



## FinHealth Study

### Questionnaire for persons above 70 years of age

#### INSTRUCTIONS TO RESPONDENTS

You can fill in this questionnaire also in the Internet: <http://www.thl.fi/finterveys>.  
Your study code (number) and password needed in the web questionnaire are 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.

 If you make some marks to the answer box which you do not mean, please blacken the entire answer box.

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

#### EXAMPLE 1.

1. How do you find your current health status?

- excellent  
 quite good  
 average  
 quite poor  
 very poor

#### EXAMPLE 2.

2. How tall are you?

1 6 5 cm



### 1. 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

### 2. Have you experienced any of the following in your living environment, and to what extent do they hinder your living?

|  | no                       | yes, but this does not hinder me at all | yes, and this hinders me to some extent | yes, and this hinders me a lot |
|--|--------------------------|---|---|--------------------------------|
| dangerous intersections and/or traffic routes                  | <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/>                | <input type="checkbox"/>       |
| slippery sidewalks or a lot of snow on the sidewalks in winter | <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/>                | <input type="checkbox"/>       |
| poorly lit traffic routes/roads and paths                      | <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/>                | <input type="checkbox"/>       |
| steep, narrow, or slippery stairs                              | <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/>                | <input type="checkbox"/>       |
| hills or considerable elevation differences                    | <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/>                | <input type="checkbox"/>       |
| traffic or industrial noise, smell or dust                     | <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/>                | <input type="checkbox"/>       |
| long distance to health services                               | <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/>                | <input type="checkbox"/>       |
| poor public transport  | <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/>                | <input type="checkbox"/>       |
| unrest or threat of violence                                   | <input type="checkbox"/> | <input type="checkbox"/>                | <input type="checkbox"/>                | <input type="checkbox"/>       |

**3. Does any of the following apply to the house you live in or to your apartment, and to what extent does it hinder your living?**

|  | no                       | yes, but<br>this does<br>not hin-<br>der me at<br>all | yes, and<br>this hin-<br>ders me<br>to some<br>extent | yes, and<br>this hin-<br>ders me<br>a lot |
|--|--------------------------|---|---|---|
| stairs   | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| heavy front doors  | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| lack of a lift/elevator  | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| doorsteps or thresholds  | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| narrow doorways  | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| lack of grab bars or railings  | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| poor lighting  | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| poor ventilation, room temperature too high/low, draft                         | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| kitchen cupboards, working surfaces, cooker or oven set up too high or too low | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| insufficient or impractical washing or toilet facilities                       | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| lack of running warm water   | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| poor laundering facilities   | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |
| need to carry in firewood or water   | <input type="checkbox"/> | <input type="checkbox"/>                              | <input type="checkbox"/>                              | <input type="checkbox"/>                  |

**4. Do you use the following assistive devices?**

|   | no                       | yes                      |
|---|--------------------------|--------------------------|
| glasses (reading spectacles, distance spectacles, bifocals or contact lenses) | <input type="checkbox"/> | <input type="checkbox"/> |
| other assistive devices for seeing  | <input type="checkbox"/> | <input type="checkbox"/> |
| assistive device for hearing (e.g. hearing aid)                               | <input type="checkbox"/> | <input type="checkbox"/> |
| walking cane or crutches  | <input type="checkbox"/> | <input type="checkbox"/> |
| rollator, 4 wheeled kick bike or other walker                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| wheelchair (manual or electric)   | <input type="checkbox"/> | <input type="checkbox"/> |



**5. Do you have any of the following appliances in your home that support your daily life or enhance your personal safety?**

|  | no                       | yes                      |
|--|--------------------------|--------------------------|
| raised toilet seats  | <input type="checkbox"/> | <input type="checkbox"/> |
| shower chair or seat in the bathroom   | <input type="checkbox"/> | <input type="checkbox"/> |
| adjustable bed   | <input type="checkbox"/> | <input type="checkbox"/> |
| grab bars  | <input type="checkbox"/> | <input type="checkbox"/> |
| door opener (electric etc)   | <input type="checkbox"/> | <input type="checkbox"/> |
| ramp at front door or stairs   | <input type="checkbox"/> | <input type="checkbox"/> |
| motion sensors or dimming sensors that automatically switch the lights on    | <input type="checkbox"/> | <input type="checkbox"/> |
| a safety phone, a personal security bracelet, or some other emergency device | <input type="checkbox"/> | <input type="checkbox"/> |

**6. Have you altered your living arrangements, or have you made plans to alter your living arrangements, due to needs at old age?**

- This is not presently an important consideration for me (please go to question 8)
- I have decided to stay in my current home, and will make, or have already made, the required adjustments to facilitate my living at home
- I have thought about moving
- I have already moved to a new place

