

# den norske *Mor & barn undersøkelsen*

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## Questionnaire FATHER

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**This questionnaire will be processed by a computer. It is therefore important that you follow these instructions:**

- Please use a blue or black ballpoint pen
- Put a cross in the box that is most relevant like this: ☒
- Should you put a cross in the wrong box correct it by filling in the box completely like this: ☐
- In the large green boxes write a number or a capital letter

**It is important that you only write in the white area of each box like this:**

Number: 

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

 Letter: 

A	B	C	D
---	---	---	---

- Datobokser er delt opp i tre deler, den første for dag i måned, den neste for månedstallet og den siste for årstallet slik at datoen skal skrives slik:

0	6
---	---

0	5
---	---

2	0	0	5
---	---	---	---

day                  month                  year

- When filling in a single figure in boxes containing two or more squares, please use the square to the right. Example: 

0	5
---	---
- Specific information concerning, for example, medication or profession should be written in the boxes or on the lines provided. Please write clearly in CAPITAL LETTERS.

*Please return the completed questionnaire in the stamped addressed envelope provided.*

**Thank you in advance**

Give the date you filled in the questionnaire

--	--

day

--	--

month

--	--	--	--

year

(Write the year with 4 digits, e.g. 2005)

### 1. Date of birth?

--	--

day

--	--

month

--	--	--	--

year

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### 2. Marital status?

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Married     | <input type="checkbox"/> Divorced/separated |
| <input type="checkbox"/> Co-habiting | <input type="checkbox"/> Widower            |
| <input type="checkbox"/> Single      | <input type="checkbox"/> Other              |

### 3. How tall are you?

--	--	--

cm

### 4. What weight are you?

--	--	--	--

kg

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### 5. What is the heaviest you have weighed since you ? were 18 years old

--	--	--	--

kg

### 6. What is the lightest you have weighed since you ? were 18 years old

--	--	--	--

kg

### 7. Have you ever dieted or limited your food intake?

☐ No      ☐ Yes

### 8. If yes, how old were you the first time you dieted or limited your food intake?

--	--

years

### 9. Are you the type of person who can eat as much as you want without gaining weight?

☐ No      ☐ Yes

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## Education and work

### 10. What level of education do you have?

(only tick for the highest level of education you have completed and any ongoing education you are taking.)

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Education	Completed	Ongoing
Secondary education .....	<input type="checkbox"/>	<input type="checkbox"/>
Further education 1-2 years .....	<input type="checkbox"/>	<input type="checkbox"/>
Further education - vocational .....	<input type="checkbox"/>	<input type="checkbox"/>
Further education 3 years – (general studies, sixth form) .....	<input type="checkbox"/>	<input type="checkbox"/>
Higher Education (university/college), up to and including 4 years .....	<input type="checkbox"/>	<input type="checkbox"/>
Higher Education (university/college), over 4 years .....	<input type="checkbox"/>	<input type="checkbox"/>
Other education .....	<input type="checkbox"/>	<input type="checkbox"/>

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### 11. What is your work situation now? (tick all that apply.)

- |   |   |
|---|---|
| 1. <input type="checkbox"/> Pupil/student           | 7. <input type="checkbox"/> Employed in public sector   |
| 2. <input type="checkbox"/> At home                 | 8. <input type="checkbox"/> Employed in private sector  |
| 3. <input type="checkbox"/> Intern/apprentice       | 9. <input type="checkbox"/> Self-employed   |
| 4. <input type="checkbox"/> Military service        | 10. <input type="checkbox"/> Family member without steady income in family company (e.g. Farming, business) |
| 5. <input type="checkbox"/> Unemployed/laid off     | 11. <input type="checkbox"/> Other _____  |
| 6. <input type="checkbox"/> Rehabilitation/disabled |   |

### 12. Describe the business at your place of work/service as accurately as possible.

(e.g. farming of grain and pigs, body shop at garage for diesel cars, insurance company, college).

