



ABOUT YOURSELF

This questionnaire asks about your health, your partner, your home,
your childhood and your beliefs and attitudes. Your answers will help us to understand how
mothers' own health and background might affect their pregnancies.

All the answers you give are confidential. Your name and address will
not be on the questionnaire.

We would be grateful if you would help us by answering as many of these
questions as possible but if there is any question you do not want to answer that is
fine. Just leave it blank.

THANK YOU VERY MUCH FOR YOUR HELP

15/07/91

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 manually	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 MEDICAL HISTORY

A1. a) How old were you when your periods first started?

have not had periods 77

do not remember 99

b) In the year before this pregnancy would you say your periods were regular?

yes 1 no, not very 2 no periods at 7
regular all

c) If regular, how many days were there from the start of one period to the start of the next one ?

_____days

A2. a) Have you ever used a contraceptive pill?

Yes 1 No 2 If **no**, go to A3.a

If **yes**,

A2. b) how old were you when you first used one? _____ years

A2. c) how many years altogether did you take a contraceptive pill?

under 1 year 1

1-2 years 2

3-4 years 3

5 years or more 4

d) Is it possible that you might have taken the pill when you were actually pregnant this time?

Yes 1 No 2

A3. a) Have you ever gone to a doctor because you thought you were infertile?

Yes 1 No 2 If **no**, go to A4.a

If **yes**,

b) what treatment was given?
.....

c) i) Did you use any treatments to help you conceive this pregnancy?

Yes 1 No 2

ii) If **yes**, which one?

.....

A4. a) What was your weight before you started this pregnancy?
(please indicate whether stones, pounds or kilos)

.....

A4. b) Are you certain of this?

Yes 1 No 2

c) Before you became pregnant, what was your size in:-

i) hipsins.

ii) waistins.

iii) bustins.

(if you don't know write NK)

d) How tall are you ?(Please indicate whether feet, inches or metres)

i) Are you certain of this?

Yes 1 No 2

A5. a) Have you ever had diabetes?

Yes 1 No 2 If **No**, go to A5.b

i) If **yes**, have you only had it when you were pregnant?

Yes 1 No 2

ii) how is/was it treated?

insulin injections 1

other drugs 2

diet only 3

iii) how old were you when you first developed it? years

A5. b) Have you ever had hypertension (high blood pressure)?

Yes 1 No 2

If **yes**, i) Have you had it only when pregnant?

Yes 1 No 2

ii) How old were you when you first developed it? years

iii) How is it treated?

A6. Have you ever had any of the following infections:

		Yes	No never	Don't know
a)	measles	1	2	9
b)	mumps	1	2	9
c)	chicken pox	1	2	9
d)	whooping cough	1	2	9
e)	cold sores	1	2	9
f)	meningitis	1	2	9
g)	genital herpes	1	2	9
h)	syphilis	1	2	9
i)	gonorrhea	1	2	9
j)	urinary infection, cystitis, pyelitis	1	2	9

A7. Have you ever had any of the following operations:

		Yes	No
a)	tonsils out	1	2
b)	adenoids out	1	2
c)	hernia repair	1	2
d)	appendix out	1	2
e)	gall bladder out	1	2
f)	D and C (a scrape)	1	2
g)	pyloric stenosis operation	1	2
h)	squint repaired	1	2
i)	plastic surgery	1	2
j)	grommets in your ears	1	2
k)	other type of operation (please tick and describe)For office use	1	2

.....

A8. Have any of the following ever happened?
(tick one in each row, and add age if you had such an incident)

		Yes and stayed in hospital	Yes saw doctor, did not stay in hospital	Yes treated at home only	No never happened	Age this first happened
a)	You were badly burnt	1	2	3	4	
b)	You were badly scalded	1	2	3	4	
c)	You took a lot of pills or medicine	1	2	3	4	
d)	You broke an arm or hand	1	2	3	4	
e)	You broke a leg or foot	1	2	3	4	
f)	You nearly drowned	1	2	3	4	
g)	You were in a road traffic accident	1	2	3	4	
h)	You were sexually assaulted	1	2	3	4	
i)	You were injured playing sports or games	1	2	3	4	
j)	You had an accident while on a bicycle	1	2	3	4	
k)	You were injured in a fight	1	2	3	4	
l)	Your parents hurt you	1	2	3	4	
m)	You were hurt by someone else	1	2	3	4	
n)	Your head was hit	1	2	3	4	
o)	You were badly cut	1	2	3	4	
p)	You had a bad fall	1	2	3	4	
q)	You had another type of accident or injury (please describe)	1	2	3	4	
					

