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Centre-No: WP-No: Patient Number

## EuroPrevall – ID



## Household and Individual Costs of Living, Health and Illness



VERSION FOR ADULTS

Research carried out by the University of East Anglia (U.E.A.) and Wageningen University (WU) for the EUROPREVALL project.



## Instructions for completing the questionnaire

This questionnaire has been developed as part of the Europrevall project, which aims to deliver improved quality of life for people with food allergies. To do this it is necessary to gather information about costs of living from people who have food allergies and from those who do not have food allergies. This is necessary so that we can compare the cost of living of those with food allergies to that of those without food allergies.

These costs include money spent on food and leisure activities, as well as on medications and trips to see health professionals and any stays in hospital. It is also important to measure the costs in terms of the amount of time spent with health professionals and in hospital. It is important that you answer all questions as fully as possible.

Some of the questions are specifically about food allergy. In these questions those without food allergies can either tick the 'not applicable' option or move on to the next relevant question (this will be indicated in block capital letters). This questionnaire may take approximately 20 - 25 minutes of your time to complete.

Some questions ask for information about you only and others ask for information about household expenditure. A household is a person living alone, or a group of people sharing either a living room or sitting room, or at least one meal per day. You will probably be able to answer most of the questions on behalf of your entire household. However, if you are not sure of the answers to some of the questions, please could you ask other members in your household for the information you need to answer the questions as fully as possible. If you can not answer the question precisely, please give your best estimate. It is important to remember that there are no 'right' or 'wrong' answers. If a question does not apply to you or anyone in your household please tick 'Not applicable'. If the question asks how much you pay for something (such as help with household duties) and your answer is nothing please enter a zero in the relevant space.

There is space for up to five household members, including your spouse/partner. If you have any further members in your household please give their details on a separate sheet of paper.

You have been given this questionnaire by your clinician as part of your participation in the EuroPrevall project. This questionnaire should be returned to researchers at the University of East Anglia (UEA). Researchers at the UEA do not have access to your personal details (your name and address). All the information you provide will be encrypted with a code number; only your clinician is able to link this number with your personal details. The information you provide in the questionnaire will only be seen by researchers at the UEA and will be analysed scientifically and anonymously. The findings will be published along with the information provided by all other participants in this survey. All the information you provide will be strictly CONFIDENTIAL and completely anonymous.

If you would like any further information about the Europrevall Project please see [www.Europrevall.org](http://www.Europrevall.org). If you have any problems completing this questionnaire or would like further information about the research you can telephone Margaret Fox at the University of East Anglia on 00 44 (0)1603 591070.

**Please return this questionnaire within the next 10 days in the enclosed pre-paid envelope.**



**I. Your household and health**

**Question 1**

**Please tell us about each member of your household: what their relationship is to you, how old they are, whether they are male or female, and whether they have a food allergy**

	Relationship to you? (son , daughter , mother , father , other)	Age?	Male or female? (Enter M or F)	Do they have a food allergy? (Circle yes or no)		Has the food allergy been diagnosed by a doctor? (Circle yes or no)	
You		_____	_____	Yes	No	Yes	No
Spouse/partner	<input type="checkbox"/> Not applicable	_____	_____	Yes	No	Yes	No
Oldest child	_____	_____	_____	Yes	No	Yes	No
Other Member 1	_____	_____	_____	Yes	No	Yes	No
Other Member 2	_____	_____	_____	Yes	No	Yes	No

**Question 1a**

**In total, how many adults and children live in your household?**

Number of adults \_\_\_\_\_ Number of Children \_\_\_\_\_

**Question 2**

**What type of food are you and any other member of your household (if any) allergic to?**

*Please tick all that apply for you and each member of your household*

	You	Spouse or partner	Oldest child	Member 1	Member 2
Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[1] Chocolate/other sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[2] Celery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[3] Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[4] Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[5] Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[6] Meat or poultry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[7] Milk & dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[8] Mustard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[9] (Pea)nuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[10] Sesame seed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[11] Shellfish/ crustacean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[12] Soya beans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[13] Sulphites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[14] Wheat/gluten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Question 3**

**When you have an allergic reaction to food do you experience any of the symptoms in the four boxes below? *Please answer yes or no or not applicable for each box***

Box 1 (*tick yes if you have one or more of the symptoms in this box*)

