Questionnaire No:

YOU AND YOUR SURROUNDINGS

All answers are confidential

Hayley

Chris

Victoria

Hannah with brother Michael

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

23/07/01

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:

		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
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

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

…….

…….

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

		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
f)	gardening	☐ 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/ machine 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.

SECTION B: YOUR HOME

Below are a number of questions about your home. They are similar to some you answered 3 years ago, and will be used to see how your circumstances might have changed.

			month	year
B1.	a)	When did you move to your present address?	☐☐	☐☐☐☐
	b)	How many times have you moved home since your study child was 7 years old ?	☐☐	

B2. Is your home:

being bought/mortgaged	☐ 0
being bought from council	☐ 1
owned - with no mortgage to pay	☐ 2
rented from council	☐ 3
rented from private landlord - furnished	☐ 4
rented from private landlord - unfurnished	☐ 5
rented from housing association	☐ 6
other (please tick & describe)	☐ 7

.....

B3. If you know your council tax band (A,B,C etc.) please write it here ☐

B4. Do you live in your own home or do you live with your parents or others?

live in own home	☐ 1
live in partner's home	☐ 2
live with your parents in their home	☐ 3
live with your partner's parents in their home	☐ 4
other situation (please tick & describe)	☐ 5

.....

B5. Do you currently live in:

a whole detached house (or bungalow)	1
a whole semi-detached house/bungalow	2
an end of terrace house	3
a whole terraced house	4
a flat/maisonette (self contained)	5
room in someone else's house	6
other (please tick & describe)	7

.....

B6. What is the lowest level of your living accommodation:

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

B7. 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) the room where the study child sleeps	1	2	3	4	5

B8. Does your home have the following?

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

B9. Apart from the kitchen, how many rooms do you have for living and/or sleeping ? ☐☐

B10. Do you have sole use of the following amenities or are they shared with other household(s)?

		Yes sole use	Yes shared	No, don't have at all
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

B11. a) Is there a working telephone in your home (include mobiles)?

No 1 — Yes, but for incoming calls only 2 → **please go to B11b on page 9**

Yes, a fully working phone or mobile phone 3 → **If <u>yes</u>, go to B12a on page 9**

If <u>no</u>,

B11. 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 (please tick & describe) [5]

.....

B12. a) Is there ever any damp, condensation or mould in your home?

Yes [1] No [2] → **If <u>no</u>, go to B13a on page 10**

If <u>yes</u>,

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]

B13. 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

B14. Taking everything into account, which of the following best describes your feeling about your home?

satisfied	1
fairly satisfied	2
dissatisfied	3
very dissatisfied	4

B15. 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	1	2	3	4
b) stripped wallpaper	1	2	3	4
c) removed paint or varnish	1	2	3	4

B16. **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)	wallpapered	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)	wallpapered	1	2	9
iii)	new carpet	1	2	9
iv)	new furniture	1	2	9
c)	**The room the study child sleeps in:**			
i)	painted	1	2	9
ii)	wallpapered	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)	wallpapered	1	2	9
iii)	new carpet	1	2	9
iv)	new furniture	1	2	9

which room (s)?.....

B17. How would you rate **your home** in relation to that of other homes with children?

a)

much cleaner	1
a bit cleaner	2
about the same	3
less clean	4
much less clean	5
don't know	9

b)

much tidier	1
a bit tidier	2
about the same	3
less tidy	4
much less tidy	5
don't know	9

B18. 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 and your family:

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

.....

.....

B19. a) Do the other people in your neighbourhood:

		No, never	**Rarely**	**Some-times**	**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

b) Do you:

		No, never	**Rarely**	**Some-times**	**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 neighbour's children	1	2	3	4	5
iv)	keep to yourself	1	2	3	4	5

B20. 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

B21. How heavy is the traffic on the street where you live?

very heavy	1
quite heavy	2
not very heavy	3
hardly any traffic	4

B22. To heat your home in winter what methods do you mainly use?
(Please tick all boxes that apply)

		(i) In main living room	(ii) In study child's bedroom	(iii) In other rooms
a)	central heating or storage heaters	1	1	1
b)	wood stoves or wood fires	1	1	1
c)	coal fires	1	1	1
d)	paraffin heaters	1	1	1
e)	gas fires (mains gas)	1	1	1
f)	gas fires (bottled gas)	1	1	1
g)	other type of heating (please tick & describe)	1	1	1
	…….		…….	…….
h)	no heating in this room	1	1	1

B23. If your home is centrally heated in winter, please describe:

a) type:

solid fuel [1]

oil [2]

gas [3]

electricity [4]

other (please tick & describe) [5] ……

no central heating [7] → **Go to B24 below**

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] no boiler [3]

other (please tick & describe) [4] ……

B24. a) Do you use gas for cooking?