### 13. Job title at this workplace?

(e.g. panel beater, foreman, lecturer, student, cleaning assistant, farmer, homemaker/at home).

### 14. How many hours of paid labour do you do per week?

  

hours

+

### 15. What was your gross income (before tax) last year?

(Incl. child benefit, unemployment benefit, cash support etc)

1. ☐ No income
2. ☐ Under 150.000 kr.
3. ☐ 150.000–199.999 kr.
4. ☐ 200.000–299.999 kr.
5. ☐ 300.000–399.999 kr.
6. ☐ 400.000–499.999 kr.
7. ☐ Over 500.000 kr

### 16. In the last 12 months have you been on sick leave?

No Yes

Without medical certificate (self-notification) .....	<input type="checkbox"/>	<input type="checkbox"/>
With medical certificate from doctor	<input type="checkbox"/>	<input type="checkbox"/>

### 17. If yes, how long in total?

Less than 1 week	1-2 weeks	2-8 weeks	More than 8 weeks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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### 18. Are you currently receiving any of the following benefits?

If yes, from when?

	No	Yes	Month	Year
Sick pay/ rehabilitation money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Benefits for vocational rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Disability pension/ limited disability pension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Social security payments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Unemployment benefit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

### 19. Could you/your household cover an unexpected expense of 10,000 kroner in the course of a month without having to take out a loan or ask for financial help?

(including use of saved funds)

- ☐ No  
☐ Yes  
☐ Don't know

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**20. Have you been exposed to any of the following in the six months before your partner became pregnant?**
*(during work and leisure) (Tick every line)*

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Chemicals, gases etc	+	No	Yes	If yes, no. of days (daily = 180 days)	Tick if you have used extractor fan or breathing protection	Tick if you have used protective gloves
1. Lead vapours, lead dust, lead particles or lead alloys . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Chromium, arsenic, cadmium or combinations of these . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Petrol/gasoline or exhaust fumes (not including filling your own car)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Mercury vapours, mercury or work with amalgam-fillings (not including treatment as a patient) . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Disinfectants, vermin poison . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Plant care substances (weedkiller, insecticides . . . . . fungicides, rodent poison)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Oil-based paint . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Water-based or latex paint . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Paint thinner, paint-, varnish/lacquer- or glue-remover or other solvents (e.g. Lynol®, white spirit, toluene, carbon tetrachloride)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Industrial dyes or inks . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Motor oil, lubricating oil or other types of oil . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Photographic chemicals (fixatives or developers) . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Substances used in welding . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Substances used in soldering . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Formalin/formaldehyde . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Chemotherapy substances/ treatments (not including your own medical treatment) . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Chemotherapy (taken in treatment as a patient) . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Nitrous oxide (laughing gas) or other anaesthetic gases (not including your own medical treatment) . . . . .		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Other substances and conditions, describe: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**21. How often have you worked with radio transmitters or radar in the last six months before your partner became pregnant?**

- ☐ Seldom/never  
☐ Few times per week  
☐ Daily  
☐ On average more than 1 hour per day

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**22. How often have you worked with X-ray equipment in the last six months (less than 2 metre's distance) before your partner became pregnant?**
*(Not including treatment as a patient)*

- ☐ Seldom/never  
☐ Few times per week  
☐ Daily  
☐ On average more than 1 hour per day

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23. Do you use a mobile phone? ☐ Nei ☐ Ja

24. If yes, how old were you when you got your first mobile phone?   years

25. Do you use "hands-free"?

- ☐ Seldom/never  
☐ Only for longer conversations  
☐ As a rule

26. If/when you use "hands-free", where is the phone usually during the conversation?

- ☐ In front trouser pocket  
☐ On a belt in front of the body  
☐ Other places on the body  
☐ Away from the body

27. How often did you talk on a mobile phone in the six months before your partner became pregnant?

- ☐ Less than once a week  
☐ 1-2 times per week  
☐ 3-6 times per week  
☐ 1-4 times per day  
☐ More than 5 times per day

