CHILDHOOD/YOUTH
What Norwegian municipality did you live in at the age of 1 year? ____________________________________________
If you did not live in Norway, give country of residence instead of municipality.
How was your family’s economic situation while you were growing up?
- Very good □
- Good □
- Difficult □
- Very difficult □
For how much of the first three years of your life
- did you live in a town/city? ____ Years
- did your family have a cat or dog in the home? ____ Years
For how much of the first 15 years of your life
- did you live in a town/city? ____ Years
- did your family have a cat or dog in the home? ____ Years

HOME
Who do you live with?
- Spouse/partner □ □ ____
- Other persons over 18 years □ □ ____
- Persons under 18 years □ □ ____
How many of the children go to day care/kindergarten/nursery school? ____
What type of home do you live in?
- Villa/ detached house □
- Farm □
- Flat /Apartment □
- Terraced /semi-detached house □
- Other □
How big is your home? _____ m²
Approximately what year was your home built? ____
Has your home been insulated after 1970? □ □
Do you live on the bottom floor/cellar level? □ □
If “YES”, is the floor laid on concrete? □ □
What is the main source of heat in your home?

- Electric heating
- Wood-burning stove
- Central heating system using:
  - Paraffin
  - Electricity

Do you have fitted carpets in the living-room?

- Yes
- No

Is there a cat in your home?

- Yes
- No

Is there a dog in your home?

- Yes
- No

WORK

If you are in paid or unpaid work, which statement describes your work best?

- I am mainly seated while working (e.g., at a desk/assembly work)
- My work requires a lot of walking (e.g., shop assistant, light industrial work, teaching)
- My work entails a lot of walking and lifting (e.g., postman/woman, nurse, building work)
- I do heavy physical work (e.g., forestry, heavy agricultural/construction work)

Do you have any influence on how your work is organised?

- No, not at all
- To a small extent
- Yes, to a large extent
- Yes, I decide myself

Are you on call; do you work shifts or nights?

- Yes
- No

Do you do any of the following jobs (full- or part-time)?

- Driver
- Farmer
- Fisherman

YOUR OWN ILLNESSES

Have you ever had:

Tick one box only for each item. Give your age at the time.

If you have had the condition several times, how old were you last time?

- Hip fracture
- Wrist/forearm fracture
- Whiplash
- Injury requiring hospital admission
- Stomach ulcer
- Duodenal ulcer
- An operation for stomach/duodenal ulcer
- Throat/neck operation

Have you you ever had, or do you still have:

Tick one box only for each item.

- Cancer
- Epilepsy
- Migraine
- Chronic bronchitis
- Psoriasis
- Osteoporosis
- Fibromyalgia/fibrositis/chronic pain syndrome
- Psychological problems for which you have sought help
- Thyroid disease
- Liver disease
- Kidney stone
- Appendectomy

Allergy and hypersensitivity:

- Atopic eczema (e.g., childhood eczema)
- Hand eczema
- Hay fever
- Food allergy
- Other hypersensitivity (not allergy)

How many times have you had a cold, influenza (flu), vomiting/diarrhoea, or similar in the last six months?

- ______ times

Have you had any of these in the last two weeks?

- Yes
- No

ILLNESS IN THE FAMILY

Tick the appropriate box for relatives that have, or have ever had the following illnesses: Tick "None" if none of your relatives have had the condition.

- Stroke or brain haemorrhage
- Myocardial infarction before age 60
- Cancer
- Asthma
- Stomach/duodenal ulcer
- Osteoporosis
- Psychological problems
- Allergy
- Diabetes
- -age when they got diabetes

Mother  Father  Brother  Sister  Child  None
**SYMPTOMS**

Do you cough approximately every day of the year? □ □

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? □ □

Have you had periods of wheezing in your chest? □ □

If "Yes", has this occurred:
- Tick one box only for each item.
  - At night □ □
  - In connection with respiratory infections □ □
  - In connection with physical exertion □ □
  - In connection with very cold weather □ □

Have you noticed sudden changes in your pulse or heart rhythm in the last year? □ □

How often do you suffer from sleeplessness?
- Never, or just a few times a year □
- 1-2 times a month □
- Approximately once a week □
- More than once a week □

If you suffer from periods of sleeplessness, what times of the year does it affect you most?
- No particular time of year □
- Especially during the dark winter months □
- Especially during the midnight sun period □
- Especially in spring and autumn □

Have you in the last twelve months suffered from sleeplessness to the extent that it has affected your ability to work? □ □

How often do you suffer from headaches?
- Seldom/Never □
- Once a month or more □
- Once a week or more □
- Every day □

Does the thought of getting a serious illness ever worry you?
- Not at all □
- Only a little □
- Some □
- Very much □

**USE OF HEALTH SERVICES**

How many visits have you made during the past year due to your own health or illness? Tick 0 if you have not had such contact

To a general practitioner (GP)/Emergency GP
Psychologist or psychiatrist
Other medical specialist (not at a hospital)
Hospital out-patient clinic

**MEDICATION AND DIETARY SUPPLEMENTS**

Have you for any length of time in the past year used any of the following medicines every day or almost daily? Indicate how many months you used them for.

Write 0 for items you have not used.

