Study ID: ☐

Name:_____

Date: ☐☐/☐☐/☐☐☐☐

Questionnaire Booklet

*Please fill out **all** the questions contained in this booklet. The answers you give are important to us and will be treated with the utmost confidentiality*

Section A - Occupation

A1. What is your current work status ?

In work - full time i.e. more than 30 hours per week	☐
part time work i.e. less than 30 hours per week	☐
keeping house	☐
wholly retired from work	☐
waiting to start a new job already obtained	☐
unemployed and looking for work	☐
out of work as temporarily sick	☐
permanently sick or disabled	☐

other please specify _____

A2. Please could you give us some details about your present/or last job.

What is (was) the name or title of your job ?

_____

What kind of work do (did) you do in your job ?

_____

What training or qualifications are (were) needed for your job ?

_____

Are (were) you working.....

as an employee	☐
as self-employed	☐

Do (did) you supervise or have management responsibility for the work of other people?

No ☐
Yes 1-24 people ☐
Yes 25 or more people ☐

A3. Do you have a partner?

Yes ☐ No ☐

If your answer is No, please go to A4

If **yes,**

A3a. What kind of work does (did) s/he do in his/her job?

_____

A3b. What training or qualifications are (were) needed for his/her job?

_____

A3c. Is (was) s/he working.....

as an employee ☐
as self-employed ☐

A3d. Does (did) s/he supervise or have management responsibility for the work of other people?

No ☐
Yes; 1-24 people ☐
Yes; 25 or more people ☐

A4. At what age did you finish full time education? _____years

A5. Does your household have any cars or vans normally available for its use?

☐ Yes ☐ No

Do you own or rent your home?

Own it/buying it ☐ Yes ☐ No

Rent it ☐ Yes ☐ No

A6a. What is your legal marital status?

Married ☐
Unmarried ☐
Divorced/Separated ☐
Widow/Widower ☐

A6b. Have you ever cohabited with someone without being married?

I am cohabiting with someone now ☐
I have cohabited with someone in the past ☐
I have never cohabited with someone ☐

Section B – Medical History

B1. Have you ever been diagnosed with diabetes?

1. Yes ☐
2. No ☐
3. Yes, gestational diabetes only ☐

B2. Has your biological father ever been diagnosed with diabetes?

1. Yes ☐
2. No ☐

B3. Has your biological mother ever been diagnosed with diabetes?

1. Yes ☐
2. No ☐

B4. How many siblings do you have? Write 0, if you do not have siblings.

_____

B5. Has at least one of your siblings been diagnosed for diabetes?

1. Yes ☐
2. No ☐

B6. Have you ever had any of the following health problems?

	Yes	No
High blood pressure (hypertension)	☐	☐
Cardiac insufficiency (inadequate blood flow to the heart)	☐	☐
Angina pectoris, chest pain during exercise	☐	☐
Coronary artery disease	☐	☐
Myocardial infarction (Heart attack)	☐	☐
Coronary (heart) bypass surgery or angioplasty	☐	☐
Cerebral infarction (stroke), transient ischemic attack (TIA)	☐	☐
Claudication (peripheral arterial disease)	☐	☐
Hypothyroidism (low thyroid function)	☐	☐
High or heightened blood cholesterol level or dyslipidemia	☐	☐

	Yes	No
Depression, other psychological illness	☐	☐
Physically disabled	☐	☐
Other chronic disease,	☐	☐

If other,

specify? _____

B7. Please list all drugs you take regularly, how much and how often you take (if you use any drugs)

Drug Name	dose	how often taken

B8. Please list all vitamin and mineral supplements and health food shops' products you take regularly, how much you take and how often you take (if you use any of them)

Supplements	dose	how often taken

B9. Have you ever smoked?

1. Yes ☐
2. No (skip to question B14) ☐

B10. Do you smoke now?

1. Not at all ☐
2. Yes, occasionally ☐
3. Yes, daily ☐

B11. If you smoked earlier but do not smoke now, when did you quit smoking?

1. 2 days – 1 month ago ☐
2. 1 – 6 months ago ☐
3. 6 – 12 months ago ☐
4. 1 – 5 years ago ☐
5. 5 - 10 years ago ☐
6. More than 10 years ago ☐

B12. If you smoke daily, how much you smoke per day (Use numbers)?

