ID number: . …….. Date……

# The Birkebeiner Ageing Study (BiAS) - questionnaire

**Part 1**:

**Age** ……..

**Gender**
☐ *Male*
☐ *Female*

**Weight and height**
*Weight (kg)……..*
*Height (cm)……*

**How many times have you completed the Birkebeiner cross country ski race?** ……

**How many times have you been awarded with the Birkebeiner Medal?** ……..

**How old were you when you first attended?** ……..

**Do you participate in other skiing events?**
☐ *Yes*
☐ *No*

**Do you participate in other bike competitions, cross country running race or street race?**
☐ *Yes*
☐ *No*

**At what age did you start with systematic training for the Birkebeiner cross country ski race (or other competitions)?** ……...

**Have you had any interruption in training (more than 3 months) due to illness?**
☐ *Yes*
☐ *No*

**Have you ever been prevented from participating in the Birkebeiner cross country ski race due to illness?**
☐ *Yes*
☐ *No*
*What was the reason? ……..*

**Do you have, or have you had atrial fibrillation (attack with rapid irregular heartbeat)?**
☐ *Yes, once*
☐ *Yes, several times*
☐ *Yes, I have a chronic condition*
☐ *No*

**Do you find that participation in Birkebeiner cross country ski race and the training it takes to affect your quality of life (well-being)?**
☐ *For the better*
☐ *Has little impact*
☐ *For the worse*
☐ *Do not know*

**Do you feel that participating in the Birkebeiner cross country ski race and the training it takes to affect the ageing process?**
☐ *Makes me feel younger than my peers*
☐ *Makes no difference*
☐ *Makes me feel older than my peers*
☐ *Do not know*

**If you look back at your life, what sport and what exercises did you start with?**
**……**

**How old were you when you started with endurance training?**
**……year**

## Part 2. CONOR- Health questionners YOUR OWN HEALTH

**1. What is your current health status? Tick one only**
☐ Poor
☐ Not so good
☐ Good
☐ Very good

**2. Do you have, or have you had?**

| | Yes | No | Age first time |
|---|---|---|---|
| Heart attack | | | |
| Angina pectoris (heart cramp) | | | |
| Cerebral stroke/ Brain haemorrhage | | | |
| Asthma | | | |
| Diabetes | | | |

**3. Have you during the last year suffered from pain and/or stiffness in muscles and joints that have lasted for at least 3 months ?**
☐ Yes ☐ No

**4. Have you in the last two weeks felt :**

| | No | A little | A lot | Very much |
|---|---|---|---|---|
| Nervous or worried | | | | |
| Anxious | | | | |
| Confident and calm | | | | |
| Irritable | | | | |
| Happy/Optimistic | | | | |
| Down/Depressed | | | | |
| Lonely | | | | |

## PHYSICAL ACTIVITY

**5a. How has your physical activity during leisure time been over the last year ?** *Think of your weekly average for the year. Time spent going to or from work counts as leisure time*

| Hours per week | None | Less than 1 | 1-2 | 3 or more |
|---|---|---|---|---|
| Light activity *(not sweating or out of breath)* | | | | |
| Hard physical activity *(sweating/out of breath)* | | | | |

**5 b. Please note physical activity during the past year in your <u>leisure time</u>. If your activity level varies between summer and winter, note an average value.**
*(Tick one only)*

- ☐ Reading, watching TV or any other sedentary activity?
- ☐ Walking, cycling, or other activity, other for at least 4 hours a week?
  *(Count also walking back and forth from work)*
- ☐ Light sports, heavy gardening?
  *(At least 4 hours per week)*
- ☐ Hard exercise, competitive sports? Regularly and several times a week

## SMOKING

**6 . How many hours a day do you normally spend in smoke-filled rooms?** *Write 0 if you don`t spend time in smoke-filled rooms*
Number of hours ……..

**7. Did any of the adults smoke at home when you grew up?**
☐ Yes ☐ No

**8. Do you now, or have you ever lived together with a daily smoker after the age of 20 years?**
☐ Yes ☐ No

**9. Do you smoke ?**

| | Yes | No |
|---|---|---|
| Cigarettes daily | | |
| Cigars/cigarillos daily | | |
| Pipe daily | | |

**10. If you previously smoked daily, how long is it since you quit?** …… number of years

**11. If you smoke daily now or previously: How many cigarettes do you, or did you usually smoke per day?** Number of cigarettes ……

**12. How old were you when you began smoking?** …….. year
**13. How many years in all have you smoked daily ?** …….. years

## COFFEE, TEA AND ALCOHOL

**14.a How many cups of coffee do you usually drink daily ?**
*Write 0 if you do not drink coffee daily*
Boiled coffee (coarsely ground), number……

Coffee other, number……..

