Questionnaire 1 part 1
For participants 18-65 year

LifeLines

General

1. Please fill in today's date Day:_____ Month:_____ Year:_____

2. What is your gender? 0 Man 0 Woman

3. What is your date of birth?? Day: X Month:_____ Year:_____

4. In which land were you born? 0 The Netherlands
0 Another land, please indicate
_____

5. In which land was your (biological) mother born? 0 The Netherlands
0 Another land, please indicate_____

6. In which land was your (biological) father born? 0 The Netherlands
0 Another land, please indicate_____

7. What is your marital status? 0 Married/registered partners/civil partners
0 Cohabiting
0 Partner but not cohabiting
0 Single
0 Widow/widower
0 Divorced
0 Other, please indicate
_____

8a. How long is your present relationship? (If applicable) _____ year

8b. What is the gender of your partner? (If applicable) 0 Man 0 Woman

9. Have you ever been divorced? 0 No
0 Yes, once
0 Yes, more than once

10a. How often in your life have you moved house, including the period that you lived with your parents? _____ moved house

10b. During how many years did you not have a permanent residence (for example onboard ship, travelled with the fair etc)? For _____ years

11. Were your parents divorced during the time that you lived with them? 0 Yes 0 No

12a. Indicate which of the following people do or do not live with you, and also indicate which you do not have.
Please only answer yes if the person lives with you for more than half of the time (for example if you have a partner but do not cohabit then choose 'NO').

Who lives with you?

My partner	0 Yes	0 No	0 I do not have (anymore)
My father	0 Yes	0 No	0 I do not have (anymore)
My mother	0 Yes	0 No	0 I do not have (anymore)
My children	0 Yes	0 No	0 I do not have (anymore)
Children of my partner	0 Yes	0 No	0 I do not have (anymore)
Partner /(girl)friend of my father or mother (stepfather/stepmother)	0 Yes	0 No	0 I do not have (anymore)
Brother(s), and /or sister(s) (or half-brother, step-brother, half-sister, step-sister)	0 Yes	0 No	0 I do not have (anymore)
Other adults (e.g. uncle, auntie, grandfather, grandmother, friends, acquaintances)	0 Yes	0 No	0 I do not have (anymore)
One person household	0 Yes	0 No	
Others, namely_____			

12b. How many people, including yourself, live together with you in your house? Please note-this is meant for where you live the most days in the week _____ persons

13. Are you left- or right handed?
0 Left handed
0 Right handed
0 As well left as right handed

Family

Please fill in the date of birth and where applicable date of death of your most direct family members. If you do not know then leave empty spaces.

Relation	**date of birth day/month/year**	**If passed away: year of death**
Parents:		
Biological father	____/____/_____	
Biological mother	____/____/_____	
Stepfather/ adoption father	____/____/_____	
Stepmother/ adoption mother	____/____/_____	
Partner	____/____/_____	
Biological children from you and your present partner		
Child 1 Son/ daughter	____/____/_____	
Child 2 Son/ daughter	____/____/_____	
Child 3 Son/ daughter	____/____/_____	
Child 4 Son/ daughter	____/____/_____	
Child 5 Son/ daughter	____/____/_____	
Child 6 Son/ daughter	____/____/_____	
Biological children from you and your previous partner		
Child 1 Son/ daughter	____/____/_____	
Child 2 Son/ daughter	____/____/_____	
Child 3 Son/ daughter	____/____/_____	
Child 4 Son/ daughter	____/____/_____	
Child 5 Son/ daughter	____/____/_____	
Child 6 Son/ daughter	____/____/_____	
Non biological children (adoption- or stepchildren)		
Child 1 Son/ daughter	____/____/_____	
Child 2 Son/ daughter	____/____/_____	
Child 3 Son/ daughter	____/____/_____	
Child 4 Son/ daughter	____/____/_____	
Child 5 Son/ daughter	____/____/_____	
Child 6 Son/ daughter	____/____/_____	

Work

1a. Do you have paid work, even if it is only for one or a few hours a week? 0 Yes (go to 1c) 0 No

