Sociodemography

General, occupation, working environment

General

SC10. In what sort of dwelling do you live?

❍ Villa / independent house
❍ Terrace houses / chain houses
❍ Apartment
❍ Other

SC11. Do you own your residence?

❍ Yes
❍ No

SC40. How many rooms, except the kitchen, does your residence have?

❍ (Number)_____ ❍

SC50. How big is your residence in square meters?

❍ Area (m2)_____
❍ Don’t know / refuse

SC30. Do you live with someone?

❑ Yes
❑ Husband/wife, fiancé/fiancée, partner, living-together
❑ Children (number)_____
❑ Brothers and sisters (number)_____
❑ Parents
❑ Friend (number)_____
❑ Other (number)_____
❑
❍ No
❍ Don’t know / refuse

SC20. What is your present marital status?

❍ Married
❍ Living-together
❍ Single
❍ Living-apart
❍ Widow / widower
❍ Same-sex

❍ Separated / Divorced
❍ Don't know / refuse

SC60. Do you have siblings?

❑ Yes
❑ Full siblings (number)_____
❑ Half siblings (number)_____
❑
❍ No
❍ Don't know / refuse

SC61. Do you have biological children?

❍ Yes ❍ No

If "yes", show SC62

SC62. How many biological children do you have?

❍ (Number)_____ ❍

SC70. Which is the highest level of education you completed / are working on?

❍ Nine year school
❍ Gymnasium
❍ University
❍ Other

Occupation

SC80. Have you ever been gainfully employed - part time or full time?

❍ Yes
❍ 0 to 2 years
❍ 3 to 5 years
❍ 6 to 10 years
❍ 11 to 20 years
❍ More than 20 years
❍
❍ No

If “yes”, show SC90

SC90. How many employers have you had during this time?

❍ 1
❍ 2
❍ 3 to 5
❍ 6 to 10
❍ More than 10
❍ Don’t know / refuse

SC100. Which of the following alternatives best describes your present situation?

❍ Employed
❍ Unemployed
❍ Running your own company or part owner
❍ Age retired
❍ Disability pension
❍ Sick-leave (since 2 months or longer)
❍ Maternity/paternity leave (since 2 months or longer)
❍ Student
❍ On leave of absence
❍ Housewife/man
❍ Other
❍

If SC100 is not “employed” or “running your own company or part owner”, show SC110

SC110. Have you been gainfully employed or run your own company in the last 5 years?

❍ Yes
❍ No

❖ **A. IF [SC100 IS “EMPLOYED” OR “RUNNING YOUR OWN COMPANY OR PART OWNER] OR SC110 IS “YES” MAKE BELOW QUESTIONS AVAILABLE**

If SC100 is “employed” or “running your own company or part owner”, show SC115

SC115. What is your present occupation and place of work?

	Occupation (e.g. engineer, nurse)	Place of work (e.g. office, hospital)	Years	Full-time	Part-time
	———	———	———	□	□

If SC110 is “yes” or SC115 is “2 years or less” or “part-time”, show SC120

SC120. In the last 5 years, what was your main occupation and place of work?

	Occupation (e.g. engineer, nurse)	Place of work (e.g. office, hospital)	Years	Full-time	Part-time
	_____	_____	_____	☐	☐

❖ **A. CONDITION STOP**

SC130. Have you ever worked shift?

❍ Yes, presently
❍ Yes, before
❍ No
❍ Don’t know / refuse

If “yes” show SC140

SC140. For how many years {have you been, were you} working shift?

❍ Less than 1 year
❍ 1 to 2 years
❍ 3 to 5 years
❍ More than 5 years

SC150. Have you ever had working hours including night work (work between 24.00 – 05.00h)?

❍ Yes, presently
❍ Yes, before
❍ No
❍ Don’t know / refuse

If “yes, presently” or “yes, before”, show SC160, SC170 and SC172

SC160. For how many years {have you been, were you} working nights?

❍ Less than 1 year
❍ 1 to 2 years
❍ 3 to 5 years
❍ 6 to 10 years
❍ 11 to 20 years

❍ More than 20 years
❍ Don’t know / refuse

SC170. How many times per month {are, were} you working nights?

❍ 1 time or less
❍ 2 to 3 times
❍ 4 to 6 times
❍ 7 times or more
❍ Don’t know / refuse

SC171. How {is, was} your "day-sleep" usually after a night shift?

	1	2	3	4	5	
Mycket dålig	□	□	□	□	□	Mycket bra

SC172. How {do, did} you manage to work nights?

	1	2	3	4	5	
No difficulty	□	□	□	□	□	Major difficulties

If SC150 is “yes, before”, show SC175 and SC177

SC175. What year did you stop working night?

❍ (Year, four digits)_____ ❍

SC177. Why did you stop working night?

❍ The working hours were too difficult
❍ Other reason

SC180. Have you ever been unemployed?

❍ Yes ❍ No

If “yes” show SC190, SC200 and SC210

SC190. Have you been unemployed several times?

❍ Yes ❍ No

SC200. What year did your unemployment begin {the last time,}?

❍ (Year, four digits)_____ ❍

SC210. For how long time were you unemployed {the last time,}?

❍ (Years)_____ ❍ (Months)_____

Working environment

SC220. Have you in the last 5 years for a longer period experienced any of the following at work?

❑ Yes
❑ Discomfort due to working with a personal computer
❑ Uncomfortable work positions
❑ Heavy manual labor
❑ Heat, cold, draught
❑ Loud noise
❑ Chemical substances
❑ Vibration
❑
❍ No

❖ **B. FOR EACH CHECKED ANSWER IN SC220 SHOW BELOW QUESTIONS**

SC240. For how long period have you experienced {checked answer} at work:

❍ Less than 1 year
❍ 1 to 2 years
❍ 3 to 5 years
❍ More than 5 years

SC250. How often have you experienced {checked answer} at work:

❍ Often ❍ Seldom

❍ Sometimes
❍ Don’t know / refuse

SC260. Has the {checked answer} made it hard for you to work?

❍ Yes
❍ No

When answer “loud noise” is check, also show SC270

SC270. Do you wear ear protection for the loud noise?

❍ Always
❍ Sometimes
❍ Seldom
❍ Never

❖ B. CONDITION STOP

SC280. Have you experienced any of the following at work?

❑ Yes
❑ Discrimination
❑ Bullying
❑ Harassment
❑ Threat or violence
❑
❍ No
❍ Don’t know / refuse

❖ C. FOR EACH CHECKED ANSWER SHOW BELOW QUESTIONS

SC290. For how long period have you experienced {checked answer} at work?

❍ Less than 1 year
❍ 1 to 2 years
❍ 3 to 5 years
❍ More than 5 years

SC300. How often have you experienced {checked answer} at work?

❍ Often
❍ Sometimes
❍ Seldom
❍ Don’t know / refuse

SC310. Has the {checked answer} made it hard for you to work?

❍ Yes ❍ No

❖ C. CONDITION STOP

SC320. Have you during the last 12 months experienced any of the following?

❑ Yes
❑ Uneasy to go to work
❑ Worried not to be good enough at work
❑ Insecurity due to reorganization
❑ Insecurity due to notice or threats about closure
❑
❍ No
❍ Don’t know / refuse

If answer “uneasy to go to work” is checked in SC320, show SC330

SC330. Has your uneasy feeling made it hard for you to work?

❍ Yes ❍ No

If answer “worried not to be good enough at work” is checked in SC320, show SC340

SC340. Has your worry about not being good enough at work made it hard for you to work?

❍ Yes ❍ No

SC350. Questions about stress at work:

	Rarely or not at all	Sometimes	Yes, mostly	Don’t know / refuse
Do you have to work very fast or intensively?	□	□	□	□
Are there often conflicting requirements at work?	□	□	□	□
Do you have to do the same thing over and over again?	□	□	□	□
Does your work require too great a	□	□	□	□

	Rarely or not at all	Sometimes	Yes, mostly	Don’t know / refuse
work effort?				

SC360.

	Yes, mostly	Sometimes	Rarely or not at all	Don’t know / refuse
Does your job require a great deal of responsibility?	□	□	□	□
Do you have a choice in deciding how you do your work?	□	□	□	□
Do you have a choice in deciding what you do at work?	□	□	□	□
Do you have the possibility of learning new things through your work?	□	□	□	□

SC370.

	Yes, mostly	Sometimes	Rarely or not at all	Don’t know / refuse
I’m enjoying my work.	□	□	□	□
It’s a good solidarity at work.	□	□	□	□
I’m enjoying my working mates.	□	□	□	□
I get along well with my superiors.	□	□	□	□

SC380.

	No	Yes	Don’t know / refuse
Are you thinking about changing jobs?	□	□	□

SC390. Have you in the past 12 months worked overtime?

- ❑ Yes
- ❑ Early mornings
- ❑ During lunch or
- ❑ In the weekends
- ❑ On vacation

breaks
❑ In the evenings

❑
❍ No

If not “no”, show SC400

SC400. How many hours per week have you on average worked overtime?

❍ 1 to 5 hours
❍ 6 to 10 hours
❍ 11 to 20 hours
❍ 21 to 30 hours
❍ More than 30 hours
❍ Don’t know / refuse

SC413. How many times have you been on a sick-leave lasting shorter than 15 days in the past 12 months?

❍ None
❍ 1 time
❍ 2 to 5 times
❍ More than 5 times
❍ Don’t know / refuse

SC416. How many times have you been on a sick-leave lasting 15 days or longer in the past 12 months?

❍ None
❍ 1 time
❍ 2 to 5 times
❍ More than 5 times
❍ Don’t know / refuse

If SC413 or SC416 is not “none” nor “don’t know / refuse”, show SC420 and SC430

SC420. For how long were you {totally,} on sick-leave?

❍ (Days)_____
❍ (Weeks)_____
❍ (Months)_____

SC430. Why were you on sick-leave {the longest time,}?

❍ (Cause)_____
❍ Don’t know / refuse

SC460. Thinking back on the last the last 12 months, how many times did you go to work though you should have stayed home sick?

❍ Never
❍ 1 time
❍ 2 to 5 times
❍ More than 5 times

SC480. If you would be on sick-leave for one week, how much missed work would you have to do when returning?

❍ Nothing
❍ About half
❍ Everything
❍ Don’t know / refuse

SC490. In the last 12 months have you had problems to sleep due to thoughts about work?

❍ Yes
❍ A couple of nights a month
❍ A couple of nights a week
❍ One night a week
❍ Every night or nearly every night
❍
❍ No
❍ Don’t know / refuse

SC500. If you think about the relationship between your working life and your private life:

	Rarely or never	Sometimes	Often	Don’t know / refuse
Does the demand in your work affect your private life in a negative manner?	☐	☐	☐	☐
Does your private life affect your work in a negative manner?	☐	☐	☐	☐
Do you have problems to get enough time for both work and private life?	☐	☐	☐	☐

Daily life

General, (diet), physical activity, sexual behavior, wireless devices

General

QL10. How do you estimate your general (physical and mental) health?

	1	2	3	4	5	
As bad as it can be	□	□	□	□	□	As good as it can be

QL20. How do you estimate your health compared to one year ago?

	1	2	3	4	5	
Much worse	□	□	□	□	□	Much better

QL30. How do you rate your overall physical health?

	1	2	3	4	5	
Poor	□	□	□	□	□	Excellent

QL40. How do you rate your overall mental health?

	1	2	3	4	5	
Poor	□	□	□	□	□	Excellent

QL50. Do you think your health status prevents you from doing things you want to do?

	1	2	3	4	5	
Not at all	❑	❑	❑	❑	❑	A great deal

QL60. How do you view your health compared to others in your age group?

	1	2	3	4	5	
Much worse	❑	❑	❑	❑	❑	Much better

QL70. During the past 4 weeks, has your physical health interfered with any of the following?

❑ Yes
❑ Work
❑ Daily activities
❑ Social life
❑
❍ No

❖ **A. FOR EACH CHECKED ANSWER IN QL70 SHOW BELOW CORRESPONDING QUESTION**

QL80. To what extent has your physical health interfered with your work?

❍ Slightly
❍ Moderate
❍ Much
❍ Don’t know / refuse

QL90. To what extent has your physical health interfered with your daily activities?

❍ Slightly
❍ Moderate
❍ Much
❍ Don’t know / refuse

QL100. To what extent has your physical health interfered with your social life?

❍ Slightly
❍ Moderate
❍ Much
❍ Don’t know / refuse

❖ **A. CONDITION STOP**

QL110. During the past 4 weeks, has your emotional well-being interfered with any of the following?

❑ Yes
❑ Work
❑ Daily activities
❑ Social life
❑
❍ No

❖ **B. FOR EACH CHECKED ANSWER IN QL110 SHOW BELOW CORRESPONDING QUESTION**

QL120. To what extent has your emotional well-being interfered with your work?

❍ Slightly
❍ Moderate
❍ Much
❍ Don’t know / refuse

QL130. To what extent has your emotional well-being interfered with your daily activities?

❍ Slightly
❍ Moderate
❍ Much
❍ Don’t know / refuse

QL140. To what extent has your emotional well-being interfered with your social life?

❍ Slightly
❍ Moderate
❍ Much
❍ Don’t know / refuse

❖ **B. CONDITION STOP**

QL150. How much of the time during the past 4 weeks:

	Most of the time	Some of the time	A little or none of the time	Don’t know / refuse
Did you have a lot of energy?	□	□	□	□
Did you feel calm and	□	□	□	□

	Most of the time	Some of the time	A little or none of the time	Don’t know / refuse
peaceful?				

QL160. How much of the time during the past 4 weeks:

	A little or none of the time	Some of the time	Most of the time	Don’t know / refuse
QL24. Have you been a very nervous person?	□	□	□	□
QL29*. Did you feel tired or worn out?	□	□	□	□
QL28. Have you felt downhearted and blue?	□	□	□	□

QL170. I am satisfied with my life.

	1	2	3	4	5	
Disagree	□	□	□	□	□	Agree

QL180. So far I have gotten the important things I want in life.

	1	2	3	4	5	
Disagree	□	□	□	□	□	Agree

QL190. If I could live my life over, I would change almost nothing.

	1	2	3	4	5	
Disagree	□	□	□	□	□	Agree

QL200. In general, I consider myself a happy person.

	1	2	3	4	5	
Disagree	□	□	□	□	□	Agree

QL210. Compared to most of my peers I consider myself happier.

	1	2	3	4	5	
Disagree	□	□	□	□	□	Agree

QL220. I enjoy life regardless of what is going on and get the most out of everything.

	1	2	3	4	5	
Disagree	□	□	□	□	□	Agree

QL230. How would you describe your overall quality of life as you have been feeling the last month?

	1	2	3	4	5	6	7	
As bad as it can be	□	□	□	□	□	□	□	As good as it can be

QL232. The following questions are about your feelings and thoughts during the last month.

How often have you:

	Never	Almost never	Sometimes	Fairly often	Very often	Don’t know/ refuse
Been upset because of something that happened unexpectedly?	□	□	□	□	□	□

	Never	Almost never	Sometimes	Fairly often	Very often	Don't know/ refuse
Felt that you were unable to control the important things in your life?						
Felt nervous and "stressed"?						
Felt confident about your ability to handle your personal problems?						
Felt that things were going your way?						
Found that you could not cope with all the things that you had to do?						
Been able to control irritations in your life?						
Felt that you were on top of things?						
Been angered because of things that were outside of your control?						
Felt difficulties were piling up so high that you could not overcome them?						

QL235. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain in the last month?

❍ Yes ❍ No

- **B1. IF QL235 IS "YES" THEN SHOW BELOW QUESTIONS.**

QL236. How long time have you had pain in the last month?

❍ Less than a week ❍ 1 week ❍ 2 weeks ❍ 3 weeks or more

QL240. Please rate the worst pain you had in the last month.

	1	2	3	4	5	6	7	8	9	10	
No pain	□	□	□	□	□	□	□	□	□	□	As bad as I can imagine

QL250. Please rate the least pain you had in the last month.

	1	2	3	4	5	6	7	8	9	10	
No pain	□	□	□	□	□	□	□	□	□	□	As bad as I can imagine

QL260. Please rate the average pain you have.

	1	2	3	4	5	6	7	8	9	10	
No pain	□	□	□	□	□	□	□	□	□	□	As bad as I can imagine

QL265. Please rate the pain you have right now.

	1	2	3	4	5	6	7	8	9	10	
No pain	□	□	□	□	□	□	□	□	□	□	As bad as I can imagine

QL270. Do you receive treatments or medications for your pain?

❍ Yes ❍ No

If QL270 is “yes”, show QL280

QL280. How much relief have pain treatments or medications provided in the last month?

	1	2	3	4	5	6	7	8	9	10	
No relief	□	□	□	□	□	□	□	□	□	□	Complete relief

❖ **B2. IF QL240 IS “4” OR HIGHER THEN SHOW BELOW QUESTIONS.**

QL290. Please rate how your pain has interfered with the following in the last month:

	Not at all	A little bit	Moderately	Quite a bit	Extremely	Vet ej / vill ej svara
Mood	❍	❍	❍	❍	❍	❍
Relations with other people	❍	❍	❍	❍	❍	❍
Walking ability	❍	❍	❍	❍	❍	❍
Sleep						
Normal work (incudes both work outside the home and housework)						
Enjoyment of life						

❖ **B1 AND B2. CONDITIONS STOP.**

QL360. Throughout our lives, most of us have time when we feel very tired or fatigued. Have you felt unusually tired or fatigued in the last week?

❍ Yes ❍ No

❖ **B3. IF QL360 IS “YES” THEN SHOW BELOW QUESTIONS.**

QL370. Please rate the fatigue you have right now.

	1	2	3	4	5	6	7	8	9	10	
No fatigue	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	As bad as I can imagine

QL380. Please rate your usual fatigue.

	1	2	3	4	5	6	7	8	9	10	
No fatigue	□	□	□	□	□	□	□	□	□	□	As bad as I can imagine

QL390. Please rate the worst fatigue you had in the last week.

	1	2	3	4	5	6	7	8	9	10	
No fatigue	□	□	□	□	□	□	□	□	□	□	As bad as I can imagine

- **B4. IF QL370 IS “4” OR HIGHER THEN SHOW BELOW QUESTIONS.**

QL400. Please rate how your fatigue has interfered with the following in the last week.

	Not at all	A little bit	Moderately	Quite a bit	Extremely	Vet ej / vill ej svara
Mood	□	□	□	□	□	□
Relations with other people	□	□	□	□	□	□
Walking ability	□	□	□	□	□	□
Sleep						
Normal work (incudes both work outside the home and housework)						
Enjoyment of life						

- **B3 AND B4. CONDITIONS STOP.**

Physical activity

QL470. State your present physical activity i.e. activities at work and at home, like walking, bicycling, training, skiing etc.

	1	2	3	4	5	
Mainly sitting	□	□	□	□	□	Vigorous physical activity

❖ **C. FOR EACH QUESTION IF A IS "YES" THEN SHOW B AND C**

QL480. In the last 7 days have you been walking more 10 minutes in a stretch - at work, for transportation or in leisure time?

A		**B**	**C**
Yes	No	How many days?	How long on average each day?
□	□	❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 30 minutes ❍ 30 to 60 minutes ❍ 1 to 4 hours ❍ 5 to 8 hours ❍ More than 8 hours
□	□	❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 30 minutes ❍ 30 to 60 minutes ❍ 1 to 4 hours ❍ 5 to 8 hours ❍ More than 8 hours

QL490. In the last 7 days have you done moderate physical activities - like normal bicycling, swimming, moderate construction work or gardening or other activity in a moderate pace?