A9. Have you ever had any of the following problems:

		Yes had it recently	Yes in past, not now	No never	Don't know
a)	hay fever	1	2	3	9
b)	indigestion	1	2	3	9
c)	bulimia	1	2	3	9
d)	asthma	1	2	3	9

e)	eczema	1	2	3	9
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A9.		Yes had it recently	Yes in past, not now	No never	Don't know
f)	epilepsy	1	2	3	9
g)	convulsions with a fever	1	2	3	9
h)	migraine	1	2	3	9
i)	back pain/slipped disc	1	2	3	9
j)	kidney disease	1	2	3	9
k)	varicose veins	1	2	3	9
l)	haemorrhoids/piles	1	2	3	9
m)	rheumatism	1	2	3	9
n)	arthritis	1	2	3	9
o)	psoriasis	1	2	3	9
p)	stomach ulcer	1	2	3	9
q)	pelvic inflammatory disease (PID)	1	2	3	9
r)	drug addiction	1	2	3	9
s)	alcoholism	1	2	3	9
t)	schizophrenia	1	2	3	9
u)	anorexia nervosa	1	2	3	9
v)	severe depression	1	2	3	9
w)	other psychiatric problem	1	2	3	9
x)	other problem (please tick & describe)	1	2	3	9

.....

A10. a) Are there any problems for which you have **regular** treatment or medicine?

Yes 1 No 2 If **No**, go to A11, on page 11.

b) If **yes**, please describe the problem and **regular** treatment or medicine:

Problem	Treatment or medicine
.....
.....
.....

.....

A11. a) Would you say that you were allergic to anything?

Yes 1 No 2 If No, go to A12.

b) If yes, is it to:

	Yes	No	Don't know
i) cat	1	2	9
ii) pollen	1	2	9
iii) dust	1	2	9
iv) insect bites or stings	1	2	9
v) something else (please describe)			

.....

A12. Have you had any of the following in the past two years:

	Yes, often	Yes, sometimes	No, not at all
a) attacks of wheezing with whistling on the chest	1	2	3
b) a dry itchy rash	1	2	3
c) a blotchy blistery rash (hives)	1	2	3
d) sneezing attacks	1	2	3
e) runny nose	1	2	3
f) watery eyes	1	2	3
g) attacks of breathlessness	1	2	3
h) cough often during the night	1	2	3
i) cough often when you wake in the morning	1	2	3

A13. a) Do you know how much you weighed when you were born?

Yes 1 No 2

aa) If yes, give weight:

b) Were you born:

more than 3 weeks before your expected date	1
at around the date expected	2
more than 3 weeks late	3
don't know	9

c)	Were you born with any of the following:	Yes	No
i)	hare lip	1	2
ii)	birthmark	1	2
iii)	cleft palate	1	2
iv)	heart disease	1	2
v)	malformed feet	1	2
vi)	unusual shaped head	1	2
vii)	spina bifida	1	2
viii)	extra finger	1	2
ix)	extra toe	1	2
x)	funny shaped fingers or hands	1	2
xi)	missing part of body	1	2
xii)	other (please describe all such problems below)	1	2

.....
.....

d) i) Were you born in a hospital?

Yes 1 No 2 Don't know 9

ii) If yes, please give:

Name of hospital:

e) Where were your parents living at the time you were born?

Town:

County:

Country:

A14. Your hearing

a) How would you rate your hearing in each ear?

	(i) Left ear	(ii) Right ear
always very good	1	1
occasional problems (eg.infections or glue ear)	2	2
there are some sounds I can not hear	3	3

never very good 4 4

I cannot hear much at all 5 5

A15. Your eyesight

a) How would you rate your sight without glasses ?

	(i) Left eye	(ii) Right eye
always very good	1	1
I can't see clearly at a distance	2	2
I can't see clearly close up	3	3
I can't see much at all	4	4

b) Are you colour blind?

Yes 1 No 2 Don't know 9

A16. When you were a child did you ever go to any of the following?

