CHILDREN OF THE 90's

Questionnaire No:

YOUR HOME & LIFESTYLE

Finding out how the environment and lifestyle affects mothers and their babies will help us to make the environment and lifestyle a healthier place.

This questionnaire asks about your environment and lifestyle. It asks about where you live and work, and about what you do.

All the answers you give are confidential. We would be grateful if you would answer as many questions as you can.

If there is any question you don't want to answer just leave it blank.

THANK YOU VERY MUCH FOR YOUR HELP

20/02/91

Recycled Paper

FILLING IN THIS BOOKLET

Most of the questions can be answered by ticking the box beside the right answer.

For example

How many times have you been to the supermarket in the past week?

None [1] 1 [2] ✓ 2-6 [3] 7 or more [4]

This means you went to the supermarket once in the past week

Sometimes there are questions with if in front of them.

For example

a) Have you been to the supermarket today?

Yes [1] No [2] ✓

This means you didn't go to the supermarket and you don't need to answer the next question

b) If yes, did you buy any carrots?

Yes [1] No [2]

In general, though, each question needs an answer.

In some questions you may be asked to describe something. It would be helpful if you wrote as clearly as possible.

The small numbers in the squares are for office use only.

SECTION A: YOUR HOME ENVIRONMENT

A1. How long have you lived in or near Avon?

less than 1 year	1
1 - 4 years	2
5 - 9 years	3
10 years or more	4
all my life	5

A2. a) When did you move to your present address?

...../...../19.... [ ][ ] [ ][ ] [ ][ ]

b) How many times have you moved home in the last 5 years? [ ][ ]

A3. Is your home:

being bought/mortgaged	0
owned - with no mortgage to pay	1
rented from council	2
rented from private landlord - furnished	3
rented from private landlord - unfurnished	4
rented from housing association	5
other (please describe)	6

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For office use [ ][ ]

A4. Do you live in your own home or do you live with your parents or others?

live in own home	1
live with parents in their home	2
other situation (please describe)	3

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For office use

A5. Do you currently live in:

a whole detached house (or bungalow)	1
a whole semi-detached house/bungalow	2
a whole terraced house	3
a flat/maisonette (self contained)	4
room in someone else's house	5
other (please describe)	6

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For office use

A6. What is the lowest level of your living accommodation:

basement	78
ground floor	00
1st floor	01
2nd floor or above, give floor	

A7. In the coldest time of year, describe the temperature in your:

	Very warm	Warm	About right	Cold	Very cold
a) living rooms	1	2	3	4	5
b) bedrooms	1	2	3	4	5

A8. In your home do you ever use:

		Yes	No
a)	central heating or storage heaters	1	2
b)	wood stoves or wood fires	1	2
c)	coal fires	1	2
d)	paraffin heaters	1	2
e)	gas fires (mains gas)	1	2
f)	gas fires (calor gas)	1	2
g)	other type of heating (please describe)	1	2

.....

For office use

A9. What is your main method of heating in winter?

.....

For office use

A10. During this pregnancy have you heated your bed using any of the following:

		No	Yes sometimes	Yes most days	Yes every day
a)	hot water bottle	1	2	3	4
b)	electric under blanket	1	2	3	4
c)	electric over blanket	1	2	3	4
d)	electric pad	1	2	3	4
e)	electric water bed	1	2	3	4
f)	other (please describe)	1	2	3	4

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For office use

A11. a) Do you use gas for cooking?

yes, ring	1
yes, oven	2
yes, rings and oven	3
no, not at all	4

b) Does your home have the following?

	Yes sole use	Yes shared with other household(s)	No
i) kitchen where there is space to sit and eat	1	2	3
ii) kitchen for cooking only	1	2	3
iii) indoor flushing toilet	1	2	3

c) Apart from the kitchen or kitchen/dining room, how many living rooms and bedrooms do you have?

i) number of living rooms: ☐☐

ii) number of bedrooms: (not regularly used as living rooms) ☐☐

A12. Do you have sole use of the following amenities or are they shared with other household(s)?

