Label

Additional questions to the health survey in Troms and Finnmark 2001-2002

The main aim of the Tromsø Study is to improve our knowledge about cardiovascular diseases in order to aid prevention. The study is also intended to improve our knowledge of cancer and other general conditions, such as allergies, muscle pains and mental conditions. We would therefore like you to answer some questions about factors that may be relevant for your risk of getting these and other illnesses. This form is part of the Health Survey, which has been approved by the Norwegian Data Inspectorate and the Regional Board of Research Ethics. The answers will only be used for research purposes and will be treated strictly confidential.

The information you give us may later be linked with information from other public health registers in accordance with the rules laid down by the Data Inspectorate and the Regional Board of Research Ethics.

If you are unsure about what to answer, tick the box that you feel fits best.

The completed form should be sent to us in the enclosed prepaid envelope. Thank you in advance for helping us.

Yours sincerely

Department of Community Medicine
University of Tromsø

National Health Screening Service

If you do not wish to answer the questionnaire, tick the box below and return the form. Then you will not receive reminders.

I do not wish to answer the questionnaire ☐

Date of completion:

Day ☐☐ Month ☐☐ Year ☐☐☐☐

T1. NEIGHBORHOOD AND HOME

1.1 In which municipality did you live at the age of 1 year? *(If you have not lived in Norway, state country of residence instead of the municipality)*

_____

1.2 What type of house do you live in? *(Tick only once)*

- Detached house/villa ☐ 1
- Farm ☐ 2
- Flat/apartment ☐ 3
- Terraced/semi-detached house ☐ 4
- Institution/care home ☐ 5
- Other ☐ 6

1.3 How big is your house? ☐☐☐ m^2 *(gross)*

1.4 Are you bothered by: *(Tick once for each line)*

	No complaint	Little complaint	Severe complaint
Moisture, drought or coldness in your home	☐	☐	☐
Other forms of bad indoor climate	☐	☐	☐
Traffic noise (cars or aircraft)	☐	☐	☐
Other noise (industrial, construction, etc.)	☐	☐	☐
Neighbour noise	☐	☐	☐
Drinking water quality	☐	☐	☐
Air pollution from traffic	☐	☐	☐
Air pollution from wood/oil heating, factory etc.	☐	☐	☐

1.5 What home language did your grandparents have? *(Tick for one or more alternatives)*

	Norwegian	Sami	Kven/ Finnish	Other language
Mother's mother	☐	☐	☐	☐
Mother's father	☐	☐	☐	☐
Father's mother	☐	☐	☐	☐
Father's father	☐	☐	☐	☐

T1. NEIGHBORHOOD AND HOME (cont.)

1.6 What do you consider yourself as? *(Tick for one or more alternatives)*

Norwegian ☐ Sami ☐ Kven/ Finnish ☐ Other ☐

1.7 Do you feel that you have enough good friends? Yes ☐ No ☐

1.8 How often do you normally take part in organised gatherings, e.g. sewing circles, sports clubs, political meetings or other associations? *(Tick only once)*

- Never, or just a few times a year ☐ 1
- 1-3 times a month ☐ 2
- Approximately once a week ☐ 3
- More than once a week ☐ 4

T2. PAID AND UNPAID WORK

2.1 If you have paid or unpaid work, how would you describe your work? *(Tick only once)*

- Mostly sedentary work? *(e.g. office work, mounting)* ☐ 1
- Work that requires a lot of walking? *(e.g. shop assistant, light industrial work, teaching)* ☐ 2
- Work that requires a lot of walking and lifting? *(e.g. Postman, nursing, construction)* ☐ 3
- Heavy manual labour? *(e.g. forestry, heavy farm-work, heavy construction)* ☐ 4

2.2 Can you decide yourself how your work (paid or unpaid) should be organised? *(Tick only once)*

- No, not at all ☐ 1
- To a small extent ☐ 2
- Yes, to a large extent ☐ 3
- Yes, I decide myself ☐ 4

2.3 Are you on call, do you work shifts or nights? Yes ☐ No ☐

T3. TOBACCO

3.1 Do you smoke?

Yes, daily ☐ 1 | Yes, sometimes ☐ 2 | No, never ☐ 3

If "Yes, sometimes"

What do you smoke?

