

Questionnaire No:

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**FATHER AND  
SURROUNDINGS**

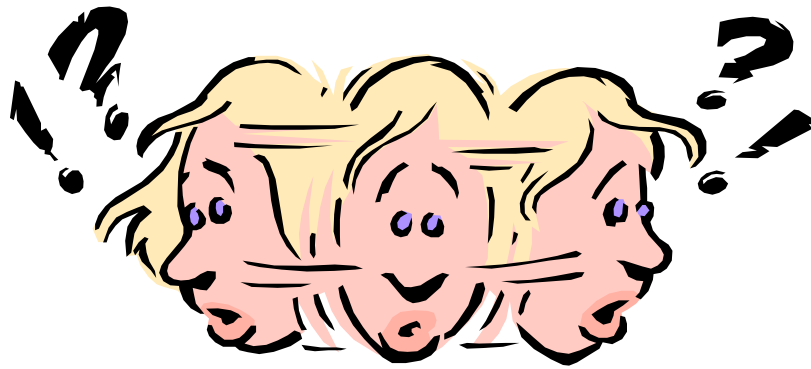
**This questionnaire is for the study child's father or the person taking the role of  
father**

**All answers are confidential**

<b>23/07/01</b>
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Please answer as much as you can.  
Just tick the box which is most accurate in your opinion.

There are no good or bad answers, just tell us what is true for you.  
If there is a question you don't want to answer or it  
doesn't apply to you – put a line through it.



We know there are some questions you have answered before but we need to  
ask them regularly so we can track the changes that  
have happened to you and your family. In time we will be able to tell whether  
the changes have had an effect on your health and that of your family.

We understand that this may be boring for you, but hope you will be patient.

THANK YOU FOR YOUR HELP

## **SECTION A: THINGS YOU DO**

A1. In the last 12 months, how often have you used any of the following, whether at work, at home or as a hobby:

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

	Every day	Most days	Once or twice a week	Less than once a week	Not at all
s) other chemicals (please tick and specify)	1	2	3	4	5

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A2. In the last 12 months, how often have you done the following:

	Every day	Most days	Once or twice a week	Less than once a week	Not at all
a) gardening	1	2	3	4	5
b) hairdressing	1	2	3	4	5
c) farm work	1	2	3	4	5
d) hospital work	1	2	3	4	5
e) shift work	1	2	3	4	5

A3. What jobs have you had **since the study child was 5** that involved exposure to chemicals or machines? Include part-time and voluntary work. If you have not had a job that involved chemicals or machines write 'None'.

Job	Materials/chemicals/ machines used	Date started (month-year)	Date stopped (month-year)
1) .....	.....	.....	.....
.....	.....	.....	.....
2) .....	.....	.....	.....
.....	.....	.....	.....
3) .....	.....	.....	.....
.....	.....	.....	.....

Job	Materials/chemicals/ machines used	Date started (month-year)	Date stopped (month-year)
4) .....	.....	.....	.....
.....	.....	.....	.....
5) .....	.....	.....	.....
.....	.....	.....	.....
6) .....	.....	.....	.....
.....	.....	.....	.....
7) .....	.....	.....	.....
.....	.....	.....	.....
8) .....	.....	.....	.....
.....	.....	.....	.....
9) .....	.....	.....	.....
.....	.....	.....	.....
10) .....	.....	.....	.....
.....	.....	.....	.....
11) .....	.....	.....	.....
.....	.....	.....	.....
12) .....	.....	.....	.....
.....	.....	.....	.....
13) .....	.....	.....	.....
.....	.....	.....	.....

If there is not enough space please continue on the back cover or on a separate sheet.

A4. In the past year have you done any of the following:

	Yes, in own home	Yes, elsewhere	Yes, both home and elsewhere	No, not at all
a) sanded floors	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
b) stripped wallpaper	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
c) removed paint or varnish	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

A5. How would you rate **your home** in relation to that of other homes with children?

a)	much cleaner	<div>1</div>
	a bit cleaner	<div>2</div>
	about the same	<div>3</div>
	less clean	<div>4</div>
	much less clean	<div>5</div>
	don't know	<div>9</div>
b)	much tidier	<div>1</div>
	a bit tidier	<div>2</div>
	about the same	<div>3</div>
	less tidy	<div>4</div>
	much less tidy	<div>5</div>
	don't know	<div>9</div>

A6. How would you describe the noise level in your home?