	Yes sole use	Yes shared	No
a) running hot water	1	2	3
b) bath	1	2	3
c) shower	1	2	3
d) garden or yard	1	2	3
e) balcony	1	2	3

A13. a) Is there a working telephone in your home?

Yes 1 No 2

If no,

b) where is the nearest working telephone that you can use in an emergency?

pay phone in the building	1
pay phone in the street	2
neighbour's phone	3
none within 5 minutes walk	4
other	5

A14. a) Do you or your partner have the use of a car (including vans, minibuses, etc.)?

Yes 1 No 2

If yes,

b) how often do you yourself have the use of a car?

never	1
not every day	2
almost every day	3
not applicable/do not drive	7

A15. How often do you have any windows open in your home:

	Windows almost always open	Windows open only when weather is good	Windows open occasionally	Windows almost never open
a) In summer:				
i) day	1	2	3	4
ii) night	1	2	3	4

A15. b) In winter:

	Windows almost always open	Windows open only when weather is good	Windows open occasionally	Windows almost never open
i) day	1	2	3	4
ii) night	1	2	3	4

c) at night the window in my bedroom is:

almost always open 1
sometimes open 2
almost never open 3

d) Are any of your windows double glazed?

yes all of them 1 yes some of them 2
no none of them 3 don't know 9

A16. a) Do you have any pets?

Yes 1 No 2 → If no, go to A17, on page 9.

If yes,,

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

	Number
i) cats	
ii) dogs	

A16. b) cont.

	Number
iii) rabbits	
iv) rodents (mice, hamster, gerbil, etc.)	
v) birds (budgerigar, parrot, etc)	
vi) other pets (please describe)	

.....

For office use

A17. Do any of the following animals or insects inhabit or invade your home or cause dirty conditions in your balcony, garden or yard?

	Yes frequently	Yes occasionally	No not at all
a) rats	1	2	3
b) mice	1	2	3
c) pigeons	1	2	3
d) cats	1	2	3
e) cockroaches	1	2	3
f) ants	1	2	3
g) dogs	1	2	3
h) other (please describe)	1	2	3

.....

For office use

A18. a) Is there ever any damp, condensation or mould in your home?

Yes [1] No [2] → If no, go to A19.a, on page 11.

If yes,

b) How much of a problem is damp or condensation?

- no damp or condensation [1]
- not serious [2]
- fairly serious [3]
- very serious [4]

c) How much of a problem is mould?

- no mould [1]
- not serious [2]
- fairly serious [3]
- very serious [4]

Please tick the boxes relating to the problems you get in each room.

A18.	Condensation on windows/ walls/ ceilings	Damp patches on walls	Mould on walls	Damp on furniture, carpets or clothes	Mould on furniture, carpets or clothes	None
d) kitchen (or kitchen/diner)	1	2	3	4	5	6
e) living room (or lounge/diner)	1	2	3	4	5	6
f) hall/landing	1	2	3	4	5	6
g) my bedroom	1	2	3	4	5	6

A18.	Condensation on windows/ walls/ ceilings	Damp patches on walls	Mould on walls	Damp on furniture, carpets or clothes	Mould on furniture, carpets or clothes	None
h) other bedrooms	1	2	3	4	5	6
i) bathroom/toilet	1	2	3	4	5	6
j) other rooms	1	2	3	4	5	6

A19. a) Does your roof leak at all? (If you have another flat above yours, please tick 'does not apply').

- does not apply [7]
- no leak [1]
- yes, slight leak [2]
- yes, serious leak [3]

b) In wet weather, does water get in from anywhere else, such as through badly fitting windows or doors?

- no leaks [1]
- yes, slight leaks [2]
- yes, serious leaks [3]

A20. Taking everything into account, which of the following best describes your feelings about your home?

- satisfied [1]
- fairly satisfied [2]
- dissatisfied [3]
- very dissatisfied [4]

A21. **In the past year** have any of the following rooms been decorated or had any brand new furniture?

