

ELIGIBILITY QUESTIONNAIRE

(STAGE 1)

Instructions

The inclusion questionnaire will be designed using Qualtrics, which is an online survey system offered by Imperial College London. The inclusion questionnaire will be completed online by the participants and will be available to the participants via the website.

*If participants answer **Yes** to Questions 1.1 and 1.2, if they are between 18 and 23 years of age and if they consider themselves as White or South Asian ethnicity (i.e. English/Welsh/Scottish/Northern Irish/British, Irish, Gypsy or Irish Traveller, Any other White background, White and Asian, Indian, Pakistani, Bangladeshi, Any other Asian background) and answer **Yes** to Question 1.5 then they are eligible to participate in the study and the safety questions will be asked (Questions 2.1 to 2.7). If participants are eligible and it is safe for them to participate then the contact details (Questions 3.1 to 3.5) will be asked. Eligible participants will be informed that they will be contacted by email or phone to book a study visit.*

No safety questions will be asked or contact details will be collected from the participants if they are not eligible to participate. The obtained information would not allow us to track the non-eligible participant and the answers to the questions do not contain any sensitive information.

1. Demographic information

1.1. Are you a student at Imperial College London?

Yes
No

1.2. Are you born in the United Kingdom (England, Scotland, Wales, Northern Ireland)?

Yes
No

1.3. What is your age range?

<18yrs
18-23
24-27
>27yrs

1.4. To which of the ethnic group do you consider that you belong?

(Choose one option that best describes your ethnic group or background)

White

English / Welsh / Scottish / Northern Irish / British
Irish
Gypsy or Irish Traveller
Any other White background, please describe:

Mixed / Multiple ethnic groups

White and Black Caribbean
White and Black African
White and Asian
Any other Mixed / Multiple ethnic background, please describe:

Asian / Asian British

Indian
Pakistani
Bangladeshi
Chinese
Any other Asian background, please describe:

Black / African / Caribbean / Black British

Caribbean
African
Any other Black / African / Caribbean background, please describe:

Other ethnic group

Arab
Any other ethnic group, please describe:

1.5. Were at least three of your grandparents born in United Kingdom, Western-Europe, South-Asia (Pakistan, India, Nepal, Bangladesh, Bhutan, Sri Lanka) or East-Africa (Kenya, Tanzania, Uganda)?

Yes
No

2. Safety Questions

2.1. In the past three months have you had any surgery on your chest or abdomen?

Yes
No

2.2. Have you had a heart attack within the past three months?

Yes
No

2.3. Do you have a detached retina or have you had eye surgery within the past three months?

Yes
No

2.4. Have you been hospitalized for any other heart problem within the past month?

Yes
No

2.5. Are you in the last trimester of pregnancy?

Yes
No

2.6. Are you currently taking medication for tuberculosis?

Yes
No

2.7. Have you had a pneumothorax within the past three months?

Yes
No

3. Contact details

3.1. What is your Surname? _____

3.2. What is your Name? _____

3.3. What is your date of birth?

_____/_____/_____
d d / m m / y y y y

3.4. What is your Phone number? _____

3.5. What is your Imperial College London email address? _____

3.6. When would it suit you to have the study visit?

	Morning (8-11am)	Lunch time (11am-2pm)	Afternoon (2-5pm)
Monday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wednesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thursday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ID _____

Date: _____ / _____ / _____
 d d m m y y y y

ELIGIBILITY QUESTIONNAIRE (STAGE 2)

Instructions

*The Eligibility questionnaire (stage 2) contains questions which are necessary to assess whether it is safe for the participant to perform spirometry. If any of the Questions 1.1 through 1.9 is **Yes** then it is not safe for the participant to perform the lung function testing. Therefore, the participant will be excluded from the study.*