	Yes	No
a) there is usually music or television on in our home	<div>1</div>	<div>2</div>
b) the noises from outside our home are disturbing (neighbours, traffic, factory)	<div>1</div>	<div>2</div>
c) it is often so noisy at home it is difficult to hold a conversation	<div>1</div>	<div>2</div>

A7. Taking everything into account, which of the following best describes your feeling about your home?

satisfied	<div>1</div>
fairly satisfied	<div>2</div>
dissatisfied	<div>3</div>
very dissatisfied	<div>4</div>

A8. Here is a list of some things that can be a problem in people's homes or in the neighbourhood. How much of a problem are the following for you:

		<b>Serious problem</b>	<b>Minor problem</b>	<b>Not a problem</b>	<b>No opinion</b>
a)	Badly fitted doors and windows	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
b)	Poor ventilation	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
c)	Noise travelling between the rooms of your home	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
d)	Noise from other homes	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
e)	Noise from outside in the street	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
f)	Rubbish or litter dumped around your neighbourhood	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
g)	Dog dirt on pavement/walkways	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
h)	Worry about vandalism	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
i)	Worry about burglaries	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
j)	Worry about muggings or attacks	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
k)	Disturbance from teenagers or youths	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>
l)	Other problems (please tick & describe)	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>

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A9. a) Do the other people in your neighbourhood:

		<b>No, never</b>	<b>Rarely</b>	<b>Some- times</b>	<b>Often</b>	<b>Always</b>
i)	visit your home	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
ii)	argue with you	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
iii)	look after your children	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
iv)	keep to themselves	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

b) Do you:

		<b>No, never</b>	<b>Rarely</b>	<b>Some- times</b>	<b>Often</b>	<b>Always</b>
i)	visit the home of your neighbours	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
ii)	argue with your neighbours	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
iii)	look after your neighbour's children	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
iv)	keep to yourself	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>

A10. What do you think of your neighbourhood as a place to live?

a very good place to live	1 <input type="text"/>
a fairly good place to live	2 <input type="text"/>
not a very good place to live	3 <input type="text"/>
not at all a good place to live	4 <input type="text"/>

A11. a) How often do you drive a car, van or lorry ?

almost every day  2-5 times a week  once a week  rarely

never  → **Go to Section B on page 11**

b) What type of fuel is used?

diesel  lead free petrol  other petrol

## SECTION B: PILLS AND POTIONS

B1. Please indicate below if you have used any **medicines** (pills, syrups, inhalers, drops, sprays, suppositories, pessaries, ointments etc including homeopathic and herbal remedies) in the last 12 months.

Please include medicines prescribed by your doctor and also those you may have purchased over the counter. (**Do not include vitamins and supplements** unless taken for a specific medical condition, as these are covered in the next section).

If possible give the full name of the medicine and indicate how often it was used. If you need more lines for a particular category please include the additional medicines under the 'Other conditions' section at the end of this question on page 14.

Medicine, pills, drops, ointment etc. for:	Yes in past 12 months	If yes, give name of substance	How often did you take/use this?			
			Every day	Most days	Some times	Once or twice
a) Headache or or migraine	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Backache	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Groin pain	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Other pain	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Indigestion	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Nausea	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often did you take/use this?

Medicine, pills, drops, ointment etc. for:	Yes in past 12 months	If yes, give name of substance	Every day	Most days	Some times	Once or twice
g) Vomiting	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
h) Diarrhoea	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
i) Piles or haemorrhoids	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
j) Constipation	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
k) Depression	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
l) Anxiety or nerves	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
m) Sleeping	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
n) Psoriasis	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
o) Eczema	<input type="text" value="1"/>	i) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
		ii) .....→	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

How often did you take this?

Medicine, pills, Yes in If yes, give

drops, ointment etc. for:	past 12 months	name of substance	Every day	Most days	Some times	Once or twice
p) Asthma	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
q) Hay fever	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
r) Other allergies	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
s) Sore throat	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
t) Cough	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
u) A cold	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
v) Flu	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
w) Other infection	<div>1</div>	i) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>
		ii) .....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>

Medicine, pills, drops, ointment etc. for:	Yes in past 12 months	If yes, give name of substance	How often did you take/use this?			
			Every day	Most days	Some times	Once or twice
x) Diabetes	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y) Epilepsy	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z) High blood pressure	<input type="checkbox"/>	i) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	ii) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
za) Other condition (please tick & describe)	<input type="checkbox"/>	.....→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zb) Other condition (please tick & describe)	<input type="checkbox"/>	.....→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zc) Other condition (please tick & describe)	<input type="checkbox"/>	.....→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
zd) Other condition (please tick & describe)	<input type="checkbox"/>	.....→	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ze) Took no medicines, pills, drops or ointment	<input type="checkbox"/>					

B2. Vitamin, mineral and other supplements are widely used. Some people take them regularly for their health, whereas others may use them more sporadically to try to improve a specific area of their health. Please indicate below whether you have used such supplements regularly, occasionally or not at all **in the last 12 months**.