		Yes	No	Don't know
a)	**Your bedroom:**			
i)	painted	1	2	9
ii)	wall papered	1	2	9
iii)	new carpet	1	2	9
iv)	new furniture	1	2	9
b)	**Your living room:**			
i)	painted	1	2	9
ii)	wall papered	1	2	9
iii)	new carpet	1	2	9
iv)	new furniture	1	2	9
c)	**Your kitchen:**			
i)	painted	1	2	9
ii)	wall papered	1	2	9
iii)	new carpet	1	2	9
iv)	new furniture	1	2	9
d)	**Any other rooms:**			
i)	painted	1	2	9
ii)	wall papered	1	2	9
iii)	new carpet	1	2	9
iv)	new furniture	1	2	9

Which room(s)? .....

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SECTION B: CHEMICALS AND MEDICINES

B1. During this pregnancy, how often have you used the following:

		Every day	Most days	About once a week	Less than once a week	Not at all
a)	disinfectant	1	2	3	4	5
b)	bleach	1	2	3	4	5
c)	window cleaner	1	2	3	4	5
d)	carpet cleaner	1	2	3	4	5
e)	oven/drain cleaner	1	2	3	4	5
f)	dry cleaning fluid	1	2	3	4	5
g)	turpentine/white spirit	1	2	3	4	5
h)	paint stripper	1	2	3	4	5
i)	household paint or varnish	1	2	3	4	5
j)	weed killers	1	2	3	4	5
k)	pesticides/insect killers (including flea or fly sprays or powders)	1	2	3	4	5
l)	aerosols or sprays including hair spray	1	2	3	4	5
m)	hair dye/bleach	1	2	3	4	5
n)	hair removal creams	1	2	3	4	5
o)	air fresheners (spray, stick or aerosol)	1	2	3	4	5
p)	other (please describe)	1	2	3	4	5

.....

For office use

B2. During this pregnancy have you ever taken any medicines, pills or used ointment or suppositories for the following:

Medicines, pills or ointments for:		Yes, taken in 1st 3 months of pregnancy	Yes, taken later in pregnancy	No, not at all
a)	nausea	1	2	4
b)	heartburn	1	2	4
c)	vomiting	1	2	4
d)	anxiety	1	2	4
e)	infection	1	2	4
f)	migraine	1	2	4
g)	difficulty going to sleep	1	2	4
h)	pain	1	2	4
i)	allergies	1	2	4
j)	skin condition	1	2	4
k)	bleeding	1	2	4
l)	depression	1	2	4
m)	piles	1	2	4
n)	constipation	1	2	4
o)	cough	1	2	4
p)	other reason (please describe)	1	2	4

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For office use

B3. During this pregnancy have you been taking any of the following?

		Yes	No
a)	iron	1	2
b)	zinc	1	2
c)	calcium	1	2
d)	folic acid/folate	1	2
e)	vitamins (please describe)	1	2

.....

f)	other supplements or diet foods (please describe)	1	2

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B4. a) Do you ever take homeopathic medicines?

Yes often 1 Yes sometimes 2 No 3

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b) If yes, please describe: .....

.....

For office use

B5. a) Please indicate how often you have taken the following pills during this pregnancy.

		Every day	Most days	Some-times	Not at all
i)	aspirin	1	2	3	4
ii)	paracetamol	1	2	3	4
iii)	codeine/anadin	1	2	3	4
iv)	mogadon, or other sleeping tablets	1	2	3	4
v)	valium, or other tranquillisers	1	2	3	4

B5. b) Please describe all pills, medicines and ointments you have taken or used **in the first months of this pregnancy.**

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	What did you take:	About how many days did you take or use it?	How many weeks pregnant were you?
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....
4.	.....	.....	.....
5.	.....	.....	.....
6.	.....	.....	.....
7.	.....	.....	.....
8.	.....	.....	.....
9.	.....	.....	.....
10.	.....	.....	.....
11.	.....	.....	.....
12.	.....	.....	.....
13.	.....	.....	.....
14.	.....	.....	.....
15.	.....	.....	.....

