Your life in 2013

V2 16/08/2013

Questionnaire number

Introduction

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

This questionnaire has been funded by a grant looking at women's health as they age, and is the first in a series of three you will receive between now and 2015. We hope to look at the way your answers change during this important part of your life.

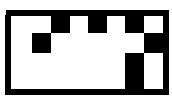
Because we are looking at changes over a number of years, many of the following questions have been asked before and will be included in the subsequent questionnaires. This allows us to pick up on any changes to your health, the way you are feeling or your life in general.

Some questions may also seem very similar to each other; this is because the combination of answers gives a clearer picture than one single answer. There may be questions that seem a bit strange and are not applicable to you because they are concerned with specific feelings or problems.

We would be very grateful if you would try to answer all the questions, but we understand that there may be questions that you either prefer not to answer or are unable to answer. We understand that some of the questions are of a sensitive nature; please remember that your answers are confidential and anonymous.

We appreciate the time and effort required to complete the questionnaire and thank you for your continued support. The success of the study is entirely dependent on the support and goodwill of the participating families.

If you do not wish to complete this questionnaire, please leave it blank and return it to us in the prepaid envelope provided. We will then know not to send you any reminders.



Filling in the questionnaire

Please use **black** pen. To answer questions simply put a cross in the box/circle which is most accurate in your opinion, like this:

If you make a mistake, shade the box/circle in like this:

then cross the correct box.

If you are answering questions which ask you to give further details, please make sure you write inside the boxes. When writing numbers inside boxes, please don't touch the sides of the box.

If you do not want to answer a question or if it does not apply to you, leave it blank. There are no right or wrong answers.

There is a blank sheet available at the back of the questionnaire if you need additional space. If you use this sheet, please clearly indicate the question number you are answering.

Contents page

Section A: Your family and home life

As you may already know, Children of the 90s is increasingly becoming a study of the whole family. The questions below are to help us build an accurate picture of your wider family structure. We are also asking questions about your home life.

Your children

A1) How many children do you have? ☐☐ (Insert number)

Please include all children you feel you have parental responsibility for, including biological, step, foster and adopted children. We have included space for up to 6 children. If you have had more than 6 children, please use the blank sheets at the back of the questionnaire and clearly indicate you are answering question A1. Please include any children that have passed away.

A2) What is the date of birth (DOB), sex and your relationship to each of these children?

a) 1st child

i) DOB Day ☐☐ Month ☐☐ Year ☐☐☐☐

ii) *(cross one option only)*

1 ◯ Male	2 ◯ Female

iii) *(cross one option only)*

1 ◯ Biological	2 ◯ Step
3 ◯ Foster	4 ◯ Adopted
5 ◯ Other (please specify)	

b) 2nd child

i) DOB Day ☐☐ Month ☐☐ Year ☐☐☐☐

ii) *(cross one option only)*

1 ◯ Male	2 ◯ Female

iii) *(cross one option only)*

1 ◯ Biological	2 ◯ Step
3 ◯ Foster	4 ◯ Adopted
5 ◯ Other (please specify)	

c) 3rd child

i) DOB Day ☐☐ Month ☐☐ Year ☐☐☐☐

ii) *(cross one option only)*

1 ◯ Male	2 ◯ Female

iii) *(cross one option only)*

1 ◯ Biological	2 ◯ Step
3 ◯ Foster	4 ◯ Adopted
5 ◯ Other (please specify)	

d) 4th child

i) DOB Day ☐☐ Month ☐☐ Year ☐☐☐☐

ii) *(cross one option only)*

1 ◯ Male	2 ◯ Female

iii) *(cross one option only)*

1 ◯ Biological	2 ◯ Step
3 ◯ Foster	4 ◯ Adopted
5 ◯ Other (please specify)	

e) 5th child

i) DOB Day ☐☐ Month ☐☐ Year ☐☐☐☐

ii) *(cross one option only)*

1 ◯ Male	2 ◯ Female

iii) *(cross one option only)*

1 ◯ Biological	2 ◯ Step
3 ◯ Foster	4 ◯ Adopted
5 ◯ Other (please specify)	

f) 6th child

i) DOB Day ☐☐ Month ☐☐ Year ☐☐☐☐

ii) *(cross one option only)*

1 ◯ Male	2 ◯ Female

iii) *(cross one option only)*

1 ◯ Biological	2 ◯ Step
3 ◯ Foster	4 ◯ Adopted
5 ◯ Other (please specify)	

A3) Have any of your children passed away?

(cross all that apply)

1 ☐ No	1 ☐ 1st child
1 ☐ 2nd child	1 ☐ 3rd child
1 ☐ 4th child	1 ☐ 5th child
1 ☐ 6th child	

A4) **If your study child has any brothers or sisters**, would you be happy to receive further details about the Children of the 90s Brothers and Sisters study to pass on?

(cross one option only)

1 ◯ Yes	2 ◯ No

If you would like to know more about our plans for the Children of the 90s Brothers and Sisters study please go to www.childrenofthe90s.ac.uk/go/siblings. If you have answered yes above, we will contact you about this study later in the year.

Your grandchildren

A5) Are you a grandparent?

(cross one option only)

1 ◯ Yes	2 ◯ No
3 ◯ Don't know	

➡ **If no or don't know, go to A9**

A6) Are any of your grandchildren the children of your Children of the 90s study son or daughter?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **If no, go to A9**

A7) How many children does your Children of the 90s son or daughter have? ☐☐

A8) What are the dates of birth of your Children of the 90s study son or daughter's children? If you do not know exactly please state month and/or year. We have included space for up to 4 grandchildren. If your study child has had more than 4 children, please use the blank sheets at the back of the questionnaire and clearly indicate you are answering question A8

		Day	Month	Year
a)	1st grandchild	☐☐	☐☐	☐☐☐☐
b)	2nd grandchild	☐☐	☐☐	☐☐☐☐
c)	3rd grandchild	☐☐	☐☐	☐☐☐☐
d)	4th grandchild	☐☐	☐☐	☐☐☐☐

A9) Is your Children of the 90s study child or their partner currently pregnant?

