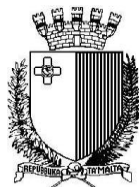


DIRECTORATE FOR  
HEALTH INFORMATION AND  
RESEARCH

MINISTRY FOR ENERGY AND HEALTH



**EUROPEAN HEALTH INTERVIEW SURVEY (EHIS)  
QUESTIONNAIRE**

**- ENGLISH VERSION -**



**2014**



INTERVIEWER NAME AND SURNAME: \_\_\_\_\_

INTERVIEWER CODE: |\_|\_|

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

QUESTIONNAIRE NUMBER: |\_|\_|\_|\_|

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

### PART A: TECHNICAL SURVEY VARIABLES

TS.1 Date of interview      |\_|\_|||\_|\_|||\_|\_|\_|\_|      (ddmmyyyy)

DAY



0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

MONTH



0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

YEAR



0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

TS.2 Questionnaire language

English     

Maltese     



**TS.3 The questionnaire was answered by:**

- Selected Individual  → GO TO TS.5
- Proxy - other member of household
- Proxy - someone outside the household

**TS.4 What is the reason for proxy respondent? (Multiple answers are possible)**

- Sample person has a cognitive impairment
- Sample person is physically debilitated
- Sample person has a hearing/speech problem
- Sample person cannot speak English or Maltese

**TS.5 Type of residence**

- Private household
- Institution

**TS.6 Locality of residence** \_\_\_\_\_

- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9

**PART B: CORE SOCIAL VARIABLES**

**CS.1 Gender**

- Male
- Female

**CS.2 Age**

\_\_\_\_|\_\_\_\_| Years

- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9

**CS.3 What is your country of birth?**

- Native-born
- Born in another EU Member State
- Born in a non-EU country



**CS.4 What is your citizenship?**

- National (Maltese citizenship)
- National of other EU Member State
- National of non EU countries

**INTERVIEWER:** IF RESPONDENT LIVES IN AN INSTITUTION GO TO QUESTION **CS.8 PAGE 7**

**CS.5 How many persons live in the household (include yourself in the number)?**

|\_|\_| persons

- 0 1 2 3 4 5 6 7 8 9  
0 1 2 3 4 5 6 7 8 9

**INTERVIEWER:** IF RESPONDENT LIVES ALONE (**CS.5=1**) GO TO QUESTION **CS.8 PAGE 7**

**CS.6 Household composition**

Introduction

*I would now like to ask you some questions about the members of your household. I will list different age groups and would like you to tell me the number of people in your household who fall within each age group (including yourself).*

**CS.6a Age groups**

**INTERVIEWER:** ENSURE THAT THE TOTAL NUMBER OF PERSONS IN THE TABLE BELOW IS EQUAL TO THE TOTAL INDICATED IN **CS.5**

Age group	Number of persons in the household
Number of persons aged 4 or younger	_ _ _  persons <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9
Number of persons aged 5 to 13	_ _ _  persons <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9



Age group	Number of persons in the household
Number of persons aged 14 to 15	__ __  persons (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
Number of persons aged 16 to 24	__ __  persons (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
Number of persons aged 25 to 64	__ __  persons (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
Number of persons aged 65 and over	__ __  persons (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)

**CS.6b Economic status**

**Introduction**

***I would like to now focus ONLY on the individuals in your household who are aged 16 to 64. Please indicate the number of individuals in your household in this age group who are presently employed:***

**INTERVIEWER: ENSURE RESPONDENT IS ONLY COUNTING THOSE HOUSEHOLD MEMBERS AGED 16 TO 64**

**Number of persons aged 16 – 64 in the household who are employed:**

|\_\_|\_\_| persons

- (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)  
 (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)



*Now I would like you to tell me the number of persons aged 16 to 64 in your household who are unemployed or economically inactive.*

**INTERVIEWER: ENSURE RESPONDENT IS ONLY COUNTING THOSE HOUSEHOLD MEMBERS AGED 16 TO 64**

**Number of persons aged 16 – 64 in the household who are unemployed or economically inactive:**

\_\_\_\_|\_\_\_\_| persons

- |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

### CS.7 Household Type

#### Introduction

*Every household is different – some households may consist of a couple with children or a couple without children. Other households may contain a single parent with children or consist of a group of friends living together. From the list I will give you I would like you to select the type of household which best describes the household you live in:*

**INTERVIEWER: PLEASE PROVIDE SHOWCARD 1 AND OFFER EXAMPLES IF NEEDED. IF RESPONDENT IS NOT SURE ASK THEM TO TAKE THE HEAD OF HOUSEHOLD AS THE REFERENCE POINT AND TELL THEM TO RELATE ALL MEMBERS TO HIM/HER. ONLY 1 ANSWER SHOULD BE SELECTED**

- A single parent with **all** children aged less than 25 years and no other household members
  
- A single parent with at least one child aged less than 25 years and other household members aged 25+ years
  
- A couple with **all** children aged less than 25 years old and no other household members
  
- A couple with at least one child aged less than 25 years and other household members aged 25+ years
  
- A couple with **all** children 25+ years and no other household members
  
- A couple and no other household members
  
- Any other type of household



**INTERVIEWER: THE NEXT QUESTIONS CONCERN ONLY THE **SELECTED INDIVIDUAL****

**CS.8 What is your legal marital status?**

CODE ONLY ONE CATEGORY

Single, that is, never married or in a registered partnership

Married or in a registered partnership

Widowed or in registered partnership that ended with death of partner (not remarried or in a new registered partnership)

Divorced and not remarried (including legally separated and dissolved registered partnership)

**INTERVIEWER: IF RESPONDENT LIVES ON HIS/HER OWN (CS5=1) OR LIVES IN AN INSTITUTION GO TO QUESTION CS.10**

**CS.9 May I just check, are you living with someone in this household as a couple?**

Yes, living with husband/wife/partner

No

**CS.10 What is the highest level of education you have achieved?**

**INTERVIEWER: HAND RESPONDENT SHOWCARD 2**

No formal education

Schools for persons with special needs

Primary

Secondary (general)

Secondary with vocational training e.g. trade school

Foundation and introductory courses at MCAST lasting 1 year or less

Post secondary (general e.g. Junior College)

Post secondary vocational completed before 2000 (excluding ITS)

Post secondary vocational courses of 2 years or less offered by MCAST, ITS or any similar private institution

Post secondary vocational course of more than 2 years offered by MCAST, ITS or any similar private institution/MCAST National Diploma

University level diploma/certificate or MCAST Higher National Diploma

Bachelor degree or equivalent (University of Malta, MCAST or other tertiary level institutions)

Postgraduate diploma/certificate

Masters degree

PhD

Other, please specify \_\_\_\_\_



**Now I'm going to ask you some questions about your current labour situation.**

**CS.11 How would you define your current labour status?**

- Working for pay or profit  
(including unpaid work for a family business or holding,  
including an apprenticeship or paid traineeship,  
including currently not at work due to  
maternity, parental, sick leave or holidays)
- Unemployed  → GO TO HS.1
- Pupil, student, further training, unpaid work experience  → GO TO HS.1
- In retirement or early retirement or has given up  
business  → GO TO HS.1
- Permanently disabled  → GO TO HS.1
- Giving a community service as ordered by court  → GO TO HS.1
- Fulfilling domestic tasks  → GO TO HS.1
- Other. Please specify: \_\_\_\_\_  → GO TO HS.1