Yes	No	How many days?	How long on average each day?
□	□	❍ 1 ❍ 2	❍ Less than 30 minutes ❍ 30 to 60 minutes

		~~How many days?~~	~~How long on average each day?~~
		❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ 1 to 4 hours ❍ 5 to 8 hours ❍ More than 8 hours
		❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 30 minutes ❍ 30 to 60 minutes ❍ 1 to 4 hours ❍ 5 to 8 hours ❍ More than 8 hours

QL500. In the last 7 days have you done vigorous physical activities - like heavy bicycling, running, aerobics, heavy lifting, heavy construction work, heavy gardening or other vigorous activities?

	Yes	No	How many days?	How long on average each day?
			❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 30 minutes ❍ 30 to 60 minutes ❍ 1 to 4 hours ❍ 5 to 8 hours ❍ More than 8 hours
			❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 30 minutes ❍ 30 to 60 minutes ❍ 1 to 4 hours ❍ 5 to 8 hours ❍ More than 8 hours

❖ C. CONDITION STOP

QL510. Which of the following do you do most in your work?

❍ Sitting still

❍ Standing or walking

❍ Manual labor (e.g. plumber, electrician, carpenter)

❍ Heavy manual labor (e.g. dock worker, miner, bricklayer, construction worker)

QL520. Have you used any of the following for transportation in the last 7 days?

	Yes	How many days?	How long on average each day?
Public transportation - bus, train or tram	☐	❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 45 minutes ❍ 45 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Private car or taxi	☐	❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 45 minutes ❍ 45 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Motorcycle or scooter	☐	❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 45 minutes ❍ 45 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Bicycle	☐	❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 45 minutes ❍ 45 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Transportation by walking	☐	❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 45 minutes ❍ 45 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours

I have not used any of these	☐

QL530. In the last 12 months how much of your leisure time have you spent watching TV, using the computer or reading?

- ❍ Less than 1 hour per day
- ❍ 1 to 2 hours per day
- ❍ 3 to 4 hours per day
- ❍ 5 to 6 hours per day
- ❍ More than 6 hours per day

QL535. In the last 12 months how much time have you spent doing home or house work?

- ❍ Less than 1 hour per day
- ❍ 1 to 2 hours per day
- ❍ 3 to 4 hours per day
- ❍ 5 to 6 hours per day
- ❍ 7 to 8 hours per day
- ❍ More than 8 hours per day

QL540. In the last 12 months how much time have you spent exercising on average?

- ❍ Less than 1 hour per week
- ❍ 1 hour per week
- ❍ 2 to 3 hours per week
- ❍ 4 to 5 hours per week
- ❍ More than 5 hours per week

QL545. Have you done any of the following sport activities in the last 12 months?

	Yes	How often?	How long on average each time?
Walking or power-walking	☐	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Aerobics or similar	☐	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Gym or weight lifting	☐	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Jogging or running	☐	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Bicycling	☐	❍ A few	❍ Less than 15 minutes

	Yes	How often?	How long on average each time?
		times ❍ Monthly ❍ Weekly ❍ Daily	❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Swimming	□	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Floor ball	□	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Football	□	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Golf	□	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Dancing	□	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Athletics	□	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Horseback riding	□	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours
Ice hockey	□	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours

	Yes	How often?	How long on average each time?
Martial arts - budo, judo etc.	☐	❍ A few times ❍ Monthly ❍ Weekly ❍ Daily	❍ Less than 15 minutes ❍ 15 to 30 minutes ❍ 30 to 60 minutes ❍ 1 to 2 hours ❍ More than 2 hours

I have not done any of these	☐

Sexual behavior

If age < 18, show only QL550 and QL570 in this module

QL550. Have you had voluntary sexual intercourse?

❍ Yes ❍ No

QL560. How old were you when you first had voluntary sexual intercourse?

❍ (Years old)_____ ❍ I have not had intercourse

QL570. Do you have a stable relationship?

❍ Yes ❍ No

If QL330 is “yrs old”, show QL580

QL580. How many times during the last 30 days have you had sexual intercourse?

❍ (Times)_____ ❍ Not at all

QL590. How many times during the last 30 days have you masturbated?

❍ (Times)_____ ❍ Not at all

❖ **D. EXIT FROM MODULE IF QL560 IS "I have not had intercourse"**

QL600. How many people of the opposite sex have you been sexually together with in your lifetime?

❍ (Number of partners)_____ ❍ Nobody

QL610. How many people of the same sex as you have you been sexually together with in your lifetime?

❍ (Number of partners)_____ ❍ Nobody

QL620. Have you ever had a sexually transmitted disease?

❍ Yes ❍ No

QL630. Have you been in a situation where there was a risk for a sexually transmitted disease and you did not use condom?

❍ Yes ❍ No

Wireless devices

QL640. How many years have you used a mobile phone at least once a week?

❍ One year or less
❍ 2 to 4 years
❍ 5 to 8 years
❍ 9 to 12 years
❍ More than 12 years
❍ I have never used a mobile phone at least once a week

❖ E. IF QL640 IS NOT “I HAVE NEVER USED…” THEN SHOW BELOW QUESTIONS

QL650. How much time per week do you use your mobile phone currently?

- ❍ Less than 5 minutes
- ❍ 6 to 29 minutes
- ❍ 30 minutes to 1 hour
- ❍ 1 to 3 hours
- ❍ 4 to 6 hours
- ❍ More than 6 hours

QL660. To what extent do you use your mobile phone compared to two years ago?

- ❍ More frequent now
- ❍ To the same extent
- ❍ Less frequent now
- ❍ Don’t know / refuse

QL670. How often do you use hands-free or speakerphone when calling?

- ❍ Most of the time
- ❍ About half the time
- ❍ Almost never or not at all
- ❍ Don’t know / refuse

If “most of the time” or “about half the time”, show QL670

QL680. When you are calling using hands-free where do you usually keep the mobile phone?

- ❍ In your hand
- ❍ In or near your front trouser pocket
- ❍ In or near your back trouser pocket
- ❍ In your chest pocket or hanging around the neck
- ❍ In another place
- ❍ Don’t know / refuse

QL690. When you are calling not using hands-free on which side of the head do you usually use the mobile phone?

- ❍ Right
- ❍ Left
- ❍ Equally left and right
- ❍ Don’t know / refuse

❖ E. CONDITION STOP

QL700. Have you used a cordless phone (DECT)?

❍ Yes
❍ Presently
❍ Before, but not now
❍
❍ No
❍ Don’t know / refuse

❖ **F. IF QL700 IS “PRESENTLY” OR “BEFORE…” THEN SHOW BELOW QUESTIONS**

MO702. For how long {have you used, did you use} cordless phone?

❍ One year or less
❍ 2 to 4 years
❍ 5 to 8 years
❍ 9 to 12 years
❍ More than 12 years
❍ Don’t know / refuse

MO704. How much time per week {do, did} you use cordless phone?

❍ Less than 5 minutes
❍ 6 to 29 minutes
❍ 30 to 59 minutes
❍ 1 to 3 hours
❍ 4 to 6 hours
❍ More than 6 hours

❖ **F. CONDITION STOP**

MO706. Have you used any of the following computer/laptop wireless connections at {work, school} or in your leisure time?

❑ Yes
❑ WLAN
❑ 3G
❑
❍ No
❍ Don’t know / refuse

❖ **G. IF THE ANSWERS “WLAN” OR “3G” IS CHECKED IN MO706 THEN SHOW BELOW QUESTIONS**

QL710. For how many years have you used wireless access at {work, school} or in your leisure time?

❍ One year or less
❍ 2 to 4 years
❍ 5 to 8 years
❍ 9 to 12 years
❍ More than 12 years
❍ Don’t know /

refuse

QL720. How many hours per day do you use wireless access at {work, school} or in your leisure time?

- ❍ Less than 30 minutes
- ❍ 30 to 59 minutes
- ❍ 1 to 3 hours
- ❍ 4 to 6 hours
- ❍ 7 to 9 hours
- ❍ 10 hours or more

❖ G. CONDITION STOP

Complementary and alternative medicine

Products, treatments, techniques

Products

KA10. {Has your child, Have you} used any of the following products on a weekly basis during the past 12 months?

	Yes
Omega-3: ACO - Omega 3, Omega Max, FriggsEskimo 3, Pikasol, etc.	☐
Ginkgo Biloba: Bio-Biloba, Ginkomax, Gink-Yo, Proginko, Seredrin, etc.	☐
Echinacea: Echinagard, Echinaforce, Esberitox, etc.	☐
Ginseng: Gericomplex, Ginsana, etc.	☐
Kan Jang	☐
Chi San	☐
Rosanae	☐
Vänderot: Valeriana forte, Valeriena, etc.	☐
Johannesört: Esbericum, Movina, Neurokan, etc.	☐
Laktobaciller	☐
Garlic products: Kwai, Kyolic, etc.	☐

{My child, I} have not used any of the above products	☐

Treatments

KA20. {Has your child, Have you} had any of the following treatments during the past 12 months?

	Yes	How often?
Professional massage	☐	❍ A few times ❍ A few times a month ❍ A few times a week
Chiropractic therapy	☐	❍ A few times ❍ A few times a month ❍ A few times a week
Naprapathy	☐	❍ A few times ❍ A few times a month ❍ A few times a week
Acupuncture	☐	❍ A few times ❍ A few times a month ❍ A few times a week
Zontherapy, Reflexology, Rosen method	☐	❍ A few times ❍ A few times a month ❍ A few times a week
Homeopathy, Chinesiology	☐	❍ A few times ❍ A few times a month ❍ A few times a week
Antroposophical medicine	☐	❍ A few times ❍ A few times a month ❍ A few times a week
Healing, Crystal therapy	☐	❍ A few times ❍ A few times a month ❍ A few times a week

{My child, I} have not had any of the above treatments	☐

Techniques

KA30. {Does your child, Do you} do any of the following activities on a regular basis?

	Yes	How often?	Since how many years?
Yoga	☐	❍ Daily ❍ A few times a week ❍ A few times a month ❍ A few times a year	❍ Less than 1 year ❍ 1 to 5 years ❍ 6 to 10 years ❍ More than 10 years
Tai Chi	☐	❍ Daily ❍ A few times a week ❍ A few times a month ❍ A few times a year	❍ Less than 1 year ❍ 1 to 5 years ❍ 6 to 10 years ❍ More than 10 years
Qi gong	☐	❍ Daily ❍ A few times a week ❍ A few times a month ❍ A few times a year	❍ Less than 1 year ❍ 1 to 5 years ❍ 6 to 10 years ❍ More than 10 years
Meditation	☐	❍ Daily ❍ A few times a week ❍ A few times a month ❍ A few times a year	❍ Less than 1 year ❍ 1 to 5 years ❍ 6 to 10 years ❍ More than 10 years
Relaxation practices	☐	❍ Daily ❍ A few times a week ❍ A few times a month ❍ A few times a year	❍ Less than 1 year ❍ 1 to 5 years ❍ 6 to 10 years ❍ More than 10 years

{My child, I} do not do any of the above	☐

Menstruation and reproduction

Menstruation, reproduction, menopause, diseases

Menstruation

MN10. How old were you when you had your first menstrual period?

❍ (years old)_____ ❍ Not got a period

❖ **A. IF MN10 IS "YEARS OLD" THEN SHOW BELOW QUESTIONS**

MN20. Have you had a menstrual period during the last year?

❍ Yes ❍ No

If "yes", show MN30

MN30. What is the reason that you did not have a menstrual period?

❍ Pregnancy or breast feeding
❍ Menopause
❍ Medication
❍ Contraceptive
❍ Gynecological surgery
❍ Intense exercise
❍ Anorexia / eating disorders
❍ Other

MN40. Do you have irregular menstrual periods?

❍ Yes ❍ No

MN50. Do you currently use any of the following contraceptives?

❍ Yes
❍ Mini pills
❍ Combination pills (regulars oral
❍ Hormonal coil
❍ P-implant

contraceptive)
❍ P-injection

❍
❍ No

MN60. Do you feel that you have had abnormal hair growth on parts of the body, i.e. on the upper lip, chin, stomach or on the thighs?

❍ Yes ❍ No

MN70. Do you suffer from severe menstrual pain?

❍ Yes ❍ No

If “yes”, show MN80

MN80. Has it been necessary for you to take any of the following measures regularly because of your pain?

❑ Yes
❑ I take time off from work
❑ I take painkillers
❑ I use hormones in the form of contraceptive pills
❑
❍ No

MN90. Do you find sexual intercourse painful?

❍ Yes ❍ No

MN100. Do you suffer from pelvic pain between your monthly periods?

❍ Yes ❍ No

Reproduction

MN110. Have you ever been pregnant?

❍ Yes ❍ No

❖ **B. IF MN110 IS “YES” THEN SHOW QUESTIONS BELOW**

MN120. Are you pregnant now?

❍ Yes ❍ No

MN130. How many times have you been pregnant?

❍ (Times)_____ ❍

MN140. Have you had miscarriage or stillbirth?

❍ No ❍ Yes (times)_____

MN150. Have you given birth to a child?

❍ Yes ❍ No

If “yes”, show MN160

MN160. How many times have you given birth?

❍ (Times)_____ ❍

❖ **B. CONDITION STOP**

MN170. Have you had gynecological surgery (excluding cesarean delivery)?

❑ Yes
❑ Operation of the cervix
❑ Removal of uterus
❑ Removal of ovary
❑ Sterilization
❑ Surgical abortion
❑ Pregnancy complications
❑ Other operation
❑
❍ No

❖ **C. FOR EACH CHECKED ANSWER IN MN170 SHOW BELOW CORRESPONDING QUESTIONS**

If “operation of the cervix”, show MN180

MN180. How old were you (the first time) when the operation of the cervix was done?

❍ (Years old)_____ ❍

If “removal or uterus”, show MN190

MN190. How old were you when you removed the uterus?

❍ (Years old)_____ ❍

If “removal of ovary”, show MN200

MN200. How old were you when you removed the ovary?

❍ (Years old)_____ ❍

If “sterilization”, show MN210

MN210. How old were you when the sterilization was done?

❍ (Years old)_____ ❍

If “surgical abortion”, show MN220

MN220. How old were you (the first time) the surgical abortion was done?

❍ (Years old)_____ ❍

If “pregnancy complications”, show MN230

MN230. How old were you (the first time) you had a pregnancy complication operation?

❍ (Years old)_____ ❍

If “other operation”, show MN240

MN240. How old were you when you had the other operation?

❍ (Years old)_____ ❍

❖ **A AND C. CONDITIONS STOP**

MN250. Have you been diagnosed with endometriosis?

❍ Yes ❍ No

MN260. Have you been diagnosed with PCO? (PCO is also known as PCLOS (polycystic ovarian syndrome))

❍ Yes ❍ No

MN270. Have you been examined or treated for infertility?

❍ Yes ❍ No

Menopause

❖ **D. IF AGE > 30**

MN280. Have you reached menopause?

❍ Yes ❍ No

❖ **E. IF MN280 IS "YES" THEN SHOW QUESTIONS BELOW**

MN290. How old where you when your menopause symptoms began?

❍ (Years old)_____ ❍

MN300. Which of the following symptoms did / do you have?

❑ Hot flushes
❑ Dry or fragile mucous membranes
❑ Mood swings
❑ Heart rushes or palpitation
❑ Sleep disorders
❑ Depression
❑
❍ None of these

MN310. Have you been treated with hormone medication due to your menopause symptoms?

❑ Yes
❑ Estrogen
❑ Estrogen with continuous progesterone
❑ Estrogen with cyclical progesterone
❑ Livial
❑
❍ No
❍ Don't know / refuse

❖ **F. FOR EACH CHECKED ANSWER IN MN310 SHOW BELOW CORRESPONDING QUESTIONS**

If "estrogen", show MN320

MN320. For how long have you used estrogen?

❍ (Years)_____ ❍

If "estrogen with continuous progesterone", show MN330

MN330. For how long have you used estrogen with continuous progesterone?

❍ (Years)_____ ❍

If “estrogen with cyclical progesterone”, show MN340

MN340. For how long have you used estrogen with cyclic progesterone?

❍ (Years)_____ ❍

If “Livial”, show MN350

MN350. For how long have you used Livial?

❍ (Years)_____ ❍

❖ **F. CONDITION STOP**

MN360. Have you used local hormonal medications for dry or fragile mucous membranes?

❑ Yes ❑ Ovestirin ❑ Vagifem ❍ No ❍ Don’t know / refuse

❖ **G. FOR EACH CHECKED ANSWER IN MN360 SHOW BELOW CORRESPONDING QUESTIONS**

If “Ovesterin”, show MN370

MN370. For how long have you used Ovestirin?

❍ (Years)_____ ❍

If “Vagifem”, show MN380

MN380. For how long have you used Vagifem?

❍ (Years)_____ ❍

- **E AND G. CONDITIONS STOP**

Diseases

MN390. Do you have difficulty controlling your urine bladder?

❍ Yes ❍ No

- **H. MN390 IS “YES” THEN SHOW BELOW QUESTIONS**
- **I. FOR EACH QUESTION IF A IS “YES” THEN SHOW B**

MN391. Do you experience frequent urination?

	A.		**B.**
	Yes	No	How much does it bother you?
	□	□	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly
	□	□	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly

MN392. Do you experience urine leakage related to the feeling of urgency?

	Yes	No	How much does it bother you?
	☐	☐	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly
	☐	☐	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly

MN393. Do you experience urine leakage related to physical activity?

	Yes	No	How much does it bother you?
	☐	☐	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly
	☐	☐	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly

MN394. Do you experience small amounts of urine leakage (drops)?

	Yes	No	How much does it bother you?
	☐	☐	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly
	☐	☐	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly

MN395. Do you experience difficulty emptying your bladder?

	Yes	No	How much does it bother you?
	□	□	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly
	□	□	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly

MN396. Do you experience pain or discomfort in the lower abdominal or genital area?

	Yes	No	How much does it bother you?
	□	□	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly
	□	□	❍ Not at all ❍ Slightly ❍ Moderately ❍ Greatly

How often during the past month:

MN397. Have you felt the strong need to urinate with little or no warning?

❍ Not at all
❍ Less than 1 time of 5
❍ Less than half the time
❍ About half the time
❍ More than half the time
❍ Almost always
❍ Don’t know / refuse

MN398. Did you have to urinate less than 2 hours after you finished urinating?

- ❍ Not at all
- ❍ Less than 1 time of 5
- ❍ Less than half the time
- ❍ About half the time
- ❍ More than half the time
- ❍ Almost always
- ❍ Don’t know / refuse

MN398.1. Did you typically get up at night to urinate?

- ❍ None
- ❍ Once
- ❍ 2 times
- ❍ 3 times
- ❍ 4 times
- ❍ 5 times or more
- ❍ Don’t know / refuse

MN399. Have you experienced pain or burning in your bladder?

- ❍ Not at all
- ❍ Once
- ❍ A few times
- ❍ Almost always
- ❍ Fairly often
- ❍ Usually
- ❍ Don’t know / refuse

MN400. Have you experienced immediate cease of pain or burning after emptying your bladder?

- ❍ Not at all
- ❍ Less than 1 time of 5
- ❍ Less than half the time
- ❍ About half the time
- ❍ More than half the time
- ❍ Almost always
- ❍ Don’t know / refuse

❖ H AND I. CONDITIONS STOP

MN450. Have you received a vaccine protecting you from cervix cancer?

❍ Yes ❍ I don’t remember the

❍ Gardasil
❍ Cervarix
name
❍ No

MN460. Have you been diagnosed with osteoporosis?

❍ Yes ❍ No

❖ J. IF AGE > 30

MN470. Does any of the following apply to you?

