den norske **Mor & barn undersøkelsen**

Questionnaire 5 – Your child at 18 months

In this questionnaire we will ask you some questions which you may recognise from previous questionnaires. We do this because we want to continue following your and your child's progress. It will help if you have child's Health card to hand so that you can use the information contained in it.

If you feel that a question is too upsetting or difficult to answer you can skip this question and go on to the next one.

The questionnaire will be processed by a computer. *It is therefore important that you following these instructions when completing it:*

- Use a blue or black ballpoint pen.
- Put a *cross* in the box that is most relevant like this: X
- If you put a cross in the wrong box, correct it by filling in the box completely like this:
- Write numbers in the large green *boxes.*

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

Number: 1 2 3 4 5 6 7 8 9 0

- Numbered boxes have two or more squares. When you enter a single-digit number, use the square on the right. *Example: 5 is entered as follows* 5
- Specific information concerning, *for example, medication* should be written on the lines provided.
  Write clearly in CAPITAL LETTERS.
- Remember to fill in the date on which you completed the questionnaire

As soon as you have completed this questionnaire, return it to us in the stamped addressed envelope provided.

Specify the day, month and year when the questionnaire EE11

EE9 Day | EE10 Month | EE11 Year *(write the year in full, e.g. 2005)*

ALDERUTFYLT_S5

ALDERRETUR_S5

ABOUT YOUR CHILD

Food and drink

1. What type of milk has your baby been given since he/she was 6 months old?
(You can enter more than one cross.)

Milk type	Child's age in months 6 - 8	9 - 11	12 - 14	15 - 18
1. Breast milk	EE12	EE13	EE14	EE15
2. Formula	EE16	EE17	EE18	EE19
3. Formula in the case of milk intolerance	EE20	EE21	EE22	EE23
4. Whole milk (sweet)	EE24	EE25	EE26	EE27
5. Low-fat milk normal (sweet)	EE28	EE29	EE30	EE31
6. Extra low-fat milk (sweet)	EE32	EE33	EE34	EE35
7. Skimmed milk (sweet)	EE36	EE37	EE38	EE39
8. Yogurt with active Lactobacillus, all types	EE40	EE41	EE42	EE43
9. Other yogurt	EE44	EE45	EE46	EE47
10. Other types of sour milk	EE48	EE49	EE50	EE51

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2. How often do you give your child the following to drink now that he/she is 18 months old? Select the frequency which is most applicable on average.
(Enter a cross in a box for each item.)

	Never	Less than once a week	1-3 times a week	4-6 times a week	1-2 times in 24 hrs	3-4 times in 24 hrs	5 or more times in 24 hours
1. Breast milk		EE736					
2. Formula		EE737					
3. Whole milk		EE738					
4. Low-fat milk		EE739					
5. Extra low-fat milk		EE740					
6. Skimmed milk		EE741					
7. Yogurt with active Lactobacillus, all types		EE742					
8. Yogurt, natural		EE965					
9. Yogurt with fruit		EE966					
10. Other types of sour milk		EE744					
11. Tap water		EE745					
12. Bottled water		EE746					
13. Cordial, sweetened		EE747					
14. Cordial, artificially sweetened		EE748					
15. Juice		EE749					
16. Fizzy drinks		EE750					
17. Diet fizzy drinks		EE751					
18. Other: _____ EE701 EE67		EE752					

3. Do you give your child the following to drink during the night now that he/she is roughly 18 months old?
(Enter a cross in a box for each item.)

	Never/ seldom	Now and then	Yes, most nights
1. Water	EE68		
2. Milk or cordial from a cup	EE69		
3. Milk or cordial from a bottle	EE70		
4. Breast milk	EE71		

4. How often do you give your child the following to eat now that he/she is 18 months old? Select the frequency which is most applicable on average.
(Enter a cross in a box for each item.)

	Never	Less than once a week	1-3 times a week	4-6 times a week	1-2 times in 24 hrs	3 or more times in 24 hrs
1. Liver paste sandwich		EE754				
2. Meat sandwich		EE755				
3. Fish sandwich (e.g. sardines, mackerel)		EE756				
4. Cheese sandwich		EE757				
5. Jam/honey sandwich		EE758				
6. Sandwich with other filling		EE759				
7. Baby porridge (instant)		EE760				
8. Home-made porridge		EE761				
9. Meat, sausages, meat balls, etc.		EE762				
10. Fish, fish balls, fish pudding, etc.		EE763				
11. Pancakes		EE764				
12. Potatoes		EE765				
13. Pasta		EE766				
14. Rice		EE767				
15. Peas, beans		EE768				
16. Other cooked vegetables		EE769				
17. Raw vegetables		EE770				
18. Fruit		EE771				
19. Cakes/waffles/biscuits		EE772				
20. Dessert/ice cream		EE773				
21. Chocolate		EE774				
22. Other sweets, jelly beans, other confectionery		EE775				

5. Do you give your child a home-made dinner or readymade (processed) baby food in a jar?

- Only home-made
- Mostly home-made
- About half and half of each
- Mostly ready-made
- Only ready-made

EE95

6. How often do you give your child organic food/drink?
(Enter a cross in a box for each item.)

	Never	Sometimes	Often	Almost always
Sweet milk	EE97			
Buttermilk/yogurt	EE98			
Vegetables/fruit	EE99			
Porridge/flour/bread	EE100			
Meat	EE101			