28. How long on average do you talk in total on the days you use your mobile phone?

- ☐ Less than 1 minute  
☐ 1-10 minutes  
☐ 11-30 minutes  
☐ 31-60 minutes  
☐ More than 60 minutes

29. How often did you work with a computer, laser printer or copying machine (at a distance of less than two meters) in the six months before your partner became pregnant? (tick every line)

	Seldom/never	Few times per week	Daily	On average more than 1 hour per day
1. Computer screen .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Laser printer .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Copying machine .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Illnesses and health problems

30. Do you have, or have you had any of the following illnesses or health problems?

	+	If yes, tick	If yes, do you remember how old you were at the first sign of illness/ problem?	If you became well or the problem stopped, at what age did this happen?
1. Hay fever, pollen allergy .....		<input type="checkbox"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
2. Urticaria (hives) .....		<input type="checkbox"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
3. Asthma .....		<input type="checkbox"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
4. Atopic dermatitis (childhood eczema) .....		<input type="checkbox"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
5. Psoriasis .....		<input type="checkbox"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
6. Other eczema/skin problem .....		<input type="checkbox"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
7. Chlamydia .....		<input type="checkbox"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
8. Herpes .....		<input type="checkbox"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years

Question continues next page

+	If yes, tick	If yes, do you remember how old you were at the first sign of illness/ problem?	If you became well or the problem stopped, at what age did this happen?
9. Genital warts .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
10. Gonorrhea .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
11. Migraine .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
12. Other frequent headaches .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
13. Constant aches or discomfort in the upper abdomen ....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
14. Crohn's disease/ulcerative colitis (diarrohea, constipation intermittent pain .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
15. Sleep problems .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
16. Diabetes .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
17. Cancer .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
18. Cardiovascular disease .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
19. Epilepsy .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
20. Repeated neck and shoulder pain .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
21. Lower back pain .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
22. Prolonged muscle pain .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
23. Bechterew's disease/rheumatoid arthritis .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
24. High blood pressure .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
25. ADHD .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
26. Anorexia/bulimia/eating disorders .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
27. Manic depressive illness .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
28. Schizophrenia .....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
29. Other long-term mental illnesses or health problems ....	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years
30. Other long-term physical illnesses or health problems ...	<input type="checkbox"/>	<div><div></div><div></div></div> years	<div><div></div><div></div></div> years

If other long-term illnesses, please describe:

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31. Do you have a congenital malformation/birth defect? ☐ No ☐ Yes +

32. If yes, which? \_\_\_\_\_

33. Did you use medicines in the six months before your partner became pregnant? ☐ No ☐ Yes

34. If yes, please give the name of the medicine(s)

Name of medicine (e.g. Valium, Rohypnol, Paracetamol)

How long did you use the medicine?

	Less than 1 week	1 week – 1 month	More than 1 month
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. Did you have any X-rays taken in the six months before your partner became pregnant? ☐ No ☐ Yes

36. If yes, what were the X-rays taken of, and how many times?

1. ☐ Teeth  times
2. ☐ Lungs  times
3. ☐ Pelvis/stomach/back  times
4. ☐ Arms and legs  times
5. ☐ Other  times

37. How many children do you have from before?

38. How many of these are with your present partner?

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## Diet and eating habits

### BREAD / CRISPBREAD / BISCUITS

39. How many slices of bread do you eat on average every day? ? (Combine all meals)

1. White bread (incl. bread rolls, baguettes, pitta, ciabatta and similar) .....
2. Medium coarse-grain bread (incl. rolls) .....
3. Coarse-grain bread .....
4. Crispbread/biscuits .....