	Yes	No	Not known
a) physiotherapist	1	2	9

If yes, what for:

b) child guidance or child psychiatrist	1	2	9
---	---	---	---

If yes, what for:

c) speech therapist	1	2	9
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If yes, what for:

	Yes	No	Not known
A16. d) special schooling	1	2	9

If yes, what for:

A17. Did you or any of your family have a problem of bedwetting or daytime wetting? (when older than 5 years)

	Yes, bed-wetting	Yes, daytime wetting	No not at all	Don't know
a) you	1	2	4	9
b) brother or sister	1	2	4	9
c) mother	1	2	4	9
d) father	1	2	4	9

A18. a) Have you had a wetting accident yourself in the past year, either during the night or day?

Yes 1 No 2

If yes,

b) Could you please indicate how many nights or days this has occurred within the past month:

i) during the night:

ii) during the day:

A19. a) Have you ever been a blood donor?

Yes 1 No 2

A19. b) If you were found to have a rare blood type during this pregnancy would you be willing to give blood?

Yes 1 No 2

A20. Many people have X-rays, barium meals and other procedures. Please indicate whether you have ever had any of the following types of X-ray.

X-ray to:	(i) During this pregnancy		(ii) In the year before this pregnancy		(iii) Any other time during your life	
	Yes	No	Yes	No	Yes	No
a) arm or hand	1	2	1	2	1	2
b) chest	1	2	1	2	1	2
c) leg or foot	1	2	1	2	1	2
d) dental	1	2	1	2	1	2
e) head or neck	1	2	1	2	1	2
f) back	1	2	1	2	1	2
g) barium meal	1	2	1	2	1	2
h) barium enema	1	2	1	2	1	2
i) IVP (intravenous pyelogram}	1	2	1	2	1	2
j) hips or pelvis	1	2	1	2	1	2
k) stomach or abdomen	1	2	1	2	1	2
l) any other (please describe)	1	2	1	2	1	2

.....
.....

SECTION B:YOUR PARTNER

The following questions are about how you and your partner behave towards each other.
Please indicate how often you and your partner behave in the ways listed.

* If you do not have a partner at the moment tick 'Not applicable'.

		Almost always	Often	Some- times	Rarely	Never	Not applicable
B1.	Is your partner affectionate toward you?	1	2	3	4	5	7
B2.	Does your partner get angry with you?	1	2	3	4	5	7
B3.	Does your partner listen to you when you want to talk about your feelings?	1	2	3	4	5	7
B4.	Do you have arguments with your partner?	1	2	3	4	5	7
B5.	Does your partner talk to you about his problems and feelings?	1	2	3	4	5	7
B6.	Do you get angry with your partner?	1	2	3	4	5	7
B7.	Do you enjoy the company of your partner?	1	2	3	4	5	7
B8.	Does your partner show his approval of you?	1	2	3	4	5	7
B9.	Do you behave affectionately toward your partner?	1	2	3	4	5	7
B10.	How old is your partner? years						

SECTION C:YOU AND YOUR PARENTS

C1. a) Were you legally adopted?

Yes 1 No 2

If yes,

b) what age were you?

C2. Were you ever "in care" of either a local authority or voluntary agency e.g. Barnados?

Yes 1 No 2 Unsure 9

C3. a) Did your parents divorce or separate before your 18th birthday?

Yes 1 No 2 **If No, go to C4**

If yes,

b) what age were you?

c) who did you mainly live with after this?

mother 1

father 2

sometimes mother,
sometimes father 3

someone else 4
(please say who)

.....

C4. Did you ever live away from home with any of the following
(other than for holidays/or short visits) before you were
18 years old?

Yes No

i) grandparents 1 2

ii) other relatives 1 2

iii) friends 1 2

iv) foster parents 1 2

v) other (please
describe) 1 2

.....

C5. Did you ever stay away from home in any of the following places before you were 18 years old?

	No	Yes for less than 1 a week	Yes for week - 1 month	Yes for 1 - 6 months	Yes over 6 months
i) hospital	1	2	3	4	5
ii) boarding school	1	2	3	4	5
iii) children's home	1	2	3	4	5
iv) hostel	1	2	3	4	5
v) in custody (detention centre, remand home, borstal etc)	1	2	3	4	5
vi) other (please describe)	1	2	3	4	5
.....					