7. Does your child have a reaction to certain foods?

- No
- Yes
- Don't know

EE102

8. If yes, what type of food does your child have a reaction to? *(You can enter a cross in more than one box.)*

1. Whole milk	EE103	8. Boiled or fried egg	EE110	14. Fruit, berries	EE116
2. Skimmed milk/low-fat milk	EE104	9. Fish/fish products	EE111	15. Vegetables/potatoes	EE117
3. Cream	EE105	10. Additives	EE112	16. Chocolate	EE118
4. Yogurt/buttermilk	EE106	11. Wheat	EE113	17. Other sweets	EE119
5. Ice cream	EE107	12. Nuts	EE114	18. Sugar	EE120
6. Cheese	EE108	13. Soya	EE115	19. Other: _____ EE702	EE121 EE122
7. Raw egg (e.g. egg flip)	EE109				

9. Are there any foods which you specifically avoid giving your child?

- No
- Yes

EE123

10. If yes, which foods do you try to avoid and how strict are you with your child's diet?

	Some reduced use compared to normal diet	Not used unmixed but allowed a little bit in different dishes	Use completely avoided (also "hidden" in dishes)
1. Milk	EE124		
2. Eggs	EE125		
3. Fish/fish products	EE126		
4. Meat/meat products	EE127		
5. Wheat	EE128		
6. Sugar	EE129		
7. Other: _____ EE703 EE131	EE130		

11. Do you give your child cold liver oil, vitamins, iron or any other dietary supplement?

- No
- Yes

EE132

12. If yes, specify which product(s) and how often you give them to your child. How old was your child when you first started giving him/her the product?

	How often do you give it to your child? Every day	How often do you give it to your child? sometimes	How old was your child when you first gave him the product? Number of months
1. Cod liver oil	EE133		EE134
2. Biovit	EE135		EE136
3. Sanasol	EE137		EE138
4. Nycoplus Multi-Vitamin mixture for children	EE139		EE140
5. Fluoride tablets	EE141		EE142
6. Iron supplement, specify: EE145 EE704	EE143		EE144
7. Other dietary supplement, specify: EE148 EE705	EE146		EE147

Growth, health and illness

Consult your child's health card and use the information contained in it to complete the following questions.

13. How many times have you been to the mother and child health centre since his/her birth?

0 - 4
5 -10
11 -15
16 or more

EE149

14. Do you want your child to be given the vaccinations that are recommended for children in Norway?

Yes, all the recommended vaccinations
Yes, some vaccinations
No, no vaccinations

EE150

15. Indicate whether your child has had any vaccinations. If yes, how many times, and indicate if there have been any sideeffects requiring a doctor or hospital to be contacted. *(Enter a cross in a box for each item.)*

Vaccinations	No	Yes	If yes, how many times? 1	2	3	Side-effect resulting in extra contact with a doctor? No	Yes	Side-effect resulting in examination/admission to hospital? No	Yes
1. DTP (diphtheria, tetanus, whooping cough)	EE776		EE151			EE152		EE153	
2. Hib (Haemophilus influenzae type b)	EE777		EE784			EE785		EE786	
3. Polio	EE778		EE956			EE957		EE958	
4. MMR (measles, mumps, rubella)	EE779		EE160			EE161		EE162	
5. DT (diphtheria, tetanus - sometimes given instead of DTP)	EE780		EE154			EE155		EE156	
6. Hepatitis B	EE781		EE163			EE164		EE165	
7. BCG (tuberculosis)	EE782		EE166			EE167		EE168	
8. Pneumococcus (Prevenar)	EE1008		EE1009			EE1010		EE1011	
9. Other vaccination: EE172 EE706	EE783		EE169			EE170		EE171	

The following questions concern any illnesses or health problems your child has had. We will first ask you about more long-term problems, then about illnesses and problems of a more acute nature.

16. Does your child have or has he/she had any of the following health problems? If yes, has your child been referred for a specialist examination?
(Enter a cross in a box for each item.)

Health problem	No	Yes, has now	Yes, had previously	If yes, has child been referred for a specialist examination? No	Yes
1. Dislocated hip (hip problem)	EE787	EE788	EE789	EE790	
2. Reduced hearing	EE791	EE792	EE793	EE794	
3. Impaired vision	EE795	EE796	EE797	EE798	

(cont.)

Health problem	No	Yes, has now	Yes, had previously	If yes, has child been referred for specialist examination? No	Yes
4. Delayed motor development (e.g. sits/walks late)	EE799	EE800	EE801	EE802	
5. Too little weight gain	EE803	EE804	EE805	EE806	
6. Too much weight gain	EE807	EE808	EE809	EE810	
7. Abnormal head circumference	EE811	EE812	EE813	EE814	
8. Heart defect	EE815	EE816	EE817	EE818	
9. Testicles not descended into scrotum	EE819	EE820	EE821	EE822	
10. Asthma	EE823	EE824	EE825	EE826	
11. Atopic eczema (childhood eczema)	EE827	EE828	EE829	EE830	
12. Urticaria (hives)	EE831	EE832	EE833	EE834	
13. Food allergy/intolerance	EE835	EE836	EE837	EE838	
14. Late or abnormal speech development	EE839	EE840	EE841	EE842	
15. Sleep problems	EE843	EE844	EE845	EE846	
16. Behavioural problems	EE847	EE848	EE849	EE850	
17. Social problems	EE967	EE968	EE969	EE970	
18. (Other) malformations: _____ EE707 EE207	EE851	EE852	EE853	EE854	
19. Other: _____ EE708 EE210	EE856	EE857	EE858	EE859	

