

### Questionnaire for Older Patients $\geq 65$ Years Attending a GP-Appointment

*The purpose of this study is to learn more about the physical and mental health of older patients. All data will be treated confidentially. Some participants may be offered further follow-up.*

Please mark your answers like this: ☒

Thank you for your help.

**We kindly ask you to complete all sections of the questionnaire and check both page sides.**

## BACKGROUND INFORMATION:

Date (today) : \_\_\_\_\_ Date of birth:     /     Gender: Male: ☐ Female: ☐

date      month      year

Marital status: Married/Partnered: ☐ Widowed: ☐ Divorced: ☐ Living alone: ☐

Living situation:      House: ☐      Apartment: ☐      Care facility: ☐

Did you pursue further education after primary school: Yes: ☐ No: ☐

Do you have higher education? (e.g., college, university): Yes: ☐ No: ☐

Do you have children or grandchildren nearby: Yes: ☐ No: ☐

Is Norwegian your native language? Yes: ☐ No: ☐

Do you smoke? Yes: ☐ No: ☐

Do you drink more than 2 units of alcohol per day on average? Yes: ☐ No: ☐ Don't know: ☐  
(= 3 or more half-liters of beer, glasses of wine, or shots of spirits daily)

Do you have any of the following health conditions? (Check all that apply)

Diabetes: ☐ Osteoporosis: ☐ High blood pressure: ☐ Rheumatoid arthritis: ☐

Osteoarthritis: ☐    Stroke: ☐    Cancer: ☐    Lung disease: ☐    Eye disease: ☐

Heart disease: ☐      Thyroid disease: ☐

Other chronic illness: ☐ \_\_\_\_\_ ( please specify)

Check if you participate in or use any of the following:

Volunteer work/association/church: ☐ Paid work: ☐ Day center: ☐

Sedative medication: ☐      Sleeping medication: ☐      Antidepressants: ☐

Home nursing care: ☐ Assistance with household tasks: ☐ Psychiatric nurse: ☐

Treatment by a psychologist or psychiatrist: ☐

I agree to be contacted if further follow-up is relevant: Yes: ☐ No: ☐

Here are some common health complaints. We ask you to evaluate each issue/symptom and indicate to what extent you have been affected by it over the past thirty days.

SHC. Ursin et al.

|     | (sett kun ett kryss for hver linje) | Not at all                 | A little                   | Some                       | Serious                    |
|-----|-------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1.  | Cold, flu                           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 2.  | Coughing                            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 3.  | Asthma                              | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 4.  | Hodepine                            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 5.  | Neck pain                           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 6.  | Upper back pain                     | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 7.  | Lower back pain                     | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 8.  | Arm pain                            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 9.  | Shoulder pain                       | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 10. | Migraine                            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 11. | Extra heartbeats                    | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 12. | Chest pain                          | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 13. | Breathing difficulties              | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 14. | Leg pain during physical activity   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 15. | Heart burn                          | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 16. | Stomach discomfort                  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 17. | Ulcer/non-ulcer dyspepsia           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 18. | Stomach pain                        | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 19. | Gas discomfort                      | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 20. | Diarrhoea                           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 21. | Obstipation                         | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 22. | Eczema                              | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 23. | Allergies                           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 24. | Heat flushes                        | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 25. | Sleep problems                      | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 26. | Tiredness                           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 27. | Dizziness                           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 28. | Anxiety                             | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 29. | Sadness/depression                  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

Sum: \_\_\_\_\_

**Over the last 2 weeks, how often have you been bothered by the following problems?**

PHQ-9

|    | <i>(only one cross per line)</i>                                                                                                                                          | Not at all                 | Several days               | More than half of the days | Nearly every day           |
|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1. | Little interest or pleasure in doing things                                                                                                                               | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 2. | Feeling down, depressed or hopeless                                                                                                                                       | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 3. | Trouble falling asleep, staying asleep, or sleeping too much                                                                                                              | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 4. | Feeling tired or having little energy                                                                                                                                     | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 5. | Poor appetite or overeating                                                                                                                                               | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 6. | Feeling bad about yourself - or that you're a failure or have let yourself or your family down                                                                            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 7. | Trouble concentrating on things, such as reading the newspaper or watching television                                                                                     | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 8. | Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 9. | Thoughts that you would be better off dead or of hurting yourself in some way                                                                                             | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

Sum: \_\_\_\_\_

**Over the last 2 weeks, how often have you been bothered by the following problems?**

GAD-7

|    | <i>(only one mark per line)</i>                | Not at all                 | Several days               | More than half of the days | Nearly every day           |
|----|------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1. | Feeling nervous, anxious or on edge            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 2. | Not being able to stop or control worrying     | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 3. | Worrying too much about different things       | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 4. | Trouble relaxing                               | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 5. | Being so restless that it is hard to sit still | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 6. | Becoming easily annoyed or irritable           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 7. | Feeling afraid if something awful might happen | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

Sum: \_\_\_\_\_