



Agency Logo

Serial Number:

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Respondent ID										First Name/Initials		
		-								-		

Interview Date:

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Interviewer ID: _____

"50+ in Europe"

The Survey of Health, Ageing and Retirement in Europe

2010/11

Self-Administered Questionnaire

Mailing Address and telephone number of survey agency

How to FILL IN this questionnaire

Most of the questions on the following pages can be answered by simply checking the box below or alongside the answer that applies to you.

Please check **ONE (1)** box:

Correct or
Incorrect

Please proceed question by question. Skip questions only if there is an explicit instruction to do so.

Example:

Do you have children?

₁ Yes

₅ No



If you check "Yes" in this example, you go on to the next question!

If you check "No" in this example, you go on to the question given in the instruction box!

How to RETURN this Questionnaire

If the interviewer is still in your home when you have completed the questionnaire, please hand it back to him or her. If not, please return the completed questionnaire in the pre-paid envelope as soon as you possibly can. *If you need a replacement envelope, please call [national survey agency] at [toll-free telephone number].*

PLEASE START THE QUESTIONNAIRE AT QUESTION 1 ON THE NEXT PAGE

ALL YOUR ANSWERS WILL REMAIN CONFIDENTIAL. THANK YOU AGAIN FOR YOUR HELP

1. First, we list some statements that people have used to describe their health. By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

(Please mark only one box in each of section A to E).

A	I have no problems in walking about	<input type="checkbox"/>	1
	I have some problems in walking about	<input type="checkbox"/>	2
	I am confined to bed	<input type="checkbox"/>	3

B	I have no problems with self-care	<input type="checkbox"/>	1
	I have some problems washing or dressing myself	<input type="checkbox"/>	2
	I am unable to wash or dress myself	<input type="checkbox"/>	3

C	I have no problems with performing my usual activities	<input type="checkbox"/>	1
	I have some problems with performing my usual activities	<input type="checkbox"/>	2
	I am unable to perform my usual activities	<input type="checkbox"/>	3

D	I have no pain or discomfort	<input type="checkbox"/>	1
	I have moderate pain or discomfort	<input type="checkbox"/>	2
	I have extreme pain or discomfort	<input type="checkbox"/>	3

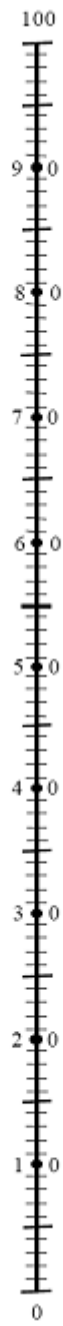
E	I am not anxious or depressed	<input type="checkbox"/>	1
	I am moderately anxious or depressed	<input type="checkbox"/>	2
	I am extremely anxious or depressed	<input type="checkbox"/>	3

2. To help people say how good or bad their health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your health is today, in your opinion. Please do this by drawing a line from the box below whichever point on the scale indicates how good or bad your health state is today.

best imaginable health state

Your own health state today



worst imaginable health state

3. Thinking about your current health insurance, please indicate who [In countries with deductibles in health insurance: PAST YOUR DEDUCTIBLE] finally pays for the costs of these types of care, should you need them:

(Please check only one box per row)

	Yourself only ▼	Mostly yourself ▼	Mostly your health insurance ▼	Your health insurance only ▼	Don't know ▼
a) Medical visits to a general practitioner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₈
b) Medical visits to specialists, when prescribed by a general practitioner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₈
c) Medical visits to specialists, when not prescribed by a general practitioner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₈
d) Medical visits to any doctor of your choice	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₈
e) Dental care	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄
f) Prescribed drugs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₈
g) Hospitalisations in public hospitals	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₈
h) Hospitalisations in private hospitals	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₈
i) Stays in a nursing home/nursing care at home in case of chronic disease or disability	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₈

4. Now we would like to ask you some questions concerning out-of-pocket expenses for your care and your personal health insurances in the last twelve months.

→ By out of pocket expenses we mean everything that is not paid by the insurance company. If you first pay but later get it reimbursed, this is not out of pocket expenses. If the insurance company pays first, but later charges you, this is out of pocket expenses.

(Please put in a "0" if you haven't paid out-of-pocket)

Not counting health insurance premiums or reimbursements from employers, about how much did you pay out-of-pocket for ...

a) ...hospital inpatient care	_____	€
b) ...outpatient care	_____	€
c) ...prescribed drugs (excluding self-medication)	_____	€
d) ...care in nursing homes, in day-care centers	_____	€
e) ...home care services	_____	€

5. Please say how much you agree or disagree with each of the following statements. How much of the time do you...

(Please mark only one box in each row)

	Often ▼	Some of the time ▼	Hardly ever or never ▼
a) ... feel you lack companionship?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b) ... feel left out?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c) ... feel isolated from others?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d) ... feel lonely?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

6. Finally, please state your sex and birth year:

a) I am...

Male	<input type="checkbox"/> ₁
Female	<input type="checkbox"/> ₂

b) I was born in (year)

Thank you very much for taking the time to answer our questions. Please give the questionnaire to the interviewer or post it back in the envelope provided.