



GENERAL INTERVIEW FORM (Mail Version)

PPT NAME:

(To be completed by research staff member)

FORM CODE:

G	N	K
---	---	---

DATE: [01/13/2025]
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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Walk half a mile without help? That's about 8 ordinary blocks.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Walk up and down stairs without help?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do heavy work around the house, like shoveling snow or washing windows, walls, or floors, without help?	<input type="checkbox"/>	<input type="checkbox"/>

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.....

F. Digital Access

The next questions are about your access to different types of computers and the internet.

11a. Do you own a smartphone?

- Yes
No.....

11b. Do you own a desktop or laptop computer?

- Yes
No.....

11c. Do you own a tablet or another portable wireless computer (e.g., iPad)?

- Yes
No.....

12. Where you live, do you have access to the internet?

- Yes → *Continue to Question 12a.*
No..... → *Skip to Question 13.*

12a. Is that internet access through a cellular data plan?

- Yes
No.....

12b. Is that internet access (also) through an internet service provider?

- Yes
No.....

G. Alcohol Consumption

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

13. Do you currently drink alcoholic beverages?

- Yes
No.....

H. Cognitive Complaints

The next question is about your memory.

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

- Yes
No.....
Do not know

I. Subjective Age

For the next question, please think about your overall life and health.

15. How old do you feel compared to your actual age? (Mark one.)

Younger	Same	Older
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

J. Unintentional Weight Loss

The next questions are about weight loss to track potential changes.

16a. Over the past year, have you lost more than 10 pounds?

- Yes → Continue to Question 16b.
No..... → Skip to Question 17.
Do not know → Skip to Question 16c.

16b. About how much lower is your weight now than a year ago? lbs

16c. Were you trying to lose weight?

- Yes
No.....
Do not know

K. 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

L. 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	Walking from one room to another on the same level?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Getting in or out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Walking up 10 steps without resting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Doing chores around the house (like vacuuming, sweeping, dusting, or straightening up?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	Preparing your own meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	Managing your money (such as keeping track of your expenses or paying bills)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	Eating, including holding a fork, cutting food, or drinking from a glass?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	Dressing yourself, including tying shoes, working zippers, or doing buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29.	Lifting or carrying something as heavy as 10 pounds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30.	Standing up from an armless chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31.	Stooping, crouching, or kneeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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