0b. Staff ID: ☐☐☐
(To be completed by research staff member)

GENERAL INTERVIEW FORM (Mail Version)

PPT NAME: ____________________
(To be completed by research staff member)

FORM CODE: G N J

DATE: 10/08/2024
Version 1.0

ADMINISTRATIVE INFORMATION

Instructions: *Please tell us who is completing this form and today's date.*

Full name of person completing this form: ______________________________
(first) (last)

Are you the study participant?

Yes....... ☐ → *Skip to Question 0a.*
No .... ☐ → *Continue to next question.*

Are you a proxy for the study participant?

Yes....... ☐
No .... ☐

0a. Today's Date: ☐☐/☐☐/☐☐☐☐
Month Day Year

QUESTIONS

Instructions: *Please answer the questions below to the best of your ability. Please answer the questions in the order they appear on the form and follow directions to skip questions, as applicable.*

A. Physical Activity

1. During leisure time, how often would you say you play sports or exercise? (Mark one.)

Never	Seldom	Sometimes	Often	Very often
☐	☐	☐	☐	☐

B. Functional Status

Instructions: *Please mark "yes" or "no" to tell us whether you are able to do the following activities:*			
Are you able to...		**Yes**	**No**
2.	Do your usual activities, such as work around the house or recreation?	☐	☐
3.	Walk half a mile without help? That's about 8 ordinary blocks.	☐	☐
4.	Walk up and down stairs without help?	☐	☐
5.	Do heavy work around the house, like shoveling snow or washing windows, walls, or floors, without help?	☐	☐

C. Falls

The next questions are about falls you may have experienced during the past 12 months.

6. In the past 12 months did you fall?

Yes .... ☐ → *Continue to Question 7.*
No .... ☐ → *Skip to Question 8.*
Do not remember .... ☐ → *Skip to Question 8.*

7. In the past 12 months, how many times did you fall?

1................................. ☐
2................................. ☐
3................................. ☐
4................................. ☐
5................................. ☐
6 or more .... ☐
Do not remember .... ☐

D. Caregiving

8. Are you currently receiving care on an ongoing basis to help with chronic illness or disability? This includes any kind of help, such as companionship, help with dressing, bathing, transportation, food preparation.

Yes .... ☐ → *Continue to Question 9.*
No .... ☐ → *Skip to Question 10.*

9. Does the care provider live with you?

Yes .... ☐
No .... ☐

E. Vaccination

10. Have you received the influenza ("flu") vaccine at any time in the past 12 months?

Yes .... ☐
No .... ☐
Unsure .... ☐

11. Have you ever had a pneumonia vaccination? This shot is usually given only once in a person's lifetime and is different from a flu shot.

Yes .... ☐
No .... ☐

F. Alcohol Consumption

The next questions are about your consumption of wine, beer and drinks made with hard liquor.

12. Have you ever consumed alcoholic beverages?

Yes .... ☐ → *Continue to Question 13.*
No .... ☐ → *Skip to Question 14.*

13. Do you currently drink alcoholic beverages?

Yes .... ☐
No .... ☐

G. Cognitive Complaints

The next questions are about your memory.

14. Do you feel as if your memory is becoming worse?

Yes .... ☐ → *Continue to Question 15.*
No .... ☐ → *Skip to Question 16.*
Do not know................ ☐ → *Skip to Question 16.*

15. Does this worry you?

Yes .... ☐
No .... ☐
Do not know................ ☐

H. Gout Questions

The next questions are about any experiences you have had with gout.

16. Have you ever been told by a physician that you had gout?

Yes .... ☐ → *Continue to Question 16a.*
No .... ☐ → *Skip to Question 17.*
Do not know .... ☐ → *Skip to Question 17.*

16a. How old were you when a physician first told you that you had gout? ☐☐
Age in years

16b. How many attacks of gout have you had in the last 12 months?

0 .... ☐ → *Continue to Question 16c.*
1 .... ☐ → *Continue to Question 16c.*
2 .... ☐ → *Continue to Question 16c.*
3 .... ☐ → *Continue to Question 16c.*
4 .... ☐ → *Continue to Question 16c.*
5 or more .... ☐ → *Skip to Question 17.*

16c. How many attacks of gout have you had in your lifetime?

0 .... ☐
1 .... ☐
2 .... ☐
3 .... ☐
4 .... ☐
5 or more .... ☐

I. Sleep

The next questions are about your sleep.

17. What time do you usually get into bed and try to go to sleep? ☐☐:☐☐ AM / PM
Hour Minute

18. What time do you get out of bed to start the day? ☐☐:☐☐ AM / PM
Hour Minute

19. How would you rate your sleep quality overall? (Mark one.)

Very Good	Fairly Good	Fairly Bad	Very Bad
☐	☐	☐	☐

J. Physical ability

Instructions: *The next questions ask how well you typically function on your own, which is without help from another person or special equipment such as a cane or walker. This does not include difficulties due to a temporary condition like a broken limb. For each activity, please mark whether you are able to perform the activity with **no difficulty**, with **some difficulty**, or you are **unable to do** the activity. If you do not know or do not do the activity, please mark **unknown/do not do**.*

How much difficulty do you have:		No difficulty	Some difficulty	Unable to do	Unknown/ Do not do
20	Walking for a quarter of a mile (about 2 or 3 blocks)?	☐	☐	☐	☐
21.	Walking from one room to another on the same level?	☐	☐	☐	☐
22.	Getting in or out of bed?	☐	☐	☐	☐
23.	Walking up 10 steps without resting?	☐	☐	☐	☐
24.	Doing chores around the house (like vacuuming, sweeping, dusting, or straightening up?)	☐	☐	☐	☐
25.	Preparing your own meals?	☐	☐	☐	☐
26.	Managing your money (such as keeping track of your expenses or paying bills)?	☐	☐	☐	☐
27.	Eating, including holding a fork, cutting food, or drinking from a glass?	☐	☐	☐	☐
28.	Dressing yourself, including tying shoes, working zippers, or doing buttons?	☐	☐	☐	☐
29.	Lifting or carrying something as heavy as 10 pounds?	☐	☐	☐	☐
30.	Standing up from an armless chair?	☐	☐	☐	☐
31.	Stooping, crouching, or kneeling?	☐	☐	☐	☐

Thank you for completing this form! Please make sure you complete all forms before mailing them back to the ARIC Study Team.