

**thl.fi/finterveysseuranta**

User id:

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## FinHealth 2017 –study **NATIONAL HEALTH SURVEY**

*Follow-up study 2020*

Dear

We recently sent you a letter regarding the FinHealth 2017- follow-up survey. According to our records, we have not yet received your response. You can respond to the survey online at **thl.fi/finterveysseuranta** with the user id and password found at the right top of this letter. After logging in, you can choose the language you prefer and begin responding to the survey. Alternatively you have the opportunity to respond to the attached paper questionnaire and post it in the included prepaid envelope.

We dearly hope that you take part in this survey. Every person selected for this survey is unique and cannot be replaced by another person.

**By responding, you can make a difference!**

Thank you for your cooperation!

Kind Regards,

Päivikki Koponen  
Research Manager

Source of address information: Population Information System, Digital and Population Data Services Agency, P.O. Box 123, FI-00531 Helsinki

### **More information on the study:**


- online at **thl.fi/finterveysseuranta**
- by e-mail at [finterveysseuranta@thl.fi](mailto:finterveysseuranta@thl.fi)
- by phone (toll-free number): 080095332 on weekdays at 8-16
- for a privacy notice containing information about the processing of personal data in the survey, see **thl.fi/finterveysseuranta**

## INSTRUCTIONS TO RESPONDENTS

You should only choose one best alternative for each question unless it is specifically stated that you may choose more than one.

You may also fill in this questionnaire online at: <http://www.thl.fi/finterveysseuranta>.

The online questionnaire requires your study number and password which can be found at the right top corner of the invitation letter.

- Tick the most suitable alternative or write the information required in the space given with a ballpoint pen. If possible, do not use a pencil.
-  In case you accidentally make markings into an unwanted box, please color in the entire box.
- You should only choose one best alternative for each question unless it is specifically stated that you may choose more than one.
- Remember to answer all questions. Enter negative answers by choosing the 'no' alternative or by writing '0' (zero) in the space given.

By responding to this survey you consent to your personal data being processed in accordance with the privacy statement and to having your survey responses linked with health and welfare register data.

Participation in the study is voluntary.

## HEALTH STATUS

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### 1. Is your present state of health

- good
- rather good
- moderate
- rather poor
- poor

### 2. Do you have any longstanding illness or health problem?

- no
- yes

### 3. Are you limited because of a health problem in activities people usually do? Would you say you are

- severely limited
- limited but not severely
- not limited at all (*proceed to question 5*)

### 4. Have you been limited for at least the past 6 months?

- yes
- no

### 5. Have you during the past month (30 days) had the following symptoms or problems?

	daily	less frequently than daily	not at all
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toothache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 6. When was the last time you used the following medication?

Please answer on every line by choosing the correct alternative.

	during the past week	1-4 weeks ago	1-12 months ago	over a year ago	never
Painkillers for headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painkillers for joint or muscle ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painkillers for another ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy or hay fever medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes medication (insulin and/ or tablets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicine for high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicine to lower your cholesterol level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acetylsalicylic acid to prevent myocardial infarction or cerebral infarction (e.g. Aspirin, Disperin, Primaspan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication to thin the blood, anticoagulants (Marevan, Pradaxa, Xarelto or Eliquis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 7. Is the condition of your teeth and the health of your mouth at present

- good  
 rather good  
 moderate  
 rather poor  
 poor

## MENTAL HEALTH

### 8. Have you during the past 12 months had a period of at least two weeks when, for most of the time

	no	yes
you have been low-spirited or depressed?	<input type="checkbox"/>	<input type="checkbox"/>
you have lost interest in most things, such as hobbies, work or other things that usually give you pleasure?	<input type="checkbox"/>	<input type="checkbox"/>

**9. How much of the time during the past 4 weeks**

	all of the time	most of the time	a good bit of the time	some of the time	a little bit of the time	none of the time
Have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10. Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks.**

	none of the time	rarely	some of the time	often	all of the time
I've been feeling optimistic about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling interested in other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've had energy to spare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been dealing with problems well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling good about myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling close to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling confident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been able to make up my own mind about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling loved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been interested in new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling cheerful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved.