**CS.12 In your (main) job do you work full-time or part-time?**

- Full-time
- Part-time

**CS.13 What is your employment status?**

CODE ONLY ONE CATEGORY

- Self-employed
- Employee with permanent job / work contract of unlimited duration
- Employee with temporary job/work contract of limited duration

**CS.14 What is your occupation in this job?**

Job title: \_\_\_\_\_

Describe what you mainly do in your job:

\_\_\_\_\_  
\_\_\_\_\_

|\_|\_|\_|  
(ISCO-08 COM, 2 digit)

- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9



**CS.15 What does the business / organisation mainly produce or do at the place where you work (e.g. chemical, fishing, hotel / restaurant, health and social work, etc.)?**

DESCRIBE FULLY – PROBE MANUFACTURING OR PROCESSING OR DISTRIBUTING ETC. AND MAIN GOODS PRODUCED, MATERIALS USED WHOLESALE OR RETAIL ETC.

---

---

\_\_\_\_|\_\_\_\_|  
(NACE Rev.2, 2 digit)

0  1  2  3  4  5  6  7  8  9

0  1  2  3  4  5  6  7  8  9

## **PART C: EUROPEAN HEALTH STATUS MODULE**

**INTERVIEWER: IF QUESTIONNAIRE IS BEING ANSWERED BY A PROXY SKIP HS.1 AND GO TO HS.2.**

*I would now like to talk to you about your health.*

**HS.1 How is your health in general?**

Very good

Good

Fair

Bad

Very bad

**HS.2 Do you have any longstanding illness or longstanding health problem?  
[By longstanding I mean illnesses or health problems which have lasted,  
or are expected to last 6 months or more].**

Yes

No



**HS.3 For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do?**

**Do you think you were ...**

- Severely limited
- Limited but not severely
- Not limited at all

***Here is a list of diseases or conditions.***

INTERVIEWER: **HAND SHOWCARD 3 AND ASK CD.1 – FIRST COLUMN IN THE TABLE BELOW.**  
 RESPONDENT TO READ OUT ONLY THE CATEGORIES THAT APPLY TO HIM/ HER, CODE ALL CATEGORIES LISTED AS “YES” AND FOR EACH DISEASE / HEALTH PROBLEM REPORTED ASK CD.2 AND CD.3.  
 IF NO DISEASE / HEALTH PROBLEM IS REPORTED IN CD.1 GO TO QUESTION DH.1.

	CD.1 Do you have or have you ever had any of the following diseases or conditions?		CD.2 Was this disease/condition diagnosed by a medical doctor?		CD.3 Have you had this disease/condition in the past 12 months?	
	Yes	No	Yes	No	Yes	No
Asthma (allergic asthma included)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic bronchitis, chronic obstructive pulmonary disease, emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Myocardial infarction (heart attack)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary heart disease (angina pectoris)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure (hypertension)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elevated blood cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke (cerebral haemorrhage, cerebral thrombosis)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoarthritis (arthrosis, joint degeneration)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



	CD.1 Do you have or have you ever had any of the following diseases or conditions?		CD.2 Was this disease/condition diagnosed by a medical doctor?		CD.3 Have you had this disease/condition in the past 12 months?	
	Yes	No	Yes	No	Yes	No
Low back disorder or other chronic back defect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neck disorder or other chronic neck defect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergy, such as rhinitis, eye inflammation, dermatitis, food allergy or other (allergic asthma excluded)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach ulcer (gastric or duodenal ulcer)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cirrhosis of the liver	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer (malignant tumour, also including leukaemia and lymphoma)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urinary incontinence, problems in controlling the bladder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Permanent injury or defect caused by an accident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anorexia / Bulimia Nervosa	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





**DH.5 How often do you brush your teeth?**

- Never
- Less than once a day
- Once a day
- Twice a day
- More than two times a day

**DH.6 Over the past 12 months did you use any of the following products to look after your teeth/mouth?**

	Yes	No
<b>Toothbrush (non-electric)</b>	<input type="radio"/>	<input type="radio"/>
<b>Toothbrush (battery operated/electric)</b>	<input type="radio"/>	<input type="radio"/>
<b>Toothpaste</b>	<input type="radio"/>	<input type="radio"/>
<b>Dental floss</b>	<input type="radio"/>	<input type="radio"/>
<b>Interdental brushes</b>	<input type="radio"/>	<input type="radio"/>
<b>Mouth wash</b>	<input type="radio"/>	<input type="radio"/>

**ACCIDENTS AND INJURIES**

**AC.1 In the past 12 months, have you had a road traffic accident that resulted in injury (external or internal)?**

- Yes
- No  → GO TO AC.3

**AC.2 Did you visit a doctor, a nurse or an emergency department of a hospital as a result of this accident?**

*CODE ONLY ONE CATEGORY*

- Visit to a doctor or nurse
- Admission to the emergency department
- No intervention was needed



**AC.3 In the past 12 months, have you had an accident at home that resulted in injury (external or internal)?**

- Yes
- No  →GO TO AC.5

**AC.4 Did you visit a doctor, a nurse or an emergency department of a hospital as a result of this accident?**

*CODE ONLY ONE CATEGORY*

- Visit to a doctor or nurse
- Admission to the emergency department
- No intervention was needed

**AC.5 In the past 12 months, have you had an accident while conducting a leisure activity that resulted in injury (external or internal)?**

- Yes
- No  → GO TO AW.1

**AC.6 Did you visit a doctor, a nurse or an emergency department of a hospital as a result of this accident?**

*CODE ONLY ONE CATEGORY*

- Admission to an emergency department
- Visit to a doctor or nurse
- No intervention was needed

### **ABSENCE FROM WORK**

**INTERVIEWER: THE NEXT QUESTION (AW.1) IS TO BE ASKED ONLY TO RESPONDENTS CURRENTLY WORKING (CODE 1 IN CS.10). FOR ALL OTHER RESPONDENTS GO TO PL.1 PAGE 15**

**AW.1 In the past 12 months, have you been absent from work due to health problems? Take into account all kinds of diseases, injuries and other health problems that you had which resulted in your absence from work.**

- Yes
- No  →GO TO PL. 1



**AW.2 In the past 12 months, how many days in total were you absent from work due to health problems?**

INTERVIEWER: MENTION ONLY IF REQUIRED "GIVE AN APPROXIMATE NUMBER"

|\_|\_|\_| days

- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9

**PHYSICAL AND SENSORY FUNCTIONAL LIMITATIONS**

**Introduction**

*Now I would like you to think about the situations you may face in everyday life. Please ignore temporary problems.*

INTERVIEWER: IF THE RESPONDENT IS **BLIND** MARK QUESTION PL.1 WITH CODE 3 AND THEN GO TO PL.3.

