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## FATHER AND THE FAMILY

This questionnaire allows us to catch up with your current circumstances, health, diet and lifestyle.

It is for the study child's father or person who takes the role of father. This could be the mother's husband or partner.

If this is relevant to more than one person, it should be the one who is most involved with the study child.

We are very grateful to you for helping us in this way.

**THANK YOU SO MUCH**



**General instruction for completing this booklet:**

**Please tick the box that most applies to you. If there is a question or section that you do not wish to answer, please put a line through it.**

**SECTION A: YOUR MEDICAL HISTORY**

A1. Have you ever had any of the following infections?

	Yes	No, never	Don't know
a) measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) genital herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) urinary infection, cystitis, pyelitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) thrush	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) have you ever had any other unusual infections? (Please tick and describe)	<input type="checkbox"/>	<input type="checkbox"/>	

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A2. Have you ever had any of the following operations:

	Yes	No
a) tonsils out	<div>1</div>	<div>2</div>
b) adenoids out	<div>1</div>	<div>2</div>
c) hernia repair	<div>1</div>	<div>2</div>
d) appendix out	<div>1</div>	<div>2</div>
e) gall bladder out	<div>1</div>	<div>2</div>
f) operation for undescended testes	<div>1</div>	<div>2</div>
g) varicose vein repair	<div>1</div>	<div>2</div>
h) squint repaired	<div>1</div>	<div>2</div>
i) plastic surgery	<div>1</div>	<div>2</div>
j) grommets/tubes in your ears	<div>1</div>	<div>2</div>
k) hypospadias repair	<div>1</div>	<div>2</div>
l) hip replacement	<div>1</div>	<div>2</div>
m) wisdom tooth removed	<div>1</div>	<div>2</div>
n) other type of operation (please tick & describe)	<div>1</div>	<div>2</div>

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A3. Have you ever had any of the following problems:

	<b>Yes, had it recently (in past year)</b>	<b>Yes, in past, not now</b>	<b>No never</b>
a) hay fever	<div>1</div>	<div>2</div>	<div>3</div>
b) indigestion	<div>1</div>	<div>2</div>	<div>3</div>
c) bulimia	<div>1</div>	<div>2</div>	<div>3</div>
d) asthma	<div>1</div>	<div>2</div>	<div>3</div>
e) eczema	<div>1</div>	<div>2</div>	<div>3</div>
f) epilepsy	<div>1</div>	<div>2</div>	<div>3</div>
g) ME or chronic fatigue syndrome	<div>1</div>	<div>2</div>	<div>3</div>
h) migraine	<div>1</div>	<div>2</div>	<div>3</div>
i) back pain/slipped disc	<div>1</div>	<div>2</div>	<div>3</div>
j) kidney disease*	<div>1</div>	<div>2</div>	<div>3</div>
k) varicose veins	<div>1</div>	<div>2</div>	<div>3</div>
l) haemorrhoids/piles	<div>1</div>	<div>2</div>	<div>3</div>
m) rheumatism	<div>1</div>	<div>2</div>	<div>3</div>
n) arthritis	<div>1</div>	<div>2</div>	<div>3</div>
o) psoriasis	<div>1</div>	<div>2</div>	<div>3</div>
p) stomach ulcer	<div>1</div>	<div>2</div>	<div>3</div>
q) drug addiction	<div>1</div>	<div>2</div>	<div>3</div>
r) alcoholism	<div>1</div>	<div>2</div>	<div>3</div>

	Yes, had it recently (in past year)	Yes, in past, not now	No never
A3. s) schizophrenia	<div>1</div>	<div>2</div>	<div>3</div>
t) anorexia nervosa	<div>1</div>	<div>2</div>	<div>3</div>
u) severe depression	<div>1</div>	<div>2</div>	<div>3</div>
v) other psychiatric problem*	<div>1</div>	<div>2</div>	<div>3</div>
w) other problem(s)* (please tick & describe)	<div>1</div>	<div>2</div>	

\* please tick appropriate box and describe below

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A4. a) Have you ever had diabetes?

Yes 

1

 No 

2

 → If **no**, go to (b) below

If **yes**

i) How is/was it treated?

insulin injections

1

other drugs

2

diet only

3

ii) How old were you when you first developed it?

years

b) Have you ever had hypertension (high blood pressure)?

Yes 

1

 No 

2

 → If **no**, go to A5 on page 7

If **yes**

i) How old were you when you first developed it?

years

ii) Do you have hypertension nowadays?

Yes ☐<sub>1</sub> No ☐<sub>2</sub>

A5. a) Are there any problems for which you have **regular** treatment or medicine nowadays?

Yes ☐<sub>1</sub> No ☐<sub>2</sub> → If **no**, go to A6 below

b) If **yes**, please describe the problem and regular treatment or medicine:

**Problem**

**Treatment or medicine**

.....	.....
.....	.....
.....	.....
.....	.....

A6. a) Would you say that you were allergic to anything?

Yes ☐<sub>1</sub> No ☐<sub>2</sub> → If **no**, go to A7 on page 8

b) If **yes**, is it to:

	<b>Yes</b>	<b>No</b>
i) cat	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
ii) pollen	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
iii) dust	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
iv) insect bites or stings	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
v) medication (e.g. penicillin)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
vi) something else (Please tick & describe)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

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A7. Have you had any of the following **in the past two years**:

	In the past 2 years:	Yes often	Yes, sometimes	No, not at all
a)	attacks of wheezing with whistling on the chest	<div>1</div>	<div>2</div>	<div>3</div>
b)	a dry itchy rash	<div>1</div>	<div>2</div>	<div>3</div>
c)	a blotchy blistery rash (hives)	<div>1</div>	<div>2</div>	<div>3</div>
d)	sneezing attacks	<div>1</div>	<div>2</div>	<div>3</div>
e)	runny nose	<div>1</div>	<div>2</div>	<div>3</div>
f)	watery eyes	<div>1</div>	<div>2</div>	<div>3</div>
g)	attacks of breathlessness	<div>1</div>	<div>2</div>	<div>3</div>
h)	cough often during the night	<div>1</div>	<div>2</div>	<div>3</div>
i)	cough often when you wake in the morning	<div>1</div>	<div>2</div>	<div>3</div>

A8. a) What is your weight nowadays?

stones	pounds	total pounds	kilos
<div></div> <div></div>	<div></div> <div></div>	OR <div></div> <div></div> <div></div>	OR <div></div> <div></div> <div></div>

i) Are you certain of this?