C6. a) Did you leave home before your 18th birthday?
Yes 1 No 2 If No, go to C7

If yes,

C6. b) At that time where did you first live?

college residence	1
hostel	2
bedsit	3
shared flat or house	4
other (please describe)	5
.....	

C7. At each of the time periods given, during your childhood, who of the following lived in your home (other than for holidays or short visits)?

		When I was aged:		
		0-5 years (i)	6-11 years (ii)	12-16 years (iii)
a)	mother	1	1	1
b)	father	1	1	1
c)	brother(s)	1	1	1
d)	sister(s)	1	1	1
e)	step-mother	1	1	1
f)	step-father	1	1	1
g)	step-brother(s)	1	1	1
h)	step-sister(s)	1	1	1
i)	mother's partner	1	1	1
j)	father's partner	1	1	1
k)	grandmother	1	1	1
l)	grandfather	1	1	1
m)	family friend	1	1	1
n)	other (please describe)	1	1	1

C8. Who would you say brought you up?			
		Yes	No	Did not have
a)	mother	1	2	3
b)	father	1	2	3
c)	brother(s)	1	2	3
d)	sister(s)	1	2	3
e)	step-mother	1	2	3
f)	step-father	1	2	3
g)	step-brother(s)	1	2	3
h)	step-sister(s)	1	2	3
i)	mother's partner	1	2	3
j)	father's partner	1	2	3
k)	grandmother	1	2	3
l)	grandfather	1	2	3
m)	adoptive mother	1	2	3
n)	adoptive father	1	2	3
o)	foster mother	1	2	3
p)	foster father	1	2	3
q)	family friend	1	2	3
r)	other (please describe)	1	2	3
			

C9.	Has your natural mother and/or mother figure had any of the following: (If you only had a natural mother, answer only under 'natural mother')							
		(i) Natural mother			(ii) Mother figure			
		Yes	No	Don't know	Yes	No	Don't know	
a)	diabetes treated with insulin	1	2	9	1	2	9	
b)	other diabetes	1	2	9	1	2	9	
c)	coronary heart disease	1	2	9	1	2	9	
d)	rheumatism	1	2	9	1	2	9	
e)	arthritis	1	2	9	1	2	9	

f)	multiple sclerosis	1	2	9	1	2	9
		(i) Natural mother			(ii) Mother figure		
		Yes	No	Don't know	Yes	No	Don't know
g)	breast cancer	1	2	9	1	2	9
h)	other cancer	1	2	9	1	2	9
i)	hypertension (high blood pressure)	1	2	9	1	2	9
j)	an alcohol problem	1	2	9	1	2	9
k)	schizophrenia	1	2	9	1	2	9
l)	chronic bronchitis	1	2	9	1	2	9
m)	a stroke	1	2	9	1	2	9
n)	depression or 'nerves'	1	2	9	1	2	9
o)	other problem ₁ (please describe)	1	2	9	1	2	9

.....

.....

C10. a) Would you say that your mother (or mother figure) was disabled in any way?

Yes 1 No 2

If yes, please describe:

b)

.....

C11. a) Would you say that any problems in your mother's (or mother figure's) physical or mental health affected you in any way?

she had no problems 4

yes, major effect 1

yes, minor effect 2

she had some problems,
but they did not
affect my upbringing 3

If yes,

b) please describe:

.....

.....

C12. Has your natural father and/or father figure had any of the following:
(If you only had a natural father, answer only under 'natural father')

Natural father Father figure		(i)			(ii)		
		Yes	No	Don't know	Yes	No	Don't know
a)	diabetes treated with insulin	1	2	9	1	2	9
b)	other diabetes	1	2	9	1	2	9
c)	coronary heart disease	1	2	9	1	2	9
d)	rheumatism	1	2	9	1	2	9
e)	arthritis	1	2	9	1	2	9
f)	multiple sclerosis	1	2	9	1	2	9
g)	prostate cancer	1	2	9	1	2	9
h)	other cancer	1	2	9	1	2	9
i)	hypertension (high blood pressure)	1	2	9	1	2	9
j)	an alcohol problem	1	2	9	1	2	9
k)	schizophrenia	1	2	9	1	2	9
l)	chronic bronchitis	1	2	9	1	2	9
m)	a stroke	1	2	9	1	2	9
n)	depression or 'nerves'	1	2	9	1	2	9
o)	other problem ₁	1	2	9	1	2	9
	(please describe)						
						

C13. a) Would you say that your father (or father figure) was disabled in any way?