## FUNCTIONING

### 11. How do you manage the following activities nowadays?

	without difficulties	with minor difficulties	with major difficulties	not at all
to walk about half a kilometre without resting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
to run a short distance (about 100 metres)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
to climb one flight of stairs without resting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
to read an ordinary newspaper print (with or without glasses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
to hear what is said in a conversation between several people (with or without a hearing aid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 12. Can you usually perform the following activities?

	without difficulties	with minor difficulties	with major difficulties	not at all
dressing and undressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cleaning your teeth and mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cooking or heating your meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
moving in your apartment from one room to another	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heavy cleaning, e.g. carrying and beating of carpets or washing windows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
leaving your apartment (to run errands, to get some fresh air)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 13. How would you estimate your present memory, learning capabilities, and ability to concentrate:

	very well	well	adequately	poorly	very poorly
How well does your memory work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to acquire new information and learn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you generally able to concentrate on matters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**14. Regardless of whether you are employed or not, please estimate your current work capacity. Are you:**

- completely fit for work
- partially unable to work
- completely unable to work?

**15. Let's assume that your work ability would receive a score of 10 points at its best. What point score would you give your current work ability?**

*Please choose the option that best applies to your working capacity.*

(completely unable to work)						(work ability at its best)				
0	1	2	3	4	5	6	7	8	9	10
<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"/>	<input type="checkbox"/>	<input type="checkbox"/>

**16. Do you use the Internet for the following?**

	yes	I need assistance, or someone else does it on my behalf	never
electronic transactions or services (e.g. online banking, Social Insurance Institution KELA, tax office, ticket sales, local public services, online shops)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
finding information (e.g. timetables, health information, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**17. What is your assessment of your ability to use the internet - online services (on computer or mobile devices)?**

- I do not use them
- novice/beginner (I use them with assistance)
- I use the basic services independently
- I use many online applications effortlessly
- expert (I can teach others)

**WELL-BEING**

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**18. Do you ever feel lonely?**

- never
- very rarely
- sometimes
- fairly often
- all the time



**19. How satisfied are you with your economic situation?**

- very satisfied
- satisfied
- somewhat satisfied
- unsatisfied
- very unsatisfied

**20. How satisfied are you with your accomplishments in life?**

- very satisfied
- satisfied
- somewhat satisfied
- unsatisfied
- very unsatisfied

**21. How satisfied are you with your family life?**

- very satisfied
- satisfied
- somewhat satisfied
- unsatisfied
- very unsatisfied
- I do not have a family

**LIFESTYLE**

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**22. How much do you exercise and stress yourself physically in your leisure time?**

- In my leisure time I read, watch TV and do other activities in which I do not move much and which do not strain me physically
- In my leisure time I walk, cycle and move in other ways several hours a week. This includes walking, fishing and hunting, and light home gardening.
- In my leisure time I exercise several hours a week. This includes running, jogging, cross country skiing, fitness training, swimming, ball games, and strenuous garden work.
- In my leisure time I practice regularly strenuous sport several times per week. This includes competitive sports such as running, orienteering, cross country skiing, swimming and ball games.

**23. Do you think you sleep enough?**

- yes, nearly always
- yes, often
- rarely or hardly ever
- I can't say





**24. Over the past month (30 days), how often have you...**

	often	sometimes	not at all
felt excessively tired or sleepy during the daytime?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
had nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
had trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**25. How often have you eaten vegetables and root vegetables (not potatoes) during the past seven (7) days as such, grated or in fresh salads?**

- not at all
- on 1 to 2 days
- on 3 to 5 days
- on 6 to 7 days
- several times a day

**26. How often have you eaten fruits or berries during the past seven (7) days?**

- not at all
- on 1 to 2 days
- on 3 to 5 days
- on 6 to 7 days
- several times a day

**27. Who mainly prepares your meals?**

- myself
- spouse/other partner
- other person living at my home
- other relative, neighbour or friend
- home help or home care
- I eat in restaurants or bars
- I eat in a sheltered housing unit, day centre, retirement/nursing home etc. (or I take the food over from above-mentioned places and eat at home)
- ready-made meals are delivered to my home

**28. Do you smoke nowadays (cigarettes, cigars, pipefuls)?**

- I have never smoked
- yes, daily
- yes, occasionally
- not at all, I quit smoking \_\_\_\_\_ (month) / \_\_\_\_\_ (year)  
*For example, if you quit smoking in July 2019, fill in 07 (month) 2019 (year).  
 If you can't recall the month, fill in only the year.*



**29. How often do you have a drink containing alcohol?**

- Never (proceed to question 32)
- Monthly or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 or more times a week

**30. How many drinks containing alcohol do you have on a typical day when you are drinking? Please see the figure for an example of alcohol units.**

- 1-2 units
- 3-4 units
- 5-6 units
- 7-9 units
- 10 units or more



**31. How often do you have six or more drinks on one occasion?**

- never
- less than monthly
- monthly
- weekly
- daily or almost daily

**32. Have any of the following people recommended you for health reasons in the past 12 months to.** (You may choose several alternatives on each row.)