Yes	<div>1</div>	No	<div>2</div>
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b) What is your size nowadays in:-

i)	hips	<div></div> <div></div>	ins.	OR	<div></div> <div></div> <div></div>	cms
ii)	waist	<div></div> <div></div>	ins.	OR	<div></div> <div></div> <div></div>	cms
iii)	chest	<div></div> <div></div>	ins.	OR	<div></div> <div></div> <div></div>	cms

(If you don't know write NK at the side)

A8. c) How tall are you?

feet	inches	centimetres
<div></div>	<div></div> <div></div>	



☐

OR

☐☐☐

i) Are you certain of this?

Yes

☐  
1

No

☐  
2A9. **Your hearing**

How would you rate your hearing in each ear?

	(i) Left ear	(ii) Right ear
always very good	<input type="checkbox"/> 1	<input type="checkbox"/> 1
occasional problems (e.g. infections or glue ear)	<input type="checkbox"/> 2	<input type="checkbox"/> 2
there are some sounds I cannot hear	<input type="checkbox"/> 3	<input type="checkbox"/> 3
never very good	<input type="checkbox"/> 4	<input type="checkbox"/> 4
I cannot hear much at all	<input type="checkbox"/> 5	<input type="checkbox"/> 5

A10. **Your eyesight**

a) How would you rate your sight without glasses?

Without glasses:	(i) Left eye	(ii) Right eye
always very good	<input type="checkbox"/> 1	<input type="checkbox"/> 1
I can't see clearly at a distance	<input type="checkbox"/> 2	<input type="checkbox"/> 2
I can't see clearly close up	<input type="checkbox"/> 3	<input type="checkbox"/> 3
I can't see much at all	<input type="checkbox"/> 4	<input type="checkbox"/> 4

A10. b) Do you wear glasses?

yes always

yes sometimes

no never

c) Are you colour blind?

Yes

No

Don't know

A11. When you were a child, what was the maximum number of brothers and sisters that lived with you at any one time? (Include half-brothers and sisters, step-brothers and sisters)

**brothers**

**sisters**

a) older than you

b) younger than you

c) a twin to you

## SECTION B: ABOUT THE HEALTH OF YOUR PARENTS

B1. Has your natural mother and/or natural father ever had any of the following:

		(i) Natural mother			(ii) Natural father		
		Yes	No	Don't know	Yes	No	Don't know
a)	diabetes treated with insulin	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
b)	other diabetes	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
c)	coronary heart disease	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
d)	rheumatism	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
e)	arthritis	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
f)	multiple sclerosis	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
g)	breast cancer (mother) prostate cancer (father)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
h)	other cancer*	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
i)	hypertension (high blood pressure)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
j)	an alcohol problem	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
k)	schizophrenia	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
l)	chronic bronchitis	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
m)	a stroke	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
n)	depression or 'nerves'	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>
o)	other problem*	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="9"/>

\* (Please tick and describe) .....

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B2. Are your natural parents still alive?

a) Mother is alive

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If no,**

(i) How old was she when she died?		years
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(ii) What did she die of? .....

	Yes	No	Don't know
b) Father is alive	1	2	9

**If no,**

(i) How old was he when he died?			years
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(ii) What did he die of? .....

## SECTION C: YOU AND FOOD

C1. How far do the following statements describe you?

	Yes, most of the time	Yes sometimes	No, not at all
a) I like to try different foods	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b) I prefer to eat familiar foods	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c) I prefer to eat the sort of foods I ate when I was a child	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d) I would like to try different foods but my partner/family only like familiar foods	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e) I would be willing to try almost any food if it were offered to me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f) I greatly enjoy eating	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
g) I eat because I need to, not because I enjoy it	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

C2. Which **one** of these statements best describes the way you feel about cooking?

I always enjoy cooking	<input type="text" value="1"/>
I enjoy cooking when I can take time over it	<input type="text" value="2"/>
I cook only because I have to, not because I enjoy it	<input type="text" value="3"/>
I avoid cooking if at all possible	<input type="text" value="4"/>
I have no real feeling towards cooking	<input type="text" value="5"/>

C3. How often do you:

	Always	Often	Sometimes	Rarely	Never	Don't do cooking
a) Add salt to vegetables, potatoes rice or pasta during cooking?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="7"/>
b) Add salt to food at the table?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	
c) Add herbs to food during cooking?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="7"/>

C3. How often do you:

	Always	Often	Sometimes	Rarely	Never
d) Add sauces to food at the table? (please specify type of sauce e.g. Tomato Ketchup)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>

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C4. When you are choosing food for meals, how much do the following influence your choice?

	A lot	Quite a bit	A little	Not at all	Don't choose food
a) Cost	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="7"/>
b) What your children prefer to eat	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<p>↓ go to C5 below</p>
c) What you prefer to eat	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
d) What other people prefer to eat (e.g. partner, other adult)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
e) Convenience of preparation	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
f) What is good (healthy) for us to eat	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
g) The special offers available when shopping	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
h) Adverts on the television/radio	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
j) Articles about food and recipes in newspapers/magazines	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
k) Dietary requirements of a member of the family	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	
l) Other (please tick and describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>		

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C5. a) Do you read the labels on packaged food?

Always	<input type="text" value="1"/>	Sometimes	<input type="text" value="2"/>	No	<input type="text" value="3"/>
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C5. b) Do you understand the information about contents and nutrition on the labels?

Usually  Partly  No

c) Do you prefer the family to have food without artificial additives?

Yes  No  Don't mind

C6. a) Do you work irregular hours?

Yes  No  → If **no**, go to C7 below

If **yes**,

b) Does this affect your eating habits?

	Yes	No
i) Type of food eaten	<input type="text" value="1"/>	<input type="text" value="2"/>
ii) Times of meals	<input type="text" value="1"/>	<input type="text" value="2"/>

C7. How often do you yourself usually eat something at each of the following meals?