1b. Have you previously had paid work? 0 Yes 0 No

In which year did you stop? _____ year

Why did you stop working? 0 Retirement 0 Medical declared unfit to work 0 Discharge/ unemployed

0 Other, namely_____

1c. Which situation(s) is (are) for you the most applicable? *(more than one answer is possible)*

0 I have paid work for 32 hours or more per week
0 I have paid work between 20 and 32 hours per week
0 I have paid work between 12 and 20 hours per week
0 I have paid work less than 12 hours
0 I am retired
0 I have taken early retirement
0 I am unemployed/ looking for work (registered by the employment agency)
0 I have been medically declared unfit to work
0 I receive social security
0 I am fulltime housewife/houseman
0 I am a student

1d. For what percent have you been declared unfit to work?

_____ %

1e. If you are unemployed/looking for work, how long have you been unemployed?

0 Less than 6 months
0 6 to 12 months
0 1 to 3 years
0 More than 3 years

2a. If you are in paid employment or have been, what was your last or present function? Please be as specific as possible-for example private secretary, welder, accounts manager (and not civil servant, manager, labourer etc).

_____
_

2b. Could you give additional information to describe what your most important functions are or were?

_____

_____

_____

2c. Have /Had you a managerial post or employed other people? If so, how many people were you responsible for?
(directly or indirectly)?
0 Yes, 1- 4
0 Yes, 5-9
0 Yes, 10-19
` 0 Yes, 20- 49
0 Yes, 50 or more
0 No

3a. How much is your net income (take home pay) per month? If you share the costs with someone, then add the net
income of your partner(s) to your income.
0 less than € 750
0 € 750 – € 1000
0 € 1000 – € 1500
0 € 1500 – € 2000
0 € 2000 – € 2500
0 € 2500 – € 3000
0 € 3000 – € 3500
0 more than € 3500
0 I do not know
0 I would rather not fill this in.

3b. How many people have to be supported from this amount?
0 1 0 2 0 3 0 4 0 5 0 6 0 More than 6

Questions for people with paid work

4a How many **days a week** do you work (in a normal week) ?
_____days

4b. How many hours **per week** on average do you spend doing paid work? _____ hours

5. How long in the last 3 months have you not worked
_____ weeks _____days
because you were ill or had problems?
(this does not include pregnancy)

6. In the last 12 months how many times have you stayed at home because you were ill or had problems? (this does not include pregnancy)
0 never
0 1-3 times
0 4-7 times
0 8 times or more

7. In the last 12 months have you stayed at home once or more than once for longer than two weeks at a time because you were ill or had problems? (this does not include pregnancy)
0 Yes
0 No

8. How long have you been working for your present employer?
0 less than 1 year
0 1-5 year
0 6-10 year
0 more than 10 year

9. Are you afraid to lose your job in the near future? 0 Yes

0 No

Education

1. What is your highest level of education?
0 No education(Primary education not completed)
0 Primary education
0 Basic vocational training (*some examples of Dutch schooling system*)
0 Secondary education (*some examples of Dutch schooling system*)
0 Senior secondary vocational education (*some examples of Dutch schooling system*)
0 General senior secondary education (*some examples of Dutch schooling system*)
0 Higher professional education(with applied emphasis) (*some examples of Dutch schooling system*)
0 Academic higher education (university)
0 Other, please indicate _____

Division/ Spending of Time

1. How many hours **per week** on average do you doing charity work
_____hours
in an organized group (with an organization or club)

2. How many hours **per week** on average do you looking after one or more members of your _____hours
family (not counting your immediate family), friends or neighbours? This includes doing shopping, cooking, cleaning, making beds, administration etc.

3. How many hours **per day** on average do you spend watching television? _____ hours _____minutes

4. During a full day, how many hours on average do you sleep?
_____hours _____minutes

Questions about your health

Could you indicate which of the following health problems you have or have had?
If you have not had a disease please fill 'no' in, unless it is otherwise indicated that you should skip that question.