**7. Which factors affect, or had an effect, on your decision regarding your living arrangements?**

|  | no                       | yes                      |
|--|--------------------------|--------------------------|
| having my children's families, or other important people living close by (to provide mutual assistance and informal care, for example) | <input type="checkbox"/> | <input type="checkbox"/> |
| overall health and functioning   | <input type="checkbox"/> | <input type="checkbox"/> |
| financial issues   | <input type="checkbox"/> | <input type="checkbox"/> |
| services within an easy distance   | <input type="checkbox"/> | <input type="checkbox"/> |
| safety (e.g. a nursing home with personnel)  | <input type="checkbox"/> | <input type="checkbox"/> |
| accessibility or convenience   | <input type="checkbox"/> | <input type="checkbox"/> |
| need for company, alleviation of loneliness, leisure time activities, etc.   | <input type="checkbox"/> | <input type="checkbox"/> |
| emotional attachment to the location   | <input type="checkbox"/> | <input type="checkbox"/> |
| new, alternative living arrangements (e.g. retirement commune, multigenerational households)   | <input type="checkbox"/> | <input type="checkbox"/> |



### 8. 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"/> |

### 9. 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"/> |

### 10. 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



**11. Do you have removable dentures?**

- complete dentures (no own teeth nor roots)
- partial dentures and own teeth
- no dentures, I have my own teeth (proceed to question 13)
- no dentures nor teeth (proceed to question 13)

**12. How often do you clean your removable dentures?**

- more often than twice a day
- twice a day
- once a day
- less frequently than every day
- never

**13. Over the past 12 months, have you received help from someone in any of the following? From whom?** You may choose more than one option on each row.

|  | I can manage without help | no, from no one, although I would have needed it | yes, from people living in the same household | yes, from people living in other households (e.g. relatives, friends) | yes, from a municipal or private service provider, non-governmental organization, etc. |
|--|---------------------------|--|---|---|--|
| activities of daily living (getting dressed, bathing, taking your medicines, etc.)                             | <input type="checkbox"/>  | <input type="checkbox"/>                         | <input type="checkbox"/>                      | <input type="checkbox"/>  | <input type="checkbox"/>   |
| housework and gardening (cooking, cleaning, snow removal, etc.)  | <input type="checkbox"/>  | <input type="checkbox"/>                         | <input type="checkbox"/>                      | <input type="checkbox"/>  | <input type="checkbox"/>   |
| health-related errands (visits to the health centre, outpatient clinic, or pharmacy)                           | <input type="checkbox"/>  | <input type="checkbox"/>                         | <input type="checkbox"/>                      | <input type="checkbox"/>  | <input type="checkbox"/>   |
| shopping, banking or similar   | <input type="checkbox"/>  | <input type="checkbox"/>                         | <input type="checkbox"/>                      | <input type="checkbox"/>  | <input type="checkbox"/>   |
| maintaining social relationships   | <input type="checkbox"/>  | <input type="checkbox"/>                         | <input type="checkbox"/>                      | <input type="checkbox"/>  | <input type="checkbox"/>   |
| arranging for services and benefits (e.g. applying for care allowance and other benefits, living arrangements) | <input type="checkbox"/>  | <input type="checkbox"/>                         | <input type="checkbox"/>                      | <input type="checkbox"/>  | <input type="checkbox"/>   |
| financial support  | <input type="checkbox"/>  | <input type="checkbox"/>                         | <input type="checkbox"/>                      | <input type="checkbox"/>  | <input type="checkbox"/>   |
| using electronic equipment (e.g. computer, mobile phone, household devices)                                    | <input type="checkbox"/>  | <input type="checkbox"/>                         | <input type="checkbox"/>                      | <input type="checkbox"/>  | <input type="checkbox"/>   |

**14. How often do you receive help in the activities listed in the previous question?**

|   | never                    | less often than once a month | 1–3 times a month        | 1–3 times a week         | daily or almost daily    | several times a day      |
|---|--------------------------|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| from people living in the same household  | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| from people living in another household (e.g. relative or friend)                 | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| from municipal or private service providers, non-governmental organizations, etc. | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**15. 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"/>                        |
| support for informal care (benefit/service)        | <input type="checkbox"/> | <input type="checkbox"/>                               | <input type="checkbox"/>                            | <input type="checkbox"/>                        |
| support in getting or using assistive devices      | <input type="checkbox"/> | <input type="checkbox"/>                               | <input type="checkbox"/>                            | <input type="checkbox"/>                        |
| services for the disabled                          | <input type="checkbox"/> | <input type="checkbox"/>                               | <input type="checkbox"/>                            | <input type="checkbox"/>                        |
| transport services                                 | <input type="checkbox"/> | <input type="checkbox"/>                               | <input type="checkbox"/>                            | <input type="checkbox"/>                        |
| evaluation of needs for services                   | <input type="checkbox"/> | <input type="checkbox"/>                               | <input type="checkbox"/>                            | <input type="checkbox"/>                        |

**THANK YOU FOR YOUR ANSWERS!**