**PL.1 Do you wear glasses or contact lenses?**

- Yes
- No
- I'm blind or cannot see at all  →GO TO PL.3

**PL.2 Do you have difficulty seeing even when wearing your glasses or contact lenses?**

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

**PL.3 Do you use a hearing aid?**

- Yes
- No
- I am profoundly deaf  →GO TO PL.6



**PL.4 Do you have difficulty hearing what is said in a conversation with one other person when in a quiet room (even when using hearing aid)?**

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all  → GP TO PL.6

**PL.5 Do you have difficulty hearing what is said in a conversation with one other person when in a noisier room (even when using hearing aid)?**

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

**PL.6 Do you have difficulty walking 500 metres on flat terrain without a stick or other walking aid or assistance?**

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

**PL.7 Do you have difficulty walking up or down 12 steps without a stick, other walking aid or assistance?**

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

**INTERVIEWER: THE NEXT QUESTIONS PC.1 – HA.21 ARE TO BE ASKED ONLY TO RESPONDENTS WHO ARE 65 YEARS AND OLDER. FOR RESPONDENTS YOUNGER THAN 65 GO TO QUESTION PN.1 PAGE 22**



## PERSONAL CARE ACTIVITIES

*Now I would like you to think about everyday personal care activities. Please ignore temporary problems.*

### **PC.1 Do you usually have difficulty feeding yourself without help?**

- No difficulty  → GO TO PC.4  
Yes, some difficulty   
Yes, a lot of difficulty   
I can't achieve it by myself

### **PC.2 Do you usually receive help with feeding yourself?**

- Yes   
No  → GO TO PC.4

### **PC.3 Do you feel you need more help?**

- Yes   
No

### **PC.4 Do you usually have difficulty getting in and out of a bed or chair without help?**

- No difficulty  → GO TO PC.7  
Yes, some difficulty   
Yes, a lot of difficulty   
I can't achieve it by myself

### **PC.5 Do you usually receive help with getting in and out of a bed or chair?**

- Yes   
No  → GO TO PC.7

### **PC.6 Do you feel you need more help?**

- Yes   
No



**PC.7 Do you usually have difficulty dressing and undressing without help?**

- No difficulty  → GO TO PC.10
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself

**PC.8 Do you usually receive help with dressing and undressing ?**

- Yes
- No  → GO TO PC.10

**PC.9 Do you feel you need more help?**

- Yes
- No

**PC.10 Do you usually have difficulty using toilets without help?**

- No difficulty  → GO TO PC.13
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself

**PC.11 Do you usually receive help when using toilets ?**

- Yes
- No  → GO TO PC.13

**PC.12 Do you feel you need more help?**

- Yes
- No

**PC.13 Do you usually have difficulty in bathing or showering without help?**

- No difficulty  → GO TO HA.1
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself



**PC.14 Do you usually receive help with bathing or showering ?**

- Yes
- No  → GO TO HA.1

**PC.15 Do you feel you need more help?**

- Yes
- No

## HOUSEHOLD ACTIVITIES

*Now I would like to ask you some questions about household activities. Please ignore any temporary problems.*

**HA.1 Do you usually have difficulty preparing meals without help?**

- No difficulty  → GO TO HA.4
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself
- Not applicable (never tried it or do not need to do it)

**HA.2 Do you usually receive help with preparing meals?**

- Yes
- No  → GO TO HA.4

**HA.3 Do you feel you need more help?**

- Yes
- No

**HA.4 Do you usually have difficulty using the telephone without help?**

- No difficulty  → GO TO HA.7
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself
- Not applicable (never tried it or do not need to do it)



**HA.5 Do you usually receive help using the telephone?**

- Yes
- No  → GO TO HA.7

**HA.6 Do you feel you need more help?**

- Yes
- No

**HA.7 Do you usually have difficulty shopping without help?**

- No difficulty  → GO TO HA.10
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself
- Not applicable (never tried it or do not need to do it)

**HA.8 Do you usually receive help shopping?**

- Yes
- No  → GO TO HA.10

**HA.9 Do you feel you need more help?**

- Yes
- No

**HA.10 Do you usually have difficulty managing your medication without help?**

- No difficulty  → GO TO HA.13
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself
- Not applicable (never tried it or do not need to do it)

**HA.11 Do you usually receive help with managing your medication?**

- Yes
- No  → GO TO HA.13



**HA.12 Do you feel you need more help?**

- Yes
- No

**HA.13 Do you usually have difficulty with doing light housework without help?**

- No difficulty  → GO TO HA.16
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself
- Not applicable (never tried it or do not need to do it)

**HA.14 Do you usually receive help with light housework?**

- Yes
- No  → GO TO HA.16

**HA.15 Do you feel you need more help?**

- Yes
- No

**HA.16 Do you usually have difficulty doing occasional heavy housework without help?**

- No difficulty  → GO TO HA.19
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself
- Not applicable (never tried it or do not need to do it)

**HA.17 Do you usually receive help with occasional heavy housework?**

- Yes
- No  → GO TO HA.19

**HA.18 Do you feel you need more help?**

- Yes
- No



**HA.19 Do you usually have difficulty taking care of finances and every day administrative tasks without help?**

- No difficulty  → GO TO PN.1
- Yes, some difficulty
- Yes, a lot of difficulty
- I can't achieve it by myself
- Not applicable (never tried it or do not need to do it)

**HA.20 Do you usually receive help with taking care of finances and every day administrative tasks?**

- Yes
- No  → GO TO PN.1

**HA.21 Do you feel you need more help?**

- Yes
- No

**PAIN**

**INTERVIEWER: IF QUESTIONNAIRE IS BEING ANSWERED BY A PROXY GO TO PART D: EUROPEAN HEALTH CARE MODULE, PAGE 23**

**PN.1 Overall how much physical pain have you had during the past 4 weeks?**

- None
- Very mild
- Mild
- Moderate
- Severe
- Very severe

**PN.2 During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?**

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely



## MENTAL HEALTH

### Introduction

*The next questions are about how you feel and how you have been during the past 2 weeks. For each question, please give the answer that comes closest to the way you have been feeling*

**MH.1** During the past 2 weeks did you...

	Not at all	Several days	More than half the days	Nearly every day
Have little interest or pleasure in doing things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt down, depressed or hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have trouble falling or staying asleep, or sleeping too much?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel tired or have little energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have a poor appetite or overate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel bad about yourself or feel like a failure?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have trouble concentrating on things, such as reading the newspaper or watching television?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Move or speak so slowly or be so restless that other people could notice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## PART D: EUROPEAN HEALTH CARE MODULE

*The next set of questions is about time spent in hospital. All types of hospitals are included. Visits to emergency departments or as outpatient only, should not be included.*

INTERVIEWER: FOR WOMEN UP TO AGE 50 YEARS, ADD:

“THE TIME SPENT IN HOSPITAL FOR GIVING BIRTH SHOULD NOT BE INCLUDED.”

**HC.1** During the past 12 months, that is since (date one year ago), have you been in hospital as an inpatient, that is overnight or longer?