Medication:
- Painkillers □ □
- Antipyretic drugs (to reduce fever) □ □
- Migraine drugs □ □
- Asthma drugs □ □
- Allergy drugs □ □
- Tranquilizers □ □
- Antidepressants □ □
- Antacids □ □
- Gastric ulcer drugs □ □
- Insulin □ □
- Diabetes tablets □ □
- Lipid lowering drugs □ □
- Heart medicine (not blood pressure) □ □
- Migraine drugs □ □
- Eczema cream/ointment □ □
- Other drugs for nervous conditions □ □
- Insulin □ □
- Cortisone tablets □ □
- Thyraxin tablets (for metabolic disorder) □ □
- Other medicine(s) □ □

Dietary supplements
- Other vitamin supplements □ □
- Cod liver oil or fish oil capsules □ □
- Iron tablets □ □
- Calcium tablets or bonemeal □ □
- Vitamin D supplement □ □
- Other medicine(s) □ □
FRIENDS
How many good friends do you have whom you can talk confidentially with and who give you help when you need it? ______ good friends
Do not count people you live with, but do include other relatives!

How many of these good friends do you have contact with at least once a month? ______

Do you feel you have enough good friends? YES ☐ NO ☐

How often do you normally take part in organised gatherings, e.g., sewing circles, sports clubs, political meetings, religious or other associations?

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

DIET
If you use butter or margarine on your bread, how many slices does a small catering portion normally cover? By this, we mean the portion packs served on planes, in cafés, etc. (i.e., 10-12g)

A catering portion is enough for about ______ slices.

What kind of fat is normally used in cooking (not on the bread) in your home?
- Creamery butter ☐
- Hard margarine ☐
- Soft margarine ☐
- Butter/margarine blend ☐
- Oils ☐

What kind of bread (bought or home-made) do you usually eat? Tick one or two boxes!

- White bread ☐
- Light textured brown bread ☐
- Ordinary brown bread ☐
- Coarse brown bread ☐
- Crisp bread ☐

How much (in number of glasses, cups, potatoes or slices) do you usually eat or drink daily of the following foodstuffs? Tick one box for each foodstuff.

- Yoghurt
- Boiled or fried egg
- Breakfast cereal/
oat meal, etc.
- For dinner
  - meat
  - sausage/meatloaf/
  - meatballs
  - fat fish (e.g., salmon/
  - redfish)
  - lean fish (e.g., cod)
  - fishballs/fishpudding/
  - fishcakes
  - vegetables
  - Mayonnaise, remoulade
  - Carrots
  - Cauliflower/cabbage/
  - broccoli
  - Apples/pears
  - Oranges, mandarines
  - Sweetened soft drinks
  - Sugarfree ("Light")
  - soft drinks
  - Chocolate
  - Waffles, cakes, etc.

ALCOHOL
How often do you usually drink beer? wine? spirits?
- Never, or just a few times a year ☐
- 1-2 times a month ☐
- Roughly once a week ☐
- 2-3 times a week ☐
- Roughly every day ☐

Approximately how often in the last year have you drunk alcohol that equals at least 5 small bottles of beer, a bottle of wine, or 1/4 bottle of spirits?
- Not in the last year ☐
- Just a few times ☐
- 1-2 times a month ☐
- 1-2 times a week ☐
- 3 or more times a week ☐

For approximately how many years has your alcohol consumption been as you described above? _____ years
WEIGHT REDUCTION
About how many times have you deliberately tried to lose weight? Write 0 if you never have.
- before age 20 _____ times
- after age 20 _____ times

If you have lost weight, about how many kilos have you ever lost at the most?
- before age 20 _____ times _____ kg
- after age 20 _____ times _____ kg

What weight would you be satisfied with (your “ideal weight”)? _____ kg

URINARY INCONTINENCE
How often do you suffer from urinary incontinence?
Never □
Not more than once a month □
Two or more times a month □
Once a week or more □

Your comments:

TO BE ANSWERED BY WOMEN ONLY
MENSTRUATION
How old were you when you had your first menstruation? _____ years
If you no longer menstruate, how old were you when you stopped having menstruation? _____ years
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

If you still menstruate or are pregnant:
What date did your last menstruation begin? day/month/year ___ / ___ / ___
Do you normally use painkillers to relieve period pains? YES □ NO □

PREGNANCY
How many children have you given birth to? _____ children
Are you pregnant at the moment? YES □ NO □ Don’t know □
During pregnancy, have you had high blood pressure and/or proteinuria?
YES □ NO □
If “Yes”, during which pregnancy? First Later
High blood pressure □ □
Proteinuria □ □

If you have given birth, fill out for each child the year of birth and approximately how many months you breastfed the child.
Child: Year of birth: Number of months breastfed:
1 ___________ ______ months
2 ___________ ______ months
3 ___________ ______ months
4 ___________ ______ months
5 ___________ ______ months
6 ___________ ______ months

CONTRACEPTION AND OESTROGEN
Do you, or have you ever, used: Now Used to Never:
Contraceptive pills (incl.minipill) □ □ □
A hormonal intrauterine device □ □ □
Oestrogen (tablets or patches) □ □ □
Oestrogen (cream or suppositories) □ □ □

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

If you use, or have ever used, contraceptive pills:
Age when you began taking the pill? _____ years
How many years in total have you taken the pill? _____ years
If you have given birth, how many years did you take the pill before your first child? _____ years
If you have stopped taking the pill:
Age when you stopped? _____ years

Thank you for helping us! Remember to post the form today!
Tromsø Health Survey