	no one	doctor or dentist	a public health nurse, or some other health care professional	family member	someone else
exercise more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
change your eating habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
reduce consumption of alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
quit smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**WEIGHT AND HEIGHT**

**33. How much do you weigh at present?**

\_\_\_\_\_ kg (an estimate suffices)

**34. How tall are you?**

\_\_\_\_\_ cm (an estimate suffices)

## SOCIAL WELFARE AND HEALTH CARE SERVICES

**35. Over the past 12 months, how many times have you been to a doctor's appointment because of your own condition?**

*Not including dentists' appointments (Mark 0 if not at all.)*

\_\_\_\_\_ times

**36. Over the past 12 months, how many times have you been to a public health nurse's, nurse's or occupational health nurse's appointment, or they have visited you at home because of your own condition? (Mark 0 if not at all.)**

\_\_\_\_\_ times

**37. Have you been in physiotherapy on a doctor's referral during the past 12 months?**

no

yes

**38. Which of the following do you primarily contact when in need of medical attention?**

*(Choose only one option)*

the health centre

a private clinic

occupational health care

student health care

a hospital outpatient clinic

other

**39. Evaluate your experiences in your primary care facility in the past 12 months**

*(not including dental care).*

	always	usually	sometimes	never	not applicable
I was able to get contact to the unit without difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had access to care without undue delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I had access to examinations (laboratory tests, X ray imaging, ultrasound scans, etc.) without undue delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traveling to the care unit was difficult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High fees have made it more difficult for me to get care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**40. When was the last time you visited a dentist?**

- during the past 12 months
- 1 to 2 years ago
- 3 to 5 years ago
- over 5 years ago
- I have never visited a dentist

**41. Did you get vaccinated against the flu for the season starting autumn 2019 and ending in the spring 2020?**

- yes
- no
- I can't remember

**42. Do you feel you have been adequately provided with the following services over the past 12 months?**

	no need	I would have needed the service but did not receive it	I have received the service but it was not adequate	I have received the service and it was adequate
home care (home help services and/or home nursing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
rehabilitation at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
rehabilitation outside your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
service centres/day centres for the elderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PROVIDING AND RECEIVING ASSISTANCE**

**43. Do you need and do you get help for your everyday activities due to your impaired functional capacity?**

- I do not need help and do not get it
- I would need help but do not get it
- I get help, but not enough
- I get enough help
- I get more help than I need

**44. Do you yourself regularly help someone, who does not live in your household, who has limited functional capacity or is ill?**

- no
- yes

**45. Do you regularly provide assistance to a person who is a member of your household and has limited functional capacity, or is ill, and could otherwise not cope at home?**

- no
- yes, my spouse or cohabitant
- yes, my child or grandchild
- yes, my own or my spouse's parents
- yes, my own or my spouse's grandparents
- some other person

**46. Estimate your possibilities to get help from people close to you when you need help or support.** *You may choose more than one option per row.*

	hus- band, wife, partner	some other relative	close friend	close fellow worker	close neigh- bour	some- one else close	no one
Who do you think really cares about you no matter what happened to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
From whom do you get practical help when needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SOCIAL RELATIONSHIPS AND QUALITY OF LIFE**

**47. Do you currently have a close friend with whom you can talk confidentially about almost any issues concerning yourself?**

- I don't have any close friends
- I have one close friend
- I have two close friends
- I have several close friends

**48. How much do you trust the following? On a scale from “I do not trust them at all” to “I trust them completely”, choose the option that best describes your opinion.**

	I do not trust them at all				I trust them completely
	1	2	3	4	5
public health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
public social services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
courts of law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
decisionmaking in your municipality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
people in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When answering questions number 49 to 51, think about your life in **the past two (2) weeks.**

**49. How would you rate your quality of life?**

- very poor
- poor
- neither poor nor good
- good
- very good



**50. How satisfied are you with?**

	<b>very dissatisfied</b>	<b>dissatisfied</b>	<b>neither satisfied nor dissatisfied</b>	<b>satisfied</b>	<b>very satisfied</b>
your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your ability to perform your daily living activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your personal relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the conditions of your living place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**51. Do you have**

	<b>not at all</b>	<b>a little</b>	<b>moderately</b>	<b>mostly</b>	<b>completely</b>
enough energy for everyday life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
enough money to meet your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CORONAVIRUS (COVID-19) EPIDEMIC**