	Yes	No	
Is there anyone with osteoporosis in your family?	☐	☐	☐
Have your menstrual periods stopped?	☐	☐	☐
Have you fractured hip, vertebra or wrist although you only had slight fall?	☐	☐	☐
Have you used cortisone pills or injections?	☐	☐	☐

❖ J. CONDITION STOP

Tobacco, alcohol and drug use

Smoking & snus, alcohol, drug use

Smoking

SM10. Have you ever smoked a whole cigarette at one time?

❍ Yes
❍ No
❍ No, but I have smoked pipe or cigar
❍ Don't know / refuse

❖ **A. EXIT MODULE IF SM10 IS NOT "YES"**

SM20. How old were you when you first smoked a whole cigarette?

❍ (Years old)_____ ❍

SM30. Have you smoked more than 100 cigarettes in your entire life?

❍ Yes ❍ No

❖ **B. EXIT MODULE IF SM30 IS NOT "YES"**

SM40. When you smoked the most in your life, how many cigarettes did you smoke?

❍ Less than 1 cigarette per month
❍ Less than 1 cigarette per day but more than one per month
❍ At least 1 cigarette per day
❍ Don't know / refuse

❖ **C. EXIT MODULE IF SM40 IS LESS THAN "AT LEAST 1 CIGARETTE PER DAY"**

SM50. How old were you when you started to smoke at least one cigarette per day?

❍ (Years old)_____ ❍

SM60. In your life for how many years have you smoked at least one cigarette per day?

❍ Less than 1 year
❍ 1 to 5 years
❍ 6 to 10 years
❍ 11 to 15 years
❍ 16 to 20 years
❍ More than 20 years
❍ Don’t know / refuse

SM70. How many cigarettes did you smoke per day during this time?

❍ (Number)_____ ❍

SM80. When you were smoking the most, how soon after waking up did you smoke your first cigarette?

❍ Within 5 minutes
❍ 6 to 30 minutes
❍ 31 to 60 minutes
❍ After 60 minutes

SM90. When you were smoking the most, did you smoke more frequently during the first hours after awakening than during the rest of the day?

❍ Yes ❍ No

SM100. When you were smoking the most, which cigarette did you hate most to give up?

❍ First cigarette in the morning
❍ Any other

SM110. When you were smoking the most, did you find it difficult to refrain from smoking in places where it was forbidden (school, church, library, movie theater etc.)?

❍ Yes ❍ No

SM120. When you were smoking the most, did you smoke even if you were so ill that you were in bed most of the day?

❍ Yes ❍ No

SM130. Do you smoke now?

❍ Yes ❍ No

If SM130 is “no”, show SM135

If SM130 is “yes”, show SM140

SM135. How old were you when you quit smoking?

❍ (Years old)_____ ❍

SM140. How many cigarettes per day do you smoke now?

❍ (Number)_____ ❍

SM150. How many serious attempts have you made to quit smoking in your entire life?

❍ (Times)_____ ❍ I have not tried to quit

SM160. For how long have you been able to stay off cigarettes the longest time?

❍ About a day ❍ About half a year
❍ About a week ❍ About a year
❍ About a month ❍ Longer than a year

Snus

SN10. In your life have you ever tried snus?

❍ Yes ❍ No

❖ D. EXIT MODULE IF SN10 IS NOT “YES”

SN20. How old were you when you first tried snus?

❍ (Years old)_____ ❍

SN30. Have you used more than 5 tins/cans in your entire life?

❍ Yes ❍ No

❖ E. EXIT MODULE IF SN30 IS NOT “YES”

SN40. When you used snus the most, how long did a tin/can last?

❍ One month or more
❍ More than a week but less than a month
❍ Less than a week
❍ Don’t know / refuse

❖ F. EXIT MODULE IF SN40 IS LASTED LONGER THAN “LESS THAN A WEEK”

SN50. How old were you when you started to use at least one tin/can per week?

❍ (Years old)_____ ❍

SN60. In your life for how many years did you use at least one tin/can per week?

❍ Less than 1 year
❍ 1 to 5 years
❍ 6 to 10 years
❍ 11 to 15 years
❍ 16 to 20 years
❍ More than 20 years
❍ Don’t know / refuse

SN70. How many days did a tin/can last during this time?

❍ 1 day
❍ 2 to 3 days
❍ 4 to 7 days
❍ Don’t know / refuse

SN80. When you were using snus the most, how soon after waking up did you use your first snus?

❍ Within 5 minutes
❍ 6 to 30 minutes
❍ 31 to 60 minutes
❍ After 60 minutes

SN90. When you were using snus the most, which snus would you hate most to give up?

❍ First snus in the morning
❍ Any other

SN100. When you were using snus the most, on average, how many minutes did you keep a fresh snus in your mouth?

❍ 10 to 19 minutes
❍ 20 to 30 minutes
❍ Over 30 minutes
❍ Don't know / refuse

SN120. When you were using snus the most:

	Yes	No	
Did you experience strong cravings for snus after 2 hours without it?	☐	☐	☐
Did you use snus more in the morning than during the rest of the day?	☐	☐	☐
Was it difficult for you not to use snus in unsuitable circumstances?	☐	☐	☐
Did you use snus even if you were so ill that you were in bed most of the day?	☐	☐	☐

SN130. Do you use snus now?

❍ Yes ❍ No

If SN130 is "no", show SN135

If SN130 is "yes", show SN140

SN135. How old were you when you quit using snus?

❍ (Years old)_____ ❍

SN140. For how many days does a tin/can last?

❍ 1 day
❍ 2 to 3 days
❍ 4 to 7 days
❍ Don’t know / refuse

SN150. How many serious attempts have you made to quit using snus in your entire life?

❍ (Times)_____
❍ I have not tried to quit

SN160. For how long were you able to stay off using snus the longest time?

❍ About a day
❍ About a week
❍ About a month
❍ About half a year
❍ About a year
❍ Longer than a year

Peers

SM170. How many people that live with you currently smoke?

❍ No one
❍ 1 person
❍ 2 persons
❍ More than 2 persons

SM180. How many of your three best friends that do not live with you smoke?

❍ No one
❍ One
❍ Two
❍ All three

SN170. How many people that live with you currently use snus?

❍ No one
❍ 1 person
❍ 2 persons
❍ More than 2 persons

SN180. How many of your three best friends that do not live with you currently use snus?

❍ No one
❍ Two
❍ All

❍ One three

Alcohol

AL10. Have you ever had a drink of alcohol?

❍ Yes ❍ No

❖ **G. EXIT MODULE IF AL10 IS NOT “YES”**

AL20. How old were you the first time you had a drink?

❍ (Years old)_____ ❍

AL30. Thinking about the last 12 months how often do you have a drink containing alcohol?

❍ Never
❍ Monthly or less
❍ 2 to 3 times a month
❍ 1 time a week
❍ 2 to 3 times a week
❍ 4 times a week or more
❍ Don’t know / refuse

❖ **H. EXIT MODULE IF AL10 IS “NEVER”.**

❖ **IF AL30 IS “2 TO 3 TIMES A MONTH” OR LESS OFTEN THEN USE THE “MONTHLY” FORMULATION IN BELOW QUESTIONS ELSE USE THE “WEEKLY” FORMULATION**

AL40. Do you drink any of the following alcoholic beverages on a {monthly, weekly} basis? (Mark all that apply)

❑ Yes
❑ "Folköl" (3,5 %)
❑ “Mellanöl” (4,5 %)
❑ Strong beer (5 - 7%)
❑ Very strong beer (> 7%)
❑ Cider (5 %)
❑ Wine
❑ Spirits
❑ Alco-pops
❑
❍ No

❖ **I. EXIT MODULE IF AL10 IS “NO”**

❖ **J. FOR EACH CHECKED ANSWER IN AL40 SHOW BELOW CORRESPONDING ANSWER OPTION**

AL50. How many bottles or cans of the following alcoholic beverages do you drink in a normal {month, week}?

	33 cl	50 cl
"Folköl”	_____	_____
"Mellanöl”	_____	_____
Strong beer	_____	_____
Very strong beer	_____	_____
Cider	_____	_____
Alco-pops	_____	_____

❖ **J. CONDITION STOP**

If AL40 has “wine” checked, show AL60

AL60. Do you drink more than one bottle of wine (75 cl) per {month, week}?

❍ Yes ❍ No

If AL60 is “no”, show AL70 and AL90

AL70. How many glasses of wine do you drink per {month, week}?

❍ 1
❍ 2
❍ 3
❍ 4
❍ 5 or more
❍ Don’t know / refuse

If AL60 is “yes”, show AL80 and AL90

AL80. How many bottles of wine do you drink per {month, week}?

❍ 2
❍ 3 to 4
❍ 5 or more
❍ Don’t know / refuse

AL90. What mix of red (including rosé wine) and white wine (including sparkling wine) do you drink?

❍ 100% red wine
❍ 75% red wine and 25% white wine
❍ 50% red wine and 50% white wine
❍ 25% red wine and 75% white wine
❍ 100 % white wine
❍ Don’t know / refuse

If AL40 has “spirits” checked, show AL100 and AL110

AL100. On average how much spirits do your drinks contain?

❍ 4 cl (About 1 small snaps of spirits)
❍ 6 cl (About 1 big snaps of spirits)
❍ 8 cl
❍ 10 cl
❍ 12 cl
❍ Don’t know / refuse

AL110. How many of these drinks do you have in a normal {month, week}?

❍ (Number)_____ ❍

❖ **K. FOR EACH CHECKED ANSWER IN AL40 SHOW BELOW CORRESPONDING ANSWER OPTION**

AL115. How much of the following do you drink on the weekends (Friday to Sunday) {in a normal week, in a normal month}?

	Your {monthly total, weekly total} **“computer fills in”**	State your weekend total
"Folköl"	_____	_____
"Mellanöl"	_____	_____
Strong beer	_____	_____
Very strong beer	_____	_____
Cider	_____	_____
Wine	_____	_____

	Your {monthly total, weekly total} **“computer fills in”**	State your weekend total
Spirits	_____	_____
Alco-pops	_____	_____

❖ K. CONDITION STOP

AL120. How often have you had {5 for men, 4 for women} or more "standard" drinks on one occasion in the past 12 months?

❍ Never
❍ Less than monthly
❍ Monthly
❍ Weekly
❍ Daily or almost daily
❍ Don’t know / refuse

❖ PICTURE SHOWING “STANDARD DRINKS”

❖ L. CALCULATE “STANDARD DRINKS” FROM AL40 ALCOHOLIC BEVERAGES. EXIT MODULE IF [WEEKLY <14 STANDARD DRINKS FOR MEN AND <9 STANDARD DRINKS FOR WOMEN] OR AL120 IS “MONTHLY” OR MORE OFTEN

AL130.How often during the last year:

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	Don’t know / refuse
Have you found that you were not able to stop drinking once you had started?	□	□	□	□	□	□
Have you failed to do what was normally expected of you because of drinking?	□	□	□	□	□	□
Have you needed a first drink in the morning to get yourself going after a heavy drinking session?	□	□	□	□	□	□
Have you had a feeling of guilt or remorse after drinking?	□	□	□	□	□	□
Have you been unable to remember what happened the night before because of your	□	□	□	□	□	□

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	Don't know / refuse
drinking?						

AL135. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?

❍ No
❍ Yes, but not in the last year
❍ Yes, during the last year
❍ Don't know / refuse

AL137. Have you or someone else been injured because of your drinking?

❍ No
❍ Yes, but not in the last year
❍ Yes, during the last year
❍ Don't know / refuse

❖ **M. EXIT MODULE IF THE SCORING FOR THE QUESTIONS AL30 (similar to AUDIT q1), AL115 (similar to AUDIT q2), AL120 (similar to AUDIT q3), AL130(AUDIT q4-q8), AL135 (AUDIT q10) AND AL137 (AUDIT q9) MISUSE ARE LESS THAN 8 FOR MALE AND 6 FOR FEMALE**

AL140. The next questions are about your drinking during the past 12 months:

	Yes	No	
Did you need to drink an increasing amount of alcohol to get an effect?	☐	☐	☐
Have you tried to stop or cut down on your drinking but were not able to do so?	☐	☐	☐
Where there periods when you spent so much time drinking or recovering from drinking that you had little time for anything else?	☐	☐	☐
Was there a period when you greatly reduced important activities because of your drinking - like sports, work or seeing friends and family?	☐	☐	☐
Where there times when you knew you had a serious physical or emotional problem caused by drinking and still continued to drink?	☐	☐	☐

AL150. In the past 12 months was there a period when your drinking or being hung over frequently interfered with your responsibilities at work, at school or at home?

❍ Yes ❍ No

If "yes", show AL170

AL170. Did you continue to drink even though your drinking caused these problems?

❍ Yes ❍ No

AL180. In the past 12 months was there a period when your drinking caused repeated arguments with your family, friends, neighbors or co-workers?

❍ Yes ❍ No

If “yes”, show AL190

AL190. Did you continue to drink even though your drinking caused arguments with these people?

❍ Yes ❍ No

AL200. In the past 12 months have you repeatedly been influenced by alcohol in situations where there was a risk that you or somebody else could get hurt - e.g. driving a car or operating a machine?

❍ Yes ❍ No

AL210. Have you ever sought treatment or help for your drinking?

❍ Yes ❍ No

AL220. Where did you go for help? (Mark all that apply)

❑ Doctor
❑ Counselor or health care worker
❑ Minister or priest
❑ Alcoholics Anonymous
❑ Other self-help group
❑ Other

AL230. Does any of your close relatives have or have had problems with alcohol use?

	No	Yes	Does not apply	
Father	□	□	□	□

	No	Yes	Does not apply	
Mother	☐	☐	☐	☐
Full brothers or sisters	☐	☐	☐	☐
Half brothers or sisters	☐	☐	☐	☐
Father’s father	☐	☐	☐	☐
Father’s mother	☐	☐	☐	☐
Mother’s father	☐	☐	☐	☐
Mother’s mother	☐	☐	☐	☐
Child	☐	☐	☐	☐

AL2420. How many of your three best friends drink alcohol?

❍ No one
❍ One
❍ Two
❍ All three

Drug use

IL10. The following questions are about non-medical use of drugs.

Have you ever used any drug except tobacco or alcohol for any of the following purposes?

- to get high
- to feel better
- to change your mood
- to enhance performance
- to grow muscles

❍ Yes
❍ No

❖ **N. EXIT MODULE IF IL10 IS “NO”**

IL20. Have you ever tried any of the following drugs? (Mark all that apply.)

❑ Codeine, Citodone, Treo-comp, Panocod
❑ Tramadol, Tradolan, Tiparol, Nobligan
❑
❑ Rohypnol
❑ Sobril, Oxascand, Stesolid, Diazepam, Xanor, Alprazolam
❑ Stilnoct, Zolpidem, Imovan, Zopiklon
❑
❑ Cannabis, marijuana, hashish
❑
❑ Hallucinogenic mushrooms (Psilocybin, Psilocin)
❑ LSD

❑ Ecstasy
❑ GHB
❑
❑ Amphetamine
❑ Methylphenidate (Ritalin, Concerta)
❑ Cocaine
❑
❑ Heroin
❑ Opium
❑ Morphine
❑ Subutex, Suboxone

❑
❑ Growth hormone
❑ Anabolic steroids
❑
❑ Other
❑
❍ None of these
❑
❑
❑
❍ Don't know / refuse

❖ **O. EXIT MODULE IF IL10 IS "NONE OF THESE"**

❖ **P. FOR EACH CHECKED ANSWER IN IL20 SHOW BELOW QUESTIONS**

IL30. How old were you the first time you tried {checked drug}?

❍ (Years old)_____ ❍

IL40. Do you use {checked drug} now?

❍ Yes ❍ No, but previously

IL50. How often {do, did} you use {checked drug} when you {use, used} it the most?

❍ Once a month or mindre sällan
❍ 2 to 4 times a month
❍ 2 to 3 times a week
❍ 4 times a week or more often

❖ **P. CONDITION STOP**

❖ **Q. EXIT IF IL40 IS "NO, BUT PREVIOUSLY" FOR ALL CHECKED DRUGS IN IL20**

If IL20 has two or more drugs checked, show IL60

IL60. How often do you use more than one type of drug on the same occasion?

❍ Never
❍ 4 times a week or more

❍ Once a month or more seldom
❍ 2 to 4 times a month
❍ 2 to 3 times a week
often
❍ Don’t know / refuse

IL70. On a typical day when you use drugs how many times do you take any drug?

❍ 1 to 2 times
❍ 3 to 4 times
❍ 5 to 6 times
❍ 7 times or more

IL80. How often during the past year have you:

	Never	Monthly	Weekly	Daily or almost daily	Don’t know / refuse
Felt that your longing for drugs was so strong that you could not resist it?	☐	☐	☐	☐	☐
Not been able to stop taking drugs once you started?	☐	☐	☐	☐	☐
Taken drugs and then neglected to do something you should have done?	☐	☐	☐	☐	☐
Needed to take a drug the morning after heavy drug use?	☐	☐	☐	☐	☐
Had guilt feelings or a bad confidence because you used drugs?	☐	☐	☐	☐	☐
Been influenced heavily by drugs?	☐	☐	☐	☐	☐

IL90. Has anyone been worried about your drug use or said to you that you should stop using drugs?

❍ No
❍ Yes, but not over the past year
❍ Yes, over the past year
❍ Don’t know / refuse

IL100. Have you or anyone else been injured because of your drug use?

❍ No
❍ Yes, but not over the past year
❍ Yes, over the past year
❍ Don’t know / refuse

Medical history

Dental, diseases, eating disorder, reflux & IBS, sleep, headache, hearing

Dental

If age >= 11, show DE10

DE10. How long has it been since {your child, you} last went to the dentist?

❍ Less than 1 year ago
❍ 1 to 2 years ago
❍ 3 to 5 years ago
❍ More than 5 years ago
❍ {My child, I} never go there
❍ Don’t know / refuse

DE20. How often {does your child, do you} brush {his/her, your} teeth?

❍ 2 times a day
❍ 1 time a day
❍ Less than one time per day
❍ Don’t know / refuse

DE30. What kind of tooth brush {does your child, do you} regularly use?

❍ Manual tooth brush
❍ Electric tooth brush

DE40. {Does your child, Do you} use tooth paste regularly?

❍ Yes
❍ No

DE50. {Does your child, Do you} use dental floss regularly?

❍ Yes
❍ No

If age in range 4 to 14, show DE60

DE60. {Has your child, Have you} lost {his/her, your} milk teeth?

❍ Yes, all the milk teeth
❍ Yes, some of the milk teeth
❍ No

DE70. How many dental fillings {does your child, do you} have approximately?

❍ (Number)_____
❍ None

If age >= 18, show DE80

DE80. Has a dentist told you that you have periodontal disease?

❍ Yes
❍ No

Diseases

DS10. Which of the following diseases do you have or have you had?

❑ Heart and circulation
❑ High blood pressure
❑ High blood fat or cholesterol
❑ Angina (Angina pectoris)
❑ Heart attack (myocardial infarct)
❑ Tachycardia / heart arrhythmia
❑ Blood clot
❑ Pulmonary disease
❑ Asthma
❑ COPD (chronic obstructive pulmonary disease)
❑ Skin
❑ Lip sores (herpes)
❑ Acne
❑ Eczema
❑ Psoriasis
❑ Endocrine system
❑ Diabetes
❑ Thyroid disease
❑ Gastrointestinal tract
❑ Sprue (celiac disease)
❑ Gall bladder problem
❑ Chron’s disease
❑ Ulcerative colitis
❑ Stomach ulcer
❑ Colon irritable
❑ Anal incontinence problem
❑ Heart burn or reflux
❑ Urology
❑ Recurrent urinary tract infections
❑ Prostate problem
❑ Kidney stones (renal stones)
❑
❍ I had none of these
❑
❑
❑

❖ **A. FOR EACH CHECKED ANSWER IN DS10 SHOW CORRESPONDING QUESTIONS BELOW**

DS11. Have you been diagnosed tachycardia / heart arrhythmia by a doctor?