Itching, rashes, tiredness, lethargy, weakness, anxiety or depression

- Yes  
 No  
 Not applicable

Box 2 (*tick yes if you have one or more of the symptoms in this box*)

Swollen lips, Swollen glands, Swollen limbs, Nausea, Vomiting, Diarrhoea, Stomach cramps, runny nose, blocked nose, itchy eyes

- Yes  
 No  
 Not applicable

Box 3 (*tick yes if you have one or more of the symptoms in this box*)

Bloating, Wind, Indigestion, Dizziness, Shortness of breath, Wheezing, Rattling in the throat

- Yes  
 No  
 Not applicable

Box 4 (*tick yes if you have one or more of the symptoms in this box*)

Discoloured skin, Fainting, Collapsing, Weak bladder, Bowel incontinence, Low blood pressure

- Yes  
 No  
 Not applicable

*If you have any other symptoms please write them in this box*

**Question 4**

**How old were YOU when you (or your parent/guardian) first realised YOU had a food allergy?**

*Please tick one box only*

- |  |   |   |  |   |  |
|--|---|---|--|---|--|
| <input type="checkbox"/> 0-2             | <input type="checkbox"/> 3-6            | <input type="checkbox"/> 7-9              | <input type="checkbox"/> 10 – 12       | <input type="checkbox"/> 13-15<br>years | <input type="checkbox"/> 16-18<br>years    |
| <input type="checkbox"/> 19 -25<br>years | <input type="checkbox"/> 26-39<br>years | <input type="checkbox"/> 40 – 64<br>years | <input type="checkbox"/> 65 or<br>over | <input type="checkbox"/> Don't<br>Know  | <input type="checkbox"/> Not<br>Applicable |

**Question 5**

**Do you or any other members of the household have any long-term illness, health problem or disability which limits your daily activities?**

*Tick yes or no or not applicable for each member of the household*

- | You                                     | Spouse/partner                          | Oldest child                            | Other Member 1                          | Other Member 2                          |
|---|---|---|---|---|
| <input type="checkbox"/> Yes            | <input type="checkbox"/> Yes            | <input type="checkbox"/> Yes            | <input type="checkbox"/> Yes            | <input type="checkbox"/> Yes            |
| <input type="checkbox"/> No             | <input type="checkbox"/> No             | <input type="checkbox"/> No             | <input type="checkbox"/> No             | <input type="checkbox"/> No             |
| <input type="checkbox"/> Not applicable | <input type="checkbox"/> Not applicable | <input type="checkbox"/> Not applicable | <input type="checkbox"/> Not applicable | <input type="checkbox"/> Not applicable |

**Question 6**

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

**Mobility**

- I have no problem in walking about
- I have some problems in walking around
- I am confined to bed

**Self-care**

- I have no problem with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

**Usual Activities (e.g. work, study, housework)**

- I have no problem with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

**Pain/discomfort**

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

**Anxiety/Depression**

- I am not anxious or depressed
  - I am moderately anxious or depressed
  - I am extremely anxious or depressed
- 

**Question 7**

How would you rate the state of your health? *Circle the option which best describes your health*

Excellent  
(1)

Very good  
(2)

Good  
(3)

Fair  
(4)

Poor  
(5)

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**II. Cost of visits to health professionals for your own health (exclude hospital admissions)**

**Question 8**

**How often (if at all) do you visit any of the following health professionals for YOUR own health (excluding hospital admissions)?** *Please tick one box for each health professional*

	Once a week	Once a month	4 times a year	3 times a year	Twice a year	Once a year	Once every 2 years	Less often	Never
[1] Family doctor (GP) at a health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[2] Nurse at a health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[3] Nurse at outpatient clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[4] Specialist (General hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[5] Specialist (University Hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[6] Dietician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[7] Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[8] Alternative therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Question 9**

**How often (if at all) are you visited in your home by any of the following health professionals for YOUR own health?**

	Once a week	Once a month	Four times a year	Three times a year	Twice a year	Once a year	Once every 2 years	Less often	Never
[1] Family doctor (GP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[2] Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[3] Specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[4] Alternative therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Question 10**

**Does anyone from your household usually accompany you when you go to see health professionals for your own health?** *Tick one option only for each health professional*