BREATHING

1. Have you had wheezing or whistling in your chest at any time? 0 Yes 0 No

If yes
1a. Have you been at all breathless when the wheezing noise was present? 0 Yes 0 No

1b. Have you had this wheezing or whistling when you did not have 0 Yes 0 No

a cold?

2. Have you had an attack of shortness of breath that came on during the day when you were at rest? 0 Yes 0 No

3. Are you short of breath if you lie (too) flat? 0 Yes 0 No

4. Have you had an attack of shortness of breath that came on following strenuous activity? 0 Yes 0 No

5. Do you wake up at night shortness of breath? 0 Yes 0 No

6. Have you been woken by an attack of shortness of breath? 0 Yes 0 No

7. Have you been woken by an attack of coughing? 0 Yes 0 No

8. Do you usually cough first thing in the morning in the winter? 0 Yes 0 No

If yes: 8a. Do you cough like this on most days for as much as three months each year? 0 Yes 0 No

9. Do you usually cough during the day, or at night, in the winter? 0 Yes 0 No

If yes: 9a. Do you cough like this on most days for as much as three months each year? 0 Yes 0 No

10. Do you usually bring up any phlegm from your chest first thing in the morning in the winter? 0 Yes 0 No

If yes: 10a Do you bring up phlegm like this on most days for as much as three months each year? 0 Yes 0 No

11. Do you usually bring up any phlegm from your chest during the day, or at night, in the winter? 0 Yes 0 No

If yes: 11a. Do you bring up phlegm like this on most days for as much as three months each year? 0 Yes 0 No

12. Do you ever have trouble with your breathing? 0 Yes 0 No

If yes: 12a. Do you have this trouble 0 continuously so that your breathing is never quite right?

0 repeatedly, but it always gets completely better?

0 only rarely?

13. Are you disabled from walking by a condition other than heart or lung disease? 0 Yes 0 No

If yes, which condition_____ go to question 14

If no: 13a. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill or walking stairs at a normal pace? 0 Yes 0 No

If no, go to question 14, if yes:

13b. Do you get short of breath walking with other people of your own age on level ground? 0 Yes 0 No

If no, go to question 14, if yes:

13c. Do you have to stop for breath when walking at your own pace on level ground? 0 Yes 0 No

If no, go to question 14, if yes:

13d. Are you short of breath when resting? 0 Yes 0 No

14. Have you ever had asthma? 0 Yes 0 No_

If yes: 14a. Was this confirmed by a doctor? 0 Yes 0 No__

14b. How old were you when you had your first attack of asthma?
_____ year

14c. How old were you when you had your last attack of asthma?
_____ year

15. Do you have COPD, lung emphysema or chronic bronchitis? 0 Yes 0 No

If yes 15a. How old were you when you first had COPD, lung emphysema or chronic bronchitis?
_____ year

16. Do you have or had any nasal allergies, including hay fever?
0 Yes 0 No

If yes: 16a How old were you when you first had hay fever or nasal allergy?
_____ year

16b. Do you still have problems with hay fever or nose allergy? 0 Yes 0 No

If no: 16c. How old were you when this stopped?
_____ year

ALLERGY

17. Can you indicate what you are allergic for? *(more than one answer is possible)*
0 I am not allergic for any of the following
0 Dust (house dust etc)
0 Domestic pets (cat, dog etc)
0 Insects (bites)
0 Pollen (grass, birch etc)
0 Food allergies (egg, peanuts etc)
0 Medicines (antibiotics etc)
0 Contact allergies (nickel, latex rubber etc)
0 Others, please indicate_____

CANCER

18a. Have you cancer or have you had cancer? (if no, go to question 19)
0 Yes 0 No

18b What sort of cancer?_____

18c. How old were you when you first got cancer? _____ year

18d. Have you been declared cancer free? 0 Yes 0 No

DIABETES MELLITUS (Diabetes)

19a. Have you diabetes mellitus (diabetes)? 0 Yes 0 No
(If no, go to question 20)

19b. What type of diabetes do you have? 0 Type 1. (Juvenile diabetes, usually from when you were a child)
0 Type 2. (Diabetes in aging population, usually occurs as people become older)
0 Other form, please indicate which_____
0 I do not know