Yes, ring(s) only [1]

yes, oven only [2]

yes, rings and oven [3]

no, not at all [4]

b) Do you use the cooker (whether gas or electric) for any other purpose than cooking (e.g. drying clothes, heating the room)?

Yes ☐ 1 No ☐ 2 Don't have a cooker ☐ 7 → **go to B25 below**

If <u>yes</u>, please describe: …….

c) How old is your cooker?

more than 20 years	☐ 1
10-19 years old	☐ 2
5-9 years old	☐ 3
2-4 years old	☐ 4
less than 2 years old	☐ 5
don't know	☐ 6

d) When you first got your present cooker – was it:

brand new ☐ 1 second hand ☐ 2

B25. When someone is cooking, how often do they get rid of the smells and steam in the kitchen using the following:

	Usually	**Sometimes**	**Not at all**	**Never cook**
a) open windows	☐ 1	☐ 2	☐ 3	☐ 7
b) ventaxia/air extractor	☐ 1	☐ 2	☐ 3	
c) extractor hood which vents to outside	☐ 1	☐ 2	☐ 3	**Go to B26 on page 18**
d) extractor hood that doesn't vent to outside	☐ 1	☐ 2	☐ 3	
e) other (please tick and describe)	☐ 1	☐ 2	☐ 3	

…….

B26. 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 <u>summer</u>:**				
i)	day	1	2	3	4
ii)	night	1	2	3	4
b)	**In <u>winter</u>:**				
i)	day	1	2	3	4
ii)	night	1	2	3	4

c) Are any of your windows double glazed? (including secondary double glazing)

yes, all of them 1 yes, some of them 2

no, none of them 3 don't know 9

d) Does your home have chimneys?

Yes 1 No 2

e) **If <u>yes</u>,** have they been blocked up?

yes, all of them 1 yes, some of them 2

no 3 don't know 9

B27. Do you use a thermometer or thermostat to help keep the temperature at the level you want in winter?

a) In main living room:

thermostat on radiators 1 room thermostat 2 room thermometer 3

none of these 4 other 5 (please describe) …….

b) In your study child's bedroom:

thermostat on radiators ☐1 room thermostat ☐2 room thermometer ☐3

none of these ☐4 other ☐5 (please describe) …….

c) What temperature do you try to maintain in winter? (If you don't try to maintain any particular temperature put 97)

(i) in living rooms ☐☐ day ☐☐ night

(ii) in room where your study child sleeps ☐☐ day ☐☐ night

B28. a) This question is about whether various appliances in your home were fitted by professionals or by you, your family or friends.

		Fitted by professionals			
		Yes	**No**	**Don't know**	**Don't have this**
(i)	central heating boiler	☐1	☐2	☐3	☐7
(ii)	gas fires	☐1	☐2	☐3	☐7
(iii)	cooker	☐1	☐2	☐3	☐7

b) Do you have these appliances regularly serviced?

		Regularly serviced	**Serviced occasionally**	**Not serviced**	**Don't have this**
(i)	central heating boiler	☐1	☐2	☐3	☐7
(ii)	gas fires	☐1	☐2	☐3	☐7
(iii)	cooker	☐1	☐2	☐3	☐7

B29. Do you have a tumble dryer?

yes, gas [1] yes, electric [2] no, don't have [3]

B30. a) How often do you drive a car, van or lorry ?

almost every day [1] 2-5 times a week [2] once a week [3] rarely [4]

never [5] → **Go to Section C on page 21**

b) What type of fuel is used?

diesel [1] lead free petrol [2] other petrol [3]

SECTION C: YOUR HOUSEHOLD

C1. a) How many people live in your household now? (including yourself)

i) ☐☐ adults (over 18 years)

ii) ☐☐ young adults (16-18 years)

iii) ☐☐ children (less than 16 years)

b) Please indicate who the adults over 18 are:

		Yes
i)	yourself	☐ 1
ii)	your husband/partner	☐ 1
iii)	your parent(s)	☐ 1
iv)	your husband's/partner's parent(s)	☐ 1
v)	other relation(s) of yourself	☐ 1
vi)	other relation(s) of your husband/partner	☐ 1
vii)	friend(s)	☐ 1
viii)	lodger	☐ 1
ix)	other (please tick and describe)	☐ 1

.....