☐ Cigarettes ☐ Pipe ☐ Cigar/cigarillos

3.2 Have you used or do you use snuff daily?

Yes, now ☐ | Yes, previously ☐ | Never ☐

If YES:

How many years altogether have you used snuff? ☐☐ years

T4. ALCOHOL

4.1 Are you a teetotaller? ..... Yes ☐ No ☐

4.2 How many times a month do you normally drink alcohol? ..... ☐☐ *Number of times*

(Do not count low-alcohol beer. Put 0 if less than once a month)

4.3 How many glasses of beer, wine or spirits do you normally drink in a fortnight?

Beer ☐☐ Wine ☐☐ Spirits ☐☐

(Do not count low-alcohol beer. Put 0 if you do not drink alcohol)

4.4 For approximately how many years has your alcohol consumption been at the same level you described above? ☐☐ years

4.5 Have you, in one or more periods in the last 5 years consumed so much alcohol that it has inhibited your work or social life?

Yes, at work ☐ 1 | Yes, socially ☐ 2 | Yes, both at work and social life ☐ 3 | No, never ☐ 4

T5. FOOD AND DIETARY SUPPLEMENTS

5.1 Do you usually eat breakfast every day? ... Yes ☐ No ☐

5.2 How many times a week do you eat a warm dinner? ..... ☐ *times*

5.3 How important is it for you to have a healthy diet?

Very ☐ 1 | Somewhat ☐ 2 | Little ☐ 3 | Not ☐ 4

5.4 Do you use the following dietary supplements?

	Yes, daily	sometimes	No
Iron tablets	☐	☐	☐
Calcium tablets or bonemeal	☐	☐	☐
Vitamin D supplements	☐	☐	☐
Cod liver oil	☐	☐	☐

T6. BODY WEIGHT

6.1 Do you currently try to change your body weight?

No ☐ 1 | Yes, I try to gain weight ☐ 2 | Yes, I try to lose weight ☐ 3

6.2 What weight would you be satisfied with (your "ideal weight")? ..... ☐☐☐ kg

T7. ILLNESSES AND INJURIES

7.1 Have you ever had:

Tick once for each question. Also give the age at the time. If you have had the condition several times, how old were you the last time

	Yes	No	Age last time
Severe injury requiring hospital admission	☐	☐	☐☐ years
Ankle fracture	☐	☐	☐☐ years
Peptic ulcer	☐	☐	☐☐ years
Peptic ulcer surgery	☐	☐	☐☐ years
Neck surgery	☐	☐	☐☐ years
Prostate surgery	☐	☐	☐☐ years

7.2 Do you have, or have you ever had:

(Tick once for each question)

	Yes	No
Cancer	☐	☐
Psoriasis.....	☐	☐
Thyroid disease	☐	☐
Glaucoma	☐	☐
Cataract	☐	☐
Osteoarthritis (arthrosis).....	☐	☐
Bent fingers	☐	☐
Skin contractions in your palms	☐	☐
Kidney stone	☐	☐
Appendectomy.....	☐	☐
Hernia surgery	☐	☐
Surgery/treatment for urine incontinence	☐	☐
Epilepsy.....	☐	☐
Poliomyelitis (polio)	☐	☐
Parkinson's disease.....	☐	☐
Migraine.....	☐	☐
Leg ulcer	☐	☐
Allergy and hypersensitivity:	Yes	No
Atopic eczema (e.g. childhood eczema)	☐	☐
Hand eczema.....	☐	☐
Food allergy	☐	☐
Other hypersensitivity (not allergy).....	☐	☐

7.3 Have you had common cold, influenza, gastroenteritis, etc. during the last 14 days? Yes ☐ No ☐

7.4 Have you during the last 3 weeks had common cold, influenza, bronchitis, pneumonia, sinusitis, or other respiratory infection? ..... Yes ☐ No ☐