19c. How old were you when you got diabetes? _____ year

19d. How were you treated? 0 I wasn't treated for diabetes
0 Diet only
0 Tablets only
0 Insulin only (injections or pump)
0 Tablets and insulin

HEART

20. Have you ever had pain or other symptoms such as a pressing, heavy feeling in your chest? 0 Yes 0 No

21. Have you ever had a heart attack? (If no, go to question 23)
0 Yes 0 No

22 How old were you when you had your first heart attack?
_____ year

23. Has your carotid artery ever been widened (aneurism of the aorta)?
0 Yes 0 No
(If no, go to question 25)

24. How old were you when the widening took place for the first time?
_____ year

25 Have you ever had angioplasty (widening of arteries with a balloon) and/or a bypass operation? (If no, go to question 27)
0 Yes 0 No

26. How old were you when you had your first angioplasty/bypass operation?
_____ year

HEART RHYTHM DISTURBANCES/PROBLEMS

27. Have you ever had symptoms of an irregular heart beat or one that was too quick?
0 Yes 0 No
(If no, go to question 31)

28. Have you ever been diagnosed as having cardiac irregularities by a doctor or in a hospital? 0 Yes 0 No

29. How old were you when you first had symptoms?
_____ year

30. How is your cardiac irregularity treated? *(more than one answer is possible)*

0 I do not have treatment for cardiac irregularities
0 With anticoagulants
0 With medicine to slow down the heart rate
0 With medicine which makes the heart rhythm normal
0 With a pacemaker
0 Other treatment, please indicate_____

OEDEMA /HEART FAILURE

31. Do you sometimes have ankles that swell up (oedema)? 0 Yes 0 No
Or do you retain fluid in another part of the body?

32. Do you have heart failure (reduced pump function of the heart)? 0 Yes
0 No *(go to question 35)*
0 I do not know *(go to question 35)*

33. How old were you when you first had heart failure? _____ year

34. How is your heart failure treated? *(more than one answer is possible)*

0 I do not have treatment for heart failure
0 With a low salt diet and/or fluid limiting
0 With medicine
0 With a pacemaker
0 I have had a transplant in _____ year
0 Other treatment, please indicate_____

BLOOD PRESSURE

35. Have you ever had high blood pressure? 0 Yes
0 No *(go to question 38)*
0 I do not know *(go to question 38)*

36. How old were you when you first had high blood pressure? _____ year

37. How is your high blood pressure treated? 0 I do not have treatment
0 With a salt free diet
0 With medicine
0 Both

CHOLESTEROL

38. Have you ever had elevated cholesterol levels? 0 Yes
0 No *(go to question 41)*
0 I do not know *(go to question 41)*

39. How old were you when you first had elevated cholesterol levels? _____ year

40. How are your elevated cholesterol levels treated? 0 I do not have treatment
0 With a diet
0 With medicine
0 Both

NEUROLOGY (BRAIN)

41. Have you ever experienced a sudden loss of function which returned later (such as loss of strength or feeling, blindness in one eye, speech problems)? 0 Yes 0 No

42. Have you ever had a stroke? (If no, go to question 44) 0 Yes 0 No

43. How old were you when you first had a stroke?
_____ year

44. Have you ever had narrowing of the carotid arteries? 0 Yes 0 No

ARMS AND LEGS

45. Have you ever had symptoms (pain, heavy of weary feeling, tingling sensation) in one of your legs during walking?
0 Yes
0 No
0 Not applicable, I can not walk

46. Have you ever had these symptoms at night? 0 Yes 0 No

If questions 45 and 46 are no, go to question 48

47. How old were you when you first had symptoms?
_____ year

48. Have you ever had slowly healing wounds at your feet? 0 Yes 0 No

49. Is one or a part of your foot/leg been amputated? (If no, go to question 51)
0 Yes 0 No

50. How old were you when you (first) had an amputation?
_____ year

51. Do you regularly have (several times a week) pain in the joints of your hands?
0 Yes 0 No

52. Do you regularly have (several times a week) pain in the joints of your feet?
0 Yes 0 No

53. Are you regularly bothered by stiffness (several times a week) in the joints of your hands? 0 Yes 0 No

54. Are you regularly bothered by stiffness (several times a week) in the joints of your feet?
0 Yes 0 No

KIDNEYS

55. Please indicate, which of the following conditions of the kidneys you have or ever have had?
(more than one answer is possible)
☐ Renal arteries (kidney)
☐ Small kidney
☐ Hydronephrosis (disturbance in volume of urine)
☐ None