C2. a) Do you have a rule that smoking never happens in particular rooms?

no smoking in house at all	☐ 1
smoking only allowed in some rooms	☐ 2
smoking allowed anywhere	☐ 3

b) How many people living in your household (including yourself) are smokers? ☐☐

C3. a) What is your present marital status?

never married 1

widowed 2

divorced 3

separated 4

married (once only) 5

married for second or third time 6

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

day month year

C4. a) Does the biological (natural) father of the 10 year old study child live with the study child?

No 1 Yes 2 → **If <u>yes</u>, go to C4c on page 23**

If <u>no</u>,

b) i) How old was the child when the natural father stopped living with the child?

months

(put 00 if the father never lived with the child)

ii) How often does the natural father see the study child?

not at all 1

less than once a month 2

about once a month 3

about once a fortnight 4

once or twice a week 5

nearly every day 6

child's father is dead 7

Go to C4c on page 23

C4. b) iii) Does he help support the child financially?

yes, on a regular basis [1]

yes, occasionally [2]

no [3]

c) Does the biological (natural) mother of the 10 year old study child live with the study child?

No [1] Yes [2] → **If <u>yes</u>, go to C5 on page 24**

If <u>no</u>,

i) How old was the child when the natural mother stopped living with the child?

[ ][ ] months

(put 00 for from birth)

ii) How often does the natural mother see the study child?

not at all [1]

less than once a month [2]

about once a month [3]

about once a fortnight [4]

once or twice a week [5]

nearly every day [6]

child's mother is dead [7]

↓

Go to C5 on page 24

iii) Does she help support the child financially ?

yes, on a regular basis [1]

yes, occasionally [2]

no [3]

To make the questions less complicated, for the rest of this section, for **partner** we mean **husband or partner.**

C5. Please indicate how many of the children living in your household have:

		Number of children
a)	you and your partner as their natural parents	☐☐
b)	their natural mother present (but their natural father is not present)	☐☐
c)	the natural father present (but not their natural mother)	☐☐
d)	neither natural parent present (please describe whether you have adopted, fostered etc.)	☐☐

.....

C6. Are there other children of yourself or your partner who visit (whether to play or to stay)?

		No	**Yes**	**Number of children**
a)	Children of my partner but not me	☐ 1	☐ 2 →	☐☐
b)	Children of myself but not my partner	☐ 1	☐ 2 →	☐☐
c)	Children of me and my partner	☐ 1	☐ 2 →	☐☐

C7. Do any of the people living in your household, including yourself and your study child, have a chronic illness or disabling condition (for example asthma, arthritis, epilepsy, depression)

Yes ☐ 1 No ☐ 2 → **If <u>no</u>, go to C8 on page 25**

If <u>yes</u>, please describe:

<u>Nature of condition(s)</u>	**<u>Person(s) involved</u>** (state relationship to you - husband/ partner, child, mother, etc.)
.....	.....
.....	.....
.....	.....
.....	.....

C8. a) Do you have any pets in the household?

Yes ☐ 1 No ☐ 2 → **If <u>no</u>, go to C9 below**

If <u>yes</u>,

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

		Number	
i)	cats	☐☐	
ii)	dogs	☐☐	
iii)	rabbits	☐☐	
iv)	rodents (mice, hamster, gerbil etc.)	☐☐	
v)	birds (budgerigar, parrot, etc.)	☐☐	
vi)	fish	☐☐	
vii)	turtles/tortoises/terrapins	☐☐	
viii)	other pets (please say how many and describe)	☐☐	.....

C9. **The other children in the household:**

How many brothers and sisters does your 10 year old study child have that **live with you or visit at least 1 day a week?** (include half-brothers and half sisters, step-brothers and step-sisters, fostered or adopted children.)

