



Danish Twins Born 1931 to 1969

QUESTIONNAIRE (MIDT)

The Danish Twin Registry 2008 - 2011

FINAL VERSION - SURVEY 201-1

PLEASE COMPLETE AT HOME AND BRING TO THE EXAMINATION

Date:

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Instructions for the questionnaire

When you fill in the questionnaire, please use a blue or black pen as the returned questionnaires will be electronically scanned. Don't use a pencil.

Most of the questions in the questionnaire must be answered by marking a box with a cross. If, for instance, you are a monozygotic twin, you mark the topmost box:

Monozygotic twins	<input checked="" type="checkbox"/>
Dizygotic twins	<input type="checkbox"/>
In doubt	<input type="checkbox"/>
Don't know.....	<input type="checkbox"/>

If you accidentally mark the wrong box, please indicate this by filling out the box completely as shown here: 

You can now mark the right box.

For some questions you will be asked to write a number. For example, you will be asked how many persons you live together with. Here you write the number as indicated below:

1.	How many persons live in your household <u>apart from yourself?</u>
Number of persons:	<input type="text" value="3"/> <i>If 0, go to question 3</i>

If you accidentally write the wrong number, please cross it out and write the correct number to the right of the crossed-out number.

For some of the questions you will be asked to write a text. Please write clearly, preferably using block letters.

Some of the questions are followed by a request to go to another question. For example, you will be asked about your hearing ability:

26.	Do you have impaired hearing?
Yes	<input type="checkbox"/>
No	<input type="checkbox"/> <i>Go to question 29</i>

If your answer is Yes, just proceed to question 27, but if your answer is No, you must go to answer 29.

Section 1: Basic information

1. **How many persons live in your household apart from yourself?**

Number of persons:

If 0 Go to Q.3

2. **Who do you live together with?**

Please mark one or more boxes

- | | | | |
|-------------------------------|--------------------------|---|------------------|
| Spouse | <input type="checkbox"/> | } | <i>Go to Q.5</i> |
| Cohabitant wife/husband | <input type="checkbox"/> | | |
| My twin | <input type="checkbox"/> | | |
| Other sisters/brothers | <input type="checkbox"/> | | |
| Child/children | <input type="checkbox"/> | | |
| Parents | <input type="checkbox"/> | | |
| Other relatives | <input type="checkbox"/> | | |
| Friend/friends | <input type="checkbox"/> | | |
| Others..... | <input type="checkbox"/> | | |

3. **For how long have you been living alone?**

Number of years:

4. **Who was the last person you lived together with?**

- | | |
|-------------------------------|--------------------------|
| Spouse | <input type="checkbox"/> |
| Cohabitant wife/husband | <input type="checkbox"/> |
| My twin | <input type="checkbox"/> |
| Other sisters/brothers | <input type="checkbox"/> |
| Child/children | <input type="checkbox"/> |
| Parents | <input type="checkbox"/> |
| Other relatives | <input type="checkbox"/> |
| Friend/friends | <input type="checkbox"/> |
| Others..... | <input type="checkbox"/> |

5. Where do you live currently?

House incl. free-hold flat and farm housing ☐

Flat incl. cohousing flat..... ☐

Senior housing ☐

Nursing home/integrated nursing home ☐

Other ☐

If other, what: _____

6. Do you still work?

Yes, full-time (35 hours or more per week) ☐

Yes, part-time (less than 35 hours per week) ☐

No, early retirement pensioner..... ☐

No, voluntarily retired with special pension ☐

No, old age pensioner ☐

Absent owing to illness for over 14 days ... ☐

Other ☐

If other, what: _____
(ex. unemployed)

Since
when
Year:

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7. What exactly is/was your latest occupation?

(fx primary school teacher, panel beater, Head of Office by the Tax Authority, shop assistant, truck driver, service engineer, master builder)

Designation of occupation: _____

8. What is your marital status at the moment?

Married/cohabitant wife or husband..... ☐

Divorced..... ☐

Separated..... ☐

Widow/widower ☐

Never been married/cohabiting ☐

} Go to Q.11

9. Is your spouse/cohabitant wife/husband still working?

Yes, full-time (35 hours or more per week) ☐

Yes, part-time (less than 35 hours per week) ☐

No, early retirement pensioner ☐

No, voluntarily retired with special pension ☐

No, old age pensioner ☐

Absent owing to illness for over 14 days ... ☐

Other..... ☐

Since
when
Year:

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If other, what: _____
(fx unemployed)