Check **Have you included the contraceptive pill, iron tablets, laxatives, vitamins, sleeping tablets, aspirin, cough mixture, pain killers, herbal medicine?**

SECTION C: THINGS YOU DO

C1. Since you became pregnant, how often have you used any of the following, whether at work or as a hobby:

		Every day	Most days	About once a week	Less than once week	Not at at all
a)	dental amalgam	1	2	3	4	5
b)	ceramics/enamels	1	2	3	4	5
c)	dry cleaning fluids	1	2	3	4	5
d)	electroplating	1	2	3	4	5
e)	glues	1	2	3	4	5
f)	leather working	1	2	3	4	5
g)	fabric/textiles	1	2	3	4	5
h)	dyes	1	2	3	4	5
i)	insecticides	1	2	3	4	5
j)	plastics	1	2	3	4	5
k)	metal cleaners/degreasers, polishers	1	2	3	4	5
l)	petrol	1	2	3	4	5
m)	paint	1	2	3	4	5
n)	photographic chemicals/ other chemicals	1	2	3	4	5
o)	electrical wiring	1	2	3	4	5
p)	machining	1	2	3	4	5
q)	soldering	1	2	3	4	5
r)	radiation (x-ray or other)	1	2	3	4	5

C2. Since becoming pregnant how often have you done the following whether at work or as a hobby:

		Every day	Most days	About once a week	Less than once a week	Not at at all
a)	domestic work in other people's homes	1	2	3	4	5
b)	hairdressing	1	2	3	4	5
c)	farm work	1	2	3	4	5
d)	hospital work	1	2	3	4	5
e)	shift work	1	2	3	4	5

C3. Have you ever had a paid job?

Yes [1] No [2] ⟶ If no, go to D1, on page 21.

C4. a) What is your present job? If you are not working, what was your most recent job?

For office use [ ][ ][ ]

.....

b) Are/were you working:

full-time [1] part-time [2] casually [3]

c) type of industry or service given:

For office use [ ][ ][ ]

.....

C5. a) About how long does/did it take you altogether to travel, to get to and from work each day?

[ ] hours [ ][ ] minutes

b) How do/did you travel to work?

By foot [1] By public transport [2] By bicycle [3]

By car [4] Work at home [5] Other (please describe) [6]

For office use [ ][ ]

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C6. What is your job like: (If you are no longer working answer for your most recent job).

		Yes, always	Yes, mostly	Some-times	Not very often	Never
a)	Do you enjoy your job?	1	2	3	4	5
b)	Do you have problems at work?	1	2	3	4	5
c)	Are the people at your work friendly?	1	2	3	4	5
d)	Are the people at your work supportive?	1	2	3	4	5
e)	Is it very noisy?	1	2	3	4	5
f)	Do you work in a smoky atmosphere?	1	2	3	4	5

C7. In the year before this pregnancy, in the first months of this pregnancy, and now did/do you do any of the following (whether at home, at school, at work or elsewhere):

		(i) In the year before this pregnancy		(ii) In the first 3 months of this pregnancy		(iii) From 4 months of this pregnancy until now	
		Yes	No	Yes	No	Yes	No
a)	Did/do you use a VDU? (television type screen)	1	2	1	2	1	2
b)	Are/were you mostly sitting?	1	2	1	2	1	2
c)	Are/were you bending a lot?	1	2	1	2	1	2
d)	Are/were you standing much of the time?	1	2	1	2	1	2
e)	Are/were you doing repet-itive, boring tasks?	1	2	1	2	1	2
f)	Did/does your job involve challenging and mentally demanding tasks?	1	2	1	2	1	2
g)	Are/were you using a lot of physical energy?	1	2	1	2	1	2
h)	In your job are/were you in contact with fumes or chemicals? (please describe)	1	2	1	2	1	2

.....