	Brothers	**Sisters**
a) younger	☐☐	☐☐
b) same age (e.g. twin of the study child)	☐	☐
c) older	☐☐	☐☐

C10. How would you describe the noise level in your home?

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

SECTION D: PILLS AND POTIONS

D1. 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 30.

			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**
a) Headache or or migraine	1	i) ……..…….. →	1	2	3	4
		ii) ……..…….. →	1	2	3	4
b) Backache	1	i) ……..…….. →	1	2	3	4
		ii) ……..…….. →	1	2	3	4
c) Period pain	1	i) ……..…….. →	1	2	3	4
		ii) ……..…….. →	1	2	3	4
d) Other pain	1	i) ……..…….. →	1	2	3	4
		ii) ……..…….. →	1	2	3	4
e) Indigestion	1	i) ……..…….. →	1	2	3	4
		ii) ……..…….. →	1	2	3	4
f) Nausea	1	i) ……..…….. →	1	2	3	4
		ii) ……..…….. →	1	2	3	4

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
g) Vomiting	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
h) Diarrhoea	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
i) Piles or haemorrhoids	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
j) Constipation	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
k) Depression	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
l) Anxiety or nerves	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
m) Sleeping	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
n) Psoriasis	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
o) Eczema	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4

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
p) Asthma	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
q) Hay fever	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
r) Other allergies	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
s) Sore throat	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
t) Cough	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
u) A cold	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
v) Flu	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
w) Other infection	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4

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) Thrush	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
y) Cystitis	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
z) Diabetes	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
za) Epilepsy	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
zb) High blood pressure	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
zc) Oral contraceptive	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
zd) HRT (hormone replacement therapy)	1	i) ……..……	1	2	3	4
		ii) ……..……	1	2	3	4
ze) Other condition (please tick & describe)	1	……..……	1	2	3	4
zf) Other condition (please tick & describe)	1	……..……	1	2	3	4

Medicine, pills, drops, or 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
zg) Other condition (please tick & describe)	1	……..…… →	1	2	3	4
zh) Other condition (please tick & describe)	1	……..…… →	1	2	3	4
zi) Took/used no medicines, pills, drops or ointment	1					

D2. 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	1	2	3
b)	Minerals (e.g. calcium, iron)	1	2	3
c)	Oil supplements e.g. fish oils, evening primrose oil	1	2	3
d)	Other supplements e.g. Ginseng	1	2	3

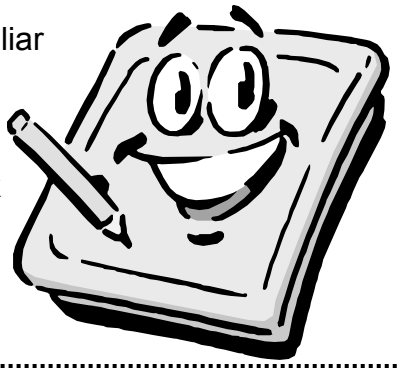
D3. Please describe below any vitamins, minerals such as iron or calcium or other supplements taken for your health in the **past month** and indicate how often you used them.

	Every day	Most days	About 1-2 times a week	Less than once a week	Not at all
a) **Vitamins** (Please say which vitamins and give brand name)					
i) ……	1	2	3	4	5
ii) ……	1	2	3	4	5
iii) ……	1	2	3	4	5

	Every day	Most days	About 1-2 times a week	Less than once a week	Not at all
b) **Mineral supplements** (Please say which minerals e.g. iron, calcium, and give brand name)					
i) ……	1	2	3	4	5
ii) ……	1	2	3	4	5
iii) ……	1	2	3	4	5
c) **Oil supplements** (Please say which, e.g. fish oils, Evening Primrose oil, and give brand name)					
i) ……	1	2	3	4	5
ii) ……	1	2	3	4	5
iii) ……	1	2	3	4	5
d) **Other supplements** (Please say which, e.g. Ginseng, Royal Jelly, and give brand name)					
i) ……	1	2	3	4	5
ii) ……	1	2	3	4	5
iii) ……	1	2	3	4	5

Some of these questions may seem familiar

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



SECTION E: YOUR OCCUPATION AND LIFESTYLE

E1. 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 E8 on page 38**
(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

→ **Now go to (iii) below**

no, stopped & started again 3

no, do not work now 4

i) when did you last stop? **month** ☐☐ **year** ☐☐☐☐ → **If do not work now go to E7 on page 38**

ii) when did you start again? **month** ☐☐ **year** ☐☐☐☐

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 ☐1 No, usually work more hours ☐2 No, usually work less hours ☐3

If no,

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

d) Does your work include weekends?