Yes 1 No 2 No father figure 7

If **yes**, please describe:

b)

C14. a) Would you say that any problems in your father's (or father figure's) physical or mental health affected you in any way?

he had no problems 4

yes, major effect 1

yes, minor effect	2
he had some problems, but they did not affect my upbringing	3
no such person	7

If **yes**, please describe:

b)

C15. a) Before you were 17 did a parent or person who cared for you die?

	Yes	No	Don't know
i) mother	1	2	9
ii) father	1	2	9
iii) mother figure	1	2	9
iv) father figure	1	2	9
v) other (please describe)	1	2	9

.....

If **yes**,

C15. b) what age were you:

i) mother died when I was:	years old
ii) father died when I was:	years old
iii) mother figure died when I was:	years old
iv) father figure died when I was:	years old
v) other figure died when I was:	years old

c) If either parent died, who cared for you after their death(s)?

	Yes	No
i) other parent	1	2
ii) relative	1	2
iii) foster parents	1	2
iv) adopted parent	1	2
v) other (please describe)	1	2

.....

We would like to know how you and your mother got on when you were a child.

This will probably have varied over your childhood and in different situations but we would like a general impression. Please tick the box to indicate how you mostly remember your mother in your first 16 years.

Mother(or person that took the place of your mother)

C16. **Never** **Sometimes** **Usually**

My mother -

a)	Spoke to me with a warm and friendly voice	1	2	3
b)	Helped me as much as I needed	1	2	3
c)	Let me do those things I liked doing	1	2	3
d)	Seemed emotionally cold to me	1	2	3
e)	Appeared to understand my problems and worries	1	2	3
f)	Was affectionate to me	1	2	3
g)	Tried to control what I did	1	2	3
h)	Invaded my privacy	1	2	3
i)	Let me decide things for myself	1	2	3
j)	Made me feel I wasn't wanted	1	2	3
k)	Talked things over with me	1	2	3
l)	Gave me the freedom I wanted	1	2	3
m)	Praised me	1	2	3
		YES	NO	
n)	Enjoyed talking things over with me	1	2	
o)	Frequently smiled at me	1	2	
p)	Tended to baby me	1	2	
q)	Seemed to understand what I needed or wanted	1	2	
r)	Could make me feel better when I was upset	1	2	
s)	Felt I could not look after myself unless she was around	1	2	
t)	Let me go out as often as I wanted	1	2	
u)	Was overprotective of me	1	2	
v)	Let me dress in any way I pleased	1	2	

C17. Was your parent's behaviour stable and predictable to you as a child?

		Always	Mostly	Rarely	Never	Not applicable
a)	mother	1	2	3	4	7
b)	father	1	2	3	4	7
c)	mother figure	1	2	3	4	7
d)	father figure	1	2	3	4	7

C18. Looking back would you call your childhood happy?
Please indicate for each age range:

		Yes very happy	Yes moderately happy	Not really happy	No quite unhappy	No very unhappy	Can't remember
i)	0-5 years	1	2	3	4	5	9
ii)	6-11 years	1	2	3	4	5	9
iii)	12-15 years	1	2	3	4	5	9

C19. Are there any comments you would like to add?

.....
.....

DIARY PAGE - CHILDHOOD HISTORY

Below we ask you to give a summary of your childhood. Please write down the place you lived, the main person or people who looked after you (e.g. mother, father, aunt) and if any major event (e.g. a death, divorce, more serious accident) happened.

Age	Where were you (Town, country)	Who was the main person/ people looking after you	Any major event
Under 1 year
1 year
2 years
3 years
4 years
5 years
6 years
7 years
8 years
9 years
10 years
11 years
12 years
13 years
14 years
15 years
16 years

SECTION D:YOUR FAMILY AND FRIENDS

D1. How many of your relatives and your partner's relatives do you see at least twice a year?

None	1	2-4	more than 4
1	2	3	4

D2. About how many friends do you have ?

None	1	2-4	more than 4
1	2	3	4

D3. Overall, would you say you belong to a close circle of friends ?

Yes	1	No	2
-----	---	----	---

D4. How many people are there that you can talk to about personal problems?