7.5 Have you ever had bronchitis or pneumonia? ..... Yes ☐ No ☐

7.6 Have you during the last 2 years had bronchitis or pneumonia? *(Tick only once)*

No ☐ 1 | 1-2 times ☐ 2 | More than 2 times ☐ 3

T8. SYMPTOMS

8.1 Have you in the last two weeks felt:
(Tick once for each question)

	No	A Little	A lot	Very much
Nervous or worried	☐	☐	☐	☐
Bothered by anxiety	☐	☐	☐	☐
Confident and calm	☐	☐	☐	☐
Irritable	☐	☐	☐	☐
Happy and optimistic	☐	☐	☐	☐
Down/depressed	☐	☐	☐	☐
Lonely	☐	☐	☐	☐
	1	2	3	4

8.2 Do you cough about daily for periods of the year? Yes ☐ No ☐

If YES:
Is your cough productive? ☐ ☐

Have you had this kind of cough for as long as 3 months in each of the last two years? ☐ ☐

8.3 Have you had episodes with wheezing in the chest? ☐ ☐

If YES:
Has this occurred: *(Tick once for each question)*

	Yes	No
At night	☐	☐
In connection with respiratory infections	☐	☐
In connection with physical exertion	☐	☐
In connection with very cold weather	☐	☐

8.4 Do you get pain in the calf while walking Yes ☐ No ☐

If YES:
How long can you go before you notice the pain? ☐☐☐ *meter*

8.5 Do you get short-winded in the following situations?
(Tick once for each question)

	Yes	No
While walking fast on level ground or slight up hills	☐	☐
While walking calmly on level ground	☐	☐
While washing or dressing yourself	☐	☐
While resting	☐	☐

8.6 Do you have to stop because of short-windedness while walking in your own pace on level ground? Yes ☐ No ☐

8.7 Have you during the last year suffered from pain and/or stiffness in muscles and joints that have lasted continuously for at least 3 months? Yes ☐ No ☐

If YES:
Has the complaint reduced your leisure time activity? Yes ☐ No ☐

For how long has the complaint endured in total?

approx. ☐☐ years and ☐☐ months

Has the complaint reduced your ability to work during the last year? *(Also applies to domestic workers and pensioners (Tick once)*

No/insignificantly	To some extend	Significantly reduced	Do not know
☐ 1	☐ 2	☐ 3	☐ 4

Have you been on sick leave due to these complaints during the last year? Yes ☐ No ☐ Do not work ☐

T8. SYMPTOMS (continue)

8.8 How often do you suffer from sleeplessness?
(Tick only once)

Never, or just a few times a year	☐ 1
1-3 times a month	☐ 2
Approximately once a week	☐ 3
More than once a week	☐ 4

8.9 If you suffer from sleeplessness monthly or more frequently, what time of the year does it affect you most?

No particular time of the year	☐ 1
Especially during the polar night	☐ 2
Especially during the midnight sun season	☐ 3
Especially in spring and autumn	☐ 4

8.10 Have you in the last year suffered from sleeplessness to the extend that it has affected your ability to work ? Yes ☐ No ☐

8.11 Do you usually sleep during the day? ☐ ☐

8.12 How often do you suffer from urinary incontinence?

Never	☐ 1
Not more than once a month	☐ 2
Two or more times a month	☐ 3
Once a week or more	☐ 4

8.13 Are you able to walk down 10 steps without holding on to something (e.g. a handrail) Yes ☐ No ☐

8.14 Do you use glasses? ☐ ☐

8.15 Do you use a hearing aid? ☐ ☐

8.16 How is your memory?
(Tick once for each question)

	Yes	No
Do you forget what you just have heard or read?	☐	☐
Do you forget where you have placed things?	☐	☐
Is it more difficult to remember now than earlier?	☐	☐
Do you more often write memos now than earlier?	☐	☐

If "YES" on one of these questions; **Is this a problem in your daily life?** Yes ☐ No ☐

T9. MEDICINES

9.1 Do you use, or have you used any of the following medicines:

	Now	Previously, but not now	Age when used 1st time	Never used
Drugs for osteoporosis	☐	☐	☐☐ years	☐
Tablets for diabetes	☐	☐	☐☐ years	☐
Drugs for hypothyroidism (thyroxine)	☐	☐	☐☐ years	☐

9.2 Do you use any medicines which you take as injections? Yes ☐ No ☐

If YES:
Give the name of the medicines (for injection):
(one name per line)