10. What exactly is/was your spouse's/cohabiting wife/husband's occupation?

(fx primary school teacher, panel beater, Head of Office by the Tax Authority, shop assistant, truck driver, service engineer, master builder, assisting wife)

Designation of occupation: _____

YOUR CHILDHOOD

- 11. Who was the primary breadwinner of the family for the major part of your childhood?** *(by breadwinner is meant the person who was primarily responsible for the income of the family)*
- My father ☐
- My mother ☐
- My stepfather ☐
- My stepmother ☐
- I lived in an institution ☐ *Go to Q.14*
- Other person ☐

If other person, who: _____

- 12. What type of school education did the breadwinner receive?** *(Education which has been completed)*
- Less than 7th grade..... ☐
- 7th-8th grade ☐
- 9th-10th grade ☐
- 11th grade or above..... ☐
- Other type ☐
- Don't know..... ☐

- 13. What exactly was the occupation of the breadwinner for the major part of your childhood?** *(fx primary school teacher, panel beater, Head of Office by the Tax Authority, shop assistant, truck driver, service engineer, nurse)*

Designation of occupation:_____

- 14. Are you and your twin?:**

Monozygotic twins ☐

Dizygotic twins..... ☐

In doubt..... ☐

Don't know ☐

15. Where did you live when you started primary school?

Capital (Copenhagen) ☐

Big provincial town (Århus, Odense, Ålborg) ☐

Other provincial town ☐

Town with less
than 500 inhabitants ☐

Village ☐

Don't remember..... ☐

15a. Which part of the country?

Zealand ☐

Lolland, Falster, Bornholm..... ☐

Funen ☐

Southern Jutland ☐

Other part of Jutland ☐

16. Where did you live at the age of 15?

Capital (Copenhagen) ☐

Big provincial town (Århus, Odense, Ålborg) ☐

Other provincial town ☐

Town with less
than 500 inhabitants ☐

Village ☐

Don't remember..... ☐

16a. Which part of the country?

Zealand ☐

Lolland, Falster, Bornholm..... ☐

Funen ☐

Southern Jutland ☐

Other part of Jutland ☐

Section 2: Health

17. How would you consider your health in general?

Excellent ☐

Good ☐

Acceptable ☐

Poor ☐

Very poor ☐

18. How would you consider your health compared with that of your co-twin?

Better..... ☐

Same ☐

Poorer ☐

My twin is not alive ☐

Don't know..... ☐

19. How would you consider your health compared with that of people your own age?

Better..... ☐

Same ☐

Poorer ☐

20. Do you feel well enough to do what you like?

Yes, always ☐

Yes, almost always..... ☐

Yes, occasionally ☐

No, hardly ever..... ☐

No, never..... ☐

21. Diseases now and earlier in your life that have been diagnosed by a doctor

*Which serious, prolonged diseases do you have now or have had previously? If a doctor has ever diagnosed you with one of the diseases mentioned below, please answer Yes and state you AGE, **when the disease was diagnosed for the first time**. If you don't remember your exact age, please state your approximate age. Mark one box per disease.*

At the end of these questions, you may include diseases that are not pre-printed.

	Yes, have now	Yes, have had	No	Age when disease was diagnosed for the first time
A. Heart diseases				
Irregular heart rythms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Other heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Pulmonary oedema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Medically treated hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
B. Clotting disorders				
Blood clot in the heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Cerebral infarct or cerebral haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Blood clot in the lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Blood clot in the leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Blood clot in the eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
C. Respiratory diseases				
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Smoker's lungs (KOL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
D. Metabolic disorders				
Diabetes Type 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Diabetes Type 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Increased metabolism (Basedow)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Decreased metabolism (Myxødem)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Enlargement of the thyroid gland (struma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Other disease in the thyroid gland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___

E. Cancers

Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, apart from skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F. Diseases in the stomach, intestines and kidneys

Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coeliakia (gluten intolerance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis ulcerosa (colon inflammation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallstone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. Neurological diseases

Inflammation of the meninges (meningitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H. Diseases in the eye

Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calcification of the retina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

J. Musculoskeletal system

Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whiplash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromy (diffuse pains)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herniated disc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes, have now	Yes, have had	No	<u>Age</u> when disease was diagnosed for the first time
K. Mental disorders				
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
Nervousness syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
L. Question for male respondents only				
Enlarged prostate (prostata)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___
M. Other serious diseases, please specify:				
_____	<input type="checkbox"/>	<input type="checkbox"/>		___
_____	<input type="checkbox"/>	<input type="checkbox"/>		___
_____	<input type="checkbox"/>	<input type="checkbox"/>		___

22. How many biological children do you have?

Number: ___

23. How many of your natural teeth do you have?

Adults have 28 teeth + 4 wisdom teeth, if any. If only a small part of a tooth remains, it should be counted in. Dental bridges etc. that replace natural teeth should not be counted in.