40. Do you use butter, margarine or oil on bread?

- ☐ No, almost never
- ☐ Yes, sometimes
- ☐ Yes, daily

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**41. How often do you add these to bread?** (Tick per line)

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+	Seldom/ never	1-2 times per week	3-4 times per week	5-7 times per week	Several times per day
1. Reduced fat cheese .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Regular cheese (yellow/brown) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Prawns/Italian salad or similar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Lean meat .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Savelat sausage, salami or similar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Liver pate or similar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Fish .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Preserves (jam/jelly), other sweet spreads .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Egg (boiled, fried, scrambled) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**DRINK**
**42. How often do you drink the following?** (Tick each line)

	Seldom/ never	1-6 glass per week	1 glass per day	2-3 glass per day	4 glass or more per day
1. Whole milk, buttermilk, yoghurt .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Low-fat and skimmed milk .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Fruit juice .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Coca Cola/Pepsi with sugar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Coca Cola/Pepsi sugar-free .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Other sugar-free fizzy drinks .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Energy drinks, Battery or similar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Filter- and instant coffee .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Boiled/Cafetiere coffee .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other coffee, espresso or similar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Tea .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DINNER**
**43. How often do you eat these meals?** (Tick each line)

	Seldom/ never	1-2 times per month	3-4 times per month	2-3 times per week	4 times or more per week
1. Sausages, hamburger .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Kebab .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pizza .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Meals with minced meat .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Pure meat .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Chicken/turkey .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Lean fish (cod, pollock, haddock etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Fatty fish (trout, salmon, mackerel, herring) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Fish balls/fish cakes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Vegetarian meals .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**VEGETABLES / FRUIT**

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**44. How often do you eat vegetables and fruit?** (Tick per line)

		Seldom/ never	1-3 times per month	1-2 times per week	3-4 times per week	5 times or more per week
1. Raw vegetables/salads .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cooked vegetables in stews .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Cooked vegetables .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fruit .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**EATING PATTERNS**

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**45. How often do you eat food bought from these places?** (Tick per line)

		Seldom/ never	1-3 times per month	1-4 times per week	5-7 times per week	Several times per day
1. Canteen/cafeteria/lunch bar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Restaurant .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Kiosk/snack bar .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Petrol/gasoline station .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. McDonalds, Burger King etc. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**46. How would you describe your diet?**

1. I have a varied diet .....	<input type="checkbox"/>
2. I do not eat fish .....	<input type="checkbox"/>
3. I do not eat meat .....	<input type="checkbox"/>
4. I am a vegetarian .....	<input type="checkbox"/>

**47. Do you use any form of dietary supplement?**☐ No ☐ Yes**48. If yes, which type?** (Tick all that apply)

1. Multivitamin-/mineral supplement .....	<input type="checkbox"/>
2. Cod-liver oil/fish oil .....	<input type="checkbox"/>
3. Protein supplement .....	<input type="checkbox"/>

**Lifestyle****49. Have you ever smoked?**

- ☐ No (go to question 53)
- ☐ Yes

**50. Did you smoke in the six months before your partner became pregnant?**

- ☐ No
- ☐ Yes, sometimes  Number cigarettes/week
- ☐ Yes, daily  Number cigarettes/day

+

**51. Do you smoke now after your partner became pregnant?**

- ☐ No
- ☐ Yes, sometimes  Number cigarettes/week
- ☐ Ja, daglig  Number cigarettes/day

**52. If yes, where do you smoke?**

- ☐ Only outside
- ☐ Both inside and outside
- ☐ Only inside

+



**53. Have you ever used smokeless/chewing tobacco ("snus")?**

- ☐ No (go to question 57)
- ☐ Yes

+

**54. If yes, did you use smokeless /chewing tobacco in the six months before your partner became pregnant?**

- ☐ No
- ☐ Yes, daily
- ☐ Yes, many times per week, but not daily
- ☐ Less often than weekly