	Never	Less than once a week	Once a week	2-4 times a week	5-6 times a week	Every day
a) Breakfast	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
b) Mid-morning snack	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
c) Mid-day meal/snack	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
d) Mid-afternoon snack	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
e) Evening meal/snack	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>
f) Late night snack/ supper	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>	<input type="text" value="6"/>

## **SECTION D: YOU AND YOUR CURRENT PARTNER**

D1. a) Do you have a wife/partner at the moment?

yes, lives with me

yes, but does not live with me

no, don't have

→ If **no**, go to Section E on page 20

b) If **yes**, is this:

your wife

a female partner

a male partner

→ If a male partner, please answer the questions below even though they refer to a female partner

Please describe your current relationship using the statements below:

		No, not true	Sometimes true	Yes, very true	Can't say
D2.	We support each other during difficult times	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D3.	We disagree about what to do when the children are naughty	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D4.	It is easy for both of us to express our opinion to each other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D5.	My wife/partner and I agree completely about how to raise the children	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D6.	I feel that our relationship is very stable	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D7.	We discuss problems and feel good about the solutions	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D8.	I worry that my wife/partner is too strict with the children	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



		<b>No, not true</b>	<b>Sometimes true</b>	<b>Yes, very true</b>	<b>Can't say</b>
D9.	My wife/partner treats me like a king	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
D10.	She spoils the children too much	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
D11.	She is perfectly honest and truthful with me	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
D12.	I feel that I can trust her completely	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
D13.	We feel very close to each other	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
D14.	I can count on my wife/partner to help me	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
D15.	She is sincere in her promises	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
D16.	She can be relied on to help me however big a problem I have	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
D17.	My wife/partner makes me feel loved	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
D18.	My wife/partner helps me out with the children	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

**No matter how well a couple get on there may be times when they disagree, get annoyed or have quarrels or fights because they're in a bad mood, tired or for some other reason.**

		<b>No</b>	<b>Yes, sometimes</b>	<b>Yes, often</b>
D19.	Have you cursed or sworn at your wife/partner?	<div>1</div>	<div>2</div>	<div>3</div>
D20.	Has your wife/partner cursed or sworn at you?	<div>1</div>	<div>2</div>	<div>3</div>
D21.	Have you ordered your wife/partner around?	<div>1</div>	<div>2</div>	<div>3</div>
D22.	Has she ordered you around?	<div>1</div>	<div>2</div>	<div>3</div>

	No	Yes, sometimes	Yes, often
D23. Have you insulted or shamed her in front of others?	<div>1</div>	<div>2</div>	<div>3</div>
D24. Has she insulted or shamed you in front of others?	<div>1</div>	<div>2</div>	<div>3</div>
D25. Have you pushed, grabbed, or shoved your wife/partner?	<div>1</div>	<div>2</div>	<div>3</div>
D26. Has your wife/partner pushed, grabbed or shoved you?	<div>1</div>	<div>2</div>	<div>3</div>
D27. Have you ever slapped her?	<div>1</div>	<div>2</div>	<div>3</div>
D28. Has she ever slapped you?	<div>1</div>	<div>2</div>	<div>3</div>
D29. Have you ever shaken your wife/partner?	<div>1</div>	<div>2</div>	<div>3</div>
D30. Has your wife/partner ever shaken you?	<div>1</div>	<div>2</div>	<div>3</div>
D31. Have you ever thrown an object at your wife/partner that could hurt her?	<div>1</div>	<div>2</div>	<div>3</div>
D32. Has she thrown an object at you that could hurt you?	<div>1</div>	<div>2</div>	<div>3</div>
D33. Have you ever kicked, bitten, or hit your wife/partner with a fist?	<div>1</div>	<div>2</div>	<div>3</div>
D34. Has she kicked, bitten, or hit you with a fist?	<div>1</div>	<div>2</div>	<div>3</div>
D35. Have you ever hit or tried to hit your wife/partner with something?	<div>1</div>	<div>2</div>	<div>3</div>
D36. Has she ever hit or tried to hit you with something?	<div>1</div>	<div>2</div>	<div>3</div>
D37. Have you ever physically twisted her arm?	<div>1</div>	<div>2</div>	<div>3</div>
	No	Yes, sometimes	Yes, often

D38.	Has she ever physically twisted your arm?	<div>1</div>	<div>2</div>	<div>3</div>
D39.	Have you ever thrown or tried to throw your wife/partner bodily?	<div>1</div>	<div>2</div>	<div>3</div>
D40.	Has she ever thrown or tried to throw you bodily?	<div>1</div>	<div>2</div>	<div>3</div>
D41.	Have you ever beaten up your wife/partner (multiple blows)?	<div>1</div>	<div>2</div>	<div>3</div>
D42.	Has she ever beaten you up (multiple blows)?	<div>1</div>	<div>2</div>	<div>3</div>
D43.	Have you ever tried to choke or strangle her?	<div>1</div>	<div>2</div>	<div>3</div>
D44.	Has she ever tried to choke or strangle you?	<div>1</div>	<div>2</div>	<div>3</div>
D45.	Have you ever threatened your wife/partner with a knife or other weapon?	<div>1</div>	<div>2</div>	<div>3</div>
D46.	Has she ever threatened you with a knife or other weapon?	<div>1</div>	<div>2</div>	<div>3</div>
D47.	Have you ever used a knife or other weapon on your wife/partner?	<div>1</div>	<div>2</div>	<div>3</div>
D48.	Has she ever used a knife or other weapon on you?	<div>1</div>	<div>2</div>	<div>3</div>

## SECTION E: EDUCATION AND OCCUPATION

E1. What educational qualifications do you, your wife or partner, your mother, and your father have? Please tick all that apply. **(By wife or partner we mean your current live-in wife or partner).**

	(i) Your self	(ii) Your wife/ partner	(iii) Your mother*	(iv) Your father*
a) CSE or GCSE (D, E, F or G)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) O-level or GCSE (A, B, or C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) A-level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Qualifications in shorthand/ typing/or other skills, e.g. hairdressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Apprenticeship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) State enrolled nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) State registered nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) City & Guilds intermediate technical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) City & Guilds final technical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) City & Guilds full technical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Teaching qualification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) University degree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) No qualifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Qualifications not known	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Not applicable, no such person		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Other (Please tick & describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(\* by this we mean the mother figure or father figure who was mostly responsible for bringing you up)

E2. What is the present employment situation of yourself and your current live-in wife or partner? Please tick all that apply.