- None ☐
- 1-9 teeth ☐
- 10 – 19 teeth ☐
- 20 - 27 teeth..... ☐
- 28 teeth or more ☐

24. Do you have problems with your eyesight that cannot be corrected by wearing glasses or contact lenses?

- Yes, mildly reduced eyesight..... ☐
- Yes, heavily reduced eyesight ☐
- Yes, blind..... ☐
- No ☐

Go to Q.26

- 25. Can you read the ordinary print in a newspaper?**
(with or without your reading glasses)
- Yes, without difficulty ☐
- Yes, with minor difficulty ☐
- Yes, with major difficulty ☐
- No ☐
-
- 26. Is your hearing impaired?**
- Yes..... ☐
- No..... ☐ *Go to Q.29*
-
- 27. Do you have hearing aids?**
- Yes..... ☐
- No ☐ *Go to Q.29*
-
- 28. Do you use hearing aids?**
- Yes, always ☐
- Yes, often ☐
- Yes, occasionally ☐
- No ☐
-
- 29. Can you hear what is being said in a normal conversation between 3 or more persons?**
(with or without your hearing aids)
- Yes, without difficulty ☐
- Yes, with minor difficulty ☐
- Yes, with major difficulty ☐
- No ☐

MALE RESPONDENTS – please go to Question 39

FEMALE RESPONDENTS PLEASE ANSWER THE FOLLOWING

30. How old were you when you had your first period?

If you do not remember, please give an approximate date.

Age: years and months

Never had a period ☐ *Go to Q.39*

Don't remember ☐

31. If you have a twin sister, which one of you had her first period?

Me ☐

My twin sister ☐

At the same time (same day) ☐

Don't know ☐

31a How long was there between yours and your twin sister's first period?

years months weeks days ☐ don't know

32. Do you still have your periods?

Yes ☐

No ☐ *Go to Q.33*

32a Are your periods regular?

Almost always regular ☐

Regular and irregular by terms ☐

Almost always irregular ☐

Regular because of hormone therapy ☐

} *Go to Q.39*

- 33. How old were you when you had your last period?**
If you do not remember, please give an approximate age.

Age:

- 34. What was the reason that your periods stopped?**

Please answer all the questions

	Yes	No	Year
Stopped naturally	<input type="checkbox"/>	<input type="checkbox"/>	<u> </u> <u> </u> <u> </u> <u> </u> <u> </u>
I had my uterus removed	<input type="checkbox"/>	<input type="checkbox"/>	<u> </u> <u> </u> <u> </u> <u> </u> <u> </u>
I had my ovaries removed	<input type="checkbox"/>	<input type="checkbox"/>	<u> </u> <u> </u> <u> </u> <u> </u> <u> </u>
Stopped for other reasons	<input type="checkbox"/>	<input type="checkbox"/>	<u> </u> <u> </u> <u> </u> <u> </u> <u> </u>

What other reasons? _____

- 35. Have you ever received hormone therapy with oestrogen at the time of or after your menopause?**

Yes ☐

No ☐ *Go to Q.39*

- 36. How old were you when you received hormone therapy with oestrogen the first time?**

If you don't remember, please give an approximate age.

Age:

- 37. Do you still receive hormone therapy with oestrogen?**

Yes ☐ *Go to Q.38*

No ☐

If "No", how old were you?

Age when therapy stopped:

- 38. How many years in all have you received oestrogen therapy?**

Number of years:

Section 3: Lung function

COUGH AND EXPECTORATION

39. Have you been coughing for at least 3 months per year?

Yes, during the last 2 years or more .. ☐

Yes, but only during the last year ☐

No ☐

40. Have you had a cough with expectoration for at least 3 months per year?

Yes, during the last 2 years or more . ☐

Yes, but only during the last year ☐

No ☐

41. Do you occasionally wake up in the night or early in the morning because you cough?

Yes, at least once a week ☐

Yes, at least once a month ☐

Yes, at least once a year ☐

No ☐

42. Does any of the following make you cough?
(please mark at least one box in every line)

	Yes	No
a) Cold weather	<input type="checkbox"/>	<input type="checkbox"/>
b) Smoke	<input type="checkbox"/>	<input type="checkbox"/>
c) Strain	<input type="checkbox"/>	<input type="checkbox"/>
d) Other things	<input type="checkbox"/>	<input type="checkbox"/>