**52. People may have concerns about the coronavirus. Have you been worried about ...**

	<b>not at all</b>	<b>a little</b>	<b>moderately</b>	<b>quite a lot</b>	<b>very much</b>
ending up in quarantine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
getting infected with coronavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
possibly infecting other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
being discriminated against or avoided because you have coronavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the economic impact of the coronavirus epidemic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
shortages of food or other daily goods due to the coronavirus epidemic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the government's ability to deal with the coronavirus outbreak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the ability of the health care system to treat all coronavirus patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
that someone close to you will be infected with coronavirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**53. The following symptoms may indicate being infected with the coronavirus. Have you experienced the following symptoms after 1.3.2020?**

	yes, during the past 30 days	yes, earlier this year	no
sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
head cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pain in the front part of your face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lost your voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
difficulties breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pain when breathing in the middle of the chest and around the windpipe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a stabbing pain in the chest elsewhere than the windpipe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
loss of your sense of smell or taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bowel symptoms (e.g. diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**54. Have you received adequate information on how to avoid getting infected with the corona virus and how to prevent it from spreading?**

- I have not received any information or the information I have received has been completely inadequate
- I have received information but I would have needed more
- I have received adequate information



**55. Which measures have you taken to avoid getting infected with the coronavirus and to prevent it from spreading?**

	Yes, I follow the instruction / recommendation	I do not follow the instruction / recommendation
I wash my hands more frequently	<input type="checkbox"/>	<input type="checkbox"/>
I use hand sanitizers more frequently	<input type="checkbox"/>	<input type="checkbox"/>
I take care of hygiene when coughing (e.g. coughing into a disposable tissue, not coughing into hands)	<input type="checkbox"/>	<input type="checkbox"/>
I stay at home if I have flu symptoms (e.g. cough, cold symptoms or sore throat)	<input type="checkbox"/>	<input type="checkbox"/>
I wear a single-use mask or cloth mask during my free time (when it is not possible to avoid close contact with other people)	<input type="checkbox"/>	<input type="checkbox"/>
I keep a 1 to 2 meter safe distance to other people outside of home	<input type="checkbox"/>	<input type="checkbox"/>
I do not shake hands with the people I meet	<input type="checkbox"/>	<input type="checkbox"/>
I do not take part in events with over 50 participants	<input type="checkbox"/>	<input type="checkbox"/>
I do not meet with people that are not part of my household	<input type="checkbox"/>	<input type="checkbox"/>
I do not travel outside of Finland	<input type="checkbox"/>	<input type="checkbox"/>

**56. How has the corona epidemic or its restrictive measures affected your everyday life (compared to the time before the epidemic)?**

*If there are things in the list that don't apply to your own life at all, select 'do not apply'.*

	no effect	yes, decreased	yes, increased	does not apply
amount of time spent with family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
contact with friends and relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
loneliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
disputes and conflicts within the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fear of or experience of domestic violence or intimate partner violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hope for the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
exercise in your free time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
participation in the activities of any club, organization or association	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sleeping difficulties, nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





	no effect	yes, decreased	yes, increased	does not apply
number of meals and snacks eaten during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
consumption of vegetables (cooked or uncooked, not including potatoes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
consumption of fruit and berries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
snacks (consumption of sweets, chocolate, soft drinks, chips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dealing with everyday chores online (e.g. online food purchases)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
online dealings with social welfare and health care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
helping someone close to you (e.g. by doing shopping for an elderly person belonging to a risk group)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**57. Has the corona epidemic weakened your financial situation?**

- very much
- quite a lot
- to some extent
- a little
- not at all

**58. Have you downloaded the Koronavilkku contact tracing app to your mobile phone**

- yes
- No, because the app is not available for my phone
- No, for other reasons



## BACKGROUND QUESTIONS

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### 59. Do you live in

- a regular private residence
- a sheltered housing unit, or care or group home providing only part-time onsite support, e.g. only daytime services
- a sheltered housing unit with 24/7 onsite support
- a retirement home (nursing home)
- somewhere else

### 60. What is your education? Mark your *highest* educational degree.

- elementary school, basic education
- lower secondary education
- vocational school/equivalent
- upper secondary education/high school
- non-university lower education
- Bachelor's Degree (university of applied science, college, or similar)
- Master's Degree (university degree, MA, or similar)

### 61. How many members are there presently in your household (yourself included)?

\_\_\_\_\_ members

### 62. How many of your household members including yourself are

(Please mark 0 for none.)

under 3 years	_____	18–64-years	_____
3-6-years	_____	65–79-years	_____
7-17-years	_____	80-years or older	_____

### 63. Which of the following alternatives best describes your current main activity:

(choose only one option)

- employed or self-employed (includes unpaid employment in a family-owned business)
- retired
- other

**THANK YOU FOR YOUR RESPONSES!**