❍ Yes ❍ No

If "blood clot", show DS12, DS13 and DS14

DS12. Where do (did) you have the blood clot?

❑ In a leg ❑ Elsewhere
❑ In a lung ❍ Don't know / refuse

DS13. Have you had repeated blood clots?

❍ Yes ❍ No

DS14. Do (did) you medicate with Waran (a blood thinner) for the blood clot?

❍ Yes ❍ No

DS15. What type of thyroid disease do (did) you have?

❍ Simple goiter
❍ Low thyroid hormone level (hypothyroidism)
❍ Toxic goiter (hyperthyroidism)
❍ Don't know / refuse

If "heartburn or reflux", show DS16 and DS18

DS16. Has your heartburn or reflux been diagnosed by a doctor?

❍ Yes ❍ No

DS17. Has your prostate problem been diagnosed by a doctor?

❍ Yes ❍ No

DS18. Has your kidney stones (renal stones) problem been diagnosed by a doctor?

❍ Yes ❍ No

DS19. Has your gall bladder problem been diagnosed by a doctor?

❍ Yes ❍ No

DS20. Has your stomach ulcer been diagnosed by a doctor?

❍ Yes ❍ No

DS21. Have you been diagnosed asthma by a doctor?

❍ Yes ❍ No

DS22. Have you been diagnosed COPD (chronic obstructive pulmonary disease) by a doctor?

❍ Yes ❍ No

DS23. Have you been diagnosed psoriasis by a doctor?

❍ Yes ❍ No

DS24. Have you been diagnosed eczema by a doctor?

❍ Yes ❍ No

If “diabetes”, show DS25 and DS26

DS25. What type of diabetes do (did) you have?

❍ Childhood-onset diabetes (type I) ❍ Adult-onset diabetes (type II) ❍ Don’t know / refuse

DS26. What medical treatment do you use for your diabetes?

- ❑ Insulin injections
- ❑ Tablets (anti-diabetics)
- ❑ Dietary restrictions
- ❑ Other

If “anal incontinence problem”, show DS27

DS27. How often do you experience the following anal incontinence problems?

	Never or rarely	Sometimes	Usually	Always	Don’t know / refuse
Flatulence or wind	▯	▯	▯	▯	▯
Involuntary loss of liquid stool	▯	▯	▯	▯	▯
Involuntary loss of solid stool	▯	▯	▯	▯	▯
Need of wearing pad due to anal incontinence problem	▯	▯	▯	▯	▯
Lifestyle alteration	▯	▯	▯	▯	▯

A. CONDITION STOP

DS30. Which of the following diseases do you have or have you had?

- ❑ Musculoskeletal
- ❑ Sciatica
- ❑ Artrosis (in hips, knees, fingers)
- ❑ Rheumatoid arthritis
- ❑ SLE (Lupus)
- ❑ Fibromyalgia
- ❑ Neurology
- ❑ Dyslexia (reading and writing) disorder
- ❑ Migraine
- ❑ Horton’s disease
- ❑ Ménière’s disease
- ❑ Epilepsy
- ❑ MS (multiple sclerosis)
- ❑ Child / adolescence
- ❑ Chicken pox
- ❑ Glandular fever (mononucleosis)
- ❑ Psychiatry
- ❑ Burnout
- ❑ Depression
- ❑ Bipolar disease
- ❑ General anxiety disorder
- ❑ Panic attacks
- ❑ Agoraphobia
- ❑ Social phobia
- ❑ Obsessive compulsive disorder
- ❑ Post traumatic stress syndrome
- ❑ Schizophrenia
- ❑ Schizoaffective disorder
- ❑ Asperger’s syndrome
- ❑ Autism
- ❑ Tourette’s syndrome
- ❑
- ❍ I had none of these
- ❍ Don’t know / refuse

❖ **B. FOR EACH CHECKED ANSWER IN DS30 SHOW CORRESPONDING QUESTIONS BELOW WHERE AVAILABLE**

If "epilepsy" is checked in DS30, show DS30.1 , DS30.2 and DS30.3

DS30.1. Have you been diagnosed epilepsy by a doctor?

❍ Yes ❍ No

DS30.2. What is the medical name of the epilepsy?

❍ Grand mal epilepsy
❍ Petit mal
❍ Located (focal) epilepsy
❍ Infantile spasm
❍ Other
❍ Don't know / refuse

DS30.3. How old where you the first time you had epilepsy?

❍ (Years old)_____ ❍

DS31. Have you been diagnosed sciatica by a doctor?

❍ Yes ❍ No

DS32.1. Which of the following have applied to you for more than 3 weeks during the past year? (Mark all that apply)

❑ Aching or painful joint(s)
❑ Stiffness in joint(s)
❑ Taken medication for aching or painful joint(s)
❑ Change in daily or leisure activities due to aching or painful joint(s)
❍ None of these
❍ Don't know / refuse

DS32.2. Have you been diagnosed artrosis by a doctor?

❍ Yes ❍ No

DS33. Have you been diagnosed rheumatoid arthritis by a doctor?

❍ Yes ❍ No

DS34. Have you been diagnosed fibromyalgia by a doctor?

❍ Yes ❍ No

DS35. Have you been diagnosed migraine by a doctor?

❍ Yes ❍ No

DS36. Have you been diagnosed Horton’s disease by a doctor?

❍ Yes ❍ No

DS37. Have you been diagnosed burnout by a doctor?

❍ Yes ❍ No

DS38. Have you been diagnosed depression by a doctor?

❍ Yes ❍ No

DS39. Have you been diagnosed general anxiety disorder by a doctor?

❍ Yes ❍ No

DS40. Have you been diagnosed panic disorder by a doctor?

❍ Yes ❍ No

DS41. Have you been diagnosed agoraphobia by a doctor?

❍ Yes ❍ No

DS42. Have you been diagnosed social phobia by a doctor?

❍ Yes ❍ N

s o

DS43. Have you been diagnosed obsessive compulsive disorder by a doctor?

❍ Yes ❍ No

DS44. Have you been diagnosed post traumatic stress disorder by a doctor?

❍ Yes ❍ No

❖ **B. CONDITION STOP**

Eating disorder

❖ **SCREENING SECTION:**

ED10. How tall are you?

❍ (cm)_____ ❍ Don’t know / refuse

ED20. How much do you weigh while wearing indoor clothing now?

❍ (kg)_____ ❍ Don’t know / refuse

If age > 18, show ED25

ED25. Not including times when you have been physically ill, what is the least you weighed since age 18?

❍ (Kg)_____ ❍ Don’t know / refuse

ED30. Have you ever had anorexia nervosa?

❍ Yes ❍ No
❍ Not sure ❍ Refuse

ED40. Have you ever had bulimia nervosa?

❍ Yes ❍ No
❍ Not sure ❍ Refuse

If ED30 is not “yes” and ED40 is not “yes”, show ED50

ED50. Has anyone been concerned that you might have an eating disorder?

❍ Yes ❍ No
❍ Refuse

ED60. Have you ever had <u>eating binges</u> when you ate what most people would regard as an unusually large amount of food in a short period of time and it felt like your eating was out of control?

❍ Yes ❍ Refuse
❍ Not sure
❍ No

ED70. Which of the following have you ever used to control your shape or weight?

	Never	A few times	More often	Don’t know / refuse
Fast or not eat (for 24 hours or more)	☐	☐	☐	☐
Use diet pills (over the counter or prescription)	☐	☐	☐	☐
Exercise more than 2 hours per day	☐	☐	☐	☐
Making yourself vomit	☐	☐	☐	☐
Use medication like laxatives or diuretics	☐	☐	☐	☐

- **C1 (ANOREXIA). CALCULATE BMI FROM ED10 AND ED25. IF BMI <= 18.5 OR (ED30 IS "YES" OR "NOT SURE") OR ED50 IS "YES" THEN SHOW THE GENERAL AND ANOREXIA SECTIONS**

- **C2 (BINGING). IF ED60 IS "YES" THEN SHOW THE GENERAL AND BINGING SECTIONS.**

- **C3 (PURGING). IF ED70 IS "MORE OFTEN" ON AT LEAST ONE QUESTION THEN SHOW THE GENERAL SECTION AND THE CORRESPONDING QUESTIONS IN THE PURGING SECTION**

❖ GENERAL SECTION: SEE CONDITION C1, C2 AND C3

ED90. What is the most you have ever weighed {for women who have been pregnant: not counting pregnancy}?

❍ (kg)_____ ❍ Don't know / refuse

ED100. How old were you when you weighed the most?

❍ (Years old)_____ ❍ .

ED110. In general how dependent has your self-esteem been on your body shape or weight?

	1	2	3	4	5	
Not at all important	□	□	□	□	□	The most important

❖ ANOREXIA SECTION: SEE CONDITION C1

ED120. Have you ever had a longer period of time when you weighed much less than other people thought you ought to weigh?

❍ Yes ❍ No

If ED120 is “yes”, show ED130

ED130. Was this due to an eating disorder?

❍ Yes ❍ No
❍ Don’t know / refuse

❖ **D. IF ED130 IS “YES” THEN SHOW BELOW QUESTIONS**

ED140. How old were you then?

❍ (Years old)_____ ❍

ED150. How low did you weight get?

❍ (Years old)_____ ❍

ED160. How tall were you then?

❍ (cm)_____ ❍ Don’t know / refuse

ED170. During the time when you were at this low weight, how afraid were you that you might gain weight or become fat?

❍ Not at all ❍ Very much
❍ Somewhat ❍ Don’t know / refuse

ED180. Did you ever think your low weight had negative consequences for your health?

❍ Not at all ❍ Very much
❍ Somewhat ❍ Don’t know / refuse

ED190. During the time when you were at this low weight, did you feel fat?

❍ Not at all ❍
❍ Somewhat

❍ Very much

If sex is “woman”, show ED200 to ED230

ED200. Before this time had your periods already started?

❍ Yes ❍ No

If ED200 is “yes”, show ED210

ED210. Did your periods stop at any time during this time of low weight?

❍ Yes ❍ No

If ED210 is “yes”, show ED220 and ED230

ED220. For how long did your periods stop?

❍ (Number of months)_____ ❍ Don’t know / refuse
❍ (Number of years)_____

ED230. How old were you when your periods stopped?

❍ (Years old)_____ ❍

❖ **D. CONDITION STOP**

BINGING SECTION: SEE CONDITION C2

Earlier you mentioned that you had eating binges when you ate what most people would regard as an unusually large amount of food in a short period of time.

ED240. When you were having eating binges, did you feel that your eating was out of control?

❍ Yes, definitely out of control
❍ Yes, somewhat out of control
❍ No
❍ Don't know / refuse

ED245. When you were binging the most, how many binges would you have in a month?

❍ (Times per month)_____
❍ Don't know / refuse

ED250. How long did your binge eating episodes usually last?

❍ Less than one month
❍ 1 to 2 months
❍ 3 to 5 months
❍ 6 to 12 months
❍ 1 year or longer
❍ Don't know / refuse

ED255. How old were you when you experienced your first binge-eating episode?

❍ (Years old)_____
❍ Don't know / refuse

ED260. How old were you when you experienced your last binge-eating episode?

❍ (Years old)_____
❍ I am still binge-eating
❍ Don't know / refuse

ED280. During eating binges, did you:

	Yes	No	
Eat much more rapidly than usual?	☐	☐	☐
Eat until you felt uncomfortably full?	☐	☐	☐
Eat large amounts of food when you didn't feel physically hungry?	☐	☐	☐
Eat alone because you were embarrassed by how much you were eating?	☐	☐	☐
Feel disgusted with yourself, depressed, or very guilty after overeating?	☐	☐	☐

ED285. How upset or distressed did binge-eating usually make you feel?

❍ Not at all
❍ Somewhat
❍ Very much
❍ Don't know / refuse

If condition C1 is true, show ED287

ED287. Did these binge episodes occur only during the period when you weighed much less than other people thought you ought to weigh?

❍ Yes ❍ No

❖ **PURGING SECTION: SEE CONDITION C3**

If "fast or not eat…", show ED290, ED291 and ED292

ED290. How old were you when you fasted the first time?

❍ (Years old)_____ ❍

ED291. When you had periods of fasting how long where they?

❍ Less than 1 month
❍ 1 to 5 months
❍ 6 to 12 months
❍ 1 year or longer

ED292. How often did you usually fast during these periods?

❍ Less than weekly
❍ Weekly
❍ Every day / nearly every day
❍

If "use diet pills…", show ED293, ED294 and ED295

ED293. How old were you when you used diet pills the first time?

❍ (Years old)_____ ❍

ED294. When you had periods using diet pills how long where they?

❍ Less than 1 month
❍ 1 to 5 months
❍ 6 to 12 months
❍ 1 year or longer

ED295. How often did you usually use diet pills during these periods?

❍ Less than weekly
❍ Every day / nearly every day
❍ Weekly
❍

If “exercise more than 2 hours…”, show ED296, ED297 and ED298

ED296. How old were you when you exercised more than 2 hours per day the first time?

❍ (Years old)_____
❍

ED297. When you had periods of exercise more than 2 hours per day how long where they?

❍ Less than 1 month
❍ 6 to 12 months
❍ 1 year or longer
❍ 1 to 5 months

If “making yourself vomit”, show ED299, ED300 and ED301

ED299. How old were you when you self-induced vomiting the first time?

❍ (Years old)_____
❍

ED300. When you had periods of self-induced vomiting how long where they?

❍ Less than 1 month
❍ 6 to 12 months
❍ 1 year or longer
❍ 1 to 5 months

ED301. How often did you usually self-induce vomiting during these periods?

❍ Less than weekly
❍ Every day / nearly every day
❍ Weekly
❍

If “use medication like…”, show ED302

ED302. Earlier you responded that you used laxatives or diuretics to lose weight. Which did you use? (Mark all that apply)

❑ Laxatives ❑ Diuretics

If the answer “laxatives” is checked in ED302, show ED303, ED304 and ED305

ED303. How old were you when you used laxatives the first time?

❍ (Years old)_____ ❍

ED304. When you had periods of using laxatives how long where they?

❍ Less than 1 month
❍ 1 to 5 months
❍ 6 to 12 months
❍ 1 year or longer

ED305. How often did you usually use laxatives during these periods?

❍ Less than weekly
❍ Weekly
❍ Every day / nearly every day
❍

If the answer “diuretics” is checked in ED302, show ED306, ED307 and ED308

ED306. How old were you when you used diuretics the first time?

❍ (Years old)_____ ❍

ED307. When you had periods of using diuretics how long where they?

❍ Less than one month
❍ 1 to 5 months
❍ 6 to 12 months
❍ 1 year or longer

ED308. How often did you usually use diuretics during these periods?

❍ Less than weekly ❍ Every day / nearly every day
❍ Weekly ❍

If condition C2 is true, show ED310

ED310. Which of the following did you use during the period when you were binge-eating? (Mark all that apply)

❑ Making yourself vomit Don’t know / refuse
❑ Laxatives
❑ Diuretics
❑ Weight loss pills
❑ Exercise more than 2 hours per day
❑ Fasting (not eating at all)

None of these

❖ **C1, C2 AND C3. CONDITIONS STOP**

Reflux, IBS

❖ **F. IF THE ANSWER “HEART BURN OR REFLUX” IN DS10 IS CHECKED THEN SHOW BELOW QUESTIONS**

RE10. Have you had heart burn or reflux in the past year?

❍ Yes ❍ No

If RE10 is “no”, show RE12

RE12. At what age did you the last time experience this or these problems?

❍ (Years old)_____ ❍

If RE10 is “yes”, show RE15 to RE50

RE15. Which symptoms do you experience?

❑ Heartburn ❑ Reflux

RE20. At what age did you first experience this or these problem?

❍ (Years old)_____ ❍

RE30. How often do you have pain or discomfort from the {heartburn, reflux}?

❍ Less than monthly ❍ Weekly
❍ Monthly ❍ Daily

RE40. Do you wake up during the night because of the {heartburn, reflux}?

❍ Yes ❍ No

RE50. Have you during the last year taken any medication because of your {heartburn, reflux}?

❍ Yes ❍ No

If RE50 is “yes”, show RE60

RE60. Which of the following medication do you use? (Mark all that apply)

❑ Novalucol, Novaluzid, Link, Rennie
❑ Andapsin, Sukralfat, Gaviscon
❑ Artonil, Ranitidin, Inside, Zantac, Pepcid, Pepcidin
❑ Omeprazol, Losec MUPS, Nexium, Lansoprazol, Lanso, Pantoloc
❑ Other
❍ Don’t know / refuse

RE70. Have you had recurrent abdominal discomfort during the last year? {excluding heartburn or reflux}

❍ Ye ❍ N

s o

❖ G. IF RE70 IS “YES” THEN SHOW BELOW QUESTIONS

RE80. Has the discomfort lasted at least 3 days per month? (not necessarily consecutive days)

❍ Yes ❍ No

If “yes”, show RE90

RE90. When did your abdominal discomfort first occur?

❍ 1 to 5 years ❍ 11 to 20 years
❍ 6 to 10 years ❍ More than 20 years

RE100. When you have abdominal discomfort, do you usually experience any of the following:

❑ Saturation after meals
❑ Feeling bloated
❑ Constipation
❑ Loose or watery stool
❑ A feeling of incomplete defecation
❑ That defecation alleviates the discomfort
❑
❍ None of these
❍ Don’t know / refuse

RE110. Where do you feel the abdominal pain?

❍ In the upper part of the abdomen
❍ In the lower part of the abdomen
❍ In both parts of the abdomen

RE120. Is your pain:

❑ Relieved by eating
❑ Triggered by eating
❑ Triggered by eating dairy products (lactose intolerance)
❑ Making you wake up at night
❑
❍ None of these

❖ **F AND G. CONDITIONS STOP**

Sleep

SP10. Is your sleep generally disturbed during sleeping, for instance by children, noise or {a snoring partner, someone snoring}?

❍ Yes ❍ No

SP20. How do you sleep in general?

	1	2	3	4	5	
Poorly	□	□	□	□	□	Very good

SP30. How much sleep do you need per day?

❍ 5 hours or less
❍ 6 hours
❍ 7 hours
❍ 8 hours
❍ 9 hours or more
❍ Don’t know / refuse

SP40. Are you a ”morning type” or an ”evening type”?

Extreme morning type		Neither		Extreme evening type	
□	□	□	□	□	

SP50. How long does it take for you to fall asleep (after put out the light)?

❍ 5 minutes or less
❍ 6 to 15 minutes
❍ 16 to 30 minutes
❍ 31 to 60 minutes
❍ More than 60 minutes
❍ Don’t know / refuse

SP60. On working days, about what time do you usually rise?

4 am or earlier	5 am	6 am	7 am	8 am	9 am	10 am or later	
□	□	□	□	□	□	□	

SP70. On the night before a working day, about what time do you usually go to bed (put out the light)?

8 pm or earlier	9 pm	9.30 pm	10 pm	10.30 pm	11 pm	12 pm	1 am or later	Does not apply	
□	□	□	□	□	□	□	□	□	

SP80. On "days off", about what time do you usually rise?

6 am or earlier	7 am	8 am	9 am	10 am	11 am	12 am or later	
□	□	□	□	□	□	□	

SP90. On the night before "days off", about what time do you usually go to bed (put out the light)?

9 pm or earlier	10 pm	11 pm	12 pm	1 am	2 am	3 am or later	Does not apply	
□	□	□	□	□	□	□	□	

SP100.