Yes

No  →GO TO HC.4



**HC.2 How many separate stays in hospital as an inpatient have you had since (date one year ago)? Count all the stays that ended in this period.**

\_\_\_\_|\_\_\_\_| stays

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

**HC.3 Thinking of all the occasions you have been in hospital at an inpatient in the past 12 months, how many nights in total did you spend in hospital?**

\_\_\_\_|\_\_\_\_|\_\_\_\_| nights

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

**HC.4 During the past 12 months, that is since (date one year ago), have you been admitted to hospital for diagnostic treatment or other types of health care, but not required to remain overnight?**

Yes

No  →GO TO HC.6

**HC.5 How many times have you been admitted as a day patient since (date one year ago)?**

\_\_\_\_|\_\_\_\_|\_\_\_\_| times

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

*The next set of questions is about visits to orthodontists and dentists.*

**HC.6 When was the last time you visited an orthodontist on your own behalf (that is, not while only accompanying a child, spouse, etc.)?**

Less than 6 months ago

6 months to less than 12 months

12 months or longer

Never



**HC.7 When was the last time you visited a dentist on your own behalf (that is, not while only accompanying a child, spouse, etc.)?**

- Less than 6 months ago
- 6 months to less than 12 months
- 12 months or longer  →GO TO HC.9
- Never  →GO TO HC.9

**HC.8 What was the reason for your last visit to the dentist? Please choose only one answer category**

- Pain/trouble with teeth, gums or mouth
- Treatment/follow-up treatment
- Routine check-up of teeth
- I don't know/don't remember

*The next set of questions is about consultations with your general practitioner or family doctor (private or public). Please include visits to your doctor's practice as well as home visits and consultations by telephone.*

**HC.9 When was the last time you consulted a private GP (general practitioner) / private family doctor on your own behalf?**

- Less than 12 months ago
- 12 months ago or longer  →GO TO HC.11
- Never  →GO TO HC.11

**HC.10 During the past four weeks ending yesterday, that is since (date), how many times did you consult a private GP (general practitioner) / private family doctor on your own behalf?**

|\_|\_| times [NONE AT ALL = 0]

- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9

**HC.11 When was the last time you consulted a government GP (general practitioner) or health centre doctor on your own behalf?**

- Less than 12 months ago
- 12 months ago or longer  →GO TO HC. 13
- Never  →GO TO HC. 13



**HC.12 During the past four weeks ending yesterday, that is since (date), how many times did you consult a government GP (general practitioner) or health centre doctor on your own behalf?**

|\_|\_| times [NONE AT ALL = 0]

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*The next questions are about consultations with medical or surgical specialists (public or private). Include visits to doctors as outpatient or emergency departments only, but do not include contact while in hospital as an in-patient or day-patient. Also include visits to doctors at the workplace or school.*

**HC.13 When was the last time you consulted a private medical or surgical specialist on your own behalf?**

- Less than 12 months ago
- 12 months ago or longer  →GO TO HC.15
- Never  →GO TO HC.15

**HC.14 During the past four weeks ending yesterday, that is since (date), how many times did you consult a private specialist on your own behalf?**

|\_|\_| times [NONE AT ALL = 0]

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**HC.15 When was the last time you consulted a government medical or surgical specialist on your own behalf?**

- Less than 12 months ago
- 12 months ago or longer  →GO TO HC.17
- Never  →GO TO HC.17

**HC.16 During the past four weeks ending yesterday, that is since (date), how many times did you consult a government specialist on your own behalf?**

|\_|\_| times [NONE AT ALL = 0]

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



**HC.17 During the past 12 months, that is since (date one year ago), have you visited on your own behalf a...?**

	Yes	No
Physiotherapist / Kinesitherapist	<input type="radio"/>	<input type="radio"/>
Dietician/Nutritionist	<input type="radio"/>	<input type="radio"/>
Speech therapist	<input type="radio"/>	<input type="radio"/>
Occupational therapist	<input type="radio"/>	<input type="radio"/>
Psychologist or psychotherapist	<input type="radio"/>	<input type="radio"/>
Podiatrist/podologist	<input type="radio"/>	<input type="radio"/>
Acupuncturist	<input type="radio"/>	<input type="radio"/>
Any other alternative medicine practitioner	<input type="radio"/>	<input type="radio"/>

**HC.18 During the past 12 months, that is since (date one year ago), have you yourself used or received any home care services?**

Yes

No

**HC.19 During the past 12 months, have you yourself used any of the following home care services provided by the private and/or public sector?**

	Private		Public	
	Yes	No	Yes	No
Home care service provided by a nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Home help by a carer (non-nursing services)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
"Meals on wheels"	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Handyman service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Telecare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



*I'd now like to ask about your use of medicines or dietary supplements in the past 2 weeks.*

**MD.1** During the past two weeks, have you used any medicines that were prescribed to you by a doctor?

- Yes
- No  →GO TO MD.2

**Were they medicines for...?**

INTERVIEWER: **HAND SHOWCARD 4** AND CODE FOR EACH ITEM A TO P.

	Yes	No
A. Asthma	<input type="radio"/>	<input type="radio"/>
B. Chronic bronchitis, chronic obstructive pulmonary disease, emphysema	<input type="radio"/>	<input type="radio"/>
C. High blood pressure	<input type="radio"/>	<input type="radio"/>
D. Lowering the blood cholesterol level	<input type="radio"/>	<input type="radio"/>
E. Pain relief	<input type="radio"/>	<input type="radio"/>
F. Heart disease	<input type="radio"/>	<input type="radio"/>
G. Diabetes	<input type="radio"/>	<input type="radio"/>
H. Allergic symptoms (eczema, rhinitis, hay fever)	<input type="radio"/>	<input type="radio"/>
I. Heart burn	<input type="radio"/>	<input type="radio"/>
J. Cancer treatment	<input type="radio"/>	<input type="radio"/>
K. Depression	<input type="radio"/>	<input type="radio"/>
L. Tension or anxiety	<input type="radio"/>	<input type="radio"/>
M. Osteoporosis	<input type="radio"/>	<input type="radio"/>
N. Sleeping tablets	<input type="radio"/>	<input type="radio"/>
O. Antibiotics (such as penicillin)	<input type="radio"/>	<input type="radio"/>
P. Hypothyroidism	<input type="radio"/>	<input type="radio"/>



**MD.2 During the past two weeks, have you used any medicines or dietary supplement or herbal medicines or vitamins not prescribed or recommended by a doctor?**

- Yes
- No  → GO TO PA. 1

**Were they medicines or supplements for ...?**

INTERVIEWER: **HAND SHOWCARD 5** AND CODE FOR EACH ITEM A TO G.