17. If a specialist referral was made, what did this examination show?

Everything was fine EE211

Still some doubts/further examinations needed

Has not been for any examination yet

Diagnosis I: _____ EE861 EE212 EE709

Diagnose II: _____ EE862 EE863 EE951

Diagnose III: _____ EE864 EE865 EE952

18. Has your child been treated with a "cushion" for a hip problem?

No

Yes EE213 How long? EE214 months

19. Has your child had any of the following illnesses/health problems between 6 and 11 months and/or 12 and 18 months? Specify how many times and whether your child has been admitted to hospital for this health problem. *(Enter a cross in a box for each item.)*

Illness/health problem	At 6 –11 months No	At 6 –11 months Yes	Number of times	At 12 -18 months No	At 12 -18 months Yes	Number of times	Was admitted to hospital for this? No	Was admitted to hospital for this? Yes
1.Common cold		EE215	EE216		EE217	EE218		EE219
2. Throat infection with confirmed streptococcal infection		EE971	EE972		EE973	EE974		EE975
3. Other type of sore throat		EE976	EE977		EE978	EE979		EE980
4. Ear infection		EE225	EE226		EE227	EE228		EE229
5. Pseudocroup		EE230	EE231		EE232	EE233		EE234
6. Bronchitis/RS virus/pneumonia		EE235	EE236		EE237	EE238		EE239
7. Gastric flu/diarrhoea		EE240	EE241		EE242	EE243		EE244
8. Urinary tract infection		EE245	EE246		EE247	EE248		EE249
9. Conjunctivitis		EE250	EE251		EE252	EE253		EE254

(cont.)

Illness/health problem	At 6 –11 months No	At 6 –11 months Yes	Number of times	At 12 -18 months No	At 12 -18 months Yes	Number of times	Was admitted to hospital for this? No	Was admitted to hospital for this? Yes
10. Febrile convulsions	EE255		EE256	EE257		EE258	EE259	
11. Other convulsions (without any fever)	EE260		EE261	EE262		EE263	EE264	
12. Chickenpox	EE866		EE867	EE868		EE869	EE870	
13. Injury or accident	EE265		EE266	EE267		EE268	EE269	
14. Other: EE275 EE710	EE270		EE271	EE272		EE273	EE274	

20. Has your child been to see the doctor or to the hospital between 6 and 11 months and/or 12 and 18 months? If yes, specify how many times. *(Enter a cross in a box for each item.)*

	At 6 – 11 months No	At 6 – 11 months Yes	At 6 – 11 months Number of times	At 12-18 months No	At 12-18 months Yes	At 12-18 months Number of times
GP (excluding mother and baby health centre)	EE276		EE277	EE278		EE279
Casualty doctor	EE280		EE281	EE282		EE283
Private specialist	EE284		EE285	EE286		EE287
Hospital outpatient clinic	EE288		EE289	EE290		EE291
Admitted to hospital	EE292		EE293	EE294		EE295

21. Has your child been referred to any of the following services?

	No	Yes
Habilitation service	EE871	
Educational psychology service	EE872	
Child psychiatric outpatient clinic/department	EE873	

22. If your child has been examined at or admitted to hospital, give the name of the hospital:

Hospital name: EE296 EE711 _____

Hospital name: EE297 EE712 _____

Hospital name: EE298 EE713 _____

23. Has your child had any of the following symptoms since the age of 6 months? If yes, at what age? *(Enter a cross in a box for each item.)*

	Had symptoms? No	Had symptoms? Yes	If yes, at what age? 6-8 mth	9-11 mth	12-14 mth	15 mth or more
1. Wheezing/whistling in the chest	EE299		EE300	EE301	EE302	EE303
2. Tightness in the chest	EE304		EE305	EE306	EE307	EE308
3. Coughing at night	EE309		EE310	EE311	EE312	EE313
4. Runny nose without a cold	EE314		EE315	EE316	EE317	EE318
5. Constipation	EE319		EE320	EE321	EE322	EE323
6. Diarrhoea	EE324		EE325	EE326	EE327	EE328
7. Itchy rash that comes and goes	EE329		EE330	EE331	EE332	EE333

24. Has your child ever been tested for allergies?

No
Yes EE334

25. If yes, what allergens were tested for and what was the result?
(You can enter a cross in more than one box.)

Test:		Was the test positive? No	Yes	Don't know
1.	Milk	EE335	EE336	
2.	Egg	EE337	EE338	
3.	Fish	EE339	EE340	
4.	Mould	EE341	EE342	
5.	Mites	EE343	EE344	
6.	Animals	EE345	EE346	
7.	Pollen	EE347	EE348	
8.	Other: EE351 EE714	EE349	EE350	

26. Have you ever tried any kind of so-called alternative medicine on your child since he/she was 6 months old?

No EE352
Yes EE353 times

27. If yes, what kind of alternative medicine?

EE354	EE715
EE355	EE716
EE356	EE717
EE357	EE718
EE358	EE719

28. Has your child received any medication since the age of 6 months? *(This means any type of medication, including natural medicines and herbal remedies)*

No
Yes EE362

29. If yes, give the name of the medication and what age your child was when he took it. *(Include all types of medication, as well as natural medicines)*

Name of medicine
(WRITE IN CAPITALS, e.g. APOCILLIN, PARACET)