**55. What type of smokeless/chewing tobacco do you usually use?**

- ☐ Normal (loose)
- ☐ Pouches
- ☐ Mini-pouches
- ☐ About the same of each type

+

**56. How much smokeless /chewing tobacco do you use per week?**

- ☐ Whole box
- ☐ Half box
- ☐ Quarter box
- ☐ Less than a quarter box



Number of boxes

**57. Have you ever used any of the following narcotic substances? (Tick for every line)**

	Never	Earlierer	Six months before your partner became pregnant	Now
Cannabis/hash .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, which: .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**58. Have you ever drunk alcohol?**

- ☐ No (go to question 62)
- ☐ Yes

**59. How often did you drink alcohol in the six months before your partner became pregnant and how often do you drink now that your partner is pregnant?**

	Before	Now
Approximately 6-7 times per week	<input type="checkbox"/>	<input type="checkbox"/>
Approximately 4-5 times per week	<input type="checkbox"/>	<input type="checkbox"/>
Approximately 2-3 times per week	<input type="checkbox"/>	<input type="checkbox"/>
Approximately once per week	<input type="checkbox"/>	<input type="checkbox"/>
Approximately 1-3 times per month	<input type="checkbox"/>	<input type="checkbox"/>
Less than once per month	<input type="checkbox"/>	<input type="checkbox"/>
Never	<input type="checkbox"/>	<input type="checkbox"/>

**Units of alcohol**

To compare different types of alcohol, we ask about what we call alcohol units (= 1,5 cl pure alcohol).  
An alcohol unit corresponds to:

- 1 bottle alcopop/cider
- 1 glass (1/3 litre) beer
- 1 wine glass red wine or white wine
- 1 sherry glass of sherry or other fortified wine
- 1 glass with a single measure of spirit or liquor

+

**60. How many alcohol units did you normally drink in the six months before your partner became pregnant and how many alcohol units now that your partner is pregnant?**

(Tick both boxes for weekends and everyday, total 4 ticks)  
(see the explanation of alcohol units on this page)

	Before		Now	
	Week-end	Every-day	Week-end	Every-day
10 or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5-6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fewer than 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**61. Have you drunk 5 alcohol units or more on at least one occasion in the six months before your partner became pregnant or now after your partner became pregnant?**

	Before	Now
Several times per week	<input type="checkbox"/>	<input type="checkbox"/>
Once per week	<input type="checkbox"/>	<input type="checkbox"/>
1-3 times per month	<input type="checkbox"/>	<input type="checkbox"/>
Less than once per month	<input type="checkbox"/>	<input type="checkbox"/>
Never	<input type="checkbox"/>	<input type="checkbox"/>

+

**62. How often are you now so physically active that you become out of breath or sweat?** (one tick for leisure time and one for work.)

	In leisure time	At work
Never.....	<input type="checkbox"/>	<input type="checkbox"/>
Less than once per week....	<input type="checkbox"/>	<input type="checkbox"/>
Once per week.....	<input type="checkbox"/>	<input type="checkbox"/>
2 – 3 times per week.....	<input type="checkbox"/>	<input type="checkbox"/>
4 – 6 times per week.....	<input type="checkbox"/>	<input type="checkbox"/>
Approximately every day.....	<input type="checkbox"/>	<input type="checkbox"/>

**63. How has your physical activity in leisure time been in the last year?** (Think of a weekly average for the year. Getting to work counts as leisure time. Answer both questions)

	Hours per week			
	None	Less than 1	1-2	3 or more
1. Light physical activity (not sweating/out of breath)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Heavy physical activity (sweating/out of breath)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**64. Describe your exercise and physical exertion in your leisure time. If the activity varies a lot, e.g. between summer and winter, take an average. The question relates to the last year** (tick the most appropriate box).

Read, watch TV or other sedentary occupation? ..... ☐

Walking, cycling or other motion, at least 4 hours per week?  
(Here you should also include walking/cycling to work, Sunday walks etc) ..... ☐

Take part in sports/athletics, heavy garden work etc at least 4 hours per week? ((Note that the activity should take at least 4 hours per week). ☐

Hard training or take part in competitive sport regularly and several times a week. .... ☐

**65. Have you ever use any of the following substances?** (Tick for every line.)

	Never	Previously	Six months before your partner became pregnant	Now
1. Anabolic steroids .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Testosterone medications .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Growth hormone (e.g.. Genotropin/Somatropin) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+

## How are you now?

**66. Have you been bothered by any of the following feelings during the past 2 weeks?** (Enter a cross in a box for each item.)

