1. YOUR OWN HEALTH

What is your current state of health? (Mark only one)
☐ Poor  ☐ Not so good  ☐ Good  ☐ Very good

Do you have or have you had?

Asthma…………………………………………………………… ☐  ☐

Chronic bronchitis, emphysema, COPD ……… ☐  ☐

Diabetes…………………………………………………………… ☐  ☐

Fibromyalgia/chronic pain syndrome……………………… ☐  ☐

Psychological problems for which you have sought help………………………………………………………………………………… ☐  ☐

Myocardial infarction (heart attack)………………………… ☐  ☐

Angina pectoris (heart cramp)…………………………………… ☐  ☐

Cerebral stroke/brain haemorrhage…………………………… ☐  ☐

Multiple sclerosis .………………………………………………… ☐  ☐

Ulcerous colitis…………………………………………………….. ☐  ☐

Do you get pain or discomfort in the chest when walking up hills or stairs, or walking fast on level ground? ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………
6. USE OF MEDICATION

Medicines, in this context, means medicines bought at a pharmacy. Food supplements and vitamins are not included here.

Do you take?
Medications for high blood pressure .
Cholesterol reducing medication .
Insulin .
Tablets for diabetes .

How often during the last 4 weeks have you used the following medications? (Tick one box for each line)

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Not used for the last 4 weeks</th>
<th>Less frequently every week</th>
<th>Every week, but not daily</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain killers without prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain killers with prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeping pills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tranquilizers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other prescribed medicines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For those medicines you have ticked off in the last two items, and you have taken during the last 4 weeks:
State the name of the medicines and your reason for taking/ having taken them (disease, symptom): (Tick one box for each line)

<table>
<thead>
<tr>
<th>Brand name of medicine (one name per line)</th>
<th>Reason for use of medicine</th>
<th>For how long time?</th>
<th>Number of times</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How much do you normally drink of the following? (Tick one box for each line)

<table>
<thead>
<tr>
<th>Drink Type</th>
<th>Rarely/never</th>
<th>1–6 glasses per week</th>
<th>2–3 glasses per day</th>
<th>4 glasses a day or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full milk, full-fat curdled milk and yoghurt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-skimmed milk, semi-skimmed curdled milk, and low-fat yoghurt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skimmed milk and skimmed curdled milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-skimmed milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruit juice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft-drinks/cola-drinks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other coffee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How many cups of coffee and tea do you usually drink per day? (Write 0 for the types you do not drink daily)

<table>
<thead>
<tr>
<th>Drink Type</th>
<th>Number of cups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filtered coffee</td>
<td></td>
</tr>
<tr>
<td>Boiled coffee (coarsely ground coffee for brewing)</td>
<td></td>
</tr>
<tr>
<td>Other coffee</td>
<td></td>
</tr>
<tr>
<td>Tea</td>
<td></td>
</tr>
</tbody>
</table>

7. FOOD AND BEVERAGES

How often do you usually eat the following foods?

<table>
<thead>
<tr>
<th>Food Type</th>
<th>Rarely/never</th>
<th>1–3 t. p. per day</th>
<th>1–3 t. p. per week</th>
<th>4–6 t. p. per week</th>
<th>1–2 t. p. per month</th>
<th>1–2 t. p. per year</th>
<th>3 t. or more p. per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fruit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Berries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheese (all types)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potatoes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boiled vegetables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresh vegetables/salad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What type of fat do you usually use? (Tick one box for each line)

<table>
<thead>
<tr>
<th>Type of Fat</th>
<th>Soft/light</th>
<th>Hard</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>On bread</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For cooking</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you use the following food supplements?

<table>
<thead>
<tr>
<th>Food Supplement</th>
<th>Yes, daily</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cod liver oil or cod liver oil capsules</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fish oil capsules (omega 3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamins and/or mineral supplement</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. SMOKING AND SNUFF USE

How many hours a day do you normally spend in smoke-filled rooms?

Did any of the adults smoke at home while you were growing up?