Yes, usually ☐1 Yes, sometimes ☐2 No, never ☐3

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

Yes, often ☐1 Yes, sometimes ☐2 No ☐3

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

very little effort, mostly sitting ☐1

some physical effort ☐2

quite a lot of physical effort ☐3

considerable physical effort ☐4

g) Do you usually work:

the basic no. of hours per week	1
basic hours plus paid overtime	2
longer than basic hours (but not paid extra)	3
self-employed - as long as necessary	4

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

Monthly salary plus performance	1	Monthly salary only	2	Weekly wage	3
Hourly paid	4	Piecework	5		
Self-employed	6	Other (please describe)	7	……	

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

Yes	1	No	2	Don't know	9

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

Less than one week	1	1, 2 or 3 weeks	2	1 or 2 months	3
3 months or more	4	not relevant (self-employed)	5	Don't know	9

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

Yes	1	No	2	Don't know	9

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

Flexitime system [1] Employer decides [2]

I decide, within certain limits [3] Negotiated with employer [4]

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 [1] Work is largely specified by others [2] Other [3]

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

A great deal [1] A fair amount [2]

Not much [3] None [4]

E2. What are the main reasons you work? (tick all that apply)

	Yes
a) financial, I am important as a breadwinner	[1]
b) financial, for family extras	[1]
c) career	[1]
d) enjoyment	[1]
e) to get out of the home	[1]
f) other (please tick & describe)	[1]

.....

E3. Are you working at the same status as you did before the study child was born?

didn't work before [7]

no, lower level [1]

yes, same level [2]

no, higher level [3]

E4. Do you find your job satisfying?

Yes [1] No [2] Sometimes [3]

E5. Do you wish that you could generally spend more time with your study child?

yes, often [1]

yes, sometimes [2]

yes, but rarely [3]

no, not at all [4]

E6. a) How do you usually travel to work? (Tick all that apply)

	Yes	**Work at home**	
i) public transport (bus, train)	[1]	[7]	→ **Go to E7 on page 38**
ii) car	[1]		
iii) cycle	[1]		
iv) walk	[1]		
v) other (please tick and describe)	[1]		…….

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	1	2	3	4
ii)	to travel home from work	1	2	3	4

E7. 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 E9 on page 39

If you are not working now:

E8. Have you chosen not to work so that you can stay at home with your children?

No [1] Yes [2] → **If yes, go to E9 on page 39**

If no,

a) Have you been looking for work? Yes [1] No [2] → **If no, go to E8c on page 39**

If yes

b) How long have you been seeking work? [ ][ ] months → **now go to E9 on page 39**

E8. c) If you have <u>not</u> been looking for work, please give reasons (tick all that apply):

(i)	do not want to work	1	(iv)	not well enough	1
(ii)	looking after family	1	(v)	other (please tick & describe)	1
(iii)	on maternity leave	1		……	

E9. In the past 2 years have you taken any courses or educational training?

		Yes	**No**
a)	training within my job	1	2
b)	evening classes	1	2
c)	university course	1	2
d)	other (please tick & describe)	1	2

.....……

E10. What is your job like? (If you are no longer working answer for your most recent job)

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

Although we asked a lot about you when you were pregnant, now that we are looking at the ears and hearing of all the study children, we find there are some questions we need to ask.

Please think back to the time when you were pregnant with your 10 year old study child. If you find this impossible to remember please write NK beside the appropriate question.

If you are not the child's biological mother just tick N/A here:

N/A ☐

Then go straight to Section G on Page 56.

SECTION F: NOISE DURING PREGNANCY

Noise at work

F1. a) Were you exposed to noise at work during pregnancy? (not including guns/explosives)

Yes ☐1 No ☐2 → **If no, go to F2a on page 44**

If yes,

b) Describe what noisy job you had during pregnancy: …….

c) About how many months pregnant were you when you stopped work? ☐ months

d) List the different noisy tasks you were doing (or were going on really close to you) in your work, starting with the noisiest:

Task 1) ……

Task 2) ……

Task 3) ……

For Task 1

e) Approximately how many hours per week at work did you spend on Task 1?