			How old was your child when he/she took this medication? 6-8 mth	9-11 mth	12-14 mth	15-18 mth
EE720_K	EE363		EE364	EE365	EE366	EE367
EE721_K	EE368		EE369	EE370	EE371	EE372
EE722_K	EE373		EE374	EE375	EE376	EE377
EE723_K	EE378		EE379	EE380	EE381	EE382
EE1003_K	EE981		EE982	EE983	EE984	EE985

30. What were your child's length, weight and head circumference when he/she was around 8 months, 1 year and the last time they were measured (15–18 months)?
(Refer to your child's health card)

	Date of measurement Day	Month	Year	Length	Head circumference	Weight
Around 8 mth	Q9_A6E_8_M			EE387 cm	EE388 cm	EE386 g
Around 1 year	Q5_A6E_1_Y			EE393 cm	EE394 cm	EE392 g
15 - 18 mth	Q5_A6E_15_18_M			EE399 cm		EE398 g

Development and behaviour

In this section you will find some questions repeated in a different form. However, please answer all the questions as well as you can.

31. Can your child walk unaided? No Yes EE986

If yes, how old was your child when he/she could first walk unaided? **Number:** EE987 months.

32. The questions that follow are about your child's development at around the age of 18 months. *(Enter a cross in a box for each item.)*

	Yes	Sometimes	Not yet
1. When you ask him/her, does your child go into another room to find a familiar toy or object? (When you ask, for instance: "Where's your ball?", "Go and get your coat" or "Go and get your blanket")		EE403	
2. Does your child say eight or more words, in addition to "mamma" and "dadda"?		EE404	
3. Without showing him/her first, does your child point to the correct picture when you say "Show me the cat" or "Where is the dog"?		EE405	
4. Does your child move around by walking, rather than by crawling on his/her hands and knees?		EE406	
5. Can your child walk well and seldom fall?		EE407	
6. Does your child walk down stairs if you hold onto one of his/her hands?		EE408	
7. Does your child throw a small ball or toy with a forward arm motion? (If he/she simply drops the ball, enter a cross under "Not yet")		EE409	
8. Does your child stack a small block or toy on top of another? (For example, small boxes or toys about 3 cm in size)		EE410	
9. Does your child turn the pages in a book by himself/herself? (He/she may turn over more than one page at a time.)		EE411	
10. Does your child hug dolls or cuddly toys when playing with them?		EE412	
11. Does your child try to get your attention show you something by pulling your hand or clothes?		EE413	
12. Does your child come to you when he/she needs help, such as with opening a box?		EE414	
13. Does your child copy the activities you do, such as wiping up a spill, sweeping, shaving or combing hair?		EE415	

33. More about your child's development *(Enter a cross in a box for each item.)*

	Yes, usually	Very seldom	Not yet
1. Does your child use sounds or words together with gestures (e.g. uses sounds when pointing or reaching towards toys or objects)?		EE874	
2. When you look at a distant object and, surprised and excited, say: "Waoo...what's that?", – does he/she turn his/her head in the same direction as you?		EE875	
3. When you enthusiastically say: "Where is the ball (or other toy)?", will your child point towards the toy, even if it is more than 1 metre away?		EE876	
4. Does your child show you a toy by looking at you and holding the toy up towards your face (from a distance just so you can look at it)?		EE988	

34. How typical is the following behaviour of your child? *(Enter a cross in a box for each item.)*

	Very typical	Quite typical	Neither/ nor	Not so typical	Not typical
1. Your child cries easily			EE416		
2. Your child is always on the go			EE417		
3. Your child prefers playing with others rather than alone			EE418		
4. Your child is off running as soon as he/she wakes up in the morning			EE419		
5. Your child is very sociable			EE420		
6. Your child takes a long time to warm to strangers			EE421		
7. Your child gets upset or sad easily			EE422		
8. Your child prefers quiet, inactive games to more active ones			EE423		
9. Your child likes to be with people			EE424		
10. Your child reacts intensely when upset			EE425		
11. Your child is friendly towards and trusting of strangers			EE426		
12. Your child complains that certain garments are too tight			EE877		
13. Your child becomes distressed by having his/her face or hair washed			EE878		

35. About your child's behaviour We are asking you about how your child usually is. If something happens seldom (for instance, if you have only seen it one or twice), enter a cross under "No". *(Enter a cross in a box for each item.)*

	Yes	No
1. Is your child interested in different sorts of toys or objects and not for instance mainly in cars or buttons?		EE886
2. When your child expresses his/her feelings, for instance by crying or smiling, do you usually understand why your child is laughing or crying?		EE1004
3. Does your child react in a normal way to sensory stimulation, such as coldness, warmth, light, pain or tickling?		EE888
4. Can you easily tell from the face of your child how he/she feels?		EE889
5. When your child has been left alone for some time, does he/she try to attract your attention, for instance, by crying or calling?		EE891
6. Is your child's behaviour without stereotyped repetitive movements, e.g. banging his/her head against the wall or rocking his/her body back and forth?		EE990
7. Does your child like to be cuddled?		EE991
8. Does your child ever laugh directly at you or at other people?		EE992
9. Does your child react when spoken to, for instance, by looking, listening, smiling, speaking or babbling?		EE897
10. Does your child ever try to comfort you if you are sad or hurt?		EE898
11. Has your child ever had things that he/she seemed to have to do in a very particular way or order, or rituals that he/she has to have you do?		EE884
12. Does your child ever do things to get you to laugh?		EE885