**14.b**
**What type of coffee do you usually drink?** *Please tick*

- ☐ Filter/instant coffee
- ☐ Boiled coffee (coarsely ground)
- ☐ Other (espresso etc)
- ☐ Do not drink coffee

**How many cups of coffee/tea do you usually drink daily?** *Write 0 if you do not drink coffee/tea daily*
Number of cups with coffee…….
Number of cups with tea……

**15 a. How many times a month do you usually drink alcohol?** *Do not count low-alcohol beer. Put 0 if less than once a month.*
Number of times…….

**15 b. Approximately how often during the past 12 months have you consumed alcohol?** *(Do not count low-alcohol beer)*

☐ 4-7 times a week ☐ 2-3 times a month ☐ Have not drunk alcohol the last year
☐ 2-3 times a week ☐ Appr. 1 time a month ☐ Have never drunk alcohol
☐ App. 1 time a week ☐ A few times last year

**16 a. How many glasses of beer, wine or spirits** do you usually drink during a two-weeks period? *Do not count low-alcohol beer. Put 0 if you do not drink alcohol.*

Beer ……. glasses Wine ……glasses Spirits …….glasses

*For those who have consumed alcohol during the past year*
**16 b. When you drank alcohol, how many glasses did you usually drink ?**
Number of glasses…….

**16 c. Approximately how often during the past 12 months have you consumed alcohol corresponding to at least 5 glasses of spirits in 24 hours?**
Number of times……..

**16 d. When you drink alcohol, do you usually drink: (Tick one or more).**
☐ Beer ☐ Wine ☐ Spirits (hard liquor)

**16. Are you a total abstainer from alcohol?**
☐Yes ☐ No

## EDUCATION

**17 a. What is the highest level of education you have completed?**

- ☐ Less than 7 year of primary school
- ☐ 7-10 years primary/secondary school
- ☐ Technical school, middle school, vocational school, 1-2 years senior high school

- ☐ High school diploma (3-4 years)
- ☐ College/university, less than 4 years
- ☐ College/university, 4 or more years

**17 b. How many years education have you completed all together?**
*(Count every year you went to school)* Number of years…….

## ILLNESS IN THE FAMILY

**18. Have one or more of your parents or siblings had a heart attack or angina pectoris?**
☐ Yes ☐ No ☐ Don't know

**19. Tick for those relatives who have or have had:**

| | Myself | Mother | Father | Brother | Sister | Child |
|---|---|---|---|---|---|---|
| Cerebral stroke or brain haemorrhage | | | | | | |
| Myocardial infarction before age 60 | | | | | | |
| Asthma | | | | | | |
| Cancer | | | | | | |
| Diabetes | | | | | | |
| Age when diabetes was first diagnosed | | | | | | |

## RESIDENLY

**20. In which muncipality did you live at the age of 1 year?** *If you did not live in Norway, give country of residence instead of municipality.* **……..**

**21. What type of dwelling do you live in?**
- ☐ Villa/detached house
- ☐ Farm
- ☐ Flat/apartment
- ☐ Terraced/semi-detached house
- ☐ Other/institution/care home

**22. How large is your home? ……**$m^2$

## FAMILY AND FRIENDS

**25. With whom do you live?** *Tick one for each question and write the number*

| | Yes | No | Number |
|---|---|---|---|
| Spouse/Partner | | | |
| Other persons older than 18 years | | | |
| Persons younger than 18 years | | | |

**27. How many good friends do you have with whom you can talk confidentially and who can provide help if you need it?**
*(Do not count people you live with, but do include other relatives)*

……

**28. Do you feel that you have enough good friends?**

☐ Yes ☐ No

**29. How often do you usually take part in organised activities, e.g. sewing circles, sports clubs, political meetings, religious or other organizations?**
☐ Never, or just a few times a year
☐ 1-3 times a month
☐ Approximately once a week
☐ More than once a week

**WORK**

**30. What is your current work situation?**
☐ Paid work
☐ Full-time housework
☐ Under education, military service
☐ Unemployed, on leave without payment
☐ Pensioner

**31 a. How many hours of paid work do you have per week?** …….number of hours

**31 b. What is your current work situation – paid work?**
☐ Yes, full-time
☐ Yes, part time
☐ No

**32. Do you receive any of the following?**
☐ Sickness benefit?
☐ Old-age pension?
☐ Rehabilitation benefit?
☐ Disability pension?
☐ Unemployment benefits?
☐ Social welfare benefits?
☐ Social benefit-single parent?