	No, I go by myself	My spouse/ partner	My spouse/ partner and other members	Others excluding partner	Not applicable
[1] Family doctor (GP) at a health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[2] Nurse at a health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[3] Nurse at outpatient clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[4] Specialist (General hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[5] Specialist (University Hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[6] Dietician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[7] Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[8] Alternative therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Question 11**

**How much time do you usually spend with health professionals when visiting for your own health (include the time you spend waiting to see and with the health professionals)?**

*Please tick one box for each health professional*

	1-10 minutes	11-15 minutes	16-20 minutes	21-30 minutes	31-60 minutes	Over an hour	Not applicable
[1] Family doctor (GP) at a health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[2] Nurse at a health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[3] Nurse at outpatient clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[4] Specialist (General hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[5] Specialist (University Hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[6] Dietician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[7] Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[8] Alternative therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Question 12**

**How do you usually travel to see health professionals when visiting for your own health?**

*Please tick one box for each health professional*

	Car	Public transport	Walk/cycle	Other	Not applicable
[1] Family doctor (GP) at a health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[2] Nurse at a health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[3] Nurse at outpatient clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[4] Specialist (General hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[5] Specialist (University Hospital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[6] Dietician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[7] Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[8] Alternative therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Question 13**

**When attending health professionals how much do you usually pay for parking fees or fares on public transport or taxis at each visit? *Please enter the amount in £s***

	Parking fees (£)	Public transport or taxi fares (£)	Not applicable
[1] Family doctor (GP) at a health centre	_____	_____	<input type="checkbox"/>
[2] Nurse at a health centre	_____	_____	<input type="checkbox"/>
[3] Nurse at outpatient clinic	_____	_____	<input type="checkbox"/>
[4] Specialist (General hospital)	_____	_____	<input type="checkbox"/>
[5] Specialist (University Hospital)	_____	_____	<input type="checkbox"/>
[6] Dietician	_____	_____	<input type="checkbox"/>
[7] Physiotherapist	_____	_____	<input type="checkbox"/>
[8] Alternative therapist	_____	_____	<input type="checkbox"/>

**Question 14**

When attending health professionals for your own health how much do you **personally** usually pay (if anything) for the consultation? *Please exclude any payment that is covered by private health insurance.*

	£s	Not applicable
[1] Family doctor (GP) at a health centre	_____	<input type="checkbox"/>
[2] Nurse at a health centre	_____	<input type="checkbox"/>
[3] Nurse at outpatient clinic	_____	<input type="checkbox"/>
[4] Specialist (General hospital)	_____	<input type="checkbox"/>
[5] Specialist (University Hospital)	_____	<input type="checkbox"/>
[6] Dietician	_____	<input type="checkbox"/>
[7] Physiotherapist	_____	<input type="checkbox"/>
[8] Alternative therapist	_____	<input type="checkbox"/>

**Question 15**

How many miles do you usually travel to see health professionals and how long does this take?

	Miles	Time taken to get there (minutes)	Not applicable
[1] Family doctor (GP) at a health centre	_____	→ _____	<input type="checkbox"/>
[2] Nurse at a health centre	_____	→ _____	<input type="checkbox"/>
[3] Nurse at outpatient clinic	_____	→ _____	<input type="checkbox"/>
[4] Specialist (General hospital)	_____	→ _____	<input type="checkbox"/>
[5] Specialist (University Hospital)	_____	→ _____	<input type="checkbox"/>
[6] Dietician	_____	→ _____	<input type="checkbox"/>
[7] Physiotherapist	_____	→ _____	<input type="checkbox"/>
[8] Alternative therapist	_____	→ _____	<input type="checkbox"/>

**Question 16**

Thinking of the visits which took place in the last 3 MONTHS, did anyone in your household lose any earnings as a result of these visits? *Tick all that apply*

No	£s	Not applicable
<input type="checkbox"/>		
Yes, I lost earnings <input type="checkbox"/>	→ How much _____	
Yes, my partner/spouse lost earnings <input type="checkbox"/>	→ How much _____	<input type="checkbox"/>
Yes, Other household member <input type="checkbox"/>	→ How much _____	<input type="checkbox"/>

**Question 17**

How many medicines have been **prescribed FOR YOU by your doctor** over the last 3 MONTHS and how many did you pay for? *Please include all repeat prescriptions*

Number of prescribed medicines \_\_\_\_\_ How many did you pay for? \_\_\_\_\_

**Question 18**

In total how much have you spent on medication bought over-the-counter in the last 3 MONTHS (please include purchases for all members of your household)

Total costs £ \_\_\_\_\_



**III. Hospital inpatient admissions in the last 12 MONTHS**

**Question 19**

Now thinking of the last 12 MONTHS, how many times (if any) have you been admitted to a day unit, a general hospital, a university hospital, or an accident and emergency ward (A&E)? If you were admitted to hospital please also state the total number of days spent in each type of hospital.