36. More about your child's play and behaviour. We are asking you again about how your child usually is. If something seldom happens (for instance, if you have only seen it one or twice), enter a cross under "No". *(Enter a cross in a box for each item.)*

	Yes	No
1. Does your child enjoy being swung, bounced on your knee, etc.?		EE1005
2. Does your child take an interest in other children?		EE434
3. Does your child like climbing on things, such as up stairs?		EE429
4. Does your child enjoy playing peek-a-boo/hide-and-seek?		EE996
5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?		EE431
6. Does your child ever use his/her index finger to point, to ask for something?		EE998
7. Does your child ever use his/her index finger to point, to indicate interest in something?		EE997
8. Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling or dropping them?		EE433
9. Does your child ever bring objects over to you to show you something?		EE428
10. Does your child look you in the eye for more than a second or two?		EE1006
11. Does you child ever seem oversensitive to noise (e.g. plugging ears)?		EE900
12. Does your child smile in response to your face or your smile?		EE1000
13. Does your child imitate you (e.g. you make a face - will your child imitate it?)?		EE879
14. Does your child respond when you call his/her name?		EE901
15. If you point at a toy across the room, does your child look at it?		EE882
16. Does your child look at things you are looking at?		EE1001
17. Does your child make unusual finger movements near his/her face?		EE880
18. Does your child try to attract your attention to his/her own activity?		EE881
19. Have you every wondered if your child is deaf?		EE1002
20. Does your child understand what people say?		EE899
21. Does your child sometimes stare at nothing or wander with no purpose?		EE883
22. Does your child look at your face to check your reaction when faced with something unfamiliar?		EE902

37. To what extent are the following statements true of your child's behaviour during the last two months? *(Enter a cross in a box for each item.)*

	Not true	Somewhat or sometimes true	Very true or often true
1. Can't concentrate, can't pay attention for long		EE435	
2. Quickly shifts from one activity to another		EE961	
3. Can't sit still, restless or hyperactive		EE903	
4. Gets into everything		EE904	

(cont.)

	Not true	Somewhat or sometimes true	Very true or often true
5. Is mostly happy and contented		EE905	
6. Clings to adults or too dependent		EE438	
7. Gets too upset when separated from parents		EE439	
8. Gets into many fights		EE962	
9. Hits others		EE442	
10. Is defiant		EE446	
11. Doesn't seem to feel guilty after misbehaving		EE447	
12. Punishment doesn't change his/her behaviour		EE448	
13. Doesn't eat well		EE963	
14. Likes almost every kind of food		EE964	
15. Resists going to bed at night		EE906	
16. Doesn't want to sleep alone		EE440	
17. Afraid to try new things		EE907	
18. Disturbed by any change in routine		EE908	
19. Too fearful or anxious		EE909	

38. How often does your child usually wake during the night?

3 or more times every night EE453
Once or twice every night
A few times a week
Seldom or never

39. How many hours in total does your child sleep in 24hrs?

10 hours or less EE454
11 - 12 hours
13 -14 hours
15 hours or more

40. About your worries *(Enter a cross in a box for each item.)*

	No	Yes	Don't know
1. Are you worried about your child's physical development?	EE910		
2. Are you worried about your child's behaviour?	EE911		
3. Are you worried because your child is demanding and difficult to cope with?	EE912		
4. Are you worried because your child is so uninterested in other children?	EE1007		
5. Have you any other worries with regard to your child's health	EE914	Specify EE915 EE953	

(Use the last page if you need more space to write)

Your child's daily routine

41. Where has your child been cared for during the day? Enter a cross for the various age groups. *(Enter a cross in a box for each item.)*

	At home with his/her mother his/her father	At home with unqualified childminder	At home with an family creche nursery	At a childminder's/In an outdoor nursery
1. 0–6 months	EE466	EE467	EE468	EE469
2. 7-9 months	EE470	EE471	EE472	EE473
3. 10-12 months	EE474	EE475	EE476	EE477
4. 13-15 months	EE478	EE479	EE480	EE481
5. 16-18 months	EE482	EE483	EE484	EE485

42. How many hours a week is your child looked after in the current childcare scheme (other than by his/her mother and father)?

EE486 hours

43. How many children in total are looked after in this childcare scheme (if day-care centre, how many in the department)?

EE487 children

44. Do you and your child live with your child's father?

Yes EE488
No

45. If your child does not live with his/her father, how much time does your child spend with him?

At least half the time EE489
At least once a week
At least once a month
Less often than once a month
Never

46. How many times have you moved house since your child was born?

EE490 times

47. Roughly how many square metres is the living area where you currently live?

EE491 m^2

48. Are the rooms where your child is heated by electrical underfloor heating?

No Yes EE916

49. If yes, which rooms? *Enter a cross in more than one box, if appropriate)*

Living room	EE917	Hall	EE921
Kitchen	EE918	Bathroom	EE922
Child's room	EE919	Other rooms	EE923
Bedroom	EE920		

50. Has their been any damage caused by damp, any visible fungal/mould growth or mouldy smell in your home during the last year *(You can enter a cross in more than one box.)*

No	EE492
Yes, damage caused by damp	EE493
Yes, visible fungal/mould growth	EE494
Yes, mouldy smell	EE495

51. What type of drinking water do you have where you live?

Water from a public or private water company	EE496
Water from your own water supply (e.g. own well)	EE497
Don't know	EE498