☐☐ hours

f) What was the source of noise? ……..

g) When trying to talk to another worker (who was also used to the conditions), without wearing hearing protection what sort of voice did you have to use:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
ii) 2 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
iii) Close to your ear	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

h) After performing Task 1, did you notice any of the following effects on your hearing, and if so, were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	☐ 1	☐ 2	☐ 3
ii) Tinnitus (noises in the ear or head)	☐ 1	☐ 2	☐ 3

j) Did you wear hearing protection during Task 1?

Yes ☐ 1 No ☐ 2 → **If <u>no</u>, go to F1m on page 42**

If <u>yes</u>,

k) What type of hearing protection did you wear? …….

l) Approximately how many hours per week performing Task 1 did you wear hearing protection?

☐☐ hours

For Task 2

F1. m) Approximately how many hours per week at work did you spend on Task 2?

☐☐ hours

n) What was the source of noise? ……..

o) When trying to talk in this working environment to another worker (who was also used to the conditions), what sort of voice did you have to use:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
ii) 2 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
iii) Close to your ear	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

p) After performing Task 2, did you notice any of the following effects on your hearing, and if so, were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	☐ 1	☐ 2	☐ 3
ii) Tinnitus (noises in the ear or head)	☐ 1	☐ 2	☐ 3

q) Did you wear hearing protection during Task 2?

Yes ☐ 1 No ☐ 2 → **If <u>no</u>, go to F1t on page 43**

If <u>yes</u>,

r) What type of hearing protection did you wear? …….

s) Approximately how many hours per week performing Task 2 did you wear hearing protection?

☐☐ hours

For Task 3

F1. t) Approximately how many hours per week at work did you spend on Task 3?

☐☐ hours

u) What was the source of noise? ……..

v) When trying to talk in this working environment to another worker (who was also used to the conditions), what sort of voice did you have to use:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
ii) 2 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
iii) Close to your ear	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

w) After performing Task 3, did you notice any of the following effects on your hearing, and if so, were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	☐ 1	☐ 2	☐ 3
ii) Tinnitus (noises in the ear or head)	☐ 1	☐ 2	☐ 3

x) Did you wear hearing protection during task 3?

Yes ☐ 1 No ☐ 2 → **If <u>no</u>, go to F2a on page 44**

If <u>yes</u>,

y) What type of hearing protection did you wear? …….

z) Approximately how many hours per week performing Task 3 did you wear hearing protection?

☐☐ hours

Social noise exposure during pregnancy

F2. a) Did you attend pop/rock concerts with live amplified music during pregnancy?

Yes ☐ 1 No ☐ 2 → **If no, go to F3a below**

If yes,

b) About how many times during pregnancy? ☐☐ times

c) Roughly how many hours did you spend at each concert? ☐☐ hours

d) If you were with another person at a concert, how loud did you have to talk to understand each other:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
ii) 2 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
iii) Close to your ear	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

e) Did you notice any of the following effects on your hearing after attending concerts, and if so, were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	☐ 1	☐ 2	☐ 3
ii) Tinnitus (noises in the ear or head)	☐ 1	☐ 2	☐ 3

F3. a) Did you attend nightclubs or discos with music amplified through speakers during pregnancy?

Yes ☐ 1 No ☐ 2 → **If no, go to F4a on page 45**

If <u>yes</u>,

F3. b) For approximately how many hours per day? ☐☐ hours/ day

c) For approximately how many days per week? ☐ days/week

d) About how many months pregnant were you when you stopped doing this? ☐ months

e) To talk with another person at a nightclub (at the place in the nightclub where you spend most of the time), how loud did you have to talk to understand each other:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
ii) 2 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
iii) Close to your ear	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

f) Did you notice any of the following effects on your hearing after attending nightclubs, and if so, were they temporary or permanent?

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	☐ 1	☐ 2	☐ 3
ii) Tinnitus (noises in the ear or head)	☐ 1	☐ 2	☐ 3

F4. a) During pregnancy, did you listen to music using earphones with a personal music system or hi-fi?