*If you have not been admitted to hospital in the last 12 months enter a zero and go on to Question 23*

Day Unit [1]	General Hospital [2]	University hospital [3]	A & E [4]
How many times _____	How many times _____	How many times _____	How many times _____
Number of days _____	Number of days _____	Number of days _____	Number of days _____

**Question 20**

In the last 12 months, have you been taken to hospital in an emergency ambulance? If so, how many times and how much did you personally pay for this (please exclude any payments covered by health insurance)

- Yes → How many times \_\_\_\_\_ How much did this cost £ \_\_\_\_\_
- No

**How do you usually travel to the hospital? Tick one box only**

- Car       Public transport       Walk/cycle       Other       Not applicable

**How far away from the hospital do you live and how long does it usually take you to travel to the hospital?**

Day Unit [1]	General Hospital [2]	University hospital [3]	A & E [4]
_____ Miles	_____ Miles	_____ Miles	_____ Miles
_____ Minutes	_____ Minutes	_____ Minutes	_____ Minutes

**In total how much have you spent on fares to travel to the hospital or on parking fees over the last 12 months?**

£ \_\_\_\_\_

**How many times were you visited by people from your household while you stayed in hospital over the last 12 months?**

\_\_\_\_\_

**How many members of your household usually come along on each visit?**

\_\_\_\_\_

**Question 21**

During the past 12 MONTHS did anyone from your household accompany you to the hospital when you were admitted? *Tick one box only*

- No, I went by myself
- Accompanied by my partner
- Accompanied by my partner and other members of the household
- Others in my household (excluding my partner)

**Question 22**

Did you, your partner/spouse or any other household members lose any earning as a result of your stays in hospital during the last 12 MONTHS? *Tick all that apply*

- |   |                    |
|---|--------------------|
| <input type="checkbox"/> No                                   |                    |
| <input type="checkbox"/> Yes, I lost earnings                 | → How much £ _____ |
| <input type="checkbox"/> Yes, my partner/spouse lost earnings | → How much £ _____ |
| <input type="checkbox"/> Yes, other household members         | → How much £ _____ |

**IV. Days off work and other activities in the LAST MONTH**

**Question 23**

During the last **MONTH** how many days (if any) have you or any other member of your household taken off work (including voluntary work) or school/college due to illness?

You	Spouse/partner	Oldest child	Member 1	Member 2
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable
<input type="text" value=" _"/> Days	<input type="text" value=""/> Days	<input type="text" value=""/> Days	<input type="text" value=""/> Days	<input type="text" value=""/> Days

**Question 24**

Please estimate much you or any other members of your household lost in earnings (if any) as a result of time off work for ill health in the last **MONTH** (£s); if no earnings were lost enter '0'?

You	Spouse/partner	Oldest child	Member 1	Member 2
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable
£ _____	£ _____	£ _____	£ _____	£ _____

**Question 25**

During the **LAST MONTH** have you or any other member of your household been unable to carry out any household tasks due to ill health? *Tick one box only*

- Yes (→ Question 26)
- No (→ Question 27)

**Question 26**

Please enter the number of days on which you and/or any other household member were unable to complete normal household tasks in the last month

	You	Spouse/partner	Other Members
		<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable
[1] Grocery shopping	_____ Days	_____ Days	_____ Days
[2] Cleaning	_____ Days	_____ Days	_____ Days
[3] Cooking	_____ Days	_____ Days	_____ Days
[4] Gardening	_____ Days	_____ Days	_____ Days
[5] Childcare	_____ Days	_____ Days	_____ Days
[6] Other	_____ Days	_____ Days	_____ Days

**Question 27**

During the **LAST MONTH**, has someone outside the household helped you with any of the household tasks you would have usually done yourself?