	Never or seldom	1 to 3 times a month	1 to 3 times a week	4 times or more a week	Don’t know / refuse
Is it difficult to fall asleep?	□	□	□	□	□
Do you have worried or disturbed sleep?	□	□	□	□	□
Do you wake up repeatedly with difficulties returning to sleep?	□	□	□	□	□
Do you wake up prematurely?	□	□	□	□	□
Do you <u>not</u> feel well rested upon awakening?	□	□	□	□	□
How often do you get too short	□	□	□	□	□

sleep?					
Do you feel restlessness in your legs at bedtime or during sleep?	❑	❑	❑	❑	❑
Do you snore loudly (according yourself or others)?	❑	❑	❑	❑	❑
Do you struggle for breath or stop breathing (according to yourself or others)?	❑	❑	❑	❑	❑
Do you have problems to stay awake during the day?	❑	❑	❑	❑	❑
Are you tired in the afternoon?	❑	❑	❑	❑	❑

SP110. Do you have problems to wind down in the evening after a stressful day?

❍ Seldom or never
❍ Sometimes
❍ Often
❍ Don’t know / refuse

SP120. How are you affected during the day if you have had a short or disturbed sleep?

	1	2	3	4	5	
I can easily do what I usually do	❑	❑	❑	❑	❑	The next day is very difficult to manage

SP130. To what extent is disturbed sleep a problem in your life?

	1	2	3	4	5	
No problem at all	❑	❑	❑	❑	❑	Major problem

Headache

HA10. Have you ever had recurrent headaches (clusters of headaches often with headache-free intervals in between?

❍ Yes ❍ Don't know / refuse
❍ No

HA15. Have you ever had daily or almost daily headaches for at least a couple of months that were not due to common cold, a fever, hangover, or some other medical condition that you are aware of?

❍ Yes ❍ Don't know / refuse
❍ No

❖ H. EXIT MODULE IF HA10 OR HA15 IS "NO"

HA20. Have you ever had recurrent headaches once in a month or more often?

❍ Yes ❍ Don't know / refuse
❍ No

HA25. How painful are your headaches normally?

	1	2	3	4	5	
Mild	□	□	□	□	□	Severe

HA30. When you have a headache do you normally experience any the following?

	Yes	No	
The pain is on either the right or the left side of the head	□	□	□
The pain is on both right and left side of the head	□	□	□
The pain is pulsating or pounding	□	□	□
The pain feels like a pressure on or around the head	□	□	□
Nausea or vomiting	□	□	□

	Yes	No	
Increased sensitivity to sound	☐	☐	☐
Increased sensitivity to light	☐	☐	☐
Physical activity makes the headache worse	☐	☐	☐

- **I. IF “MIGRAINE” IN DS10 IS “YES”; OR AT LEAST TWO OF “PAIN ON EITHER SIDE”, “PULSATING”, “WORSENED BY PHYSICAL ACTIVITY” IN HA30 IS “YES” AND HA20 IS MORE THAN “MILD” AND [“INCREASED SENSITIVITY TO SOUND AND LIGHT” IN DS10 IS “YES” OR “NAUSSEA OR VOMITING” IN DS10 IS “YES”]; THEN SHOW BELOW QUESTIONS**

HA40. Do you usually have short-lasting visual disturbances right before the headaches starts? (Visual disturbance may be bright dots, zig-zag lines or reading problems.)

❍ Yes ❍ No

HA50. Can you feel when a headache attack is coming?

❍ Yes ❍ No

- **I. CONDITION STOP**

HA60. Does your headache interfere with normal daily activity?

❍ Yes ❍ No

HA70. Have you consulted a doctor due to your headache?

❍ Yes ❍ No

If HA70 is “yes”, show HA75

HA75. How old were you the first time you talked to a medical doctor about the headache?

❍ (Years old)_____ ❍

HA80. Do common pain killers alleviate your headache?

❍ Yes ❍ No

Hearing

HE10. How is your hearing?

❍ Good
❍ Slightly impaired
❍ Extremely impaired
❍ Don’t know / refuse

HE20. Do you use earphones frequently (e.g. listening to mp3, radio or playing computer games)?

❍ Yes ❍ No

❖ **J. IF HE20 IS “YES” SHOW QUESTIONS BELOW**

HE30. How high volume do you usually use with your earphones?

❍ Low
❍ Medium
❍ High
❍ Don’t know / refuse

HE40. How often do you use earphones?

❍ Daily
❍ Weekly
❍ Monthly
❍ Don’t know / refuse

HE50. For how many years have you used earphones?

❍ Less than 1 year
❍ 1 to 5 years
❍ 6 to 10 years
❍ More than 10 years

❖ J. CONDITION STOP

HE60. Do you have a constant ringing or other bothersome noise in your ears (tinnitus)?

❍ Yes
❍ Sometimes, but the noise do not disturb me
❍ Continuously, the noises are very disturbing
❍
❍ No
❍ Don’t know / refuse

HE70. Have you experienced attacks of dizziness in the past 12 months?

❍ Yes
❍ No
❍

HE80. Have you had recurrent ear infections in your life?

❍ Yes ❍ No

If HE70 is “yes”, show HE82, HE84 and HE86

HE82. Do you experience severe dizziness when going to bed?

❍ Yes
❍ No
❍

HE84. Have you ever experienced impaired hearing and tinnitus when having an attack of dizziness?

❍ Yes
❍ No
❍

HE86. Have you ever collapsed when having severe dizziness?

❍ Yes
❍ No
❍

❖ **K. IF HE10 IS “SLIGHTLY IMPAIRED” OR “EXTREMELY IMPAIRED” SHOW QUESTIONS BELOW**

HE90. Do you use a hearing aid?

❍ Yes ❍ No

HE100.

	No, not at all	Sometimes, some difficulty	Yes, great difficulty	Don’t know / refuse
Do you have difficulty hearing when talking with a person in a quiet room?	☐	☐	☐	☐
Do you have difficulty hearing when talking to several people at the same time?	☐	☐	☐	☐
Do you have difficulty hearing when talking to a person in city traffic?	☐	☐	☐	☐
Do you have difficulty hearing where different sounds come from, for example sounds from cars in traffic?	☐	☐	☐	☐
Do you have difficulty with your hearing and therefore avoid meeting people?	☐	☐	☐	☐

❖ **K. CONDITION STOP**

Injuries

IN1. In the past 12 months, did you have any injuries that were serious enough to make you unable to do your normal activities for at least one day?

Examples of an injury:

- Accident - e.g. falling over, being hit, hitting something, vehicle accident.

- Harmful incident - e.g. bites/stings, being attacked, choking, near drowning.

- Exposure to harmful factors - e.g. swallowing poisons, inhaling fumes, loud sounds, electric shock

- ❍ Yes, once
- ❍ Yes, several times
- ❍ No
- ❍ Don’t know / refuse

If IN1 is “yes, several times”, show IN1.5

IN1.5. How many times were you injured in the past 12 months?

- ❍ Two times
- ❍ Three times
- ❍ Four times
- ❍ Five times
- ❍ Six times
- ❍ Seven times or more
- ❍ No
- ❍ Don’t know / refuse

- ❖ **A. EXIT IF IN1 IS “NO”**
- ❖ **B. FOR EACH INJURY OCCATION IN IN1 SHOW BELOW QUESTIONS**

IN9. What part of the body was injured {the i:th time}?

- ❍ Arms or legs
- ❍ Head
- ❍ Abdomen
- ❍ Pelvis
- ❍ Don’t know /

❍ Back/spine refuse
❍ Thorax

If IN9 is “arms or legs”, show below IN9.1

IN9.1. What kind of arm or leg injury did you have {the i:th time}?

❍ Superficial
❍ Wound (other than burn)
❍ Dislocation, ligament injury
❍ Fracture
❍ Blood vessel or nerve injury
❍ Burn
❍ Frostbite
❍ Other
❍ Don’t know / refuse

If IN9 is “head”, show below IN9.1 to IN9.6

IN9.1. What kind of head injury did you have {the i:th time}?

❍ Superficial
❍ Wound (other than burn)
❍ Fracture
❍ Brain injury
❍ Burn
❍ Frostbite
❍ Other
❍ Don’t know / refuse

IN9.2. Was the injury associated with:

	Ja	Nej	
Any period of observed or self-reported transient confusion, disorientation, or impaired consciousness	☐	☐	☐
Any period of observed or self-reported loss of consciousness lasting 30 minutes or less	☐	☐	☐
Any period of observed or self-reported loss of consciousness more than 30 minutes	☐	☐	☐
Any period of observed or self-reported dysfunction of memory (amnesia) around the time of injury	☐	☐	☐
Irritability, lethargy, or vomiting following head injury	☐	☐	☐
Headache, dizziness, fatigue, or poor concentration, soon after the injury	☐	☐	☐

If IN9 is “back/spine”, show below IN9.1

IN9.1. What kind of back/spine injury did you have {the i:th time}?

- ❍ Superficial
- ❍ Wound (other than burn)
- ❍ Dislocation, ligament injury
- ❍ Fracture
- ❍ Nerve injury (paresis or reduced sensibility)
- ❍ Burn
- ❍ Frostbite
- ❍ Other
- ❍ Don’t know / refuse

If IN9 is “thorax”, show below IN9.1

IN9.1. What kind of thorax injury did you have {the i:th time}?

- ❍ Superficial
- ❍ Wound (other than burn)
- ❍ Dislocation, ligament injury
- ❍ Fracture ribs (not spine)
- ❍ Internal organ injury
- ❍ Burn
- ❍ Frostbite
- ❍ Other
- ❍ Don’t know / refuse

If IN9 is “abdomen”, show below IN9.1

IN9.1. What kind of abdomen injury did you have {the i:th time}?

- ❍ Superficial
- ❍ Wound (other than burn)
- ❍ Internal organ injury
- ❍ Burn
- ❍ Frostbite
- ❍ Other
- ❍ Don’t know / refuse

If IN9 is “pelvis”, show below IN9.1

IN9.1. What kind of pelvis injury did you have {the i:th time}?

- ❍ Superficial
- ❍ Wound (other than burn)
- ❍ Internal organ injury
- ❍ Burn
- ❍ Frostbite
- ❍ Other
- ❍ Don’t know / refuse

IN10. Did {the injury, any injury} cause you to seek medical attention? (Any visit to medical facility)

❍ Yes ❍ No

If IN10 is “yes”, show IN11

IN11. Did this injury require admission to hospital (spent at least one night in hospital)?

❍ Yes ❍ No

- **B AND C. CONDITIONS STOP**

IN12. Because of an injury, have you:

	Yes	No	
Difficulty seeing, even if wearing glasses?	□	□	□
Difficulty hearing, even if using a hearing aid?	□	□	□
Difficulty remembering or concentrating?	□	□	□
Difficulty (with self-care such as) washing all over or dressing?	□	□	□
Difficulty communicating using your customary language?	□	□	□

If any question in IN12 is “yes”, show IN17

IN17. For how long has the disability from the injury been present?

❍ Less than 1 month ❍ More than 6 months
❍ 1 to 6 months ❍ Don’t know / refuse

IN18. Do you consider yourself to be at a higher risk than average to sustain an injury in the coming 5 years?

❍ Yes ❍ No

If IN18 is “yes”, show IN19

IN19. What do you think is the main cause of this increased risk?

❍ Your pattern of behavior or personality
❍ Exposure to dangerous environment (traffic, machinery, farm activities etc.)
❍ High risk sport or leisure time activities
❍ Other
❍ Don’t know / refuse

Inflammation and allergy

General exposures, asthma and COPD, allergy and chronic sinusitis

General exposures

IA10. How often do you vacuum clean your living room and bedroom floors?

❍ 2 times a week or more
❍ 1 time a week
❍ 2 times a month
❍ 1 time a month
❍ 2 or 3 times in half a year
❍ More seldom

IA20. How often do you wash your living room and bedroom floors?

❍ 2 times a week or more
❍ 1 time a week
❍ 2 times a month
❍ 1 time a month
❍ 2 or 3 times in half a year
❍ More seldom

IA30. For how many years have you used your current bed?

❍ (Years)_____ ❍

IA40. Is there a mattress pad or mattress cover on your bed?

❍ Yes ❍ No

If “yes”, show IA50

IA50. Is the mattress pad or mattress cover washed more often than every second month?

❍ Yes ❍ No

IA60. Is there condensation on the inside of your living room or bedroom windows in the winter?

❍ Yes, it happens ❍ No

If “yes”, show IA70

IA70. How often does the condensation occur in the winter (Nov-March)?

❍ Monthly ❍ Daily
❍ Weekly ❍ Don’t know / refuse

IA80. Are there, or have there been, any stains caused by moisture in your residence?

❍ Yes ❍ No

IA90. Are there, or has there been, any mold or mildew odor in your residence?

❍ Yes ❍ No

IA100. Is there a gas stove in your residence?

❍ Yes ❍ No

If “yes”, show IA110

IA110. Is the gas stove used daily?

❍ Yes ❍ No

❖ **A. IF SM130 IS “YES” THEN SHOW BELOW QUESTIONS**

IA120. Do you smoke at home?

❍ Yes
❍ No
❍

If “yes”, show IA130

IA130. Do you mostly smoke near the kitchen fan, on the balcony, or near an open window?

❍ Yes ❍ No

- **A. CONDITION STOP**

Asthma

- **B. IF ANSWER TO DS10(ASTHMA) IS UNCHECKED THEN SHOW BELOW QUESTIONS**

IA140. Have you had wheezing / whistling in your chest at any time in the last 12 months?

❍ Yes
❍ No
❍

IA150. Have you had an attack of shortness of breath following strenuous activity in the last 12 months?

❍ Yes ❍ No

IA160. Have you been woken at night by an attack of shortness of breath in the last 12 months?

❍ Yes ❍ No

- **B. CONDITION STOP**

- **C. IF ANSWER TO DS10(ASTHMA) IS CHECKED THEN SHOW BELOW QUESTIONS**

IA170. How old were you when you had your first attack of asthma? (If unsure, give your best guess!)

❍ (Years old)_____ ❍

IA180. How many attacks of asthma have you had in the last 12 months?

❍ (Number)_____ ❍

IA190. Are you currently taking any medicine (including inhalers or tablets) for asthma?

❍ Yes
❍ No
❍

IA200. Have you been hospitalized with asthma in the last 12 months?

❍ Yes
❍ No
❍

If IA190 is "yes", show IA202 and IA204

IA202. Have you used fast-acting bronchodilator medicine - Bricanyl, Ventoline, Buventol or Airomir for your asthma more than two times in the past week?

❍ Yes
❍ No
❍

IA204. Have you during the past 6 months used:

	Yes, regularly	Yes, periodically	No	Don’t know / refuse
Cortisone for inhalation - Pulmicort, Flutide, Becotide, Asmanex, Beclomet	☐	☐	☐	☐
Long-acting bronchodilator medicine - Serevent, Oxis	☐	☐	☐	☐
A combination of long-acting bronchodilator and cortisone - Seretide, Symbicort	☐	☐	☐	☐
Singulair (tablets)	☐	☐	☐	☐

❖ **C. CONDITON STOP**

COPD

❖ **D. IF AGE >= 40 OR ANSWER ON DS10(COPD) IS CHECKED THEN SHOW BELOW QUESTIONS**

IA210. Do you cough on most days for at least three months each year?

❍ Yes ❍ No

If “yes”, show IA220

IA220. For how many years have you had this cough?

❍ Less than 2 years
❍ 2 to 5 years
❍ More than 5 years
❍ Don’t know / refuse

IA230. When not having a cold, do you bring up phlegm from your chest on most days for at least three months each year?

❍ Yes ❍ No

If “yes”, show IA240

IA240. For how many years have you had this phlegm?

❍ Less than 2 years
❍ 2 to 5 years
❍ More than 5 years
❍ Don’t know / refuse

❖ **E. IF IA210 OR IA230 IS “YES” THEN SHOW BELOW QUESTIONS**

IA250. Are you troubled by shortness of breath when walking in a hurry or up a small hill?

❍ Yes ❍ No

If “no”, show IA260

IA260. Are you troubled by shortness of breath when walking with people in your age on level ground?

❍ Yes ❍ No

If “no”, show IA270

IA270. Do you sometimes have to stop for a breath after walking about 100 meters on level ground?

❍ Yes ❍ No

If “no”, show IA280

IA280. Are you short of breath when dressing or undressing?

❍ Yes ❍ No

❖ **D AND E. CONDITONS STOP**

Allergy and chronic sinusitis

IA290. Do you have any nasal allergies including hay fever?

❍ Yes ❍ No

❖ **F. IF IA290 IS “YES” THEN SHOW BELOW QUESTIONS**

IA291. Have you been troubled by nasal allergies in the last 12 months?

❍ Yes ❍ No

IA292. Have you ever been troubled by nasal allergies for more than 4 days in any one week?

❍ Yes ❍ No

IA293. Did this happen for more than 4 weeks continuously?

❍ Yes ❍ No

IA294. Has your nose problem been accompanied by itchy or watery eyes?

❍ Yes ❍ No

❖ **F. CONDITON STOP**

IA300. Have you ever had an illness or trouble caused by eating a particular food?

❍ Yes ❍ No

If “yes”, show IA310

IA310. Have you nearly always the same illness or trouble after eating this type of food?

❍ Yes ❍ No

❖ G. IF QUESTIONS IA300 AND IA310 ARE “YES” THEN SHOW BELOW QUESTIONS

IA320. What kind of food is this? (Mark all that apply)

❑ Nuts, almond, peanuts, seed
❑ Pip or stone fruit (e.g. apple, raspberry, peach, coconut)
❑ Fish, shellfish
❑ Egg
❑ Soy
❍ Don’t know / refuse

IA330. Which kind of illness or trouble do you experience? (Mark all that apply)

❑ A rash or itchy skin
❑ Diarrhea or vomiting
❑ Runny or stuffy nose
❑ Severe headaches
❑ Breathlessness
❑ Other

❖ G. CONDITON STOP

IA340. Do you experience having any of the following allergies?

❑ Yes
❑ Pollen allergy
❑ Pet allergy
❑ Mite allergy
❑ Bee or wasp allergy
❑ Contact allergy
❑
❍ No
❍ Don’t know / refuse

❖ **H. FOR EACH CHECKED ANSWER IN IA340 SHOW THE CORRESPONDING BELOW QUESTIONS**

If “pollen allergy”, show IA350 and IA360

IA350. What kind of pollen allergy do you experience?

❑ Tree ❑ Grass

IA360. Has your pollen allergy been diagnosed by a doctor?

❍ Yes ❍ No

If “pet allergy”, show IA370

IA370. Has your pet allergy been diagnosed by a doctor?

❍ Yes ❍ No

If “mite allergy”, show IA375

IA375. Has your mite allergy been diagnosed by a doctor?

❍ Yes ❍ No

If “bee or wasp allergy”, show IA380

IA380. Has your bee or wasp allergy been diagnosed by a doctor?

❍ Yes ❍ No

If “contact allergy”, show IA390

IA390. Has your contact allergy been diagnosed by a doctor?

❍ Yes ❍ No

IA392. Have you during the past year used nasal spray containing cortisone - e.g. Nasonex, Flutide Nasal, Rhinocort eller Budesonide Nasal?

❍ Yes, regularly
❍ Yes, periodically
❍ No

IA394. Have you during the past year used antihistamine tablets - e.g. Loratadin, Clarityn, Aerius, Cetirizin, Kestin or Telfast?

❍ Yes, regularly
❍ Yes, periodically
❍ No

❖ H. CONDITON STOP

IA400. Have you for more than 12 weeks during the last 12 months been troubled by any of the following?