[Please make sure you have answered each of the three columns]

C8. What jobs have you had since the age of 16? Include part-time and voluntary work. If you have not worked write 'None'.

	Job	Materials/machines or chemicals used	Date started (month-year)	Date stopped (month-year)
1)	.....	.....	.....	.....
2)	.....	.....	.....	.....
3)	.....	.....	.....	.....
4)	.....	.....	.....	.....
5)	.....	.....	.....	.....
6)	.....	.....	.....	.....
7)	.....	.....	.....	.....
8)	.....	.....	.....	.....
9)	.....	.....	.....	.....
10)	.....	.....	.....	.....

If there is not enough space please continue on the back cover.

For office use

SECTION D: YOUR HOUSEHOLD

D1. a) How many people live in your household? (including yourself)

i) ☐☐ adults (over 18 years)

ii) ☐☐ young adults (16 - 18 years)

iii) ☐☐ children (0 - 15 years)

b) Please indicate who the adults over 18 in your household are:

		Yes	No
i)	yourself	1	2
ii)	your partner	1	2
iii)	your parent(s)	1	2
iv)	your partner's parent(s)	1	2
v)	other relation(s) of yourself	1	2
vi)	other relations of your partner	1	2
vii)	friend(s)	1	2
viii)	lodger	1	2
ix)	other (please describe)	1	2

..... For office use ☐☐

D2. a) Do you currently have a partner?

yes, husband 1

yes, other male partner 2

no, not at all 3 — If no, go to D4, on page 22.

other (please describe) 4

..... For office use ☐☐

If yes,

b) is your partner the father of your unborn child?

Yes 1 No 2 Not sure 3

D2. c) does your partner live with you?

Yes [1] No [2]

If your partner does live with you:

d) how long have you lived together?

[ ][ ] years [ ][ ] months

D3. How would you assess your partner's physical health

always fit and well	1
usually fit and well	2
sometimes unwell	3
often unwell	4
always unwell	5

D4. a) What is your present marital status?

never married	1
widowed	2
divorced	3
separated	4
married (once only)	5
married for second or third time	6

b) If married, what was the date of the most recent marriage?

...../...../19.... [ ][ ] [ ][ ] [ ][ ]

c) How many other marriages/live-in partners have you had? [ ][ ]

D5. Please indicate how many of the children (aged 18 or under) living with you have:

Number of children

a) you and your partner as their natural parents [ ][ ]

b) you as their natural mother (but their natural father is not present) [ ][ ]

D5. cont.

Number of children

c) your partner as the natural father (but you are not their natural mother) [ ][ ]

d) neither you nor your partner as natural parents (please describe whether you have adopted, fostered etc.) [ ][ ]

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For office use [ ][ ] [ ][ ]

D6. Are there other children of yourself or your partner who do not live with you?

	Yes	No
a) children of my partner	1	2
b) children of myself	1	2
c) children of partner & self	1	2

D7. a) Do any of the people living in your household, including yourself and your children have a long lasting disorder, illness or disabling condition? (e.g. asthma, epilepsy, arthritis, depression)

Yes [1] No [2]

If yes, please describe:

b) nature of illness/condition: .....

.....

c) person involved: .....

d) the consequences for the household: .....

.....

D8. a) Were you deliberately trying to get pregnant this time?

Yes [1] No [2] —— If no, go to D9, on page 24.

If yes,

D8. b) for how long had you been trying?

under 6 months	1
6-11 months	2
1-2 years	3
3 years or more	4

D9. How would you describe your reaction when you **first found you were pregnant?**

(tick one only)

overjoyed	1
pleased	2
mixed feelings	3
not happy	4
very unhappy	5
no particular feelings	6

D10. a) Does becoming a mother mean giving up something that is important to you?

yes, a great deal	1
yes, quite a lot	2
not really	3
definitely not	4
don't know	9

Please add any extra comments you wish to make: For office use

.....

b) Does becoming a mother give you new opportunities and interests?

yes, a great deal	1
yes, quite a lot	2
not really	3
definitely not	4
don't know	9

Please add any extra comments you wish to make: For office use

.....