*Tick one box only*

- Yes (→ Question 28)
- No (→ Question 29)

**Question 28**

How many hours help did you receive in **THE LAST MONTH** and how much did it cost in total?

Number of Hours \_\_\_\_\_ → Total Cost £ \_\_\_\_\_

**V. Costs of living**

**Question 29**

In the last 12 MONTHS have you or anyone else in your household obtained any aids/appliances or modifications to help you in the home, because of ill health (e.g. kitchenware, bread oven, blender)?

*Tick one box only*

- Yes (→Question 30)  
 No (→Question 31)

**Question 30**

Please tell us how many you bought and how much they cost in total?

Number of Items \_\_\_\_\_ Total cost £ \_\_\_\_\_

**Question 31**

On average, how much is spent EACH WEEK on food shopping for your household?

*(If you do not know, please ask the person in your household who does the weekly food shopping)*

£ \_\_\_\_\_.

**Question 32**

On average, how much TIME do you (or the person who does the shopping/cooking in your household) spend shopping for food and preparing food EACH WEEK?

*(If you do not know, please ask the person in your household who does the weekly food shopping)*

Time spent shopping for food each week? \_\_\_\_ hours      Time spent preparing food each week? \_\_\_\_ hours

**Question 33**

How much do you spend per week on food at work/school/college (e.g. canteen food)?

£ \_\_\_\_\_  Not applicable

**IF NO MEMBERS OF YOUR HOUSEHOLD HAVE FOOD ALLERGIES PLEASE GO TO QUESTION 35**

**Question 34**

If you (or other members of your household) did not have a food allergy would you spend more, the same or less money and time on food each week?

*(If you do not know, please ask the person in your household who does the shopping and cooking)*

*Tick one box for each question*

	More	Same	Less	Not sure
[1] Money spent on food shopping would be...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[2] Money spent on food at work/school would be..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[3] Time spent shopping would be....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[4] Time spent preparing food would be...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**VI. Leisure activities**

**Question 35**

Over the PAST MONTH have you eaten meals in any establishments outside of your home, excluding meals at work (e.g. café, restaurant, snack bar etc)?

- Yes → How many times \_\_\_\_\_
- No

**Question 36**

In total, how much did you spend on eating meals outside of the home over the PAST MONTH (excluding meals at work)?

*Please enter 0 if you did not spend any money on eating out in the past month*

£ \_\_\_\_\_

**Question 37**

Over the PAST MONTH how many times have you ordered takeaway or delivery food?

*Please enter 0 if you did not have any*

Number \_\_\_\_\_

**Question 38**

In total, how much did you spend on takeaway or delivery meals in the LAST MONTH?

*Please enter 0 if you did not spend money on takeaway or delivery food in the last month*

£ \_\_\_\_\_  Not applicable

**Question 39**

Now thinking back over the last 12 MONTHS, have you had any holidays away from home?

- Yes → How many times? \_\_\_\_\_ How many days in total \_\_\_\_\_ → go to Question 40)
- No (→ go to Question 42)

**Question 40**

How much did you spend in total on holidays away from home in the last 12 MONTHS?

£ \_\_\_\_\_

**Question 41**

How much did you spend on food while on holiday away from home in the last 12 MONTHS?

£ \_\_\_\_\_

**VII. Everyday life**

**Question 42**

Here is a picture of a ladder. Suppose we say that the top of the ladder represents the best possible life for you (and for each member of your household) and the bottom represents the worst possible life. Where on the ladder do you feel you, your partner and other members of your household stand at the present time?

Please draw a line through the most relevant rung for yourself and each member of your family.