56. Have you ever had a blood test for possible kidney problems?
0 Yes 0 No

57. Have you ever had a urine test? 0 Yes, once
(if no, go to question 60) 0 Yes, several times, indicate. _____ times
0 No

58. Do you know what the results are of the urine test(s). If tests have been done more than once could you indicate how often the same result was found *(more than one answer is possible)*
☐ Normal _____ times
☐ Traces of a urinary tract infection or kidney stones _____ times
☐ A small amount of blood, without a bladder infection or kidney stones _____ times
☐ Protein in urine _____ times
☐ I do not know the results (anymore) _____ times

59. Did you ever had protein in your urine, and is that still present?
0 Yes, only found during pregnancy
0 Yes, I ever had protein in my urine (not during pregnancy), but this is not the case anymore.
0 Yes, still protein present in my urine
0 No, protein never found

60. Have you ever had an abnormal kidney function detected? (If no, go to question 63)
0 Yes 0 No

61. Is that still present? (If no, go to question 63) 0 Yes 0 No

62. How serious is this? 0 Not serious
0 Moderate
0 Serious
0 I do not know

63. Do you have a renal disease? (If no, go to question 65)
0 Yes 0 No

64. How are you treated ? 0 No, I am not treated for renal diseases
0 Yes, with medicine
0 Yes, with medicine and diet
0 Yes, with dialysis
0 Yes, I had a transplantation

65. Have you ever been operated on or for your kidneys? *(more than one answer is possible)*
☐ No
☐ Yes, in connection with kidney stones, in the year _____
☐Yes, a kidney was removed due to a medical problem
☐ Yes, I donated a kidney in the year_____
☐ Yes, I had a transplantation in the year_____
☐ Yes, I have had angioplasty of the renal arteries in the year_____

THYROID

66 Do you have medicine because you thyroid works too quickly or slowly? 0 Yes 0 No

67. Have you ever had medicine because your thyroid worked too quickly or slowly?
0 Yes 0 No

EYES EARS AND MOUTH

68. Do you have glasses or contact lenses? 0Yes, only for close up (reading etc)
0 Yes, only for distance (driving, watching TV etc)
0 For both close up and distance

0 No

69. Is your daily life restricted due to problems with your sight?
0 Yes, seriously restricted
0 Yes, slightly restricted
0 No, not restricted

70. Do you need a hearing aid? 0 Yes 0 No

71. Is your daily life restricted due to problems with your hearing?
0 Yes, seriously restricted
0 Yes, slightly restricted
0 No, not restricted

72a. Do you have inflammation of the gums diagnosed by a dentist? 0 Yes 0 No
If no, go to question 73

72b. How old were you when this was diagnosed? _____ year

73. Do you have your own set of teeth? 0 Yes, (almost) complete
0 Yes, but some elements are missing or replaced
0 No, I have dentures
0 No, I have partly dentures
0 No, but do not have dentures

OTHER PROBLEMS/DISEASES

74. Please fill in with a cross which of the diseases you have or have had. *(more than one answer is possible)*

☐None of the diseases

HEART, CIRCULATORY, LUNGS

☐ Heart valve problems
☐ Atherosclerosis(clogging of the arteries
☐ Thrombosis
☐ Lung embolism

HEAD

☐ Migraine
☐ Cataracts
☐ Chronic throat/sinus infections

STOMACH, INTESTINES, LIVER AND GALL

☐ Stomach (gastric)ulcer
☐ Ulcerative colitis
☐ Crohn’s disease
☐ Spastic or irritated bowel syndrome
☐ Hepatitis
☐ Cirrhosis of the liver
☐ Coeliac disease
☐ Gall stones