	(i) Yourself	(ii) Your wife or partner	No live-in wife/ partner
a) Working for an employer full-time (more than 30 hours a week)	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 7
b) Working for an employer part-time (one hour or more a week)	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
c) Self-employed, employing other people	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
d) Self-employed, not employing other people	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
e) On a government employment or training scheme	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
f) Waiting to start a job already accepted	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
g) Unemployed and looking for a job	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
h) At school or in other full-time education	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
i) Unable to work because of long-term sickness or disability	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
j) Retired from paid work	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
k) Looking after the home or family	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
l) Carrying out voluntary work	<input type="checkbox"/> 1	<input type="checkbox"/> 1	
m) Other (please tick & describe)	<input type="checkbox"/> 1	<input type="checkbox"/> 1	

.....

E3. To recap, are you in a paid job at the moment?

Yes  No  → If **no**, go to E4 on page 23

If **yes**,

These questions are about your present job

(If you have more than one job, answer for the main job)

	Yes usually	Yes sometimes	No ↓
a) Can you decide yourself when to have a holiday?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b) Can you decide what you do at work?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c) Can you decide the order in which you do your different tasks at work?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d) Can you decide when to take a break?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e) Is your work monotonous?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f) Do you have scope for on-the-job development?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
g) Does the job fit well with your educational background and/or experience?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
h) Do you have to work at a fast pace?	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

### Your present job (or last main job(s))

E4. As far as you can, please describe the actual job, occupation, trade or profession. (Use precise terms such as shoe shop supervisor, car mechanic, primary school teacher, toolroom foreman, van driver. If the occupation is known by a special name, please use that name. If in H.M. forces, give the rank in addition to the actual job. Please also describe the type of industry or service given: i.e. Give details of what is made, materials used, or services given).

- a) Actual job, occupation, trade or profession

.....

- b) Type of industry or service given (main things done in job)

.....

- c) Hours worked in a normal week: 

--	--

- d) How long have you had this job?

- |                  |   |
|------------------|---|
| less than 1 year | 1 |
| 1-2 years        | 2 |
| 3 years or more  | 3 |

- e) Have you been promoted since starting this job?

- |     |   |    |   |
|-----|---|----|---|
| Yes | 1 | No | 2 |
|-----|---|----|---|

- f) How much paid holiday are you allowed?

		days per year (don't count Bank Holidays)
--	--	---

- g) Please tick which of the following currently apply to you:

- |               |   |
|---------------|---|
| foreman       | 1 |
| manager       | 2 |
| supervisor    | 3 |
| leading hand  | 4 |
| self-employed | 5 |
| none of these | 6 |

- E4. h) Are you in contact with particular fumes or chemicals in your job?

always	<input type="text" value="1"/>	often	<input type="text" value="2"/>	sometimes	<input type="text" value="3"/>
rarely	<input type="text" value="4"/>	never	<input type="text" value="5"/>	don't know	<input type="text" value="9"/>

Please describe the fumes or chemicals .....

.....

E5. Do you think you have been unfairly treated in the last 12 months because of:

	<b>Yes often</b>	<b>Yes sometimes</b>	<b>No not at all</b>
a) Your sex	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b) Your skin colour	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c) The way you dress	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d) Your family background	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e) The way you speak	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f) Your religion	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
g) Other (please tick & describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

.....



E6. How would you describe the race or ethnic group of yourself, your live-in wife or partner and your natural parents?

	(i) Yourself	(ii) Wife/ partner	(iii) Your mother	(iv) Your father
white	<div>01</div>	<div>01</div>	<div>01</div>	<div>01</div>
black/Caribbean	<div>02</div>	<div>02</div>	<div>02</div>	<div>02</div>
black/African	<div>03</div>	<div>03</div>	<div>03</div>	<div>03</div>
black/other (please describe below)	<div>04</div>	<div>04</div>	<div>04</div>	<div>04</div>
Indian	<div>05</div>	<div>05</div>	<div>05</div>	<div>05</div>
Pakistani	<div>06</div>	<div>06</div>	<div>06</div>	<div>06</div>
Bangladeshi	<div>07</div>	<div>07</div>	<div>07</div>	<div>07</div>
Chinese	<div>08</div>	<div>08</div>	<div>08</div>	<div>08</div>
any other ethnic group (please tick & describe)	<div>09</div>	<div>09</div>	<div>09</div>	<div>09</div>

.....

**SECTION F: YOUR HOUSEHOLD**

F1. a) How many people live in your household now? (including yourself)

- i)  adults (over 18 years)
- ii)  young adults (16-18 years)
- iii)  children (less than 16 years)

b) Please indicate who the adults over 18 are:

- |  | Yes                       |
|--|---------------------------|
| i) yourself                                | <input type="text"/><br>1 |
| ii) your wife/partner                      | <input type="text"/><br>1 |
| iii) your parent(s)                        | <input type="text"/><br>1 |
| iv) your wife's/partner's parent(s)        | <input type="text"/><br>1 |
| v) other relation(s) of yourself           | <input type="text"/><br>1 |
| vi) other relation(s) of your wife/partner | <input type="text"/><br>1 |
| vii) friend(s)                             | <input type="text"/><br>1 |
| viii) lodger                               | <input type="text"/><br>1 |
| ix) other (please tick and describe)       | <input type="text"/><br>1 |

.....

F2. a) Do you have a rule that smoking never happens in particular rooms?

- no smoking in house at all   
1
- smoking only allowed in some rooms   
2
- smoking allowed anywhere   
3

b) How many people living in your household (including yourself) are smokers?

F3. a) What is your present marital status?

- |                                     |                                |
|-------------------------------------|--------------------------------|
| never married                       | <input type="text" value="1"/> |
| widower                             | <input type="text" value="2"/> |
| divorced                            | <input type="text" value="3"/> |
| separated                           | <input type="text" value="4"/> |
| married (once only)                 | <input type="text" value="5"/> |
| married for second<br>or third time | <input type="text" value="6"/> |

- b) If married, what was the date of the most recent marriage?
- |                      |                      |                      |                      |
|----------------------|----------------------|----------------------|----------------------|
|                      | day                  | month                | year                 |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

- F4. a) Does the biological (natural) mother of the 8 year old study child live with the study child?

