Questionnaire No:

YOUR ENVIRONMENT

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

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

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

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

THANK YOU VERY MUCH FOR YOUR HELP

23/01/92

Recycled Paper

FILLING IN THIS BOOKLET

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

For example

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

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

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

Sometimes there are questions with if in front of them.

For example

a) Have you been to the supermarket today?

Yes [1] No [2 ✓]

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

b) If yes, did you buy any carrots?

Yes [1] No [2]

In general, though, each question needs an answer.

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

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

SECTION A: YOUR HOME ENVIRONMENT

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

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

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

...../...../19....

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

A3. Is your home:

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

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For office use

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

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

.....

For office use

A5. Do you currently live in:

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

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For office use

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

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

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

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

A8. In your home do you ever use:

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

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For office use

E8. If your home is centrally heated in winter, please describe:

a) type:

solid fuel 1

oil 2

gas 3

electricity 4

other (please describe) 5 .....

b) how is heating distributed?

radiators 1 warm air 2 storage heaters 3

under floor heating 4 other 5 please describe .....

c) where is the boiler?

kitchen 1 living room 2 other (please describe) 3 no boiler 4

.....

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

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

.....

For office use

A11. a) Do you use gas for cooking?

yes, ring only 1

yes, oven only 2

yes, rings and oven 3

no, not at all 4

b) Do you use the cooker for any other purpose than cooking (eg. drying clothes, heating the room)?

Yes 1 No 2

If yes, please describe: .....

c) How old is your cooker?

more than 10 years old 1

5 - 10 years old 2

2 - 4 years old 3

less than 2 years old 4

don't know 9

A11. d) Does your home have the following?

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

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

i) number of living rooms: ☐☐

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

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

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

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

Yes 1 No 2

If no,

A13. b) where is the nearest working telephone that you can use in an emergency?

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

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

Yes [1] No [2]

If yes,

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

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

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

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

A15. b) In winter:

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

c) at night the window in my bedroom is:

almost always open 1
sometimes open 2
almost never open 3

d) Are any of your windows double glazed?

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

A16. a) Do you have any pets?

Yes 1 No 2

If no, go to A17.

If yes,

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

	Number
i) cats	
ii) dogs	

		Number
A16. b) iii)	rabbits	
iv)	rodents (mice, hamster, gerbil, etc.)	
v)	birds (budgerigar, parrot, etc)	
vi)	other pets (please describe)	

For office use

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

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

For office use

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

Yes [1] No [2]

If no, go to A19.a

If yes,

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

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

c) How much of a problem is mould?

no mould	1
not serious	2
fairly serious	3
very serious	4

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

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

A18.

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

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

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

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

no leaks	1
yes, slight leaks	2
yes, serious leaks	3

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

satisfied	1
fairly satisfied	2
dissatisfied	3
very dissatisfied	4

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

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

For office use

Which room(s)? .....

SECTION B: CHEMICALS AND MEDICINES IN YOUR ENVIRONMENT

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

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

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For office use

B2. Please describe any pills, medicines and ointments you have taken or used **since the beginning of this pregnancy.**

For office use

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

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

B3. a) How many cigarettes a day do you smoke at the moment? ☐☐

b) What brand do you usually smoke? For office use ☐☐☐

.....

c) What is the packet colour and tar rating of this brand?

.....

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

B4. a) Since you became pregnant have you changed how often you drink or smoke:

		Yes, went off it	**Yes, decided to cut down**	**Yes, craved more of it**	**Yes, decided to have more**	**No change**	**I never have this**
i)	tea	1	2	3	4	5	6
ii)	coffee	1	2	3	4	5	6
iii)	cola	1	2	3	4	5	6
iv)	alcoholic drinks	1	2	3	4	5	6
v)	cigarettes	1	2	3	4	5	6

B4. b) At present how much of the following do you usually drink in a day:

		Weekday	Weekend day	For office use
i)	ordinary tea (cups)	.....	.....	
ii)	decaffeinated tea (cups)	.....	.....	
iii)	coffee (cups)	.....	.....	
iv)	decaffeinated coffee (cups)	.....	.....	
v)	beer or lager (half-pints)	.....	.....	
vi)	wine (glasses)	.....	.....	
vii)	spirits (pub-measures)	.....	.....	
viii)	cola/pepsi (cans)	.....	.....	
ix)	decaffeinated cola/pepsi (cans)	.....	.....	
x)	other alcoholic drinks (pub measures)	.....	.....	
xi)	milk (glasses)	.....	.....	
xii)	other drinks (please describe)	.....	.....	
	.....			
	.....			