(cross one option only)

1 ◯ Yes, my study child is pregnant	2 ◯ Yes, my study child's partner is pregnant
3 ◯ No	4 ◯ Don't know

➡ **If no or don't know, go to A12**

A10) What is the expected due date of their baby? If you do not know the exact date please state month and/or year

Day	Month	Year
☐☐	☐☐	☐☐☐☐

A11) Are you happy to receive further details about the COCO90s (Children of the Children of the 90s) study to pass on to your study child?

(cross one option only)

1 ◯ Yes	2 ◯ No
3 ◯ They are already part of the study	

If you would like to know more about our plans for the Children of the Children of the 90s study please go to www.childrenofthe90s.ac.uk/participants/coco90s/. We will contact you about this study later in the year

Your partner

A12) Do you currently have a partner who lives with you?

(cross one option only)

1 ◯ Yes	2 ◯ No

A13) What is your **present** marital/relationship status?

(cross one option only)

1 ◯ Never married	2 ◯ Widowed
3 ◯ Divorced	4 ◯ Separated
5 ◯ Married	6 ◯ Living as married
7 ◯ Civil partnership	

Your home

A14) Is your home

(cross one option only)

1 ◯ Owned - with mortgage?	2 ◯ Being bought from council?
3 ◯ Owned - with no mortgage to pay?	4 ◯ Rented from council?
5 ◯ Rented from private landlord – furnished?	6 ◯ Rented from private landlord – unfurnished?
7 ◯ Rented from housing association?	8 ◯ Other?

A15) If you know your council tax band (A, B, C, etc.) please write it here: ☐

A16) How many people live in your household now (including yourself)?

a) Adults (18 years and older) ☐☐

b) Young adults (16-17 years) ☐☐

c) Older children (14-15 years) ☐☐

d) Younger children (less than 14 years) ☐☐

Events in your life

A17) Listed below are a number of events which may have brought changes in your life. Have any of these occurred **in the last year**?

(cross one option on each line)	1 Yes	2 No
Your partner died	1 ○	2 ○
One of your children died	1 ○	2 ○
Your parent died	1 ○	2 ○
You were very ill	1 ○	2 ○
Your partner was very ill	1 ○	2 ○
One of your children was ill	1 ○	2 ○
Your parent was ill	1 ○	2 ○
You lost your job	1 ○	2 ○
You were divorced	1 ○	2 ○
You and your partner separated	1 ○	2 ○
You got married	1 ○	2 ○

Section B: Your employment and finances

The section below is about your employment, and that of your partner. If you do not currently have a partner who lives with you, please only complete the sections about yourself. We will also ask some questions about your financial situation.

Your job

B1) Are you/your partner **currently**?

(cross all that apply on each row)	1 Yourself	2 Your partner
Employed in a paid job (full or part-time)	1 ☐	2 ☐
Retired	1 ☐	2 ☐
Unemployed and seeking work	1 ☐	2 ☐
Unable to work through sickness/disability	1 ☐	2 ☐
Full/part-time student	1 ☐	2 ☐
Doing voluntary work	1 ☐	2 ☐
Looking after family/home	1 ☐	2 ☐
Self employed	1 ☐	2 ☐
Full/Part time carer	1 ☐	2 ☐
Other, please describe:	1 ☐	2 ☐

B2) Please describe the current or most recent job held by **yourself and your partner**

(If you have more than one job, please describe your main role)

(Use precise terms such as Primary Teacher, Laboratory Technician, Care Assistant, Mortgage Adviser, Bus Driver, Software Developer, Call Centre Operator. If the occupation is known by a special name, please use that name. If in HM Forces, give the rank in addition to the actual job. Please also describe the type of industry or service given and give details of what is made, materials used or services given).

		Yourself	**Your partner**
a)	What is the job title?		
b)	What is the business/industry?		
c)	Please describe the main things you do, or your partner does, in this job.		
d)	When did you/your partner start this job?	Month ☐☐ Year ☐☐☐☐	Month ☐☐ Year ☐☐☐☐
e)	If not current, when did you/your partner end this job?	Month ☐☐ Year ☐☐☐☐	Month ☐☐ Year ☐☐☐☐
f)	How many hours do you/your partner work in a usual week?	Hours (nearest whole hour) ☐☐☐	Hours (nearest whole hour) ☐☐☐
g)	Are you/your partner employees?	1 ☐	1 ☐

➡ **Complete B3 and B4**

h)	Are you/your partner self-employed?	1 ☐	1 ☐

➡ **Complete B5 and B6**

For employees only

B3) In your job, do you or your partner have any formal responsibility for supervising the work of other employees? Do not include supervising children e.g. teachers.

(cross one option on each line)	1 Yes	2 No
Yourself	1 ○	2 ○
Your partner	1 ○	2 ○

B4) How many people work for your employer in the place where you or your partner work? We mean the actual building/branch or part of a building.

	(cross one option on each line)	1 1-9	2 10-24	3 25-499	4 500 or more
a)	Yourself	1 ○	2 ○	3 ○	4 ○
b)	Your partner	1 ○	2 ○	3 ○	4 ○

For self-employed only

B5) Do you or your partner work on your own or do you have employees?

	(cross one option on each line)	1 On own or with partner but no employees	2 With employees
a)	Yourself	1 ○	2 ○
b)	Your partner	1 ○	2 ○

B6) How many people do you or your partner employ where you or your partner work?

	(cross one option on each line)	1 1-9	2 10-24	3 25-499	4 500 or more
a)	Yourself	1 ○	2 ○	3 ○	4 ○
b)	Your partner	1 ○	2 ○	3 ○	4 ○

Your household finances

B7) On average, about how much is your take-home household income each month? Include all earnings, social benefits, tax credits etc.

(cross one option only)

1 ◯ Less than £899	2 ◯ £900-£1149
3 ◯ £1150-£1549	4 ◯ £1550-£1849
5 ◯ £1850-£2099	6 ◯ £2100-£2399
7 ◯ £2400-£2799	8 ◯ £2800-£3399
9 ◯ £3400-£4000	10 ◯ £4001 or more
11 ◯ Don't know	

B8) How much do you, as a household, pay for rent or mortgage **each month**?

(cross one option only)

1 ◯ Nothing	2 ◯ Less than £200
3 ◯ £200-£249	4 ◯ £250-£299
5 ◯ £300-£349	6 ◯ £350-£399
7 ◯ £400-£499	8 ◯ £500-£599
9 ◯ £600-£699	10 ◯ £700-£799
11 ◯ £800-£999	12 ◯ £1000 or more
13 ◯ Don't know	14 ◯ Paid in full by benefits

B9) Do you, as a household, have any outstanding debts (not including mortgages)?