No  Yes  → If yes, go to F4c on page 28

If no,

- b) i) How old was the child when the natural mother stopped living with the child?

months

(put 00 if the mother never lived with the child)

- ii) How often does the natural mother see the study child?

- |                        |                                |
|------------------------|--------------------------------|
| not at all             | <input type="text" value="1"/> |
| less than once a month | <input type="text" value="2"/> |
| about once a month     | <input type="text" value="3"/> |
| about once a fortnight | <input type="text" value="4"/> |
| once or twice a week   | <input type="text" value="5"/> |
| nearly every day       | <input type="text" value="6"/> |

child's mother  
is dead

Go to F4c  
on page 28

F4. b) iii) Does she help support the child financially ?

yes, on a regular basis

yes, occasionally

no

c) Does the biological (natural) father of the 8 year old study child live with the study child?

No

Yes



**If yes, go to F5 on page 29**

**If no,**

i) How old was the child when the natural father stopped living with the child?

months

(put 00 for from birth)

ii) How often does the natural father see the study child?

not at all

less than once a month

about once a month

about once a fortnight

once or twice a week

nearly every day

child's father  
is dead



**Go to F5  
on page 29**

iii) Does he help support the child financially ?

yes, on a regular basis

yes, occasionally

no

To make the questions less complicated, for the rest of this section, for **partner** we mean **wife or partner**.

F5. Please indicate how many of the children living with you have:

**Number of children**

- a) you and your partner as their natural parents
- b) you as their natural father (but their natural mother is not present)
- c) your partner as the natural mother (but you are not their natural father)
- d) neither you nor your partner as natural parents (please describe whether you have adopted, fostered etc.)

 
 
 
 

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F6. Are there other children of yourself or your partner who visit (whether to play or to stay)?

**No Yes Number of children**

- a) Children of my partner but not me



 

- b) Children of myself but not my partner



 

- c) Children of me and my partner



 

F7. Do any of the people living in your household, including yourself and your study child, have a chronic illness or disabling condition?

Yes

No



**If no, go to F8 on page 30**

**If yes, please describe:**

**Nature of condition(s)**

**Person(s) involved**

(state relationship to you - wife/partner, child, mother, etc.)

.....

.....

.....

.....

.....

.....

.....

.....

F8. a) Do you have any pets?

Yes  No  → If **no**, go to F9a below

If **yes**,

b) How many of the following pets do you have?

	Number
i) cats	<input type="text"/> <input type="text"/>
ii) dogs.	<input type="text"/> <input type="text"/>
iii) rabbits	<input type="text"/> <input type="text"/>
iv) rodents (mice, hamster, gerbil etc.)	<input type="text"/> <input type="text"/>
v) birds (budgerigar, parrot, etc.)	<input type="text"/> <input type="text"/>
vi) fish	<input type="text"/> <input type="text"/>
vii) turtles/tortoises/terrapin	<input type="text"/> <input type="text"/>
viii) other pets (please say how many and describe)	<input type="text"/> <input type="text"/> .....

F9. a) On average, about how much is the take home family income each week (include social benefits etc.)?

less than £100	<input type="text" value="1"/>	£100 - £199	<input type="text" value="2"/>	£200 - £299	<input type="text" value="3"/>
£300 - £399	<input type="text" value="4"/>	£400 or more	<input type="text" value="5"/>	don't know	<input type="text" value="9"/>

b) Out of this, how much do you pay for rent, loans or mortgage each week?

nothing	<input type="text" value="1"/>	less than £20	<input type="text" value="2"/>	£20 - £39	<input type="text" value="3"/>	£40 - £59	<input type="text" value="4"/>
£60 - £79	<input type="text" value="5"/>	£80 - £99	<input type="text" value="6"/>	£100 or more	<input type="text" value="7"/>	don't know	<input type="text" value="9"/>

F9. c) About how much do you spend on food for the whole family each week?

less than £20	<input type="text" value="1"/>	£20 - £29	<input type="text" value="2"/>	£30 - £39	<input type="text" value="3"/>	£40 - £49	<input type="text" value="4"/>
£50 - £59	<input type="text" value="5"/>	£60 - £79	<input type="text" value="6"/>	£80 or more	<input type="text" value="7"/>	don't know	<input type="text" value="9"/>

d) How much do you spend on child care each week (playgroup, childminder, baby sitter etc.)

nothing	<input type="text" value="1"/>	less than £20	<input type="text" value="2"/>	£20 - £39	<input type="text" value="3"/>	£40 - £59	<input type="text" value="4"/>
£60 - £79	<input type="text" value="5"/>	£80 - £99	<input type="text" value="6"/>	£100 or more	<input type="text" value="7"/>		
varies	<input type="text" value="8"/>	don't know	<input type="text" value="9"/>				

e) Do you manage to save at all? Yes  No

f) Do you receive any financial help from your parents or other relatives?

Yes  No

g) Do you give financial help to your parents or other relatives?

Yes  No

## **SECTION G: YOUR FEELINGS**

G1. Below are a number of statements which you may use to describe yourself. Please indicate if you think these apply to you. Each statement applies to how you feel **nowadays**.

<b>Nowadays:</b>	<b>Doesn't apply</b>	<b>Applies a bit</b>	<b>Moderately applies</b>	<b>Certainly applies</b>
a) I feel calm	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b) I feel secure	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c) I feel tense	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d) I feel strained	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
e) I feel at ease	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
f) I feel upset	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
g) I am presently worrying over possible misfortunes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
h) I feel satisfied	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
i) I feel frightened	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
j) I feel comfortable	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
k) I feel self-confident	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
l) I feel nervous	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
m) I am jittery	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
n) I feel indecisive	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
o) I am relaxed	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
p) I feel content	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
q) I am worried	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
r) I feel confused	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
s) I feel steady	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
t) I feel pleasant	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>



G2. Below are a number of statements which you may use to describe yourself. Please indicate if you think these apply to you. Each statement applies to how you **generally** feel.

