

MULTIPLE RISK FACTOR INTERVENTION TRIAL

FOURTH ANNUAL MEDICAL HISTORY
AND BEHAVIOR QUESTIONNAIRE

Year of Follow-up **4**

Attach ID Label Here

The following set of questions includes a Medical History Questionnaire and some questions to study the relationship between the occurrence of heart disease and factors such as behavioral characteristics and physical activity. These questions are arranged in four parts. They are as follows:

- Part I - Medical History
- Part II - Nutrition
- Part III - Events During the Past Year
- Part IV - Leisure Time Physical Activities

Please follow these directions when completing this questionnaire:

- 1 Read every question carefully and answer every one. Unless otherwise indicated, only one response should be selected for each question. PLEASE USE BALLPOINT PEN AND PRESS FIRMLY.
- 2 It is essential that you bring this completed questionnaire with you to your scheduled appointment. A protective envelope is enclosed for your convenience. PLEASE DO NOT FOLD THE QUESTIONNAIRE.

The answers you give are treated completely confidentially and will become part of your study record.

PLEASE BRING ALL MEDICINES THAT YOU ARE CURRENTLY TAKING, OR HAVE TAKEN DURING THE PAST TWO WEEKS, TO THE NEXT VISIT SO THAT THE DOCTOR CAN IDENTIFY THEM.

Your present address and telephone number:

ADDRESS: _____

Street Apartment No.

City State Zip Code

Home Telephone Number Work Telephone Number

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If you wish the results of the tests, the ECG and physical examination sent to your physician, please give his name and address below and check the box.

NAME: _____

ADDRESS: _____

Street Apartment No.

City State Zip Code

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Please give the name and address of someone who is not living in your household but who will know where you are if we should need to contact you. If this person is a married woman, please give her husband's name also in the space provided.

Name: _____

First Last Husband

Street No. and Name

City State Zip Code

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PART I – MEDICAL HISTORY QUESTIONNAIRE

A complete and accurate medical history is essential in evaluating your health status. This questionnaire is intended to help you become more aware of your physical well-being and to help our staff with your examination at the next visit.

DURING THE PAST 12 MONTHS HAS A DOCTOR TOLD YOU THAT YOU HAD ANY OF THE FOLLOWING?
(Check either yes, no, or not sure for each item.)

- | | | | | |
|---|----|------------------------------|-----------------------------|-----------------------------------|
| MHQ01V48 <input type="checkbox"/> 1. High blood pressure (hypertension) | 28 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ02V48 <input type="checkbox"/> 2. Heart attack (myocardial infarction, coronary occlusion or coronary thrombosis) | 29 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ03V48 <input type="checkbox"/> 3. Angina | 30 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ04V48 <input type="checkbox"/> 4. Congenital heart disease (born with heart defect) | 31 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ05V48 <input type="checkbox"/> 5. Rheumatic fever, chorea (St. Vitus Dance) | 32 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ06V48 <input type="checkbox"/> 6. Rheumatic heart disease | 33 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ07V48 <input type="checkbox"/> 7. Stroke | 34 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ08V48 <input type="checkbox"/> 8. Diabetes (sugar in the blood or urine) | 35 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ09V48 <input type="checkbox"/> 9. Gout | 36 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ10V48 <input type="checkbox"/> 10. Kidney disease (nephritis, pyelonephritis, glomerulonephritis, kidney infection) | 37 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ11V48 <input type="checkbox"/> 11. Kidney stones | 38 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ12V48 <input type="checkbox"/> 12. Prostate infection, enlargement or other prostate disease | 39 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ13V48 <input type="checkbox"/> 13. Urinary tract infection, bladder infection, other bladder disease | 40 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ14V48 <input type="checkbox"/> 14. Bronchitis | 41 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ15V48 <input type="checkbox"/> 15. Pneumonia | 42 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ16V48 <input type="checkbox"/> 16. Pleurisy | 43 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ17V48 <input type="checkbox"/> 17. Emphysema | 44 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ18V48 <input type="checkbox"/> 18. Tuberculosis | 45 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ19V48 <input type="checkbox"/> 19. Thyroid problem or disease | 46 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ20V48 <input type="checkbox"/> 20. Colitis or inflammation of the colon | 47 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ21V48 <input type="checkbox"/> 21. Ulcer (stomach or duodenal), or intestinal bleeding | 48 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ22V48 <input type="checkbox"/> 22. Hepatitis | 49 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ23V48 <input type="checkbox"/> 23. Cirrhosis or other liver disease | 50 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ24V48 <input type="checkbox"/> 24. Anemia | 51 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ25V48 <input type="checkbox"/> 25. Cancer | 52 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ26V48 <input type="checkbox"/> 26. Nervous, emotional or mental disorder | 53 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ27V48 <input type="checkbox"/> 27. Rheumatoid arthritis | 54 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ28V48 <input type="checkbox"/> 28. Other arthritis | 55 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| <input type="checkbox"/> 29. Epilepsy or seizures or fits | 56 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ30V48 <input type="checkbox"/> 30. Allergies | 57 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ31V48 <input type="checkbox"/> 31. Asthma | 58 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| MHQ32V48 <input type="checkbox"/> 32. Hives or hay fever | 59 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| <input type="checkbox"/> 33. Other major diseases (specify) _____ | 60 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| <input type="checkbox"/> 34. During the past 12 months have you been told by a doctor that you have gallstones or gall bladder disease? | 61 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| <input type="checkbox"/> 35. During the past 12 months have you had x-rays taken of your gall bladder? | 62 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| <input type="checkbox"/> 36. During the past 12 months have you had surgery for gall bladder disease? | 63 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| <input type="checkbox"/> 37. During the past 12 months have you had surgery on your heart or arteries? | 64 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |

CASURG48

DURING THE PAST 12 MONTHS HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

- | | | | | |
|---|----|------------------------------|-----------------------------|-----------------------------------|
| 38. Skin rash or unusual bruises? | 65 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 39. Headaches that were so bad you had to stop what you were doing? | 66 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 40. Headache attack, racing heart and sweating, all at the same time? | 67 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 41. Faintness or light-headedness when you stand up quickly? | 68 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 42. Your heart beating unusually fast or skipping beats? | 69 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 43. Blacking out or losing consciousness? | 70 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 44. Frequent stomach pains? | 71 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 45. Waking up early, having trouble getting back to sleep? | 72 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 46. Black or tarry stools? | 73 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 47. Bright red blood in your stools? | 74 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 48. Allergies to medicines? | 75 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |
| 49. Unexplained weight loss? | 76 | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> not sure |

50 Were you hospitalized for any reason in the past 12 months?

HOSP48

1 yes →

2 no ↓

Please give the name and address of the hospital you visited.

A. _____
 Hospital

 Street

 City - State

B. _____
 Hospital

 Street

 City - State

C. _____
 Hospital

 Street

 City - State

51. During the past 12 months, about how many times have you seen or talked to a medical doctor for health reasons? Do not count the MRFIT physicians. (check one)

- 78 1 zero times during past year 2 one - two times during past year 3 three - five times during past year 4 six or more times during past year

52. During the past 12 months, about how many visits have you made to the dentist? (check one)

- 79 1 zero times during past year 2 one time during past year 3 two times during past year 4 three or more times during past year

53. About how many days during the past 12 months were you kept in bed for all or most of the day because of illness, disability or injury? (check one)

- 80 1 zero - three days during past year 2 four - six days during past year 3 seven - nine days during past year 4 ten or more days during past year

RATACT48

54. Considering all the things you do, how would you rate yourself as to the amount of physical activity you get compared with other men your age? (check one)

- 81 1 I am much less active than others 2 I am somewhat less active than others 3 I am about the same 4 I am somewhat more active 5 I am much more active

55. During the past four weeks, how often did you take aspirin or similar drugs containing aspirin such as Alka-Seltzer, Anacin, APC, Bufferin, Darvon Compound, Dristan, Empirin, or Excedrin? (check one)

- 82 1 daily 2 four, five, six days per week 3 one, two, three days per week 4 occasionally - less often than one day per week 5 not at all

ASPIR48

THINKING ABOUT THE LAST 12 MONTHS PLEASE ANSWER THE FOLLOWING QUESTIONS:

56. Have you ever awakened at night gasping for breath?

- 83 1 yes 2 no

CHF48

57. Do you usually cough first thing in the morning in the winter? (If you cough with your first smoke or when first going outside, you should mark "yes". Do not respond "yes" for clearing of throat or a single cough.)

- 84 1 yes 2 no

COUGH48

58. Do you usually cough during the day or at night in the winter? (Do not respond "yes" for a single cough.)

- 85 1 yes →
 2 no ↓

59. Do you cough like this on most days for as much as 3 months each year? 86 1 yes 2 no

Continue with question 60.