(cross one option only)

1 ◯ Yes	2 ◯ No

B10) How often do you, as a household, have money left over at the end of the month that you could save?

(cross one option only)

1 ◯ Always	2 ◯ Most months
3 ◯ Sometimes	4 ◯ Hardly ever
5 ◯ Never	6 ◯ Don't know

B11) How often does your household save money?

(cross one option only)

1 ◯ Regularly	2 ◯ From time to time
3 ◯ Very occasionally	4 ◯ Never

B12) How well would you say your household is managing financially these days? Would you say you are:

(cross one option only)

1 ◯ Living comfortably	2 ◯ Doing alright
3 ◯ Just about getting by	4 ◯ Finding it quite difficult
5 ◯ Finding it very difficult	6 ◯ Don't know

Section C: Your Health

The following questions ask for your views about your health and how you feel about life in general. If you are unsure about how to answer any question, try and think about your overall health and give the best answer you can. Do not spend too much time answering, as your immediate response is likely to be the most accurate.

C1) In general, would you say your health is:

(cross one option only)

1 ◯ Excellent	2 ◯ Very good
3 ◯ Good	4 ◯ Fair
5 ◯ Poor	

C2) Compared to 3 months ago, how would you rate your health in general **now**?

(cross one option only)

1 ◯ Much better than 3 months ago	2 ◯ Somewhat better than 3 months ago
3 ◯ About the same	4 ◯ Somewhat worse now than 3 months ago
5 ◯ Much worse now than 3 months ago	

C3) The following questions are about activities you might do during **a typical day**. Does **your health limit you in these activities?** If so, how much?

(cross one option on each line)		1 Yes, limited a lot	2 Yes, limited a little	3 No, not limited at all
a)	**Vigorous activities,** such as running, lifting heavy objects, participating in strenuous sports	1 ◯	2 ◯	3 ◯
b)	**Moderate activities,** such as moving a table, pushing a vacuum, bowling or playing golf	1 ◯	2 ◯	3 ◯
c)	Lifting or carrying groceries	1 ◯	2 ◯	3 ◯
d)	Climbing **several** flights of stairs	1 ◯	2 ◯	3 ◯
e)	Climbing **one** flight of stairs	1 ◯	2 ◯	3 ◯
f)	Bending, kneeling or stooping	1 ◯	2 ◯	3 ◯
g)	Walking **more than a mile**	1 ◯	2 ◯	3 ◯
h)	Walking **half a mile**	1 ◯	2 ◯	3 ◯
i)	Walking **100 yards**	1 ◯	2 ◯	3 ◯
j)	Bathing and dressing yourself	1 ◯	2 ◯	3 ◯

C4) During the **past 2 weeks,** has your physical health caused you to:

	(cross one option on each line)	1 All of the time	2 Most of the time	3 Some of the time	4 A little of the time	5 None of the time
a)	Cut down on the amount of time you spent on work or other activities	1 ○	2 ○	3 ○	4 ○	5 ○
b)	Accomplish less than you would like	1 ○	2 ○	3 ○	4 ○	5 ○
c)	Be limited in the kind of work or other activities you perform	1 ○	2 ○	3 ○	4 ○	5 ○
d)	Have difficulty performing the work or other activities (e.g. it took more effort)	1 ○	2 ○	3 ○	4 ○	5 ○

C5) During the **past 2 weeks** have any emotional problems caused you to:

	(cross one option on each line)	1 All of the time	2 Most of the time	3 Some of the time	4 A little of the time	5 None of the time
a)	Cut down on the amount of time you spent on work or other activities	1 ○	2 ○	3 ○	4 ○	5 ○
b)	Accomplish less than you would like	1 ○	2 ○	3 ○	4 ○	5 ○
c)	Do work or other activities less carefully than usual	1 ○	2 ○	3 ○	4 ○	5 ○

C6) During the **past 2 weeks,** to what extent have your physical health or emotional problems interfered with your normal social activities with family, neighbours or groups?

(cross one option only)

1 ◯ Not at all	2 ◯ Slightly
3 ◯ Moderately	4 ◯ Quite a bit
5 ◯ Extremely	

C7) How much bodily pain have you had during the **past 2 weeks**?

(cross one option only)

1 ◯ None	2 ◯ Very mild
3 ◯ Mild	4 ◯ Moderate
5 ◯ Severe	6 ◯ Very severe

C8) During the **past 2 weeks,** how much did pain interfere with your normal work (including both outside the home and housework)?

(cross one option only)

1 ◯ Not at all	2 ◯ Slightly
3 ◯ Moderately	4 ◯ Quite a bit
5 ◯ Extremely	

C9) For each question below please give one answer that comes closest to the way you have been feeling.

How much time during the **last 2 weeks:**

	(cross one option on each line)	1 All of the time	2 Most of the time	3 A good bit of the time	4 Some of the time	5 A little of the time	6 None of the time
a)	Did you feel full of life?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
b)	Have you been a very nervous person?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
c)	Have you felt so down in the dumps that nothing would cheer you up?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
d)	Have you felt calm and peaceful?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
e)	Did you have a lot of energy?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
f)	Have you felt downhearted and low?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
g)	Did you feel worn out?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
h)	Have you been a happy person?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
i)	Did you feel tired?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○

C10) During the **past 2 weeks**, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

(cross one option only)

1 ○ All of the time	2 ○ Most of the time
3 ○ Some of the time	4 ○ A little of the time
5 ○ None of the time	

C11) How **true** or **false** is each of the following statements for you?

	(cross one option on each line)	1 Definitely true	2 Mostly true	3 Not sure	4 Mostly false	5 Definitely false
a)	I seem to get ill more easily than other people	1 ○	2 ○	3 ○	4 ○	5 ○
b)	I am as healthy as anybody I know	1 ○	2 ○	3 ○	4 ○	5 ○
c)	I expect my health to get worse	1 ○	2 ○	3 ○	4 ○	5 ○
d)	My health is excellent	1 ○	2 ○	3 ○	4 ○	5 ○

Other health issues

C12) Have you **ever** been told that you have had any of the following conditions?