If other things, what:

ASTHMA

43. Have you now or have you had asthma?

Yes ☐

No ☐ Go to Q. 47

44. Have you had an asthma attack during the past 12 months?

Yes ☐

No ☐

45. Has a doctor ever told you that you have or have had asthma?

Yes ☐

No ☐

46. Do you presently take medication for asthma (e.g. by inhaler spray, nebuliser or tablet)

Yes ☐

No ☐

WHEEZY BREATHING

47. Have you ever had a wheezy breathing when you were not having a cold?

Yes, at least once a week ☐

Yes, at least once a month ☐

Yes, at least once a year ☐

No ☐ Go to Q. 49

48. Have you had a wheezy breathing when you were not having a cold during the past 12 months?

Yes ☐

No ☐

49. Have you had a wheezy breathing and been short of breath?
- Yes, at least once a week ☐
- Yes, at least once a month ☐
- Yes, at least once a year ☐
- No ☐ *Go to Q. 51*

50. Have you had a wheezy breathing and been short of breath during the past 12 months?

Yes ☐

No ☐

51. Does any of the following make you cough or give you a wheeze?

(please mark one box in every line)

	Yes	No
a) Cold weather	<input type="checkbox"/>	<input type="checkbox"/>
b) Smoke.....	<input type="checkbox"/>	<input type="checkbox"/>
c) Exertion	<input type="checkbox"/>	<input type="checkbox"/>
d) Other things	<input type="checkbox"/>	<input type="checkbox"/>

If other things, what:

SHORTNESS OF BREATH AND PROBLEMS BREATHING

52. Have you been short of breath at any time of day when you were resting during the past 12 months?

Yes ☐

No ☐

53. Have you been short of breath after heavy exertion at any time during the past 12 months?

Yes ☐

No ☐

54. Have you woken up short of breath at any time during the past 12 months?
- Yes ☐
- No ☐
55. Are you bothered by shortness of breath when you get dressed, or are you so bothered by shortness of breath that you are unable to get out of your home?
- Yes ☐
- No ☐
56. Do you have to stop to regain your breath when you are walking at your own speed on even ground?
- Yes ☐
- No ☐
57. Are you getting short of breath when you walk together with other people your own age on even ground?
- Yes ☐
- No ☐
58. Are you bothered by shortness of breath when you walk fast on even ground or when you walk a little uphill?
- Yes ☐
- No ☐

OPPRESSION IN THE CHEST

59. Have you woken up feeling a weight on your chest at any time during the past 12 months?
- Yes ☐
- No ☐

Section 4: Mental well-being

*Please answer the following questions based on how you are feeling **now** compared with ½-1 year ago.*

60. Are you happy with your life as it is now?

Yes, always ☐

Yes, almost always ☐

Yes, occasionally ☐

No, hardly ever ☐

No, never ☐

61. How often do you feel happy?

Most of the time ☐

Occasionally ☐

Never or hardly ever ☐

62. Have you been feeling lonely lately?

Yes, most of the time ☐

Yes, occasionally ☐

No ☐

63. Do you feel tense and are you more worried about trifles than you used to be?

Yes, most of the time ☐

Yes, occasionally ☐

No ☐

64. Do you consider yourself to be nervous?

Yes ☐

No ☐

65. Do you feel sad, depressed or unhappy now?

Yes, most of the time ☐

Yes, occasionally ☐

No ☐

66. Do you feel like you're worth nothing at times?

Yes, mostly ☐

Yes, occasionally ☐

No ☐

67. How do look upon your future?

Are you optimistic ☐

Are you neutral ☐

Are you pessimistic ☐

68. Do you sometimes feel that life is not worth living?

Yes ☐

No..... ☐

Section 5: Living habits and life style

TOBACCO

69. Do you smoke now?

Yes, more than 1 cigarette, cheroot, pipe of
tobacco per day ☐ *Go to Q. 63*

Yes, but less than 1 cigarette, cherool, pipe of
tobacco per day ☐ *Go to Q. 63*

No..... ☐

70. Did you smoke earlier?

Yes, more than 1 cigarette, cheroot, pipe of
tobacco per day ☐

Yes, but less than 1 cigarette, cheroot, pipe of
tobacco per day ☐

No ☐ *Go to Q. 66*

71. When did you quit smoking?

Year:

72. Do you inhale now (or when you were smoking)?

Yes ☐

No ☐

73. How much do you smoke (or did you smoke) on average per day? (please fill in every question)

Number of cigarettes with filter:

