### Health Questionnaire

**Part. ID:** | **Date:** | **Tester:**
---|---|---

#### 1. General Questions

**Gender:**
- [ ] male
- [ ] female
- [ ] other: __________________

**Age:**
_____________________________________________________

**Weight:**
_____________________________________________________

**Height:**
_____________________________________________________

**Years of education***:
_____________________________________________________

* Primary and secondary school including apprenticeship or university

**Do you smoke?**
- [ ] No
- [ ] Yes, I smoke ________ (amount of) cigarettes per day.

**Do you drink coffee?**
- [ ] No
- [ ] Yes, 1-3 cups per day
- [ ] Yes, more than 3 cups per day

**Do you drink alcohol?**
- [ ] No
- [ ] Yes, 1-7 units per week **
- [ ] Yes, more than 7 units per week **

**How would you rate your current health state?**
- [ ] very good
- [ ] good
- [ ] fair
- [ ] poor
- [ ] I don’t know

**How would you rate your health state compared to peers of the same age?**
- [ ] better
- [ ] same
- [ ] worse
- [ ] I don’t know

**How would you rate your balance?**
- [ ] very good
- [ ] good
- [ ] fair
- [ ] poor
- [ ] I don’t know

**How would you rate your general muscle strength?**
- [ ] very good
- [ ] good
- [ ] fair
- [ ] poor
- [ ] I don’t know

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**Note:**

**One unit is considered as one glass of wine (=2dl), one beer, or a small amount of high-proof alcohol.**
Did your doctor diagnose you with one of the below mentioned diseases?

| Disease                                | Yes | No  | I don’t know |
|----------------------------------------|-----|-----|-------------|
| Diabetes mellitus                      |     |     |             |
| Polyneuropathy (nerve damage)          |     |     |             |
| Hypertension (high blood pressure)     |     |     |             |
| Heart failure                          |     |     |             |
| Heart attack                           |     |     |             |
| Stroke                                 |     |     |             |
| Malignant tumor / cancer               |     |     |             |
| Respiratory disorders (bronchial tubes)|     |     |             |
| Stomach or intestinal disorders        |     |     |             |
| Joint diseases (rheumatism, arthrosis, gout) |     |     |             |
| Osteoporosis (bone loss)               |     |     |             |
| Eye diseases                           |     |     |             |

If yes, which one? ____________________________

Which medication do you regularly take at the moment?
(type, frequency, dose; e.g. ASS 100, daily, 1 pill?)
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Do you have any pain?

| No pain | less than daily | daily |
|---------|----------------|-------|

How strong is the pain (pain intensity)?

| Little pain | Moderate pain | Sometimes very strong pain |
|-------------|---------------|-----------------------------|

Where do you have pain (localization)?

- back pain
- bone pain
- chest pain during usual activity
- headache
- pain in the hip
- wound pain
- joint pain (except pain in the hip)
- muscle soreness
- stomach ache
- other localization: ____________________________

Do you suffer from:

| Hearing problems: | Yes | No |
|-------------------|-----|----|
| Visual problems:  |     |    |
| Dizziness:        |     |    |
| Gait problems:    |     |    |
3. Questions about mobility and physical activity

Do you have problems with your legs (wounds on the feet, varicose veins, arthrosis knee or hip pain), which limit the mobility?

- □ yes
- □ yes, sometimes
- □ no
- □ I don’t know

Do you use walking aids?

- □ none
- □ cane / stick / crutch
- □ rollator

Are you afraid of falling?

- □ no, never
- □ sometimes
- □ often
- □ yes, always

How many times did you fall in the last 6 months?

Number:  
- □ 0
- □ 1
- □ >1

Why? (if known): __________________________________________________________

How often during the week do you do the following leisure / sport activities and for how long?

| Activity          | Time Spent |
|-------------------|------------|
| To go for a walk  |            |
| Fitness / exercise|            |
| Gardening         |            |
| Others            |            |

Do / did you play sports actively?

- □ yes
- □ no

Why did you stop? __________________________________________________________

Do / did you experience motion sickness on cars, trains, ships, airplanes, etc.?

- □ yes
- □ no

If yes, what vehicle(s) do / did you experience? ______________________________________

What is your main profession?

- □ sedentary work
- □ light physical work
- □ moderate physical work
- □ hard physical work

Thank you for answering the health questionnaire!