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

<i>For the interviewer</i>	
177.	Did the respondent show any sign of confusion at any time during the interview, such as difficulty in remembering dates, places or other things?
	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

If yes, state the signs:

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178. What is the housing situation of the twin?

1. ☐ House including town house
2. ☐ Apartment
3. ☐ Special dwelling for elderly people
4. ☐ Nursing home
5. ☐ Other type, such as

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179. Is the respondent so severely handicapped that it was difficult to make the interview or to fulfil the tasks?

1. ☐ Yes
2. ☐ No

**If yes, what kind of handicap**

- a. ☐ Reduced hearing
- b. ☐ Reduced vision
- c. ☐ Speak difficulties
- d. ☐ Paralysis
- e. ☐ Amputation
- f. ☐ Shaky hands
- g. ☐ Dementia or senility
- h. ☐ If other kinds of handicap, state the type:

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180. The interview was made with:

- 1 ☐ IP alone  
2 ☐ IP and proxy

180a. How is the proxy related to the twin?

- 1 ☐ Spouse  
2 ☐ Child  
3 ☐ Grand child  
4 ☐ Twin  
5 ☐ Brother/sister  
6 ☐ Other relatives  
7 ☐ Nursing staff  
8 ☐ Home care  
9 ☐ Friend/girlfriend/aquaintance  
10 ☐ Other

180b. How often does the proxy meet the twin?

- 1 ☐ daily  
2 ☐ weekly  
3 ☐ monthly  
4 ☐ More seldom

181. Interviewer's evaluation of the interview?

- 1 ☐ Easy to perform  
2 ☐ Sometimes difficult  
3 ☐ Difficult to perform