Generally:	Doesn't apply	Applies a bit	Moderately applies	Certainly applies
a) I feel pleasant	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b) I tire quickly	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c) I feel like crying	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
d) I wish I could be as happy as others seem to be	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
e) I am losing out on things because I can't make up my mind soon enough	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
f) I feel rested	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
g) I am 'calm, cool and collected'	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
h) I feel that difficulties are piling up so that I cannot overcome them	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
i) I worry too much over something that doesn't really matter	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
j) I am happy	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
k) I am inclined to take things hard	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
l) I lack self-confidence	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
m) I feel secure	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
n) I try to avoid facing a crisis or difficulty	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
o) I feel blue	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
p) I am content	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
G2 cont.	Doesn't	Applies	Moderately	Certainly

Generally:	apply	a bit	applies	applies
q) Some unimportant thought runs through my mind and bothers me	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
r) I take disappointments so keenly that I can't put them out of my mind	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
s) I am a steady person	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
t) I become tense and upset when I think about my present concerns	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

**Your feelings in the past week:**

G3. I have been able to laugh and see the funny side of things:

As much as I always could	<input type="text" value="1"/>
Not quite so much now	<input type="text" value="2"/>
Definitely not so much now	<input type="text" value="3"/>
Not at all	<input type="text" value="4"/>

G4. I have looked forward with enjoyment to things:

As much as I ever did	<input type="text" value="1"/>
Rather less than I used to	<input type="text" value="2"/>
Definitely less than I used to	<input type="text" value="3"/>
Hardly at all	<input type="text" value="4"/>

**In the past week:**

G5. I have blamed myself unnecessarily when things went wrong:

Yes, most of the time	<input type="text" value="1"/>
Yes, some of the time	<input type="text" value="2"/>
Not very often	<input type="text" value="3"/>
Never	<input type="text" value="4"/>

G6. I have been anxious or worried for no good reason:

No, not at all	<input type="text" value="1"/>
Hardly ever	<input type="text" value="2"/>
Yes, sometimes	<input type="text" value="3"/>
Yes, often	<input type="text" value="4"/>

G7. I have felt scared or panicky for no very good reason :

Yes, quite a lot	<input type="text" value="1"/>
Yes, sometimes	<input type="text" value="2"/>
No, not much	<input type="text" value="3"/>
No, not at all	<input type="text" value="4"/>

G8. Things have been getting on top of me:

Yes, most of the time I haven't been able to cope	<input type="text" value="1"/>
Yes, sometimes I haven't been coping as well as usual	<input type="text" value="2"/>
No, most of the time I have coped quite well	<input type="text" value="3"/>
No, I have been coping as well as ever	<input type="text" value="4"/>

**In the past week:**

G9. I have been so unhappy that I have had difficulty sleeping:

Yes, most of the time	<input type="text" value="1"/>
Yes, sometimes	<input type="text" value="2"/>
Not very often	<input type="text" value="3"/>
No, not at all	<input type="text" value="4"/>

G10. I have felt sad or miserable:

Yes, most of the time	<input type="text" value="1"/>
Yes, quite often	<input type="text" value="2"/>
Not very often	<input type="text" value="3"/>
No, not at all	<input type="text" value="4"/>

G11. I have been so unhappy that I have been crying :

Yes, most of the time	<input type="text" value="1"/>
Yes, quite often	<input type="text" value="2"/>
Only occasionally	<input type="text" value="3"/>
Never	<input type="text" value="4"/>

G12. The thought of harming myself has occurred to me :

Yes, quite often	<input type="text" value="1"/>
Sometimes	<input type="text" value="2"/>
Hardly ever	<input type="text" value="3"/>
Never	<input type="text" value="4"/>

## **SECTION H: YOUR DIET**

H1. Families eat a variety of different things. How often nowadays do you eat the following foods? Please answer every question even if you never eat the food (in this case tick “Never or rarely”).

	<b>I eat:</b>	<b>Never or rarely</b>	<b>Once in 2 weeks</b>	<b>1-3 times a week</b>	<b>4-7 times a week</b>	<b>More than 7 times a week</b>
a)	Oat cereals (e.g. porridge Ready Brek, muesli)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b)	Wholegrain or bran cereals (e.g. All Bran, Bran Flakes, Weetabix, Wheatflakes, Fruit & Fibre, Shredded Wheat)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c)	Other cereals (e.g. Cornflakes Rice Krispies, Special K, Frosties)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d)	Sausages, Burgers	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e)	Meat Pies, Pasties (pork pie, steak/meat pie, Cornish pastie etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f)	Vegetarian Pies, Pasties (cheese and onion pasty, vegetable samosa, onion bhaji, vegetable grills etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g)	Ham, bacon, paté and cold meats (e.g. salami, luncheon meat, garlic sausage etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h)	Beef: roast, stews, mince etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
i)	Lamb or pork: roast, chops, stews etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
j)	Liver, kidney, heart and other offal	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

H1.	I eat:	Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than 7 times a week
k)	Chicken/Turkey in crispy coating (e.g. chicken nuggets, turkey burgers, chicken fingers etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
l)	Poultry: roast, baked or stewed (chicken, turkey etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
m)	Shellfish (prawns, scampi, crab, cockles, mussels etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
n)	White fish in breadcrumbs or batter (e.g. fishfingers, chip shop fish, breaded cod, plaice or haddock).	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
o)	White fish without coating (e.g. grilled fish, cod in parsley sauce etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
p)	Tuna	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
q)	Other fish (pilchards, sardines, mackerel, herrings, kippers, trout, salmon etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
r)	Eggs, quiche/flans, omelettes etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
s)	Cheese	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
t)	Pizza	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
u)	Oven chips	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
v)	Fried chips, potato waffles and croquettes, Alphabites etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
w)	Roast potatoes (cooked in fat or oil)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

H1.	Never	Once in	1-3	4-7	More than
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	<b>I eat:</b>	<b>or rarely</b>	<b>2 weeks</b>	<b>times a week</b>	<b>times a week</b>	<b>7 times a week</b>
x)	Boiled, mashed, jacket potatoes	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
y)	Rice (boiled, or fried, not rice pudding)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
z)	Canned pasta (e.g. spaghetti rings, ravioli, macaroni cheese etc.) Pot Noodles, Super Noodles etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
za)	Boiled pasta (e.g. spaghetti fusilli, lasagne), bulgar wheat or cous-cous	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

H2. Do you eat the fat on meat?

yes, all of it	<div>1</div>
yes, some of it	<div>2</div>
no	<div>3</div>
never eat meat	<div>4</div>

H3. How many times nowadays do you eat;