1. Cigarettes _____ per day
2. Pipes _____ per day
3. Cigars _____ per day

B13. Have you planned to quit smoking?

1. No, I will not quit ☐
2. Yes, I am planning to quit ☐
3. Yes, I have tried to reduce / quit ☐

B14. How many hours sleep did you get last night? _____

B15. On average, how many hours do you sleep in 24 hours? _____

Section C – Illness Perception

For the following questions, please circle the number that best corresponds to your views:

1. How much does your risk of diabetes affect your life?

0	1	2	3	4	5	6	7	8	9	10
No affect at all										Severely affects my life

2. How long do you think your risk of diabetes will continue?

0	1	2	3	4	5	6	7	8	9	10
A very short time										Forever

3. How much control do you feel you have over your risk of diabetes?

0	1	2	3	4	5	6	7	8	9	10
Absolutely no control										Extreme amount of control

4. How much do you think treatment can help your risk of diabetes?

0	1	2	3	4	5	6	7	8	9	10
Not at all										Extremely helpful

5. How much do you experience symptoms from your risk of diabetes?

0	1	2	3	4	5	6	7	8	9	10
No symptoms at all										Many severe symptoms

6. How concerned are you about your risk of diabetes?

0	1	2	3	4	5	6	7	8	9	10
Not at all concerned										Extremely concerned

7. How well do you feel you understand your risk of diabetes?

0	1	2	3	4	5	6	7	8	9	10
Don't understand at all										Understand very clearly

8. How much does your risk of diabetes affect you emotionally? (e.g. does it make you angry, scared, upset or depressed?)

0	1	2	3	4	5	6	7	8	9	10
Not at all affected emotionally										Extremely affected emotionally

Please list in rank-order the three most important factors that you believe caused your pre-diabetes.

The most important causes for me:-

1. _____
2. _____
3. _____

SECTION D - Physical Activity

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think *only* about those physical activities that you did for at least 10 minutes at a time.

1. During the **last 7 days**, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling?

   _____ **days per week**

   ☐ No vigorous physical activities → ***Skip to question 3***

2. How much time did you usually spend doing **vigorous** physical activities on one of those days?

   _____ **hours per day**

   _____ **minutes per day**

   ☐ Don't know/Not sure

Think about all the **moderate** activities that you did in the **last 7 days**. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

3. During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

   _____ **days per week**

   ☐ No moderate physical activities → ***Skip to question 5***

4. How much time did you usually spend doing **moderate** physical activities on one of those days?

_____ **hours per day**

_____ **minutes per day**

☐ Don't know/Not sure

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

5. During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time?

_____ **days per week**

☐ No walking → ***Skip to question 7***

6. How much time did you usually spend **walking** on one of those days?

_____ **hours per day**

_____ **minutes per day**

☐ Don't know/Not sure

The last question is about the time you spent **sitting** on weekdays during the **last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. During the **last 7 days**, how much time did you spend **sitting** on a **week day**?

_____ **hours per day**

_____ **minutes per day**

☐ Don't know/Not sure

Section E - QUALITY OF LIFE QUESTIONNAIRE (15D©)

Please read through all the alternative responses to each question before placing a cross (x) against the alternative which best describes **your present health status**. Continue through all 15 questions in this manner, giving only **one** answer to each.

1. MOBILITY

1 ☐ I am able to walk normally (without difficulty) indoors, outdoors and on stairs.

2 ☐ I am able to walk without difficulty indoors, but outdoors and/or on stairs I have slight difficulties.

3 ☐ I am able to walk without help indoors (with or without an appliance), but outdoors and/or on stairs only with considerable difficulty or with help from others.

4 ☐ I am able to walk indoors only with help from others.

5 ☐ I am completely bed-ridden and unable to move about.

2. VISION

1 ☐ I see normally, i.e. I can read newspapers and TV text without difficulty (with or without glasses).

2 ☐ I can read papers and/or TV text with slight difficulty (with or without glasses).

3 ☐ I can read papers and/or TV text with considerable difficulty (with or without glasses).

4 ☐ I cannot read papers or TV text either with glasses or without, but I can see enough to walk about without guidance.

5 ☐ I cannot see enough to walk about without a guide, i.e. I am almost or completely blind.