KIDNEY, BLADDER

☐ Kidney stones
☐Chronic bladder infection
☐Incontinent

NEUROLOGICAL DISEASES

☐Epilepsy
☐Multiple sclerosis
☐Spasticity
☐ Parkinsons disease
☐Dementia

BLOOD

☐ Anaemia
☐ Clotting disease

MOTOR DISEASES

☐ Fibromyalgia
☐ Arthrosis (degeneration of joints)
☐ Rheumatic disease (inflammation of the joints)
☐ Osteoporosis (decrease in bone density)
☐ Back or neck hernia
☐ Repetitive strain injury

SKIN

☐ Serious acne
☐Eczema
☐ Psoriasis

OTHER

☐Other
☐Chronic fatigue syndrome
☐Burn out
☐Depression
☐ Panic disorder
☐Social phobia
☐Acrophobia
☐Other anxiety syndromes
☐Manic depressive syndrome(bipolar)
☐Schizophrenia
☐Eating problems
☐Obsession/compulsive problems
☐ADHD

75. Have you another disease that we have not mentioned or have you had it?
0 No
0 Yes, please indicate (*more than one disease is possible*)
1. .....
2. .....
3. .....
4. .....
5. .....

76. Have you ever had an operation? (If no, go to question 77) 0
Yes 0 No

76a. Can you indicate why you had an operation, how old were you when you first had this operation and how often you have had to have the operation?

Removal of tonsils. Age:_____year Number of operations _____

Appendicitis Age:_____year Number of operations _____

Hernia of the stomach Age:_____year Number of operations _____

Knee operation (meniscus etc) Age:_____year Number of operations _____

Caesarean section Age:_____year Number of operations _____

Sterilisation Age:_____year Number of operations _____

Varicose veins Age:_____year Number of operations _____

Hernia of the spine Age:_____year Number of operations _____

Other operations
Age:_____year Reason:_____ Number of operations: _____

Age:_____year Reason:_____ Number of operations: _____

Age:_____year Reason:_____ Number of operations: _____

Age:_____year Reason:_____ Number of operations: _____

Age:_____year Reason:_____ Number of operations: _____

Age:_____year Reason:_____ Number of operations: _____

77. Do you take medicine that a doctor has prescribed for you? (If no, go to question 78)
0 Yes 0 No

77a. Can you say what medicine that is, how old were you when you started taking it, and why you need it?

Medicine	Age started	Reason

1. ....
2. ....
3. ....
4. ....
5. ....
6. ....
7. ....
8. ....
9. ....
10. ....

78. Which of the following medicines have you had in the last year without a prescription from the doctor?
(more than one answer possible)

0 None of these below
0 Painkillers or medication for high temperature, like aspirin or acetaminophen
0 Medicine for coughs, cold, flu, sore throat etc
0 Preventative medicines such as vitamins, minerals, tonics, iron tablets
0 Laxatives
0 Other medicines for the stomach and digestive system
0 Sleep or anti stress medicine
0 Other, please indicate_____

79. Does this include homeopathic and herbal remedies? 0
Yes 0 No

80. Over the last year, which of the following painkillers did you use and how many?

Please only tick one box in each row.	None	Less than 10 units a year	Between 10-50 units a year	Between 50- 200 units a year	More than 200 units a year
Medicines containing Acetaminophen Names of medication available on the Dutch market are mentioned: Paracetamol, Antigrippine, Citrosan, Femerital, (kinder)Finimal, Hedex, Hot Coldrex, Momentum, Daro hoofdpijn-poeder, Paracetamol-coffeine, Panadol (plus), Paracof, Para Don, Sanalgin, Saridon, Sinaspril, Spalt, Witte Kruis					
Medicines containing Acetylsalicylacid Names of medication available on the Dutch market are mentioned: AC cod, Alka Seltzer, Apacod, APC, Ascal, Carbasalaat Calcium poeders, Aspirine, Aspro, Chefarine, Coldrex C, Rhonal					
Medicines containing Ibuprofen or Naproxen Names of medication available on the Dutch market are mentioned: (Actifen, Advil, Aleve, Brufen (siroop), Femapirin, Femex, Ibuprofen, Naproxen, Nurofen, Relian)					