D11. How do you feel about your pregnancy **now?**

overjoyed	1
pleased	2
mixed feelings	3
not happy	4
very unhappy	5
no particular feelings	6

D12. How do you think your partner feels about your pregnancy?

overjoyed	1
pleased	2
mixed feeling	3
not happy	4
very unhappy	5
no particular feelings	6

have no partner 7

D13. How has your partner reacted to you since you have become pregnant?

	When he first knew	**Now**
supportive	1	1
indifferent	2	2
resentful	3	3
have no partner	7	7
other (please describe)	4	4

For office use

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SECTION E: YOUR PREVIOUS PREGNANCIES

E1. Have you ever been pregnant before?

Yes [1] No [2] ——— If no, go to Section F, on page 29.

If yes,

E2. a) How many times have you been pregnant altogether before this time?

[ ][ ]

b) Is this the first pregnancy with your present partner?

Yes [1] No [2] Am not sure [9]

E3. a) How many children still living, of your own do you have?

[ ][ ]

b) Do they all live with you?

Yes [1] No [2] Don't have children [7]

E4. a) Have you ever had any miscarriages?

Yes [1] No [2]

b) If yes, how many times have you miscarried?

[ ][ ]

E5. a) Have you ever had any abortions or terminations?

Yes [1] No [2]

E5. b) If yes, how many ?

[ ][ ]

E6. a) Have you ever had a stillborn baby ?

Yes [1] No [2]

b) If yes, how many?

[ ][ ]

E7. a) Have you ever had any babies who were born alive but died later?

Yes [1] No [2]

If yes, please describe:

b) how many?

[ ][ ]

c) what caused their death? .....

.....

.....

d) how old were they when they died? .....

E8. Were any of your babies under 5lb 8oz (2500 grammes) at birth?

Yes [1] No [2] Don't know [9]

E9. a) Were any of your babies born more than 3 weeks early?

Yes [1] No [2] Don't know [9]

E9. b) Have you ever had a caesarean section?

Yes [1] No [2] Don't know [9]

E10. How old were you when you became pregnant for the very first time?

[ ][ ] years

E11. a) What was the outcome of the last pregnancy before this pregnancy?

miscarriage	1
abortion or termination	2
stillbirth	3
liveborn baby that died	4
liveborn baby still alive	5
other (please describe)	6

.....

For office use [ ][ ]

b) Please give the date of your last birth/miscarriage/abortion or termination before this pregnancy:

day [ ][ ] month [ ][ ] 19 year [ ][ ]

c) Did you breast feed your last baby?

Yes [1] No [2] Have not had a baby [7]

d) If yes, for how long?

under 1 month	1
1-3 months	2
more than 3 months	3

SECTION F: ABOUT YOURSELF

In general:	Very like me	Moderately like me	Moderately unlike me	Very unlike me
F1. I feel insecure when I say goodbye to people	1	2	3	4
F2. I worry about the effect I have on other people	1	2	3	4
F3. I avoid saying what I think for fear of being rejected	1	2	3	4
F4. I feel uneasy meeting new people	1	2	3	4
F5. If others knew the real me, they would not like me	1	2	3	4
F6. I feel secure when I'm in a close relationship	1	2	3	4
F7. I don't get angry with people for fear that I may hurt them	1	2	3	4
F8. After a row with a friend, I feel uncomfortable until I have made peace	1	2	3	4
F9. I am always aware of how other people feel	1	2	3	4
F10. I worry about being criticised for things I have said or done	1	2	3	4
F11. I always notice if someone doesn't respond to me	1	2	3	4
F12. I worry about losing someone close to me	1	2	3	4
F13. I feel that people generally like me	1	2	3	4
F14. I will do something I don't want to do rather than offend or upset someone	1	2	3	4
F15. I can only believe that something I have done is good when someone tells me	1	2	3	4
F16. I will go out of my way to please someone I am close to	1	2	3	4
F17. I feel anxious when I say goodbye to people	1	2	3	4