	(cross one option on each line)	1 Yes	2 No	3 If yes, please give the year of most recent diagnosis
a)	Heart attack (coronary thrombosis or myocardial infarction)	1 ○	2 ○	☐☐☐☐
b)	Heart failure	1 ○	2 ○	☐☐☐☐
c)	Angina	1 ○	2 ○	☐☐☐☐
d)	Other heart trouble	1 ○	2 ○	☐☐☐☐
e)	Aortic aneurysm	1 ○	2 ○	☐☐☐☐
f)	Narrowing or hardening of the arteries in the leg (including claudication)	1 ○	2 ○	☐☐☐☐
g)	High blood pressure	1 ○	2 ○	☐☐☐☐
h)	High cholesterol	1 ○	2 ○	☐☐☐☐
i)	Pulmonary embolism (PE)	1 ○	2 ○	☐☐☐☐
j)	Deep vein thrombosis (DVT)	1 ○	2 ○	☐☐☐☐

C13)

a) Have you ever been told by the doctor that you have had a stroke?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to C14**

b) Please give year of most recent stroke:

☐☐☐☐

c) Did the symptoms last more than 24 hours?

(cross one option only)

1 ◯ Yes	2 ◯ No

d) Have you made a complete recovery from your stroke?

(cross one option only)

1 ◯ Yes	2 ◯ No

C14)

a) Have you ever been told by a doctor that you have cancer?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to C15**

b) What type of cancer(s)? Please write in the space below starting with the most recent:

	Year of diagnosis ☐☐☐☐
	Year of diagnosis ☐☐☐☐
	Year of diagnosis ☐☐☐☐

C15)

a) Have you ever been told by a doctor that you have osteoporosis?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to C16**

b) What year was it diagnosed? ☐☐☐☐

C16)

a) Have you ever been told by a doctor that you have arthritis?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to C17**

b) What year was it diagnosed? ☐☐☐☐

c) Please give the type of arthritis if known:

(cross one option only)

1 ◯ Osteoarthritis	2 ◯ Rheumatoid arthritis
3 ◯ Other (please give details)	

d) Which joints are affected?

(cross one option on each line)	1 Yes	2 No
i) Knees	1 ◯	2 ◯
ii) Hips	1 ◯	2 ◯
iii) Hands, fingers and/or wrists	1 ◯	2 ◯
iv) Back	1 ◯	2 ◯
v) Neck	1 ◯	2 ◯
vi) Shoulders	1 ◯	2 ◯
vii) Feet/toes	1 ◯	2 ◯
viii) Other (please give details):	1 ◯	2 ◯

e) During the **past year** have you had pain, aching, stiffness or swelling on **most** days for **at least one month,** in your:

(cross one option on each line)	1 Yes	2 No
i) Knees	1 ◯	2 ◯
ii) Hips	1 ◯	2 ◯
iii) Hands, fingers and/or wrists	1 ◯	2 ◯
iv) Back	1 ◯	2 ◯
v) Neck	1 ◯	2 ◯
vi) Shoulders	1 ◯	2 ◯
vii) Feet/toes	1 ◯	2 ◯
viii) Other (please give details):	1 ◯	2 ◯

C17)

a) Have you had a fall in the last 12 months?

(cross one option only)

1 ◯ Yes | 2 ◯ No

➡ **<u>If no</u>, go to C18**

b) How many times have you fallen in the last 12 months? ☐☐☐

c) Did you seek medical attention?

(cross one option only)

1 ◯ Yes | 2 ◯ No

C18)

a) Have you ever fractured your hip?

(cross one option only)

1 ◯ Yes | 2 ◯ No

➡ **<u>If no</u>, go to C19**

b) What was the year of your last hip fracture? ☐☐☐☐

C19)

a) Have you ever fractured your wrist?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to C20**

b) What was the year of your last wrist fracture? ☐☐☐☐

C20) Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

(cross one option only)

1 ◯ Yes	2 ◯ No
3 ◯ Unable to walk	

C21) Do you get short of breath walking with other people of your own age on level ground?

(cross one option only)

1 ◯ Yes	2 ◯ No
3 ◯ Unable to walk	

C22) In the past twelve months, have you at any time been awoken at night by an attack of shortness of breath?

(cross one option only)

1 ◯ Yes	2 ◯ No

C23) Have you ever been told by a doctor that you have chronic bronchitis or emphysema?

(cross one option only)

1 ◯ Yes	2 ◯ No

C24) Have you ever been told by a doctor that you have asthma?

(cross one option only)

1 ◯ Yes	2 ◯ No

C25)

a) Have you ever been told by a doctor that you have diabetes?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to C26**

b) What year was this first diagnosed? ☐☐☐☐

c) How is your diabetes controlled?

(cross one option on each line)

	1 Yes	2 No
Diet	1 ◯	2 ◯
Tablets	1 ◯	2 ◯
Insulin	1 ◯	2 ◯

C26)

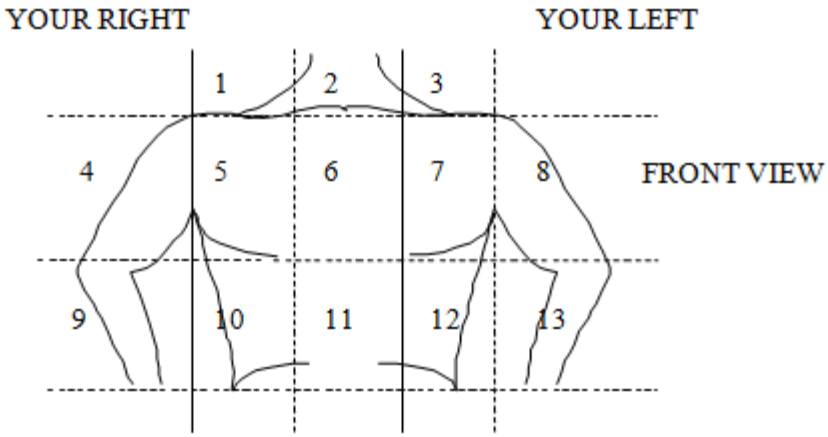
a) Do you ever have any pain or discomfort in your chest?

(cross one option only)

1 ◯ Yes | 2 ◯ No

➡ **<u>If no</u>, go to C32**

b) Where do you get this pain or discomfort? Please cross the appropriate boxes underneath the diagram.



☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13

C27) When you walk at an ordinary pace on the level does this produce the pain?

(cross one option only)

1 ◯ Yes | 2 ◯ No

3 ◯ Unable to walk

C28) When you walk uphill or hurry does this produce the pain?

(cross one option only)

1 ◯ Yes | 2 ◯ No

3 ◯ Unable to walk

C29) When you get any pain or discomfort in your chest on walking, what do you do?

(cross one option only)

1 ◯ Stop	2 ◯ Slow down
3 ◯ Continue at same place	4 ◯ Not applicable

C30) Does the pain or discomfort in your chest go away if you stand still?

(cross one option only)

1 ◯ Yes	2 ◯ No

C31) How long does it take to go away?

(cross one option only)

1 ◯ 10 minutes or less	2 ◯ More than 10 minutes

Your medications

C32) Do you **currently** take any regular medication?

(cross one option only)

1 ◯ Yes	2 ◯ No

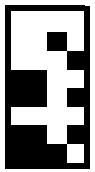
➡ **<u>If no</u>, go to C34**

C33) Please tell us which medications you are currently taking. Include all prescription and non-prescription medicines, vitamins, supplements etc

➡ **We have included space for up to 10 medications on the next page**

If you require more space, please use the blank sheets at the back of the questionnaire and clearly indicate you are answering question C33

	Name of medication	Amount	How often	Reason for taking
	Example: Paracetamol	Example: 50mg	Example: 3 times a day	Example: Back pain
a)				
b)				
c)				
d)				
e)				
f)				
g)				
h)				
i)				
j)				



Your body

C34) Please tell us your weight and measurements.
Use **either** metric **or** imperial measurements.

		Metres	Centimetres		Feet	Inches		
a)	Height	☐	☐☐	**or**	☐	☐☐	**or**	1 ☐ Don't Know

		Kg			St	Lbs		
b)	Weight	☐☐☐		**or**	☐☐	☐☐	**or**	1 ☐ Don't Know

		Cm			Inches			
c)	Hips	☐☐☐		**or**	☐☐☐		**or**	1 ☐ Don't Know

		Cm			Inches			
d)	Waist	☐☐☐		**or**	☐☐☐		**or**	1 ☐ Don't Know

		Cm			Inches			
e)	Bust	☐☐☐		**or**	☐☐☐		**or**	1 ☐ Don't Know

f) Please tell us your bra measurement

Size eg. 36

☐☐

Cup

(cross one option only)

1 ○ AA	2 ○ A	3 ○ B	4 ○ C	5 ○ D
6 ○ DD	7 ○ E	8 ○ F	9 ○ FF	10 ○ G
11 ○ GG	12 ○ H	13 ○ HH	14 ○ J	15 ○ JJ
16 ○ K	17 ○ KK	18 ○ L	19 ○ LL	
1 ☐ Don't Know				

If you are concerned about any of the health issues raised in this section, you may wish to contact your GP.

Section D: Reproductive Health

In this section we will be asking questions about your reproductive health. We know this is a sensitive subject, but it is important to ask about it now because we are interested in all aspects of your health and how it might be changing at this stage in your life.

D1)

a) Are you currently pregnant?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to D2**

b) How long were you trying before you became pregnant?

Months

☐☐ ➡ **Go to D3**

D2)

a) Are you currently trying to get pregnant?

(cross one option only)

1 ◯ Yes, we are trying	2 ◯ No, but intend to later
3 ◯ No	

➡ **<u>If no/no, but intend to later</u>, go to D3**

b) For how long have you been trying?

Months

☐☐

D3) How many pregnancies have you ever had? ☐☐ ➡ **<u>If 00</u>, go to D5**

D4) What was the outcome of each of these pregnancies? We have included space for up to 10 pregnancies. If you have had more than 10 pregnancies, please use the blank sheets at the back of the questionnaire and clearly indicate you are answering question D4

	(cross one option on each line)	1 Miscarriage	2 Termination of an unwanted pregnancy	3 Termination for medical reasons	4 Baby stillborn	5 Baby born alive	6 Year pregnancy ended/birth year
a)	1st	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐
b)	2nd	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐
c)	3rd	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐
d)	4th	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐
e)	5th	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐
f)	6th	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐
g)	7th	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐
h)	8th	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐
i)	9th	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐
j)	10th	1 ○	2 ○	3 ○	4 ○	5 ○	☐☐☐☐

D5) What forms of contraception are you and your partner using now? (please cross **all** that you have used **in the past 3 months**)

	(cross one option on each line)	1 Yes	2 No
a)	Withdrawal	1 ○	2 ○
b)	The pill	1 ○	2 ○
c)	Intrauterine device (coil, no hormones)	1 ○	2 ○
d)	Intrauterine device (coil, with hormones, such as a mirena coil)	1 ○	2 ○
e)	Condom/sheath	1 ○	2 ○
f)	Calendar/rhythm method	1 ○	2 ○
g)	Diaphragm/cap	1 ○	2 ○
h)	Spermicide	1 ○	2 ○
i)	Contraceptive injection (such as Depo-Provera)	1 ○	2 ○
j)	Contraceptive implant (such as Implanon)	1 ○	2 ○
k)	I have been sterilised	1 ○	2 ○
l)	My partner has been sterilised	1 ○	2 ○
m)	I am no longer fertile	1 ○	2 ○
n)	None	1 ○	2 ○
o)	Other (please describe)	1 ○	2 ○

D6) Have you ever had any of the following operations? (For each operation cross the no or yes option. If yes, please give the date of the operation. If you cannot remember the month and year give your age at the time of the operation).

a) Removal of uterus (womb) and both ovaries (hysterectomy and bilateral oopherectomy) 1 ◯ Yes 2 ◯ No

Month Year Age (years)
If yes ☐☐ ☐☐☐☐ **or** ☐☐

b) Removal of uterus (womb) only (hysterectomy) 1 ◯ Yes 2 ◯ No

Month Year Age (years)
If yes ☐☐ ☐☐☐☐ **or** ☐☐

c) Removal of uterus (womb) and one ovary (hysterectomy and oophorectomy) 1 ◯ Yes 2 ◯ No

Month Year Age (years)
If yes ☐☐ ☐☐☐☐ **or** ☐☐

d) Removal of both ovaries only (bilateral oophorectomy) 1 ◯ Yes 2 ◯ No

Month Year Age (years)
If yes ☐☐ ☐☐☐☐ **or** ☐☐

e) Removal of one ovary only (oophorectomy) 1 ◯ Yes 2 ◯ No

Month Year Age (years)
If yes ☐☐ ☐☐☐☐ **or** ☐☐

D7) In the last 12 months have you had a period or menstrual bleeding?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If yes</u>, go to D9**

D8) Were your periods stopped by:

(cross all that apply)

1 ☐ Surgery?	1 ☐ Chemotherapy or radiation therapy?
1 ☐ Pregnancy or breastfeeding?	1 ☐ No obvious reason/menopause?
1 ☐ Contraception?	