Experience health care

1. Please indicate with which of the following you have had contact in the last 12 months?

0 None
0 GP
0 Medical specialist
0 Dentist /dental hygiene specialist
0 Work doctor
0 Municipal health and social department
0 Dietician
0 Ergo therapist
0 Physiotherapist
0 Speech therapist
0 Caesar therapist
0 House hold help
0 Regional institute for mental health
0 General social worker
0 Clinic for addiction
0 Psychologist
0 Alternative treatments
0 GP services outside office hours
0 Addiction clinic North Netherlands

How do you rate your health? (SF-36/ Rand-36)

This part of the questionnaire is about your health. Please try to answer every question as accurately as you can.

1. In general, would you say your health is:

0 Excellent
0 Very good
0 Good
0 Fair
0 Poor

2. Compared to one year ago, how would your rate your health in general now?

0 Much better now than one year
0 ago Somewhat better now than
0 one year ago
0 About the same
0 Somewhat worse now than one year ago Much worse now than one year ago

3 The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

		Yes, Limited a Lot	Yes, Limited a little	No, Not limited at All
A	**Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	0	0	0
B	**Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	0	0	0
C	Lifting or carrying groceries	0	0	0
D	Climbing **several** flights of stairs	0	0	0
E	Climbing **one** flight of stairs	0	0	0
F	Bending, kneeling, or stooping	0	0	0
G	Walking **more than a mile**	0	0	0
H	Walking **several blocks**	0	0	0
I	Walking **one block**	0	0	0
J	Bathing or dressing yourself	0	0	0

4 During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

		Yes	**No**
A	Cut down the amount of time you spent on work or other activities	0	0
B	**Accomplished less** than you would like	0	0
C	Were limited in the **kind** of work or other activities	0	0

D	Had **difficulty** performing the work or other activities (for example, it took extra effort)	0	0

5 During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

		Yes	**No**
A	Cut down the **amount of time** you spent on work or other activities	0	0
B	**Accomplished less** than you would like	0	0
C	Didn't do work or other activities as **carefully** as usual	0	0

6 During the **past 4 weeks,** to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

0 Not at all
0 Slightly
0 Moderately
0 Quite a bit
0 Extremely

7 How much **bodily** pain have you had during the **past 4 weeks**?

0 None
0 Very mild
0 Mild
0 Moderate
0 Severe
0 Very severe

8 During the **past 4 weeks,** how much did **pain** interfere with your normal work (including both work outside the home and housework)?

0 Not at all
0 A little bit
0 Moderately
0 Quite a bit
0 Extremely

9 These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

	How much of the time during the **past 4 weeks** . . .	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a	Did you feel full of pep?	0	0	0	0	0	0
b	Have you been a very nervous person?	0	0	0	0	0	0
c	Have you felt so down in the dumps that nothing could cheer you up?	0	0	0	0	0	0
d	Have you felt calm and peaceful?	0	0	0	0	0	0
e	Did you have a lot of energy?	0	0	0	0	0	0
f	Have you felt downhearted and blue?	0	0	0	0	0	0
g	Did you feel worn out?	0	0	0	0	0	0
h	Have you been a happy person?	0	0	0	0	0	0
i	Did you feel tired?	0	0	0	0	0	0

10 During the **past 4 weeks,** how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

0 All of the time
0 Most of the time
0 Some of the time
0 A little of the time
0 None of the time

11 How TRUE or FALSE is <u>each</u> of the following statements for you.

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
A	I seem to get sick a little easier than other people	0	0	0	0	0
B	I am as healthy as anybody I know	0	0	0	0	0
C	I expect my health to get worse	0	0	0	0	0
D	My health is excellent	0	0	0	0	0