❑ Yes
❑ Stuffed nose
❑ Pain or pressure around the forehead, nose and eyes
❑ Snot or phlegm
❑ Deteriorated sense of smell
❑
❍ No
❍ Don’t know / refuse

Mental Health

Personality questions

Every person has its own opinion about different things. The sections that follow are about differences in attitudes, interests and feelings. There is no right or wrong answers to these questions. Your answers describe how you think, feel and act in different situations. We ask you to have in mind how you in general think, feel and act. Don’t think too long at any question.

	Never	Sometimes	Most of the time	Almost always	
Do you like plenty of bustle and excitement around you?	☐	☐	☐	☐	☐
Are you often uneasy and feel that there is something you want without knowing what it is?	☐	☐	☐	☐	☐
Do you almost always have an answer when spoken to?	☐	☐	☐	☐	☐
Are you sometimes happy or sometimes sad without any special reason?	☐	☐	☐	☐	☐
Do you prefer to keep in the background when you are in company with other people?	☐	☐	☐	☐	☐
Do you regard yourself as happy and carefree?	☐	☐	☐	☐	☐
Do you often reach decisions too late?	☐	☐	☐	☐	☐
Do you often feel tired and listless without any special reason?	☐	☐	☐	☐	☐
Do you have a lively manner?	☐	☐	☐	☐	☐

	Never	Sometimes	Most of the time	Almost always	
Can you quickly describe your thoughts in words?	☐	☐	☐	☐	☐

	Never	Sometimes	Most of the time	Almost always	
Are you often lost in your own thoughts?	□	□	□	□	□
Do you have anything against selling things or asking people for money for some charitable cause?	□	□	□	□	□
Are you extremely sensitive in any respect?	□	□	□	□	□
Are you ever too restless to sit still?	□	□	□	□	□
Do you keep things to yourself, except with good friends?	□	□	□	□	□
Do you have any nervous problems?	□	□	□	□	□
Do you like to crack jokes and tell funny stories to your friends?	□	□	□	□	□
Do you worry too long after an embarrassing experience?	□	□	□	□	□
Would you call yourself a nervous person?	□	□	□	□	□

	Never	Sometimes	Most of the time	Almost always	
Are you a worrier?	□	□	□	□	□
Do you often feel “fed-up”?	□	□	□	□	□
Do you often worry about things you should not have done or said?	□	□	□	□	□
Are your feelings easily hurt?	□	□	□	□	□
Would you call yourself tense or highly strung?	□	□	□	□	□
Are you easily hurt when people find fault with you or the work you do?	□	□	□	□	□
Are you often troubled by feelings of guilt?	□	□	□	□	□
Are you an irritable person?	□	□	□	□	□

	Never	Sometimes	Most of the time	Almost always	
Do you live to solve problems or riddles?	□	□	□	□	□
Do you find it easy to empathize with others?	□	□	□	□	□
Do you have great intellectual curiosity?	□	□	□	□	□
Do you find it interesting to take up new hobbies?	□	□	□	□	□
Do you like to ponder on theories and/or philosophical ideas?	□	□	□	□	□
Do you often try out new and foreign foods?	□	□	□	□	□

Screening questions

Depression screening

SC21. Have you ever in your life had a period of time lasting 2 weeks or longer when most of the day you felt sad, empty or depressed?

❍ Yes ❍ No

SC23. Have you ever had a period lasting 2 weeks or longer when you lost interest in most things you usually enjoy like work, hobbies, and personal relationships?

❍ Yes ❍ No

- **A. IF SC21 OR SC23 IS “YES” THEN ACTIVATE THE DEPRESSION FOLLOW-ON MODULE**

Perinatal depression screening

- **A. EXIT IF SEX IS “MAN” OR MN150 IS “NO” (I.E. NOT GIVEN BIRTH TO A CHILD)**

PN10. During any of your pregnancies did you feel sad, miserable, or very anxious? This means a period of at least 2 weeks when you were not yourself and which was definitely worse than the normal ups and downs of life.

- ❍ Yes
- ❍ No
- ❍

PN20. After any of your deliveries, within the first six months postpartum, did you feel sad, miserable, or very anxious? By this we mean a period of at least 2 weeks, when you were not yourself and which was definitely worse than the normal ups and downs of life.

- ❍ Yes
- ❍ No
- ❍

- ❖ **B. IF PN10 AND PN20 IS “YES” THEN ACTIVATE THE PERINATAL DEPRESSION FOLLOW-ON MODULE**

Premenstrual dysphoric disorder screening

- ❖ **A. EXIT IF SEX IS “MAN” OR AGE <18**

PD10. During the past year, were most of your menstrual periods preceded by a time period lasting about one week when your mood significantly changed?

❍ Yes ❍ No

PD20. During this premenstrual time, do you have difficulty in your usual activities or relationships with others, are you less efficient at work, or do you avoid other people?

❍ Yes ❍ No

PD30. Do these premenstrual symptoms start before your period and stop within a few days after your menstrual period begins?

❍ Yes ❍ No

❖ **B. EXIT IF PD10, PD20 OR PD30 IS "NO"**

PD40. Do you experience some or any of the following premenstrual symptoms?

	Not at all	Mild	Moderate	Severe
Anger / irritability	□	□	□	□
Anxiety / tension	□	□	□	□
Tearful / increased sensitivity to rejection	□	□	□	□
Depressed mood / hopelessness	□	□	□	□

	Not at all	Mild	Moderate	Severe
Decreased interest in work activities	□	□	□	□
Decreased interest in home activities	□	□	□	□
Decreased interest in social activities	□	□	□	□
Difficulty concentrating	□	□	□	□

	Not at all	Mild	Moderate	Severe
Fatigue / lack of energy	□	□	□	□
Overeating / food cravings	□	□	□	□
Insomnia	□	□	□	□
Hypersomnia (needing more sleep)	□	□	□	□
Feeling overwhelmed or out of control	□	□	□	□
Breast tenderness	□	□	□	□
Headaches	□	□	□	□
Joint / muscle pain	□	□	□	□
Bloating	□	□	□	□
Weight gain	□	□	□	□

- **C1. CALCULATE PMDD AND PMS SCORING SO FAR**
- **C2. EXIT IF THE PD40 SCORING CONDITIONS ALREADY CONCLUDE PMDD OR PMS**

PD50. Have your symptoms interfered with the following?

	Not at all	Mild	Moderate	Severe
Your work efficiency or productivity	□	□	□	□
Your relationships with coworkers	□	□	□	□
Your relationships with your family	□	□	□	□
Your social life activities	□	□	□	□
Your home responsibilities	□	□	□	□

Suicidality screening and follow-on questions

SD2. Did you ever seriously think about committing suicide?

- ❍ No
- ❍ Yes, once
- ❍ Yes, several times
- ❍

- ❖ **A. EXIT IF SD2 IS “NO”**

SD2a. How old were you {when, the first time} this happened?

- ❍ (Years old)_____
- ❍

If SD2 is “yes, several times”, show SD3a

SD3a. How old were you the last time this happened?

- ❍ (Years old)_____
- ❍

SD4. Did you ever make a plan for committing suicide?

- ❍ No
- ❍ Yes
- ❍

- ❖ **B. EXIT IF SD4 IS “NO”**

SD6. Did you ever attempt suicide?

- ❍ Yes

❍ No
❍

❖ **C. EXIT IF SD6 IS “NO”**

SD6a. How many times have you tried to kill yourself in your lifetime?

❍ (Times)_____
❍

SD8. How old were you {then, the first time}?

❍ (Years old)_____
❍

If SD6a times is over 1, show a else b

SD9. {**a**: Think about the most serious attempt you made to commit suicide, **b**: Think about the attempt you made to commit suicide}. Which of these three statements best describes what happened to you?

❍ I made a serious attempt to kill myself and it was only luck that I did not succeed
❍ I tried to kill myself, but knew that the method was not fool-proof
❍ My attempt was a cry for help. I did not intend to die
❍ Don’t know / refuse

SD11. Did it result in an injury or poisoning?

❍ Yes
❍ No
❍

SD12. Did it require medical attention?

❍ Yes
❍ No
❍

If SD12 is “yes”, show SD13

SD13. Did it require overnight hospitalization?

❍ Yes
❍ No
❍

SD14.2. What method did you use to try to commit suicide? (Check all that apply.)

❑ Gun
❑ Razor, knife or other sharp instrument
❑ Overdose or prescription medications
❑ Overdose of over-the-counter medications
❑ Overdose of other drug (e.g. heroin, crack, alcohol)
❑ Hanging, strangulation, suffocation
❑ Drowning
❑ Jumping from high places
❑ Motor vehicle crash
❑ Other
❍ Don’t know / refuse

General anxiety disorder screening

G1. Have you ever had a period in your life, six months or longer, when you were more anxious or worried a lot more about things than most other people with the same problems as you?

❍ Ye ❍
s
❍ No

G2. Did you also feel depressed during the whole of this period when you had anxiety?

❍ Ye ❍
s
❍ No

Panic disorder screening

SC20.1. Have you ever in your life had an attack of unexpected fear or panic when all of a sudden:

- you felt very frightened, anxious, or uneasy
- or you became short of breath, dizzy, or your heart pounded
- or you thought that you might lose control, die, or go crazy?

❍ Yes ❍ No

If SC20.1 is “yes”, show SC20.2 and SC20.3

SC20.2. Has such an attack of unexpected fear or panic happened several times?

❍ Yes ❍ No

SC20.3. Has the attack of fear or panic always had a reasonable explanation why it happened?

❍ Yes ❍ No

- **A. IF SC20.1, SC20.2 AND SC20.3 IS “YES” THEN ACTIVATE THE PANIC DISORDER FOLLOW-ON MODULE**

Agoraphobia screening

- **A. IF CONDITION A IN THE PANIC DISORDER SCREENING MODULE IS TRUE THEN SHOW BELOW QUESTIONS**

SC30.1. Was there ever a time in your life when you became very upset or nervous whenever you were in crowds, public places, or traveling?

❍ Yes ❍ No

If SC30.1 is “yes”, show SC30.2 and SC30.3

SC30.2. Did you stay away from these situations whenever you could because of your fear?

❍ Yes ❍ No

SC30.3. Do you think your fear was much stronger than it should have been in these situations?

❍ Yes ❍ No

- **A. CONDITION STOP**
- **B. IF SC30.1, SC30.2 AND SC30.3 IS “YES” THEN ACTIVATE THE AGORAPHOBIA FOLLOW-ON MODULE**

Obsessive compulsive disorder screening

OC1. Have you ever been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them. For example: hurting someone even though you really didn't want to or being contaminated by germs or dirt? At anytime during your life, have you had any of these kinds of thoughts?

❍ Yes ❍ No

OC2. Was there every anything you had to do over and over again and couldn't resist doing, like washing your hands over and over again, counting up to a certain number, or checking something several times to make sure you had done it right?

❍ Yes ❍ No

- **A. IF OC1 OR OC2 IS “YES” THEN ACTIVATE THE OBSESSIVE COMPULSIVE DISORDER FOLLOW-ON MODULE**

Post traumatic stress disorder screening

PT1. Sometimes things happen to people that are extremely upsetting- things like being in a life threatening situation like a major disaster, very serious accident or fire; being physically or sexually assaulted or raped, including childhood abuse, seeing another person killed or dead, or badly hurt, or hearing about something horrible that has happened to someone you are close to. At anytime during your life, have any of these kinds of things happened to you?

❍ Yes ❍ No

PT2. Did you ever participate in combat, either as a member of a military, or as a member of an organized non-military group?

❍ Yes ❍ No

- **A. IF PT1 OR PT2 IS “YES” THEN ACTIVATE THE POST TRAUMATIC STRESS DISORDER FOLLOW-ON MODULE**

Social phobia screening

SC29. Was there ever a time in your life when you felt very afraid or really, really shy with people, like meeting new people, being in a group, going to parties, going on a date, or using a public bathroom?

❍ Yes ❍ No

- **A. IF SC29 IS “YES” THEN ACTIVATE THE SOCIAL PHOBIA FOLLOW-ON MODULE**

Specific phobia screening and follow-on

SI10. The next questions are about things that make some people afraid even though they know there is no real danger.

	No	Yes	
Bugs, snakes, dogs, or any other animals?	□	□	□
Still water, like in a swimming pool or a lake, or weather events, like storms, thunder, or lightning?	□	□	□
Closed spaces, like caves, tunnels, closets, or elevators?	□	□	□
High places like roofs, balconies, bridges, or staircases?	□	□	□
Fear of flying or airplanes?	□	□	□

❖ **A. EXIT IF ALL QUESTIONS IN SI10 IS “NO”**

SI20.

	No	Yes	
Was there ever a time in your life you became very upset or nervous whenever you were faced with this or these situations?	□	□	□
Did you ever stay away from this or these situations whenever you could because of your fear?	□	□	□
Do you think your fear was ever much stronger than it should have been?	□	□	□

ADHD screening and follow-on

AD1-6. How often do you

	Never or rarely	Sometimes	Often	Don’t know / refuse
Have problems remembering appointments or obligations?	□	□	□	□
Avoid or delay getting started if you have a task that requires a lot of thought?	□	□	□	□
Have difficulty getting things in order when you have to do a task that requires organization?	□	□	□	□
Have trouble wrapping up the final details of a project, once the challenging parts have been done?	□	□	□	□

	Never or rarely	Sometimes	Often	Don’t know / refuse
Fidget or squirm with your hands or feet when you have to sit down for a long time?	□	□	□	□
Feel overly active and compelled to do things, like you were driven by a motor?	□	□	□	□

- **A. EXIT IF AT LEAST THREE QUESTIONS IN THE RANGE AD1 TO AD6 ARE LESS FREQUENT THAN “OFTEN”**

	Never or rarely	Sometimes	Often	Don’t know / refuse
AD7. How often do you make careless mistakes when you have to work on a boring or difficult project?	□	□	□	□
AD8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	□	□	□	□
AD9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	□	□	□	□
AD10. How often do you misplace or have difficulty finding things at home or at work?	□	□	□	□
AD11. How often are you distracted by activity or noise around you?	□	□	□	□
AD12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	□	□	□	□

	Never or rarely	Sometimes	Often	Don’t know / refuse
AD13. How often do you feel restless or fidgety?	□	□	□	□

	Never or rarely	Sometimes	Often	Don't know / refuse
AD14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	○	○	○	○
AD15. How often do you find yourself talking too much when you are in social situations?	○	○	○	○
AD16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	○	○	○	○
AD17. How often do you have difficulty waiting your turn in situations when turn taking is required?	○	○	○	○
AD18. How often do you interrupt others when they are busy?	○	○	○	○

Traumatic life events screening

SL1. Has any of the following happened to you in your life?

- ❑ Divorce or separation
- ❑ Serious money problems (e.g. not money for food)
- ❑ Been discriminated in a highly disturbing way
- ❑ Been subject to bullying
- ❑
- ❑ Seen a serious accident
- ❑ Been involved in a serious accident
- ❑ Been involved in a natural disaster (e.g. tsunami, hurricane, forest fire)
- ❑ Been sent to jail because of a crime
- ❑ Close family member sent to jail
- ❑
- ❍ None of these
- ❍ Don't know / refuse

SL2. Has any of the following happened to you in your life?

- ❑ Death of close friend
- ❑
- ❑ Serious physical or mental illness
- ❑ Serious illness or injury of close family member
- ❑ Been adopted or placed in foster care
- ❑ Divorce or separation of your parents during your childhood before age 18
- ❑ Separated from your child against your will
- ❑ Before age 18 witnessed physical violence between family members

❑ Death of child
❑ Death of close family member (other than child)
❑
❑ Been physically neglected (e.g. not fed)
❑ Been emotionally abused or neglected (e.g. frequently shamed)
❑
❍ None of these
❍ Don’t know / refuse

SL3. Have you experienced any of the following? (Mark all that apply)

❑ Been witness to a robbery or mugging
❑ Been victim of a robbery or mugging
❑ Been stalked, threatened to be killed or seriously harmed
❑
❑ Before age 18 been abused (not sexually) or physically attacked by someone you knew
❑ As adult been abused (not sexually) or physically attacked by someone you knew
❑ Bothered or harassed by sexual remarks
❑ Before age 18 been touched or made to touch sexually against your will
❑ As adult been touched or made to touch in a sexual offending manner
❑ Forced to have sex before age 18
❑ Forced to have sex as adult
❑ Had sex in exchange for money or drugs
❑
❍ None of these
❍ Don’t know / refuse

SL4. Have you been seriously disturbed by someone close to you having any of these stressful life events?

❍ Yes ❍ No

Chronic fatigue syndrome screening and follow-on

CF10. Have you felt abnormally tired during the last six months?

❍ Yes ❍ No

If CF10 is “yes”, show CF20

CF20. Did you feel this tiredness during all six months?

❍ Yes ❍ No

If CF20 is “yes”, show CF30

CF30. Did you feel too tired to live a normal life during those six months?

❍ Yes ❍ No

If sex is “female” and MN150 is “yes”, show CF40

CF40. Did this unusual tiredness occur only during pregnancy?

❍ Yes ❍ No

- **A. IF CF10, CF20 AND CF30 IS “YES” AND IF CF40 IS “YES” FOR FEMALE ANSWERED “YES” ON MN150 THEN SHOW BELOW QUESTIONS**

CF50. How long at a stretch have you felt this abnormal tiredness?

❍ (Number of weeks)_____ ❍ (Number of years)_____
❍ (Number of months)_____ ❍ Don’t know / refuse

CF60. How old were you when the problem started?

❍ (Years old)_____ ❍

CF70. Do you suffer from a disease which is the cause of this long-lasting tiredness?

❍ Yes ❍ No

If CF70 is “yes”, show CF80

CF80. Was this disease diagnosed by a medical doctor?

❍ Yes ❍ No

CF90. Are you incapable of working as a result of the tiredness?

❍ Yes, incapable of work or on disability because of tiredness or pain
❍ Yes, partly incapable of work (per cent)____
❍ No
❍ Don’t know / refuse

CF100. Does your tiredness impair your social life, e.g. leisure activities?

❍ Yes ❍ No

CF110. During the last six months of abnormal tiredness did you also suffer from?

❑ Awakening without feeling thoroughly rested
❑ Short-term memory problem or concentration difficulties
❑ Feeling sick for 24 hours or more after exertion
❑ New type of headache
❑ Sore throat
❑ Tender lymph glands in the throat or in the armpits
❑ Muscle pain
❑ Pain in several joints without redness or swelling
❍ None of these
❑
❍ Don’t know / refuse

CF120. During that period of abnormal tiredness, after exertion, did you feel sick for more than 24 hours?

❍ Yes ❍ No

❍ No

CF130. Did this feeling last longer than 24 hours?

❍ Yes ❍ No

CF140. If you were to rest for a few days, to what extent would your tiredness be relieved?

❍ Completely ❍ Not at all
❍ Somewhat ❍ Don’t know / refuse

❖ **A. CONDITION STOP**

Gambling screening and follow-on

GA1. How often have you gambled in the last 12 months?

This includes betting on horses, playing Bingo, playing Lotto, the Lottery, betting on sports, casino gambling, playing machines (other than at casinos), playing poker for money, and internet gambling.

❍ Never or a few times ❍ Daily
❍ Monthly ❍
❍ Weekly

❖ **A. EXIT IF GA1 IS “NEVER OR A FEW TIMES”**

	Never	Sometimes	Most of the time	Almost always	
GA2. How often have you bet more than you could really afford to lose?	□	□	□	□	□
GA3. How often have you needed to gamble with larger amounts of money to get the same feeling of excitement?	□	□	□	□	□
GA4. How often have you gone back another day to try to win back the money you lost?	□	□	□	□	□
GA5. How often have you borrowed money or sold anything to get money to gamble?	□	□	□	□	□
GA6. How often have you felt that you might have a problem with gambling?	□	□	□	□	□
GA7. How often have you felt that gambling has caused you any health problems, including stress or anxiety?	□	□	□	□	□
GA8. How often have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?	□	□	□	□	□
GA9. How often has your gambling caused financial problems for you or your household?	□	□	□	□	□
GA10. How often have you felt guilty about the way you gamble or what happens when you gamble?	□	□	□	□	□

Tourette’s syndrome screening

TO10. Have you ever had motor tics - i.e. repeated movement that you can't stop yourself from doing?

