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.

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
- Farm
- Flat/apartment
- Terraced/semi-detached house
- Institution/care home
- Other

1.3 How big is your house? m² (gross)

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

1.6 What do you consider yourself as? (Tick for one or more alternatives)
- Mostly sedentary work? (e.g. office work, mounting)
- Work that requires a lot of walking? (e.g. shop assistant, light industrial work, teaching)
- Work that requires a lot of walking and lifting? (e.g. Postman, nursing, construction)
- Heavy manual labour? (e.g. forestry, heavy farm-work, heavy construction)

1.7 Do you feel that you have enough good friends?

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
- 1-3 times a month
- Approximately once a week
- More than once a week

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?
- Work that requires a lot of walking?
- Work that requires a lot of walking and lifting?
- Heavy manual labour?

2.2 Can you decide yourself how your work (paid or unpaid) should be organised? (Tick only once)
- No, not at all
- To a small extent
- Yes, to a large extent
- Yes, I decide myself

2.3 Are you on call, do you work shifts or nights?

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

National Health Screening Service
University of Tromsø

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:

T
### T3. TOBACCO

| 3.1 Do you smoke? | Yes, daily | Yes, sometimes | No, never |
|--------------------|------------|----------------|-----------|
| 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? | | | |

### T4. ALCOHOL

| 4.1 Are you a teetotaller? | Yes | No |
|----------------------------|-----|----|
| 4.2 How many times a month do you normally drink alcohol? | | |
| (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? | | |

| 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 | No |
|--------------------------------------------------------------------------------------------------------------------------------|------|----|
| Yes, at work | | |
| Yes, socially | | |
| Yes, both at work and socially | | |
| No, never | | |

### 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? | | |

| 5.3 How important is it for you to have a healthy diet? | Very | Somewhat | Little | Not |
|---------------------------------------------------------|------|----------|-------|-----|
| | | | | |

| 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 | Yes, I try to gain weight | Yes, I try to lose weight |
|---------------------------------------------------|----|--------------------------|------------------------|
| 6.2 What weight would you be satisfied with (your “ideal weight”)? | | | kg |
T8. SYMPTOMS

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

- Nervous or worried
- Bothered by anxiety
- Confident and calm
- Irritable
- Happy and optimistic
- Down/depressed
- Lonely

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?

Yes ☐ No ☐

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

- While walking fast on level ground
- 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?

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

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

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
- Especially during the polar night
- Especially during the midnight sun season
- Especially in spring and autumn

8.10 Have you in the last year suffered from sleeplessness to the extent that it has affected your ability to work?

Yes ☐ No ☐

8.11 Do you usually sleep during the day?

Yes ☐ No ☐

8.12 How often do you suffer from urinary incontinence?

- Never
- 1-3 times a month
- Two or more times a month
- More than once a week

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?

Yes ☐ No ☐

8.15 Do you use a hearing aid?

Yes ☐ No ☐

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

- Do you more often write memos now than earlier?
- Is it more difficult to remember now than earlier?
- Do you forget where you have placed things?
- Do you forget what you just have heard or read?

T9. MEDICINES

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

- Drugs for osteoporosis
- Tablets for diabetes
- Drugs for hypothyroidism

Age when used 1st time: Never ☐ Previously, but not now ☐

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)*

| Disease                        | Mother | Father | Brother | Sister | Child |
|--------------------------------|--------|--------|---------|--------|-------|
| 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?

| Number | Brothers | Sisters | Children |
|--------|----------|---------|----------|

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

Yes, daily/almost daily ☐ Yes, sometimes ☐ No ☐

10.4 Do you or your family receive home aid or home nursing care? ☐

10.5 Is your mother alive? ☐

Yes No

Age at death: ___ years

10.6 Is your father alive? ☐

Yes No

Age at death: ___ years

T11. MOBILE TELEPHONE

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

Yes, always ☐ Yes, sometimes ☐ No ☐

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   |            | T                           |
| 2nd   |            |                             |
| 3rd   |            |                             |
| 4th   |            |                             |
| 5th   |            |                             |
| 6th   |            |                             |

(If more children, use additional sheet)

12.2 If you still have menstruate or are pregnant:

What date did your last menstruation start?

Day ☐ Month ☐ Year T

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

It stopped by itself ☐

Uterus surgery ☐

Surgically removed both ovaries ☐

Other reason (e.g. radiation, chemotherapy) ☐

12.4 Do you use or have you used prescribed estrogen (tablets or patches)? ☐

If YES:

How old were you when you started taking estrogen? ☐

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

12.5 Do you use or have you used oral contraceptive pills? ☐

If YES:

How old were you when you started taking the pill? ☐

If you stopped taking the pill, How old were you when you stopped? ☐

12.6 Apart from pregnancy and after giving birth, have you ever stopped having menstruation for 6 months or more?

Yes, always ☐ Yes, sometimes ☐ No ☐

If YES:

How many times? ☐

12.7 How is your current menstruation status?

I have not had menstruation in the last year ☐

I have regular menstruation ☐

I have irregular menstruation ☐

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

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

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

Thank you for the help!

Remember to mail the form today!