Number of cigarettes without filter:

Number of cheroots:

Number of cigars:

Number pipes of tobacco:

74. For how many years have you smoked regularly?

Number of whole years :

ALCOHOL

Please answer the following questions based on your situation during the last 6 months

75. Do you ever drink alcohol in any form?

Yes, at least once a week..... ☐

Yes, at least once a month ☐

Yes, but not every month..... ☐

No, never ☐ *Go to Q. 69*

76. How much do you drink on average per week?

Please fill out every line with whole numbers

Numbers of beer:

Number of strong alcoholic drinks:

Number of glasses of red wine:

Number of glasses of white wine:

Number of glasses of dessert wine:

77. How would you describe your alcohol consumption now compared with earlier on?

Larger than earlier on..... ☐

Same as earlier on..... ☐

Less than earlier on ☐

EATING AND DRINKING HABITS

78. How much of the following do you drink on average per day?

Number of cups of coffee:

Number of cups of tea:

79. How often do you eat the following?

	Never	Once or less a month	Twice a month	Once a week	2-3 times a week	Once a day	2-3 times a day	4 or more times a day
a) Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Raw vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Boiled vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Fruit juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Vegetable juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICAL ACTIVITY AND EXERCISE HABITS

Please answer the questions based on your situation during the past year.

- 80. How often have you exercised, done aerobic or gymnastic exercises so that you perspired and/or became short of breath?**

Never..... ☐

One or more times a year ☐

One or more times a month ☐

One or more times a week ☐

Daily ☐

- 81. How often have you taken a brisk walk for at least 30 minutes in order to get exercise?**

Never..... ☐

One or more times a year ☐

One or more times a month ☐

One or more times a week ☐

Daily..... ☐

- 82. How often have you ridden your bicycle for at least 3 km?**

Never..... ☐

One or more times a year ☐

One or more times a month ☐

One or more times a week ☐

Daily..... ☐

- 83. How often have you done stretch exercises, yoga, or pilates to increase suppleness, strength and a better balance?**

Never..... ☐

One or more times a year ☐

One or more times a month ☐

One or more times a week ☐

Daily..... ☐

84. How often have you been engaged in hard physical activity at work or at home?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily ☐

85. How often have you been engaged in physically strenuous sports like tennis, running, swimming or riding a bicycle over a long distance?

- Never..... ☐
- One to more times a year ☐
- One to more times a year ☐
- One to more times a year ☐
- Daily ☐

I NTELLECTUAL AND CULTURAL ACTIVITIES

*Please answer the following questions based on your situation **during the past year***

86. How often have you been to museums, art galleries or the like?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily..... ☐

87. How often have you used the internet or a library or consulted an encyclopedia to find information that could answer a question or solve a problem?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily ☐

88. How often have you solved a sudoku, a cross-word puzzle or the like?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily..... ☐

89. How often have you read a book, a news magazine or a technical report?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily ☐

90. How often have you attended a course, a study group or been to a public lecture?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily..... ☐

91. How often have you written a story, a report, a poem, an essay or kept a diary?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily..... ☐

92. How often have you gone to the cinema, the theatre or a concert?

Never..... ☐

One or more times a year ☐

One or more times a month ☐

One or more times a week ☐

Daily ☐

93. How often have you read a newspaper?

Never..... ☐

One or more times a year ☐

One or more times a month ☐

One or more times a week ☐

Daily..... ☐

SOCIAL ACTIVITIES

Please answer the following questions based on your situation during the last year

94. How often have you participated in a party or a social arrangement?

Never..... ☐

One or more times a year ☐

One or more times a month ☐

One or more times a week ☐

Daily..... ☐

95. How often have you been to a restaurant, to the cinema or the like together with friends or relatives?

Never..... ☐

One or more times a year ☐

One or more times a month ☐

One or more times a week ☐

Daily ☐

96. How often have you been in contact with family or friends over the phone or via mail?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily ☐

97. How often have you invited family or friends to dinner in your own home?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily ☐

98. How often have you visited friends or family in their homes?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily ☐

99. How often have you participated in association meetings or meetings in general?

- Never..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily ☐

100. How often do you meet with your twin?

- My twin is not alive ☐
- Never ☐
- Hardly ever..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily ☐

101. How often do you speak with your twin over the phone?

- My twin is not alive ☐
- Never ☐
- Hardly ever..... ☐
- One or more times a year ☐
- One or more times a month ☐
- One or more times a week ☐
- Daily ☐

Many thanks for your help!

If you have any comments, please write them here:
