

Health survey

Personal Invitation

Don't write here

5.3 (Municipality)

(County)

(Country)

↓

9.3 (Business)

9.4 (Occupation)

14.7 (Mark)

1. YOUR OWN HEALTH

1.1 What is your current state of health? (Tick one only)

Poor 1 Not so good 2 Good 3 Very good 4

1.2 Do you have, or have you had?:

	Yes	No	Age first time
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Chronic bronchitis/emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Fibromyalgia/chronic pain syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Psychological problems for which you have sought help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
A heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Angina pectoris (heart cramp)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Cerebral stroke/brain haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>

1.3 Have you noticed attacks of sudden changes in your pulse or heart rhythm in the last year? Yes No

1.4 Do you get pain or discomfort in the chest when: Walking up hills, stairs or walking fast on level ground? Yes No

1.5 If you get such pain, do you usually:

Stop? 1 Slow down? 2 Carry on at the same pace? 3

1.6 If you stop, does the pain disappear within 10 minutes? Yes No

1.7 Can such pain occur even if you are at rest?..... Yes No

2. MUSCULAR AND SKELETAL COMPLAINTS

2.1 Have you suffered from pain and/or stiffness in muscles and joints during the last 4 weeks?

(Give duration only if you have had problems)

	No complaint			Duration	
	Some complaint	Severe complaint	Up to 2 weeks	2 weeks or more	
Neck/shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms, hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper part of your back...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar region	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips, legs, feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 2 3 1 2

2.2 Have you ever had:

	Yes	No	Age last time
Fracture in the wrist/forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Hip fracture?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>

3. OTHER COMPLAINTS

3.1 Below is a list of various problems. Have you experienced any of this during the last week (including today)?

(Tick once for each complaint)

	No complaint	Little complaint	Pretty much	Very much
Sudden fear without reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt afraid or anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faintness or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt tense or upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tend to blame yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed, sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of being useless, worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling that everything is a struggle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of hopelessness with regard to the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 2 3 4

4. USE OF HEALTH SERVICES

4.1 How many times in the last 12 months have you been to/used: (Tick once for each line)

	None	1-3 times	4 or more
General practitioner (GP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical officer at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist or psychiatrist (private or out-patient clinic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other specialist (private or out-patient clinic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency GP (private or public)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital admission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home nursing care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alternative practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. CHILDHOOD/YOUTH AND AFFILIATION

5.1 How long altogether have you lived in the county? year (Put 0 if less than half a year)

5.2 How long altogether have you lived in the municipality? year (Put 0 if less than half a year)

5.3 Where did you live most of the time before the age of 16? (Tick one option and specify)

Same municipality 1

Another municipality in the county 2 Which one: _____

Another county in Norway 3 Which one: _____

Outside Norway 4 Country:: _____

5.4 Have you moved within the last five years?

No 1 Yes, one time 2 Yes, more than once 3

6. BODY WEIGHT

6.1 Estimate your body weight when you were 25 years old: kg

7. FOOD AND BEVERAGES

7.1 How often do you usually eat these foods? (Tick once per line)

	Rarely /never	1-3 times /month	1-3 times /week	4-6 times /week	1-2 times /day	3 times or more /day
Fruit, berries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheese (all types).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boiled vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fresh vegetables/salad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatty fish (e.g. salmon, trout, mackerel, herring)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

7.2 What type of fat do you usually use? (Tick once per line)

	Don't use	Butter	Hard margarine	Soft/light margarine	Oils	Other
On bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

7.3 Do you use the following dietary supplements:

	Yes, daily	Sometimes	No
Cod liver oil, fish oil capsules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins and/or mineral supplements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.4 How much of the following do you usually drink? (Tick once per line)

	Rarely /never	1-6 glasses /week	1 glass /day	2-3 glasses /day	4 glasses or more /day
Full milk, full-fat curdled milk, yoghurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Semi-skimmed milk, semi-skimmed curdled milk, low-fat yoghurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skimmed milk, skimmed curdled milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extra semi-skimmed milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mineral water (e.g. Farris, Ramløsa etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cola-containing soft drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other soda/soft drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

7.5 Do you usually drink soft drink: with sugar 1 without sugar 2

7.6 How many cups of coffee and tea do you drink daily? Number of cups (Put 0 for the types you don't drink daily)

Filtered coffee	<input type="text"/>
Boiled coffee/coarsely ground coffee for brewing	<input type="text"/>
Other type of coffee	<input type="text"/>
Tea	<input type="text"/>

7.7 Approximately how often have you during the last year consumed alcohol? (Do not count low-alcohol and alcohol-free beer)

Never consumed alcohol	Have not consumed alcohol last year	A few times last year	About 1 time a month
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2-3 times per month	About 1 time a week	2-3 times a week	4-7 times a week
<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8

To those who have consumed the last year:

7.8 When you drink alcohol, how many glasses or drinks do you normally drink? number

7.9 Approximately how many times during the last year have you consumed alcohol equivalent to 5 glasses or drinks within 24 hours? Number of times

7.10 When you drink, do you normally drink: (Tick one or more)

Beer	Wine	Spirits
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. SMOKING

8.1 How many hours a day do you normally spend in smoke-filled rooms? Number of total hours

8.2 Did any of the adults smoke at home while you were growing up? Yes No

8.3 Do you currently, or did you previously live together with a daily smoker after your 20th birthday? Yes, now Yes, previously Never

8.4 Do you/did you smoke daily? If NEVER: Go to question 9 : (EDUCATION AND WORK)

8.5 If you smoke daily now, do you smoke: Yes No

Cigarettes?.....