	Not bothered	A little bothered	Quite bothered	Very bothered
1. Feeling fearful .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nervousness or shakiness inside .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. feeling hopeless about the future .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling blue .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Worrying too much about things .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling everything is an effort .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling tense or keyed up .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Suddenly scared for no reason .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+

+

**67. Have you ever experienced the following for a period of 2 weeks or more earlier in life?** (Tick for each line)

	No	Yes
1. Felt depressed, sad .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Had problems with appetite or eaten too much .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Been bothered by feeling weak or lack of energy .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Really blamed yourself and felt worthless .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Had problems with concentration or had problems making decisions .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Had at least 3 of the problems named above simultaneously .....	<input type="checkbox"/>	<input type="checkbox"/>

**68. If you have had 3 or more of these problems at the same time:**

+

How many times has it occurred?

times

How many weeks did the longest period last?

weeks

+

**69. What kind of perception do you have of yourself? (Tick for each line.)**
Strongly  
agree

Agree

Disagree

Strongly  
disagree

1. I have a positive attitude towards myself .....

☐
☐
☐
☐

2. I feel really useless at times .....

☐
☐
☐
☐

3. I feel that I don't have much to be proud of .....

☐
☐
☐
☐

4. I feel that I'm a valuable person, on an equal footing with anyone else, at any rate

☐
☐
☐
☐

+

**70. Describe yourself as you usually are: (Tick for every line)**
Strongly  
disagreeDisagree  
somewhatNeither  
NorAgree  
somewhatStrongly  
agree