	Yes	No
A. Pain relief	<input type="radio"/>	<input type="radio"/>
B. Cold, flu or sore throat	<input type="radio"/>	<input type="radio"/>
C. Allergic symptoms (eczema, rhinitis, hay fever)	<input type="radio"/>	<input type="radio"/>
D. Heart burn	<input type="radio"/>	<input type="radio"/>
E. Bone/joint care supplements	<input type="radio"/>	<input type="radio"/>
F. Omega-3/fish oils	<input type="radio"/>	<input type="radio"/>
G. Any other vitamins, minerals or tonics	<input type="radio"/>	<input type="radio"/>

***Now I would like to ask about flu vaccination.***

**PA.1 When was the last time you were vaccinated against *influenza*?**

|\_|\_| Month 0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

|\_|\_|\_| Year

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

Too long ago (not in the past 12 months)

Never

***Now I would like to ask you some questions about your blood pressure, blood cholesterol and blood sugar.***



**PA.2 When was the last time that your blood pressure was measured by a health professional?**

- Within the past 12 months
- 1 to less than 3 years ago
- 3 to less than 5 years ago
- More than 5 years ago
- Never

**PA.3 When was the last time that your blood cholesterol was measured by a health professional?**

- Within the past 12 months
- 1 to less than 3 years ago
- 3 to less than 5 years ago
- More than 5 years ago
- Never

**PA.4 When was the last time that your blood glucose was measured by a health professional?**

- Within the past 12 months
- 1 to less than 3 years ago
- 3 to less than 5 years ago
- More than 5 years ago
- Never

***The next questions are about faecal occult blood test and colonoscopy examination.***

**PA.5 When was the last time you had a stool sample tested for blood (faecal occult blood test)?**

- Within the past 12 months
- 1 to less than 2 years ago  → GO TO PA.7
- 2 to less than 3 years ago  → GO TO PA.7
- 3 years or more  → GO TO PA.7
- Never  → GO TO PA.7

**PA.6 Was your most recent stool sample test (FOB) conducted in the public health sector?**

- Yes
- No



**PA.7 When was the last time you had a colonoscopy**

- Within the past 12 months
- 1 to less than 5 years ago
- 5 to less than 10 years ago
- 10 years or more
- Never

THE NEXT QUESTIONS ARE FOR **WOMEN ONLY**. FOR **MEN** GO TO **SA.1** PAGE 32

**PA.8 When was the last time you had a mammography (breast X-ray)?**

- Within the past 12 months
- More than 1 year, but not more than 2 years ago
- More than 2 years, but not more than 3 years ago
- More than 3 years ago  → GO TO PA.11
- Never  → GO TO PA.11

**PA.9 During your last mammography, was an ultrasound of the breast also conducted?**

- Yes
- No

**PA.10 Was your most recent mammography conducted in the public health sector?**

- Yes
- No

**PA.11 When was the last time you had a cervical smear test?**

- Within the past 12 months
- More than 1 year, but not more than 2 years ago
- More than 2 years, but not more than 3 years ago
- More than 3 years ago  → GO TO SA.1
- Never  → GO TO SA.1

**PA.12 Was your most recent cervical smear test conducted in the public health sector?**

- Yes
- No



**INTERVIEWER: GO TO UN.1A PAGE 33 IF QUESTIONNAIRE IS BEING COMPLETED BY A PROXY**

*Now I would like to ask you some questions about your satisfaction with the health care system in Malta, both private and public. Your answers should reflect your personal experience with using the service. If you have never personally used any of the services listed, please select “never used this service”.*

**SA.1 In general, how satisfied would you say you are by the services provided by the following health care providers, both private and public?**

**INTERVIEWER: HAND SHOWCARD 6.**

	<b>Very satisfied</b>	<b>Fairly satisfied</b>	<b>Neither satisfied nor dissatisfied</b>	<b>Fairly dissatisfied</b>	<b>Very dissatisfied</b>	<b>Never used this service</b>
<b>Private Hospitals (including emergency departments)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Government Hospitals (including emergency departments)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Private Dentists, orthodontists and other dental care specialists</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Government Dentists, orthodontists and other dental care specialists</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Private Medical or surgical specialists</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Government Medical or surgical specialists</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Private Family doctors or GPs</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Government Family doctors or GPs</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Home care services</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



**UN1.A Have you experienced delay in getting health care in the past 12 months because the date of the appointment you were given was too far off?**

- Yes
- No
- No need for health care

**UN1.B Have you experienced delay in getting health care in the past 12 months due to distance or transport problems?**

- Yes
- No
- No need for health care

**INTERVIEWER: IF QUESTIONNAIRE IS BEING ANSWERED BY A PROXY SKIP UN.1C AND GO TO UN.2**

**UN1.C Was there any time in the past 12 months where you delayed getting health care because of family/work related commitments?**

- Yes
- No
- No need for health care

**UN.2 Was there any time in the past 12 months when you needed the following kinds of health care, but could not afford it?**

	Yes	No	No need for this type of care in past 12 months
<b>Medical examination or treatment</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Dental examination or treatment</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Prescribed medicines</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Mental health care (e.g. psychologist or psychiatrist)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## HEALTH INSURANCE

**SA.2 Are you covered by a private health insurance?**

- Yes
- No  →GO TO BMI.1

**SA.3 If yes, who pays for it?**

- Self
- Employer
- Both
- Don't know

**SA.4 What does it cover?**

(Please answer ALL the questions)

- |                                     | Yes                   | No                    |
|-------------------------------------|-----------------------|-----------------------|
| a) Consultations / out-patient only | <input type="radio"/> | <input type="radio"/> |
| b) Hospital treatment, local        | <input type="radio"/> | <input type="radio"/> |
| c) Hospital treatment, abroad       | <input type="radio"/> | <input type="radio"/> |

**INTERVIEWER: IF QUESTIONNAIRE IS BEING ANSWERED BY A PROXY GO TO FV.1 PAGE 38**

## PART E: EUROPEAN HEALTH DETERMINANTS MODULE

*Now I'm going to ask you about your height and weight.*

**INTERVIEWER: PLEASE FILL IN DON'T KNOW IF RESPONDENT DOES NOT KNOW THEIR WEIGHT AND/OR HEIGHT.**

**BMI.1 How tall are you without shoes?**

\_|\_|\_|\_| cm

- |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Don't know



**BMI.2 How much do you weigh without clothes and shoes?**

|\_|\_|\_| kg

- 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9
- 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9
- 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9

Don't know ○

**PHYSICAL ACTIVITY**

**Introduction**

*Firstly, think about the TIME you spend DOING work. Think of work as the things that you have to do such as paid and unpaid work, work around your home, taking care of family, studying or training.*

**PE.1 When you are WORKING, which of the following best describes what you do? Would you say ...**

- Mostly sitting or standing ○
- Mostly walking or tasks of moderate physical effort ○
- Mostly heavy labour or physically demanding work ○
- Not performing any working tasks ○

**Introduction**

*The next questions EXCLUDE the WORK-RELATED PHYSICAL ACTIVITIES that you have already mentioned. Now I would like to ask you about the way you usually GET TO AND FROM PLACES, for example to work, to school or for shopping.*