Other reason, please describe: ☐

➡ **Go to D10**

D9) In the **last 3 months** have you had a period or menstrual bleeding?

(cross one option only)

1 ◯ Yes	2 ◯ No

D10) When was your **last** period? (Include current period if bleeding now).

Month Year

☐☐ ☐☐☐☐

If you cannot remember the month and year please give your age at the time:

Years

☐☐

D11) These questions are for **everybody**. If you are still having periods tell us about the most recent changes. If your periods have stopped tell us about the changes before your last period.

a) In the **last few years/in the years before your last period** did your periods:

(cross one option only)

1 ◯ Become more regular?	2 ◯ Become less regular?
3 ◯ Remain about the same? (i.e. as regular/irregular as before)	4 ◯ Don't remember

➡ **<u>If remain about the same or don't remember</u>, go to D12**

b) If more regular or less regular, when did you first notice this change?

(cross one option only)

1 ◯ Up to one year before last period	2 ◯ Between 1 and 2 years before last period
3 ◯ Between 2 and 3 years before last period	4 ◯ Between 3 and 4 years before last period
5 ◯ More than 4 years before last period	

c) **In the last few years or in the years before your last period** how many days do you/did you usually have between the start (first day) of one period and the start of the next period?

(cross one option only)

1 ◯ Less than 21 days	2 ◯ 21-25 days
3 ◯ 26-31 days	4 ◯ 32-39 days
5 ◯ 40-50 days	6 ◯ More than 50 days
7 ◯ Too irregular to estimate	

D12) Please describe your most recent periods:

	(cross one option on each line)	1 Very	2 Moderately	3 Mildly	4 Not at all
a)	How heavy are/were your periods	1 ◯	2 ◯	3 ◯	4 ◯
b)	How painful are/were your periods	1 ◯	2 ◯	3 ◯	4 ◯
c)	Are/were your periods irregular	1 ◯	2 ◯	3 ◯	4 ◯

d) How many days does/did bleeding usually last? Days ☐☐

D13)

a) Do/did you generally find that in the days before or during your periods you have particular problems?

(cross one option only)

1 ◯ Yes | 2 ◯ No

➡ **<u>If no</u>, go to D14**

b) Which problems did you experience?

	(cross all that apply on each row)	1 Yes, before	2 Yes, during
i)	Very fatigued	1 ☐	2 ☐
ii)	Irritable	1 ☐	2 ☐
iii)	Depressed	1 ☐	2 ☐
iv)	Anxious	1 ☐	2 ☐
v)	Other (please describe)	1 ☐	2 ☐

D14) Have you had a D and C (scrape) since your study child's 7th birthday?

(cross one option only)

1 ◯ Yes | 2 ◯ No

3 ◯ Don't know

➡ **<u>If no or don't know</u>, go to D16**

D15) Was this because of?

	(cross one option on each line)	1 Yes	2 No
a)	Heavy periods	1 ○	2 ○
b)	Painful periods	1 ○	2 ○
c)	Fibroids	1 ○	2 ○
d)	Termination	1 ○	2 ○
e)	Infertility	1 ○	2 ○
f)	Miscarriage	1 ○	2 ○
g)	Don't know	1 ○	2 ○
h)	Other (please describe)	1 ○	2 ○

D16) Have you ever had hormone replacement therapy (HRT)?

(cross one option only)

1 ○ Yes | 2 ○ No

➡ **<u>If no</u>, go to Section E**

D17) When did you first start HRT?

Month Year

☐☐ ☐☐☐☐

If you cannot remember the month and year please give your age at the time:

Years

☐☐

D18) Before you first started HRT had your menstrual periods stopped?

(cross one option only)

1 ○ Yes | 2 ○ No

➡ **<u>If no</u>, go to D20**

D19) What was the date of your last period **before** starting HRT?

Month Year

☐☐ ☐☐☐☐

If you cannot remember the month and year please give your age at the time:

Years

☐☐

D20) Have you ever stopped HRT and then started again?

(cross one option only)

1 ◯ Yes	2 ◯ No

D21) Are you currently on HRT?

(cross one option only)

1 ◯ Yes	2 ◯ No

If you feel you have problems with any of the issues raised in this section, you may wish to contact your GP

Section E: Sexual health

In addition to the reproductive health questions in the previous section we would like to ask you questions about your sexual health. We know this is a particularly personal subject. Please remember that your answers are confidential and anonymous.

E1) Which statement best describes your circumstances?

(cross one option only)

- 1 ◯ I live with my sexual partner
- 2 ◯ I have a sexual partner but we do not live together
- 3 ◯ I do not have a sexual partner

E2) How often do you think about sex? This includes times of just being interested in sex, daydreaming or fantasizing about sex, as well as times when you wanted to have sex.

(cross one option only)

- 1 ◯ Not at all
- 2 ◯ Once in the last month
- 3 ◯ 2-3 times in the last month
- 4 ◯ Once a week
- 5 ◯ 2-3 times a week
- 6 ◯ 4-6 times a week
- 7 ◯ Once a day
- 8 ◯ More than once a day

E3) Are you worried or distressed by your current level of sexual drive/desire?

(cross one option only)

- 1 ◯ Not at all worried or distressed
- 2 ◯ A little bit worried or distressed
- 3 ◯ Moderately worried or distressed
- 4 ◯ Very worried or distressed
- 5 ◯ Extremely worried or distressed

E4) Compared with a year ago, has your sexual drive/desire changed?

(cross one option only)

- 1 ◯ Increased a lot
- 2 ◯ Increased moderately
- 3 ◯ Neither increased or decreased
- 4 ◯ Decreased moderately
- 5 ◯ Decreased a lot

E5) Did you have a sexual partner in the last month?

(cross one option only)

- 1 ◯ Yes
- 2 ◯ No

➡ **<u>If no</u>, go to E8**

E6) In the last month, how many times have you attempted sexual intercourse?

(cross one option only)

1 ◯ Not at all	2 ◯ Once in the last month
3 ◯ 2-3 times in the last month	4 ◯ Once a week
5 ◯ 2-3 times a week	6 ◯ 4-6 times a week
7 ◯ Once a day	8 ◯ More than once a day

E7) Apart from when you attempted sexual intercourse, how frequently do you engage in activities such as kissing, fondling, petting etc?

(cross one option only)

1 ◯ Not at all	2 ◯ Once in the last month
3 ◯ 2-3 times in the last month	4 ◯ Once a week
5 ◯ 2-3 times a week	6 ◯ 4-6 times a week
7 ◯ Once a day	8 ◯ More than once a day

E8) How often do you masturbate?

(cross one option only)

1 ◯ Not at all	2 ◯ Once in the last month
3 ◯ 2-3 times in the last month	4 ◯ Once a week
5 ◯ 2-3 times a week	6 ◯ 4-6 times a week
7 ◯ Once a day	8 ◯ More than once a day

E9) Are you worried or distressed by the overall frequency of your sexual activities (including intercourse, kissing etc and masturbation)?

(cross one option only)

1 ◯ Not at all worried or distressed	2 ◯ A little bit worried or distressed
3 ◯ Moderately worried or distressed	4 ◯ Very worried or distressed
5 ◯ Extremely worried or distressed	

➡ **<u>If not at all worried or distressed</u>, go to E11**

E10) If you are worried or distressed by the current frequency of your sexual activities, do you consider them to be:

(cross one option only)

1 ◯ Too frequent?	2 ◯ Not frequent enough?

E11) Compared with a year ago, has the overall frequency of your sexual activities changed?

(cross one option only)

1 ◯ Increased a lot	2 ◯ Increased moderately
3 ◯ Neither increased or decreased	4 ◯ Decreased moderately
5 ◯ Decreased a lot	

E12) It is common for men to experience erectile problems. In the last month how often was your husband/partner able to get and keep an erection good enough for sexual intercourse?

(cross one option only)

1 ◯ Always	2 ◯ Usually
3 ◯ Sometimes	4 ◯ Never
5 ◯ Not applicable	

E13) When you have sexual stimulation, how often do you have the feeling of orgasm or climax?

(cross one option only)

1 ◯ Almost never/never	2 ◯ A few times (much less than half the time)
3 ◯ Sometimes (about half the time)	4 ◯ Most of the time (much more than half the time)
5 ◯ Almost always/always	6 ◯ No sexual intercourse/masturbation

E14) Are you worried or distressed by your current orgasmic experience?

(cross one option only)

1 ◯ Not at all worried or distressed	2 ◯ A little bit worried or distressed
3 ◯ Moderately worried or distressed	4 ◯ Very worried or distressed
5 ◯ Extremely worried or distressed	

E15) Compared with a year ago, has the enjoyment of your orgasmic experience changed?

(cross one option only)

1 ◯ Decreased a lot	2 ◯ Decreased moderately
3 ◯ Neither increased or decreased	4 ◯ Increased moderately
5 ◯ Increased a lot	

E16) How satisfied are you with your overall sex life?

(cross one option only)

1 ◯ Very satisfied	2 ◯ Moderately satisfied
3 ◯ About equally satisfied and dissatisfied	4 ◯ Moderately dissatisfied
5 ◯ Very dissatisfied	

E17) How satisfied are you with your general (non-sexual) relationship with your partner?

(cross one option only)

1 ◯ Very satisfied	2 ◯ Moderately satisfied
3 ◯ About equally satisfied and dissatisfied	4 ◯ Moderately dissatisfied
5 ◯ Very dissatisfied	6 ◯ No partner

If you feel you have a problem with any of the issues raised in this section, you may wish to contact:

Bristol NHS Sexual Health Services Advice Line 0117 342 6944, your GP or visit www.nhs.uk/sexualhealth.

Section F: Your feelings

The questions in this section ask you about your feelings and the way you behave. You may have answered these questions in other questionnaires, but you might be feeling differently now. We would be very grateful if you would try to answer all of the questions but we understand if there are questions that you either prefer not to answer or are unable to answer.

Please say how true the following statements are of you.

(cross one option on each line)		1 Very like me	2 Moderately like me	3 Moderately unlike me	4 Very unlike me
F1)	I avoid saying what I think for fear of being rejected	1 ○	2 ○	3 ○	4 ○
F2)	If others knew the real me they would not like me	1 ○	2 ○	3 ○	4 ○
F3)	If other people knew what I am really like they would think less of me	1 ○	2 ○	3 ○	4 ○
F4)	I always expect criticism	1 ○	2 ○	3 ○	4 ○
F5)	I don't like people to really know me	1 ○	2 ○	3 ○	4 ○
F6)	My value as a person depends enormously on what others think of me	1 ○	2 ○	3 ○	4 ○

		1 Almost always true	2 Often true	3 Sometimes true	4 Seldom true	5 Never true
F7)	I am able to do things as well as most other people	1 ○	2 ○	3 ○	4 ○	5 ○
F8)	I feel I do not have much to be proud of	1 ○	2 ○	3 ○	4 ○	5 ○
F9)	I take a positive attitude towards myself	1 ○	2 ○	3 ○	4 ○	5 ○
F10)	Sometimes I think I am no good at all	1 ○	2 ○	3 ○	4 ○	5 ○
F11)	I am a useful person to have around	1 ○	2 ○	3 ○	4 ○	5 ○
F12)	I feel I cannot do anything right	1 ○	2 ○	3 ○	4 ○	5 ○
F13)	When I do a job I do it well	1 ○	2 ○	3 ○	4 ○	5 ○
F14)	I feel that my life is not very useful	1 ○	2 ○	3 ○	4 ○	5 ○
F15)	I am unlucky	1 ○	2 ○	3 ○	4 ○	5 ○