SECTION C: ELECTRICAL EQUIPMENT

C1. If you have any of the following equipment in your home **how often are you in the same room when it is in use:**

		Usually	Sometimes	Never	Do not have
a)	refrigerator	1	2	3	4
b)	washing machine	1	2	3	4
c)	tumble dryer	1	2	3	4
d)	dishwasher	1	2	3	4
e)	freezer	1	2	3	4
f)	microwave oven	1	2	3	4
g)	hoover/vacuum cleaner	1	2	3	4
h)	electrical deep fat fryer	1	2	3	4
i)	electric cooker	1	2	3	4
j)	electric kettle	1	2	3	4
k)	extractor fan	1	2	3	4
l)	ioniser	1	2	3	4

C2. Is your hot water tank <u>usually</u> heated electrically?

Yes [1] No [2]

C3. Do you have fluorescent lights (striplights) anywhere?

		Yes	No
i)	in the kitchen	[1]	[2]
ii)	in the bathroom	[1]	[2]
iii)	in other rooms	[1]	[2]

C4. a) <u>During this pregnancy</u>, at work were there:

		Yes	No	I did not go to work
i)	fluorescent lights	[1]	[2]	[7]
ii)	desk lamps	[1]	[2]	[7]
iii)	electric heaters	[1]	[2]	[7]

b) Do you tend to collect static electricity and have shocks when you touch metal?

Yes a lot [1] Yes occasionally [2] No not at all [3]

C5. Since the beginning of your pregnancy, at any time, how often have you used the following electrical equipment:

		Every day	3-6 days a week	Once or twice a week	Less than once a week	Not at all
a)	food mixer/liquidiser/ coffee grinder	1	2	3	4	5
b)	vacuum cleaner	1	2	3	4	5
c)	floor polisher	1	2	3	4	5
d)	iron	1	2	3	4	5
e)	hair dryer/hair curlers/ tongs	1	2	3	4	5
f)	electric typewriter	1	2	3	4	5
g)	photocopiers/fax machines	1	2	3	4	5
h)	personal computer or V.D.U.	1	2	3	4	5
i)	power tools	1	2	3	4	5
j)	sun bed/sun lamp	1	2	3	4	5
k)	microwave oven	1	2	3	4	5
C5. l)	other electric equipment (please describe)	1	2	3	4	5

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For office use

C6. How many hours a day are you in a room in which the following are switched on:

	Over 6 hours a day	3 - 6 hours a day	1 - 2 hours a day	Less than 1 hour a day	No not at all
a) TV	1	2	3	4	5
b) video recorder	1	2	3	4	5
c) radio	1	2	3	4	5
d) record player, CD or tape recorder	1	2	3	4	5

C7. Do you use any of the following electrical equipment in these rooms:

	Kitchen		Living room		Your bedroom		Other room	
	Yes	No	Yes	No	Yes	No	Yes	No
a) radio	1	2	1	2	1	2	1	2
b) fridge	1	2	1	2	1	2	1	2
c) freezer	1	2	1	2	1	2	1	2
d) television	1	2	1	2	1	2	1	2
e) video recorder	1	2	1	2	1	2	1	2
f) electric fire	1	2	1	2	1	2	1	2
g) fan heater	1	2	1	2	1	2	1	2
h) oil-filled radiator	1	2	1	2	1	2	1	2
i) under-floor heating	1	2	1	2	1	2	1	2
j) storage heater	1	2	1	2	1	2	1	2
k) other electric heater (please describe)	1	2	1	2	1	2	1	2

.....

For office use

C8. Would you say that you are the sort of person who feels the cold more than most?

yes, definitely [1] yes, but only recently [2] no [3]

C9. a) Do you own an electric blanket?

yes, over blanket [1] yes, under blanket [2] no [3] → **If no go to Section D**

If yes,

b) how old is it?

less than 1 year [1] 1-2 years [2] 3-4 years [3]

5 years or more [4] don't know [9]

c) how often do you keep it switched on while you are in bed?

i) in winter:

usually [1] sometimes [2] never [3]

ii) in summer:

usually [1] sometimes [2] never [3]

d) have you kept it on while you were in bed this pregnancy?