**33. Do you work shifts or nights?**
☐ Yes ☐ No

**34. If you have paid or unpaid work, which statement describes your work best?**
☐ Mostly sedentary work? *(e.g. office work, mounting)*

☐ Work that requires a lot of walking? *(e.g. shop assistant, light industrial work, teaching)*

☐ Work that requires a lot of walking and lifting? *(e.g. postman, nursing, construction)*

☐ Heavy manual labour? (e.g. forestry, heavy farmwork, heavy construction)

**35. Do you decide yourself how your work will be done? (Tick one only)**

☐ Not at all
☐ Very little
☐ Yes, sometimes
☐ Yes, my own decision

**36 a. Do you have any of the following occupations ?** *(full time or part time) Tick one for each question*

| | Yes | No |
|---|---|---|
| Driver | | |
| Farmer | | |
| Fisherman | | |

**36 b. What occupation/title did you have at this work?** *Ex secretary, teacher, industrial worker, nursing, carpenter, leader, salesman, driver etc)*

Occupation:……

## YOUR OWN ILLNESS and INJURIES

**37. Have you ever had:**

*Tick one for each question. State age at event. If it has happened several times, write age at the last event.*

| | Yes | No | Age at last time |
|---|---|---|---|
| Hip fracture | | | |
| Wrist/forearm fracture | | | |
| Whiplash | | | |
| Injury requiring hospital admission | | | |

**38. Do you have or have you ever had?**

*Tick yes or no for each question*

| | Yes | No |
|---|---|---|
| Hay fever | | |
| Chronic bronchitis/emphysema | | |
| Osteoporosis | | |
| Fibromyalgia/fibrositis/chronic pain syndrome | | |
| Psychological problems for which you have sought help | | |

**39. Do you cough almost daily for some periods of the year?**

☐ Yes ☐ No

**40.** *If yes,*
**do you bring up phlegm?**

☐ Yes ☐ No

**41. If you cough almost daily for some periods of the year, have you had this kind of cough for as long as 3 months in each of the last two years?**

☐ Yes ☐ No

**42. How often do you suffer from sleeplessness?**

☐ Never, or just a few times a year
☐ 1-3 times a month
☐ Approximately once a week
☐ More than once a week

**43. Have you in the last twelve months suffered from sleeplessness to the extent that it has affected your ability to work ?**
☐ Yes ☐ No

## USE OF MEDICATION

**44 . Do you take?**

| | Currently | Previously | Never |
|---|---|---|---|
| Lipid lowering drugs | | | |
| Medications for high blood pressure | | | |

**45 a. Have you for any length of time in the past year used any of the following medications every day or almost daily?** *Indicate how many months you have used the medication. Write 0 if you did not take the medication.*

**Medications:**

Painkillers …… months.
Sleeping pills …… months.
Tranquilizers …… months.
Antidepressants …… months.
Allergy pills …… months.
Asthma medication …… months.

Only medication bought at pharmacy. Do not include dietary supplements.

**45 b. How often during the last 4 weeks have you taken any of the following medication?** *Tick one per line*

| | Daily | Weekly but not daily | Less than weekly | Not taken last 4 weeks |
|---|---|---|---|---|
| Painkillers without prescription | | | | |
| Painkillers on prescription | | | | |
| Sleeping pills | | | | |
| Tranquilizers | | | | |
| Antidepressants | | | | |
| Other medication on prescription | | | | |

## DIETARY SUPPLEMENTS

**46 a. Have you for any length of time in the past year taken any of the following daily or almost daily?** *Indicate how many months you have used them. Write 0 if you did not take any.*

Iron tablets …….. months
Vitamin D supplements …….. months
Other vitamin supplements …….. months

Cod liver oil …….. months

**46 b. Do you take any of the following?**

| | Yes, daily | Sometimes | No |
|---|---|---|---|
| Cod liver oil, capsules, Fish oil capsules | | | |
| Vitamin and or mineral supplements | | | |

**THE REST OF THE FORM SHOULD ONLY BE FILLED IN BY WOMEN**

**47. How old were you when you started menstruating?**

……..year

**48. If you no longer menstruate, how old were you when you stopped menstruating?**

……..year

**50. How many children have you given birth to?**

……children

**51. If you have given birth, what year was the child born and how many months did you breastfeed each child**

| Child | Year born | Number of months with breastfeeding |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

**52. Do you use or have you ever used:**

| | Now | Previously | Never |
|---|---|---|---|
| Contraceptive pills (OC) (incl. minipill) | | | |
| Contraceptive injections | | | |
| Hormonal intrauterine device | | | |
| Estrogen (tablets or patches) | | | |
| Estrogen (cream or suppositories) | | | |