❍ Yes
❍ No
❍

TO20. Have you ever had vocal tics - i.e. when you can't stop yourself from making noises?

❍ Yes
❍ No
❍

- **A. IF TO10 IS "YES" THEN SHOW TO30 AND TO35.**
- **B. IF TO20 IS "YES" THEN SHOW TO40 AND TO45.**

TO30. Which of the following motor tics have you ever had? (Mark all that apply)

❑ Excessive blinking of eyes
❑ Raising of eyebrow
❑ Squinting of eyes
❑ Rolling eyes up, down or sideways
❑ Twitching of nose
❑ Flaring of nostrils
❑ Pouting of mouth (as if giving a kiss)
❑ Stretching mouth wide open
❑ Nodding of head
❑ Screwing up of face
❑ Touching chin to shoulder
❑ Stretching neck
❑ Shrugging shoulder
❑ Jerking movement of arm or leg
❑ Other motor tics

TO35. How old were you when your motor tics first began?

❍ At birth ❍ (Years old)_____

TO40. Which of the following vocal tics have you ever had? (Mark all that apply)

- ❑ Throat clearing
- ❑ Excessive sniffing
- ❑ Coughing as a habit
- ❑ Gulping
- ❑ High-pitched squeaks
- ❑ Making little noises, e.g. ‘Ah’, ‘Eh’, ‘Eee’
- ❑ Sucking noises
- ❑ Burping, not just when eating or drinking
- ❑ A word said repeatedly and out of context
- ❑ Swearing, without meaning to and without being annoyed
- ❑ Other vocal tics

TO45. How old were you when your vocal tics first began?

❍ At birth ❍ (Years old)_____

Mental Health

Follow-on questions for screening questions

Depression follow-on

- **A. IF CONDITION A IN THE DEPRESSION SCREENING MODULE IS TRUE THEN SHOW BELOW QUESTIONS**

D2. Earlier in the interview, you mentioned having periods that lasted several days or longer when you felt sad, empty, or depressed most of the day. Did these periods always happen after the loss of a loved one?

- ❍ Yes
- ❍ No
- ❍

D3. For the next few questions, please think of the two-week period when these feelings were worst. For how long did the feelings of being sad, blue or depressed usually last?

- ❍ All day long or most of the day
- ❍ Less often
- ❍ Don't know / refuse

- **B. IF D3 IS "ALL DAYS LONG OR MOST OF THE DAY" THEN SHOW BELOW QUESTIONS**

D4. During those two weeks, did you feel this way…

- ❍ Every day or almost every day
- ❍ Less often
- ❍ Don't know / refuse

If D4 is “every day or almost every day”, show D5 and D6

D5. During those two weeks did you lose interest in most things?

- ❍ Yes
- ❍ No
- ❍

- ❖ **B. CONDITION STOP**
- ❖ **C. IF D3 IS “LESS OFTEN” THEN SHOW BELOW QUESTIONS**

D8. Think of the-two-week period when you had the most complete loss of interest in things. For how long did the loss of interest usually last?

- ❍ All day long or most of the day
- ❍ Less often
- ❍ Don’t know / refuse

If D8 is “all day or most of the day”, show D9 and D10

D9. How often did you feel this during the two weeks?

- ❍ Every day or almost every day
- ❍ Less often
- ❍ Don’t know / refuse

- ❖ **C. CONDITION STOP**
- ❖ **D. IF DS3 IS “ALL DAYS LONG OR MOST OF THE DAY” OR D9 IS “EVERY DAY OR ALMOST EVERY DAY” THEN SHOW BELOW QUESTIONS**

D10. Did you feel tired out or low on energy all the time, during these two weeks?

- ❍ Yes
- ❍ No
- ❍

D11. Did your appetite significantly increase or decrease during this time?

- ❍ Appetite stayed about the same
- ❍ Significant increase in appetite

- ❍ Significant decrease in appetite
- ❍ Both – significant increase at some times and significant decrease at other times
- ❍ Don’t know / refuse

D12. During this time, did your weight change?

- ❍ Weight stayed about the same
- ❍ Gained weight
- ❍ Lost weight
- ❍ Both gained and lost weight
- ❍ Don’t know / refuse

If D12 is “gained weight” or “lost weight”, show D13

D13. About how much weight did you {gain, lose}?

- ❍ 1 kg
- ❍ 2 kg
- ❍ 3 kg
- ❍ 4 kg
- ❍ 5 kg or more
- ❍ Don’t know / refuse

D15. Did you sleep much more than usual or much less than usual?

- ❍ Yes
- ❍ No
- ❍

If D15 is “yes”, show D16 and D17

D16. Did you have more trouble falling asleep, staying asleep, or waking too early than usual?

- ❍ Yes
- ❍ No
- ❍

If D16 is “yes”, show D17

D17. How often did you have trouble falling asleep during those two weeks?

❍ Every night or nearly every night
❍ Less often
❍ Don’t know / refuse

D18. Did you sleep much more than usual?

❍ Yes
❍ No
❍

If D18 is “yes”, show D19

D19. During those two weeks, how often did you sleep much more than usual?

❍ Every night or nearly every night ❍ Less often

D20. Did you have a lot more trouble thinking or concentrating than usual?

❍ Yes
❍ No
❍

D21. During this time, were you so fidgety or restless that you were unable to sit still and that other people noticed it?

❍ Yes
❍ No
❍

D22. During this time, did you talk or more move more slowly than usual so that other people noticed it?

❍ Yes
❍ No
❍

D23. People sometimes feel down on themselves, no good, or worthless. Did you feel this way during this time?

❍ Yes
❍ No
❍

D24. Did you think a lot about death during this time – either your own, someone else's, or death in general?

- ❍ Yes
- ❍ No
- ❍

- ❖ **E. IF D5 OR D10 IS "YES" OR D12 IS NOT "DON'T KNOW/REFUSE" OR D17 IS "EVERY NIGHT OR NEARLY EVERY NIGHT" OR [D20, D21, D22, D23 OR D24] IS "YES"; THEN SHOW BELOW QUESTIONS**

- ❖ **F. IF D4 IS "EVERY DAY OR ALMOST EVERY DAY" THEN SHOW BELOW QUESTIONS**

D25. You have told us that you had at least two week in a row when you {were tired and had no energy}{had appetite problems} {had problems with your weight}{had sleeping problems}{had problems concentrating}{were nervous or restless}{talked or moved slower than usual slow}{had problems with your confidence} {had thoughts about death}. To what extent did these symptoms interfere with your work, social life, or relationships?

- ❍ Completely or a lot
- ❍ Somewhat
- ❍ A little or not at all
- ❍ Don't know / refuse

D26. During this time, to what extent were you distressed by these symptoms?

- ❍ Completely or a lot
- ❍ Somewhat
- ❍ A little or not at all
- ❍ Don't know / refuse

D27. How old were you the first time you had two weeks in a row when you were sad, blue or depressed and also {were tired and had no energy}{had appetite problems} {had problems with your weight}{had sleeping problems}{had problems concentrating} {were nervous or restless}{talked or moved slower than usual slow}{had problems with your confidence} {had thoughts about death}?

- ❍ (Years old)_____
- ❍

D28. How old were you the last time you felt like this?

- ❍ (Years old)_____
- ❍

- **F. CONDITION STOP**

- **G. IF D9 IS “EVERY DAY OR ALMOST EVERY DAY” THEN SHOW BELOW QUESTIONS**

D29. How old were you the first time you had two weeks in a row when you lost interest in things and also had some other things like {were tired and had no energy}{had appetite problems} {had problems with your weight}{had sleeping problems}{had problems concentrating}{were nervous or restless}{talked or moved slower than usual slow}{had problems with your confidence} {had thoughts about death}?

- ❍ (Years old)_____
- ❍

D30. How old were you the last time you felt like this?

- ❍ (Years old)_____
- ❍

- **G. CONDITION STOP**

- **H. IF D4 IS “EVERY DAY OR ALMOST EVERY DAY” OR D9 IS “EVERY DAY OR ALMOST EVERY DAY” THEN SHOW BELOW QUESTIONS**

D31. How many times have you felt like this during your life?

- ❍ (Times)_____
- ❍

D32. Did you ever in your life talk to a medical doctor or other professional about depression? (A professional means a psychologist, counselor, spiritual advisor, herbalist, acupuncturist, or other healing professional.)

- ❍ Yes
- ❍ No
- ❍

If D32 is “yes”, show D32a

D32a. How old were you the first time you talked to a professional about depression?

- ❍ (Years old)_____
- ❍

- **A, D, E, G AND H. CONDITIONS STOP**

Perinatal depression follow-on

- **A. IF CONDITION B IN THE PERINATAL DEPRESSION SCREENING MODULE IS TRUE THEN SHOW BELOW QUESTIONS**

PN30. Earlier, you mentioned having felt sad, miserable, or very anxious during pregnancy or after a delivery. Please think about the worst episode during your pregnancy or after delivery. During the worst episode of feeling sad, miserable, or very anxious during pregnancy or following delivery, how often:

	Often	Sometimes	Rarely	Never	Don't know / refuse
Did you feel able to laugh or see the funny side of things?	□	□	□	□	□
Were you able to look forward to things with excitement?	□	□	□	□	□
Did you blame yourself unnecessarily when things went wrong?	□	□	□	□	□
Were you anxious or worried for no good reason?	□	□	□	□	□
Did you feel scared or panicky for no good reason?	□	□	□	□	□
Did you feel overwhelmed?	□	□	□	□	□
Were you so unhappy that you had difficulty	□	□	□	□	□

	Often	Sometimes	Rarely	Never	Don’t know / refuse
sleeping?					
Did you feel sad or miserable?	❑	❑	❑	❑	❑
Were you so unhappy that you cried?	❑	❑	❑	❑	❑
Did the thought of harming yourself occur to you?	❑	❑	❑	❑	❑

- **B. EXIT IF ALL QUESTIONS IN PN30 IS “NEVER”**

PN40. During the worst episode of feeling sad, miserable, or very anxious during pregnancy or following delivery, did the symptoms cause you problems or interfere with your day-to-day life?

- ❍ Yes
- ❍ No
- ❍

PN50. During the worst episode, when did these symptoms begin?

- ❍ During pregnancy
- ❍ After delivery
- ❍ Don’t know / refuse

If PN50 is “during pregnancy”, show PN51
If PN50 is “after delivery”, show PN52

PN51. In which period of your pregnancy did these problems start?

- ❍ 1st trimester
- ❍ 2nd trimester
- ❍ 3rd trimester
- ❍ Don’t know / refuse

PN52. How long time after your delivery did these problems start?

- ❍ 0 to 4 weeks
- ❍ 1 to 3 months
- ❍ More than 3 months postpartum
- ❍ Don’t know / refuse

PN60. During the worst episode, how long did these symptoms last?

- ❍ Less than 2 weeks
- ❍ 2 to 4 weeks
- ❍ 1 month or longer
- ❍ Don’t know / refuse

PN70. Did you ever talk to a medical doctor or other professional about feeling sad, miserable, or very anxious during pregnancy or following delivery? (A professional means a psychologist, counselor, spiritual advisor, herbalist, acupuncturist, or other healing professionals.)

- ❍ Yes
- ❍ No
- ❍

If PN70 is “yes”, show PN80

PN80. How old were you the first time you talked to a professional about depression?

- ❍ (Years old)_____
- ❍

- ❖ **A. CONDITION STOP**

Panic disorder follow-on

- ❖ **A. IF CONDITION A IN THE PANIC DISORDER SCREENING MODULE IS TRUE THEN SHOW BELOW QUESTIONS**

PD1. Intro2. Earlier you mentioned having attacks when all of a sudden you had several problems like being short of breath, your heart pounding or feeling dizzy, and being afraid you would die or go crazy. Think of a bad attack like that. During that attack, which of the following problems did you have?

	Yes	No	
Did your heart pound or race?	☐	☐	☐
Were you short of breath?	☐	☐	☐
Did you have nausea or discomfort in your stomach?	☐	☐	☐
Did you feel dizzy or faint?	☐	☐	☐
Did you sweat?	☐	☐	☐
Did you tremble or shake?	☐	☐	☐
Did you feel like you were choking?	☐	☐	☐
Did you have pain or discomfort in your chest?	☐	☐	☐
Were you afraid that you might lose control of yourself or go crazy?	☐	☐	☐
Did you feel that you or things around you seemed unreal?	☐	☐	☐
Were you afraid that you might die?	☐	☐	☐
Did you have hot flushes or chills?	☐	☐	☐
Did you have numbness or tingling sensations?	☐	☐	☐

- **B. EXIT IF LESS THAN FOUR QUESTIONS IN PD1 IS “YES”**

PD2.1 During your attacks, did problems like {key phrases in PD1} begin suddenly?

- ❍ Yes
- ❍ No
- ❍

If PD2.1 is “yes”, show PD2.2 and PD4

PD2.2 During your attacks, did problems like racing heart, shortness of breath, or fear of losing control reach their peak within 10 min after the attacks began?

- ❍ Yes
- ❍ No
- ❍

PD4. About how many of these sudden attacks have you had in your entire lifetime?

- ❍ (Number of attacks)_____
- ❍ Don’t know / refuse

PD9. How old were you the very first time you had one of these attacks?

- ❍ (Years old)_____
- ❍

PD10d. How old were you the last time you had one of these attacks?

- ❍ (Years old)_____
- ❍

PD13. After having one of these attacks, did you ever have a month or more when you had any of the following experiences:

	Yes	No	
You were often worried that you might have another attack or worried that something terrible might happen because of the attacks?	□	□	□
You changed your everyday activities or avoided certain situations because of fear about having another attack?	□	□	□

PD17. Attacks of this sort can occur “out of the blue”. Did you ever have an attack that occurred unexpectedly “out of the blue”?

- ❍ Yes
- ❍ No
- ❍

If PD17 is “yes”, show PD17a

PD17a. About how many attacks in your lifetime occurred unexpectedly “out of the blue”?

- ❍ (Number of attacks)_____
- ❍ Don’t know / refuse

PD50. Did you ever in your life talk to a medical doctor or other a about your attacks? (A professional means a psychologist, counselor, spiritual advisor, herbalist, acupuncturist, or other healing professional.)

- ❍ Yes
- ❍ No
- ❍

- ❖ **A. CONDITION STOP**

Agoraphobia follow-on

- ❖ **A. IF CONDITION B IN THE AGORAPHOBIA SCREENING MODULE IS TRUE THEN SHOW BELOW QUESTIONS**

AG1. The next questions are about strong fears of crowds, public places, and traveling. Did you ever strongly fear any of the following situations?

	Yes	No	
AG1a. Being home alone?	□	□	□
AG1b. Being in crowds?	□	□	□

	Yes	No	
AG1c. Traveling away from home?	❑	❑	❑
AG1d. Traveling alone or being alone away from home?	❑	❑	❑
AG1e. Using public transportation?	❑	❑	❑
AG1f. Driving a car?	❑	❑	❑
AG1g. Standing in a line in a public place?	❑	❑	❑
AG1h. Being in a department store, shopping mall, or supermarket?	❑	❑	❑
AG1i. Being in a movie theater, auditorium, lecture hall, or church?	❑	❑	❑
AG1j. Being in a restaurant or any other public place?	❑	❑	❑
AG1k. Being in a wide, open field or street?	❑	❑	❑

- **B. EXIT IF LESS THAN FOUR QUESTIONS IN AG1 IS "YES"**

AG3i2. You had a fear of a number of the situations on the list. Can you remember your exact age the very first time you had a fear of one of these situations?

- ❍ Yes
- ❍ No
- ❍

If AG3i2 is "yes", show AG3b1

AG3b1. How old were you?

❍ (Years old)_____ ❍

AG4. People with fears like this differ in what it is they fear about the situations. Which of the following fears did you experience:

	Yes	No	
AG4a. Fear of being alone or of being separated from your loved ones?	❑	❑	❑

	Yes	No	
AG4b. Fear that there was some real danger, like that you might be robbed or assaulted?	☐	☐	☐
AG4c. Fear that you might get sick to your stomach or have diarrhea?	☐	☐	☐
AG4d. Fear that you might have a panic attack?	☐	☐	☐
AG4e. Fear that you might have a heart attack or some other emergency?	☐	☐	☐
AG4f. Fear that you might become physically ill and be unable to get help?	☐	☐	☐
AG4g. Fear that it might be difficult or embarrassing to escape?	☐	☐	☐
AG4h. Fear that some other terrible thing might happen?	☐	☐	☐
AG4i. Fear that help might not be available if you needed it?	☐	☐	☐

AG5. Was there ever a time when you almost always became very upset or anxious whenever you were faced with one of these situations?

- ❍ Yes
- ❍ No
- ❍

AG6. Did you ever avoid one of these situations whenever you could because of your fear?

- ❍ Yes
- ❍ No
- ❍

AG8. Was there a particular incident or event that caused your fear of these situations to start the very first time?

- ❍ Yes
- ❍ No
- ❍

If AG8 is “yes”, show AG8a

AG8a. Did you have a panic attack as a result of that incident or event?

- ❍ Yes
- ❍ No
- ❍

AG9. Think of the time in your life when your fear (and avoidance) was most severe and frequent. When you were faced with these situations, or thought you would have to be, did you ever have any of the following experiences?

	Yes	No	
Did your heart ever pound or race?	❑	❑	❑
Did you ever sweat?	❑	❑	❑
Did you tremble or shake?	❑	❑	❑
Did you have a dry mouth?	❑	❑	❑

AG13. Now a question about how your fear (or avoidance) may have impacted your life. Were you ever unable to leave your home for an entire day because of your fear?

❍ Yes
❍ No
❍

If AG13 is "yes", show AG13a

AG13a. What is the longest period of days, weeks, months or years you were unable to leave your home?

❍ (Days)_____
❍ (Weeks)_____
❍ (Months)_____
❍ (Years)_____
❍

AG14. Some people are unable to go out of their home unless they have someone they know with them, like a family member or friend. Was this ever true for you?

❍ Yes
❍ No
❍

AG15. How much did your fear (or avoidance) of these situations ever interfere with either your work, your social life, or your personal relationships?

❍ Not at all
❍ A little
❍ Some
❍ A lot
❍ Extremely
❍

If AG15 is “a lot” or “extremely”, show AG15.1

AG15.1. How often during that time were you unable to carry out your daily activities or to take care of yourself because of your fear (or avoidance) of these situations?

- ❍ Often
- ❍ Sometimes
- ❍ Not very often
- ❍ Never
- ❍

AG17b. How old were you the last time (you either strongly feared or avoided one of these situations)?

- ❍ (Years old)_____
- ❍

AG24. Did you ever in your life talk to a medical doctor or other a about your fear (or avoidance) of these situations? (A professional means psychologist, counselor, spiritual advisor, herbalist, acupuncturist, or other healing professional.)

- ❍ Yes
- ❍ No
- ❍

If AG24 is “yes”, show AG24a

AG24a. How old were you the first time (you talked to a professional about your fear)?

