

Family name:

Surname:

Address:
.....

Tel. Private:..... at work:.....

ID-No: |_|_|_|

9.2 When did you have your last balloon-dilatation?

d	d	.	m	m	.	y	y		

10. Did a doctor diagnose a stroke yes no

If 'yes',

10.1 How many strokes did you have?

10.2 When did you have your last stroke?

d	d	.	m	m	.	y	y		

11. Do you suffer from diabetes? yes no

10.1 If 'yes', is your diabetes treated with insulin? yes no

12. Do you have a pace maker yes no

13. Do you smoke now? (yes: ≥ 1 cigarette/year) yes no

Check of NYHA criteria:

14. cardiac diseases and

14.1 Symptoms only on severe exertion. Almost normal lifestyle possible yes no

14.2 Symptoms occur on moderate exertion. Patient has to avoid certain situations such as carrying shopping several flights of stairs yes no

14.3 Symptoms occur on mild exertion Activity is markedly restricted yes no

14.4 Symptoms occur frequently, even at rest. yes no

Suitability for the study

15. Are you prepared to come every second week at the same time to the examination for 1.5 hours? yes no

16. Do you plan to leave the city for holidays for weeks or months during the next 6 months? yes no

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| congestive heart failure | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| valvular defect | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| other heart problems | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| asthma | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| chronic bronchitis | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| COPD | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| emphysema | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| pneumioconiosis | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| nasal allergy including hay fever | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| chronic renal diseases | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| other chronic diseases | <input type="checkbox"/> yes | <input type="checkbox"/> no |

If 'yes', specify

.....

.....

10. In general, would you say your health is:

- excellent
- very good
- good
- fair
- poor

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

a. *Vigorous activities*, such as running, lifting heavy objects, participating in strenuous sports

- yes, limited a lot
- yes, limited a little
- no, not limited at all

b. *Moderate activities*, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

- yes, limited a lot
- yes, limited a little
- no, not limited at all

c. Lifting or carrying groceries

- yes, limited a lot
- yes, limited a little
- no, not limited at all

d. Climbing *several* flights of stairs

- yes, limited a lot
- yes, limited a little
- no, not limited at all

e. Climbing *one* flight of stairs

- yes, limited a lot
- yes, limited a little
- no, not limited at all

f. Bending, kneeling, or stooping

- yes, limited a lot
- yes, limited a little
- no, not limited at all

g. Walking *more than a mile*

- yes, limited a lot
- yes, limited a little
- no, not limited at all

h. Walking *several blocks*

- yes, limited a lot
- yes, limited a little
- no, not limited at all

i. Walking *one block*

- yes, limited a lot
- yes, limited a little
- no, not limited at all

j. Bathing or dressing yourself

- yes, limited a lot
- yes, limited a little
- no, not limited at all

12. How much *bodily* pain have you had during the *past 4 weeks*?

- none
- very mild
- mild
- moderate
- severe
- very severe

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

- not at all
- a little bit
- moderately
- quite a bit
- extremely

14. Does your well-being depend on the weather?

- not at all
- some what
- a lot

15. Are you taking any capsules containing vitamins? yes no

15.1 If 'yes',

- daily
- once a week
- as needed

16. Is your home/apartment

- facing the street yes
- facing a backyard or a park yes
- facing both, the street and the backyard yes

17. Is your dwelling

- one family house detached from any other house yes no
- one family house attached to one or more other houses yes no
- apartment/more family house yes no
- Neubaublock (only in Germany) yes no

18. When was this building originally built?

- Less than 1 year ago
- 1990 - 1997
- 1980 - 1989
- 1970 - 1979
- 1960 - 1969
- 1945 - 1959
- before 1945

19. How many floors are in this building? ||

20. At which floor is your home? (basement/1st floor =1) ||

21. Does your home have central heating? yes no

21.1 If 'no', which of the following fuels do you use for heating

- coal, wood yes no
- gas yes no
- electric yes no
- oil yes no

22. Do you regularly use a gas range or gas oven for cooking? yes no

23. Do you sleep with the windows open at night mostly during the winter months? yes no

24. How much are you annoyed by the traffic noise at home if the windows are kept open? (please circle the number)

no annoyance |||||||||||| unbearable annoyance
0 1 2 3 4 5 6 7 8 9 10

25. How much are you annoyed by air pollution at home i. e. smell of the traffic and industry, when you keep the window open? (please circle the number)

no annoyance ||||||||||| unbearable annoyance
0 1 2 3 4 5 6 7 8 9 10