<table>
<thead>
<tr>
<th>Smoke-Filled Rooms</th>
<th>Number of whole hours</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Smoke-Filled Rooms</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
Do you currently, or did you previously live together with a daily smoker after your 20th birthday?  

Yes  No

Are you currently, or were you previously a daily smoker?  

Yes currently  Yes previously  No

If current daily smoker, do you smoke  

Sigarettes  

Cigars/cigarillos/pipes  

Rolling tobacco  

Yes  No

If you previously smoked daily, how many years is it since you stopped smoking?  

Number of years

If you currently smoke, or have smoked before, how many cigarettes do you smoke per day?  

Number of cigarettes

If you currently smoke, or have smoked before, how old were you when you began smoking daily?  

Age in years

If you currently smoke, or have smoked before, how many years in all have you smoked daily?  

Number of years

Do you take or have you been taking snuff daily?  

Yes currently  Yes previously  No

If you have been taking snuff, for how many years in all have you been taking snuff?  

Number of years

Sickness benefit/Sick pay  

Rehabilitation benefit  

Social welfare benefits  

Transition benefit for single parents

11. THE REST OF THE QUESTIONNAIRE IS TO BE ANSWERED BY WOMEN ONLY

How old were you when you started menstruating?  

Age in years

If you no longer menstruate, how old were you when you stopped menstruating?  

Age in years

Are you pregnant at the moment?  

Yes  No  Uncertain  Above fertile age

How many children have you given birth to?  

Number of children

If you have given birth, enter what year each child was born  

(If you didn’t breastfeed, write 0)

Children  Year of birth  Breastfed

1. child  

2. child  

3. child  

4. child  

5. child  

(If more children, use an extra sheet of paper)

Do you use or have you ever used?  

Contraceptive pills/minipill/contraceptive injection?  

Hormonal intrauterine device?  

Estrogen (cream or suppositories)?  

Contraceptive injection?  

Do you use prescription obliged estrogen, for how many years have you used it?  

Number of years

If you use contraceptive pills, hormonal intrauterine device, or estrogen, what brand do you currently use?  

Specify

10. EDUCATION AND WORK

How many years of schooling/education have you completed?  

(Count all years you have attended school or been studying)  

Number of years

How content are you with your job?  

Very content  Content  Discontent  Very discontent

Do you believe that you are in danger of losing your current work or income within the next 2 years?  

Yes  No

Do you receive any of the following benefits?  

1–3 times  4+  None

GP (general practitioner)  

Medical specialist  

Emergency GP  

Admission to a hospital  

Home nursing care

9. EXERCISE AND PHYSICAL ACTIVITY

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

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

<table>
<thead>
<tr>
<th>Hours per week</th>
<th>Less than 1 hour</th>
<th>1–2 hours</th>
<th>3 hours or more</th>
</tr>
</thead>
</table>

Light activity (not sweating or out of breath)  

Hard physical activity (sweating or out of breath)  

Describe your exercise and physical exertion in leisure time. If your activity varies much, for example between summer and winter, then give an average. The question refers only to the last twelve months. (Tick the box that is most appropriate)

Reading, watching TV, or other sedentary activity  

Walking, cycling, or other forms of exercise at least 4 hours a week  

Participation in recreational sports, heavy gardening, etc.  

Participation in hard training or sports competitions regularly and several times a week  

10. USE OF HEALTH SERVICES

How many times during the past year have you personally used?  

(Tick one box for each line)

GP (general practitioner)  

Medical specialist  

Emergency GP  

Admission to a hospital  

Home nursing care
Home aid, organised by the municipality.
Physiotherapist.
Chiropractor.
Dentist.
Alternative medical practitioner.