Yes ☐ 1 No ☐ 2 → **If <u>no</u>, go to F5a on page 46**

If yes, when you did so:

F4. b) For approximately how many hours per day? ☐☐ hours/day

c) For approximately how many days per week? ☐ days/week

d) When with another person while you were listening to music using earphones, with the volume at your normal level, how loud did they have to talk for you to understand them:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
ii) 2 feet away from you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
iii) Close to your ear	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

e) Did you notice any of the following effects on your hearing after listening to music using earphones, and were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	☐ 1	☐ 2	☐ 3
ii) Tinnitus (noises in the ear or head)	☐ 1	☐ 2	☐ 3

F5. a) During pregnancy, did you listen to the TV or computer games using earphones?

Yes ☐ 1 No ☐ 2 → **If no, go to F6a on page 47**

If yes,

b) For approximately how many hours per day? ☐☐ hours/day

c) For approximately how many days per week? ☐ days/week

F5. d) On average, to communicate with another person while you were listening to the TV/computer games using earphones, with the volume at your normal listening level, how loud did they have to talk for you to understand them:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	1	2	3	4	5
ii) 2 feet away from you	1	2	3	4	5
iii) Close to your ear	1	2	3	4	5

e) Did you notice any of the following effects on your hearing after listening to the TV/computer games using earphones, and were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	1	2	3
ii) Tinnitus (noises in the ear or head)	1	2	3

F6. a) During pregnancy, did you listen to music through speakers (in your home or elsewhere)?

Yes 1 No 2 → **If no, go to F7a on page 48**

If yes,

b) Approximately how many hours per day? ☐☐ hours/day

c) Approximately how many days per week? ☐ days/week

F6. d) On average, to communicate with another person while you were listening to music through speakers, with the volume at your normal listening level, how loud did you have to talk to understand each other:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	1	2	3	4	5
ii) 2 feet away from you	1	2	3	4	5
iii) Close to your ear	1	2	3	4	5

e) Did you notice any of the following effects on your hearing after listening to music through speakers, and were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	1	2	3
ii) Tinnitus (noises in the ear or head)	1	2	3

F7. a) During pregnancy, did you listen to in-car music?

Yes 1 No 2 → **If <u>no</u>, go to F8a on page 49**

If <u>yes</u>,

b) For approximately how many hours per day? ☐☐ hours/day

c) For approximately how many days per week? ☐ days/week

F7. d) On average, to communicate with another person in the car, with the volume at your normal listening level, how loud did you have to talk to understand each other:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	1	2	3	4	5
ii) 2 feet away from you	1	2	3	4	5
iii) Close to your ear	1	2	3	4	5

e) Did you notice any of the following effects on your hearing after listening music in the car, and were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	1	2	3
ii) Tinnitus (noises in the ear or head)	1	2	3

F8. a) During pregnancy did you carry out DIY using power tools?

Yes 1 No 2 → **If <u>no</u>, go to F9a on page 50**

If <u>yes</u>,

b) For approximately how many hours in total? ☐☐ hours

c) About how many months pregnant were you when you did it for the last time? ☐ months

F8. d) On average, to communicate with another person whilst using power tools, how loud did you have to talk to understand each other:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	1	2	3	4	5
ii) 2 feet away from you	1	2	3	4	5
iii) Close to your ear	1	2	3	4	5

e) Did you notice any of the following effects on your hearing after using power tools, and were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	1	2	3
ii) Tinnitus (noises in the ear or head)	1	2	3

F9. a) During pregnancy, did you ride a motor cycle?

Yes 1 No 2 → **If <u>no</u>, go to F10a on page 51**

If <u>yes</u>,

b) About how many hours per day? ☐☐ hours/day

c) For approximately how many days per week? ☐ days/week

d) How many months pregnant were you when you did this for the last time? ☐ months

e) Did you notice any of the following effects on your hearing after riding a motor cycle, and were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	1	2	3
ii) Tinnitus (noises in the ear or head)	1	2	3

F10. a) During pregnancy, apart from guns and explosions, were you exposed to any other loud noise?