Cigars/cigarillos?.....

A pipe?.....

8.6 If you previously smoked daily, how long is it since you quit? Number of years

8.7 If you currently smoke, or have smoked previously:

How many cigarettes do you or did you normally smoke per day? Number of cigarettes

How old were you when you began daily smoking? Age in years

How many years in all have you smoked daily? Number of years

9. EDUCATION AND WORK

9.1 How many years of education have you completed? Number of years

(Include all the years you have attended school or studied)

9.2 Do you currently have paid work?

Yes, full-time 1 Yes, part-time 2 No 3 T

9.3 Describe the activity at the workplace where you had paid work for the longest period in the last 12 months. (e.g. Accountancy firm, school, paediatric department, carpentry workshop, garage, bank, grocery store, etc.)

Business: _____

If retired, enter the former business and occupation. Also applies to 9.4

9.4 Which occupation/title have or had you at this workplace? (e.g. Secretary, teacher, industrial worker, nurse, carpenter, manager, salesman, driver, etc.)

Occupation: _____

9.5 In your main occupation, do you work as self-employed, as an employee or family member without regular salary?

Self-employed Employee Family member

9.6 Do you believe that you are in danger of losing your current work or income within the next two years? Yes No

9.7 Do you receive any of the following benefits? Yes No

Sickness benefit (are on sick leave)

Old age pension, early retirement (AFP) or survivor pension

Rehabilitation/reintegration benefit

Disability pension (full or partial)

Unemployment benefits during unemployment

Social welfare benefits

Transition benefit for single parents

10. EXERCISE AND PHYSICAL ACTIVITY

10.1 How has your physical activity in leisure time been during this last year?

Think of a weekly average for the year.

Time spent going to work is count as leisure time. Answer both questions.

Hours per week

	None	Less than 1	1-2	3 or more
Light activity (not sweating/out of breath).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard physical activity (sweating/out of breath).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4

10.2 Describe exercise and physical exertion in your leisure time. If your activity varies much e.g. between summer and winter, then give an average. The question refers only to the last year. (Tick the most appropriate box)

Reading, watching TV or other sedentary activity? 1

Walking, cycling or other forms of exercise at least 4 hours a week? 2
(Include walking or cycling to work, Sunday walk/stroll, etc.)

Participation in recreational sports, heavy gardening, etc.? 3
(Note: duration of activity at least 4 hours a week)

Participation in hard training or sports competitions, regularly several times a week? 4

11. FAMILY AND FRIENDS

11.1 Do you live with: Spouse/partner?.....

Yes No

11.2 How many good friends do you have? Number of friends

Count the ones you can talk confidentially with and who can give you help when you need it. Do not count people you live with, but do include other relatives.

11.3 How much interest do people show for what you do? (Tick only once)

Great interest	Some interest	Little interest	No interest	Uncertain
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

11.4 How many associations, sport clubs, groups, religious communities or similar do you take part in? Number

11.5 Do you feel that you can influence what happening in your local community where you live? (Tick only once)

Yes, a lot	Yes, some	Yes, a little	No	Never tried
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

12. ILLNESS IN THE FAMILY

12.1 Have one or more of your parents or siblings had a heart attack (heart wound) or angina pectoris (heart cramp)?.....

Yes No Don't know

12.2 Tick for the relatives who have or have had any of the illnesses: (Tick for each line)

	Mother	Father	Brother	Sister	Child	None of these
Cerebral stroke or brain haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack before age of 60 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12.3 If any relatives have diabetes, at what age did they get diabetes (if for e.g. many siblings, consider the one who got it earliest in life):

Don't know, not applicable	Mother's age	Father's age	Brother's age	Sister's age	Child's age
<input type="checkbox"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>

13. USE OF MEDICINES

With medicines, we mean drugs purchased at pharmacies. Supplements and vitamins are not considered here.

13.1 Do you use: Now Previously, but not now Never used

Blood pressure lowering drugs

Cholesterol-lowering drugs

13.2 How often have you during the last 4 weeks used the following medicines? (Tick once for each line)

	Not used in the last 4 weeks	Less than every week	Every week but not daily	Daily
Painkillers non-prescription	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painkillers on prescription	<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"/>
Tranquillizers	<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"/>
Other prescription medicines ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4

13.3 For those medicines you have checked in points 13.1 and 13.2, and that you've used during the last 4 weeks:

State the name and the reason that you are taking/have taken these (disease or symptom):
(Tick for each duration you have used the medicine)

Name of the medicine: (one name per line)	Reason for use of the medicine	How long have you used the medicine	
		Up to 1 year	1 year or more
		<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"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

If there is not enough space here, you may continue on a separate sheet that you attach

14. THE REST OF THE FORM IS TO BE ANSWERED BY WOMEN ONLY

14.1 How old were you when you started menstruating? Age in years

14.2 If you no longer menstruating, how old were you when you stopped menstruating? Age in years

14.3 Are you pregnant at the moment?

Yes No Uncertain Above fertile age

1 2 3 4

14.4 How many children have you given birth to? Number of children

14.5 Do you use, or have you ever used? (Tick once for each line)

	Now	Before, but not now	Never
Oral contraceptive pills/mini pill/contraceptive injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormonal intrauterine device (IUD) (not ordinary IUD) ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Estrogen (tablets or patches)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Estrogen (cream or suppositories)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14.6 If you use/have used prescription estrogen: How long have you used it? Number of years

14.7 If you use contraceptive pills, mini pill, contraceptive injection, hormonal IUD or estrogen, what brand do you use?