# Longevity Core Questionnaire - Version 2024/10

## Part 1: General information

1. Full Name

2. Date of Birth (YYYY/MM/DD)

3. What **city and country** is currently your main residence?

   _____ [City]
   _____ [Country]

4. Biological sex at birth:
   [ ] F
   [ ] M

5. Current weight
   _____ [ ] kg OR [ ] pounds

6. Height
   _____ [ ] m OR [ ] feet.inches

7. Cigarette smoking?
   [ ] never smoker
   [ ] past smoker
   [ ] current smoker
      a. If current, how many cigarettes per day (not including e-cigarettes)?
         _____/per day

8. Is your biological mother still living?
   [ ] yes
   [ ] no
      a. If not, at what age did she die?
         _____ years old

9. Is your biological father still living?
   [ ] yes
   [ ] no
      a. If not, at what age did he die?
         _____ years old

10. How old do you feel?
    _____ years

**Part 2: Health status**

1. Over the past month, how often have you felt stressed or unable to cope with the demands of your life?
   [ ] Never
   [ ] Rarely
   [ ] Sometimes
   [ ] Often
   [ ] Always

2. Has a doctor told you that you have any of the following? (leave blank if not)If yes, please provide details and any medication related to these diseases.

| **Condition** | If Yes, **year** of diagnosis | If yes, please provide **prescribed medication** for this condition |
|---|---|---|
| ***Diabetes*** | | |
| Type 1 Diabetes | | |
| Type 2 Diabetes | | |
| Gestational Diabetes | | |
| Pre-Diabetes | | |
| ***Cardiovascular (heart disease or conditions)*** | | |
| Hypertension (high blood pressure) | | |
| Myocardial infarction | | |
| Angina pectoris | | |
| Congestive heart failure | | |
| Atrial fibrillation | | |
| ***Respiratory or lung disease or conditions*** | | |
| Chronic bronchitis | | |
| Emphysema | | |
| ***Neurological disorders or conditions*** | | |
| Stroke | | |
| Neurodegenerative disease (e.g., Alzheimer's, Parkinson disease) | | |
| ***Other*** | | |
| Malignant cancers | | |

| | | |
|---|---|---|
| Gastrointestinal or digestive system disease or conditions (e.g., Crohn's disease, inflammatory bowel disease, etc.) | | |
| Medical conditions or disease of the genitourinary system (i.e., conditions involving reproductive organs or the kidneys or bladder) | | |
| Anemia | | |
| Psychiatric illness | | |
| Endocrine disease (disease involving glands that secrete hormones) *OTHER* than diabetes (i.e., hypothyroidism or hyperthyroidism, disease of the pancreas, etc.) | | |
| Muscular or skeletal disorders or conditions | | |
| Allergy or immune system disease or conditions | | |
| Chronic infections (e.g., persistent infections, including hepatitis, long Covid) | | |
| **Any other medical conditions not covered above?** | | |

**Part 3: Physical activity**

1. During the **last 7 days**, on how many days did you do **moderate** or **vigorous** physical activities (excluding walking) for more than 10 minutes at a time?
   ___ days

2. How **much time** did you usually spend doing **moderate** or **vigorous** physical activities on one of those days?
   ___ hours per day
   ___ minutes per day
   [ ] Don't know/not sure

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

4. How **much time** did you usually spend walking on one of those days?
   ___ hours per day
   ___ minutes per day

[ ] Don't know/not sure

5. How representative is your activity level over the last 7 days compared to your:
    a. Activity level over the last 30 days:
        [ ] similar
        [ ] different
        If activity has changed, please specify why and how:

    b. Activity level over the last 3 months:
        [ ] similar
        [ ] different
        If activity has changed, please specify why and how:

**Part 4: Sleep**

1. On average, over a 24-hour period, do you sleep:
    [ ] <5 hours,
    [ ] 5 hours
    [ ] 6 hours
    [ ] 7 hours
    [ ] 8 hours
    [ ] 9 hours
    [ ] 10+ hours

2. Overall, was your typical night's sleep during the past 4 weeks:
    [ ] Very sound or restful
    [ ] Sound or restful
    [ ] Average quality
    [ ] restless
    [ ] very restless

**Part 5: Dietary habits**

1. Are you following any of these diets? (Mark all or any that apply)

| | If Yes, **for how many years?** |
|---|---|
| Low carb | |
| Keton | |
| Vegan | |
| Vegetarian | |
| Gluten free | |
| Mediterranean | |
| Intermittent fasting | |
| DASH | |

| | |
|---|---|
| Low sodium | |
| Other | |

If other, please provide details:

2. How often do you consume these food items?

| | Frequently (daily) | Occasionally (Once or several times a week) | Rarely or never (L than once a week) |
|---|---|---|---|
| Fruit (including fruit juice) | | | |
| Vegetables | | | |
| Bread, potatoes, pasta, or rice | | | |
| Beans and pulses, and other high-fiber food (e.g., broccoli, chia seeds) | | | |
| Red meat | | | |
| White meat and fish | | | |
| Cheese, dairy and eggs | | | |
| Fermented foods (including kimchi, sauerkraut, yogurt, kombucha, etc.) | | | |
| Sweets, cakes, biscuits, and chocolate | | | |
| Savory snacks (Crisps) | | | |
| Alcohol | | | |

**Part 6: Interventions**

1. Do you currently take any medication(s)?
   [ ] no
   [ ] yes

   If yes, please list each medication, dose, and frequency, and since what year you are taking it:

2. Do you currently take any supplements?
   [ ] no
   [ ] yes
   If yes, please list medication, dose, and frequency, and since what year you are taking it: