The Raine Study Gen2_27 year follow up

Thank you for completing this questionnaire.

The purpose of this questionnaire is to collect background information about you that may be related to your general health and well being

Please complete all the questions.

Please use a pen to complete the questionnaire

All your responses are confidential and will be de-identified. Your responses will be entered and kept in a secure database and only used for analyses as part of a large de-identified amalgamated database. This questionnaire will have your contact details removed. It will then be stored with all other Raine Study information in our secure storage facilities.

If you have any questions please contact the Raine Study, telephone 6488 6952, mobile 0447 863944, email: rainestudy@uwa.edu.au.

CONTACT DETAILS

Your contact details will not be stored with your questionnaire information. All contact details are stored separately in a secure password protected database and are not used for any other purpose

Your name, surname..... FIRST NAME SURNAME (SENSITIVE)

Date you completed the questionnaire..... DNWN

Contents

1. BACKGROUND

The following questions ask about you, your relationships, your education and household and are important factors that may influence your health and well-being.

CHILDREN

Do you have any biological children? CH

0 ○ No (*Please go to Q1.2*)

1 ○ Yes

What is/are your children's date(s) of birth?

Please list each of your children's sex and date of birth

	Male	Female	Date of Birth (SENSITIVE) / YEAR OF BIRTH
First child PCSX1	0	1	CHDD1 (SENSITIVE) / PCBY1
Second child PCSX2	0	1	CHDD2 (SENSITIVE) / PCBY2
Third child PCSX3	0	1	CHDD3 (SENSITIVE) / PCBY3
Fourth child PCSX4	0	1	CHDD4 (SENSITIVE) / PCBY4

1.2 Are you or is your partner currently pregnant? PG_CUR_1 & PG_CUR_P

○ No, *(Please go to 1.3)* ○ Yes, I am pregnant ○ Yes, my partner is pregnant

NOTE
In data we have 2 variables for Q1.2
G227_PG_CUR (Are you currently pregnant?) with values 0 (No) and 1 (Yes)
G227_PG_CUR_P (Is your partner currently pregnant?) with values 0 (No) and 1 (Yes)

What is the expected due date of your baby? PG_EDD .....

1.3 Are you and your partner trying for a baby at the moment? PG_PL2

0 ○ No, please go to Q2 1 ○ Yes

When did you start trying? PG_PL3

0 ○ < 3 months ago
1 ○ 3 to 6 months ago
2 ○ 6 – 12 months ago
3 ○ Longer than one year ago

2. ACCOMMODATION

What type of accommodation do you live in? *(Please select one)* DWEL

1 ○ A separate house
2 ○ Semi-detached house/row or terrace house/townhouse etc
3 ○ Flat/unit/apartment
4 ○ "Granny" flat
5 ○ Caravan, park home, boat
6 ○ Aged care accommodation or nursing home
7 ○ Homeless, temporary accommodation, improvised home, tent, sleeping out
8 ○ Other *(please specify)* ..... DWEL_OTH .....

The dwelling is: *(Please select one)* DWEL1

1 ○ Owned outright
2 ○ Owned with a mortgage
3 ○ Being purchased under a rent/buy scheme
4 ○ Being rented
5 ○ Being occupied rent free
6 ○ Being occupied under a life tenure scheme
0 ○ None of the above

Who do you live with? *(Please select all that apply)*

○ I live alone LIV1
○ With a partner LIV2
○ My child/children/step children LIV3
○ My parent(s)/step-parent(s)/in-laws LIV4
○ Other relatives LIV5
○ Friends LIV6 26/04/2023
LIV6 & LIV7 were combined into LIV9-My frients/flatmates (shared accomodation)
○ Shared accommodation LIV7
○ Other - please specify ..... LIV8 & LIV8_OTH .....

3. INCOME

Are you receiving any government benefits, pension or allowance? BNF

- 0 ○ No (*Please go to Q3.1)*
- 1 ○ Yes
- 2 ○ Prefer not say (*Please go to Q3.1)*

Which government benefits, pension or allowance are you receiving? *(Please select all that apply)*

- BN28 ○ Baby Bonus
- BN20 ○ Carer Allowance (child)
- BN23 ○ Carer Payment (child)
- BN21 ○ Carer Allowance (adult)
- BN22 ○ Carer Payment (adult)
- BN25 ○ Child Care Benefit
- BN26 ○ Child Care Rebate
- BN31 ○ Crisis Payment
- BNF4 ○ Disability Support pensions
- BN15 ○ Family Tax Benefit Part A
- BN16 ○ Family Tax Benefit Part B
- BN27 ○ JET Child Care Fee
- BN29 ○ Assistance Maternity Immunisation
- BN18 ○ Mobility Allowance
- BN11 ○ Newstart Allowance
- BNF2 ○ Parenting Payment
- BN14 ○ Remote area/zone allowance
- BN17 ○ Rent Assistance
- BNF7 ○ Sickness Allowance
- BNF6 ○ Workers comp
- BNF9 ○ Other benefit - please specify: BNF9_OTH

3.1. What is the total amount of YOUR usual salary/wage, before tax, per week or benefit payment per week (annual amount in brackets)? *(Please select one)* INC1_BT

- ○ No Income
- ○ $1-$149 ($1-$7,799)
- ○ $150-$299 ($7,800-$15,599)
- ○ $300-$399 ($15,600-$20,799)
- ○ $400-$499 ($20,800-$25,999)
- ○ $500-$649 ($26,000-$33,799)
- ○ $650-$799 ($33,800-$41,599)
- ○ $800-$999 ($41,600-$51,999)
- ○ $1,000-$1,249 ($52,000-$64,999)
- ○ $1,250-$1,499 ($65,000-$77,999)
- ○ $1,500-$1,749 ($78,000-$90,999)
- ○ $1,750-$1,999 ($91,000-$103,999)
- ○ $2,000-$2,499 ($104,000-$129,999)
- ○ $2,500-$2,999 ($130,000-$155,999)
- ○ $3,000 or more ($156,000 or more)
- ○ Don't know
- ○ Prefer not to say

NOTE
In data, (YOUR) income has been regrouped and coded as follows:

- 0 ○ No Income
- 1 ○ $1-$299 ($1-$15,599)
- 2 ○ $300-$399 ($15,600-$20,799)
- 3 ○ $400-$799 ($20,800-$41,599)
- 4 ○ $800-$999 ($41,600-$51,999)
- 5 ○ $1,000-$1,249 ($52,000-$64,999)
- 6 ○ $1,250-$1,499 ($65,000-$77,999)
- 7 ○ $1,500-$1,999 ($78,000-$103,999)
- 8 ○ $2,000-$2,499 ($104,000-$129,999)
- 9 ○ $2,500-$2,999 ($130,000-$155,999)
- 10 ○ $3,000 or more ($156,000 or more)
- 11 ○ Don't know
- 12 ○ Prefer not to say

What is the total amount of YOUR HOUSEHOLD'S usual salary/wage, before tax, per week or benefit payment per week? (All adult income combined, annual amount in brackets) *(Please select one)* INC2_BT

- ○ No Income
- ○ $1-$149 ($1-$7,799)
- ○ $150-$299 ($7,800-$15,599)
- ○ $300-$399 ($15,600-$20,799)
- ○ $400-$499 ($20,800-$25,999)
- ○ $500-$649 ($26,000-$33,799)
- ○ $650-$799 ($33,800-$41,599)
- ○ $800-$999 ($41,600-$51,999)
- ○ $1,000-$1,249 ($52,000-$64,999)
- ○ $1,250-$1,499 ($65,000-$77,999)
- ○ $1,500-$1,749 ($78,000-$90,999)
- ○ $1,750-$1,999 ($91,000-$103,999)
- ○ $2,000-$2,499 ($104,000-$129,999)
- ○ $2,500-$2,999 ($130,000-$155,999)
- ○ $3,000-$3,499 ($156,000-$181,999)
- ○ $3,500-$3,999 ($182,000-$207,999)
- ○ $4,000 or more ($208,000 or more)
- ○ Don't know
- ○ Prefer not to say

Note
In data, FAMILY income has been regrouped and coded as follows:

- 0 ○ No Income
- 1 ○ $1-$299 ($1-$15,599)
- 2 ○ $300-$399 ($15,600-$20,799)
- 3 ○ $400-$799 ($20,800-$41,599)
- 4 ○ $800-$999 ($41,600-$51,999)
- 5 ○ $1,000-$1,249 ($52,000-$64,999)
- 6 ○ $1,250-$1,499 ($65,000-$77,999)
- 7 ○ $1,500-$1,999 ($78,000-$103,999)
- 8 ○ $2,000-$2,499 ($104,000-$129,999)
- 9 ○ $2,500-$2,999 ($130,000-$155,999)
- 10 ○ $3,000-$3,499 ($156,000-$181,999)
- 11 ○ $3,500-$3,999 ($182,000-$207,999)
- 12 ○ $4,000 or more ($208,000 or more)
- 13 ○ Don't know
- 14 ○ Prefer not to say

Do you currently have any of the following? (excluding Medicare) (*Please select all that apply*)

- ○ Private health insurance HINS2
- ○ Health care concession card HINS3
- ○ None HINS1
- ○ Other, please specify ..... HINS4 & HINS4_OTH

4. EDUCATION

What is the highest level of education or training you have completed? *(Please select one)* ED33

- 0 ○ Did not go to school
- 1 ○ Primary school
- 2 ○ Secondary school (high school)
- 3 ○ Apprentice
- 4 ○ TAFE, college
- 5 ○ Other training course
- 6 ○ University undergraduate degree
- 7 ○ University post graduate degree

NOTE
Value labels have been changed to the following, due to alignment of this variable across years.
0=Did not go to school
1=Primary school
2=Secondary school (high school)
3=TAFE, college
4=University undergraduate degree
5=University post graduate degree
6=Apprentice
7=Other training course (eg. Vocational training course, personal training course)
111=For Y20 only - Other education excluding primary/secondary school and University
222=For Y22 only - Other education excluding primary/secondary school, TAFE, college, and University
999=not stated

What is the highest year of high school you have completed? *(Please select one)* ED34

- 1 ○ Year 12 (or equivalent)
- 2 ○ Year 11 (or equivalent)
- 3 ○ Year 10 (or equivalent)
- 4 ○ Year 9 (or equivalent)
- 5 ○ Other, please specify ED34_OTH

Are you currently studying or doing a course? EED35(No=0,Yes=1) D35A

- 8 ○ No, (*please go to Q4.1)*
- 1 ○ Yes – Studying full-time
- 2 ○ Yes – Studying part-time

Where are you studying? ED36

- 1 ○ University
- 2 ○ TAFE/College
- 3 ○ Vocational training (e.g. emergency services
- 4 ○ Other, please specify ED36_OTH

.....

4.1 Did you take a gap year before or during your studies? EDGAP1

- 0 ○ No, (*please go to Q4.2)*
- 1 ○ Yes, When did you take it (after high school, after 1st year of studying) EDGAP2

.....

For how long (months)..... EDGAP3

Where did you spend your gap year?..... EDGAP4

.....

4.2 How many years have you been in education? Please write down the number of years you spent at each stage of your education.

	Years
School education (primary and secondary)	EDYR1
TAFE, Technical College	EDYR2
Vocational training	EDYR3
University - undergraduate	EDYR4
University - postgraduate	EDYR5
Other studies	EDYR6

Other studies - specify EDYR6_OTH

5. WORK

The following questions are about your work history, workplace environment and job satisfaction

What has been your usual occupation or job? YJOB

Which of the following describes your current employment situation? *(Please select one)* YWRK

0 ○ Retired
1 ○ Employed full-time (casual or permanent)
2 ○ Employed part-time (casual or permanent)
3 ○ Employed, but away from work (e.g. on long service leave)
4 ○ Unemployed looking for full time work (Please go to Q5.1)
5 ○ Unemployed looking for part time work (Please go to Q5.1)
6 ○ Not in the labour force (not looking for work, unable to work) (Please to Q5.1)
7 ○ Do paid casual work
8 ○ Doing unpaid or voluntary work
9 ○ Other, please specify..... YWRK_OTH

G227_YWRK_YN
Variable label:
"Are you currently in a paid employment? Yes/No"
Values:
0/4/5/6/8/9 of G227_YWRK corresponds to 0=No in G227_YWRK_YN, and 1/2/3/7 of G227_YWRK corresponds to 1=Yes in G227_YWRK_YN.

What is your current occupation or job?

a. Job title..... YEMP G227_YJOB_CODE

b.Job description YJOB_DESC.....

c. Street address ..... JOB_ADDRESS (SENSITIVE).....

For how many years or months have you worked in your current occupation or job?

YMON_TOTAL (= TOTAL MONTHS)

a. Years..... -dropped

b. Months..... -dropped

Industry: For your current job (the one you work the most hours in each week), what industry do you work in? *(Please select one)?* YIND

1 ○ A - Agriculture, Forestry and Fishing
2 ○ B - Mining
3 ○ C - Manufacturing
4 ○ D - Electricity, Gas, Water and Waste Services
5 ○ E - Construction
6 ○ F - Wholesale Trade
7 ○ G - Retail Trade)
8 ○ H - Accommodation and Food Services
9 ○ I - Transport, Postal and Warehousing
10 ○ J - Information Media and Telecommunications
11 ○ K - Financial and Insurance Services
12 ○ L - Rental, Hiring and Real Estate Services
13 ○ M - Professional, Scientific and Technical Services
14 ○ N - Administrative and Support Services
15 ○ O - Public Administration and Safety
16 ○ P - Education and Training
17 ○ Q - Health Care and Social Assistance
18 ○ R - Arts and Recreation Services
19 ○ S - Other Services YIND_OTH

G227_YHRS_CAT
0 hours =0
1 - 15 hours =1
16 - 24 hours =2
25 - 34 hours =3
35 - 39 hours =4
40 hours =5
41 - 48 hours =6
49 - 55 hours =7
more than 55 hours=8
Not applicable =888
Not stated =999

How many hours per week do you usually work in all (current) jobs? *(Please select one)* G227_YHRS_CAT

0 ○ 1-15
1 ○ 16-24
2 ○ 25-34
3 ○ 35-39
4 ○ 40
5 ○ 41-48
6 ○ 49-55
7 ○ More than 55

renamed the variable, and recoded values as above in order to align this variable across all years

***5.1* Please list the main jobs that you have had in the last 5 years, starting from the most recent.** *(not including your current job)*

Occupation	Industry code (see above, A, B etc)	Approx number of years
JOB1 - JOB9	JOB1_IND - JOB9_IND	JOB1_YR - JOB9_YR

The following questions are about your working environment and job satisfaction.

How often do you get help or support from your colleagues? WSU1

- 4 ○ Always
- 3 ○ Often
- 2 ○ Sometimes
- 1 ○ Seldom
- 0 ○ Never/hardly ever
- 7 ○ Not relevant
- 8 ○ Do not work *(please go to Q6)*

How often do you get help or support from your supervisors? WSU2

- 4 ○ Always
- 3 ○ Often
- 2 ○ Sometimes
- 1 ○ Seldom
- 0 ○ Never/hardly ever
- 7 ○ Not relevant

Please indicate your response to the following statements:

	Strongly agree 4	Agree 3	Neither agree or disagree 2	Disagree 1	Strongly disagree 0
The job allows me to make a lot of decisions on my own WAD7	☐	☐	☐	☐	☐
I can work at home sometimes WAD2	☐	☐	☐	☐	☐
The job allows me to plan how I do my work WAD8	☐	☐	☐	☐	☐
I can control the way I work WAD1	☐	☐	☐	☐	☐
The job involves performing relatively simple tasks WAD9	☐	☐	☐	☐	☐
The job requires that I engage in a large amount of thinking WAD10	☐	☐	☐	☐	☐
I never seem to have enough time to get everything done at work WAD11	☐	☐	☐	☐	☐
The job requires a lot of physical effort WAD12	☐	☐	☐	☐	☐

Is your work heavy or monotonous? *Please indicate on the scale below* WK1

Not at all									Extremely
1	2	3	4	5	6	7	8	9	10

Which of the following statements best describes the work that you do in your current job *(Please select one)* WK2

1 ○ Sedentary occupation (e.g. secretary- where you spend most of your time sitting)

2 ○ Standing occupation (e.g. shop assistant, security guard spend most of your time standing/walking but not intense physical effort)

3 ○ Physical work (e.g. plumber, nurse - a job that requires some physical effort including handling of heavy objects and use of tools)

4 ○ Heavy manual work (e.g. bricklayer - a job that involves very vigorous physical activity including handling very heavy objects)

If you take into consideration your work routines, management, salary, promotion possibilities and work mates, how satisfied are you with your job? *(Please select one)* WSAT

Not satisfied at all									Completely satisfied
1	2	3	4	5	6	7	8	9	10

Now please think of your work experiences over the past 4 weeks (28 days). In the spaces provided below, write the number of days you spent in each of the following work situations.

In the past 4 weeks (28 days), how many days did you?

	Days
Miss an entire work day because of problems with your physical or mental health? *(Please include only days missed for your own health, not someone else's health.)*	WMS1
Miss an entire work day for any other reason (including vacation).	WMS2
Miss part of a work day because of problems with your physical or mental health? *(Please include only days missed for your own health, not someone else's health.)*	WMS3
Miss part of a work day for any other reason (including vacation).	WMS4
Come in early, go home late, or work on your day off?	WMS5

About how many hours altogether did you work in the past 4 weeks (28 days)?

As a guide if you work for 8 hours on a typical working day then a:

5 day working week = 40 hour working week x 4 = 160 hours
4 day working week = 32 hour working week x 4 = 128 hours
3 day working week = 24 hour working week x 4 = 96 hours
2 day working week = 16 hour working week x 4 = 64 hours
1 day working week = 8 hour working week x 4 = 32 hours

Number of hours worked in the past 4 weeks (28 days)? WHRS_TRUNC ..... hours

Number of hours worked in the past 4 weeks (28 days)? - truncated at 18hrs a day, 7 days a week, 4 weeks = 504 hours

On a scale from 0 to 10 where 0 is the worst job performance any one could have at your job and 10 is the performance of a top worker:

	Worst performance 0	1	2	3	4	5	6	7	8	9	Top performance 10
How would you rate the usual performance of most workers in a job similar to yours? WPF1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How would you rate your usual job performance over the past year or two? WPF2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How would you rate your overall job performance on the days you worked during the past 4 weeks (28 days)? WPF3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Bullying at work

Bullying takes place when one or more persons systematically and over time feel that they have been subjected to negative treatment from one or one or more persons, in a situation in which the person(s) exposed to the treatment has difficulty in defending themselves against them. If there has been a one or two times when you have had a conflicting situation with someone equally strong as you, this is not bullying.

Have you been bullied at work? BU7(No=0, Yes=1)

How often were you bullied? BU7A

1 ○ Yes, occasionally
2 ○ Now and then
3 ○ Once a week
4 ○ Several times a week

6. GENERAL HEALTH

We realise that some of these questions may seem very personal, but all information that you provide us is helpful. As before, even if some questions seem remarkably similar, we need to ask you each and every one. Please answer them carefully and independently.

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. *For each of the following questions please mark the box that best describes your answer.*

(1)	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is? OAL8	1	2	3	4	5

The following questions are about activities you might do during a typical day. Does your **health now limit you** in these activities? If so, how much?

(2)	Yes, limited a lot	Yes, limited a little	No, not limited at all
(a) **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf LI12	1	2	3
(b) Climbing **several** flights of stairs LI14	1	2	3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

(3)	All of the time	Most of the time	Some of the time	A little of the time	None of the time
(a) **Accomplished less** than you would like LI22	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
(b) Were limited in the **kind** of work or other activities LI23	☐	☐	☐	☐	☐

During the past **4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

(4)	All of the time	Most of the time	Some of the time	A little of the time	None of the time
(a) **Accomplished less** than you would like LI26	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
(b) Did work of other activities **less carefully than usual** LI27	☐	☐	☐	☐	☐

(5)	Not at all	Slightly	Moderately	Quite a bit	Extremely
During the **past 4 weeks**, how much did **pain** interfere with your normal work? (including both work outside the home and housework) PN26	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

These questions are about how you feel and how things have been with you **during the past 4 weeks.** For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**.

(6)	Not at all 1	A little bit 2	Moderately 3	Quite a bit 4	Extremely 5
Have you felt calm and peaceful? FE23	☐	☐	☐	☐	☐
Did you have a lot of energy? FE24	☐	☐	☐	☐	☐
Have you felt downhearted and depressed? FE25	☐	☐	☐	☐	☐

(7)	All of the time	Most of the time	Some of the time	A little of the time	None of the time
During the past 4 weeks, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)? LI28	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

derived variables Labels

BP_T: SF-12 Bodily Pain Domain T-Score
GH_T: SF-12 General Health Domain T-Score
MCS: SF-12 Mental Health Composite Score
MH_T: SF-12 Mental Health Domain T-Score
PCS: SF-12 Physical Health Composite Score
PF_T: SF-12 Physical Function Domain T-Score
RE_T: SF-12 Role Emotional Domain T-Score
RP_T: SF-12 Role Physical Domain T-Score
SF_T: SF-12 Social Functioning Domain T-Score
VT_T: SF-12 Vitality Domain T-Score

How tense or anxious have you felt in the past week? *(Please select one)* LI36

Absolutely calm and relaxed 0	1	2	3	4	5	6	7	8	9	**anxious as I have ever felt** 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How much have you been bothered by feeling depressed in the past week? *(Please select one)* LI37

Not at all 0	1	2	3	4	5	6	7	8	9	**Extremely** 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

DERIVED VARIABLE LABEL

OREBRO OMPSQ-SF score

7. GENERAL MOOD AND WELLBEING.

Please read each statement and select a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

	Did not apply to me at all	Applied to me to some degree, or some of the time	Applied to me a considerable degree, or a good part of time	Applied to me very much, or most of the time	
I found it hard to wind down	0	1	2	3	G227_DASS22
I was aware of dryness of my mouth	0	1	2	3	G227_DASS2
I couldn't seem to experience any positive feeling at all	0	1	2	3	G227_DASS3
I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion.)	0	1	2	3	G227_DASS4
I found it difficult to work up the initiative to do things	0	1	2	3	G227_DASS42
I tended to over-react to situations	0	1	2	3	G227_DASS6
I experienced trembling (e.g. in the hands)	0	1	2	3	G227_DASS41
I felt that I was using a lot of nervous energy	0	1	2	3	G227_DASS12
I was worried about situations in which I might panic and make a fool of myself	0	1	2	3	G227_DASS40
I felt that I had nothing to look forward to	0	1	2	3	G227_DASS10
I found myself getting agitated	0	1	2	3	G227_DASS39
I found it difficult to relax	0	1	2	3	G227_DASS8
I felt down-hearted and blue	0	1	2	3	G227_DASS26
I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3	G227_DASS35
I felt I was close to panic	0	1	2	3	G227_DASS28
I was unable to become enthusiastic about anything	0	1	2	3	G227_DASS31
I felt I wasn't worth much as a person	0	1	2	3	G227_DASS17
I felt that I was rather touchy	0	1	2	3	G227_DASS18
I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3	G227_DASS25
I felt scared without any good reason)	0	1	2	3	G227_DASS20
I felt that life was meaningless	0	1	2	3	G227_DASS38

DERIVED VARIABLE LABEL

G227_DASS_ANX_CAT: DASS - Anxiety Score Category
G227_DASS_ANX_SCORE: DASS - Anxiety Score
G227_DASS_DEP_CAT: DASS - Depression Score Category
G227_DASS_DEP_SCORE: DASS - Depression Score
G227_DASS_STR_CAT: DASS - Stress Score Category
G227_DASS_STR_SCORE: DASS - Stress Score
G227_DASS_TOT_SCORE: DASS - Overall Score

7.2 Have any of the following happened to you in the last year? *(Please select all that apply)*

LST13 ○ Serious illness or injury to yourself
LST14 ○ Serious illness or injury to a close relative
LST2 ○ Death of a close family member
LST3 ○ Death of a close family friend or relative
LST4 ○ Separation due to marital difficulties
LST16 ○ Broken off a steady relationship
LST15 ○ Serious problem with a close friend, neighbour or relative
LST17 ○ Unemployed/seeking work for more than one month
LST7 ○ Your own job loss (not voluntary)
LST9 ○ Major financial crisis
LST18 ○ Problems with police and court appearance
LST19 ○ Something valuable lost or stolen

The following questions are about your feelings in the past 4 weeks

	All of the time 5	Most of the time 4	Some of the time 3	A little of the time 2	None of the time 1
1. In the past 4 weeks, about how often did you feel tired out for no good reason? FL44	☐	☐	☐	☐	☐
2. (In the past 4 weeks,) about how often did you feel nervous? FL45	☐	☐	☐	☐	☐
3. (In the past 4 weeks,) about how often did you feel so nervous that nothing could calm you down? FL46	☐	☐	☐	☐	☐
4. (In the past 4 weeks,) about how often did you feel hopeless? FL47	☐	☐	☐	☐	☐
5. (In the past 4 weeks,) about how often did you feel restless or fidgety? FL48	☐	☐	☐	☐	☐
6. (In the past 4 weeks,) about how often did you feel so restless you could not sit still? FL49	☐	☐	☐	☐	☐
7. (In the past 4 weeks,) about how often did you feel depressed? FL50	☐	☐	☐	☐	☐
8. (In the past 4 weeks,) about how often did you feel that everything was an effort? FL51	☐	☐	☐	☐	☐
9. (In the past 4 weeks,) about how often did you feel so sad that nothing could cheer you up? FL52	☐	☐	☐	☐	☐
10. (In the past 4 weeks,) about how often did you feel worthless? FL53	☐	☐	☐	☐	☐

derived variable	Label
K10:	Sum Score

This questionnaire asks about a number of different things that people sometimes do to hurt themselves. Please be sure to read each question carefully and respond honestly. Often, people who do these kinds of things to themselves keep it a secret, for a variety of reasons. However, honest responses to these questions will provide us with greater understanding and knowledge about these behaviors and the best way to help people. Please answer yes to a question only if you did the behaviour intentionally, or on purpose, to hurt yourself. Do not respond yes if you did something accidentally (e.g. you tripped and banged your head on accident). Also, please be assured that your responses are completely confidential.

Have you intentionally tried to hurt or harm yourself in anyway, e.g. cutting, burning or scratching yourself or banging your head? SHANY_E

0 ○ *No, Please go to Q8,* 1 ○ *Yes, Please continue with Q7.1*

(7.1) Have you ever intentionally (i.e., on purpose) cut or carved on your wrist, arms, or other area(s) of your body (without intending to kill yourself)? (Please select one): SHCUT_E

0 ○ NO *(please go to Q7.2)* 1 ○ YES, if yes

How old were you when you first did this? SHCUT_A1 .....Years old

How many times have you done this? SHCUT_N .....Times

When was the last time you did this? SHCUT_M dropped Days ago dropped .Months ago dropped years ago

derived variable: SHCUT_A2

(7.2) Have you ever intentionally (i.e., on purpose) burned yourself? SHBURN_E

0 ○ NO *(please go to Q7.3)* 1 ○ YES, if yes

How old were you when you first did this? SHBURN_A1 .....Years old

How many times have you done this? SHBURN_N .....Times

When was the last time you did this? SHBURN_M dropped Days ago dropped .Months ago dropped years ago

derived variable: SHBURN_A2

(7.3) Have you ever intentionally (i.e., on purpose) severely scratched yourself, to the extent that scarring or bleeding occurred? SHSCR_E

0 ○ NO *(please go to Q7.4)* 1 ○ YES, if yes

How old were you when you first did this? SHSCR_A1 .....Years old

How many times have you done this? SHSCR_N .....Times

When was the last time you did this? SHSCR_M dropped Days ago dropped .Months ago dropped years ago

derived variable: SHSCR_A2

(7.4) Have you ever intentionally (i.e., on purpose) banged your head against something to the extent that it caused a bruise to appear. SHBANG_E

0 ○ NO *(please go to Q8)* 1 ○ YES, if yes

How old were you when you first did this? SHBANG_A1 .....Years old

How many times have you done this? SHBANG_N .....Times

When was the last time you did this? SHBANG_M dropped Days ago dropped .Months ago dropped years ago

derived variable: SHBANG_A2

8. PHYSICAL PAIN

The following questions are about aches or pains in your muscles, bones or joints, including neck, back, hip or knee pain.

Please indicate the sites below in which you have had pain in the last month. *(Please select all that apply)*

PN70 ○ Neck
PN71 ○ Left shoulder
PN72 ○ Right shoulder
PN73 ○ Left arm
PN74 ○ Right arm
PN75 ○ Upper back
PN76 ○ Lower back
PN77 ○ Left leg
PN78 ○ Right leg
PN79 ○ Other *(please state)*..... PN79_OTH
PN116 ○ ~~I have not had any pain in the last month *(If no pain please go to **Q8.1**)*~~

To harmonize the variable across years, we have dropped G227_PN116 and created G227_PN66 - "Pain site - in last month - have you had any physical pain?" 1=Yes,had pain; 0=No, haven't had pain

How many days of work have you missed because of pain during the past 12 months? *(Please select one)* PN93

0 days	1-2 days	3-7 days	8-14 days	13-30 days	1 month	2 months	3-6 months	6-12 months
0	1	2	3	4	5	6	7	8

How long have you had your current pain problem? *(Please select one)* WPN6

0 ○ 0 days
1 ○ 1-2 days
2 ○ 3-7 days
3 ○ 8-14 days
4 ○ 15-30 days)
5 ○ 1 month
6 ○ 2 months
7 ○ 3-6 months
8 ○ 6-12 months
9 ○ Over 1 year

How would you rate the pain you have had in the last week? *(Please select one)* PN80

No Pain 0	1	2	3	4	5	6	7	8	9	**Pain as bad as it could be** 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

In the past three months, on average, how bad was your pain on 0-10 scale *(Please select one)* PN81

No Pain 0	1	2	3	4	5	6	7	8	9	**Pain as bad as it could be** 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How often would you say that you have experienced pain episodes, on average, during the past three months? *(Please select one)* PN82

Never 0	1	2	3	4	5	6	7	8	9	**Always** 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Based on all things you do to cope, or deal with your pain, on an average day, how much are you able to decrease it? *(Please select one)* PN83

Can't decrease it all 0	1	2	3	4	5	6	7	8	9	**Can decrease it completely 10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

In your view, how large is the risk that your current pain may become persistent? PN84

No risk 0	1	2	3	4	5	6	7	8	9	**Very large risk** 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

In your estimation, what are the chances that you will be working normal duties in 3 months? PN95A

No chance 0	1	2	3	4	5	6	7	8	9	**Very large chance** 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Here are some of the things that other people have told us about their pain. For each statement, select one number from 0 to 10 to say how much physical activities, such as bending, lifting, walking or driving, would affect your pain.

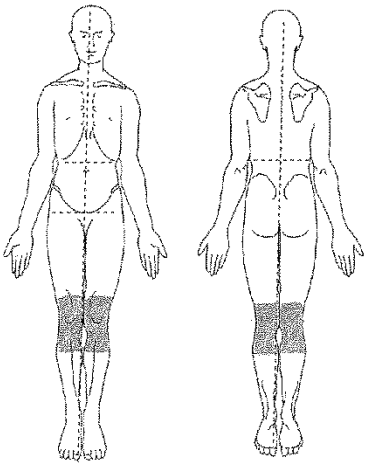
	Completely disagree 0	1	2	3	4	5	6	7	8	9	**Completely agree** 10
Physical activity makes my pain worse PN85	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
An increase in pain is an indication that I should stop what I'm doing until the pain decreases PN86	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I should not do my normal work with my present pain. PN87	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For the next 5 questions, please select the one number that best describes your current ability to participate in each of these activities.

	Cant'do it because of a pain problem 0	1	2	3	4	5	6	7	8	9	**Can do it without pain being a problem** 10
I can do light work for an hour PN88	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I can walk for an hour PN89	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I can do ordinary household chores PN90	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I can do the weekly shopping PN91	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I can sleep at night PN92	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	No 0	Yes 1
(1) Is your pain work-related in that it was caused by your work? WPN1	☐	☐
(2) Is your pain work-related in that your pain developed outside of work but is made worse by work? WPN2	☐	☐
(3) Have you reported your pain to your employer? WPN3	☐	☐
(4) Have you claimed workers' compensation for your pain? WPN4	☐	☐

8.1 The following questions relate to pain you may have experienced in your knee.



How often do you experience knee pain in the shaded area marked on the diagram? PN100

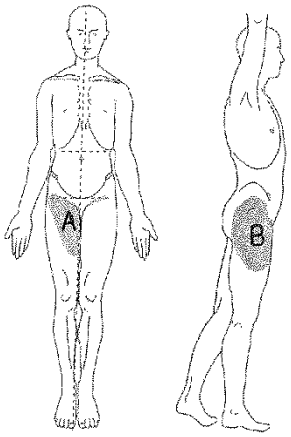
0 ○ Never *(please go to Q8.3)*
1 ○ Monthly
2 ○ Weekly
3 ○ Daily
4 ○ Always

The following questions relate to the amount pain you have experienced in either knee in the last week. **For each situation please enter the amount of pain experienced in the last week during the following activities**. If both knees are painful, please answer with regard to the most painful knee.

	None 0	Mild 1	Moderate 2	Severe 3	Extreme 4
Twisting/pivoting on your knee PN101A	☐	☐	☐	☐	☐
Straightening knee fully PN101B	☐	☐	☐	☐	☐
Bending knee fully PN101C	☐	☐	☐	☐	☐
Walking on flat surface PN101D	☐	☐	☐	☐	☐
Going up or down stairs PN101E	☐	☐	☐	☐	☐
At night while in bed PN101F	☐	☐	☐	☐	☐
Sitting or lying PN101G	☐	☐	☐	☐	☐
Standing upright PN101H	☐	☐	☐	☐	☐

Derived variable Label
KOOS: KOOS Total Pain Score

8.3 The following questions relate to pain you may have experienced in your hip. The diagram indicates two areas of the hip in which people commonly experience pain



How often do you experience hip pain in the shaded area marked A on the diagram? *(The diagram shows the right hip but your pain can be in either hip)* PN102A

0 ○ Never
1 ○ Monthly
2 ○ Weekly
3 ○ Daily
4 ○ Always

How often do you experience hip pain in the shaded area marked B on the diagram? PN102B

(The diagram shows the right hip but your pain can be in either hip)

0 ○ Never
1 ○ Monthly
2 ○ Weekly
3 ○ Daily
4 ○ Always

*(If "never' to both of the above two questions, please go to **Q8.4**)*

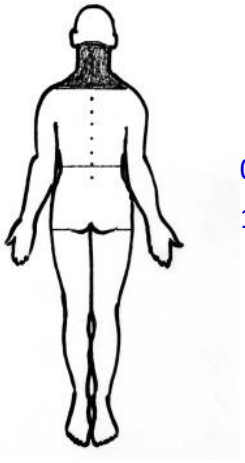
The following questions relate to the amount pain you have experienced in either hip in the last week. **For each situation please enter the amount of pain experienced in the last week during the following activities**. If both hips are painful, please answer with regard to the most painful hip.

	None 0	Mild 1	Moderate 2	Severe 3	Extreme 4
Straightening your hip fully PN103A	☐	☐	☐	☐	☐
Bending your hip fully PN103B	☐	☐	☐	☐	☐
Walking on a flat surface PN103C	☐	☐	☐	☐	☐
Going up or down stairs PN103D	☐	☐	☐	☐	☐
At night while in bed PN103E	☐	☐	☐	☐	☐
Sitting or lying PN103F	☐	☐	☐	☐	☐
Standing upright PN103G	☐	☐	☐	☐	☐
Walking on a hard surface (asphalt, concrete, etc.) PN103H	☐	☐	☐	☐	☐
Walking on an uneven surface PN103I	☐	☐	☐	☐	☐

Which of your hips was most painful? PN102 1 ☐ Left 2 ☐ Right

Derived variable	Label
HOOS:	HOOS Total Pain Score

8.4The following questions relate to pain you may have experienced in neck/shoulder. The diagram indicates the area where neck and shoulder pain is experienced.



Have you ever had neck/shoulder pain? PN9

(Anywhere in the shaded area in the picture)

0 ○ No *(Please go to Q8.5)*

1 ○ Yes

Has your neck/shoulder been painful at any time in the last month? PN11

0 ○ No

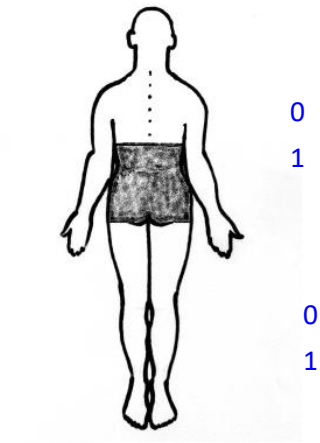
1 ○ Yes

How would you rate the usual intensity neck/shoulder pain that you have had during the past month? PN11A

No Pain 0	1	2	3	4	5	6	7	8	9	Pain as bad as it could be 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	No	Yes
	0	1
(a) In the past month, did you seek health professional advice or treatment for your neck/shoulder pain? PN104A	☐	☐
(b) In the past month, did you take medication to relieve your neck/shoulder pain?	☐	☐ PN104B
(c) In the past month, did your neck/shoulder pain interfere with your normal activities? PN104C	☐	☐
(d) In the past month, did your neck/shoulder pain interfere with recreational physical activities (e.g. sport, walking, cycling etc.) PN104D	☐	☐
(e) In the past month, did you miss work because of your neck/shoulder pain?	☐	☐ PN104E
(f) In the past month, did your neck/shoulder pain interfere with your work activities? PN104F	☐	☐
(g) Has your present neck/shoulder pain lasted for more than 3 months continuously (it hurt more or less every day)? PN12A	☐	☐
(h) Has your present neck/shoulder pain lasted for more than 3 months off and on (it hurt at least once a week but not every day)? PN12B	☐	☐

8.5The following questions relate to pain you may have experienced in lower back. The diagram indicates the area where low back pain is experienced.



Have you ever had low back pain?PN38
(Anywhere in the shaded area in the picture)

0 ○ No *(Please go to **Q9**)*
1 ○ Yes

Has your low back been painful at any time in the last month? PN40

0 ○ No
1 ○ Yes

How would you rate the usual intensity of low back pain that you have had during the past month? PN40A

No Pain 0	1	2	3	4	5	6	7	8	9	Pain as bad as it could be 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	No	**Yes**
(a) In the past month, did you seek health professional advice or treatment for your low back pain? PN105A	0 ☐	1 ☐
(b) In the past month, did you take medication to relieve your low back pain? PN105B	☐	☐
(c) In the past month, did your low back pain interfere with your normal activities?	☐	☐ PN105C
(d) In the past month, did your low back pain interfere with recreational physical activities (e.g. sport, walking, cycling etc.)? PN105D	☐	☐
(e) In the past month, did you miss work because of your low back pain? PN105E	☐	☐
(f) In the past month, did your low back pain interfere with your work activities?	☐	☐ PN105F
(g) Has your present low back pain lasted for more than 3 months continuously (it hurt more or less every day)? PN41	☐	☐
(h) Has your present low back pain lasted for more than 3 months off and on (it hurt at least once a week but not every day)? PN49	☐	☐

Derived variable Label
PSI: Pain Severity Index

9. ASTHMA AND ALLERGY

The following questions are about breathing difficulties and allergies

9.1 Have you wheezed in the last 12 months? RE34

0 ○ No *(Please go to Q9.2)*
1 ○ Yes

In the last 12 months, how often on average has your sleep been disturbed due to wheezing? RE36

0 ○ Never woken with wheezing
1 ○ Less than one night per week
2 ○ One or more nights per week
3 ○ Don't know

Wheezing ever been severe enough to limit your speech to only one or two words at a time between breaths?

0 ○ No RE37
1 ○ Yes
2 ○ Don't know

Your chest sounded wheezy during or after exercise? RE8

0 ○ No
1 ○ Yes
2 ○ Don't know

***9.2* Do you think you have ever had asthma?** AS1

0 ○ No
1 ○ Yes
2 ○ Don't know

Has a doctor (GP, respiratory specialist) ever told you that you have asthma? AS2

0 ○ No
1 ○ Yes
2 ○ Don't know
3 ○ Never had asthma

Do you still have asthma? AS16

0 ○ No
1 ○ Yes
3 ○ Don't have asthma *(Please go to 9.3)*
2 ○ Don't know

Have you taken/used any of the following asthma medications in the last 12 months? AS67

0 ○ No *(Please go to Q9.3)*
1 ○ Yes

If yes, Please select all medications you have used in the last 12 months.

AS18 ○ Ventolin
AS20 ○ Respolin
AS26 ○ Bricanyl
AS35 ○ QVAR
AS39 ○ Flixotide
AS41 ○ Pulmacort
AS50 ○ OXIS
AS52 ○ Serevent
AS54 ○ Singulaire
AS59 ○ Seretide
AS61 ○ Symbacort
AS63 ○ Prednisolone
AS65 ○ Other (please specify) ..... AS65_OTH

What triggers your asthma? (*Please select all that apply)*

AS69 ○ Viral infection
AS70 ○ Grass
AS71 ○ Pollen
AS72 ○ Animal
AS73 ○ Dust
AS75 ○ Other (please specify) ..... AS75_OTH
AS74 ○ Don't know

***9.3*In the last 12 months, have you had a problem with sneezing or a runny or blocked nose (including hay fever) when you DID NOT have a cold or flu?** RE69

0 ○ No *(Please go to Q9.4)*
1 ○ Yes

In the last 12 months, was this nose problem accompanied by itchy-watery eyes? RE63

0 ○ No
1 ○ Yes

In the last 12 months, how many episodes of allergic nose problem have you had (including hay fever)?

0 1 to 2 ○ HF3
1 ○ 3 to 12
2 ○ More than 12

In which of the last 12 months did this problem occur? *(Please select all that apply)*

RE80 ○ January
RE81 ○ February
RE82 ○ March
RE83 ○ April
RE84 ○ May
RE85 ○ June
RE86 ○ July
RE87 ○ August
RE88 ○ September
RE89 ○ October
RE90 ○ November
RE91 ○ December

Has a doctor (GP) ever told you that you have an allergic nose problem? RE24

0 ○ No
1 ○ Yes

What was the trigger/cause of these problems?

HF7A ○ Grass
HF7B ○ Pollen
HF7C ○ Animal
HF7E ○ Dust
HF7D ○ Other *(Please specify)*..... HF7D_OTH
HF7F ○ Don't know

Have you taken/used any medication for an allergic nose problem (including hay fever) in the last 12 months?

0 ○ No *(Please go to Q9.4)* HF32
1 ○ Yes

If yes, please list the medication(s) below and indicate whether it was prescribed by a doctor.

Name of medication		Prescribed by Doctor		Not prescribed by Doctor	Not this medicine
Steriod nasal spray	HF34A	HF34	2	1	0
Non-steriod nasal spray	HF36A	HF36	2	1	0
Antihistamine drops/tablets	HF38A	HF38	2	1	0
Other medicine	HF40A	HF40	2	1	0

***9.4* Do you think that you have ever had an allergic reaction in the eyes (including hay fever)?** CO1

0 ○ No
1 ○ Yes
2 ○ Don't know

Has a doctor (GP, respiratory specialist) ever told you that you had an allergic reaction in the eyes (including hay fever)? CO2

0 ○ No
1 ○ Yes
2 ○ Don't know

In the last 12 months, have you suffered from an allergic reaction in the eyes (including hay fever)? CO4

0 ○ No *(Please go to **Q9.5**)*
1 ○ Yes

In the last 12 months, how many episodes of allergic reaction in the eyes have you had (including hay fever)? CO5

0 ○ 1 to 2
1 ○ 3 to 12
2 ○ More than 12

In which of the last 12 months did this problem occur? *(Please select all those applicable)*

CO21 ○ January
CO22 ○ February
CO23 ○ March
CO24 ○ April
CO25 ○ May
CO26 ○ June
CO27 ○ July
CO28 ○ August
CO29 ○ September
CO30 ○ October
CO31 ○ November
CO32 ○ December

What was the trigger/cause of these problems?

CO6A ○ Grass
CO6B ○ Pollen
CO6C ○ Animal
CO6D ○ Dust
CO6E ○ Other *(Please specify)*..... CO6E_OTH
CO6F ○ Don't know

Have you taken/used any medication for an allergic eye reaction (including hay fever) in the last 12 months? CO48

0 ○ No *(Please go to Q9.5)*
1 ○ Yes

If yes, please list the medication(s) below and indicate whether it was prescribed by a doctor.

Name of medication			Prescribed by Doctor	Not prescribed by Doctor	Not this medicine
Eye drops	CO50A	CO50	2	1	0
Steriod tablets	CO52A	CO52	2	1	0
Antihistamine drops	CO54A	CO54	2	1	0
Other medicine	CO56A	CO56	2	1	0

***9.5* Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?** RS1

0 ○ No
1 ○ Yes

Do you get short of breath walking with other people your own age on level ground? RS2

0 ○ No
1 ○ Yes

Do you have to stop for breath when walking at your own pace on level ground? RS3

0 ○ No
1 ○ Yes

Do you ever get short of breath at rest? RS4

0 ○ No
1 ○ Yes

Do you usually cough first thing in the morning? RS5

0 ○ No
1 ○ Yes

Do you usually cough during the day or at night? RS6

0 ○ No
1 ○ Yes

If yes to either,

Do you cough like this on most days for as much as three months each year? RS7

0 ○ No
1 ○ Yes

Do you usually bring up phlegm from your chest first thing in the morning? RS8

0 ○ No
1 ○ Yes

Do you usually bring up phlegm from your chest during the day or at night? RS9

0 ○ No
1 ○ Yes

If yes to either,

Do you bring up phlegm like this on most days for as much as three months each year? RS10

0 ○ No
1 ○ Yes

Have you ever had eczema or an itchy rash which was coming and going for at least 12 months? RH1

0 ○ No *(Please go to **Q9.6**)*
1 ○ Yes

Has this eczema/itchy rash at any time affected any one of the following places – the folds of the elbows, behind the knees, in front of the ankles, under the buttocks or around the neck, ears or eyes? RH3

0 ○ No
1 ○ Yes

In the last 12 months, how often, on average, have you been kept awake at night by this itchy rash? RH6

0 ○ Never in the last 12 months
1 ○ Less than one night per week
2 ○ One or more nights per week

Has this rash cleared completely during the last 12 months? RH5

0 ○ No
1 ○ Yes

Do you think that you have ever had eczema? RH7

0 ○ No
1 ○ Yes
2 ○ Don't know

Has a doctor (GP, respiratory specialist) ever told you that you have eczema? RH11

0 ○ No
1 ○ Yes
2 ○ Don't know

In the last 12 months, have you suffered from eczema? RH12

0 ○ No *(Please go to Q9.6)*
1 ○ Yes

In the last 12 months, how many episodes of eczema have you had? RH13

0 ○ 1 to 2
1 ○ 3 to 12
2 ○ More than 12

In which of the last 12 months did this problem occur? (Please select all those applicable)

RH28 ○ January
RH29 ○ February
RH30 ○ March
RH31 ○ April
RH32 ○ May
RH33 ○ June
RH34 ○ July
RH35 ○ August
RH36 ○ September
RH37 ○ October
RH38 ○ November
RH39 ○ December

Have you taken/used any medication for eczema in the last 12 months? RH49

0 ○ No *(Please go to Q9.6)*
1 ○ Yes

If yes, please list the medication(s) below and indicate whether it was prescribed by a doctor.

Name of medication			Prescribed by Doctor	Not prescribed by Doctor	Not this medicine
Moisturisers	RH63A	RH63	2	1	0
Steriod Creams	RH65A	RH65	2	1	0
Oral Steriods	RH67A	RH67	2	1	0
Tacrolimus Creams	RH69A	RH69	2	1	0
Other medicine	RH71A	RH71	2	1	0

***9.6* Do you have any food allergies?** FAL

0 ○ No *(Please go to Q10)*
1 ○ Yes

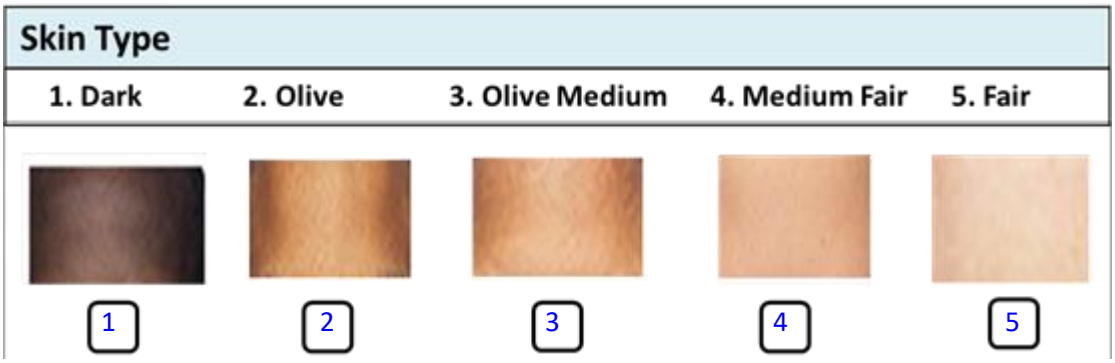
If yes, please tick all foods that you are allergic to

FD1A ○ Peanut Products
FD2A ○ Wheat/Yeast
FD3A ○ Dairy
FD4A ○ Fruit
FD5A ○ Eggs
FD6A ○ Seafood
FD7A ○ Preservatives/Colouring
FD8A ○ Other (please specify).....FD8A_OTH.....

10. SUN EXPOSURE

We are interested in knowing details about time you spend outdoors and sun exposure.

Which of the following best describes your natural skin colour that is not exposed to the sun (e.g. on your underarm)? (Please mark only one response) UV1D



Imagine you spent 30 minutes in the sun in the middle of the day for the first time in summer. If you were not wearing sunscreen, would you (please mark only one response): UV2

- 3 ○ Get severe sunburn with blistering
- 2 ○ Have painful sunburn
- 1 ○ Get mildly burnt
- 0 ○ Not get sunburnt at all

After this initial reaction, would you get a tan? UV2A

- 0 ○ No
- 1 ○ Yes

Imagine you spent short periods of time in the sun every day over the summer (without sunscreen). How would your skin look at the end of summer? UV2B

- 3 ○ Very tanned
- 2 ○ Moderately tanned
- 1 ○ Lightly tanned
- 0 ○ No sun tan at all

How many bad sunburns with pain lasting longer than a day would you estimate you have had in your lifetime? (Please mark only one response) UV3

- 0 ○ None
- 1 ○ One
- 2 ○ 2-10
- 3 ○ More than 10

In the **summer** on an **average work day**, how many hours do you spend **outdoors in the sun**? (Including sports, recreation, outdoor work and anything else done outside) SUN_JDS (=TOTAL MINUTES)

Hours - dropped **Minutes** - dropped

In the **summer** on an average **non-working day**, how many hours do you spend **outdoors in the sun?** (Including sports, recreation, outdoor work and anything else done outside) SUN_HDS (=TOTAL MINUTES)

Hours -dropped **Minutes** - dropped

In the **winter** on an **average work day**, how many hours do you spend **outdoors in the sun**? (Including sports, recreation, outdoor work and anything else done outside) SUN_JDW (= TOTAL MINUTES)

Hours -dropped **Minutes** -dropped

In the **winter** on an **average non-working day**, how many hours do you spend **outdoors in the sun** (including sports, recreation, outdoor work and anything else done outside?) SUN_HDW (=TOTAL MINUTES)

Hours -dropped **Minutes** -dropped

When outdoors in the sun, how much of the time do you

	Never	**seldom**	**half of the time**	**usually**	**always**	**cannot judge**
Wear a hat with a brim or a visor? UV5	0	1	2	3	4	5
Wear sunglasses? UV6	☐	☐	☐	☐	☐	☐

11. EYES

What is the main reason you wear sunglasses? (Please mark only one response)

UV27a ○ Protection from eye disease
UV27b ○ Driving
UV27c ○ Medical condition/doctor's advice
UV27d ○ Glare
UV27e ○ Sport
UV27f ○ Fashion/looks cool
UV27g ○ School requirement
UV27h ○ Influenced by family member
UV27j ○ Don't wear sunglasses
UV27i ○ Other - please specify ……UV27i_OTH……..

What is the main reason you do NOT wear sunglasses? (Please mark only one response)

UV28a ○ Inconvenient
UV28b ○ Uncomfortable
UV28c ○ Decreases vision
UV28d ○ Wears prescription glasses
UV28e ○ Expensive
UV28f ○ Not fashionable
UV28g ○ Not necessary
UV28i ○ Forget to
UV28j ○ Don't have any
UV28h ○ Other - please specify ……UV28h_OTH……..

NOTE:
In data, G227_UV28k ("always wear sunglasses") with values 0-No and 1-Yes was derived from UV28h_OTH.

Have you <u>ever</u> worn (or needed to wear) glasses/spectacles and/or contact lenses for your vision?

0 ○ No *(please go to Q11.1)* GLSE
1 ○ Yes

GL1
What age did you start wearing them? ..... *Age in years*

Do you <u>currently</u> wear (or need to wear) glasses/spectacles and/or contact lenses for your vision? GLS

0 ○ No
1 ○ Yes……GLS_NOTE…….. (please specify why)

If yes, do you use: GL2 1 Contact lenses 2 Glasses/spectacles 3 Both

***11.1* Has a doctor ever told you that you have any of the following problems with your eyes? (Select all that apply)**

EY19 ○ Diabetes related eye disease
EY27 ○ Injury or trauma resulting in loss of vision
EY18 ○ Macular degeneration
EYE7 ○ Glaucoma
EYE8 ○ Cataract
EY10 ○ Dry eye syndrome
EY29 ○ Other serious eye condition. Please specify:. EY29_OTH .....
EYE5 ○ None of the above

Do you currently use artificial tear eye drops or gel? E130

0 ○ No
1 ○ Yes

For the past three months or longer, have you had dry eyes? (This is described as a foreign body sensation with itching and burning, sandy feeling, not related to allergy) E131

0 ○ No
1 ○ Yes

Have you had any eye surgeries? EY28

0 ○ No
1 ○ Yes

If yes, please specify ..... LASER SURGERY: EYE32 (0= No, 1=Yes)

..... OTHER SURGERY: EYE33 (0= No, 1=Yes)

..... OTHER SURGERY (specified): EYE33**T**

12. PHYSICAL ACTIVITY

The following questions relate to how physically active you are.

The following questions will ask you about the time you spent being physically active in the last 7 days. Please answer each question, even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

12.1 Think about all the **vigorous physical activities** that you did in the last 7 days. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

During the last 7 days, on how many days did you do **vigorous physical activities** like heavy lifting, digging, aerobics, or fast bicycling?

- ○ No vigorous activities *(Please go to Q12.2)*
- ○ Yes (how many **days per week**?) ☐ IPAQ_VIG_D

How much time did you usually spend doing **vigorous** physical activities on one of those days?

Hours per day G227_IPAQ_VIG_HPD ☐☐ **Minutes per day** G227_IPAQ_VIG_MPD ☐☐ VIG_MINS (=TOTAL MINUTES/DAY)

12.2 Think about all the **moderate physical activities** that you did in the last 7 days. Moderate activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

During the last 7 days, on how many days did you do **moderate physical activities** like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

- ○ No moderate activities *(Please go to Q12.3)*
- ○ Yes (how many **days per week**?) ☐ IPAQ_MOD_D

How much time did you usually spend doing **moderate** physical activities on one of those days?

Hours per day G227_IPAQ_MOD_HPD ☐☐ **Minutes per day** G227_IPAQ_MOD_MPD ☐☐ MOD_MINS (=TOTAL MINUTES/DAY)

12.3 Think about the time you spent **walking** in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

During the last 7 days, on how many days did you **walk** for at least 10 minutes at a time?

- ○ No walking *(Please go to Q12.4)*
- ○ Yes (how many **days per week**?) ☐ IPAQ_WALK_D

How much time did you usually spend **walking** on one of those days?

Hours per day ☐☐ G227_IPAQ_WALK_HPD

Minutes per day ☐☐ G227_IPAQ_WALK_MPD

WALK_MINS (=TOTAL MINUTES/DAY)

12.4 This question is about the time you spent **sitting on weekdays and weekends** during the last 7 days. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting to watch television.

During the last 7 days, how much time did you spend **sitting** on a **week day**?

Hours per day (dropped) ☐☐

Minutes per day (dropped) ☐☐

SIT_WD_TRUNC (=TOTAL MINUTES/DAY)

During the last 7 days, how much time did you spend **sitting** on a **weekend** day?

Hours per day (dropped) ☐☐

Minutes per day (dropped) ☐☐

SIT_WE_TRUNC (=TOTAL MINUTES/DAY)

During the last 7 days what proportion (stated as a %) of your typical work day was spent doing the following? *(This involves only your work day, and does not include travel to and from work, or what you did in your leisure time - note: the sum of all activities should total 100%)*

1. Sitting (including driving) WK6
2. Standing WK7
3. Walking WK8
4. Heavy labour or physically demanding tasks WK9

DERIVED VARIABLES	LABEL
VIG_MET	IPAQ: Vigorous activity - MET minutes per week
MOD_MET	IPAQ: Moderate activity - MET minutes per week
WALK_MET	IPAQ: Walking - MET minutes per week
TOT_MET	IPAQ: TOTAL MET minutes per week
IPAQ_CAT	IPAQ: Physical Activity Category

13 TECHNOLOGY USE

This next section asks about your use of information technology (mobile phones, computers, television etc.) - How often and how long you use these electronic devices.

	WEEKDAY (Mon – Fri)		WEEKEND (Sat – Sun)		Total
	Over a typical Monday to Friday, on **how many days** do you use this device? (Tick ONE only)	On each of these weekdays, for about **how long** do you use this device **per day?** (Tick ONE only)	Over a typical Saturday to Sunday, on **how many days** do you use this device? (Tick ONE only)	On each of these weekend days, for about **how long** do you use this device **per day?** (Tick ONE only)	What percent of your **total** weekly use of this device is for **work** purposes? (Tick ONE only)
13.1 Television 	**TVWD** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days 3 ○ 3 days 4 ○ 4 days 5 ○ 5 days	**TVWDH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**TVWE** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days	**TVWEH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**TVWP** 0 ○ Do not use for work 1 ○ about 25% 2 ○ about 50% 3 ○ about 75% 4 ○ only use for work
13.2 Desktop computer 	**DWD** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days 3 ○ 3 days 4 ○ 4 days 5 ○ 5 days	**DWDH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**DWE** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days	**DWEH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**DWP** 0 ○ Do not use for work 1 ○ about 25% 2 ○ about 50% 3 ○ about 75% 4 ○ only use for work

DERIVED VARIABLE	LABEL
TVWD_TOT	TV: Total minutes/ weekday
TVWE_TOT	TV: Total minutes/ weekend
TV7D_TOT	TV: Total minutes/ week
TV7D_WTOT	TV: Total minutes/week for work
TVWD_PD	TV: Average minutes on weekday
TVWE_PD	TV: Average minutes on weekend
TV7D_PD	TV: Average minutes of daily use

DERIVED VARIABLE	LABEL
DWD_TOT	Desktop: Total minutes/ weekday
DWE_TOT	Desktop: Total minutes/ weekend
D7D_TOT	Desktop: Total minutes/ week
D7D_WTOT	Desktop: Total minutes/week for work
DWD_PD	Desktop: Average minutes on weekday
DWE_PD	Desktop: Average minutes on weekend
D7D_PD	Desktop: Average minutes of daily use

	WEEKDAY (Mon – Fri)		WEEKEND (Sat – Sun)		Total
	Over a typical Monday to Friday ,on **how many days** do you use this device? (Tick ONE only)	On each of these weekdays, for about **how long** do you use this device **per day?** (Tick ONE only)	Over a typical Saturday to Sunday, on **how many days** do you use this device? (Tick ONE only)	On each of these weekend days, for about **how long** do you use this device p**er day?** (Tick ONE only)	What percent of your **total** weekly use of this device is for **work** purposes? (Tick ONE only)
13.3 Laptop 	**LWD** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days 3 ○ 3 days 4 ○ 4 days 5 ○ 5 days	**LWDH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**LWE** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days	**LWEH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**LWP** 0 ○ Do not use for work 1 ○ about 25% 2 ○ about 50% 3 ○ about 75% 4 ○ only use for work
13.4 Tablet (e.g. iPad, Samsung Galaxy Tab, Kindle e-reader) 	**TWD** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days 3 ○ 3 days 4 ○ 4 days 5 ○ 5 days	**TWDH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**TWE** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days	**TWEH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**TWP** 0 ○ Do not use for work 1 ○ about 25% 2 ○ about 50% 3 ○ about 75% 4 ○ only use for work

DERIVED VARIABLE	LABEL
TWD_TOT	Tablet: Total minutes/ weekday
TWE_TOT	Tablet: Total minutes/ weekend
T7D_TOT	Tablet: Total minutes/ week
T7D_WTOT	Tablet: Total minutes/week for work
TWD_PD	Tablet: Average minutes on weekday
TWE_PD	Tablet: Average minutes on weekend
T7D_PD	Tablet: Average minutes of daily use

DERIVED VARIABLE	LABEL
LWD_TOT	Laptop: Total minutes/ weekday
LWE_TOT	Laptop: Total minutes/ weekend
L7D_TOT	Laptop: Total minutes/ week
L7D_WTOT	Laptop: Total minutes/week for work
LWD_PD	Laptop: Average minutes on weekday
LWE_PD	Laptop: Average minutes on weekend
L7D_PD	Laptop: Average minutes of daily use

	WEEKDAY (Mon – Fri)		WEEKEND (Sat – Sun)		Total
	Over a typical Monday to Friday, on **how many days** do you use this device? (Tick ONE only)	On each of these weekdays, for about **how long** do you use this device **per day?** (Tick ONE only)	Over a typical Saturday to Sunday, on **how many days** do you use this device? (Tick ONE only)	On each of these weekend days, for about **how long** do you use this device **per day?** (Tick ONE only)	What percent of your **total** weekly use of this device is for **work** purposes? (Tick ONE only)
13.5 Mobile phone (i.e. smartphone or non-smartphone) 	**MWD** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days 3 ○ 3 days 4 ○ 4 days 5 ○ 5 days	**MWDH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**MWE** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days	**MWEH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**MWP** 0 ○ Do not use for work 1 ○ about 25% 2 ○ about 50% 3 ○ about 75% 4 ○ only use for work
13.6 Non-active electronic games (played sitting e.g. Xbox or PS3 console games and PSP or Nintendo DS handheld games) 	**NEWD** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days 3 ○ 3 days 4 ○ 4 days 5 ○ 5 days	**NEWDH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**NEWE** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days	**NEWEH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**NEWP** 0 ○ Do not use for work 1 ○ about 25% 2 ○ about 50% 3 ○ about 75% 4 ○ only use for work

DERIVED VARIABLE	LABEL
MWD_TOT	Mobile: Total minutes/ weekday
MWE_TOT	Mobile: Total minutes/ weekend
M7D_TOT	Mobile: Total minutes/ week
M7D_WTOT	Mobile: Total minutes/week for work
MWD_PD	Mobile: Average minutes on weekday
MWE_PD	Mobile: Average minutes on weekend
M7D_PD	Mobile: Average minutes of daily use

DERIVED VARIABLE	LABEL (NE= Non-active Electronic gaming
NEWD_TOT	NE console: Total minutes/ weekday
NEWE_TOT	NE console: Total minutes/ weekend
NE7D_TOT	NE console: Total minutes/ week
NE7D_WTOT	NE console: Total minutes/week for work
NEWD_PD	NE console: Average minutes on weekday
NEWE_PD	NE console: Average minutes on weekend
NE7D_PD	NE console: Average minutes of daily use

	WEEKDAY (Mon – Fri)		WEEKEND (Sat – Sun)		Total
	Over a typical Monday to Friday, on **how many days** do you use this device? (Tick ONE only)	On each of these weekdays, for about **how long** do you use this device **per day?** (Tick ONE only)	Over a typical Saturday to Sunday, on **how many days** do you use this device? (Tick ONE only)	On each of these weekend days, for about **how long** do you use this device **per day?** (Tick ONE only)	What percent of your **total** weekly use of this device is for **work** purposes? (Tick ONE only)
13.7 Active electronic games (played actively and moving about e.g. Xbox Kinect, Wii, PS3 Move) 	**AEWD** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days 3 ○ 3 days 4 ○ 4 days 5 ○ 5 days	**AEWDH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**AEWE** 0 ○ Do not use 1 ○ 1 day 2 ○ 2 days	**AEWEH** 0 ○ Do not use 1 ○ 5 minutes 2 ○ 15 minutes 3 ○ 30 minutes 4 ○ 1 hour 5 ○ 2 hours 6 ○ 3 hours 7 ○ 4 hours 8 ○ 5 hours 9 ○ 6 hours 10 ○ 7 hours 11 ○ 8 hours 12 ○ 9 hours 13 ○ 10 hours 14 ○ 11 hours 15 ○ >=12 hours	**AEWP** 0 ○ Do not use for work 1 ○ about 25% 2 ○ about 50% 3 ○ about 75% 4 ○ only use for work

DERIVED VARIABLE	LABEL (AE= Active Electronic gaming)
IT_AEWD_TOT	AE console: Total minutes/ weekday
IT_AEWE_TOT	AE console: Total minutes/ weekend
IT_AE7D_TOT	AE console: Total minutes/ week
IT_AE7D_WTOT	AE console: Total minutes/week for work
IT_AEWD_PD	AE console: Average minutes on weekday
IT_AEWE_PD	AE console: Average minutes on weekend
AE7D_PD	AE console: Average minutes of daily use

13.8 How old were you when you got your first mobile phone? ……. Age in years MOB_AGE

☐ I have never had a mobile phone. MOB_EVER (0=No, 1=Yes)

DERIVED VARIABLE	LABEL (AE= Active Electronic gaming)
IT_ALLWD_TOT	ALL devices: Total minutes/ weekday
IT_ALLWE_TOT	ALL devices: Total minutes/ weekend
IT_ALL7D_TOT	ALL devices: Total minutes/ week
IT_ALLWD_PD	ALL devices: Average minutes on weekday
IT_ALLWE_PD	ALL devices: Average minutes on weekend
IT_ALL7D_PD	ALL devices: Average minutes of daily use

14. SLEEP

The following questions are about how you sleep and the quality of your sleep.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

It is important that you answer each question as best you can.

Situation	Chance of dozing (0-3)			
	would never doze	slight chance of dozing	moderate chance of dozing	high chance of dozing
(1) Sitting and reading EPW1	0	1	2	3
(2) Watching TV EPW2	0	1	2	3
(3) Sitting inactive in a public place (e.g. a theatre or a meeting) EPW3	0	1	2	3
(4) As a passenger in a car for an hour without a break EPW4	0	1	2	3
(5) Lying down to rest in the afternoon when circumstances permit EPW5	0	1	2	3
(6) Sitting and talking to someone EPW6	0	1	2	3
(7) Sitting quietly after lunch without alcohol EPW7	0	1	2	3
(8) In a car, while stopped for a few minutes in the traffic EPW8	0	1	2	3

DERIVED VARIABLE	LABEL
EPW_SCORE	Epsworth Sleepiness score
EPW_CAT	Epsworth Sleepiness Scale Category

Instructions: Below is a list of common sleep complaints. During the past month, how many nights, or days per week, have you had, or been told you had, the following symptoms? If you have experienced any of these symptoms, please indicate how long it has lasted - in weeks, months or years.

During the past month… _F = FREQUENCY	**Never** 0	**Do not Know** 7	**Rarely,** less than once per week 1	**Sometimes,** 1-2 times per week 2	**Frequently** 3-4 times per week 3	**Always,** 5-7 times per week 4	**How long has the symptom lasted** (number of weeks, months or years)
1. Difficulty falling asleep PSSQ1	☐ 0	☐ 7	☐ 1	☐ 2	☐ 3	☐ 4	☐ weeks ☐ months ☐ years
2. Difficulty staying asleep PSSQ2	☐	☐	☐	☐	☐	☐	☐ weeks ☐ months ☐ years
3. Frequent awakenings from sleep PSSQ3	☐	☐	☐	☐	☐	☐	☐ weeks ☐ months ☐ years
4. Feeling that your sleep is not sound PSSQ4	☐	☐	☐	☐	☐	☐	☐ weeks ☐ months ☐ years
5. Feeling that your sleep is unrefreshing PSSQ5	☐	☐	☐	☐	☐	☐	☐ weeks ☐ months ☐ years

If you checked "never", or "do not know' for **all of these symptoms**, YOU MAY STOP answering this question and go to Q14.1

If you checked "rarely" to "always" for **any of these symptoms** please continue with questions 6 to 13

Instructions: If you have experienced **any** sleep symptoms **during the past month** please circle the appropriate number to let us know how your sleep is affecting your daily life

During the past month	Not all	A little bit	Moderately	Quite a bit	Extremely
6. How much do your sleep problems bother you? PSSQ6	0	1	2	3	4
7. Have your sleep difficulties affected your work? PSSQ7	0	1	2	3	4
8. Have your sleep difficulties affected your social life? PSSQ8	0	1	2	3	4
9. Have your sleep difficulties affected other important parts of your life? PSSQ9	0	1	2	3	4
10. Have your sleep difficulties made you feel irritable? PSSQ10	0	1	2	3	4
11. Have your sleep problems caused you to have trouble concentrating? PSSQ11	0	1	2	3	4
12. Have your sleep difficulties made you feel fatigued? PSSQ12	0	1	2	3	4
13. How sleepy do you feel during the day? PSSQ13	0	1	2	3	4

DERIVED VARIABLES	LABEL
PSSQ_SSC	PSSQ Sleep Symptom Criterion
PSSQ_DURC4	PSSQ Duration Criterion >=4 weeks
PSSQ_DURC13	PSSQ Duration Criterion >=13 weeks
PSSQ_DIC	PSSQ Daytime Impairment Criterion
PSSQ_INS4	PSSQ Diagnosed Insomnia Criterion >= 4 weeks
PSSQ_INS13	PSSQ Diagnosed Insomnia Criterion >= 13 weeks

. Please choose the correct response to each question

14.1

1. Do you snore? BERQ1

1 ○ Yes
0 ○ No *(Please go to Q5*)*
2 ○ Don't know *(Please go to Q5*)*

If you snore

2. Your snoring is: BERQ2

1 ○ Slightly louder than breathing
2 ○ As loud as talking
3 ○ Louder than talking
4 ○ Very loud; can be heard in adjacent rooms

3. How often do you snore? BERQ3

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1-2 times a month
5 ○ Never or nearly never

4. Has your snoring ever bothered other people? BERQ4

1 ○ Yes
0 ○ No
2 ○ Don't know

*5. Has anyone noticed that you quit breathing during your sleep? BERQ5

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1- 2 times a month
5 ○ Never or nearly never

6. How often do you feel tired or fatigued after your sleep? BERQ6

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1- 2 times a month
5 ○ Never or nearly never

7. During your wake time, do you feel tired, fatigued, or not up to par? BERQ7

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1- 2 times a month
5 ○ Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle? BERQ8

1 ○ Yes
0 ○ No *(Please go to Q10*)*

If yes

9. how often does this occur? BERQ9

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1- 2 times a month
5 ○ Never or nearly never

*10. Do you have high blood pressure? BERQ10

1 ○ Yes
0 ○ No
2 ○ Don't know

These questions relate to your sleep over the past month
The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

(1) During the past month, what time have you usually gone to bed at night?

[BED TIME] 00:00 (24 hr clock) PSQI1

(2) During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

[NUMBER OF MINUTES] PSQI2

(3) During the past month, what time have you usually gotten up in the morning?

[GETTING UP TIME] 00:00 (24 hr clock) PSQI3

(4) During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

[HOURS OF SLEEP PER NIGHT] *decimal points* PSQI4

For each of the remaining questions, check the one best response. Please answer all questions

(5) During the past month, how often have you had trouble sleeping because you …

	Not during the past month 0	less than once week 1	Once or twice a week 2	Three or more times a week 3
(a) Cannot get to sleep within 30 minutes PSQI5A	☐ 0	☐ 1	☐ 2	☐ 3
(b) Wake up in the middle of the night or early morning PSQI5B	☐	☐	☐	☐
(c) Have to get up to use the bathroom PSQI5C	☐	☐	☐	☐
(d) Cannot breathe comfortably PSQI5D	☐	☐	☐	☐
(e) Cough or snore loudly PSQI5E	☐	☐	☐	☐
(f) Feel too cold PSQI5F	☐	☐	☐	☐
(g) Feel too hot PSQI5G	☐	☐	☐	☐
(h) Had bad dreams PSQI5H	☐	☐	☐	☐
(i) Have pain PSQI5I	☐	☐	☐	☐
(j) Other reason(s), please describe PSQI5J_OTH				
How often during the past month have you had trouble sleeping because of this PSQI5J	☐	☐	☐	☐

(6) During the past month, how would you rate your sleep quality overall? PSQI6

[0] Very good [1] Fairly good [2] Fairly bad [3] Very bad

(7) During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")? PSQI7

0 ○ Not during the past month
1 ○ Less than once a week
2 ○ Once or twice a week
3 ○ Three or more times a week

(8) During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity PSQI8

0 ○ Not during the past month
1 ○ Less than once a week
2 ○ Once or twice a week
3 ○ Three or more times a week

(9) During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done? PSQI9

0 ○ No problem at all
1 ○ Only a very slight problem
2 ○ Somewhat of a problem
3 ○ A very big problem

(10) Do you have a bed partner or roommate? PSQI10

0 ○ No bed partner or roommate
1 ○ Partner/roommate in other room
2 ○ Partner in same room, but not same bed
3 ○ Partner in same bed

(11) During the past month, how many times per night do you wake up? SL_WAKE_NF

0 ○ Never
1 ○ Less than once a week
2 ○ 1-6 times per week
3 ○ 1-2 times per night
4 ○ 3-5 times per night
5 ○ More than 5 times per night

DERIVED VARIABLES	LABEL
PSQI_TOT	PSQI Total Score - Continuous
PSQI_CAT	PSQI Total Score - Categorical

15. EATING HABITS and WEIGHT

Do you know how much you weigh? W1

0 ○ No

1 ○ Yes ⟶ Your current weight in kilograms is W2

Are you worried about your weight? W3

0 ○ No, not at all
1 ○ A little
2 ○ Moderately
3 ○ Very

Do you consider yourself to be: W4

0 ○ Underweight
1 ○ Normal weight
2 ○ A bit overweight
3 ○ Very overweight

The following questions are concerned with the past 4 weeks only (28 days)

Please answer all of the questions

On how many days, in the past 4 weeks:

Please mark one response for each item	0 days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day	
1. Have you been trying hard to eat less to change your shape or weight? (even if you haven't been able to do so)	0	1	2	3	4	5	6	W8_4
2. Have you gone for 8 or more waking hours without eating anything in order to influence your shape or weight?	☐	☐	☐	☐	☐	☐	☐	W35_4
3. Have you tried to avoid eating foods that you like in order to influence your shape or weight?	☐	☐	☐	☐	☐	☐	☐	W9_4
4. Have you tried to follow definite rules regarding your eating in order to influence your shape or weight; for example, a calorie limit, a set amount of food, or rules about what or when you should eat?	☐	☐	☐	☐	☐	☐	☐	W10_4
5. Has thinking about food or its calorie content made it difficult to concentrate on things you are interested in; for example, read, watch TV, follow a conversation?	☐	☐	☐	☐	☐	☐	☐	W11_4
6. Have you been afraid of losing control over eating?	☐	☐	☐	☐	☐	☐	☐	W12_4
7. Have you eaten in secret (do not count binge eating)?	☐	☐	☐	☐	☐	☐	☐	W15_4
8. Have you had a definite fear that you might gain weight or become fat?	☐	☐	☐	☐	☐	☐	☐	W16_4
9. Have you felt fat?	☐	☐	☐	☐	☐	☐	☐	W38_4
10. Have you had a strong desire to lose weight?	☐	☐	☐	☐	☐	☐	☐	W39_4

11. Have there been times when you felt that you'd eaten what other people would regard as an unusually large amount of food given the circumstances? W14_4	☐ 0 NO, *go to Q 12*	☐ 1 YES, *go to Q 11a*
11a. How many such episodes have you had over the past four weeks?	W14A_4	episodes
11b. During these episodes, did you have a sense of having lost control over your eating (of not being able to stop eating or of not being able to control how much or what you ate)? W54_4	☐ 0 NO, *go to Q 12*	☐ 1 YES, *go to Q 11c*
11c. If so, for how many of the above episodes did you experience this sense of loss of control?	W54A_4	episodes
12. Have you made yourself sick (vomit) as a means of controlling your shape or weight? W17_4	☐ 0 NO, *go to Q 13*	☐ 1 YES, *go to Q 12a*
12a. How many times have you done this over the past four weeks?	W17A_4	times
13. Have you taken laxatives as a means of controlling your shape or weight? W55_4	☐ 0 NO, *go to Q 14*	☐ 1 YES, *go to Q 13a*
13a. How many times have you done this over the past four weeks?	W55A_4	times
14. Have you exercised hard as a means of controlling your shape or weight? W19_4	☐ 0 NO, *go to Q 15*	☐ 1 YES, *go to Q 14a*
14a. How many days have you done this over the past four weeks?	W19A_4	days
14b. For how long for each day (on average)?	W19B_4	hours

	Not at all	A bit	Slightly	Moderately	Quite a bit	Quite a lot	Markedly
15. Has your **weight** influenced how you think about (judge) yourself as a person? W20_4	☐0	☐1	☐2	☐3	☐4	☐5	☐6
16. Has your **shape** influenced how you think about (judge) yourself as a person? W46_4	☐0	☐1	☐2	☐3	☐4	☐5	☐6

16. ALCOHOLIC, NON-ALCOHOLIC and ENERGY DRINKS

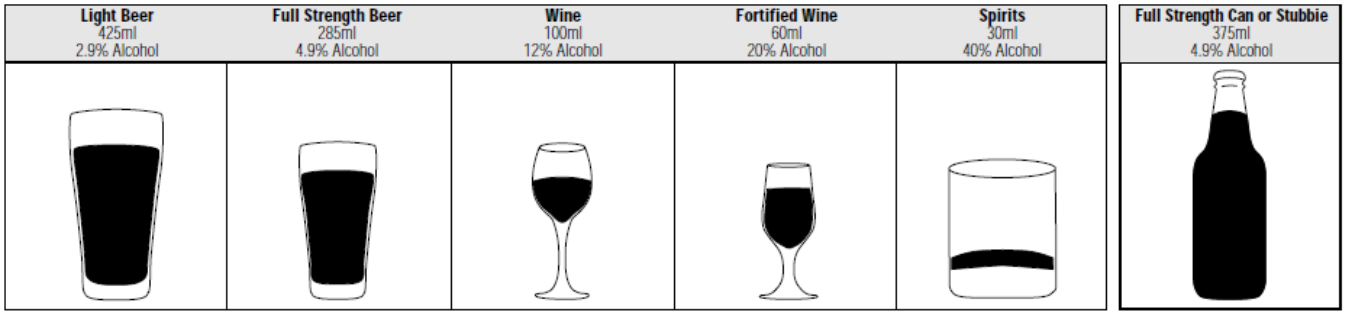
We would like to know how often and how much of the following drinks you usually consume.
When answering these questions please answer in number of glasses, cans, cups, stubbies etc.
To assist you, below each type of drink is the type of measurement.
Please fill in every line (tick NEVER if you don't consume the type of drink)
Please indicate the number of drinks you usually consume for the time selected. E.g you drink water every day, and usually **6** glasses per day

	Never	Less than once a month	1 day per month	2 days per month	3 days per month	1 day per week	2 days per week	3 days per week	4 days per week	5 days per week	6 days per week	Every day	Average number of drinks
Water (250 ml glass)													
DK1	0	1	2	3	4	5	6	7	8	9	10	11	DK19
Fizzy drink (e.g cola, lemonade) can or glass													
DK2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK20
Diet fizzy drink (e.g. Diet cola, diet lemonade) can or glass													
DK3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK21
Energy drink (e.g Redbull, V, Monster) can													
DK4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK22
Diet energy drink (can)													
DK5	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK23
Tea (cup)													
DK6	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK24
Herbal tea (cup)													
DK7	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK25
Green tea (cup)													
DK8	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK26
Instant coffee (cup)													
DK9	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK27
Ground coffee (ie filter coffee, cappuccino, flat white) cup, mug													
DK10	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK28
Beer (can stubby)													
DK11	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK29
Alcoholic soda (eg alcopop, cruiser, UDL)													
DK12	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK30
Red wine (wine glass)													
DK13	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK31
White wine, champagne (wine glass)													
DK14	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK32
Sherry, port (small wine glass 30 ml)													
DK15	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK33
Vodka (shots)													
DK16	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK34

	Never	Less than once a month	1 day per month	2 days per month	3 days per month	1 day per week	2 days per week	3 days per week	4 days per week	5 days per week	6 days per week	Every day	Average number of drinks
Whiskey (30 mL)													
DK17	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK35
Other spirits (shots)													
DK18	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK36
Milk full fat (250 ml glass)													
DK55	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK59
Milk (hi lo, skim or any other type) 250 ml glass													
DK56	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK60
Non cows milk (eg soy, almond, coconut) 250 ml glass													
DK57	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK61
Flavoured milk (eg ice coffee, choc chill) box or bottle													
DK58	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	DK62

We would like to ask you some questions about your alcohol consumption.

16.2 Please answer the following questions in terms of standard drinks. The following gives you an idea of one standard drink. A full strength can or stubby, and a can or bottle of alcoholic soda is 1.5 standard drinks.



*The guide above contains examples of **one standard drink**.*

A full strength can or stubbie contains ***one and a half standard drinks***.

	Never	Monthly or less	2-4 times a month	2-3 times a week,	4 or more times a week
How often do you have a drink containing alcohol? ALC_F	0 ☐ Go to Q17	1 ☐	2 ☐	3 ☐	4 ☐
	1 or 2	**3 or 4**	**5 or 6**	**7 to 9**	**10 or more**
How many standard drinks do you have on a typical day when you are drinking? ALC_DKN_T	0	1	2	3	4
	Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
How often do you have six or more standard drinks on one occasion? ALC_DKN6_F	0	1	2	3	4
How often during the last year have you found that you were not able to stop drinking once you had started? ALC_XSTOP	☐	☐	☐	☐	☐
How often during the last year have you failed to do what was normally expected of you because of drinking? ALC_EF1	☐	☐	☐	☐	☐
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? AH45	☐	☐	☐	☐	☐
How often during the last year have you had a feeling of guilt or remorse after drinking? AH46	☐	☐	☐	☐	☐
How often during the last year have you been unable to remember what happened the night before because you had been drinking? AH47	☐	☐	☐	☐	☐
Have you or someone else been injured because of your drinking? AH48	☐	☐	☐	☐	☐
Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down? AH49	☐	☐	☐	☐	☐

In the last year, have you drunk more than you meant to? ALC_MORE

0 ○ No
1 ○ Yes

Have you felt you wanted or needed to cut down on your drinking in the last year? ALC_CUT1

0 ○ No
1 ○ Yes

17. SMOKING

The following questions are about your smoking history. It is important to know if you smoke/have ever smoked, or spend time with people who smoke.

17.1 Have you ever smoked cigarettes (including roll ups)? SM1

0 ○ No *(Please go Q17.7)*
1 ○ Yes

17.2 Have you smoked any cigarettes (including hand rolled) in the past 30 days? SM2

0 ○ No
1 ○ Yes (Please go to Q17.3)

SM6A

If you have not smoked any cigarettes in the past 30 days, how old were you when you last stopped smoking?

How many cigarettes per day did you smoke SM9

0 ○ Less than one
1 ○ 1-5
2 ○ 6-10
3 ○ 11-15
4 ○ 16-20
5 ○ More than 20

(Please go to Q17.7)

17.3 How many cigarettes per day do you currently smoke? SM4

0 ○ Less than one
1 ○ 1-5
2 ○ 6-10
3 ○ 11-15
4 ○ 16-20
5 ○ More than 20

17.4 At what age did you start smoking regularly? SM40

17.5 In the last year, have you ever smoked more than you meant to? SM46

0 ○ No
1 ○ Yes

17.6 Have you felt you wanted or needed to cut down on your smoking in the last year? SM47

0 ○ No
1 ○ Yes

17.7 Over the past 3 years, have you lived for more than 6 months with anyone that smokes cigarettes/cigars? SM42

0 ○ No
1 ○ Yes

17.8 Are you currently exposed to tobacco smoke at home? SM41

0 ○ No, *please go to Q17.9*
1 ○ Yes

If Yes, how long have you been exposed to tobacco smoke at home SMK_LIV_EXPYR (= TOTAL MONTHS)

-dropped ……years - dropped ……months

17.9 Are you exposed to tobacco smoke at work? SM43

0 ○ No, please go to Q17.10
1 ○ Yes
2 ○ I don't work, please go to Q17.10

If Yes, how long have you been exposed to tobacco smoke at work SMK_WRK_EXPYR (= TOTAL MONTHS)

-dropped ……years - dropped ……months

17.10 Do you currently use electronic cigarettes or E-cigarettes, such as Ruyan or NJOY? SM44

0 ○ No
1 ○ Yes

17.11 Do you currently use nicotine replacement therapy? SM45

0 ○ No
1 ○ Yes

18. DRUG USE

18.1 Have you ever tried or used the following drugs for <u>non-medicinal purposes</u> in the past 12 months, and if so, on average, how often?

	Never 0	Only tried once 1	Less than monthly 2	About monthly 3	About weekly 4	daily 5	Don't know 7
Marijuana/cannabis DG1	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 7
Opioids (heroin morphine, pethidine) DG17	☐	☐	☐	☐	☐	☐	☐
Amphetamines (speed, ecstasy, diet pills) DG6	☐	☐	☐	☐	☐	☐	☐
Ritalin DG19	☐	☐	☐	☐	☐	☐	☐
Methamphetamines (ice) DG18	☐	☐	☐	☐	☐	☐	☐
Other Methamphetamines (MDMA, molly) DG20	☐	☐	☐	☐	☐	☐	☐
Cocaine HCl (powder cocaine, coke) DG9	☐	☐	☐	☐	☐	☐	☐
GHB (liquid ecstasy, liquid G, blue nitro, fantasy) DG11	☐	☐	☐	☐	☐	☐	☐
Freebase cocaine (crack) DG21	☐	☐	☐	☐	☐	☐	☐
Nitrous (laughing gas) DG8	☐	☐	☐	☐	☐	☐	☐
Other inhalants (glue, petrol, solvents) DG2	☐	☐	☐	☐	☐	☐	☐
Hallucinogens (LSD, acid, mushrooms, Ketamine,) DG16	☐	☐	☐	☐	☐	☐	☐
Sedatives or sleeping pills e.g. Valium, Rohypnol (**for recreational use**) DG14	☐	☐	☐	☐	☐	☐	☐
Painkiller/analgesics e.g. panadeine forte, nurofen plus (**for recreational use**). DG3	☐	☐	☐	☐	☐	☐	☐
Methadone/Buprenorphine DG10	☐	☐	☐	☐	☐	☐	☐
Other, please list DRG5							
DRG5_OTH	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

18.2 In the last year, have you ever smoked more marijuana than you meant to? DG22

8 ○ No, don't smoke marijuana (*please go to Q18.4*)
0 ○ No
1 ○ Yes

18.3 Have you felt you wanted or needed to cut down on your marijuana smoking in the last year? DG22A

0 ○ No
1 ○ Yes

18.4 In the last year, have you ever used other drugs more than you meant to? DG23

8 ○ No, don't use drugs *(please go to Q19)*
0 ○ No
1 ○ Yes

18.5 Have you felt you wanted or needed to cut down on your use of other drugs in the last year? DG23A

0 ○ No
1 ○ Yes

19. MEDICATIONS

The following questions are about your health and medical history, doctor-prescribed medications, over-the-counter medications or supplements you may take.

Do you currently take medication(s) prescribed by a doctor? PMD_CUR

0 ○ No *(Please go to Q19.1)*
1 ○ Yes, If yes, please list all **PRESCRIBED** medications you currently take, e.g. Coversyl, Lipitor, mini pill,

Medication	Condition medication addresses	Dose in mgs	Frequency e.g. daily, twice a day	How long have you been taking this medication at th current dose? In years or months
G227_PMD1	G227_PMD1_COND	G227_PMD1_DOSE	G227_PMD1_FREQ	G227_PMD1_DUR_M G227_PMD1_DUR_YR
G227_PMD2	G227_PMD2_COND	G227_PMD2_DOSE	G227_PMD2_FREQ	G227_PMD2_DUR_M G227_PMD2_DUR_YR
G227_PMD3	G227_PMD3_COND	G227_PMD3_DOSE	G227_PMD3_FREQ	G227_PMD3_DUR_M G227_PMD3_DUR_YR
G227_PMD4	G227_PMD4_COND	G227_PMD4_DOSE	G227_PMD4_FREQ	G227_PMD4_DUR_M G227_PMD4_DUR_YR
G227_PMD5	G227_PMD5_COND	G227_PMD5_DOSE	G227_PMD5_FREQ	G227_PMD5_DUR_M G227_PMD5_DUR_YR
G227_PMD6	G227_PMD6_COND	G227_PMD6_DOSE	G227_PMD6_FREQ	G227_PMD6_DUR_M G227_PMD6_DUR_YR

19.1 Antibiotics and probiotics

Have you taken any antibiotic tablets or intravenous (through the vein) antibiotics within *the last 3 months*? ATB_EVER

0 ○ No *(Please go to Q19.2)*
1 ○ Yes

If yes, please list the name of the antibiotic (e.g. penicillin), duration of course (e.g. 7 days) and approximately how long ago you took them (e.g. 1 month ago).

Name of antibiotic	Duration (e.g. 7 days)	How long ago did you take them
G227_ATB1_NAME	G227_ATB1_DUR	G227_ATB1_WHEN
G227_ATB2_NAME	G227_ATB2_DUR	G227_ATB2_WHEN
G227_ATB3_NAME	G227_ATB3_DUR	G227_ATB3_WHEN
G227_ATB4_NAME	G227_ATB4_DUR	G227_ATB4_WHEN
G227_ATB5_NAME	G227_ATB5_DUR	G227_ATB5_WHEN
G227_ATB6_NAME	G227_ATB6_DUR	G227_ATB6_WHEN

If yes, please identify the condition that the antibiotics were used to treat; ATB_COND

1 ○ Respiratory tract infection (bronchitis or pneumonia)
2 ○ Sinusitis
3 ○ Urinary tract infection
4 ○ Skin infection (or cellulitis)
5 ○ Acne
6 ○ Ear infection (or otitis media or otitis externa)
7 ○ Gastroenteritis
8 ○ Sexually transmitted infection (e.g. chlamydia or gonorrhea)
9 ○ Other, *Please specify* '..... ATB_COND_OTH .....

19.2 Over the counter medications

Have you taken any non-prescription medications in the last 3 months? (e.g. paracetomol, ibuprofen, aspirin etc) G227_CMED

- ○ No *(Please go to Q19.3)*
- ○ Yes, please list

Medication	Condition medication addresses	Dose in mgs	Frequency e.g. daily, twice a day	When did you last have this medication
G227_OTC1	G227_OTC1_COND	G227_OTC1_DOSE	G227_OTC1_FREQ	G227_OTC1_LAST
G227_OTC2	G227_OTC2_COND	G227_OTC2_DOSE	G227_OTC2_FREQ	G227_OTC2_LAST
G227_OTC3	G227_OTC3_COND	G227_OTC3_DOSE	G227_OTC3_FREQ	G227_OTC3_LAST
G227_OTC4	G227_OTC4_COND	G227_OTC4_DOSE	G227_OTC4_FREQ	G227_OTC4_LAST
G227_OTC5	G227_OTC5_COND	G227_OTC5_DOSE	G227_OTC5_FREQ	G227_OTC5_LAST
G227_OTC6	G227_OTC6_COND	G227_OTC6_DOSE	G227_OTC6_FREQ	G227_OTC6_LAST

19.3 Have you taken any pro-biotics (e.g. Yakult, Inner Health Plus, kambucha, kefir etc) within *the last 3 months*? G227_PRB_EVER

- ○ No *(Please go to Q19.4)*
- ○ Yes

If yes, please specify the total number of days in the last 3 months that you have taken probiotics;

Name of substance or supplement (or product)	How much	Frequency (e.g. daily, weekly)	When did you last consume any probiotics (e.g. 2 weeks ago)
G227_PRB1_NAME	G227_PRB1_DOSE	G227_PRB1_FREQ	G227_PRB1_WHEN
G227_PRB2_NAME	G227_PRB2_DOSE	G227_PRB2_FREQ	G227_PRB2_WHEN
G227_PRB3_NAME	G227_PRB3_DOSE	G227_PRB3_FREQ	G227_PRB3_WHEN

19.4 Vitamins, supplements or other substances

Do you currently take supplements or substances (e.g. anabolic agents, peptides, beta-blockers, stimulants) that have not been prescribed by a doctor for the purpose of:

Enhancing your performance in an important area of your life such as work, study, or sport (e.g. anabolic agents, peptides, beta-blockers, stimulants)? G227_PERF_CURR

○ No *(Please go to **b**)* ◯ Yes *(Please complete **a**)*

a. Name of substance or supplement (or product)	Dose in mgs	Frequency (e.g. daily, weekly)	How long have you been taking this substance or supplement (yrs and mnths)?
G227_PERF1	G227_PERF2_DOSE	G227_PERF2_FREQ	G227_PERF2_DUR_M G227_PERF2_DUR_YR
G227_PERF2	G227_PERF2_DOSE	G227_PERF2_FREQ	G227_PERF2_DUR_M G227_PERF2_DUR_YR
G227_PERF3	G227_PERF3_DOSE	G227_PERF3_FREQ	G227_PERF3_DUR_M G227_PERF3_DUR_YR

Losing weight (e.g. diuretics, stimulants)? G227_WT_CURR

○ No *(Please go to **c**)* ◯ Yes *(Please complete **b**)*

b. Name of substance or supplement (or product)	Dose in mgs	Frequency (e.g. daily, weekly)	How long have you been taking this substance or supplement (yrs and mnths)?
G228_WT1	G227_WT1_DOSE	G227_WT1_FREQ	G227_WT1_DUR_M G227_WT1_DUR_YR
G227_WT2	G227_WT2_DOSE	G227_WT2_FREQ	G227_WT2_DUR_M G227_WT2_DUR_YR
G227_WT3	G227_WT3_DOSE	G227_WT3_FREQ	G227_WT3_DUR_M G227_WT3_DUR_YR

Building muscles (e.g. growth hormones, steroids, protein powder, creatine, pre-workout)?

○ No *(Please go to **d**)* ◯ Yes *(Please complete **c**)* G227_MUS_CURR

c. Name of substance or supplement (or product)	Dose in mgs	Frequency (e.g. daily, weekly)	How long have you been taking this substance or supplement (yrs and mnths)?
G227_MUS1	G227_MUS1_DOSE	G227_MUS1_FREQ	G227_MUS1_DUR_M G227_MUS1_DUR_YR
G227_MUS2	G227_MUS2_DOSE	G227_MUS2_FREQ	G227_MUS2_DUR_M G227_MUS2_DUR_YR
G227_MUS3	G227_MUS3_DOSE	G227_MUS3_FREQ	G227_MUS3_DUR_M G227_MUS3_DUR_YR

Improving your general health or well-being (e.g. fish oil, calcium, VitB, VitC etc)

G227_GEN_CURR

○ No *(Please go to **Q20**)* ◯ Yes *(Please complete **d**)*

d. Name of substance or supplement (or product)	Dose in mgs	Frequency (e.g. daily, weekly)	How long have you been taking this substance or supplement (yrs and mnths)?
G227_GEN1	G227_GEN1_DOSE	G227_GEN1_FREQ	G227_GEN1_DUR_M G227_GEN1_DUR_YR
G227_GEN2	G227_GEN2_DOSE	G227_GEN2_FREQ	G227_GEN2_DUR_M G227_GEN2_DUR_YR
G227_GEN3	G227_GEN3_DOSE	G227_GEN3_FREQ	G227_GEN3_DUR_M G227_GEN3_DUR_YR

20. MEDICAL HISTORY

*** 20*** We are interested in knowing your recent medical history and any major illness you may have had over the last 5 years?

ENDOCRINE DISEASE: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Polycystic ovary syndrome — ENDO_PCOS_5Y
- ○ Endometriosis — ENDO_ENDOM_5Y
- ○ Osteoporosis — ENDO_OSTPORS_5Y
- ○ Kidney disease — ENDO_KIDNEY_5Y
- ○ Thyroid disease — ENDO_THYROID_5Y
- ○ None of the above — ENDO_NO_5Y

NEUROLOGICAL CONDITIONS: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Alzheimer's disease — NEURO_ALZHM_5Y
- ○ Vascular dementia (Multi-infarct dementia) — NEURO_VDEM_5Y
- ○ Parkinson's disease — NEURO_PARKINS_5Y
- ○ Attention Deficit (Hyperactivity) Disorder — NEURO_ADHD_5Y
- ○ Anxiety disorder (including Post Traumatic Stress Disorder) — MH_ANXD_5Y
- ○ Bipolar disorder — MH_BPD_5Y
- ○ Schizophrenia — MH_SCHZ_5Y
- ○ Epilepsy — NEURO_EPIL_5Y
- ○ Chronic Fatigue (ME) — NEURO_CFS_5Y
- ○ None of the above — NEURO_NO_5Y

DEPRESSION: Have you ever been told by a doctor that you have depression? MH_DEPR

- 0 ○ No
- 1 ○ Yes

ALLERGIES AND RESPIRATORY DISEASE: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Asthma or bronchial asthma — RESP_AST_5Y
- ○ Eczema — RESP_ECZ_5Y
- ○ Bronchitis — RESP_BRON_5Y
- ○ Chronic obstructive pulmonary disease (COPD) — RESP_COPD_5Y
- ○ Hay fever or allergic rhinitis — RESP_ARH_5Y
- ○ Pleurisy — RESP_PLRSY_5Y
- ○ Pneumonia — RESP_PNEUM_5Y
- ○ Sinusitis — RESP_SINUS_5Y
- ○ None of the above — RESP_NO_5Y

AUTOIMMUNE DISEASE – Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Ankylosing Spondylitis AID_ANKSP_5Y
- ○ Multiple sclerosis AID_MLSC_5Y
- ○ SLE (lupus) AID_SLE_5Y
- ○ None of the above AID_NO_5Y

DIABETES: Has a doctor ever diagnosed you with diabetes? DIAB_EVER

0 ○ No *(Please go to Sleep problems)*

1 ○ Yes - please enter year diagnosed (e.g. 2010) ..... DIAB_YEAR

What kind of diabetes were you diagnosed with? DIAB_TYPE

1 ○ Type 1 diabetes (also known as insulin dependent diabetes)

2 ○ Type 2 diabetes (also known as non-insulin dependent diabetes)

SLEEP PROBLEMS: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Obstructive sleep apnoea SL_OSA_5Y
- ○ Narcolepsy SL_NAR_5Y
- ○ Loud or disruptive snoring SL_SNR_5Y
- ○ Insomnia disorder SL_INS_5Y
- ○ Excessive (too much) sleepiness SL_EXC_5Y
- ○ Restless legs or periodic leg movements of sleep SL_RLS_5Y
- ○ None of the above SL_NO_5Y

GASTROINTESTINAL DISORDERS: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Stomach (gastric) or duodenal ulcer GIT_ULCER_5Y
- ○ Colon cancer CA_COLON_5Y
- ○ Colonic polyps GIT_POLYP_5Y
- ○ Coeliac disease GIT_COELIAC_5Y
- ○ Gastro-oesophageal reflux disease GIT_REFLUX_5Y
- ○ Hiatus Hernia GIT_HIATH_5Y
- ○ Crohn's disease GIT_CROHN_5Y
- ○ Ulcerative colitis (or proctitis) GIT_ULCOL_5Y
- ○ Irritable bowel syndrome GIT_IBS_5Y
- ○ Diverticular disease GIT_DIVERT_5Y
- ○ Gallstones GIT_GALLST_5Y
- ○ Haemorrhoids GIT_PILES_5Y
- ○ Other (please specify)..... GIT_OTHN_5Y GIT_OTH_5Y
- ○ None of the above GIT_NO_5Y

GASTROINTESTINAL DISORDERS: Have you ever had surgery on your gastrointestinal tract? *(Please select all that apply)*

○	No	GITS_NONE
○	Cholecystectomy (removal of gall bag/gall bladder)	GITS_CHOL
○	Appendicectomy (removal of appendix)	GITS_APPEN
○	Colectomy (removal of part of the colon)	GITS_COL
○	Lap or gastric banding	GITS_BAND
○	Gastric bypass surgery	GITS_BYPASS
○	Other (please specify)…… GITS_OTHN ……	GITS_OTH

CARDIOVASCULAR DISEASE: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

○	Angina	CVD_ANG_5Y
○	Claudication (problems with blood supply to your legs that causes pain on walking)	CVD_CLD_5Y
○	High blood pressure	CVD_HT_5Y
○	High cholesterol	CVD_HCHOL_5Y
○	Implant or cardiac pacemaker	CVD_IMPL_5Y
○	Myocardial infarction/ Heart attack	CVD_MI_5Y
○	Transient ischaemic attack (TIA)	CVD_TIA_5Y
○	Stroke	CVD_STROKE_5Y
○	Carotid surgery (endarterectomy or stent)	CVD_CEAS_5Y
○	Coronary angioplasty or stent	CVD_ANGPL_5Y
○	Coronary bypass	CVD_BYPASS_5Y
○	None of the above	CVD_NO_5Y

In the last 5 years, have you been diagnosed with cancer? CANCER_ANY_5Y

0 ○	No *(Please go to Other medical conditions)*	
1 ○	Yes	

In the last 5 years, what type of cancer(s) were you diagnosed with?
(Please select all that apply)

○	Breast Cancer	CANCER_BREAST_5Y
○	Prostate Cancer	CANCER_PROSTATE_5Y
○	Skin Cancer	CANCER_SKIN_5Y
○	Bowel Cancer	CANCER_BOWEL_5Y
○	Lung Cancer	CANCER_LUNG_5Y
○	Blood cancer	CANCER_BLOOD_5Y
○	Lymphoma	CANCER_LYMPHOMA_5Y
○	Other, *Please specify* '…… CANCER_OTHN_5Y	CANCER_OTH_5Y

OTHER MEDICAL CONDITIONS: Has a health professional ever diagnosed you with any of the following conditions in the past five years?? *(Please select all that apply)*

○	Chronic ear infection	EAR_CINF_5Y
○	Ménières Disease	EAR_MEND_5Y
○	Trauma to the head or neck	TRM_HN_5Y
○	Anaemia	ANAEMIA_5Y
○	Arthritis	ARTHRITIS_5Y
○	Migraine	MIGRAINE_5Y
○	Headache	HEADACHE_5Y
○	Cirrhosis of the liver	CIRRHOSIS_5Y
○	Fatty liver	FATLIV_5Y
○	Poliomyelitis	POLIO_5Y
○	Urinary tract infection	UTI_5Y
○	Other major medical condition(s) – please list below	DIS_OTH_5Y
○	No other major medical conditions	DIS_NO_5Y

Please list any other major medical condition(s) that you have been diagnosed with in the last 5 years**.**

Name of condition
DIS_OTHN_5Y

Accidents, injuries, hospital admissions

In the past 5 years, have you had any accidents or injuries which required you to go to a doctor (GP), hospital or clinic? HOSP

0 ○ No *(Please go to Q20.1)*

1 ○ Yes

Please describe the accident, the injury and any treatment (e.g. Broke leg playing football) and list every accident or injury separately, giving as much detail as possible

Injury	How did it happen?	When did it happen?	Treatment
Sprained wrist	Fell down stairs	2 years ago	Physiotherapy
HOSP1_INJ	HOSP1_CAUSE	HOSP1_TIME	HOSP1_TREAT
HOSP2_INJ	HOSP2_CAUSE	HOSP2_TIME	HOSP2_TREAT
HOSP3_INJ	HOSP3_CAUSE	HOSP3_TIME	HOSP3_TREAT
HOSP4_INJ	HOSP4_CAUSE	HOSP4_TIME	HOSP4_TREAT

20.1 In the past 5 years, have you been admitted to a hospital or day surgery? AE

0 ○ No *(Please go to **Q20.2**)*

1 ○ Yes

Please list each admission separately, giving as much detail as possible.

Date	Which hospital	Reason for admission
October 2015	Hollywood	Knee arthroscopy
AE1_DAT	AE1_HOSP	AE1_REA AE1_ICD10
AE2_DAT	AE2_HOSP	AE2_REA AE2_ICD10
AE3_DAT	AE3_HOSP	AE3_REA AE3_ICD10
AE4_DAT	AE4_HOSP	AE4_REA AE4_ICD10

20.2 Approximately how many times have you seen the following health professionals about your health in the last 12 months? 0 1 2 3 4 5 6 7

	0	1	2	3	4	5	6-10	11 +
GP or family doctor HRP_GP	☐	☐	☐	☐	☐	☐	☐	☐
Accident and Emergency HRP_EMER	☐	☐	☐	☐	☐	☐	☐	☐
Hospital outpatient (department or clinic) HRP_OUT	☐	☐	☐	☐	☐	☐	☐	☐
Private medical specialist HRP_SPEC	☐	☐	☐	☐	☐	☐	☐	☐
Dentist, dental therapist, orthodontist HRP_DEN	☐	☐	☐	☐	☐	☐	☐	☐
Optician/optometrist HRP_OPT	☐	☐	☐	☐	☐	☐	☐	☐
Dietician/nutritionist HRP_DIET	☐	☐	☐	☐	☐	☐	☐	☐
Physiotherapist HRP_PHYS	☐	☐	☐	☐	☐	☐	☐	☐
Occupational therapist (OT) HRP_OT	☐	☐	☐	☐	☐	☐	☐	☐
Speech therapist HRP_SP	☐	☐	☐	☐	☐	☐	☐	☐
Psychologist/psychiatrist HRP_PSY	☐	☐	☐	☐	☐	☐	☐	☐
Podiatrist HRP_POD	☐	☐	☐	☐	☐	☐	☐	☐
Chiropractor HRP_CHI	☐	☐	☐	☐	☐	☐	☐	☐
Alternative therapist e.g. iridologist HRP_ALT	☐	☐	☐	☐	☐	☐	☐	☐

When did you last visit the dentist? Why did you visit the dentist? DENT1

1 ○ In the last 6 months

2 ○ Between 6 months and a year ago

3 ○ Over a year ago

4 ○ Never

Why did you visit the dentist? DENT2

1 ○ Check up with no treatment
2 ○ Check up with scale and clean
3 ○ Check up with minor treatment (e.g. Small filling)
4 ○ Check up with follow-up treatment (e.g. Large filling, crown)
5 ○ Ongoing long-term treatment
6 ○ To see the hygienist (scale and polish)
7 ○ Emergency

21. RELATIONSHIPS

21.1 What is your current relationship status? *(Please mark only one response)* PTNR1

0 ○ Single and not in a relationship
1 ○ In a relationship but NOT living together
2 ○ In a relationship AND living together
3 ○ Married (in a registered marriage)

What is your current marital status? *(Please select one)* MAR

0 ○ Never married
1 ○ Married
2 ○ Widowed
3 ○ Divorced
4 ○ Separated
5 ○ De Facto

Is your primary partner male or female? P_6

○ No primary partner (Please go to Q21.1)
○ Male
○ Female
○ Other, please specify …… P6_OTH

New value "Non-binary" was created based on responses, and values were re-coded as follows:
"No primary partner"=0,
"Male"=1,
"Female"=2,
"Non-binary"=3,
"Other, please specify"=4

How long have you been with your primary partner? PTNR_DUR (=TOTAL MONTHS)

……(dropped)…….. weeks ……(dropped)……..months……(dropped)……years ☐777 don't know

21.1 Which of these statements best describes you? (Please mark only one response) SX11

1 ○ I have felt attracted only to females, never to males

2 ○ I have felt attracted more often to females and at least once to a male

3 ○ I am about equally attracted to females and males

4 ○ I have felt attracted more often to males and at least once to a female

5 ○ I have felt attracted only to males, never to females

0 ○ I have never felt attracted to anyone at all

What do you identify as: (Please mark only one response) SXO3

0 ○ Heterosexual

1 ○ Gay/Lesbian

2 ○ Bisexual

3 ○ Not sure

4 ○ Other - please specify SXO3_OTH .....

Do you identify as: (Please mark only one response)SX123

1 ○ Female

0 ○ Male

2 ○ Transgender female

3 ○ Transgender male

4 ○ Nonbinary

5 ○ Other - please specify .....SX123_OTH.....

Regarding your sexual experiences

How old were you when you first had an experience of:

		Haven't 0	Under 14 1	14to18 2	18to20 3	20to25 4	over 25 5
SX13	Deep kissing	☐	☐	☐	☐	☐	☐
SX14	Touching a partner's genitals with your hands	☐	☐	☐	☐	☐	☐
SX15	Being touched on your genitals by a partner's hand	☐	☐	☐	☐	☐	☐
SX16	Giving oral sex	☐	☐	☐	☐	☐	☐
SX17	Receiving oral sex	☐	☐	☐	☐	☐	☐
SX119	Penis-vaginal intercourse	☐	☐	☐	☐	☐	☐
SX120	Anal intercourse (giving or receiving)	☐	☐	☐	☐	☐	☐

Over the last year, with how many partners have you had oral sex, or vaginal or anal intercourse? *(Please mark only one response)* SX95

- 8 ○ Have not had a sexual partner *(Please go to ***Q21.3**)*
- 0 ○ Have not had a sexual partner in the last year
- 1 ○ 1 person
- 2 ○ 2 people
- 3 ○ 3 people
- 4 ○ 4 people
- 5 ○ 5-10 people
- 6 ○ 11 or more people

Over the last year, have your partners been PTNR2

- 0 ○ Male only
- 1 ○ Female only
- 2 ○ Male and female

Over your LIFETIME, have your partners been:PTNR3

- 0 ○ Male only
- 1 ○ Female only
- 2 ○ Male and female

In the last year, have you ever had oral sex or vaginal/anal intercourse when you didn't want to? SX23

- 0 ○ No *(Please go to Q21.2)*
- 1 ○ Yes

What were the reasons for this? (Please mark all responses that apply)

- SX24 ○ Had been drinking at the time
- SX25 ○ Was high at the time
- SX26 ○ Partner thought I should
- SX27 ○ Friends thought I should
- SX96 ○ Felt I could not say no
- SX28 ○ Other reason - please specify ..... SX28_OTH .....

21.2 CONTRACEPTION AND PREGNANCY

Do you currently use contraception? SXC4

- 0 ○ No
- 1 ○ Yes

What kind(s) of contraception do you or your partner use? (Please mark all that apply)

- o Male condoms PTNR4A
- o Female condoms PTNR4B
- o Diaphragm PTNR4C
- o Oral contraceptive pill (please give the name: _____) PTNR4D PTNR4D_NOTE
- o Coil / Inter uterine device (ICU, Ring) PTNR4E
- o Injection (Depo Provera) PTNR4F
- o Implant (e.g. Implanon) PTNR4G
- o Withdrawal SXC4I
- o Sterilisation (vasectomy, tubal ligation) PTNR4I
- o Contraceptive vaginal ring PTNR4J
- o Other (please specify) ..... PTNR4K PTNR4K_OTH

NOTE: Several women completed both the Reproductive and Participant Questionnaire, and thus responded twice to the above question about contraception (Q21.2). As such, for these participants, responses from the Reproductive Questionnaire have been reported for these variable.

Why do you, or why does your partner use this contraceptive? *(Please mark* all *responses that apply)*

PTNR5A ○ To prevent pregnancy

PTNR5B ○ To prevent sexually transmitted infections

PTNR5C ○ For painful periods

PTNR5D ○ For heavy periods

PTNR5E ○ For another reason - please specify ..... PTNR5E_OTH .....

Have you ever had (or caused) a pregnancy?SX62

0 ○ No *(Please go to ***Q21.3**)*

2 ○ Don't know

1 ○ Yes

How did the pregnancy(ies) end? (all that apply)

		Number of:
SX98_I ○	Livebirth	SX98 .....
SX99_I ○	Stillbirth	SX99 .....
SX100_I ○	Miscarriage	SX100 .....
SX126_I ○	Ectopic pregnancy	SX126 .....
SX101_I ○	Abortion/termination	SX101 .....

Derived variable:
SX124 - Total number of pregnancies

Was the last pregnancy SX102

0 ○ Planned

1 ○ Unplanned but wanted

2 ○ Unplanned and unwanted

***21.3* How much would you like to become a parent sometime soon?** SX61

0 ○ I am already a parent

1 ○ I really want to be a parent soon

2 ○ It would be nice to be a parent soon

3 ○ I don't care if I do or don't become a parent soon

4 ○ I would prefer not to be a parent soon

5 ○ I really don't want to be a parent soon

21.4 SEXUALLY TRANSMITTED DISEASE

In your opinion how likely is it that you might catch a sexually transmissible infection? SX80

0 ○ Never

1 ○ Very unlikely

2 ○ Unlikely

3 ○ Likely

4 ○ Very likely

Have you ever been diagnosed with a sexually transmissible infection? SX30

0 ○ No *(Please go to Q22)*

1 ○ Yes

Which genital or sexually transmitted infections have you been diagnosed with and at what age?
(Please mark all responses that apply)

0=NO; 1=YES		**AGE in years**
○ Candidiasis/Thrush	SI1	SI13
○ Chlamydia	SI2	SI14
○ Genital herpes	SI3	SI15
○ Genital warts	SI4	SI16
○ Gonorrhoea	SI5	SI17
○ Hepatitis B	SI6	SI18
○ HIV/AIDS	SI7	SI19
○ Pubic lice/crabs	SI8	SI20
○ Syphilis	SI9	SI21
○ Bacterial vaginosis	SI11	SI23
○ Hepatitis C	SI12	SI24
○ Other - please specify	SI10	SI22
	SI10_OTH	SI22_OTH

22. DRIVING

Do you have a drivers' license? DRV

0 ○ No *(Please go to **Q23***)*

2 ○ No, but drive

1 ○ Yes

When did you get your drivers' license?

(Date on back of license) Month…… DRV_MON Year…… DRV_YR

We would like to get an accurate estimate of how many km you drive in a typical week, to help with this it may be helpful to think of the places you drive to in a typical week e.g. work, sport, beach, shops, friends, family, etc. This table is to assist you calculate the total km's to complete the question below*

Place	Times per week	KM estimate	= total KM
e.g. home to work	5	10	50 km

In a typical week, how many km do you generally drive? Total km ..... DRV_KM

	Never 0	Hardly ever 1	Occasionally 2	Quite often 3	Frequently 4	Nearly all the time 5
How often do you drive without a seatbelt? DRV5	☐	☐	☐	☐	☐	☐
How often do you drive after drinking too much? DRV6	☐	☐	☐	☐	☐	☐
How often do you exceed the speed limit by at least 20kph DRV7	☐	☐	☐	☐	☐	☐
How often do you text while driving? DRV8	☐	☐	☐	☐	☐	☐
How often do you talk on the phone on a hands free system while driving? DRV9	☐	☐	☐	☐	☐	☐
How often do you talk on the phone while driving? DRV10	☐	☐	☐	☐	☐	☐
How often do you become angry with other drivers and indicate hostility? DRV11	☐	☐	☐	☐	☐	☐

How many car accidents have you ever had while driving a car? SL70

.....

How many car accidents have you ever had because you felt sleepy or fell asleep behind the wheel of a car? SL71

.....

How many 'near miss' car accidents have you ever had due to sleepiness? SL69

.....

Have you ever fallen asleep whilst you were behind the wheel? SL67

0 ○ No *(Please go to next section)*

1 ○ Yes

Has this occurred: SL68

0 ○ Only once

1 ○ 2-5 times

2 ○ 6-20 times

3 ○ 21-100 times

4 ○ More than 100 times

7 ○ Not sure

23. HEARING

The following questions are about your hearing, including questions on noisy activities (leisure and work), tinnitus (noises in your ears), hyperacusis (intolerance to sound) and dizziness.

23.1 How would you rate your hearing? HEAR_RATE

Very good	Good	Average	Poor	Very Poor
4	3	2	1	0

Do you have trouble hearing when there is background noise? HEAR_BKN

0 ○ No
1 ○ Yes

Do any members of your family or close friends ever say they think you have a hearing loss? HEAR_LOSS_TH

0 ○ No
1 ○ Yes

Thinking of your current lifestyle and leisure activities, how would you describe the risk of it leading to some degree of permanent hearing loss? HEAR_LOS_OP

0 ○ No risk of hearing loss
1 ○ A very small risk of hearing loss
2 ○ A small risk of hearing loss
3 ○ A medium risk of hearing loss
4 ○ A large risk of hearing loss
5 ○ A very large risk of hearing loss
7 ○ Don't know

Do you use a hearing aid or other hearing device? HEAR_LOS_EFF (0=NO; 1= YES)

If you have a hearing impairment, does it affect your daily life and activities?

8 ○ I don't have a hearing impairment HEAR_LOS_EFF1
0 ○ Not at all
1 ○ Occasionally
2 ○ Frequently
3 ○ Constantly

Do you use a hearing aid or other hearing device? HEAR_AID

0 ○ No
1 ○ Hearing aid in one ear
2 ○ Hearing aid in both ears
3 ○ Cochlear implant
4 ○ Bone Anchored Hearing Aid (BAHA)

○ Other, please describe: ..... HEAR_AID_OTH

How often are you involved in these activities?

	More than once a week	Once a week	Once a month	Once every 3 to 6 months	Less than once a year	Never	Do you usually wear hearing protection during these activities?	
	5	4	3	2	1	0	Yes 1	No 0
Attend a live sporting event HEAR_ACT1_F	☐	☐	☐	☐	☐	☐	☐	☐ HEAR_ACT1_P
Visit a pub or registered club e.g. RSL club HEAR_ACT2_F	☐	☐	☐	☐	☐	☐	☐	☐ HEAR_ACT2_P
Attend a fitness class set to music e.g. aerobics, spin HEAR_ACT3_F	☐	☐	☐	☐	☐	☐	☐	☐ HEAR_ACT3_P
Go to a concert or live music venue HEAR_ACT4_F	☐	☐	☐	☐	☐	☐	☐	☐ HEAR_ACT4_P
Go to a night club or dance-music venue HEAR_ACT5_F	☐	☐	☐	☐	☐	☐	☐	☐ HEAR_ACT5_P
Use of DIY equipment e.g. electric saw, lawnmowers, drills HEAR_ACT6_F	☐	☐	☐	☐	☐	☐	☐	☐ HEAR_ACT6_P

If you do any of the activities above, on average, how long would you do each activity?

	Never attend 0	Less than an hour 1	Between 1 – 3 hours 2	Between 3 – 5 hours 3	Between 5-8 hours 4	More than 8 hours 5
Attend a live sporting event HEAR_ACT1_H	☐	☐	☐	☐	☐	☐
Visit a pub or registered club e.g. RSL club HEAR_ACT2_H	☐	☐	☐	☐	☐	☐
Attend a fitness class set to music e.g. aerobics, spin HEAR_ACT3_H	☐	☐	☐	☐	☐	☐
Go to a concert or live music venue HEAR_ACT4_H	☐	☐	☐	☐	☐	☐
Go to a night club or dance-music venue HEAR_ACT5_H	☐	☐	☐	☐	☐	☐
Use DIY equipment e.g. electric saw, lawnmowers, drills HEAR_ACT6_H	☐	☐	☐	☐	☐	☐

23.2 Have you worked in a place where it was so noisy that you had to raise your voice to be heard by others? HEAR_WRK_E

0 ○ No ---> please go to Q23.3

1 ○ Yes

If yes, did you wear hearing protection? HEAR_WRK_HPR

0 ☐ Never 1 ☐ Occasionally 2 ☐ Frequently 3 ☐ Always

How long have you worked at a noisy workplace? HEAR_WRK_DUR

0 ☐ Less than 6 months 1 ☐ 6-12 months 2 ☐ 1-2 years 3 ☐ 3 + years

During your time at a noisy workplace, how many days per week would you be exposed to an environment that was so noisy that you had to raise your voice to be heard by others? HEAR_WRK_F

☐ 1 or less per week (0) ☐ 2-3 days per week (1) ☐ 3-4 days per week (2) ☐ Everyday (3)

Thinking about your average day, how long would you spent in a workplace so noisy you had to raise your voice? HEAR_WRK_HPD

☐ Less than 1 hour (0) ☐ 1-3 hours (1) ☐ 3-5 hours (2) ☐ 5-8 hours (3) ☐ More than 8 hours (4)

23.3 Do you ever experience <u>ringing or buzzing</u> in your ears (i.e. tinnitus)? HEAR_TIN0

0 ○ Never, please go to Q23.4

1 ○ Occasionally

2 ○ Sometimes

3 ○ Often

4 ○ Always

7 ○ Unsure, please go to Q23.4

What is the frequency of your tinnitus? HEAR_TIN_F

0 ☐ Intermittent 1 ☐ Constant

What is the nature of your tinnitus? HEAR_TIN_N

0 ☐ Ringing or hissing 1 ☐ Roaring 2 ☐ Pulsing 3 ☐ Other

How often does tinnitus affect your daily life and activities? HEAR_TIN_E

0 ☐ Not at all 1 ☐ Occasionally 2 ☐ Frequently 3 ☐ Constantly

23.4 Do you consider yourself <u>sensitive or intolerant to everyday sounds</u> (hyperacusis)? HEAR_SEN0

0 ○ No, please go to Q23.5
1 ○ Yes

Is it possible for you to concentrate on a task if it is not completely quiet around you? HEAR_CONC

0 ☐ No 1 ☐ Yes, most of the time 2 ☐ Yes

Are you sensitive to any of these sounds? *(Select all that apply)*

HEAR_SEN1 ☐ Noise
HEAR_SEN2 ☐ Paper
HEAR_SEN3 ☐ Talk
HEAR_SEN4 ☐ Music
HEAR_SEN5 ☐ Clatter
HEAR_SEN6 ☐ Mechanical and monotonous sounds
HEAR_SEN7 ☐ Other

How do you feel when you are exposed to these sounds? *(Select all that apply)*

HEAR_EM1 ☐ Tense
HEAR_EM2 ☐ Afraid
HEAR_EM3 ☐ Pain
HEAR_EM4 ☐ Angry
HEAR_EM5 ☐ Vague
HEAR_EM6 ☐ Irritated
HEAR_EM7 ☐ Other

If you are intolerant to some sound, how often does it affect your daily life and activities? HEAR_EM7A

0 ☐ Not at all 1 ☐ Occasionally 2 ☐ Frequently 3 ☐ Constantly

23.5 Do you experience any <u>imbalance or dizziness</u>? HEAR_DIZ0

0 ○ No, please go to Q24
1 ○ Yes

What is the nature of your imbalance or dizziness? (Select all that apply)

HEAR_DIZ_T1 ○ Spinning or sensation of movement
HEAR_DIZ_T2 ○ Light-headedness
HEAR_DIZ_T3 ○ Unsteadiness on feet
HEAR_DIZ_T4 ○ Other, please describe: HEAR_DIZ_T4A

How often do you experience this imbalance or dizziness? HEAR_DIZ_F1

3 ☐ Daily 2 ☐ Weekly 1 ☐ Monthly 0 ☐ Less frequently than monthly

How long do the specific episodes of imbalance or dizziness last? HEAR_DIZ_D1

0 ○ Seconds to less than 2 minutes
1 ○ 2 to 20 minutes
2 ○ Over 20 minutes to hours
3 ○ Hours to days

How long do the after-effects of feeling unwell or off-colour last? HEAR_DIZ_D2

0	1	2	3
☐ No after-effects	☐ Minutes	☐ Hours	☐ Days

Do you suffer from any of the following symptoms for more than 20 minutes that you associate with your dizziness or imbalance? *(Select all that apply.)*

HEAR_SYM1 ○ Fullness (blockage) in the ears
HEAR_SYM2 ○ Tinnitus
HEAR_SYM3 ○ Reduced hearing
HEAR_SYM4 ○ Nausea
HEAR_SYM5 ○ Vomiting
HEAR_SYM6 ○ None of these
HEAR_SYM7 ○ Other, please describe: ……HEAR_SYM7A……

Does your dizziness or imbalance occur when: *(Select all that apply)*

HEAR_DIZ1 ☐ Sitting
HEAR_DIZ2 ☐ Walking
HEAR_DIZ3 ☐ Sneezing
HEAR_DIZ10 ☐ None of these
HEAR_DIZ4 ☐ Straining
HEAR_DIZ5 ☐ Bending down
HEAR_DIZ6 ☐ Hearing a loud noise
HEAR_DIZ7 ☐ Looking up to a high shelf
HEAR_DIZ8 ☐ Lying down and rolling over to one side
HEAR_DIZ9 ☐ Standing up

HEAR_DIZ11 ☐ Other, please describe: ……HEAR_DIZ11A……

How often does your dizziness or imbalance affect your daily life and activities? HEAR_DIZ_F2

0 ☐ Not at all 1 ☐ Occasionally 2 ☐ Frequently 3 ☐ Constantly

24. TATTOOS

The following questions are about tattoos

Do you have, or ever had, a tattoo or tattoos? TATT_EVER

0 ○ No ⇨ Do you think you will get a tattoo TATT_FUT ☐0 No ☐1 Yes ☐7 not sure

⇨ *Thank you for completing the tattoo questions*

1 ○ Yes, *please complete the following questions*

How many tattoos do you have? TATT_N

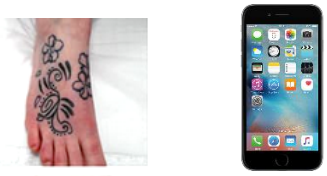
1 ○ One
2 ○ Two
3 ○ Three to five
4 ○ Six to ten
5 ○ More than 10

What type of tattoo(s) do you have? *(Select all that apply)*

TATT_TYP ○ Professional
TATT_TYA ○ Amateur
TATT_TYM ○ Permanent makeup

Please indicate all areas where you have a tattoo(s), and the approximate size of the tattoo(s). If you have more than one tattoo in one area, please indicate the size of the largest tattoo.

Sizes are:

Small the size of a bankcard or smaller	**Medium** approximately the size of an Iphone	**Large** the size of an Ipad or larger
		

		Small 1	**Medium** 2	**Large** 3	**What are the main colours in your tattoo(s)?**				
		Bankcard size	Iphone size	Ipad size	Black	Red	Blue	Green	other
Trunk	TATT_TS	☐ 1	☐ 2	☐ 3	TATT_TCK ☐	TATT_TCR ☐	TATT_TCB ☐	TATT_TCG ☐	TATT_TCO ☐
Arms	TATT_AS	☐	☐	☐	TATT_ACK ☐	TATT_ACR ☐	TATT_ACB ☐	TATT_ACG ☐	TATT_ACO ☐
Legs	TATT_LS	☐	☐	☐	TATT_LCK ☐	TATT_LCR ☐	TATT_LCB ☐	TATT_LCG ☐	TATT_LCO ☐
Head/neck	TATT_HS	☐	☐	☐	TATT_HCK ☐	TATT_HCR ☐	TATT_HCB ☐	TATT_HCG ☐	TATT_HCO ☐

Do you have any history of experiencing an adverse tattoo reaction? TATT_ADV

(An adverse tattoo reaction is any skin sign or symptom that differs or goes beyond from what you would consider a normal part of tattooing or tattoo healing, such as persistent redness, itching, rash, irritation, swelling, scarring, infection, disfigurement, raising, and photosensitivity. Please also describe any more general reactions related to your tattoo, such as dizziness, headache, nausea and fever.)

0 ○ No → *Thank you for completing this questionnaire*
1 ○ Yes → *Please complete the following questions*

Please describe the adverse reaction(s) in your own words: TATT_ADV_DES ……

……

When did the adverse reaction(s) begin? -DROPPED …… **days/weeks/months*** **after tattoo placement**
TATT_ADV_DAY = (TOTAL DAYS)

** Please cross out what is not applicable*

What is the main colour of ink of the tattoo that caused the adverse reaction(s)? TATT_ADV_C

0 ○ Black
1 ○ Red
2 ○ Blue
3 ○ Green
4 ○ Other: …… TATT_ADV_CO

How long did the adverse reaction(s) persist? TATT_ADV_D

0 ○ Less than 4 weeks
1 ○ 1 to 4 months
2 ○ Longer than 4 months

****MEN, for you, this is the end of the questionnaire****
Thank you for completing it.

Women, please complete the next questions relating to menstruation.

Are you biologically male or female for menstruation questions? SEXB

0 ○ Male

1 ○ Female

For women, the following are questions relating to menstruation,

25. FOR WOMEN ONLY - MENSTRUATION

How often do you usually have a menstrual period? (If you are currently pregnant answer this referring to when you were not pregnant)? (Please mark only one response) PER1

0 ○ Never *(please go to Q25.1)*

1 ○ Very irregularly

2 ○ Less than once per month

3 ○ Every month

4 ○ More than once per month

Using the scale below where 0 is the least pain and 10 is the worst pain, how would you describe the worst pain you commonly experience during your menstrual cycle? PER2

0 (None)	2	3	4	5	6	7	8	9	10 (Unbearable)
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

25.1 Pelvic pain

	No 0	yes 1	not applicable 8
Do you regularly experience pelvic pain that is not during your period? PER3	☐ 0	☐ 1	☐ 8
Do you regularly experience pain during intercourse? PER4	☐	☐	☐
Do you regularly take medication for cramps or pelvic pain? PER5	☐	☐	☐

25.2 These questions ask for details about your period. Periods can be different from month to month. Please make sure you read all of the options. For this questionnaire, period refers to any bleeding that you have from your vagina, even if it is irregular.

Some of the questions may sound similar. Just read through each question carefully and give your best answer.

You may have other medical problems that could affect your answers. Please try to focus on questions and answers ONLY as they relate to your period.

During the past month, did you have ANY bleeding? PER6

0 ○ No *(please go to Q12)*

1 ○ Yes *(please continue to Q1)*

1. During the past month, how would you describe your periods? PER7

Very Light	Light	Moderate	Heavy	Very Heavy
0	1	2	3	4

*Instructions for questions **2, 3, and 4.***
"High absorbency" sanitary products mean any type of tampon or a pad that is NOT a thin pantyliner.
"Soaked" means completely or almost completely stained and filled with blood.

2. On your heaviest day of bleeding during the past month, how many high absorbency sanitary products did you soak (either completely or almost completely)? PER8

0	1-4	5-8	9-12	13-16	More than 16
0	1	2	3	4	5

3. During the past month, how often did you need to wear either an incontinence brief or more than one high absorbency sanitary product (either more than one pad, a pad and a tampon, more than one tampon) at a time to contain your bleeding? PER9

Never	1-3 times	4-6 times	7-10 times	11 times or greater
0	1	2	3	4

4. During the past month, how many times have you had an episode of bleeding that soaked through your "outer" clothes (pants, skirt, dress)? PER10

Never	1-3 times	4-6 times	Greater than 6 times
0	1	2	3

5. During the past month, how many times did you need to get out of bed in the middle of night (or during sleep hours) to change your sanitary products? PER11

Never	1-3 times	4-6 times	7-10 times	11 times or greater
0	1	2	3	4

6. During the past month, how many times did you pass blood clots (clumps of blood)? PER12

Never	1-3 times	4-6 times	Greater than 6 times
0	1	2	3

7. During the past month, how often did passing blood clots (clumps of blood) stain your clothing?

Never	1-3 times	4-6 times	Greater than 6 times
0	1	2	3

PER13

8. Please fill in the following statement about pain related to your period. During the past month, my period was associated with… PER14

No pain	Slight pain	Moderate pain	Severe pain
0	1	2	3

9. During the past month, how many weeks did your periods last? PER15

0 ○ 1 week or less out of 4 week

1 ○ More than 1 week, less than 2 weeks out of 4 weeks

2 ○ More than 2 weeks, less than 3 weeks out of 4 weeks

3 ○ More than 3 weeks out of 4 weeks

10. During the past month, on how many days do you think your work at your job suffered because you were bleeding? PER16

0 ○ I am currently not working outside of the home

1 ○ Never, my bleeding does not affect my work.

2 ○ 1-3 days

3 ○ 4-8 days

4 ○ 9-12 days

5 ○ 13 days or more

11. During the past month, on how many days did you miss work because you were bleeding? PER17

0 ○ I am currently not working outside of the home

1 ○ Never, my bleeding does not affect my work schedule

2 ○ 1-3 days

3 ○ 4-8 days

4 ○ 9-12 days

5 ○ 13 days or more

12. During the past month, on how many days did you avoid family activities (grocery shopping, household chores) when you thought you would be bleeding? PER18

0 ○ Never

1 ○ 1-3 days

2 ○ 4-8 days

3 ○ 9-12 days

4 ○ 13 days or more

13. During the past month, when would you carry sanitary products (pads, tampons) with you (in your pocket, in your bag)? PER19

0 ○ Every day, in case I had any bleeding

1 ○ On the days when I had bleeding and on days when I guessed that I might have bleeding

2 ○ Only on the days that I had bleeding

14. During the past month, on how many days did you avoid social activities (such as getting together with friends, going shopping for fun, going sight-seeing) when you thought you would be bleeding?

Never	1-3 days	4-8 days	9-12 days	13 days or more
0	1	2	3	4

PER20

5. During the past month, on how many days did you plan your activities (work, social, or family) based on whether or not there was a bathroom nearby? PER21

Never	1-3 days	4-8 days	9-12 days	13 days or more
0	1	2	3	4

16. During the past month, on how many days did you bring extra clothes with you (to work, out shopping) in case you had staining from your period? PER22

Never	1-3 days	4-6 days	Greater than 6 days
0	1	2	3

17. During the past month, on how many days did you choose what to wear based on whether or not you were bleeding? PER23

Never	1-3 days	4-8 days	9-12 days	13 days or more
0	1	2	3	4

18. On a scale of 0-10, with 0 being no concern at all and 10 being extremely concerned, please rate your overall concern about bleeding staining your clothes. PER24

0 (no concern)	2	3	4	5	6	7	8	9	10 (extremely concerned)
0	☐	☐	☐	☐	☐	☐	☐	☐	10

19. During the past month, would you say that your period start date was… PER25

Completely predictable	Somewhat predictable	Not at all predictable
2	1	0

20. During the past month, would you say that your period end date was… PER26

Completely predictable	Somewhat predictable	Not at all predictable
2	1	0

End of Questions

Thank you for completing the questionnaire.

The Raine Study

The Raine Study Gen2_27 year follow up

This is short questionnaire to obtain information on your general alcohol, energy drinks and caffeine intake during the last week.

1. Do you drink soft drinks and/or energy drinks? DQ_SOFTD

0 ○ No (*Please go to Q2)*

1 ○ Yes, Please provide details of a **TYPICAL** week's soft drink consumption in the table below:

Please indicate as best you can recall the TYPE and VOLUME of SOFT DRINK and/or ENERGY DRINK you consumed over a typical 7 day week.

- Type of **soft drink** e.g. Coca Cola, Diet Coke, Coca Cola Life, Pepsi, Pepsi Max, Mountain Dew, Sunkist, Fanta, Sprite
- Type of **energy drink** e.g. Red Bull, V, Monster, Mother
- Amount consumed. E.g. 250ml *can,* 330ml *glass bottle*, large, standard or small glass

NOTE: data are derived sugar and caffeine consumption by day, then in a typical week

Day	Amount and type	Office Use
Example: Monday	1 x 330ml bottle Coca Cola 1 x 250ml can Red Bull	
Monday DQ_Sugar_Mon & DQ_CAFF_Mon		
Tuesday DQ_Sugar_Tue & DQ_CAFF_Tue		
Wednesday DQ_Sugar_Wed & DQ_CAFF_Wed		
Thursday DQ_Sugar_Thur & DQ_CAFF_Thur		
Friday DQ_Sugar_Fri & DQ_CAFF_Fri		
Saturday DQ_Sugar_Sat & DQ_CAFF_Sat		
Sunday DQ_Sugar_Sun & DQ_CAFF_Sun		

In a typical week - DQ_Sugar_PW & DQ_CAFF_PW

2. Do you drink alcohol?

0 ○ No *(Please go to Q3)* DQ_Alc

1 ○ Yes, *Please record with as much detail as possible, the TYPE and VOLUME of ALCOHOL you consumed over the past 7 days*

Type of beverage. E.g.	Beer	Carlton draft, Toohey's blue etc
	Alcoholic Soda	Smirnoff ice, Bacardi breezer, alcoholic ginger beer etc
	Wine	red wine, white wine, champagne, chardonnay, sherry, port etc
	Spirits	vodka, gin, whisky, tequila, brandy etc
Amount consumed.	number of stubbies, cans, glasses (Large, Standard, Small), shots etc	

Start from yesterday and work backwards.

NOTE: data are derived ethanol consumption by day, then in a typical week

Day	Amount and type	
Example: Monday	*1 stubby of Crown Lager, 3 large glasses of Shiraz,*	
Monday DQ_Alc_Mon		
Tuesday DQ_Alc_Tue		
Wednesday DQ_Alc_Wed		
Thursday DQ_Alc_Thur		
Friday DQ_Alc_Fri		
Saturday DQ_Alc_Sat		
Sunday DQ_Alc_Sun		

In a typical week - DQ_Alc_LW_TOT

Is this the amount that you would typically drink over a week? DQ_Alc_Wk

0 ○ No If no, why (e.g. party on Wednesday night)..DQ_Alc_Wk_REASON.....

1 ○ Yes

How frequently do you usually drink the following alcohol-containing beverages?

	1 Every day	2 5-7 times per week	3 1-4 times per week	4 1-4 times per month	5 Less than once per month	0 Never
Beer DQ_Beer_Freq	☐	☐	☐	☐	☐	☐
Wine DQ_Wine_Freq	☐	☐	☐	☐	☐	☐
Spirits DQ_Spirits_Freq	☐	☐	☐	☐	☐	☐
Alcoholic Soda DQ_Spirits_Mix_Freq	☐	☐	☐	☐	☐	☐

For how long have you consumed the amount of alcoholic drinks that you now drink? DQ_Alc_Cons

For less than one year	1-2 years	2-5 years	More than 5 years
☐ 1	☐ 2	☐ 3	☐ 4

3. Caffeine consumption

We are interested to know how much caffeine from drinks, chocolate or tablets you may consume.

Do you drink beverages (tea, coffee) that contain caffeine? DQ_CAFF

0 ○ No (*Please go to Q5)*

1 ○ Yes, Please write the number of cups or glasses consumed per day if you consume the beverage daily OR if you don't have it every day, fill in the cups/glasses consumed per week.

NOTE: data are derived to indicate cups (day/week/month), & caf (mg) of each item

Type of drink	**Number of cups/glasses <u>per day</u>**	**Number of cups/glasses <u>per week</u>**	**Number of cups/glasses <u>per month</u>**	**Never**
Black tea (not including herbal teas)	DQ_BlkTea_PD	DQ_BlkTea_PW	DQ_BlkTea_PM	☐ DQ_BlkTea
Decaffeinated tea (not including herbal teas)	DQ_DTea_PD	DQ_DTea_PW	DQ_DTea_PM	☐ DQ_DTea
Green tea	DQ_GrnTea_PD	DQ_GrnTea_PW	DQ_GrnTea_PM	☐ DQ_GrnTea
Herbal tea	DQ_HerbTea_PD	DQ_HerbTea_PW	DQ_HerbTea_PM	☐ DQ_HerbTea
Iced tea	DQ_IceTea_PD	DQ_IceTea_PW	DQ_IceTea_PM	☐ DQ_IceTea
Coffee – regular brewed E.g. Cappuccino, Latte, flat white	DQ_Coff_PD	DQ_Coff_PW	DQ_Coff_PM	☐ DQ_Coff
Coffee – decaf brewed E.g. decaf latte, decaf flat white	DQ_DCoff_PD	DQ_DCoff_PW	DQ_DCoff_PM	☐ DQ_DCoff
Coffee – regular instant E.g. Nescafe, Moccona	DQ_InCoff_PD	DQ_InCoff_PW	DQ_InCoff_PM	☐ DQ_InCoff
Coffee – decaf instant e.g. decaf Nescafe	DQ_InDCoff_PD	DQ_InDCoff_PW	DQ_InDCoff_PM	☐ DQ_InDCoff
Regular Espresso restaurant style	DQ_EsCoff_PD	DQ_EsCoff_PW	DQ_EsCoff_PM	☐ DQ_EsCoff
Decaf espresso restaurant style	DQ_DEsCoff_PD	DQ_DEsCoff_PW	DQ_DEsCoff_PM	☐ DQ_DEsCoff
Chocolate beverages e.g. hot chocolate, chocolate milk	DQ_Choc_PD	DQ_Choc_PW	DQ_Choc_PM	☐ DQ_Choc
Iced coffee	DQ_IceChoc_PD	DQ_IceChoc_PW	DQ_IceChoc_PM	☐ DQ_IceChoc

Caffeine (mg) of each item:

G227_DQ_CAFF_BlkTea_PW
G227_DQ_CAFF_Dtea_PW
G227_DQ_CAFF_GrnTea_PW
G227_DQ_CAFF_HerbTea_PW
G227_DQ_CAFF_IceTea_PW
G227_DQ_CAFF_Coff_PW
G227_DQ_CAFF_Dcoff_PW
G227_DQ_CAFF_InCoff_PW
G227_DQ_CAFF_InDCoff_PW
G227_DQ_CAFF_EsCoff_PW
G227_DQ_CAFF_DEsCoff_PW
G227_DQ_CAFF_Choc_PW
G227_DQ_CAFF_IceChoc_PW

Total amount of caffeine:

G227_DQ_Caff_PW_Tot

4. Do you eat chocolate of any sort? DQ_EatChoc

0 ○ No, (*Please go to Q6)*

1 ○ Yes, please indicate the amount and type of chocolate in grams that you consumed in the past 7 days.

Day	Amount and type	Office Use
Example: Monday	1 x 53 g Mars bar 1 x 200 g Cadbury family block - crunchie	
Monday DQ_EatChoc_Mon		
Tuesday DQ_EatChoc_Tue		
WednesdayDQ_EatChoc_Wed		
Thursday DQ_EatChoc_Thur		
Friday DQ_EatChoc_Fri		
Saturday DQ_EatChoc_Sat		
Sunday DQ_EatChoc_Sun		

Total milligrams of caffeine consumed through chocolate last week- G227_DQ_EatChoc_caff_LW_Tot

5. Do you consume any over-the-counter caffeine containing tablets? DQ_cafftab

○ No

○ Yes, please indicate the type and amount that you took in the last week

Day	Name of table	Dose of tablet	How many tablets?
Example: Monday	NoDoz Acacin	100 mg 500 mg	2 1
Monday DQ_cafftab_Mon			
Tuesday DQ_cafftab_Tue			
Wednesday DQ_cafftab_Wed			
Thursday DQ_cafftab_Thu			
Friday DQ_cafftab_Fri			
Saturday DQ_cafftab_Sat			
Sunday DQ_cafftab_Sun			

Total milligrams of caffeine consumed through tablets last week - G227_DQ_cafftab_LW_TOT

**** THANK YOU FOR COMPLETING THIS QUESTIONNAIRE****