		Used in last 12 months		
		Regularly	Occasionally	Not at all
a)	Vitamins	<div>1</div>	<div>2</div>	<div>3</div>
b)	Minerals (e.g. calcium, iron)	<div>1</div>	<div>2</div>	<div>3</div>
c)	Oil supplements e.g. fish oils, evening primrose oil	<div>1</div>	<div>2</div>	<div>3</div>
d)	Other supplements e.g. Ginseng	<div>1</div>	<div>2</div>	<div>3</div>

B3. Please describe below any vitamins, minerals such as iron or calcium or other supplements taken for your health in the **past month** and indicate how often you used them.

		Every day	Most days	About 1-2 times a week	Less than once a week	Not at all
a) <b>Vitamins</b> (Please say which vitamins and give brand name)						
i)	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii)	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii)	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
b) <b>Mineral supplements</b> (Please say which minerals e.g. iron, calcium, and give brand name)						
i)	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
ii)	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>
iii)	.....	<div>1</div>	<div>2</div>	<div>3</div>	<div>4</div>	<div>5</div>

	Every day	Most days	About 1-2 times a week	Less than once a week	Not at all
<b>c) Oil supplements</b>					
(Please say which, e.g. fish oils, Evening Primrose Oil, and give brand name)					
i) .....	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
ii) .....	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
iii) .....	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
<b>d) Other supplements</b>					
(Please say which e.g. Ginseng, Royal Jelly, and give brand name)					
i) .....	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
ii) .....	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>
iii) .....	1 <input type="text"/>	2 <input type="text"/>	3 <input type="text"/>	4 <input type="text"/>	5 <input type="text"/>



Some of these questions may seem familiar.

Please bear with us – but we need to ask them again.



## **SECTION C: YOUR OCCUPATION AND LIFESTYLE**

C1. a) Since the study child was 5 years old have you worked at all? (please tick all that apply).

- no, not at all ☐ 7 → If **no**, go to Question C8 on page 22
- (i) yes, paid work at home ☐ 1
- (ii) yes, paid work outside home ☐ 1
- (iii) yes, voluntary work ☐ 1

b) Have you been working all the time since you started work after the study child was 5?

- yes, same job all the time ☐ 1
- yes, but not always the same job ☐ 2
- no, stopped & started again ☐ 3
- no, do not work now ☐ 4
- Now go to (iii) below
- month year
- i) when did you last stop?     → If do not work now go to C7 on page 22
- month year
- ii) when did you start again?
- iii) how many jobs are you now doing?
- iv) Whether or not you are self-employed, what job(s) are you doing? (please describe the job(s) you do and the type of industry/employer(s) you work for). If you are self-

employed please also say so.

.....  
.....

c) How many hours did you work last week ?   hours

(i) Was this a typical week?

Yes   No, usually work more hours   No, usually work less hours

**If no,**

(ii) how many hours in a usual week?   hours

d) Does your work include weekends?

Yes, usually   Yes, sometimes   No, never

e) Do you work in the evenings or at night?

Yes, often   Yes, sometimes   No

f) How would you describe the physical effort you need for your current job(s)?

very little effort, mostly sitting    
some physical effort    
quite a lot of physical effort    
considerable physical effort

g) Do you usually work:

the basic no. of hours per week

basic hours plus paid overtime

longer than basic hours (but not paid extra)

self-employed - as long as necessary

h) Which of the following best describes how you are paid in your present job?

Monthly salary  
plus performance

Monthly salary  
only

Weekly  
wage

Hourly paid

Piecework

Self-employed

Other (please  
describe)

.....

i) Are you on a recognised pay scale with increments, either automatic or performance related?

Yes

No

Don't know

j) If you decided to leave your job, how much notice are you officially required to give?

Less than  
one week

1, 2 or  
3 weeks

1 or 2  
months

3 months  
or more

not relevant  
(self-employed)

Don't know

k) In your sort of work, are there opportunities for promotion either in your current organisation or by changing employers?