You	Your partner	Oldest child	Member 1	Member 2
	[ ] Not applicable	[ ] Not applicable	[ ] Not applicable	[ ] Not applicable
[ 10 ] best possible	[ 10 ] best possible	[ 10 ] best possible	[ 10 ] best possible	[ 10 ] best possible
[ 9 ]	[ 9 ]	[ 9 ]	[ 9 ]	[ 9 ]
[ 8 ]	[ 8 ]	[ 8 ]	[ 8 ]	[ 8 ]
[ 7 ]	[ 7 ]	[ 7 ]	[ 7 ]	[ 7 ]
[ 6 ]	[ 6 ]	[ 6 ]	[ 6 ]	[ 6 ]
[ 5 ]	[ 5 ]	[ 5 ]	[ 5 ]	[ 5 ]
[ 4 ]	[ 4 ]	[ 4 ]	[ 4 ]	[ 4 ]
[ 3 ]	[ 3 ]	[ 3 ]	[ 3 ]	[ 3 ]
[ 2 ]	[ 2 ]	[ 2 ]	[ 2 ]	[ 2 ]
[ 1 ]	[ 1 ]	[ 1 ]	[ 1 ]	[ 1 ]
[ 0 ] worst possible life	[ 0 ] worst possible life	[ 0 ] worst possible life	[ 0 ] worst possible life	[ 0 ] worst possible life

**Question 43**

Please tell us about any significant life events which have occurred because of your health?

*Tick all that apply*

- [1] My choice of job or career has been restricted
- [2] I gave up my job
- [3] I was dismissed from my job
- [4] I changed jobs
- [5] I moved to different home/city
- [6] I have been unable to participate in sports and hobbies
- [7] My social life is restricted
- [8] I changed schools
- [9] I have been hospitalised
- [10] I have delayed having children/expanding my family
- [11] The relationship with my partner broke down
- [12] I have had an Anaphylactic shock
- [13] I have experienced a change in emotions (anger, fear, anxiety, feeling left out, trauma)
- [15] None of the above

**Question 44**

Do you use the internet, libraries or helplines to obtain advice and information about health or illness?

- Yes → How many minutes per month? \_\_\_\_\_
- No



**Question 50**

How much do you and your partner/spouse get paid PER MONTH for your job after tax and other deductions are taken out? If your's or your spouse's/partner's pay changes from week to week, please tick the boxes which give the closest average amount you both get paid.

*Tick one box only for you and one box only for your partner/spouse*

£ PER MONTH	Your income	Your Spouse's/Partner's income
Not applicable	<input type="checkbox"/>	<input type="checkbox"/>
[1] 67 or less	<input type="checkbox"/>	<input type="checkbox"/>
[2] 68 - 135	<input type="checkbox"/>	<input type="checkbox"/>
[3] 136 - 202	<input type="checkbox"/>	<input type="checkbox"/>
[4] 203 - 337	<input type="checkbox"/>	<input type="checkbox"/>
[5] 338 - 472	<input type="checkbox"/>	<input type="checkbox"/>
[6] 473- 606	<input type="checkbox"/>	<input type="checkbox"/>
[7] 607 - 808	<input type="checkbox"/>	<input type="checkbox"/>
[8] 809 - 1,010	<input type="checkbox"/>	<input type="checkbox"/>
[9] 1,011 - 1,212	<input type="checkbox"/>	<input type="checkbox"/>
[10] 1,213 - 1,482	<input type="checkbox"/>	<input type="checkbox"/>
[11] 1,483 - 1,751	<input type="checkbox"/>	<input type="checkbox"/>
[12] 1752 - 2, 021	<input type="checkbox"/>	<input type="checkbox"/>
[13] 2,022 - 2,358	<input type="checkbox"/>	<input type="checkbox"/>
[14] 2,359 - 2,694	<input type="checkbox"/>	<input type="checkbox"/>
[15] 2,695-3,031	<input type="checkbox"/>	<input type="checkbox"/>
[16] More than 3,031	<input type="checkbox"/>	<input type="checkbox"/>

**Question 51**

Please enter the best estimate of your total monthly household income (adding together the income of all the members of your household, including benefits and allowances such as state pensions, unemployment benefit, disability/incapacity allowances, income support, family tax credit etc after tax and other deductions have been taken out?

£ \_\_\_\_\_

**Question 52**

Thinking of your present situation, what total monthly household income (adding together your's and your spouse/partner's income after tax and other deductions have been taken out) would you consider for your family to be.....? *Please enter an amount on each line*

Very bad? £ \_\_\_\_\_

Bad? £ \_\_\_\_\_

Insufficient? £ \_\_\_\_\_

Sufficient? £ \_\_\_\_\_

Good? £ \_\_\_\_\_

Very Good? £ \_\_\_\_\_

**Thank you very much for your co-operation!!!  
Please return the questionnaire in the prepaid envelope**