3. HEARING

1 ☐ I can hear normally, i.e. normal speech (with or without a hearing aid).

2 ☐ I hear normal speech with a little difficulty.

3 ☐ I hear normal speech with considerable difficulty; in conversation I need voices to be louder than normal.

4 ☐ I hear even loud voices poorly; I am almost deaf.

5 ☐ I am completely deaf.

4. BREATHING

1 ☐ I am able to breathe normally, i.e. with no shortness of breath or other breathing difficulty.

2 ☐ I have shortness of breath during heavy work or sports, or when walking briskly on flat ground or slightly uphill.

3 ☐ I have shortness of breath when walking on flat ground at the same speed as others my age.

4 ☐ I get shortness of breath even after light activity, e.g. washing or dressing myself.

5 ☐ I have breathing difficulties almost all the time, even when resting.

5. SLEEPING

1 ☐ I am able to sleep normally, i.e. I have no problems with sleeping.

2 ☐ I have slight problems with sleeping, e.g. difficulty in falling asleep, or sometimes waking at night.

3 ☐ I have moderate problems with sleeping, e.g. disturbed sleep, or feeling I have not slept enough.

4 ☐ I have great problems with sleeping, e.g. having to use sleeping pills often or routinely, or usually waking at night and/or too early in the morning.

5 ☐ I suffer severe sleeplessness, e.g. sleep is almost impossible even with full use of sleeping pills, or staying awake most of the night.

6. EATING

1 ☐ I am able to eat normally, i.e. with no help from others.

2 ☐ I am able to eat by myself with minor difficulty (e.g. slowly, clumsily, shakily, or with special appliances).

3 ☐ I need some help from another person in eating.

4 ☐ I am unable to eat by myself at all, so I must be fed by another person.

5 ☐ I am unable to eat at all, so I am fed either by tube or intravenously.

7. SPEECH

1 ☐ I am able to speak normally, i.e. clearly, audibly and fluently.

2 ☐ I have slight speech difficulties, e.g. occasional fumbling for words, mumbling, or changes of pitch.

3 ☐ I can make myself understood, but my speech is e.g. disjointed, faltering, stuttering or stammering.

4 ☐ Most people have great difficulty understanding my speech.

5 ☐ I can only make myself understood by gestures.

8. ELIMINATION

1 ☐ My bladder and bowel work normally and without problems.

2 ☐ I have slight problems with my bladder and/or bowel function, e.g. difficulties with urination, or loose or hard bowels.

3 ☐ I have marked problems with my bladder and/or bowel function, e.g. occasional 'accidents', or severe constipation or diarrhoea.

4 ☐ I have serious problems with my bladder and/or bowel function, e.g. routine 'accidents', or need of catheterization or enemas.

5 ☐ I have no control over my bladder and/or bowel function.

9. USUAL ACTIVITIES

1 ☐ I am able to perform my usual activities (e.g. employment, studying, housework, free-time activities) without difficulty.

2 ☐ I am able to perform my usual activities slightly less effectively or with minor difficulty.

3 ☐ I am able to perform my usual activities much less effectively, with considerable difficulty, or not completely.

4 ☐ I can only manage a small proportion of my previously usual activities.

5 ☐ I am unable to manage any of my previously usual activities.

10. MENTAL FUNCTION

1 ☐ I am able to think clearly and logically, and my memory functions well

2 ☐ I have slight difficulties in thinking clearly and logically, or my memory sometimes fails me.

3 ☐ I have marked difficulties in thinking clearly and logically, or my memory is somewhat impaired.

4 ☐ I have great difficulties in thinking clearly and logically, or my memory is seriously impaired.

5 ☐ I am permanently confused and disoriented in place and time.

11. DISCOMFORT AND SYMPTOMS

1 ☐ I have no physical discomfort or symptoms, e.g. pain, ache, nausea, itching etc.

2 ☐ I have mild physical discomfort or symptoms, e.g. pain, ache, nausea, itching etc.

3 ☐ I have marked physical discomfort or symptoms, e.g. pain, ache, nausea, itching etc.

4 ☐ I have severe physical discomfort or symptoms, e.g. pain, ache, nausea, itching etc.

5 ☐ I have unbearable physical discomfort or symptoms, e.g. pain, ache, nausea, itching etc.