_____

_____

T10. ILLNESS IN THE FAMILY

10.1 Tick for the relatives who have or have ever had any of the diseases: *(Tick for each line)*

	Mother	Father	Brother	Sister	Child	None of these
Heart attack (heart wound)	☐	☐	☐	☐	☐	☐
Angina pectoris (heart cramp)	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Aneurysm.....	☐	☐	☐	☐	☐	☐
Gastric/duodenal ulcer	☐	☐	☐	☐	☐	☐
Hip fracture	☐	☐	☐	☐	☐	☐
Psychological problems ..	☐	☐	☐	☐	☐	☐
Allergy	☐	☐	☐	☐	☐	☐
Osteoarthritis (arthrosis) ..	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐

10.2 How many siblings and children do you have?

	Brothers	Sisters	Children
Number	☐☐	☐☐	☐☐

10.3 Do you usually do extra caring work because of illness etc. in your close family?

Yes, daily/almost daily ☐ 1 Yes, sometimes ☐ 2 No ☐ 3

10.4 Do you/your family receive home aid or home nursing care?..... Yes ☐ No ☐

	Yes	No	Age at death
10.5 Is your mother alive?	☐	☐	☐☐☐ years
10.6 Is your father alive?	☐	☐	☐☐☐ years

T11. MOBILE TELEPHONE

11.1 Do you have (own, rent, etc.) a mobile telephone?

Yes, always ☐ 1 Yes, sometimes ☐ 2 No ☐ 3

If Yes:

What do you use your mobile telephone for, and how often do you use it? *(Tick once for each line)*

	Number of times per day				
	30 or more	10-29	2-9	1 or less	Never
Conversations..	☐	☐	☐	☐	☐
Text messaging	☐	☐	☐	☐	☐
	12345				

T12. THE REST IS TO BE ANSWERED BY WOMEN ONLY

12.1 If you have given birth, fill in each child's birth year and how many months you breastfed after delivery.
(If you did not breastfeed, write 0)

Child:	Birth year:	Number of months breastfed:
1st child	☐☐☐☐	☐☐
2nd child	☐☐☐☐	☐☐
3rd child	☐☐☐☐	☐☐
4th child	☐☐☐☐	☐☐
5th child	☐☐☐☐	☐☐
6th child	☐☐☐☐	☐☐

(If more children, use additional sheet)

T12. THE REST IS TO BE ANSWERED BY WOMEN ONLY

12.2 If you still have menstrate or are pregnant:
What date did your last menstruation start?

Day ☐☐ Month ☐☐ Year ☐☐☐☐

12.3 If you no longer menstruate; why did your periods stop? *(Tick once)*

It stopped by itself ..... ☐ 1
Uterus surgery ..... ☐ 2
Surgically removed both ovaries ..... ☐ 3
Other reason (e.g. radiation, chemotherapy) ... ☐ 4

12.4 Do you use or have you used prescribed estrogen (tablets or patches)?..... Yes ☐ No ☐

If YES:
How old were you when you started taking estrogen ? ..... ☐☐ years

If you stopped using estrogen,
How old were you when you stopped taking estrogen?..... ☐☐ years

12.5 Do you use or have you used oral contraceptive pills?..... Yes ☐ No ☐

If YES:
How old were you when you started taking the pill?..... ☐☐ years

How many years in total have you taken the pills?.... *Number of years* ☐☐

If you have given birth:
How many years did you take the pill before your first delivery?... *Number of years* ☐☐

If you stopped taking the pill:
How old were you when you stopped?.... ☐☐ years

12.6 Apart from pregnancy and after giving birth, have you ever stopped having menstruation for 6 months or more? Yes ☐ No ☐

If YES:
How many times?..... ☐☐ times

12.7 How is your current menstruation status?

I have not had menstruation in the last year ☐ 1
I have regular menstruation ..... ☐ 2
I have irregular menstruation ..... ☐ 3

12.8 When you were 25-29 years old, how many days usually passed between the start of two periods?

Minimum ☐☐ days Maximum ☐☐ days Do not know ☐

The periods were of approximately equal length every time?..... Yes ☐ No ☐

How many days did a typical menstrual bleeding period last?... ☐☐ days

Thank you for the help!
Remember to mail the form today!

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