**PE.2 In a typical week, on how many days do you WALK for at least 10 minutes continuously in order to get to and from places?**

|\_|\_| Days per week

- 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

**INTERVIEWER NOTE: IF RESPONDENT ANSWERS ZERO OR DOES NOT KNOW FOR PE.2 SKIP TO QUESTION PE.4. OTHERWISE ASK PE.3.**



**PE.3 How much time do you spend walking in order to get to and from places on a typical day?**

- 10 – 29 minutes per day
- 30 – 59 minutes per day
- 1 hour to less than 2 hours per day
- 2 hours to less than 3 hours per day
- 3 hours or more per day

**PE.4 In a typical week, on how many days do you BICYCLE for at least 10 minutes continuously in order to get to and from places?**

|\_\_\_| Days per week

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7

**INTERVIEWER NOTE: IF RESPONDENT ANSWERS ZERO OR DOES NOT KNOW FOR QUESTION PE.4 , SKIP TO QUESTION PE.6. OTHERWISE ASK PE.5.**

**PE.5 How much time do you spend bicycling in order to get to and from places on a typical day?**

- 10 – 29 minutes per day
- 30 – 59 minutes per day
- 1 hour to less than 2 hours per day
- 2 hours to less than 3 hours per day
- 3 hours or more per day

**Introduction**

***The next questions EXCLUDE the WORK and TRANSPORT ACTIVITIES that you have already mentioned. Now I would like to ask you about SPORTS, FITNESS and RECREATIONAL (LEISURE) PHYSICAL ACTIVITIES.***

***Firstly I will ask you about walking. Exclude any walking done to get to and from places and focus ONLY on walking done for SPORT, FITNESS and RECREATION (LEISURE).***

**PE.6 In a typical week, on how many days do you walk for at least 10 minutes continuously for fitness or recreation (leisure)?**

|\_\_\_| Days per week

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7



**INTERVIEWER NOTE:** IF RESPONDENT ANSWERS ZERO OR DOES NOT KNOW, SKIP TO QUESTION PE.8 OTHERWISE ASK PE.7.

**PE.7** How much time in total do you spend walking for fitness or recreation (leisure) in a typical week (hours or minutes)?

\_\_\_\_|\_\_\_\_| hours **OR** \_\_\_\_|\_\_\_\_|\_\_\_\_| minutes

- 0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9
- 0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9
- 0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9

*Now I will ask you about moderate activities that make you breathe somewhat harder than normal such as cycling at a regular pace or tennis.*

**PE.8** In a typical week, on how many days do you carry out moderate sports, fitness or recreational (leisure) physical activities for at least 10 minutes continuously?

\_\_\_\_| Days per week

- 0 ○1 ○2 ○3 ○4 ○5 ○6 ○7

**INTERVIEWER NOTE:** IF RESPONDENT ANSWERS ZERO, OR DOES NOT KNOW, SKIP TO QUESTION PE.10. OTHERWISE ASK PE.9.

**PE.9** How much time in total do you spend on moderate sports, fitness or recreational (leisure) physical activities in a typical week (hours or minutes)?

\_\_\_\_|\_\_\_\_| hours **OR** \_\_\_\_|\_\_\_\_|\_\_\_\_| minutes

- 0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9
- 0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9
- 0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9

*Now I will ask you about vigorous activities which make you breathe much harder than normal such as fast cycling or aerobics. Remember I refer only to SPORTS, FITNESS AND RECREATIONAL (LEISURE) PHYSICAL ACTIVITIES.*

**PE.10** In a typical week, on how many days do you carry out vigorous sports, fitness or recreational (leisure) physical activities for at least 10 minutes continuously?

\_\_\_\_| Days per week

- 0 ○1 ○2 ○3 ○4 ○5 ○6 ○7



**INTERVIEWER NOTE:** IF RESPONDENT ANSWERS ZERO OR DOES NOT KNOW, SKIP TO QUESTION PE.12. OTHERWISE ASK PE.11.

**PE.11 How much time in total do you spend on vigorous sports, fitness or recreational (leisure) physical activities in a typical week (hours or minutes)?**

|\_|\_| hours **OR** |\_|\_|\_| minutes

- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9

**PE.12 In a typical week on how many days do you carry out physical activities specifically designed to strengthen your muscles such as resistance training, weight lifting, push-ups, sit ups etc? Include all such activities even if you have mentioned them before.**

|\_| Days per week

- 0  1  2  3  4  5  6  7

## **NUTRITION**

### **Introduction**

*The next set of questions are about your consumption of fruit, vegetables and other food*

**FV.1 How often do you eat fruits (excluding packaged juices)?**

- Once or more a day
- 4 to 6 times a week  → GO TO FV.3
- 1 to 3 times a week  → GO TO FV.3
- Less than once a week  → GO TO FV.3
- Never  → GO TO FV.3

**FV.2 How many portions of fruit, of any sort do you eat each day?**

**INTERVIEWER NOTE:** HAND RESPONDENT SHOWCARD 7

|\_|\_| Number of portions

- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9



**FV.3 How often do you eat vegetables or salad (excluding packaged juices and potatoes)?**

- Once or more a day
- 4 to 6 times a week  → GO TO NU.1
- 1 to 3 times a week  → GO TO NU.1
- Less than once a week  → GO TO NU.1
- Never  → GO TO NU.1

**FV.4 How many portions of vegetables or salad, of any sort do you eat each day?**

**INTERVIEWER NOTE: HAND RESPONDENT SHOWCARD 7**

|\_\_|\_\_| Number of portions

- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9

**NU.1 Is salt added to your meals during cooking (excluding cubes)?**

- Almost always
- Occasionally
- Never (or low salt alternative)
- I don't know

**NU.2 Do you add salt to your meals at the table?**

- Almost always
- Occasionally
- Never (or low salt alternative)

**NU.3 How often do you drink sugar free soft drinks?**

- Daily
- 4 to 6 times a week  → GO TO NU.5
- 1 to 3 times a week  → GO TO NU.5
- Less than once a week  → GO TO NU.5
- Never  → GO TO NU.5



**NU.4 How many glasses do you drink each day?**

**INTERVIEWER NOTE: HAND RESPONDENT SHOWCARD 8**

|\_\_|\_\_| Number of glasses

- 0  1  2  3  4  5  6  7  8  9  
 0  1  2  3  4  5  6  7  8  9

**NU.5 How often do you drink regular soft drinks?**

- Daily   
 4 to 6 times a week  → GO TO NU.7  
 1 to 3 times a week  → GO TO NU.7  
 Less than once a week  → GO TO NU.7  
 Never  → GO TO NU.7

**NU.6 How many glasses do you drink each day?**

**INTERVIEWER NOTE: HAND RESPONDENT SHOWCARD 8**

|\_\_|\_\_| Number of glasses

- 0  1  2  3  4  5  6  7  8  9  
 0  1  2  3  4  5  6  7  8  9

**NU.7 On how many days during the last week (7-day period) have you consumed the following foods and drinks?**

	Never	1 – 2 days	3 – 5 days	6 – 7 days
Chicken/rabbit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meat products	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sweet pastries (including biscuits, cakes, fancy cakes, gateaux etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sweets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## ENVIRONMENT WHERE YOU LIVE

**EN.1** Thinking about the past 12 months, when you were at home, to what extent were you exposed to any of the following conditions?