In general:	Very like me	Moderately like me	Moderately unlike me	Very unlike me
F18. I feel happy when someone compliments me	1	2	3	4
F19. I fear that my feelings will overwhelm me	1	2	3	4
F20. I can make other people feel happy	1	2	3	4
F21. I find it hard to get angry with people	1	2	3	4
F22. I worry about criticising people	1	2	3	4
F23. If someone is critical of something I do, I feel bad	1	2	3	4
F24. If other people knew what I am really like, they would think less of me	1	2	3	4
F25. I always expect criticism	1	2	3	4
F26. I can never be really sure if someone is pleased with me	1	2	3	4
F27. I don't like people to really know me	1	2	3	4
F28. If someone upsets me, I am not able to put it easily out of my mind	1	2	3	4
F29. I feel others do not understand me	1	2	3	4
F30. I worry about what others think of me	1	2	3	4
F31. I don't feel happy unless people I know admire me	1	2	3	4
F32. I am never rude to anyone	1	2	3	4
F33. I worry about hurting the feelings of other people	1	2	3	4
F34. I feel hurt when someone is angry with me	1	2	3	4
F35. My value as a person depends enormously on what others think of me	1	2	3	4
F36. I care about what people feel about me	1	2	3	4

SECTION G: YOUR LIFESTYLE

G1. a) Have you ever been a smoker?

Yes [1] No [2] —— If no, please go to G2, on page 33.

If yes,

b) at what age did you start smoking regularly?

[ ][ ] years

c) which of the following have you smoked regularly?

	Yes	No
cigarette	1	2
pipe	1	2
cigar	1	2
other	1	2

d) What was the maximum number of times a day you smoked?

30+	30	25-29	25	20-24	20	15-19	15
10-14	10	5-9	05	1-4	01	0	00

e) Have you now stopped smoking?

Yes [1] No [2]

If yes, how long ago?

[ ][ ] years [ ][ ] months

G1. f) Did you smoke regularly at any of the following times in the last 9 months?

	Before pregnancy	First 3 months of pregnancy	Last 2 weeks
No	1	1	1
Yes, cigarettes	2	2	2
Yes, cigars	3	3	3
Yes, pipe	4	4	4
Yes, other (please describe)	5	5	5

Sep 0 10/7/14

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For office use

g) how many times per day did you smoke -

i) **just before you became pregnant**

per day

30+	30	25-29	25	20-24	20	15-19	15
10-14	10	5-9	05	1-4	01	0	00

ii) **in the first 3 months of your pregnancy**

per day

30+	30	25-29	25	20-24	20	15-19	15
10-14	10	5-9	05	1-4	01	0	00

iii) **in the last 2 weeks?**

per day

30+	30	25-29	25	20-24	20	15-19	15
10-14	10	5-9	05	1-4	01	0	00

G1. h) What brand and type of cigarette or tobacco do/did you usually smoke?

For office use

(i) brand: .....

(ii) type: filtered 1 unfiltered 2 roll-your-own 3

pipe/cigar 4

Please send us an empty packet/carton of the brand you usually smoke.

G2. a) Did your mother ever smoke?

Yes 1 No 2 Don't know 9

i) If yes, did she smoke when she was expecting you?

Yes 1 No 2 Don't know 9

b) Did your father ever smoke?

Yes 1 No 2 Don't know 9

G3. a) Does your partner smoke?

No	1	If no, or don't have a partner, go to G4, on page 34.
Yes, cigarettes	2	
Yes, cigars	3	
Yes, pipe	4	
Yes, other (please describe)	5	.....
Don't have a partner	7	Go to G4, on page 34.

For office use

If yes,

b) about how many times per day does your partner smoke at the moment?

30+	30	25-29	25	20-24	20	15-19	15
10-14	10	5-9	05	1-4	01	don't know	99

c) what brand, and type of cigarette/tobacco does your partner smoke?