12. DEPRESSION

1 ☐ I do not feel at all sad, melancholic or depressed.

2 ☐ I feel slightly sad, melancholic or depressed.

3 ☐ I feel moderately sad, melancholic or depressed.

4 ☐ I feel very sad, melancholic or depressed.

5 ☐ I feel extremely sad, melancholic or depressed.

13. DISTRESS

1 ☐ I do not feel at all anxious, stressed or nervous.

2 ☐ I feel slightly anxious, stressed or nervous.

3 ☐ I feel moderately anxious, stressed or nervous.

4 ☐ I feel very anxious, stressed or nervous.

5 ☐ I feel extremely anxious, stressed or nervous.

14. VITALITY

1 ☐ I feel healthy and energetic.
2 ☐ I feel slightly weary, tired or feeble.
3 ☐ I feel moderately weary, tired or feeble.
4 ☐ I feel very weary, tired or feeble, almost exhausted.
5 ☐ I feel extremely weary, tired or feeble, totally exhausted.

15. SEXUAL ACTIVITY

1 ☐ My state of health has no adverse effect on my sexual activity.
2 ☐ My state of health has a slight effect on my sexual activity.
3 ☐ My state of health has a considerable effect on my sexual activity.
4 ☐ My state of health makes sexual activity almost impossible.
5 ☐ My state of health makes sexual activity impossible.

Section F: Eating Habits

Purpose

The purpose of this questionnaire is to get an idea of your usual eating habits. For the listed foods, we would like to know how many servings you eat in a typical day or week. A serving is an average portion that would be served at a meal. If you usually eat more than one serving of the food at a time, you should count all the servings you eat.

Instructions

For each food listed, tick the box that describes the number of servings that you usually eat. If you never eat a particular food, tick the box under "None".

Please do not leave any lines blank.

About how many **pieces or slices per day** do you eat of the following types of bread, rolls, or chapattis? (Please tick one box on each line)

	Breads & Rolls	None	Less than 1 a day	1 to 2 a day	3 to 4 a day	5 or more a day
1.	White bread rolls, chapattis or parathas					
2.	Brown bread or rolls, or brown chapattis, or parathas					
3.	Wholemeal bread , rolls, chapattis, or parathas					

About how many **servings per week** do you eat of the following types of breakfast cereal or porridge? (Please tick one box on each line)

	Breakfast cereals	None	Less than 1 a week	1 to 2 a week	3 to 5 a week	6 or more a week
4.	Sugared type: Frosties, Coco Pops, Ricicles Sugar Puffs Rice or Corn type: Corn Flakes, Rice Krispies, Special K					
5.	Porridge or Ready Brek Wheat type: Shredded Wheat, Weetabix, Fruit 'n Fibre, Puffed Wheat, Nutri-grain, Start Muesli type: Alpen, Jordan's					
6.	Bran type: All-Bran, Bran Flakes, Sultana Bran					

About how many **servings per week** do you eat of the following foods?
(Please tick one box on each line)

	Vegetable foods	None	Less than 1 a week	1 to 2 a week	3 to 5 a week	6 to 7 a week	8 to 11 a week	12 or more a week
7.	Pasta, rice, or dishes made from grains such as millet, semolina and cornmeal INCLUDE: plain boiled rice, rice and peas, pilau and biryani							
8.	Potatoes (excluding chips), yams, cassava, plantains, breadfruit, sweet potatoes or taro/eddo							
9.	Peas, lentils (dhal) or beans (including baked beans)							
10.	Other types of vegetables (cooked or raw as in salads)							
11.	Fruit (including fresh, frozen or canned fruit)							

About how many **servings per week** do you eat of the following foods?
(Please tick one box on each line)

		None	Less than 1 a week	1 to 2 a week	3 to 5 a week	6 or more a week
12.	Cheese (any except cottage)					
13.	Beef, pork, or lamb (for vegetarians: nuts) **INCLUDE**: burgers, sausages, bacon, ham, meat pies, meat curries, casseroles, and processed meat					
14.	Chicken or turkey (including processing types)					
15.	Fish (NOT fried fish)					
16.	ANY fried food **INCLUDE**: fried fish, fried chicken, chips, fried breakfast, samosas, West Indian soup or stew, fried rice, puris and bhajis					