Safety Questions

1. I just want to check the safety questions that you answered when you volunteered and check that nothing has changed.

1.1. Have you had any surgery on your chest or abdomen?

Yes
No

1.2. Have you had a heart attack within the past three months?

Yes
No

1.3. Do you have a detached retina or have you had eye surgery within the past three months?

Yes
No

1.4. Have you been hospitalized for any other heart problem within the past month?

Yes
No

1.5. Are you in the last trimester of pregnancy?

Yes
No

1.6. Does the participant have a resting pulse of greater than 120 beats per minute?

Yes
No

1.7. Are you currently taking medication for tuberculosis?

Yes
No

1.8. Have you had a pneumothorax within the past three months?

Yes
No

1.9. *Is there some other reason why this participant should not perform the spirometry maneuver?*
If **yes**, record reason.

Yes
No

If the answer to any of Questions 1.2. through 1.9. is "Yes", then the participant will be excluded from the study.

2. Researcher ID _____

ID _____

Date: _____ / _____ / _____
 d d m m y y y y

MEASUREMENT QUESTIONNAIRE

Instructions

The Measurements questionnaire contains questions related to respiratory disease and/or symptoms and will record the results of the anthropometric and cardiovascular measurement and lung function testing.

1. Demography

1.1. What is the participant's sex?

Male
Female

2. Respiratory infection

2.1 Have you had a respiratory infection (cold) in the last three weeks?

Yes
No

3. Medications for breathing

3.1. Have you taken any medications for breathing in the last 24 hours?

Yes
No

If yes, record name/type of medication(s) used.

If Question 3.1 is yes and the medication used includes any of the types below, go to question 3.2. If no, go to question 4

TYPE OF MEDICATION	EXAMPLES	
Short-acting beta-2 agonist	albuterol, salbutamol	6 hours prior to clinic visit
Anticholinergic inhaler	Atrovent, ipratropium	6 hours prior to clinic visit
Long-acting beta-2 agonist (including combination preparations that contain a LABA)	Serevent, Advair, formoterol, Symbicort	12 hours prior to clinic visit
Oral beta-2 agonist	Albuterol	12 hours prior to clinic visit
Oral theophylline	Theodur	12-24 hours prior to clinic visit, depending upon preparation
Long-acting anticholinergic	Spiriva, tiotropium	24 hours prior to clinic visit

3.2. Did you use a short acting beta agonist or anticholinergic inhaler, either alone or in combination with some other product, in the last six hours?

Yes
No

3.3 Did you use a long acting beta agonist or oral beta 2 agonist, either alone or in combination with some other product, in the last 12 hours?

Yes
No

3.4. Did you use an oral theophyllin/ long acting anticholinergic, either alone or in combination with some other product, in the last 24 hours?

Yes
No

4. Smoking

4.1. When did you last smoke?

i) _____ hrs ago
ii) _____ days ago

Enter 999 if non smoker or ex smoker (has not smoked in the last month)

ID _____

Date: _____ / _____ / _____
 d d m m y y y y

5. Cardiovascular measurements

5.1.A. Pulse	_____ bpm
5.1.B. Pulse	_____ bpm
5.1.C. Pulse	_____ bpm
5.2.A. Blood pressure (Syst/Dia)	_____/____ mm Hg
5.2.B. Blood pressure (Syst/Dia)	_____/____ mm Hg
5.2.C. Blood pressure (Syst/Dia)	_____/____ mm Hg

6. Anthropometric measurements

6.1. Height	_____ cm
6.2. Weight	_____._____ kg
6.3.A Long bone length (ulna)	_____ cm
6.3.B Long bone length (ulna)	_____ cm
6.4.A Long bone length (demispan)	_____ cm
6.4.B Long bone length (demispan)	_____ cm

7. Measurements Compliance – Prebronchodilator Spirometry

7.1. Acceptable pre-bronchodilator test completed?	Yes <input type="checkbox"/>
	No <input type="checkbox"/>
7.2. Unable to obtain satisfactory spirometry (check one)?	
The participant did not understand the instructions	<input type="checkbox"/>
The participant was unable to physically cooperate	<input type="checkbox"/>
refused	<input type="checkbox"/>
not applicable	<input type="checkbox"/>
7.3. Were any adverse events related to the spirometry maneuver observed by the evaluator?	Yes <input type="checkbox"/>
	No <input type="checkbox"/>
If yes, please describe the event	

ID _____

Date: _____ / _____ / _____
 d d m m y y y y

7.4. If the participant had a condition that would affect the result of their spirometry test (e.g., kyphosis, missing limbs, etc) note that condition here

8. Measurement Compliance - Bronchodilator

8.1. Bronchodilator administered?

Yes

No

9. Measurements Compliance – Postbronchodilator Spirometry

9.1. Acceptable post-bronchodilator test completed?

Yes

No

9.2. Unable to obtain satisfactory spirometry (check one)?

The participant did not understand the instructions

The participant was unable to physically cooperate

refused

not applicable

9.3. Were any adverse events related to the spirometry maneuver observed by the evaluator?

Yes

No

If yes, please describe the event

9.4. If the participant had a condition that would affect the result of their spirometry test (e.g., kyphosis, missing limbs, etc) note that condition here

10. Cardiovascular measurements before completing study visit

10.1.A. Pulse _____ bpm

10.1.B. Pulse _____ bpm

10.2.A. Blood pressure (Syst/Dia) _____ / _____ mm Hg

10.2.B. Blood pressure (Syst/Dia) _____ / _____ mm Hg

11. Researcher ID

ID _____

Date: _____ / _____ / _____
 d d m m y y y y

CORE QUESTIONNAIRE

PART A – Respiratory Symptoms, disorders and comorbidities

These questions pertain mainly to your chest. Please answer yes or no if possible. If you are in doubt about whether your answer is yes or no, please answer no.

Cough

1. Do you usually cough when you don't have a cold? Yes
[If **yes**, continue with Question 1A; If **no**, skip to Question 2] No

1A. Are there months in which you cough on most days? Yes
[If **yes**, ask both Questions 1B & 1C; If **no**, skip to Question 1] No

1B. Do you cough on most days for as much as three months each year? Yes
No

1C. For how many years have you had this cough? Less than 2 years
2-5 years
More than 5 years

Phlegm

2. Do you usually bring up phlegm from your chest, or do you usually have phlegm in your chest that is difficult to bring up when you don't have a cold? Yes
No
[If **yes**, continue with Question 2A; If **no**, skip to Question 3]

2A. Are there months in which you have this phlegm on most days? Yes
[If **yes**, ask both Questions 2B & 2C; If **no**, skip to Question 3] No

2B. Do you bring up this phlegm on most days for as much as three months each year? Yes
No

2C. For how many years have you had this phlegm? Less than 2 years
2-5 years
More than 5 years

Wheezing/Whistling

3. Have you had wheezing or whistling in your chest at any time in the last 12 months? Yes
No
[If **yes**, ask both Questions 3A & 3B; If **no**, skip to Question 4]

3A. In the last 12 months, have you had this wheezing or whistling only when you have a cold? Yes
No

3B. In the last 12 months, have you ever had an attack of wheezing or whistling that has made you feel short of breath? Yes
No

ID _____
Date: _____ / _____ / _____
 d d m m y y y y

Breathlessness

4. Are you unable to walk due to a condition other than shortness of breath? Yes
[If **yes** to Question 4, please describe this condition on the line below No
and then skip to Question 5. If **no** or unsure, go directly to Question 20.]

Nature of condition(s): _____

5. Are you troubled by shortness of breath when hurrying on the Yes
level or walking up a slight hill? No
[If **yes**, ask Question 5A through 5D; If **no**, skip to Question 6]

5A. Do you have to walk slower than people of your age on Yes
level ground because of shortness of breath? No
Does not apply

5B. Do you ever have to stop for breath when walking at Yes
your own pace on level ground? No
Does not apply

5C. Do you ever have to stop for breath after walking Yes
about 100 yards (or after a few minutes) on level ground? No
Does not apply

5D. Are you too short of breath to leave the house or Yes
short of breath on dressing or undressing? No
Does not apply

Diagnosed lung disease

6. Has a doctor or other health care provider ever told you that Yes
you have asthma, asthmatic bronchitis or allergic bronchitis? No
[If **yes**, ask Question 6A. If **no**, skip to Question 7]

6A. Do you still have asthma, asthmatic bronchitis or allergic bronchitis? Yes
No

7. Has a doctor or other health care provider ever told you that Yes
you have chronic bronchitis? No
[If **yes**, ask Question 7A. If **no**, skip to Question 8]

7A. Do you still have chronic bronchitis? Yes
No

Exacerbations

8. Have you ever had a period when you had breathing problems that got so Yes
bad that they interfered with your usual daily activities or caused you No
to miss work? [If **yes**, ask Question 8A. If **no**, skip to Question 9]

8A. How many such episodes have you had in the past 12 months? _____ episodes
[If 25A > 0, ask Questions 8B and 8C, else skip to Question 9]

8B. For how many of these episodes did you need to see a doctor or other health care provider in the _____ episodes
past 12 months?

ID _____
Date: _____/_____/_____
 d d m m y y y y

8C. For how many of these episodes were you hospitalized overnight in the past 12 months?
[If 8C > 0, ask Question 8C1, else skip to Question 9] _____ episodes

8C1. All together, for how many total days were you hospitalized overnight for breathing problems in
the past 12 months? _____ days

Comorbidities

9. Has a doctor or other health care provide ever told you that you had:

	Yes	No
A. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
B. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
C. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

[If yes to 9C, then ask 9C1; otherwise, skip to Question 10]

9C1. Are you currently taking medicine for tuberculosis? Yes
[If no to 9C1, then ask 9C2; otherwise, skip to Question 10] No

9C2. Have you ever taken medicine for tuberculosis? Yes
No

10. Have you ever had an operation on your chest in which a part of your lung was removed?
Yes
No

11. Were you hospitalized as a child for breathing problems prior to the age of 10?
Yes
No
Don't Know

12. Has a doctor or other health care professional told your father, mother, sister or brother that they had a diagnosis of emphysema, chronic bronchitis or COPD?
Yes
No

PART B - Quality of life

13. In general, would you say your health is: (*Check one*)

- Excellent
- Very good
- Good
- Fair
- Poor

14. The following questions are about activities you might do during a typical day. Does ***your health now limit*** you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	Not limited at all
14a. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14b. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. **During the past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all the time
15a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15b. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. **During the past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all the time
16a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16b. Didn't do work or other activities as carefully as usually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. **During the past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- Not at all
- Slightly
- Moderately
- Quite a bit
- Extremely

ID _____

Date: _____ / _____ / _____
d d m m y y y y

18. These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. 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 of the time	None of the time
18a. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18b. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18c. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. **During the past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- All the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

20. Now we'd like to ask you some questions about how your health may have changed. Compared to one year ago,

	Much better	Slightly better	About the same	Slightly worse	Much worse
20a. How would you rate your physical health in general now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20b. How would you rate your emotional problems (such as feeling anxious, depressed or irritable) now ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ID _____

Date: _____/_____/_____
 d d m m y y y y

PART C - Management Section

Now I am going to ask you about medicines that you may be taking to help with your breathing. I want to know about medicines that you take on a regular basis and medicines that you may take only for the relief of symptoms. I would like you to tell me each medicine that you take, what form do you take it in, and how often you take it each month.

21. In the past 12 months, have you taken any medications for your breathing (including medications for nasal congestion)? Yes
 If participant does not take any medications to help their breathing, skip to Question 27. No

21.A. Medication Name (not entered)				
21.B. Medication Code				
21.C. Formulation	Pills <input type="checkbox"/>	Pills <input type="checkbox"/>	Pills <input type="checkbox"/>	Pills <input type="checkbox"/>
	Inhaler <input type="checkbox"/>	Inhaler <input type="checkbox"/>	Inhaler <input type="checkbox"/>	Inhaler <input type="checkbox"/>
	Nebulizer <input type="checkbox"/>	Nebulizer <input type="checkbox"/>	Nebulizer <input type="checkbox"/>	Nebulizer <input type="checkbox"/>
	Liquid <input type="checkbox"/>	Liquid <input type="checkbox"/>	Liquid <input type="checkbox"/>	Liquid <input type="checkbox"/>
	Suppository <input type="checkbox"/>	Suppository <input type="checkbox"/>	Suppository <input type="checkbox"/>	Suppository <input type="checkbox"/>
	Injection <input type="checkbox"/>	Injection <input type="checkbox"/>	Injection <input type="checkbox"/>	Injection <input type="checkbox"/>
	Other <input type="checkbox"/>	Other <input type="checkbox"/>	Other <input type="checkbox"/>	Other <input type="checkbox"/>
21.D. Is the medicine taken on most days or just when you have symptoms or both? (If 'most days' ask Q26E if both ask 'both' 26E and Q26F)	Most days <input type="checkbox"/>	Most days <input type="checkbox"/>	Most days <input type="checkbox"/>	Most days <input type="checkbox"/>
	Symptoms <input type="checkbox"/>	Symptoms <input type="checkbox"/>	Symptoms <input type="checkbox"/>	Symptoms <input type="checkbox"/>
	Both <input type="checkbox"/>	Both <input type="checkbox"/>	Both <input type="checkbox"/>	Both <input type="checkbox"/>
	Other <input type="checkbox"/>	Other <input type="checkbox"/>	Other <input type="checkbox"/>	Other <input type="checkbox"/>
21.E. When you are taking the medication how many days a week do you take it?	__ days/week	__ days/week	__ days/week	__ days/week
21.F. When you are taking the medication, how many months in the past 12 months have you taken it?	0-3 <input type="checkbox"/>	0-3 <input type="checkbox"/>	0-3 <input type="checkbox"/>	0-3 <input type="checkbox"/>
	4-6 <input type="checkbox"/>	4-6 <input type="checkbox"/>	4-6 <input type="checkbox"/>	4-6 <input type="checkbox"/>
	7-9 <input type="checkbox"/>	7-9 <input type="checkbox"/>	7-9 <input type="checkbox"/>	7-9 <input type="checkbox"/>
	10-12 <input type="checkbox"/>	10-12 <input type="checkbox"/>	10-12 <input type="checkbox"/>	10-12 <input type="checkbox"/>

22. Please tell me about any other products that you take or things you do to help your breathing that you have not already told me about.

Medicine or Activity	Code

ID _____
Date: _____/_____/_____
 d d m m y y y y

PART D - Smoking

Now I am going to ask you about smoking. First I will ask about cigarettes, including hand rolled cigarettes, and then I will ask about other items that are smoked.

23.1. Have you <u>ever</u> smoked cigarettes ?	Yes <input type="checkbox"/>
	No <input type="checkbox"/>
<i>("Yes," means more than 20 packs of cigarettes in a lifetime or more than 1 cigarette each day for a year) [if yes, ask questions 23.2 through 23.5; otherwise, skip to Question 24.1]</i>	
23.2. How old were you when you first started regular cigarette smoking?	_____ years old
23.3. <u>If you have stopped smoking</u> , how old were you when you last stopped? <i>(If the participant has not stopped smoking, record as code '999'.)</i>	_____ years old
23.4. On average over the entire time that you smoke(d), about how many cigarettes per day/per week do (did) you smoke? i) _____ cigarettes/day ii) _____ cigarettes/week	
23.5. On average over the entire time that you smoke(d), do (did) you primarily smoke manufactured or hand-rolled cigarettes?	Manufactured <input type="checkbox"/> Hand-rolled <input type="checkbox"/>

24.1. Have you <u>ever</u> smoked a water pipe ?	Yes <input type="checkbox"/>
	No <input type="checkbox"/>
<i>("Yes," means more than 1 water pipe per week for one year at any time in your life) [if yes, ask questions 24.2 through 24.4; otherwise, skip to Question 25.1]</i>	
24.2. How old were you when you first started regular water pipe smoking?	_____ years old
24.3. <u>If you have stopped smoking</u> , how old were you when you last stopped? <i>(If the participant has not stopped smoking, record as code '999'.)</i>	_____ years old
24.4. On average over the entire time that you smoke(d), about how many water pipe per day/per week do (did) you smoke? i) _____ water pipes /day ii) _____ water pipes /week	

Second hand smoke exposure

25.1. Not counting yourself, how many people in your household smoke regularly?	_____
25.2. Do people smoke regularly in the room where you work?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't work <input type="checkbox"/>
25.3. How many hours per day, are you exposed to other people's tobacco smoke in the following locations?	
25.3.1. At home	_____ hours
25.3.2. In workplace	_____ hours
25.3.3. Bars, restaurants, cinemas or similar social settings	_____ hours
25.3.4. Elsewhere	_____ hours

ID _____

Date: _____ / _____ / _____

d d m m y y y y

PART E – Family history

Family Composition

26. How many siblings do you have? _____
If the answer to Question 26 is >0 then ask Question 27 to 28, otherwise skip to Question 29.1.

27. How many older siblings do you have? _____

28. How many older brothers do you have? _____

Family history – Education

29.1 What is the highest level of schooling your mother has completed?

Primary School

Middle School

High School

Some College (Trade/Professional/Community)

Four Year College/University

None

Unknown

29.2 What is the highest level of schooling your maternal grandmother has completed?

Primary School

Middle School

High School

Some College (Trade/Professional/Community)

Four Year College/University

None

Unknown

29.3 What is the highest level of schooling your maternal grandfather has completed?

Primary School

Middle School

High School

Some College (Trade/Professional/Community)

Four Year College/University

None

Unknown

29.4 What is the highest level of schooling your father has completed?

Primary School

Middle School

High School

Some College (Trade/Professional/Community)

Four Year College/University

None

Unknown

29.5 What is the highest level of schooling your paternal grandmother has completed?

Primary School

Middle School

High School

Some College (Trade/Professional/Community)

Four Year College/University

None

Unknown

ID _____
 Date: _____/_____/_____
 d d m m y y y y

29.6 What is the highest level of schooling your paternal grandfather has completed?

Primary School
 Middle School
 High School
 Some College (Trade/Professional/Community)
 Four Year College/University
 None
 Unknown

Family history – Occupation

30.1. What has been your father's usual occupation or job? _____
If the he has never worked then enter "never worked" and go to question 31.1

30.2. What does/did he actually do in his work (describe) _____

30.3. What industry does he work in? _____
If father unemployed put 999

30.4. For how many years has your father worked at this job? _____ years

30.5. Is your father:

A manager working for an employer?
 A foreman or supervisor working for an employer?
 Working for an employer, but neither a manager, supervisor or foreman?
 Self-employed?

30.6. Enter ISCO code here: _____

31.1. What has been your paternal grandfather's usual occupation or job? _____
If the he has never worked then enter "never worked" and go to question 32.1

31.2. What does/did he actually do in his work (describe) _____

31.3. What industry did he work in? _____
If grandfather unemployed put 999

31.4. For how many years has your paternal grandfather worked at this job? _____ years

31.5. Has your paternal grandfather been a farmer?
If yes go to Question 31.6., otherwise skip to Question 31.7. Yes
 No

31.6. Has your paternal grandfather been:
If Question 31.6. is being completed then skip to 32.1.

An owner, but didn't work on the farm
 An owner, but worked on the farm
 A tenant, worked on the farmer but didn't own the farm
 Employed on the farm but not a tenant or owner

ID _____
Date: _____/_____/_____
 d d m m y y y y

31.7. Was your paternal grandfather:
A manager working for an employer?
A foreman or supervisor working for an employer?
Working for an employer, but neither a manager, supervisor or foreman?
Self-employed?

31.8. Enter ISCO code here: _____

32.1. Did your paternal grandmother work outside the home? Yes
No
If Question 32.1 is Yes then go to Question 32.2 to 32.9, otherwise skip to Question 33.1

32.2. What was your paternal grandmother's usual occupation or job? _____

32.3. What does/did she actually do in her work (describe) _____

32.4. What industry did she work in? _____
If grandmother unemployed put 999

32.5. For how many years has your paternal grandmother worked at this job? _____
years

32.6. Has your paternal grandmother been a farmer? Yes
If yes go to 32.7. else skip to 32.8. No

32.7. Has your paternal grandmother been:
If Question 32.7. is being completed then skip to 33.1.
An owner, but didn't work on the farm
An owner, but worked on the farm
A tenant, worked on the farmer but didn't own the farm
Employed on the farm but not a tenant or owner

32.8. Was your paternal grandmother:
A manager working for an employer?
A foreman or supervisor working for an employer?
Working for an employer, but neither a manager, supervisor or foreman?
Self-employed?

32.9. Enter ISCO code here: _____

33.1. Has or does your mother work outside the home? Yes
If Question 33.1. is Yes then go to Question 33.2 to 33.7, No
otherwise skip to Question 34.1

33.2. What has been your mother's usual occupation or job? _____

33.3. What does/did she actually do in her work (describe) _____

33.4. What industry does she work in? _____
If mother unemployed put 999

ID _____
Date: _____/_____/_____
 d d m m y y y y

33.5. For how many years has your mother worked at this job? _____ years

33.6. Is your mother:

A manager working for an employer?

A foreman or supervisor working for an employer?

Working for an employer, but neither a manager, supervisor or foreman?

Self-employed?

33.7. Enter ISCO code here: _____

34.1. What has been your maternal grandfather's usual occupation or job? _____
If the he has never worked then enter "never worked" and go to question 35.1

34.2. What does/did he actually do in his work (describe) _____

34.3. What industry did he work in? _____
If grandfather unemployed put 999

34.4. For how many years has your maternal grandfather worked at this job? _____ years

34.5. Has your maternal grandfather been a farmer?
If yes go to Question 34.6., otherwise skip to Question 34.7. Yes
No

34.6. Has your maternal grandfather been:
If Question 34.6. is being completed then skip to 35.1

An owner, but didn't work on the farm

An owner, but worked on the farm

A tenant, worked on the farmer but didn't own the farm

Employed on the farm but not a tenant or owner

34.7. Was your maternal grandfather:

A manager working for an employer?

A foreman or supervisor working for an employer?

Working for an employer, but neither a manager, supervisor or foreman?

Self-employed?

34.8. Enter ISCO code here: _____

35.1. Did your maternal grandmother work outside the home?
Yes
No
If Question 35.1 is Yes then go to Question 35.2 to 35.9, otherwise skip to Question 36.1

35.2. What was your maternal grandmother's usual occupation or job? _____

35.3. What does/did she actually do in her work (describe) _____

35.4. What industry did she work in? _____
If grandmother unemployed put 999

35.5. For how many years has your maternal grandmother worked at this job? _____ years

ID _____

Date: _____/_____/_____

d d m m y y y y

35.6. Has your maternal grandmother been a farmer?
If yes go to 35.6. else skip to 35.8. Yes
No

35.7. Has your maternal grandmother been:
If Question 35.7. is being completed then skip to 36.1.

An owner, but didn't work on the farm

An owner, but worked on the farm

A tenant, worked on the farmer but didn't own the farm

Employed on the farm but not a tenant or owner

35.8. Was your maternal grandmother:

A manager working for an employer?