	<b>Never or rarely</b>	<b>Once in 2 weeks</b>	<b>1-3 times a week</b>	<b>4-7 times a week</b>	<b>More than 7 times a week</b>
a) Baked beans	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b) Peas, broad beans	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c) Sweetcorn	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d) Cabbage, brussel sprouts spinach, broccoli and other dark green leafy vegetables	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

H3. How many times nowadays do you eat;

		<b>Never or rarely</b>	<b>Once in 2 weeks</b>	<b>1-3 times a week</b>	<b>4-7 times a week</b>	<b>More than 7 times a week</b>
e)	Other green vegetables (cauliflower, runner beans, leeks, courgettes etc.)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
f)	Carrots	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
g)	Other root vegetables (turnip, swede, parsnip etc.)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
h)	Tomatoes (cooked or raw)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
i)	Salads or raw vegetables	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
j)	Pulses - dried peas, beans, lentils, chick peas etc.	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
k)	Soya 'Meat', TVP, Soya-type Vegeburgers, Bean Curd (Tofu, Miso etc.)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
l)	Peanuts (salted or roast, peanut butter)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
m)	Other nuts (e.g. almonds, cashews), and nut roast etc.	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
n)	Fresh citrus fruit (e.g. oranges, grapefruit, satsumas, tangerines etc.)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
o)	Other fresh fruit (e.g. apple, banana, pear, bunch of grapes, peach)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
p)	Canned fruit	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
q)	Yoghurt, Fromage Frais, Milk puddings (e.g. rice pudding, semolina), mousse	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>
r)	Ice cream, choc ice, chocolate ice cream bar etc.	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>	<input type="text" value="5"/>



		<b>Never or rarely</b>	<b>Once in 2 weeks</b>	<b>1-3 times a week</b>	<b>4-7 times a week</b>	<b>More than 7 times a week</b>
H3.						
s)	Pudding (e.g. fruit pie crumble, cheesecake, gateaux)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
t)	Custard, cream, Elmlea, Tip-Top, evaporated milk etc. on puddings	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
u)	Cakes or buns (fruit cake, sponge, teacake, doughnut, flapjack, scone, custard tart, cream cake etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
v)	Crispbreads (Ryvita, crackerbread etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
w)	Full-coated chocolate biscuits (e.g. Club, Kit Kat, Penguin, Breakaway etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
x)	Other biscuits e.g. rich tea, shortcakes, digestive and chocolate digestive, Hob Nobs	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
y)	Chocolate (dairy milk or plain nut, fruit, filled etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
z)	Sweets (peppermints, boiled sweets, toffees etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
za)	Crisps, corn snacks (e.g. Wotsits, Quavers), tortilla chips etc.	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

H4. How many times a week nowadays do you drink:

	Never or rarely	Once in 2 weeks	1-3 times a week	4-7 times a week	More than 7 times a week
a) Fruit juice from a carton, tin or freshly squeezed including tomato juice	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b) Squash, fruit drinks or Ribena	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
c) Cola drinks (e.g. Coca Cola, Pepsi etc.)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
d) Other fizzy drinks (e.g. lemonade)	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
e) Bottled water	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
f) Water from tap	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
g) Milk on its own	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
h) Flavoured milk drinks (e.g. Horlicks, Ovaltine, milkshakes) or yoghurt drinks	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

H5. When you have a soft drink (e.g. lemonade, cola or squash) how often do you choose low calorie or diet soft drinks?

always	<div>1</div>
sometimes	<div>2</div>
not at all	<div>3</div>
don't drink soft drinks	<div>4</div>

H6. When you have a cola drink how often do you choose decaffeinated cola?

always	<input type="text" value="1"/>
sometimes	<input type="text" value="2"/>
not at all	<input type="text" value="3"/>
don't drink cola	<input type="text" value="4"/>

H7. How many pieces of bread, rolls or chappatis do you eat on a usual day?

less than 1	1-2	3-4	5 or more
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

H8. What type of bread do you eat?

	Yes, usually	Yes, sometimes	No, not at all
a) White bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b) Soft grain white bread (e.g. Mighty White)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c) Brown/granary bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d) Wholemeal bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
e) Chappatis or pitta bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
f) Naan bread	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

H9. What sort of fat do you mainly use?

		(i) On bread or vegetables		(ii) For frying	
		Yes	No	Yes	No
a)	Butter, ghee, dripping, lard, solid cooking fat	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
b)	Polyunsaturated margarine e.g. Flora, sunflower margarine, Vitalite, I-Can't-Believe-its-Not-Butter	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
c)	Hard or soft margarine e.g. Blue Band, Stork, Clover, supermarket own brand	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
d)	Low fat spread e.g. Delight, St Ivel Gold, Flora Xtra Light	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
e)	Olive oil or monounsaturated spread e.g. Olivio, Olive Gold, Mono	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
f)	Sunflower oil, corn oil, soya oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
g)	Olive oil, hazelnut oil, rapeseed oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
h)	Other vegetable oil	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
i)	Other (please tick and describe)	<div>1</div>	<div>2</div>	<div>1</div>	<div>2</div>
		.....		.....	

H10. How many slices of bread (or rolls) spread with fat do you eat each day? (include shop bought sandwiches)

--	--

H11. What types of milk do you use?

	Yes, usually	Yes, sometimes	No, not at all
a) Full fat (e.g. silver or gold top)	<div>1</div>	<div>2</div>	<div>3</div>
b) Semi-skimmed (e.g. red stripe)	<div>1</div>	<div>2</div>	<div>3</div>
c) Skimmed (e.g. blue stripe)	<div>1</div>	<div>2</div>	<div>3</div>
d) Dried Milk (e.g. Marvel)	<div>1</div>	<div>2</div>	<div>3</div>
e) Goat/sheep milk	<div>1</div>	<div>2</div>	<div>3</div>
f) Soya milk	<div>1</div>	<div>2</div>	<div>3</div>
g) Other (please tick and describe)	<div>1</div>	<div>2</div>	<div>3</div>

.....

H12. Is this milk usually:

Pasteurised	UHT	Sterilised	other (please describe)
<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div> .....

H13. a) How many cups of tea do you drink in a day?  
(do not include herbal teas)

--	--

b) How many spoons of sugar in each cup?

--	--

c) How many cups per day are with milk?

--	--

d) How many cups per day are decaffeinated?