	Severely exposed	Somewhat exposed	Not exposed	Don' t know
Noise (as road traffic, train traffic, airplane traffic, factories, neighbours, animals, restaurant/bars/disco)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Air pollution (fine dust, grime, dust, fume)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bad smells (industrial, agricultural, sewer, waste)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**INTERVIEWER NOTE:** IF QUESTIONNAIRE IS BEING ANSWERED BY A PROXY THIS IS THE END OF QUESTIONNAIRE. PLEASE GO TO SELF-COMPLETED QUESTIONNAIRE.

## SOCIAL SUPPORT AND INFORMAL CARE

**SS.1** How many people in your life are so close to you that you can count on them if you have a serious personal problem?

- None
- 1 or 2
- 3 to 5
- 6 or more

**SS.2** How much concern and positive interest do you feel people show you?

- A lot of concern and interest
- Some concern and interest
- Uncertain
- Little concern and interest
- No concern and interest



**SS.3 How easy is it to get practical help from neighbours if you should need it?**

- Very easy
- Easy
- Possible
- Difficult
- Very difficult

**IC1. Do you provide care or assistance to one or more persons suffering from an age related problem, chronic health condition or infirmity, at least once a week?**

**INTERVIEWER NOTE:** RESPONDENT SHOULD EXCLUDE ANY CARE PROVIDED AS PART OF THEIR PROFESSION

- Yes
- No  → END OF QUESTIONNAIRE

**IC.2 Is this person or are these persons...?**

**INTERVIEWER NOTE:** ONLY ONE ANSWER ALLOWED. IN CASE MULTIPLE PERSONS ARE INVOLVED SAY: "SELECT THE ONE TO WHOM YOU ARE PROVIDING THE MOST CARE"

- Members of your family
- Someone else

**IC.3 For how many hours per week do you provide care or assistance?**

- Less than 10 hours per week
- At least 10 but less than 20 hours per week
- 20 hours per week or more

**END OF QUESTIONNAIRE**



QUESTIONNAIRE NUMBER: |\_|\_|\_|\_|

### SELF-COMPLETION FORM

The questions have to be answered personally. Before giving an answer, read the question and its response categories carefully. Please mark the circle that best describes your answer to each question or write numbers when required in the open boxes |\_|\_|.

**Answer Selection:** Correct = ● Incorrect = ✗ ✓ ⊖

In cases where you make a mistake, kindly follow the example below by placing a small cross on the wrong answer:

**Wrong answer:** ✗

Instructions following the sign "→" near a circle indicate the question to which you should go to after you have filled in the circle. In cases where the circle is not followed by the sign "→", you should go to the next question.

Fill in one circle per question, unless suggested otherwise (i.e. 'Please fill in ALL circles that apply').

Your answers will remain confidential so please be honest.

**PLEASE NOTE THAT ROWS OF NUMBERED BUBBLES:**

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9

**ARE FOR OFFICE USE ONLY. DO NOT FILL THEM IN!**

**The questionnaire was answered by:**

Selected Individual ○

Interviewer ○

Other ○

### SMOKING

**SK.1 Do you smoke?**

Yes, daily ○ → GO TO TABLE 1 PAGE 44

Yes, occasionally ○ → GO TO TABLE 2 PAGE 44

Not at all ○ → GO TO TABLE 3 PAGE 45

**PLEASE COMPLETE THE QUESTIONS IN THE RELEVANT TABLE ACCORDING TO THE SMOKING STATUS YOU SELECTED ABOVE**



**TABLE 1 – DAILY SMOKERS ONLY**

**SK.2 What kind of tobacco product do you mostly consume? Choose the ONE product you smoke most often.**

- Cigarettes (manufactured and/or hand rolled)
- Cigars  → GO TO SK.5 PAGE 45
- Pipe tobacco  → GO TO SK.5 PAGE 45
- Other  → GO TO SK.5 PAGE 45

**SK.3 On average, how many cigarettes do you smoke each day?**

|\_|\_| Cigarettes (manufactured and/or hand rolled)

- 0  1  2  3  4  5  6  7  8  9
- 0  1  2  3  4  5  6  7  8  9

→ GO TO SK.5 PAGE 45

**TABLE 2 – OCCASIONAL SMOKERS ONLY**

**SK.2 What kind of tobacco product do you mostly consume? Choose the ONE product you smoke most often.**

- Cigarettes (manufactured and/or hand rolled)
- Cigars
- Pipe tobacco
- Other

**SK.4 Have you ever smoked (cigarettes, cigars, pipes) daily, or almost daily, for at least one year?**

- Yes  → GO TO SK.5 PAGE 45
- No  → GO TO SK.5 PAGE 45



**TABLE 3 – NON-SMOKERS ONLY**

**SK.4 Have you ever smoked (cigarettes, cigars, pipes) daily, or almost daily, for at least one year?**

Yes  → GO TO SK.5

No  → GO TO SK.5

**SK.5 How often are you exposed to tobacco smoke indoors at home?**

Never or almost never

Less than 1 hour per day

1 hour or more per day

**SK.6 How often are you exposed to tobacco smoke indoors in public places and transport (bars, restaurants, shopping malls, arenas, bingo halls, bowling alleys, trains, metro, bus)?**

Never or almost never

Less than 1 hour per day

1 hour or more per day

**SK.7 How often are you exposed to tobacco smoke indoors at your workplace?**

Never or almost never

Less than 1 hour per day

1 hour or more per day

Not relevant (don't work or don't work indoors)

**SK.8 During the past 7 days, including today, did you smoke e-cigarettes?**

Yes

No  → GO TO SK.10

**SK.9 During the past 7 days, including today, on how many days did you smoke e-cigarettes?**

▬ days  0  1  2  3  4  5  6  7



**SK.10** During the past 7 days, including today, did you smoke a shisha pipe/hookah pipe?

- Yes
- No  → GO TO AL.1

**SK.11** During the past 7 days, including today, on how many days did you smoke a shisha pipe/hookah pipe?

|\_\_| days  0  1  2  3  4  5  6  7

## **ALCOHOL CONSUMPTION**

*The following questions are about your use of alcoholic beverages during the past 12 months.*

**AL.1** During the past 12 months, how often have you had an alcoholic drink of any kind (that is beer, wine, spirits, liqueurs or other alcoholic beverages)?

- Every day or almost every day
- 5 – 6 days a week
- 3 – 4 days a week
- 1 – 2 days a week
- 2 – 3 days a month
- Once a month
- Less than once a month
- Not in the past 12 months (but i have consumed alcohol before)  → GO TO CN.1
- Never consumed alcohol or only a few sips in my whole life  → GO TO CN.1

**AL.2** Thinking of Monday to Thursday, on how many of these 4 days do you usually drink alcohol?

- On all 4 days
- On 3 of the 4 days
- On 2 of the 4 days
- On 1 of the 4 days
- On none of the 4 days  → GO TO AL.4



**AL.3** From Monday to Thursday, how many drinks do you have on average on such a day when you drink alcohol? Use the picture below as a guide.