Yes [1] No [2]

SECTION D: THINGS YOU DO

D1. Since you became pregnant, how often have you used any of the following, whether at work or as a hobby:

		Every day	Most days	About once a week	Less than once a week	Not at all
a)	dental amalgam	1	2	3	4	5
b)	ceramics/enamels	1	2	3	4	5
c)	dry cleaning fluids	1	2	3	4	5
d)	electroplating	1	2	3	4	5
e)	glues	1	2	3	4	5
f)	leather working	1	2	3	4	5
g)	fabric/textiles	1	2	3	4	5
h)	dyes	1	2	3	4	5
i)	insecticides	1	2	3	4	5
j)	plastics	1	2	3	4	5
k)	metal cleaners/degreasers, polishers	1	2	3	4	5
l)	petrol	1	2	3	4	5
m)	paint	1	2	3	4	5

		Every day	Most days	About once a week	Less than once a week	Not at all
D1. n)	photographic chemicals	1	2	3	4	5
o)	electrical wiring	1	2	3	4	5
p)	machining	1	2	3	4	5
q)	soldering	1	2	3	4	5
r)	radiation (x-ray or other)	1	2	3	4	5
s)	other chemicals (please specify)	1	2	3	4	5

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.....

D2. Since becoming pregnant how often have you done the following whether at work or as a hobby:

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

D3. What jobs have you had since the age of 16? Include part-time and voluntary work. If you have not worked write 'None'.

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

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

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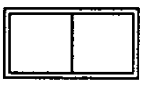

SECTION E: YOUR HOUSEHOLD

E1. a) How many people live in your household? (including yourself)

i) ☐☐ adults (over 18 years)

ii) ☐☐ young adults (16 - 18 years)

iii) ☐☐ children (0 - 15 years)

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

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

.....

For office use ☐☐

E2. a) Do you currently have a partner?

yes, husband 1

yes, other male partner 2

no, not at all 3

other (please describe) 4

.....

For office use ☐☐

If no, go to Question E4.

If yes,

E2. b) is your partner the father of your unborn child?

Yes [1] No [2] Not sure [3]

c) does your partner live with you?

Yes [1] No [2]

If your partner does live with you:

d) how long have you lived together?

[ ][ ] years [ ][ ] months

E3. How would you assess your partner's physical health

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

E4. a) What is your present marital status?

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

E4. b) If <u>married</u>, what was the date of the most recent marriage?

...../...../19....

(if never married, put NA for not applicable)

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

E5. Please indicate how many of the children (aged 18 or under) living with you have:

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

For office use

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E6. Are there other children of yourself or your partner who do not live with you?

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

E7. a) Do any of the people living in your household, including yourself and your children have a long lasting disorder, illness or disabling condition? (e.g. asthma, epilepsy, arthritis, depression)

Yes [1] No [2]

If yes, please describe:

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

.....

c) person involved: .....

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

.....

SECTION F: YOUR SOCIAL ENVIRONMENT

F1. a) What do you think of your neighbourhood as a place to live?

a very good place to live	1
a fairly good place to live	2
not a very good place to live	3
not at all a good place to live	4

b) Do the other people in your neighbourhood:

		No,never	Rarely	Sometimes	Often	Always
i)	visit your home	1	2	3	4	5
ii)	argue with you	1	2	3	4	5
iii)	look after your children	1	2	3	4	5
iv)	keep to themselves	1	2	3	4	5

c) Do you:

		No,never	Rarely	Sometimes	Often	Always
i)	visit the home of your neighbours	1	2	3	4	5
ii)	argue with your neighbours	1	2	3	4	5
iii)	look after your neighbours children	1	2	3	4	5
iv)	keep to yourself	1	2	3	4	5

F2. How worried are you that in your neighbourhood:

		Very worried	Fairly worried	Not very worried	Not at all worried	Don't know
a)	you might have your home broken into and something stolen	1	2	3	4	9
b)	you might be mugged or robbed	1	2	3	4	9
c)	you might be sexually assaulted or pestered	1	2	3	4	9
d)	you might have your home or property damaged by vandals	1	2	3	4	9

F3. Is your neighbourhood:

		Yes usually	Yes sometimes	No not at all
i)	lively	1	2	3
ii)	friendly	1	2	3
iii)	noisy	1	2	3
iv)	clean	1	2	3
v)	attractive	1	2	3
vi)	polluted/dirty	1	2	3

SECTION G

G1. Please put the date of completing this questionnaire:

day		month		year			
				1	9	9	

G2. Please give your date of birth:

day		month		year			
				1	9		

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

Space for any comments you might like to make:

VERY MANY THANKS FOR ALL YOUR HELP

When completed, return the questionnaire to:

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

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

For office use only:

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