For office use

i) brand: .....

ii) type: filtered 1 unfiltered 2 roll-your-own 3

pipe/cigar 4

d) at what age did your partner start smoking? years don't know 99

G4. a) Apart from yourself and your partner, are there any other members of your household who smoke?

Yes 1 No 2

For office use

b) If yes, how many: .....

G5. How often did you smoke marijuana/grass/cannabis/ganja -

	Every day	2-4 times a week	Once a week	Less than once a week	Not at all
a) In the 6 months before you conceived	1	2	3	4	5
b) In the first 3 months of pregnancy	1	2	3	4	5
c) Between 3 months and now	1	2	3	4	5

G6. How often have you taken the following during this pregnancy:

	Nearly every day	At least once a week	At least once a month	Not at all
a) amphetamines	1	2	3	4
b) barbiturates	1	2	3	4
c) crack	1	2	3	4
d) cocaine	1	2	3	4
e) heroin	1	2	3	4
f) methadone	1	2	3	4
g) other (please describe)	1	2	3	4

For office use

.....

G7. How often have you drunk alcoholic drinks? Please indicate for each of the following times:

	Never	Less than once a week	At least once a week	1-2 glasses every day	At least 3-9 glasses every day	At least 10 glasses every day
a) Before this pregnancy	1	2	3	4	5	6
b) 1st 3 months of this pregnancy	1	2	3	4	5	6
c) At around the time you first felt the baby move	1	2	3	4	5	6

G8. How many days in the past month have you drunk the equivalent of 2 pints of beer, 4 glasses of wine or 4 pub measures of spirit?

everyday	5	more than 10 days	4
5-10 days	3	3-4 days	2
1-2 days	1	none	0

G9. Which is the alcoholic drink you have most often drunk during this pregnancy?

(tick one only)

wine	1
beer/lager	2
sherry/port	3
gin/whisky/vodka/brandy	4
other (please describe)	5
don't drink at all	7

..... For office use

G10. How would you describe your partner's alcohol drinking? Which of the following statements best applies:

Never drinks alcohol	1
Very occasionally (less than once a week)	2
Occasionally (at least once a week)	3
Drinks 1-2 glasses nearly every day	4
Drinks 3-9 glasses every day	5
Drinks at least 10 glasses a day	6
Don't have a partner	7
Don't know	9

G11. At present how much of the following do you usually drink in a day:

At present		Weekday	Weekend day	For office use	
a)	ordinary tea (cups)	.....	.....		
b)	decaffeinated tea (cups)	.....	.....		
c)	coffee (cups)	.....	.....		
d)	decaffeinated coffee (cups)	.....	.....		
e)	beer or lager (half-pints)	.....	.....		
f)	wine (glasses)	.....	.....		
g)	spirits (pub-measures)	.....	.....		
h)	cola/pepsi (cans)	.....	.....		
i)	decaffeinated cola/pepsi cans	.....	.....		
j)	other alcoholic drinks (pub measures)	.....	.....		
k)	milk (glasses)	.....	.....		
l)	other drinks (please describe)	.....	.....		

.....

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SECTION I

I1. Please put the date of completing this questionnaire:

day	month	year
		1 9 9

I2. Please give your date of birth:

day	month	year
		1 9

N.B. Have you remembered to enclose an empty cigarette packet?

Space for any comments you might like to make:

VERY MANY THANKS FOR ALL YOUR HELP

When completed, put in the envelope provided and either bring to the clinic or post to:

Dr. Jean Golding,
Children of the Nineties - ALSPAC,
Institute of Child Health,
24 Tyndall Avenue,
Bristol.
BS8 1BR.

Please remember, because this is strictly confidential, the people who look at this booklet will not know your name. They will be unable to give you any help or contact anyone after reading what you have written. If you feel you need advice, please feel free to contact our hotline (Bristol 256260, during office hours). Alternatively your General Practitioner should be able to advise you.

For office use only:

Cig	Code 1	Code 2	Code 3	Key 1	Key 2	edit	corr.	int.