Yes [1] No [2] → **If no, go to F11a below**

If yes,

b) Please give details ……..

c) For approximately how many hours per day? [ ][ ] hours/day

d) For approximately how many days per week? [ ] days/week

e) On average, to communicate with another person how loud did you have to talk to understand each other:

When they were:	**Normal voice**	**Raised voice**	**Very loud voice**	**Shout**	**Impossible to communicate**
i) 4 feet away from you	[1]	[2]	[3]	[4]	[5]
ii) 2 feet away from you	[1]	[2]	[3]	[4]	[5]
iii) Close to your ear	[1]	[2]	[3]	[4]	[5]

f) Did you notice any of the following effects on your hearing and were they temporary or permanent:

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	[1]	[2]	[3]
ii) Tinnitus (noises in the ear or head)	[1]	[2]	[3]

Gun shots during pregnancy

F11. a) Did you fire guns during pregnancy?

Yes [1] No [2] → **If no, go to F12 on page 54**

F11. b) Name the make and model of each gun you fired:

1. ……..

2. ……..

3. ……..

For Gun 1

F11. c) Approximately how many rounds did you fire during pregnancy? ☐☐☐

d) Did you wear hearing protection?

Yes ☐1 No ☐2 → **If no, go to F11g below**

If yes,

e) Which type of hearing protection did you use? ……

f) How many rounds did you fire wearing hearing protection? ☐☐☐

g) How many rounds did you fire without wearing hearing protection? ☐☐☐

h) Did you notice any immediate effect on your hearing after firing?

Yes ☐1 No ☐2 → **If no, go to F11 part l) at the top of page 53**

If yes,

i) Which ear?

Left ☐1 Right ☐2 Both ☐3

j) What was the effect?

Slight ☐1 Moderate ☐2 Severe ☐3

k) Was it a temporary or permanent effect?

Temporary ☐1 Permanent ☐2

For Gun 2

F11. l) Approximately how many rounds did you fire during pregnancy? ☐☐☐

m) Did you wear hearing protection?

Yes ☐1 No ☐2 → **If no, go to F11p below**

If yes,

n) Which type of hearing protection did you use? ……

o) How many rounds did you fire wearing hearing protection? ☐☐☐

p) How many rounds did you fire without wearing hearing protection? ☐☐☐

q) Did you notice any immediate effect on your hearing after firing?

Yes ☐1 No ☐2 → **If no, go to F11u below**

If yes,

r) Which ear?

Left ☐1 Right ☐2 Both ☐3

s) What was the effect?

Slight ☐1 Moderate ☐2 Severe ☐3

t) Was it a temporary or permanent effect?

Temporary ☐1 Permanent ☐2

For Gun 3

u) Approximately how many rounds did you fire during pregnancy? ☐☐☐

v) Did you wear hearing protection?

Yes ☐1 No ☐2 → **If no, go to F11y on page 54**

If <u>yes</u>,

F11. w) Which type of hearing protection did you use? ……

x) How many rounds did you fire wearing hearing protection? ☐☐☐

y) How many rounds did you fire without wearing hearing protection? ☐☐☐

z) Did you notice any <u>immediate</u> effect on your hearing after firing?

Yes ☐1 No ☐2 → **If <u>no</u>, go to F12 below**

If <u>yes</u>,

za) Which ear?

Left ☐1 Right ☐2 Both ☐3

zb) What was the effect?

Slight ☐1 Moderate ☐2 Severe ☐3

zc) Was it a temporary or permanent effect?

Temporary ☐1 Permanent ☐2

Explosions

F12. a) Were you exposed to any explosions during pregnancy?

Yes ☐1 No ☐2 → **If <u>no</u>, go to Section G on page 56**

If <u>yes</u>,

b) How many explosions ☐☐

c) Describe the type of explosion ……..

d) Did you wear hearing protection?

Yes ☐1 No ☐2

F12. e) Did you notice any of the following after any of the explosions?

	Yes temporary	**Yes permanent**	**No**
i) Dullness of hearing	1	2	3
ii) Tinnitus (noises in the ear or head)	1	2	3

SECTION G:

G1. This questionnaire was completed by: (Please tick all that apply)

		Yes
a)	child's biological mother	1
b)	child's mother figure	1
c)	someone else (please describe)	1 .....

G2. Do you live in the same house as the study child?

Yes 1 No 2

G3. Please give the date on which you completed this questionnaire:

day month year

2 0 0

G4. Please give your date of birth:

day month year

19

G5. Please give your study child's date of birth:

day month year

199

THANK YOU VERY MUCH FOR YOUR HELP

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 Int