None	1	2-4	more than 4
1	2	3	4

D5. How many people talk to you about their personal problems or their private feelings?

None	1	2-4	more than 4
1	2	3	4

D6. If you have to make an important decision, how many people are there with whom you can discuss it?

None	1	2-4	more than 4
1	2	3	4

D7. How many people are there among your family and friends from whom you could borrow £100 if you needed to?

None	1	2-4	more than 4
1	2	3	4

D8. How many of your family and friends would help you in times of trouble?

None	1	2-4	more than 4
1	2	3	4

D9. During the last month, how many times did you get together with one or more friends?

None	1	2-4	more than 4
1	2	3	4

D10. During the last month, how many times did you get together with one or more of your relatives or your partner's relatives?

None	1	2-4	more than 4
1	2	3	4

The following statements are about the help and support you have.

	This is exactly how I feel	This is often how I s feel	This is how I ometimes feel	I never feel this way
D11. I have no one to share my feelings with	1	2	3	4
D12. My partner provides the emotional support I need	1	2	3	4
D13. There are other pregnant women with whom I can share my experiences	1	2	3	4
D14. I believe in moments of difficulty my neighbours would help me	1	2	3	4
D15. I'm worried that my partner might leave me	1	2	3	4
D16. There is always someone with whom I can share my happiness and excitement about my pregnancy	1	2	3	4
D17. If I feel tired I can rely on my partner to take over	1	2	3	4
D18. If I was in financial difficulty I know my family would help if they could	1	2	3	4
D19. If I was in financial difficulty I know my friends would help if they could	1	2	3	4
D20. If all else fails I know the state will support and assist me	1	2	3	4

D21. Do you believe in God or in some divine power?

yes	1
am not sure	2
no, not at all	3

D22. Do you feel that God (or some divine power) has helped you at any time?

D23. Yes 1 Not sure 2 No 3
Would you appeal to God for help if you were in trouble?
Yes 1 Not sure 2 No 3

D24. a) What sort of religious faith would you say you had?
(tick one only)

Church of England	01	Roman Catholic	02
Jehovah's Witness	03	Christian Science	04
Mormon	05	Other Christian (please describe)	06
Jewish	7	Buddhist	08
Sikh	9	Hindu	10
Muslim	11	Rastafarian	12
None	0	Other (please describe)	13
.....			
.....			

D24. b) How long have you had this particular faith?

all my life	1
more than 5 years	2
3-5 years	3
1-2 years	4
less than a year	5

D25. Do you go to a place of worship?

yes, at least once a week	1
yes, at least once a month	2
yes, at least once a year	3
not at all	4

D26. Do you obtain help and support from leaders or other members of religious groups?

	Yes	No
a) Leaders of your religious group (e.g. priests, rabbis, imams)	1	2
b) Other members of <u>your</u> religious group	1	2
c) Members of <u>other</u> religious group	1	2

(please describe)

.....

SECTION E:YOUR OUTLOOK ON LIFE

	Yes	No
E1. Did getting good marks at school mean a great deal to you?	1	2
E2. Are you often blamed for things that just aren't your fault?	1	2
E3. Do you feel that most of the time it doesn't pay to try hard because things never turn out right anyway?	1	2
E4. Do you feel that if things start out well in the morning that it's going to be a good day no matter what you do?	1	2
E5. Do you believe that whether or not people like you depends on how you act?	1	2
E6. Do you believe that when bad things are going to happen they are just going to happen no matter what you try to do to stop them?	1	2
E7. Do you feel that when good things happen they happen because of hard work?	1	2
E8. Do you feel that when someone doesn't like you there's little you can do about it?	1	2
E9. Did you usually feel that it was almost useless to try in school because most other children were cleverer than you?	1	2
E10. Are you the kind of person who believes that planning ahead makes things turn out better?	1	2
E11. Most of the time, do you feel that you have little to say about what your family decides to do?	1	2
E12. Do you think it's better to be clever than to be lucky?	1	2

SECTION F

F1. Please put the date of completing this questionnaire:

day month year
 199

F2. Please give your date of birth:

day month year
 19

Space for any comments you might like to make:

VERY MANY THANKS FOR ALL YOUR HELP

When completed, put in the envelope provided and either bring to the clinic or post 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.