52. Do you live close to high-voltage lines?

No
Yes, closer than 50 metres EE499
Yes, 50–100 metres away
Yes, but more than 100 metres away

53. Are there pets where your child lives or at the childminder's?

No EE500
Yes, at home EE947
Yes, at the childminder's EE948
EE949

54. If yes, what kind of pets?
(You can enter a cross in more than one box.)

Dog	EE501
Cat	EE502
Guinea pig, rabbit, mouse, rat, etc.	EE503
Budgie, other type of bird	EE504

Other type of animal: EE506 EE505 EE724 _____

55. Is your child ever present in a room where someone smokes?

EE507
Yes, every day Number of times per day EE508
Yes, several times a week
Yes, sometimes
Don't know
No

56. How many months old was your child when he/she got his/her first tooth?

Number of months EE1012
Don't remember EE1013

57. How often are your child's teeth brushed?

Twice a day or more EE509
Once a day
sometimes
Never

58. Do you use fluoride toothpaste when brushing your child's teeth?

No EE510
Sometimes
Yes, usually

59. How often is your child outside at the moment?

Seldom EE959
Often, but less than one hour a day on average
1 - 3 hours a day on average
More than 3 hours a day

60. How many hours on average does your child sit in front of a TV/video every day?

4 hours EE512
3 hours
1 -2 hours
Less than 1 hour
Seldom/never

61. Does your child go to or has been to swimming classes for babies?

EE513
No
Yes
If yes, how long has your child been going? EE514 months

62. Does your child use a dummy/pacifier now at 18 months?

Seldom or never EE515
Only when he/she goes to sleep
Quite often
Most of the time

ABOUT YOURSELF

Health, illness and use of medication

63. What is your civil status at the moment? EE520

Married
Cohabiting
Single
Separated/divorced
Widowed
Other

64. Are you pregnant at the moment? EE521

No
Yes

If yes, how many weeks? EE522

65. Are you suffering from a long-term illness that has started during the last 12 months?

No EE523
Yes, specify _____ EE524 EE725

66. Have you yourself been admitted to hospital during the last 12 months?

No EE525
Yes, which hospital? _____ EE526 EE726

67. Are you taking at the moment any cod liver oil, vitamins or other dietary supplements?

No EE527
Yes, specify

1. _____ EE528 EE727
2. _____ EE529 EE728
3. _____ EE530 EE729
4. _____ EE531 EE730

68. What is your current weight?

EE924 , kg

69. Have you during the last 6 months or at any time previously: *(Enter a cross in a box for each item.)*

	Last 6 months			Previously		
	Yes	Perhaps	No	Yes	Perhaps	No
1. Felt yourself that you were too fat?		EE925			EE926	
2. Been really afraid of putting on weight or becoming too fat?		EE927			EE928	
3. Heard others say you were too thin, while you yourself thought that you were too fat?		EE929			EE930	
4. Felt that it was extremely important for your self-image to maintain a particular weight?		EE931			EE932	

70. Have you at some time during the last 6 months or previously in your life - for a period lasting at least 3 months - experienced any of the following situations, and if so, how frequently was this? (Select the period you were affected the most.) *(Enter a cross in a box for each item.)*

	Last 6 months			Previously		
	At least twice a week	1-4 times a mth	Seldom/ never	At least twice a week	1-4 times a mth	Seldom/ never
1. Felt that you were losing control when eating and couldn't stop before you had eaten too much?		EE933			EE934	
2. Used vomiting to control your weight?		EE935			EE936	
3. Used laxatives to control your weight?		EE937			EE938	
4. Used fasting to control your weight?		EE939			EE940	
5. Used hard physical exercise to control your weight?		EE941			EE942	

71. Have you at some time during the last six months or previously in your life gone at least three months without any periods (without you being pregnant or giving birth/breast-feeding) in connection with a period when you had eating problems?

No, never EE943
Yes, during the last 6 months
Yes, previously

72. Have you experienced pain during the last 12 months in any of the following places? *(Enter a cross in a box for each item.)*

	Seldom/never	Slight pain	Some pain	Major pain
1. Stomach	EE532			
2. Arms/legs	EE533			
3. Neck/shoulders	EE534			
4. Head	EE535			
5. Back	EE536			
6. Pelvis (pelvic girdle pains)	EE537			

73. Have you experienced any pain in your back or pelvis during the last 12 months. Enter a cross to indicate how much pain you have felt in different places:

	Some pain	Major pain
1. In the small of the back	EE538	
2. One of the pelvic//sacroiliac joints at the back	EE539	
3. Both pelvic/sacroiliac joints at the back	EE540	
4. Over the coccygeal bone	EE541	
5. In the buttocks	EE542	
6. Over the pubic bone	EE543	
7. Groin	EE544	
8. Other back pains	EE545	
9. Other pains	EE546	

74. Currently, do you wake during the night because of pelvic pain?

No, never EE547

Yes, but seldom

Yes, often

75. Do you have such problems walking at the moment because of pelvic pains that you have to use a stick or crutches?

No, never EE548

Yes, but not every day - the pain varies from day to day

Yes, must use a stick or crutches every day

76. Did you receive any treatment for pelvic pain after your last birth?

No EE549

Yes

77. If yes, what type of treatment did you receive?
(You can enter a cross in more than one box.)

Physiotherapy EE550

Chiropractic EE551

Medication EE552

Other: EE553 EE554 EE731 _____

78. Do you have any of the following problems at the moment? *(Enter a cross in a box for each problem.)*

	How often do you have problems?					How much at a time?	
Problems:	Never	1–4 times a month	1–6 times a week	Once a day	More than Once a day	Drops	Large amounts
1. Incontinence when coughing, sneezing or laughing			EE555			EE556	
2. Incontinence during physical activity (running/jumping)			EE557			EE558	
3. Incontinence with a strong need to urinate			EE559			EE560	
4. Problems retaining faeces			EE561				
5. Problems retaining flatus			EE562				