1 standard drink contains 10g of pure alcohol

- 16 or more drinks a day
- 10 – 15 drinks a day
- 6 – 9 drinks a day
- 4 – 5 drinks a day
- 2 drinks a day
- 3 drinks a day
- 1 drink a day
- Less than 1 drink a day

**AL.4** Thinking of Friday to Sunday, on how many of these 3 days do you usually drink alcohol?

- On all 3 days
- On 2 of the 3 days
- On 1 of the 3 days
- On none of the 3 days  → GO TO AL.6



**AL.5 From Friday to Sunday, how many drinks do you have on average on such a day when you drink alcohol? Use the picture below as a guide.**



1 standard drink contains 10g of pure alcohol

- 16 or more drinks a day
- 10 – 15 drinks a day
- 6 – 9 drinks a day
- 4 – 5 drinks a day
- 3 drinks a day
- 2 drinks a day
- 1 drink a day
- Less than 1 drink a day

**AL.6 In the past 12 months, how often have you had 6 or more drinks containing alcohol on one occasion? Use the picture below as a guide.**



1 standard drink contains 10g of pure alcohol

- Every day or almost every day
- 5 – 6 days a week
- 3 – 4 days a week
- 1 – 2 days a week
- 2 – 3 days a month
- Once a month
- Less than once a month
- Not in the past 12 months
- Never in my whole life



**AL.7 During the past 7 days, on how many days did you drink alcohol in the following contexts?**

Alone	<input type="checkbox"/>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
At a bar, pub or café	<input type="checkbox"/>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
At a sports or entertainment event	<input type="checkbox"/>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
At lunch (at home or a restaurant)	<input type="checkbox"/>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
At dinner (at home or a restaurant)	<input type="checkbox"/>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7
Before driving a car	<input type="checkbox"/>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7

**DRUGS**

**Here are some questions about the use of drugs such as cannabis (marijuana) cocaine, etc.**

**CN.1 Have you ever tried any of the substances listed below?**

Fill in ONE circle for each line.

		Yes within the past month	Yes within the past year (but not within the past month)	Yes previously (but not within the past year)	No I have never tried the substance
a	Tranquilisers/ Sedatives <b>with</b> a doctor's prescription	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b	Tranquilisers/ Sedatives <b>without</b> a doctor's prescription	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c	Cannabis (hashish/ marijuana)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d	Ecstasy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e	Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f	Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**If you answered NEVER to ALL the above-mentioned substances please skip the next question and move on to question DS.1**



**CN.1 How old were you when you took any of the substances for the first time? Fill in ONE circle each**

		Under 10 years	10-14 yrs	15-19 yrs	20-24 yrs	25-29 yrs	30-34 yrs	35 yrs and over	Never
a	Tranquilisers/ Sedatives <b>with</b> a doctor's prescription	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b	Tranquilisers/ Sedatives <b>without</b> a doctor's prescription	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c	Cannabis (hashish/ marijuana)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d	Ecstasy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e	Cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f	Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**SEXUAL HEALTH**

**DS.1 At what age did you first have sexual intercourse (vaginal and/or anal sex)?**

|\_|\_| years

If no sexual activity → GO TO DS.10 PAGE 53

0  1  2  3  4  5  6  7  8  9

0  1  2  3  4  5  6  7  8  9

**DS.2 If you have been sexually active in the past 12 months, how often did you (or your partner) use contraception.**

**Choose only ONE option**

I have not been active in the past 12 months  → GO TO DS.6

Never  → GO TO DS.5

Rarely

Sometimes

Frequently

Always



**DS.3 If you (or your partner) have made use of contraceptives in the past 12 months, which methods did you use?**

**Please fill in ALL the circles that apply.**

	<b>Yes</b>	<b>No</b>
Natural family planning [e.g. temperature & safe period]	<input type="radio"/>	<input type="radio"/>
Withdrawal	<input type="radio"/>	<input type="radio"/>
Contraceptive pill	<input type="radio"/>	<input type="radio"/>
Cap/ diaphragm	<input type="radio"/>	<input type="radio"/>
Coil	<input type="radio"/>	<input type="radio"/>
Intra Uterine System [e.g. Mirena]	<input type="radio"/>	<input type="radio"/>
Condom	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

**DS.4 Of the times you had sexual intercourse in the past 12 months did you use condoms as a way of preventing sexually transmitted infections?**

- Never
- Rarely
- Sometimes
- Frequently
- Always

**DS.5 How many sexual partners have you had in the past 12 months?**

□□□□

- 0 1 2 3 4 5 6 7 8 9  
0 1 2 3 4 5 6 7 8 9

**DS.6 The next question is about sexual dysfunction. Please respond to the question that applies to you.**

<u>WOMEN ONLY</u>	<u>MEN ONLY</u>
<p><b>a) Do you <i>frequently</i> suffer from pain or discomfort during sexual intercourse?</b></p> <p>Yes <input type="radio"/></p> <p>No <input type="radio"/></p>	<p><b>b) Do you <i>frequently</i> have problems getting and maintaining an erection?</b></p> <p>Yes <input type="radio"/></p> <p>No <input type="radio"/></p>



**DS.7 Have you ever sought help from a professional person about any problems related to your inability to perform sexually?**

- Yes
- No  → GO TO DS.9

**DS.8 If you answered yes to DS.7 above, was the person a...**

- GP/family doctor
- Gynaecologist
- Sex therapist
- Psychologist
- Other, specify: \_\_\_\_\_

**DS.9 Have you ever been told by a nurse/doctor/midwife that you have a sexually transmitted infection (STI)?**

- Yes
- No

**DS.10 Are you aware that there are free services for the testing and treatment of sexually transmitted infections in Malta?**

- Yes
- No

## **OUT-OF-POCKET EXPENSES**

During the interview you indicated that in recent periods you have used health care services on your own behalf (that is, not while only accompanying a child, spouse, etc.). For these health care services you used recently, please indicate how much you had to pay out-of-pocket. Please read the questions attentively and use any element (such as bills, etc.) that can help you in providing the amount.

**By out-of-pocket expenses we mean personal expenses related to health, including medicines that are not reimbursed by an insurance agency.**

For the care services you didn't use during the periods indicated, please fill in the answer "Does not apply".

Your answers will remain confidential.



**OP.1 For the dental care on your own behalf during the past year at the date of the interview, about how much did you pay out-of-pocket?**

\_\_\_\_|\_\_\_\_|\_\_\_\_| Amount €

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Does not apply

**OP.2 For the visits to private GPs/family doctors on your own behalf during the past four weeks at the date of the interview, about how much did you pay out-of-pocket?**

\_\_\_\_|\_\_\_\_|\_\_\_\_| Amount €

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Does not apply

**OP.3 For the visits to private medical or surgical specialists on your own behalf during the past four weeks at the date of the interview, about how much did you pay out-of-pocket?**

\_\_\_\_|\_\_\_\_|\_\_\_\_| Amount €

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Does not apply

**OP.4 For the medicines prescribed to you by a doctor, that you used during the past two weeks at the date of the interview, about how much did you pay out-of-pocket?**

\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| Amount €

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Does not apply