--	--

H14. a) How many cups of coffee do you drink in a day ?

--	--

b) How many spoons of sugar in each cup?

--	--

c) How many cups per day are with milk?

--	--

d) How many cups per day are decaffeinated?

--	--

e) How many are made with real (not instant) coffee?

--	--

H15. a) Do you drink herbal teas at all?

Yes, often

Yes occasionally

No, not at all

→ If **no**, go to  
H16 below

If **yes**,

b) How many cups/mugs of herbal teas have you drunk in the past week?

--	--

c) Please list the types of herbal teas you have drunk in the past 3 months:

.....

H16. Do you eat organic foods?

	Yes, usually organic	Yes sometimes organic	No, never organic
a) Fruit	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
b) Vegetables	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
c) Meat	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>
d) Other (please tick and describe)	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>

.....

H17. Apart from herbal teas, are there any other health foods (whether or not bought from a health food shop) that you often eat or drink?

Yes

No

If **yes**, please describe below:

.....

H18. Are you at present on any kind of special diet?

Yes

No

If **yes**, please describe below:

.....

H19. a) During the last week **how many** of each type of alcoholic drink did you have on each day? (Please put a number).

		Mon.	Tues.	Wed.	Thurs	Frid.	Sat.	Sun.
(i)	Beer, lager or cider (no. of ½ pints)							
(ii)	Wine (no. of glasses)							
(iii)	Spirits (no. of single pub measures)							
(iv)	Other alcoholic drinks (please describe) (no. of glasses or measures)							
(v)	Low alcohol drink (no. of glasses or ½ pints)							

b) Is this week fairly typical of your alcohol drinking?

No  Yes  → **If yes, go to H20 below**

c) **If no**, would you normally drink:

More  Less

H20. For your main meal of the day how often do you eat take-away foods or have meals out?

Never or rarely	<input type="text" value="1"/>
1-3 times a month	<input type="text" value="2"/>
1-2 times a week	<input type="text" value="3"/>
3-4 times a week	<input type="text" value="4"/>
5-7 times a week	<input type="text" value="5"/>

H21. For your main meal of the day how often do you eat an oven/microwave ready or convenience meal (e.g. Menu Master lasagne, individual shepherds pie, ready prepared chilli con carne etc.)?

Never or rarely	<div>1</div>
1-3 times a month	<div>2</div>
1-2 times a week	<div>3</div>
3-4 times a week	<div>4</div>
5-7 times a week	<div>5</div>



## SECTION J: LIFESTYLE

J1. a) Have you ever been a smoker?

Yes  No  → If **no**, go to J2 on page 50

If **yes**,

b) At what age did you start smoking regularly?

years

c) Which of the following have you ever smoked regularly?

	Yes	No
i) cigarettes	<input type="text" value="1"/>	<input type="text" value="2"/>
ii) pipe	<input type="text" value="1"/>	<input type="text" value="2"/>
iii) cigar	<input type="text" value="1"/>	<input type="text" value="2"/>
iv) other	<input type="text" value="1"/>	<input type="text" value="2"/>

d) Have you now stopped smoking?

Yes  No  → If **no**, go to (e) below

If **yes**, how long ago?

years   months

e) Have you smoked regularly in the last 2 weeks?

No  Yes, cigarettes  Yes, cigars  Yes, pipe   
 Yes, other  (please describe) .....

f) How many times per day have you smoked in the last 2 weeks?

30+ <input type="text" value="30"/>	25-29 <input type="text" value="25"/>	20-24 <input type="text" value="20"/>	15-19 <input type="text" value="15"/>
10-14 <input type="text" value="10"/>	5-9 <input type="text" value="05"/>	1-4 <input type="text" value="01"/>	0 <input type="text" value="00"/>

J1. g) What brand of cigarette/tobacco do you smoke?

i) brand .....

ii) type:      filtered 1      unfiltered 2      roll-your-own 3  
                 pipe/cigar 4

J2. a) Is/was your mother a smoker?

Yes 1      No 2      Don't know 3

**If yes,**

i) Did she smoke when she was expecting you?

Yes 1      No 2      Don't know 3

b) Is/was your father a smoker?

Yes 1      No 2      Don't know 3

J3. Have you ever actually made yourself sick (vomit) because you wanted to lose weight or because you had eaten too much?

Yes, in past year 1      Yes, but not in past year 2      No, never 3

J4. Have you ever taken laxatives because you wanted to lose weight or because you had eaten too much?

Yes, in past year 1      Yes, but not in past year 2      No, never 3

J5. a) Are you, or have you ever been a vegetarian?

Yes, I am now 1      Yes, in past not now 2      No, never 3

**If yes,**

i) For how many years of your life have you been or were you a vegetarian?

years (If less than one year put 00)

- J5. b) Are you, or have you ever been, a vegan (i.e. do/did not eat meat, poultry, fish, eggs, butter, milk or cheese)?

yes, I am now       yes, in past not now       no, never

If yes,

- i) For how many years of your life have you been/were you vegan?

years (If less than one year put 00)

- J6. Which of the following statements describes best the way in which you travel nowadays?

usually walk everywhere       cycle mostly   
usually get in a car       mostly use public transport

- J7. How much do you do the following in a normal week?

	More than 6 hours per week	2-6 hours per week	Less than two hours per week	Never ↓
a) jogging	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
b) aerobics	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
c) keep-fit exercises	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
d) yoga	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
e) squash	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
f) tennis/badminton	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
g) swimming	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h) brisk walking	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i) weight training	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
j) cycling	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
k) other exercise	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

(please tick & describe)

.....

**SECTION K:**

K1. This questionnaire was completed by: (tick all that apply)

- a) Biological father

1
- b) Mother’s partner

1
- d) Other (please tick and describe)

1

.....

K2. Please give the date on which you completed this questionnaire:

day

month

year

K3. Please give the date of birth of your study child:

day

month

year

199

**THANK YOU VERY MUCH FOR YOUR HELP**

Space for any additional comment you would like to make

**NB. Please remember we cannot reply to any comment unless you sign it.**

When completed, please return the questionnaire to:

**Professor Jean Golding  
Children of the Nineties - ALSPAC  
Institute of Child Health  
24 Tyndall Avenue  
Bristol  
BS8 1BR      Tel: Bristol 928 5007**

For office use only

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