Yes

No

Don't know

l) Who decides what time you start and leave work?

Flexitime system  Employer decides

I decide, within certain limits  Negotiated with employer

m) Does your job require you to design and plan important aspects of your own work, or is your work largely specified for you?

I am required to design/plan my work  Work is largely specified by others  Other

n) How much influence do you personally have in deciding what tasks you are to do?

A great deal  A fair amount

Not much  None

C2. What are the main reasons you work? (tick all that apply)

**Yes**

- |   |                                |
|---|--------------------------------|
| a) financial, I am important as a breadwinner | <input type="text" value="1"/> |
| b) financial, for family extras               | <input type="text" value="1"/> |
| c) career                                     | <input type="text" value="1"/> |
| d) enjoyment                                  | <input type="text" value="1"/> |
| e) to get out of the home                     | <input type="text" value="1"/> |
| f) other (please tick & describe)             | <input type="text" value="1"/> |

.....

C3. Are you working at the same status as you did before the study child was born?

didn't work before

no, lower level

yes, same level

no, higher level

C4. Do you find your job satisfying?

Yes

No

Sometimes

C5. Do you wish that you could generally spend more time with your study child?

yes, often

yes, sometimes

yes, but rarely

no, not at all

C6. a) How do you usually travel to work? (Tick all that apply)

**Yes**

**Work at home**

i) public transport (bus, train)

→ Go to C7 on page 22

ii) car

iii) cycle

iv) walk

v) other

(please tick and describe)

.....

b) How long does it usually take:

	Less than 15 mins	15-29 mins	30-59 mins	An hour or more
i) to travel to work	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>
ii) to travel home from work	<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

C7. Please list all jobs you have had since your study child's 7th birthday, apart from your present job if you are currently working.

Age of child at start of job	Job	Hours worked in usual week
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

**If you are working now please go to Question C9 on page 23**

**If you are not working now:**

C8. Have you chosen not to work so that you can stay at home with your children?

No  Yes  → If yes, go to C9 on page 23

**If no,**

a) Have you been looking for work? Yes  No  → If no, go to C8c on page 23

**If yes**

b) How long have you been seeking work?   months → now go to C9 on page 23

c) If you have not been looking for work, please give reasons (tick all that apply):

- |                           |                          |                                    |                          |
|---------------------------|--------------------------|------------------------------------|--------------------------|
| (i) do not want to work   | <input type="checkbox"/> | (iv) not well enough               | <input type="checkbox"/> |
| (ii) looking after family | <input type="checkbox"/> | (v) other (please tick & describe) | <input type="checkbox"/> |
| (iii) retired             | <input type="checkbox"/> | .....                              |                          |

C9. In the past 2 years have you taken any courses or educational training?

- |                                   | Yes                      | No                       |
|-----------------------------------|--------------------------|--------------------------|
| a) training within my job         | <input type="checkbox"/> | <input type="checkbox"/> |
| b) evening classes                | <input type="checkbox"/> | <input type="checkbox"/> |
| c) university course              | <input type="checkbox"/> | <input type="checkbox"/> |
| d) other (please tick & describe) | <input type="checkbox"/> | <input type="checkbox"/> |

.....

C10. What is your job like? (If you are no longer working answer for your most recent job)

- |  | Yes,<br>always           | Yes,<br>mostly           | Some-<br>times           | Not<br>very<br>often     | Never<br>↓               |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) Do you enjoy your job?                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Do you have problems at work?           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Are the people at your work friendly?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Are the people at your work supportive? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Is it very noisy?                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Do you work in a smoky atmosphere?      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**THANK YOU VERY MUCH FOR YOUR HELP**

**SECTION D:**

D1. This questionnaire was completed by: (Please tick all that apply)

**Yes**

a) child's biological father

☐

b) mother's husband/male partner

☐

c) mother's female partner

☐

d) someone else  
(please describe)

☐

.....

D2. Do you live in the same house as the study child?

Yes

☐

No

☐

D3. Please give the date on which you completed this questionnaire:

day

month

year

D4. Please give your date of birth:

day

month

year

19

D5. Please give your study child's date of birth:

day

month

year

199

Space for any additional comments you would like to make.

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

When completed, please return the questionnaire to:

**Professor Jean Golding  
Children of the Nineties – ALSPAC  
Institute of Child Health  
24 Tyndall Avenue  
Bristol, BS8 1BR Tel: Bristol 9285007**

For office use only:  
coder

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