60. Do you usually bring up any phlegm (mucus) from your chest first thing in the morning in the winter? 87 1 yes 2 no

61. Do you usually bring up any phlegm from your chest during the day—or at night—in the winter?

PHLEGM48 88

1 yes
2 no

62. Do you bring up phlegm like this on most days for as much as 3 months each year? 89 1 yes 2 no

63. In the past 3 years, have you had a period of increased cough and phlegm lasting for 3 weeks or more? 90 1 yes, once 2 yes, more than once 3 no

DYSPNE48 64. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? 91 1 yes 2 no

65. Do you get short of breath walking with other people of your own age on level ground? 92 1 yes 2 no

66. Have you ever had asthma? 93 1 yes 2 no

67. Have you ever had any pain or discomfort in your chest?

ROSEAN48 94
ROSEMI48

1 yes
2 no

69. Do you get it when you walk uphill or hurry? 96 1 yes 2 no

70. Do you get it when you walk at an ordinary pace on the level? 97 1 yes 2 no

71. When you get it in your chest what do you do?
98 1 stop 2 slow down 3 continue at same pace

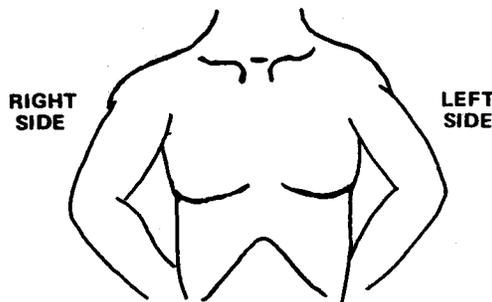
72. Does it go away when you stand still?

99 1 yes
2 no
73. How soon? 100 1 10 min. or less 2 more than 10 min.
Continue with question 74.

68. Have you ever had any pressure or heaviness in your chest?

1 yes
2 no

74. Where do you get this pain or discomfort? (Mark the place or places with an "X" on the diagram.)



DO NOT USE

101 1 yes 2 no

102 1 yes 2 no

103 1 yes 2 no

75. Have you ever had a severe pain across the front of your chest lasting for half an hour or more? 104 1 yes 2 no

76. Do you get a pain in either leg on walking?

1 yes
2 no

ROSEIC48 105 77. Does this pain ever begin when you are standing still or sitting? 106 1 yes 2 no

78. Do you get this pain in your calf? (or calves?) 107 1 yes 2 no

79. Do you get it when you walk uphill or hurry? 108 1 yes 2 no

80. Do you get it when you walk at an ordinary pace on the level? 109 1 yes 2 no

81. Does the pain ever disappear while you are still walking? 110 1 yes 2 no

82. What do you do if you get it when you are walking?
111 1 stop 2 slow down 3 continue at same pace

83. What happens to it if you stand still?
112 1 usually continues more than 10 min. 2 usually disappears in 10 min. or less

Continue with question 84.

PLEASE ANSWER THE FOLLOWING QUESTIONS AS DIRECTED

84. In the past 12 months, have you had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand, leg, foot or face?

- 113
1 yes
2 no

85. How many attacks of such numbness or tingling have you had? (Check one)
114 1 only one 2 two 3 three - five 4 more than five

86. How long did the attack(s) usually last? (Check one)
115 1 usually less than 5 minutes 2 from 5 minutes to an hour 3 from 1 to 6 hours
4 from 6 to 24 hours 5 more than a day

87. Did you see a doctor for the numbness or tingling? 116 1 yes 2 no

NDNUMB48



88. During the past 12 months, have you had any sudden attacks of paralysis or loss of use of either arm, hand, leg or foot?

- 117
1 yes
2 no

89. How many attacks of such paralysis have you had? (Check one)
118 1 only one 2 two 3 three - five 4 more than five

90. How long did the attack(s) usually last? (Check one)
119 1 usually less than 5 minutes 2 from 5 minutes to an hour 3 from 1 to 6 hours
4 from 6 to 24 hours 5 more than a day

91. Did you see a doctor for this paralysis? 120 1 yes 2 no

NDPARL48



92. In the past 12 months, have you had any sudden loss of eyesight or blurring of vision for a short period of time?

- 121
1 yes
2 no

93. What part of your vision was affected? (Check one)
122 1 right eye 2 left eye 3 both eyes
4 vision to the right side 5 vision to the left side

94. How many attacks of loss of eyesight or blurring of vision have you had? (Check one)
123 1 only one 2 two 3 three - five 4 more than five

95. How long did the attack(s) usually last? (Check one)
124 1 usually less than 5 minutes 2 from 5 minutes to an hour 3 from 1 to 6 hours
4 from 6 to 24 hours 5 more than a day

96. Did you see a doctor for this vision problem? 125 1 yes 2 no

NDANOP48



97. In the past 12 months, have you had any sudden attacks of changes in speech, loss of speech or inability to say words for more than two minutes?