1. Liven up in a party .....

☐
☐
☐
☐
☐

2. Care little about others .....

☐
☐
☐
☐
☐

3. Am always well prepared .....

☐
☐
☐
☐
☐

4. Become easily stressed .....

☐
☐
☐
☐
☐

5. Have a rich vocabulary .....

☐
☐
☐
☐
☐

6. Do not say much .....

☐
☐
☐
☐
☐

7. Am interested in other people .....

☐
☐
☐
☐
☐

8. Leave things lying around .....

☐
☐
☐
☐
☐

9. Am usually relaxed .....

☐
☐
☐
☐
☐

10. Have problems understanding abstract ideas .....

☐
☐
☐
☐
☐

11. Feel at ease with other people .....

☐
☐
☐
☐
☐

12. Offend people .....

☐
☐
☐
☐
☐

13. Am attentive to detail .....

☐
☐
☐
☐
☐

14. Worry about many things .....

☐
☐
☐
☐
☐

15. Have a lively imagination .....

☐
☐
☐
☐
☐

16. Stay in the background .....

☐
☐
☐
☐
☐

17. Have empathy with other people .....

☐
☐
☐
☐
☐

18. Mess things up .....

☐
☐
☐
☐
☐

19. Rarely feel in low spirits .....

☐
☐
☐
☐
☐

20. Am not interested in abstract ideas .....

☐
☐
☐
☐
☐

21. Initiate conversations .....

☐
☐
☐
☐
☐

22. Am not interested in other peoples' problems .....

☐
☐
☐
☐
☐

23. Complete tasks at once .....

☐
☐
☐
☐
☐

24. Am easily interrupted .....

☐
☐
☐
☐
☐

25. Have excellent ideas .....

☐
☐
☐
☐
☐

26. Have little to say .....

☐
☐
☐
☐
☐

27. Am good-natured .....

☐
☐
☐
☐
☐

28. Often forget to put things back .....

☐
☐
☐
☐
☐

29. Become easily upset .....

☐
☐
☐
☐
☐

30. Do not have a good imagination .....

☐
☐
☐
☐
☐

+

+ continues next page

+	+	Strongly disagree	Disagree somewhat	Neither Nor	Agree somewhat	Strongly agree
31. Talk to many people at a party .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Am not interested in other people .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Like order and tidiness .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Lot of mood changes .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Am quick to understand things .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Do not like to attract attention .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Take time to help others .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Shirk from responsibilities .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Often have mood swings .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Often use difficult words .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Have nothing against being the centre of attention .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Am sensitive to other peoples' feelings .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Perform according to plan .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Become easily irritated .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Use time to think things over .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Am quiet in company with strangers .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Put others at their ease .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Am thorough in my work .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Often feel down .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Am full of ideas .....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+

**71. Do you agree or disagree with the following statements?** (Tick only one box per line)

	Disagree completely	Disagree	Disagree somewhat	Neither Nor	Agree somewhat	Agree	Agree completely
1. My life is largely what I wanted it to be .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My life is very good .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I am satisfied with my life .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. To date, I have achieved what is important for me in my life ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If I could start all over, there is very little I would do differently ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**72. Feeling of anxiety and restlessness in the last six months.** (Tick for every line)

	Never	Seldom	Sometimes	Often	Very often
1. How often do you have problems completing the final aspects of a task when the challenging part is already done? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How often do you have problems putting things in the right order when you are involved in tasks that require organisation? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When you have a task which requires a great deal of careful preparation, how often do you avoid or put off starting it? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How often do you have problems remembering appointments or duties? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. When you have to sit still for a long time, how often do you move your hands and feet in an agitated and restless way? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How often do you feel hyperactive and obliged to do things, as if you are being driven by an machine? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+

+

**73. Have you experienced any of the following during the last 12 months?** (Tick for every line)

	No	Yes	+
1. Problems at work/study place . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
2. Financial problems . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
3. Got divorced, separated or ended a relationship . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
4. Problems or conflicts with family, friends or neighbours . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
5. Serious concerns that something is wrong with the baby we are expecting	<input type="checkbox"/>	<input type="checkbox"/>	
6. Serious personal illness or injury . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
7. Close relative has been seriously ill or injured . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
8. Involved in a serious traffic accident, fire or robbery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
9. Have lost someone close to me . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
10. Forced into sexual activity . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
11. Exposed to physical violence . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
12. Other, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	

+

**74. How much do you agree with these descriptions of your relationship with your wife/partner?** (Tick one box in each line)

	Completely agree	Agree	Agree somewhat	Disagree somewhat	Disagree	Disagree completely
1. My partner and I have problems in our relationship . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I am very happy in my relationship . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. My partner is usually understanding . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I am satisfied with my relationship to my partner . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. We agree about how children should be raised . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**75. Do you have anyone other than your wife/partner you can ask for advice in a difficult situation?**

- ☐ No  
☐ Yes 1-2 people  
☐ Yes more than 2 people

**76. How often do you meet or talk on the telephone with your family (other than your wife/partner and children) or close friends?**

- ☐ Once a month or less  
☐ 2-8 times a month  
☐ More than twice a week

**77. Do you often feel lonely?**

- ☐ Almost never  
☐ Seldom  
☐ Sometimes  
☐ Usually  
☐ Almost always

+

**78. How often do you experience the following in your everyday life?** (Tick only one box per item)

	Never	Seldom	Sometimes	Often	Very often
1. Feel pleased about something . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feel happy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Feel joyful as though everything is going your way . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feel that you will scream at someone or hit something . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feel angry, irritated or annoyed . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feel mad with someone . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

+

***If there is something else you would like to tell us, please write it on the next page.***

+

+

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

+

Please return the completed questionnaire in the stamped addressed envelope provided to:

**The Norwegian Mother and Child Study  
Norwegian Institute for Public Health  
Dept. for Medical Birth Registry  
Kalfarveien 31  
5018 Bergen**

[illegible]

+