A foreman or supervisor working for an employer?

Working for an employer, but neither a manager, supervisor or foreman?

Self-employed?

35.9. Enter ISCO code here: _____

Family history – Place of birth

36.1. Where was your mother born? City/region: _____
Country: _____

36.2. Where was your maternal grandmother born? City/region: _____
Country: _____

36.3. Where was your maternal grandfather born? City/region: _____
Country: _____

36.4. Where was your father born? City/region: _____
Country: _____

36.5. Where was your paternal grandmother born? City/region: _____
Country: _____

36.6. Where was your paternal grandfather born? City/region: _____
Country: _____

Family history – Place of childhood

37.1. What term best describes the place your mother lived most of the time during her childhood?

Farm

Village in rural area

Small town

Suburb or a city

Don't know

37.2. What term best describes the place your maternal grandmother lived most of the time during her childhood?

Farm

Village in rural area

Small town

Suburb or a city

Don't know

ID _____
 Date: _____/_____/_____
 d d m m y y y y

37. 3. What term best describes the place your <u>maternal grandfather</u> lived most of the time during his childhood?	Farm	<input type="checkbox"/>
	Village in rural area	<input type="checkbox"/>
	Small town	<input type="checkbox"/>
	Suburb or a city	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
37. 4. What term best describes the place your <u>father</u> lived most of the time during his childhood?	Farm	<input type="checkbox"/>
	Village in rural area	<input type="checkbox"/>
	Small town	<input type="checkbox"/>
	Suburb or a city	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
37. 5. What term best describes the place your <u>paternal grandmother</u> lived most of the time during her childhood?	Farm	<input type="checkbox"/>
	Village in rural area	<input type="checkbox"/>
	Small town	<input type="checkbox"/>
	Suburb or a city	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
37. 6. What term best describes the place your <u>paternal grandfather</u> lived most of the time during his childhood?	Farm	<input type="checkbox"/>
	Village in rural area	<input type="checkbox"/>
	Small town	<input type="checkbox"/>
	Suburb or a city	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>

Family history – Smoking

38.1. Did your <u>mother</u> smoke regularly before your pregnancy?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
38.2. Did your <u>father</u> smoke regularly before your pregnancy?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
38.3. Did your <u>mother</u> smoke regularly during your pregnancy?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
38.4. Did your <u>father</u> smoke regularly during your pregnancy?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
38.5. Did your <u>mother</u> smoke regularly during your childhood?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>

ID _____
Date: ____ / ____ / ____
 d d m m y y y y

38.6. Did your <u>father</u> smoke regularly during your childhood?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
38.7. Does your <u>mother</u> smoke regularly nowadays?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>
38.8. Does your <u>father</u> smoke regularly nowadays?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>

PART F - Birth linkage, GP and withdrawal details

Birth linkage

This section will only be completed if the participant consents to accessing birth weight information (See consent form).

39. Is your birth name different from your current name?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
<i>If the answer to Questions 39 is "Yes", then proceed with Questions 39.1 and 39.2. If the answer to Question 39 is No then skip to Question 40.</i>		
39.1. What was your Birth Surname?	_____	
39.2. What was your Birth Name?	_____	
40. What is your NHS number?	____ / ____ / _____	

General practice contact details

This section will only be completed if the participant consents to sending the results of the lung function testing to their GP (See consent form).

41.1. What is the name of your GP practice?	_____
41.2. What is the contact address of your GP practice?	_____

Withdrawal

42. Define the circumstance under which the participant withdrew if the participant withdrew	_____

53. Researcher ID _____