- 126
1 yes
2 no

98. How many attacks of loss of speech have you had? (Check one)
127 1 only one 2 two 3 three - five 4 more than five

99. How long did the attack(s) usually last? (Check one)
128 1 usually less than 5 minutes 2 from 5 minutes to an hour 3 from 1 to 6 hours
4 from 6 to 24 hours 5 more than a day

100. Did you see a doctor for your speech problem? 129 1 yes 2 no

NDDYSP48



Continue with question 101.

101. During the past 12 months, have you had any spells of dizziness, difficulty in walking, lightheadedness or loss of balance? Check yes or no for each condition to indicate whether an attack occurred or not.

	Yes	No
Dizziness	130 1 <input type="checkbox"/>	2 <input type="checkbox"/>
Spinning sensation (vertigo)	131 1 <input type="checkbox"/>	2 <input type="checkbox"/>
Loss of balance	132 1 <input type="checkbox"/>	2 <input type="checkbox"/>
Difficulty walking	133 1 <input type="checkbox"/>	2 <input type="checkbox"/>
Blackouts or fainting	134 1 <input type="checkbox"/>	2 <input type="checkbox"/>

102. Is "yes" checked one or more times in question 101?

1 yes

135

2 no

NDATAX48



103. About how many total attacks of all conditions checked do you think you have had in the past 12 months? (Check one)

136 1 only one 2 two 3 three - five 4 more than five

104. How long did attack(s) usually last? (Check one)

137 1 usually less than 5 minutes 2 from 5 minutes to an hour
3 from 1 to 6 hours 4 from 6 to 24 hours 5 more than a day

105. Did you see a doctor for any of these spells? 138 1 yes 2 no

Continue with Part II

Continue with Part II

NDALL48



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PART II – NUTRITION

Please answer the following questions concerning the meals you eat and your usual pattern of drinking alcoholic beverages.

1. Are you presently employed?

- 25 1 yes
2 no

2. Which answer best describes the total number of meals you usually eat on a typical work day? (Check one)

26 1 1 meal a day 2 2 meals a day 3 3 meals a day 4 4 or more meals a day

3. Which answer best describes the total number of meals you usually eat away from home on a typical work day? (Check one)

27 1 0 meals away from home 2 1 meal away from home 3 2 meals away from home 4 3 or more meals away from home

4. Which answer best describes the total number of meals you usually eat on a typical non-work day? (Check one)

28 1 1 meal a day 2 2 meals a day 3 3 meals a day 4 4 or more meals a day

5. Which answer best describes the total number of meals you usually eat away from home on a typical non-work day? (Check one)

29 1 0 meals away from home 2 1 meal away from home 3 2 meals away from home 4 3 or more meals away from home

6. When you go to work do you usually carry a lunch prepared at home?

30 1 yes
2 no

7. If yes, how long have you been carrying a lunch? (Check one)

31 1 less than 1 year 2 1-2 years 3 more than 2 years

Continue with question 8.

8. Which answer best describes the total number of meals you eat out (e.g. meals purchased at a restaurant, cafeteria, snack bar, delicatessen, vending machine, drive-in or take-out food store) in a typical week? (Check one)

- 32 1 0 meals 2 1-3 meals 3 4-6 meals 4 7-9 meals 5 10-12 meals 6 13 or more meals

9. Would you consider your answer to question 8 above a change from a year ago of the number of meals you ate out?

- 33 1 yes
2 no

10. If yes, how much of a change? (Check one)

34 1 eat out less often 2 eat out more often

11. Do you drink wine, beer, whiskey or liquor (cocktails, gin, vodka, scotch, bourbon, rum, etc.)?

- 35 1 yes
2 no

12. Which answer best describes how often you drink wine, beer, whiskey or liquor? (Check one)

36 1 less than once per week 2 1 to 2 times a week 3 3 to 4 times a week 4 nearly every day 5 every day

13. When you drink alcoholic beverages, how many do you usually drink in a day?

37 number of drinks per day

14. On how many weekdays (Monday, Tuesday, Wednesday and Thursday) do you usually drink alcoholic beverages?

1 0 days → Continue with question 16.