12. In the previous 7 days, to what extent have you been limited by (SCL-12);

		Not at all	A little	Moderately	Quite a bit	Extremely
1	Headaches	0	0	0	0	0
2	Faintness or dizziness	0	0	0	0	0
3	Pains in hart or chest	0	0	0	0	0
4	Pains in lower back	0	0	0	0	0
5	Nausea or upset stomach	0	0	0	0	0
6	Soreness of your muscles	0	0	0	0	0
7	Trouble getting your breath	0	0	0	0	0
8	Hot or cold spells	0	0	0	0	0
9	Numbness or tingling in your body	0	0	0	0	0
10	A lump in your throat	0	0	0	0	0
11	Feeling weak in parts of your body	0	0	0	0	0
12	Heavy feelings in arms or legs	0	0	0	0	0

Questions for women

1. How often have you been pregnant? (Irrespective of the outcome)
_____ times

2a. How many miscarriages (to 16 weeks) have you had?
_____

2b. What was the date of the last miscarriage? Day _____ Month____
Year_____

3. How many times have you had an abortion?

_____times

4a. How many times have you given birth? _____
times

4b. Could you please fill in what the year of birth was, the length of the pregnancy, and if the baby was alive 24 hours after the birth. By birth we mean a pregnancy of more than 16 weeks. The length of a normal pregnancy is 40 weeks.
(multiple birth: for each child one row)

Year of given birth	Duration of pregnancy	Baby alive 24 hours after birth
	… weeks	0 Yes 0 No
	… weeks	0 Yes 0 No
	… weeks	0 Yes 0 No
	… weeks	0 Yes 0 No
	… weeks	0 Yes 0 No
	… weeks	0 Yes 0 No

5. Are you pregnant now? 0 Yes 0 No

6. How old were you when you first had periods (menstruation)?
_____ year

7. Do you still have periods (menstruation)? 0 Yes
0 No (If no, go to question 7.3)

7.1 Is your menstruation regular? 0 Yes
(if you are pregnant then fill in how it was 0 No, it has never been regular
before the pregnancy) 0 No, in the last few months it has not been regular

7.2 What is on average the length of your cycle? 0 Less than 24 days
(from the first day of menstruation to the first 0 24-26 days
day of the next menstruation) 0 27-29 days
0 30-32 days
0 More than 32 days

7.3 If you no longer have periods, how old were you when you last had a period?
_____ year

8. Has your uterus (womb) and/or ovary/ovaries been removed?

Uterus	0 No	0 Yes, in _____ (year)
One ovary	0 No	0 Yes, in _____ (year)
Both ovaries	0 No	0 Yes, in _____ (year)

9. Have you ever used hormonal contraception? (the pill, Depo Provera, IUD)?
0 Yes 0 No
If not, go to question 10, if yes:

9.1 How many months **in the last 10 years** have you used hormonal contraception?
_____months

9.2 Have you used hormonal contraception **in the last** month?
0 Yes 0 No

10. Have you ever had hormonal treatment for any other reason than contraception?
0 Yes 0 No

If yes:
10.1. Have you ever had hormonal treatment to help induce a pregnancy?
0 Yes 0 No

10.2. Have you ever had hormonal treatment for the menopause? 0 Yes 0 No

If yes
10.2.1. How many months, **during your whole life**, have you had hormonal treatment? (total time)
_____years and _____months

10.2.2. **In the last month** have you had hormonal treatment? 0 Yes 0 No

Questions for women who no longer have menstruation/periods

11a. **In the last 5 years before you stopped menstruating**, did you use hormonal contraception (also Depo Provera or IUD device)?
0 Yes 0 No

11b. **In the last 5 years before you stopped menstruating**, did you have hormonal treatment for any other reason other than contraception?
0 Yes 0 No

Questions about the questionnaire

1. How much time did it take you to fill in this questionnaire? _____hours and _____minutes

2a. Did you find it difficult to fill in this questionnaire?

0 Yes, most or all of the questions or sections were difficult to fill in.
0 Somewhat, a reasonable number of the questions or sections were difficult to fill in.
0 A bit, some of the questions or sections were difficult to fill in
0 No, the questionnaire was easy to fill in.

2b. Which questions did you find unclear or you were not certain of your answer?

Page	Question number	Please give an explanation