- ❍ (Years old)_____
- ❍

- ❖ **A. CONDITION STOP**

Obsessive compulsive disorder follow-on

- **A. IF CONDITION A IN THE OBSESSIVE COMPULSIVE DISORDER SCREENING MODULE IS TRUE THEN SHOW BELOW QUESTIONS**

O1. Some people have repeated unpleasant thoughts, images, or impulses that they can't get out of their heads. For example, some people have the idea that their hands are dirty no matter how much they wash them. Did you ever have a time in your life when you were bothered by any of the following:

	Yes	No	
O1a. A recurrent, persistent concern about dirt, germs, or contamination?	☐	☐	☐
O1b. A recurrent, persistent concern about harming someone, or being responsible for things going wrong?	☐	☐	☐
O1c. A recurrent, persistent concern about having things symmetrical, lined up, or ordered in exactly the right way, or a recurrent urge to count or touch things?	☐	☐	☐
O1d. A recurrent, persistent concern about having to save or keep things, even if they have little monetary or sentimental value?	☐	☐	☐
O1e. Any another disturbing thought that kept entering your mind, such as concerns about doing something terrible or morally wrong, sexual thoughts that you found disturbing and unpleasant, or some other repeated, upsetting thought, image, or impulse?	☐	☐	☐

- **B. IF AT LEAST ONE QUESTION IN O1 IS "YES" THEN SHOW BELOW QUESTIONS**

O3. You mentioned {key phrases in O1}. The next questions focus only on these thoughts, not on anything you might have done when the thoughts came to mind. Sometimes unpleasant thoughts of this sort are related to day-to-day problems in areas like finances, work, personal relationships, or planning for the future. How often did your unpleasant thoughts focus on day-to-day problems?

❍ All the time
❍ Most of the time
❍ Sometimes
❍ Rarely
❍ Never
❍

If O3 is not “never”, show O3a

O3a. How often did your unpleasant thoughts focus on things other than day-to-day problems?

- ❍ All the time
- ❍ Most of the time
- ❍ Sometimes
- ❍ Rarely
- ❍ Never
- ❍

O5. How much did these unpleasant thoughts ever upset you or cause you emotional distress?

- ❍ Extremely
- ❍ A lot
- ❍ Some
- ❍ A little
- ❍ Not at all
- ❍

O6. During the time in your life when you had these unpleasant thoughts, how often did any of them seem excessive or unreasonable to you?

- ❍ All the time
- ❍ Most of the time
- ❍ Sometimes
- ❍ Rarely
- ❍ Never
- ❍

❖ **B1. O5 IS “EXTREMELY”, “A LOT” OR “SOME” THEN SHOW BELOW QUESTIONS**

O8a. How often did you try to resist the unpleasant thoughts or push them out of your mind?

- ❍ Often
- ❍ Sometimes
- ❍ Rarely
- ❍ Never
- ❍

If O8a is “rarely” or “never”, show O8b and O8c

O8b. How often did you try to ignore these unpleasant thoughts or think about other things?

❍ Often
❍ Sometimes
❍ Rarely
❍ Never

If O8b is “rarely” or “never”, show O8c

O8c. Some people react to unpleasant thoughts by thinking or doing something over and over. For example, a person who worries about leaving the door unlocked might check the lock again and again. Or a person who has a terrible thought might pray, count, or repeat words in his mind over and over. How often did you react to your unpleasant thoughts by thinking or doing something over and over?

❍ Often
❍ Sometimes
❍ Rarely
❍ Never

❖ **C. IF ALL QUESTIONS IN O8a, O8b OR O8c IS MORE OFTEN THAN “NEVER” THEN SHOW BELOW QUESTIONS**

O10. How often were these thoughts so strong that you could not get them out of your mind no matter how hard you tried?

❍ Often
❍ Sometimes
❍ Rarely
❍ Never

O11. How much did these thoughts ever interfere with either your work, your social life, or your personal relationships?

❍ Not at all
❍ A little
❍ Some
❍ A lot
❍ Extremely
❍

O12c. How old were you the last time you had any of these unpleasant thoughts?

❍ (Years old)_____
❍

O16. The next questions ask about your experiences with these unpleasant thoughts. On average, how much of your time was occupied by these thoughts?

❍ Less than 1 hour a day
❍ 1 to 3 hours a day
❍ More than 3 and up to 8 hours a day
❍ 8 hours or more a day
❍ Don’t know / refuse

O19. How much of an effort did you make to resist these unpleasant thoughts or to turn your attention away from them as they entered your mind?

❍ None
❍ A little
❍ Some
❍ A lot
❍ An extreme effort
❍ Don’t know / refuse

O20. How much control did you have over these unpleasant thoughts?

❍ No control
❍ Little control
❍ Moderate control
❍ Much control
❍ Complete control
❍ Don’t know / refuse

- **B, B1 AND C. CONDITIONS STOP**

O21. Some people feel driven to do certain behaviors over and over, either physically or in their mind. For example, some people check the stove in their home again and again, many times a day, no matter how many times they see that the stove is turned off. Did you ever have a time in your life when you repeatedly carried out any of the following behaviors:

	Yes	No	
Repeatedly washing, cleaning, or decontaminating?	□	□	□
Repeatedly checking things like locks or stoves, or repeatedly making sure that no harm or injury was done to yourself or someone else?	□	□	□
Repeatedly straightening, lining up, arranging, counting, or touching things, or	□	□	□

	Yes	No	
doing things in an exactly defined order?			
Always having to save things, to the point where you could not throw away things that you no longer needed or cared about?	☐	☐	☐
Any other repetitive behaviors that you felt driven to do, such as going over and over a moral argument in your mind, or praying over and over for forgiveness, or some other physical or mental act you felt you had to do repeatedly?	☐	☐	☐

- **D. EXIT IF ALL QUESTIONS IN O21 IS NOT "YES" AND ALL QUESTIONS IN O8 IS "NEVER" OR DON'T KNOW / REFUSE**
- **D1. IF NO QUESTION IN O21 IS "YES" AND AT LEAST ONE QUESTIONS IN O8 IS MORE OFTEN THAN "NEVER" THEN DO NOT SHOW BELOW QUESTIONS**

O24. The next questions focus just on these repeated behaviors, not the thoughts I asked about earlier. During the time in your life when you were doing these repeated behaviors, how often did any of them seem excessive or unreasonable to you?

❍ All the time
❍ Most of the time
❍ Sometimes
❍ Rarely
❍ Never
❍

If O24 is "never", show O24a

O24a. Did you ever think these behaviors were useless or unnecessary, or that you overdid them?

❍ Yes
❍ No
❍

- **D2. IF O24a IS NOT "YES" OR O24 IS MORE OFTEN THAN "NEVER" THEN SHOW BELOW QUESTIONS**
- **D3. IF O24a IS NOT "YES" AND AT LEAST ONE QUESTIONS IN O8 IS MORE OFTEN THAN "NEVER" THEN DO NOT SHOW BELOW QUESTIONS**

O26a. How often did doing these repeated behaviors make you feel less anxious or upset?

❍ Often ❍ Never

❍ Sometimes
❍ Rarely
❍ Never

If O26a is “rarely”, show O26b

O26b. How often did doing these repeated behaviors keep you from becoming anxious or upset?

❍ Often
❍ Sometimes
❍ Rarely
❍ Never

If O26b is “rarely”, show O26c

O26c. How often did you ever feel that something bad might happen if you did not do these repeated behaviors?

❍ Often
❍ Sometimes
❍ Rarely
❍ Never

❖ **E. IF NONE OF O26a, O26b AND O26c IS “NEVER” THEN SHOW O28, O28a AND O28b**

O28. How often did you try to resist doing these repeated behaviors?

❍ Often
❍ Sometimes
❍ Rarely
❍ Never

O28a. How often were the urges to carry out these behaviors ever so strong that you could not resist them no matter how hard you tried?

❍ Often
❍ Sometimes
❍ Rarely
❍ Never

O28b. Some people not only feel some relief when they do these behaviors, but also find them pleasurable or enjoyable. How often did you find these repeated behaviors pleasurable?

❍ Often
❍ Sometimes
❍ Rarely
❍ Never
❍

- **E. CONDITION STOP**
- **F. IF O28a IS MORE OFTEN THAN "NEVER" THEN SHOW BELOW QUESTIONS**
- **G. EXIT IF THE ANTECEDENT IN CONDITON C IS FALSE**

O31. How much did these repeated behaviors ever upset you or cause you emotional distress?

❍ Extremely
❍ A lot
❍ Some
❍ A little
❍ Not at all
❍

O32. How much did these repeated behaviors ever interfere with either your work, your social life, or your personal relationships?

❍ Not at all
❍ A little
❍ Some
❍ A lot
❍ Extremely
❍

O33c. How old were you the last time you carried out any of these repeated behaviors?

❍ (Years old)_____
❍

O37. The next questions ask about your experiences with these repeated behaviors. On average, how much time a day did you spend performing these behaviors?

❍ Less than 1 hour
❍ 1 to 3 hours
❍ More than 3, up to 8 hours
❍ 8 hours or more
❍ Don't know / refuse

- **D1, D3 AND F. CONDITIONS STOP**

O60a. Think of the very first time in your life when you experienced the unpleasant thoughts or the repeated behaviors. How old were you?

- (Years old)_____
-

If O60a is “don’t know / refuse”, show O60b

O60b. About how old were you the first time you had an experience of this sort?

- Before started school
- Before teens
- Before 20s
- Whole life
-

O69. Did you ever in your life talk to a medical doctor or other professional about these unpleasant thoughts or repeated behaviors? (A professional means a psychologist, counselor, spiritual advisor, herbalist, acupuncturist, or other healing professional.)

- Yes
- No
-

If O69 is “yes”, show O70

O70. How old were you the first time you talked to a medical doctor or other professional about these unpleasant thoughts, thoughts or repeated behaviors?

- (Years old)_____
-

- **A AND D2. CONDITIONS STOP**

Post traumatic stress disorder follow-on

- **A. IF CONDITION A IN THE POST TRAUMATIC STRESS DISORDER SCREENING MODULE IS TRUE THEN SHOW BELOW QUESTIONS**
- **B. FOR EACH BELOW QUESTION IF "YES" THEN SHOW SUB QUESTION A. IF SUB QUESTION A IS "YES" THEN SHOW THE SUB QUESTIONS B AND C. IF SUB QUESTION A IS "NO" THEN SHOW B**

PT4. Did you ever live as a civilian in a place where there was ongoing terror of civilians for political, ethnic, religious or other reasons?

Yes	No	**A.** Was this an ongoing event?	**B.** How old where you when this happened {, the first time}?	**C.** How many times did this happen?
☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT5. Were you ever a refugee – that is, did you ever flee from your home to a foreign country or place to escape danger or persecution?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4

		Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
				❍ 5 or more

PT6. Were you ever kidnapped or held captive?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT8. Were you ever involved in a life-threatening automobile accident?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT9. Did you ever have any other life- threatening accident, including on your job?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3

		Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
				❍ 4 ❍ 5 or more

PT10. Were you ever involved in a major natural disaster, like a devastating tsunami, flood, hurricane, or earthquake?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT12. Did you ever have a life-threatening illness?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT13. As a child, were you ever badly beaten up by your parents or the people who raised you?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

❑	❑	❍ Yes ❍ No Was this an ongoing event?	How old where you when this happened {, the first time}?	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more How many times did this happen?

PT14. Were you ever badly beaten up by a spouse or romantic partner?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
❑	❑	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
❑	❑	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT15. Were you ever badly beaten up by anyone else?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
❑	❑	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
❑	❑	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT16. Were you ever mugged, held up, or threatened with a weapon?

Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
❑	❑	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
					❍ 5 or more
	□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
	□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
	□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT17. The next two questions are about sexual assault. The first is about rape. We define this as someone either having sexual intercourse with you or penetrating your body with a finger or object when you did not want them to, either by threatening you or by using force, or when you were so young that you did not know what was happening. Did this ever happen to you?

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
	□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
	□	□	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT18. Other than rape, were you ever sexually assaulted or molested?

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT19. Has someone ever stalked you – that is, followed you or kept track of your activities in a way that made you feel you were in serious danger?

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT20. Did someone very close to you ever die unexpectedly; for example, they were killed in an accident, murdered, committed suicide, or had a fatal heart attack at a young age?

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT21. Did you ever have a son or daughter who had a life-threatening illness or injury?

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT22.1. When you were a child, did you ever witness serious physical fights at home, like when your father beat up your mother?

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT22. Did anyone very close to you ever have an extremely traumatic experience, like being kidnapped, tortured or raped?

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

PT23. Did you ever see someone being badly injured or killed, or unexpectedly see a dead body?

	Yes	No	Was this an ongoing event?	How old where you when this happened {, the first time}?	How many times did this happen?
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more
	☐	☐	❍ Yes ❍ No	_____	❍ 2 ❍ 3 ❍ 4 ❍ 5 or more

- **B. CONDITION STOP**
- **C. IF ANY QUESTIONS IN THE RANGE PT4 TO PT13 IS “YES” THEN SHOW BELOW QUESTIONS**

PT62. Let me review. You had {if 1 experience: the experience; if 2 or 3 experiences: the experiences; if more than 3 experiences: experiences like}{keyphrases of PT4 to PT23}.

After {an experience like this, experiences like these}, people sometimes have problems like upsetting memories or dreams, feeling emotionally distant from other people, trouble sleeping or concentrating, and feeling jumpy or easily startled.

Did you have any of these problems after any of the traumatic experiences you have gone through?

❍ Yes
❍ No
❍

- **D. EXIT IF PT62 IS “NO”.**

If PT62 is “yes”, show PT62.2

PT62.2. Did you ever in your life talk to a medical doctor or other a about (this problem/any of these problems)? (A professional means psychologist, counselor, spiritual advisor, herbalist, acupuncturist, or other healing professional.)

❍ Yes
❍ No
❍

If PT62.2 is “yes”, show PT62.2a

PT62.2a How old were you the first time you talked to a professional about this problem or any of these problems?

❍ (Years old)_____

❍

PT66.1 These are the traumas you had: {key phrases from PT4 to PT23}.

PT67. At the time of the trauma(s) listed above:

	Yes	No	
PT67a1. Were you terrified or very frightened?	☐	☐	☐
PT67a. Did you feel helpless?	☐	☐	☐
PT67b. Did you feel shocked or horrified?	☐	☐	☐
PT67c. Did you feel numb?	☐	☐	☐

	Yes	No	
PT68. In the weeks, months, or years after the traumatic event(s), in the past or currently, did you try not to think about what happened?	☐	☐	☐
PT69. Did you purposely stay away from places, people or activities that reminded you of the traumatic event(s)?	☐	☐	☐
PT70. Were you ever unable to remember some important parts of what happened?	☐	☐	☐
PT71. Did you lose interest in doing things you used to enjoy?	☐	☐	☐
PT72. Did you feel emotionally distant or cut-off from other people?	☐	☐	☐
PT73. Did you have trouble feeling normal feelings like love, happiness, or warmth toward other people?	☐	☐	☐
PT74. Did you feel you had no reason to plan for the future because you thought it would be cut short?	☐	☐	☐
PT86. Did you ever have repeated unwanted memories or intrusive thoughts of the traumatic event(s) - that is, you kept remembering it even when you didn’t want to?	☐	☐	☐

	Yes	No	
PT87. Did you ever have repeated unpleasant dreams about the traumatic event(s)?	☐	☐	☐
PT88. Did you have flashbacks – that is, suddenly act or feel as if the traumatic event(s) were happening all over again?	☐	☐	☐
PT89. Did you get very upset when you were reminded of the traumatic event(s)?	☐	☐	☐
PT90. When you were reminded of the traumatic event(s), did you ever have physical reactions like sweating, your heart racing, or feeling shaky?	☐	☐	☐
PT102. Since the time of the traumatic event(s), have you trouble falling or staying asleep?	☐	☐	☐
PT103. Have you been more irritable or short-tempered than you usually are?	☐	☐	☐
PT104. Have you had more trouble concentrating or keeping your mind on what you were doing?	☐	☐	☐
PT105. Have you been much more alert or watchful, even when there was no real need to be?	☐	☐	☐
PT106. Have you been more jumpy or easily startled by ordinary noises?	☐	☐	☐

PT114. How much distress did these reactions cause you?

- ❍ None
- ❍ Mild
- ❍ Moderate
- ❍ Severe
- ❍ Very severe
- ❍ Don't know / refuse

PT115. How much did this or these problems disrupt or interfere with your normal, daily life?

- ❍ Not at all
- ❍ A little
- ❍ Some
- ❍ A lot
- ❍ Extremely
- ❍ Don't know / refuse

❖ **A AND C. CONDITIONS STOP**

Social phobia follow-on

- **A. IF CONDITION A IN THE SOCIAL PHOBIA SCREENING MODULE IS TRUE THEN SHOW BELOW QUESTIONS**

SO1. Earlier you mentioned having a strong fear of certain social or performance situations. Did you ever strongly fear any of the following situations?

	Yes	No	
SO1a. Meeting new people?	□	□	□
SO1b. Talking to people in authority?	□	□	□
SO1c. Speaking up in a meeting or class?	□	□	□
SO1d. Going to parties or other social gatherings?	□	□	□
SO1e. Acting, performing, or giving a talk in front of an audience?	□	□	□
SO1f. Taking an important exam or interviewing for a job, even though you were well prepared?	□	□	□
SO1g. Working while someone watches?	□	□	□
SO1h. Entering a room when others are already present?	□	□	□

SO1*. Has there ever been a time in your life when you felt shy, afraid, or uncomfortable in the following situations?

	Yes	No	
SO1i. Talking with people you don’t know very well?	□	□	□
SO1j. Expressing disagreement to people you didn’t know very well?	□	□	□
SO1k. Writing or eating or drinking while someone watches?	□	□	□

	Yes	No	
SO1l. Urinating in a public bathroom or using a bathroom away from home?	☐	☐	☐
SO1m. Being in a dating situation?	☐	☐	☐
SO1n. Any other social or performance situation where you could be the center of attention or where something embarrassing might happen?	☐	☐	☐

- **B. EXIT IF LESS THAN FOUR QUESTIONS IN SO1 IS "YES"**

SO3. You had a fear of {keyphrases in O1}. How old were you the very first time you had a fear of this or any of these situations?

❍ (Years old)_____ ❍ Don't know / refuse

If SO3 is "don't know / refuse", show SO3b

SO3b. About how old were you?

❍ Before started school
❍ Before teenager
❍ Not before teenager
❍ Don't know / refuse

SO4. Do you think the fear was ever excessive, or unreasonable, or much stronger than it should have been?

❍ Yes
❍ No
❍

- **C. EXIT IF SO4 IS "NO"**

SO5. Was there ever a time when you almost always became very upset or anxious whenever you were faced with any of the social or performance situations?

❍ Yes
❍ No
❍

S06. Did you ever avoid this or these situations whenever you could because of your fear?

- ❍ Yes
- ❍ No
- ❍

SO16. How much did your fear (or avoidance) ever interfere with either your work, your social life, or your personal relationships?

- ❍ Not at all
- ❍ A little
- ❍ Some
- ❍ A lot
- ❍ Extremely
- ❍

If SO16 is “some”, “a lot” or “extremely”, show SO16.1

SO16.1. How often during that time were you unable to carry out your daily activities or to take care of yourself because of your fear (or avoidance)?

- ❍ Often
- ❍ Sometimes
- ❍ Not very often
- ❍ Never
- ❍

SO18a. How old were you the last time you either strongly feared or avoided this or any of these situations?

- ❍ (Years old)_____
- ❍

SO25. Did you ever in your life talk to a medical doctor or other a about your fear (or avoidance) of {this situation, these situations}? (A professional means psychologist, counselor, spiritual advisor, herbalist, acupuncturist, or other healing professional.)

- ❍ Yes
- ❍ No
- ❍

If SO25 is “yes”, show SO25a

SO25a. How old were you the first time (you talked to a professional about your fear)?

- (Years old)_____
-

❖ A. CONDITION STOP