How many doctors have you been seeing for the last 12 months? (Number)

Have you been given a regular GP, whose name you know? Yes No

When you are being examined, which language do you and your doctor communicate in?
- Norwegian
- Sami
- Use an interpreter
- Other language

Do you think it happens that you and your doctor misunderstand each other due to linguistic problems?
- Never
- Rarely
- Sometimes
- Often
- Not sure

If an interpreter is needed, is your doctor good enough to request it?
- Yes, always
- Yes, most of the time
- No, not always
- No, never
- Don't like to use interpreter

How satisfied/dissatisfied are you with the following aspects with the municipal health service in your municipality?

The distance to your doctor? Very satisfied Satisfied Dissatisfied Don't know

Your doctor's availability on telephone?

How soon you can get an appointment with your doctor?

How long time you are allowed with your doctor?

Your possibility to explain about you pains and problems?

Your doctor's understanding of your cultural background?

The information your doctor gives about your health and the examination and treatment you get?

Your doctor's language skills (Sami or Norwegian)?

The local health services in your municipality totally?

On the whole, how satisfied/dissatisfied are you with the local health services in your municipality?

How long is it since you last went to see a doctor? (Report whole numbers)

If you have ever used an alternative practitioner, which did you use?
- A traditional healer (guvllar, reader, “blåser”, laying on of hands)
- A (modern) healer
- A zone therapist, homeopath, kinesiologist etc.
- An acupuncture practitioner
- A zone therapist, homeopath, kinesiologist etc.

How long is it since you last used an alternative practitioner? (Report whole numbers)

Suppose that you would get the need for help/assistance from the local health- and social services (home nursing care, home assistance services, social services, physiotherapy etc.),

Do you know where to approach? Yes No Uncertain

Do you feel confident that you will receive help if you need it?

If you today receive help from the local health and social services, are you satisfied with the help they offer?

INJURIES/ACCIDENTS

Have you been in accidents that resulted in treatment by a doctor and/or hospital admission?

If yes, what kind of accidents have you been treated for?
- Car accident
- Motor cycle accident
- Snowmobile accident
- 4-wheel motor cycle
- Tractor
- Accident by falling
- Cutting injury
- Other

Has/have the accident(s) lead to reduced ability to work?
- Completely
- Partly
- Not at all

FAMILY AND LINGUISTIC BACKGROUND

In Northern Norway there live people of different ethnic background. That is, they speak different languages and have different cultures. Examples of ethnic background, or ethnic group, is Norwegian, Sami and Kven.

Which language did/do you, your parents and grand parents speak at home? (Tick one or more boxes)
- Norwegian
- Sami
- Kven
- Other, specify
What is your, your father’s, and your mother’s ethnic background? (Tick one or more boxes)

Norwegian Sami Kven Other, specify

What do you consider yourself to be? (Tick one or more boxes)

Norwegian Sami Kven Other, specify

EMployment/economy

What type of work/livelihood do you have? (Tick one or more boxes)

Full time job with a fixed salary
Part time job with a fixed salary
Seasonal work
Self-employed
Unemployed
Homemaker (fulltime housework)
Old age pension
Disability pension
Other, specify:

Would you be willing to move if you were offered work somewhere else?

Yes
No
Parts of the year
Uncertain

Bullying

By bullying we mean when one or more persons systematically and over time say or do bad things against you, and you have difficulty in defending yourself against them.

Have you experienced bullying?

Yes, for the last 12 months
Yes, previously
No

If you have been bullied, what kind of bullying did you experience? (Tick one or more boxes)

Talking behind your back/gossip
Being ignored
Discriminating remarks
Other, specify:

Can you state where the bullying takes/took place?

At school
At boarding school/dormitory
At work
In local community
Other, specify:

How much money do you on average gamble per week?

Less than 100 NOK
100–500 NOK
501–1000 NOK
More than 1000 NOK

How often do you participate in gambling (national lottery, football betting, gambling machines etc.)?

Never/rarely
1–3 times a month
Once a week
2–6 times a week
Daily

How many persons are living in your household? (Number of persons)

How large is your family’s/household’s gross income each year?

Less than 150,000 NOK
150,000–300,000 NOK
301,000–450,000 NOK
451,000–600,000 NOK
601,000–750,000 NOK
More than 750,000 NOK