79. Do you regularly take medication? *(This means any type of medication, including natural medicines.)*

No EE563

Yes

80. If yes, give the name of the medicines and how often you take them. *(Include all types of medication, as well as natural medicines.)*

Name of medicine *(e.g. APOCILLIN, PARACET)*			How often do you take them? Every day	Every day for certain periods	Sometimes
	EE732_K	EE564		EE565	
	EE733_K	EE566		EE567	
	EE734_K	EE568		EE569	
	EE735_K	EE570		EE571	

Finances – lifestyle

81. How much leave did you and the child's father take after the birth? *(Specify either the number of months or weeks.)*

	Months		Weeks
Yourself	EE572	or	EE573
Child's father	EE574	or	EE575

82. Are you in paid employment?

No EE576

Yes

83. If so, how many hours do your work a week?

EE577 hours

84. If you are in paid employment, have you taken any time off sick since you went back to work? If yes, specify how many days you were off sick.

		Number of days
No	EE578	
Yes, due to own illness.	EE579	EE580
Yes, due to your child being ill.	EE581	EE582

85. Would your current finances allow you to cope with an unexpected bill of NOK 3,000 for a dental visit or a repair, for instance?

No EE583

Yes

Don't know

86. Have you found it difficult sometimes during the last six months to cope with running expenses for food, transport, rent, etc.?

No, never EE584

Yes, but infrequently

Yes, sometimes

Yes, often

87. How often are you so physically active (during your spare time or at work) that you get out of breath and sweat?

	Spare time	At work
1. Never	EE585	EE586
2. Less than once a week		
3. Once a week		
4. Twice a week		
5. 3-4 times a week		
6. 5 times or more a week		

88. How often do you exercise at present? *(Enter a cross in a box for each item.)*

Activity		Never	1-3 times a month	Once a week	Twice a week	3 times or more a week
1. Walking	EE590					
2. Brisk walking	EE591					
3. Running/jogging/orienteering	EE592					
4. Cycling	EE593					
5. Training studio/weight training	EE594					
6. Aerobics/gymnastics/dance without running and jumping	EE595					
7. Aerobics/gymnastics/dance with running and jumping	EE596					
8.Dancing (swing/rock/folk)	EE597					
9. Skiing	EE598					
10. Ball sports	EE599					
11. Swimming	EE600					
12. Riding	EE601					
13. other	EE602					

89. What are your and your partner's smoking habits at home at the moment?

	Yourself	Your partner/ husband
1. Don't smoke	EE603	EE605
2. Smoke sometimes		
3. Smoke every day		
4. If every day, number of cigarettes per day	EE604	EE606

90. How often do you consume alcohol at the moment?

EE607

- Roughly 6–7 times a week
- Roughly 4–5 times a week
- Roughly 2-3 times a week
- Roughly once a week
- Roughly 1-3 times a month
- Less often than once a month
- Never

91. How many units do you usually drink when you consume alcohol? (Enter a cross for both weekends and weekdays). *(See explanation below.)*

	Weekend	Weekdays
10 or more	EE608	EE609
7-9		
5-6		
3-4		
1-2		
Less than 1		

Alcohol units

In order to compare different types of alcohol, we ask for the number of alcohol units (= 1.5 cl of pure alcohol). This means the following in practice:

1 glass (1/3 litre) of beer	= 1 unit
1 wine glass of red or white wine	= 1 unit
1 sherry glass of sherry or other fortified wine	= 1 unit
1 brandy glass of spirits or liqueur	= 1 unit
1 bottle of alcopop/cider	= 1 unit

A little more about yourself and how you are keeping now

92. If you have a husband/boyfriend/partner, to what extent do you agree with the following descriptions? *(Enter a cross in a box for each item.)*

	Totally agree	Agree	Slightly agree	Slightly disagree	Disagree	Totally disagree
1. My husband/partner and I have a close relationship	EE610					
2. My partner and I have problems in our relationship	EE611					
3. I am very happy in my relationship	EE612					
4. My partner is usually understanding	EE613					
5. I often think about ending our relationship	EE614					
6. I am satisfied with my relationship with my partner	EE615					
7. We often disagree about important decisions	EE616					
8. I have been lucky in my choice of partner	EE617					
9. We agree on how children should be raised	EE618					
10. I think my partner is satisfied with our relationship	EE619					

93. Do you have anyone other than yourspouse/boyfriend/partner whom you can seek advice from in a difficult situation?

EE620

- No
- Yes, 1 or 2 people
- Yes, more than 2 people

94. How often do you see or talk on the telephone to your family (apart from your household) or close friends?

EE621

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

95. Do you often feel lonely?

EE622

- Almost never
- Seldom
- Sometimes
- Generally
- Almost always

96. How accurate are these statements to you? *(Enter a cross in a box for each item.)*

	Not accurate	Slightly accurate	Almost accurate	Totally accurate
1. I always manage to solve difficult problems if I try hard enough	EE623			
2. If anyone opposes me, I find a way to get what I want	EE624			
3. I am sure that I can cope with unexpected events	EE625			
4. I am calm when I encounter difficulties because I trust my ability to cope	EE626			
5. When I am in a difficult situation, I usually find a solution	EE627			