38 2 1 day
3 2 days
4 3 days
5 4 days

15. When you drink on a weekday, how many drinks do you usually drink in a day?

40 number of drinks per day

16. On how many days of a weekend (Friday, Saturday and Sunday) do you usually drink alcoholic beverages?

1 0 days → Continue with Part III.

42 2 1 day
3 2 days
4 3 days

17. When you drink on a weekend, how many drinks do you usually drink in a day?

43 number of drinks per day

Continue with Part III

DRKALC48

OFTALC48

ALCD48

DRINKS48



Continue with Part III

PART III – EVENTS DURING THE PAST YEAR

Read down the list of events and put a ✓ after any event which you have experienced within the past 12 months.

Events Concerning Your Health

Within the past 12 months, have you experienced:

1. A physical illness or injury which kept you in bed for a week or more, or sent you to the hospital? 45 1
2. Worries about physical symptoms which the doctor couldn't explain? 46 1
3. Mental illness or problems that required hospitalization? 47 1
4. The realization that you are an alcoholic or a drug addict? 48 1
5. A major change in eating, sleeping, or smoking habits? 49 1
6. A change in your physical appearance such as the development of scars, major weight change, or limp? 50 1
7. Not being able to do things you used to because of age? 51 1
8. A change in your usual level of physical activity? 52 1

Events Concerning You and Your Work

Within the past 12 months, have you experienced:

9. Success and/or awards at work? 53 1
10. A change to a new type of work? 54 1
11. More responsibilities? 55 1
12. Fewer responsibilities? 56 1
13. A promotion? 57 1
14. A demotion? 58 1
15. A transfer? 59 1
16. More hours? 60 1
17. Fewer hours? 61 1
18. A major career decision? 62 1
19. Going into business for yourself? 63 1
20. Major reorganization of your business? 64 1
21. A business failure? 65 1
22. Personal troubles with your boss, fellow workers, or people working under your supervision? 66 1
23. Not being able to work because of a disability? 67 1
24. Being fired or laid off work? 68 1
25. Quitting your job? 69 1
26. Problems getting a new job? 70 1
27. Retirement from work? 71 1
28. Becoming more involved in creative hobbies or sports? 72 1

Events Concerning Your Feelings and Thoughts

Within the past 12 months, have you experienced:

29. Feelings of being overwhelmed by difficult life situations? 73 1
30. The realization that you will never attain an important goal? 74 1
31. More thoughts about dying than usual? 75 1
32. Planning a suicide? 76 1
33. Unpleasant thoughts or images which keep coming back? 77 1
34. Feeling confused for over 3 days? 78 1
35. Feeling very angry, nervous, or sad for over 3 days? 79 1
36. Feeling worried about financial security? 80 1
37. Feelings of intense loneliness? 81 1
38. Feelings of being intensely disliked by someone? 82 1
39. Feelings of being uninvolved, distant from others, or very shy? 83 1

Events Concerning Your Marriage

Within the last 12 months, have you experienced:

- 40. Getting married? 84 1
- 41. In-law problems? 85 1
- 42. Separation from your wife because of marital problems? 86 1
- 43. Starting to live with your wife again after having been separated? 87 1
- 44. Problems because of your wife's health? 88 1
- 45. Getting divorced? 89 1

Events Concerning You and Your Children

Within the last 12 months, have you experienced:

- 46. Serious concern over your child's health? 90 1
- 47. Having your child doing very poorly in school? 91 1
- 48. Being persistently disobeyed by your child? 92 1
- 49. Having your child run away or get into serious trouble? 93 1
- 50. Intense arguments or disagreements with an older child? 94 1
- 51. Loss of contact with, or separation on bad terms from your child? 95 1

Events Concerning You and Others Not of Your Family

Within the last 12 months, have you experienced:

- 52. Doing something that caused another person's injury? 96 1
- 53. A "falling-out" of a close friendship? 97 1
- 54. Discrimination because of your race, age, religion, or appearance? 98 1
- 55. Fewer social activities than before? 99 1

Other Important Events

Within the last 12 months, have you experienced:

- 56. A change in where you live? 100 1
- 57. Involvement in a law suit (other than divorce) or a court appearance on a serious charge? 101 1
- 58. Serious or persistent financial difficulties? 102 1
- 59. Giving up a hobby or sport? 103 1
- 60. Being the victim of a crime such as assault or burglary? 104 1
- 61. An accident (automobile, at work, home, etc.)? 105 1
- 62. A vacation? 106 1