		None	Less than 1 a week	1 to 2 a week	3 to 5 a week	6 or more a week
17.	Cakes, pies, puddings, pastries or Indian sweets					
18.	Sweet or savoury snacks such as chocolate, crisps, biscuits, Bombay mix, sev and chanachur					

About how much of the following types of milk do you yourself use **in a day**, for example in cereal, tea, or coffee? (Please tick one box on each line)

	Milks	None	Less than a quarter pint	About a quarter pint	About half a pint	1 pint or more
19.	Full cream (silver top) or Channel Islands (gold top)					
20.	Semi-skimmed (green or red striped top)					
21.	Skimmed (blue checked top)					

About how many **rounded teaspoons per day** do you usually use of the following types of spreads, for example on bread, sandwiches, toast, potatoes, or vegetables?

	Spreads	None	1 a day	2 a day	3 a day	4 a day	5 a day	6 a day	7 or more
22.	Butter, ghee or margarine such as sunflower or olive spread, Flora, Vitalite, Clover, Olivio, Stork, Utterly Butterly								
23.	**Low fat spreads** (e.g. Shape, Delight, Flora Lite, half fat butter, half fat ghee, etc)								

What type of fat do you usually use for the following purposes?
(Please tick one box on each line)

		Butter, lard, or **dripping**	**Solid cooking fat** (White Flora, Cookeen) **Half-fat butter Hard margarine** (Stork) **or ghee**	**Soft margarine** (sunflower, soya) **Reduced fat spread** (olive, Flora Buttery, Olivio)	**Vegetable oil** or **Low fat spread** (Flora Light, Olivite, St. Ivel Gold) or **peanut oil**	**No fat used**
24.	As a spread on bread, chapattis, vegetables etc					
25.	For frying					
26.	For baking or cooking					

Section G - Anxiety & Depression

Instructions - These questions will help us to know how you are feeling. Read every sentence. Place an X on the answer that best describes how you have been feeling during the **LAST WEEK**. You do not have to think too much to answer. For these questions, spontaneous answers are the most important.

1. I feel tense or wound up:
- ☐ Most of the time
- ☐ A lot of the time
- ☐ From time to time
- ☐ Not at all

2. I still enjoy the things I used to enjoy
- ☐ Definitely as much
- ☐ Not quite as much
- ☐ Only a little
- ☐ Hardly at all

3. I get a sort of frightened feeling as if something awful is about to happen
- ☐ Very definitely and quite badly
- ☐ Yes, but not too badly
- ☐ A little but it doesn't worry me
- ☐ Not at all

4. I can laugh and see the funny side of things
- ☐ As much as I always could
- ☐ Not quite as much now
- ☐ Definitely not so much now
- ☐ Not at all

5. Worrying thoughts go through my mind
- ☐ A great deal of the time
- ☐ A lot of the time
- ☐ From time to time but not often
- ☐ Only occasionaly

6. I feel cheerful
- ☐ Not at all
- ☐ Not often
- ☐ Sometimes
- ☐ Most of the time

7. I can sit at ease and feel relaxed
- ☐ Definitely
- ☐ Usually
- ☐ Not often
- ☐ Not at all

8. I feel as if I am slowed down
- ☐ Nearly all of the time
- ☐ Very often
- ☐ Sometimes
- ☐ Not at all

9. I get a sort of frightened feeling like butterflies in the stomach
- ☐ Not at all
- ☐ Occasionally
- ☐ Quite often
- ☐ Very often

10. I have lost interest in my appearance
- ☐ Definitely
- ☐ I don't take as much care as I should
- ☐ I may not take quite as much care
- ☐ I take just as much care as ever

11. I feel restless, as if I have to be on the move

- ☐ Very much indeed
- ☐ Quite a lot
- ☐ Not very much
- ☐ Not at all

12. I look forward with enjoyment to things

- ☐ As much as I ever did
- ☐ Rather less than I used to
- ☐ Definitely less than I used to
- ☐ Hardly at all

13. I get a sudden feeling of panic

- ☐ Very often indeed
- ☐ Quite often
- ☐ Not very often
- ☐ Not at all

14. I can enjoy a good TV or radio programme or book

- ☐ Often
- ☐ Sometimes
- ☐ Not often
- ☐ Very seldom

Thank you for completing this Questionnaire.
Please go back and check that you have provided an answer for each question.