97. In your daily life, how often do you *(Enter a cross in a box for each item.)*

		Seldom/ never	Fairly seldom	Sometimes	Often	Very often
1. Feel pleased about something	EE628					
2. Feel happy	EE629					
3. Feel joyful, as though everything is going your way	EE630					
4. Feel that you will scream at someone or hit something.	EE631					
5. Feel angry, irritated or annoyed	EE632					
6. Feel mad at somebody	EE633					

98. How do you feel about yourself? *(Enter a cross in a box for each item.)*

		Totally agree	Agree	Disagree	Totally disagree
1. I have a positive attitude towards myself	EE634				
2. I feel completely useless at times	EE635				
3. I feel that I do not have much to be proud of	EE636				
4. I feel that I'm a valuable person, as good as anyone else	EE637				

99. 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	EE638				
2. Nervousness or shakiness inside	EE639				
3. feeling hopeless about the future	EE640				
4. Feeling blue	EE641				
5. Worrying too much about things	EE642				
6. Feeling everything is an effort	EE643				
7. Feeling tense or keyed up	EE644				
8. Suddenly scared for no reason	EE645				

100. Have you experienced any of the following situations in the last year (since the previous questionnaire)? If yes, how painful and difficult was this for you? *(Enter a cross in a box for each item.)*

	No	Yes	If yes: Not so bad	If yes: Painful/ difficult	If yes: Very painful/ difficult
1. Have had problems at work or where you study	EE649	EE650			
2. Have had financial problems	EE651	EE652			
3. Have been divorced, separated or ended your relationship with your partner	EE653	EE654			
4. Have had problems or conflicts with your family, friends or neighbours	EE655	EE656			
5. Have been seriously worried that there is something wrong with your child	EE657	EE658			
6. Have been seriously ill or injured (your self)	EE659	EE660			
7. Has anyone close to you been seriously ill or injured	EE661	EE662			
8.Have been involved in a serious accident, fire or robbery	EE663	EE664			
9. Have lost someone close to you	EE665	EE666			
10. Have been pressurized into having sexual intercourse	EE667	EE668			
11. Other	EE669	EE670			

101. How would you rate your quality of life?

Very poor	EE671
Poor	
Neither poor nor good	
Good	
Very good	

102. How satisfied are you with your health?

Very dissatisfied	EE672
Dissatisfied	
Neither satisfied nor dissatisfied	
Satisfied	
Very satisfied	

103. The following questions ask about how much you have experienced certain things in the last two weeks. *(Enter a cross in a box for each item.)*

		Not at all	A little	A certain amount	A lot/ very	Totally/ extremely
1.	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	EE673				
2.	To what extent do you need medical treatment to be able to function in your daily life?	EE674				
3.	How much do you enjoy life?	EE675				
4.	To what extent do you feel your life to be meaningful?	EE676				
5.	How well are you able to concentrate?	EE677				
6.	How safe do you feel in your daily life?	EE678				
7.	How healthy is your physical environment?	EE679				

104. The following questions ask about how completely you experienced or were able to do certain things in the last two weeks. *(Enter a cross in a box for each item.)*

		Not at all/None	A little	To a certain extent	Mostly Almost	Always
1.	Do you have enough energy for everyday life?	EE680				
2.	Are you able to accept your bodily appearance?	EE681				
3.	Have you enough money to meet your needs?	EE682				
4.	How accessible is the information that you need in your day-to-day life?	EE683				
5.	To what extent do you have the opportunity for leisure activities?	EE684				

105. How well are you able to get around?

Very badly	EE685
Badly	
Neither well nor badly	
Well	
Very well	

106. The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks. *(Enter a cross in a box for each item.)*

		Very dissatisfied	Dis- satisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
1.	How satisfied are you with your sleep?	EE686				
2.	How satisfied are you with your ability to perform your daily living activities?	EE687				
3.	How satisfied are you with your capacity for work?	EE688				
4.	How satisfied are you with yourself?	EE689				
5.	How satisfied are you with your personal relationships?	EE690				
6.	How satisfied are you with your sex life?	EE691				
7.	How satisfied are you with the support you get from your friends?	EE692				
8.	How satisfied are you with the conditions where you live?	EE693				
9.	How satisfied are you with your access to health services?	EE694				
10.	How satisfied are you with your transport?	EE695				

107. The following question relates to how often you have experienced or had negative feelings during the last two weeks?

		Never	Seldom	Quite often	Very often	Always
How often do you have negative feelings, such as blue mood, despair, anxiety, depression?	EE696					

COMMENTS:

EE697

CHILD'S MEASUREMENTS AND WEIGHT

108. If any of the measurements in Question 30 are missing from the child's health card, can we contact the well baby clinic for them?

No EE944

Yes Name of well baby clinic _____ EE945 EE954

Post code or district _____ EE946 EE955

Have you remembered to fill in on page 1 the date on which you completed the questionnaire?

Thank you very much for your help!

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

Den norske Mor og Barn undersøkelsen
Nasjonalt folkehelseinstitutt
Avd. for medisinsk fødselsregister
Kalfarveien 31
5018 Bergen