## International Physical Activity Questionnaire (IPAQ)

The questions will ask you about the time you spent being physically active in the **last 7 days.**

| | Activity Level | |
|---|---|---|
| **Remember: Think only about those physical activities that you did for at least 10 minutes at a time.** | | |
| **1a:** During the last 7 days, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling,? Think about *only* those physical activities that you did for at least 10 minutes at a time. | ……days per week | None *(Skip to question 2a)* |
| **1b:** How much time in total did you usually spend on one of those days doing vigorous physical activities*?* | ……..hours<br>……minutes | |
| **2a:** Again, think *only* about those physical activities that you did for at least 10 minutes at a time. During the last 7 days, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking. | ……days per week | None *(Skip to question 3a)* |
| **2b:** How much time in total did you usually spend on one of those days doing moderate physical activities*?* | ……hours<br>……minutes | |
| **3a:** During the last 7 days, on how many days did you **walk** for at least 10 minutes at a time? This includes walking at work and at home, walking to travel from place to place, and any other walking that you did solely for recreation, sport, exercise or leisure. | ……days per week | None *(Skip to question 4)* |
| **3b:** How much time in total did you usually spend walking on one of those days*?* | ……hours<br>……minutes | |
| **4:** The last question is about the time you spent sitting on weekdays while at work, at home, while doing course work and during leisure time. This includes time spent sitting at a desk, visiting friends, reading traveling on a bus or sitting or lying down to watch television. During the last 7 days, how much time in total did you usually spend *sitting* on a **week day?** | ……hours<br>……minutes | |

**SF-12**

**This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.**

**Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.**

**1. In general, would you say your health is:**

- □ *Excellent*
- □ *Very good*
- □ *Good*
- □ *Fair*
- □ *Poor*

**2-3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

| Activity | Yes, limited a lot | Yes, limited a little | No, not limited at all |
|---|---|---|---|
| 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | | | |
| 3. Climbing several flights of stairs | | | |

4- 5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like □ *Yes* □ *No*
5. Were limited in the kind of work or other activities □ *Yes* □ *No*

6-7. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depresses or anxious)?

6. Accomplished less than you would like? □ *Yes* □ *No*
7. Did work or other activities less carefully than usual? □ *Yes* □ *No*

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- □ *Not at all*
- □ *A little bit*
- □ *Moderately*
- □ *Quite a bit*
- □ *Extremely*

9-11. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes close to the way you have been feeling. How much of the time during the past 4 weeks..

| | All of the time | Most of the time | A good bit of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|---|---|
| 9. Have you felt calm and peaceful? | | | | | | |
| 10. Did you have a lot of energy? | | | | | | |
| 11. Have you felt downhearted and blue? | | | | | | |

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

**Modified Health Assessment Questionnaire – MHAQ.**

Please check the response that best describes your usual abilities OVER THE COURSE OF THE LAST WEEK.

| Are you able to: | Without any difficulty | With some difficulty | With much difficulty | Unable to do |
|---|---|---|---|---|
| Dress yourself, including tying shoelaces and doing buttons? | | | | |
| Get in and out of bed? | | | | |
| Lift a full cup or glass to your mouth? | | | | |
| Walk outdoors on flat ground? | | | | |
| Wash and dry your entire body? | | | | |
| Bend down to pick up clothing from the floor? | | | | |
| Turn regular faucets on and off? | | | | |
| Get in and out of a bus, car, train, or airplane? | | | | |

**The self- esteem scale.**

| | Strongly agree | Agree | No disagreement/ agreement | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| I feel that I have a number of good qualities | | | | | |
| All in all, I am inclined to feel that I am a failure | | | | | |
| I am able to do things as well as most other people | | | | | |
| I take a positive attitude toward myself | | | | | |
| I certainly feel useless at times | | | | | |
| I wish I could have more respect for myself | | | | | |
| I feel that I am a person of worth, at least on an equal plane with others | | | | | |
| I feel I do not have much to be proud of | | | | | |
| On the whole, I am satisfied with myself | | | | | |
| At times I think I am no good at all | | | | | |

**Mastery Scale**

| | Strongly agree | Agree | No disagreement/ agreement | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| I have little control about things that happen to me | | | | | |
| What will happen in the future considerably depends on myself | | | | | |
| Some of my problems I can't seem to solve at all | | | | | |
| There is not much that I can do to change important things in my life | | | | | |
| I often feel helpless dealing with the problems of life | | | | | |
| Sometimes I feel like a play ball of life | | | | | |
| I can do almost everything, if I want to | | | | | |

**To what extent do you agree with the following statements about your relationship with your training and your relationship to activities like the Birkebeiner cross country ski race?**

| | Strongly disagree | | | Strongly agree |
|---|---|---|---|---|
| The sport means a lot to my quality of life | | | | |
| Good sports performance means a lot to me | | | | |
| Participation in the Birkebeiner cross country ski race is a motivation for practicing systematic | | | | |