		1 Almost always true	2 Often true	3 Sometimes true	4 Seldom true	5 Never true
F16)	I feel that I am a person of worth, at least equal to others	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯
F17)	I feel I have a number of good qualities	1 ◯	2 ◯	3 ◯	4 ◯	5 ◯

In the past week

F18) I have blamed myself unnecessarily when things went wrong

(cross one option only)

1 ◯ Yes, most of the time	2 ◯ Yes, some of the time
3 ◯ Not very often	4 ◯ Never

F19) I have been anxious or worried for no good reason

(cross one option only)

1 ◯ Yes, often	2 ◯ Yes, sometimes
3 ◯ Hardly ever	4 ◯ No, not at all

F20) I have felt scared or panicky for no good reason

(cross one option only)

1 ◯ Yes, quite a lot	2 ◯ Yes, sometimes
3 ◯ No, not much	4 ◯ No, not at all

F21) Things have been getting on top of me

(cross one option only)

1 ◯ Yes, most of the time I haven't been able to cope	2 ◯ Yes, sometimes I haven't been coping as well as usual
3 ◯ No, most of the time I have coped quite well	4 ◯ No, I have been coping as well as ever

F22) I have been so unhappy that I have had difficulty sleeping

(cross one option only)

1 ◯ Yes, most of the time	2 ◯ Yes, sometimes
3 ◯ Not very often	4 ◯ No, not at all

F23) I have felt sad or miserable

(cross one option only)

1 ◯ Yes, most of the time	2 ◯ Yes, sometimes
3 ◯ Not very often	4 ◯ No, not at all

F24) I have been so unhappy I have been crying

(cross one option only)

1 ◯ Yes, most of the time	2 ◯ Yes, quite often
3 ◯ Only occasionally	4 ◯ Never

F25) The thought of harming myself has occurred to me

(cross one option only)

1 ◯ Yes, quite often	2 ◯ Sometimes
3 ◯ Hardly ever	4 ◯ Never

F26) I have been able to laugh and see the funny side of things

(cross one option only)

1 ◯ As much as I always could	2 ◯ Not quite so much now
3 ◯ Definitely not so much now	4 ◯ Not at all

F27) I have looked forward with enjoyment to things

(cross one option only)

1 ◯ As much as I ever did	2 ◯ Rather less than I used to
3 ◯ Definitely less than I used to	4 ◯ Hardly at all

If you feel concerned about any of the issues raised in this section you may wish to contact Mind on 0300 1233 393, or your GP.

Section G: Alcohol and tobacco

In this section we are asking about your alcohol and tobacco use. Alcohol includes beer, wine, 'alcopops', cider and spirit drinks like vodka.

G1) How often do you have a drink containing alcohol?

(cross one option only)

1 ◯ Never	2 ◯ Once a month or less
3 ◯ 2 to 4 times a month	4 ◯ 2 to 3 times a week
5 ◯ 4 or more times a week	

➡ **<u>If never</u>, go to G11**

Please count one drink as approximately half a pint of beer, a small glass of wine or a single pub measure of spirits.

G2) How many drinks containing alcohol do you have on a typical day when you are drinking?

(cross one option only)

1 ◯ 1 or 2	2 ◯ 3 or 4
3 ◯ 5 or 6	4 ◯ 7, 8 or 9
5 ◯ 10 or more	

G3) How often do you have six or more drinks on one occasion?

(cross one option only)

1 ◯ Never	2 ◯ Less than monthly
3 ◯ Monthly	4 ◯ Weekly
5 ◯ Daily or almost daily	

G4) How often during the last year have you found that you were not able to stop drinking once you had started?

(cross one option only)

1 ◯ Never	2 ◯ Less than monthly
3 ◯ Monthly	4 ◯ Weekly
5 ◯ Daily or almost daily	

G5) How often during the last year have you failed to do what was normally expected from you because of drinking?

(cross one option only)

1 ◯ Never	2 ◯ Less than monthly
3 ◯ Monthly	4 ◯ Weekly
5 ◯ Daily or almost daily	

G6) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(cross one option only)

1 ◯ Never	2 ◯ Less than monthly
3 ◯ Monthly	4 ◯ Weekly
5 ◯ Daily or almost daily	

G7) How often during the last year have you had a feeling of guilt or remorse after drinking?

(cross one option only)

1 ◯ Never	2 ◯ Less than monthly
3 ◯ Monthly	4 ◯ Weekly
5 ◯ Daily or almost daily	

G8) How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(cross one option only)

1 ◯ Never	2 ◯ Less than monthly
3 ◯ Monthly	4 ◯ Weekly
5 ◯ Daily or almost daily	

G9) Have you or someone else been injured as a result of your drinking?

(cross one option only)

1 ◯ Yes, during the last year	2 ◯ Yes, but not in the last year
3 ◯ No	

G10) Has a relative, friend, a doctor or another health worker been concerned about your drinking or suggested you cut down?

(cross one option only)

1 ◯ Yes, during the last year	2 ◯ Yes, but not in the last year
3 ◯ No	

G11) Are you currently a smoker (cigarettes or tobacco)?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to G15**

G12) Do you smoke every day?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to Section H**

G13) How old were you when you started smoking regularly (at least one cigarette or equivalent per day)?

Years old

☐☐

G14)

a) How many cigarettes do you usually smoke **each day**?

Cigarettes

☐☐

b) If hand-rolled, how much tobacco do you use **per week**?

Oz ☐☐ **<u>or</u>** Grams ☐☐☐

For non-smokers only

G15) Have you ever smoked in the past?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to Section H**

G16) When you smoked in the past did you smoke every day?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to Section H**

G17) How old were you when you started smoking regularly (at least one cigarette or equivalent per day)?

Years old

☐☐

G18)

a) How many cigarettes did you usually smoke **each day**?

Cigarettes

☐☐

b) If hand-rolled, how much tobacco do you use **per week**?

Oz ☐☐ **<u>or</u>** Grams ☐☐☐

G19) How long ago did you stop smoking? If you can't remember give your age at the time you stopped.

Years ☐☐ Months ☐☐ **<u>or</u>** Years old ☐☐

If you feel you have any concerns about issues raised in this section, you may wish to contact your GP or Alcoholics Anonymous on 0845 769 7555.

Section H: Your physical activity

In this section we are asking about your physical activity. We are interested in how your activities might be changing at this stage in your life.

H1) Which of the following forms of transport do you use **most often**?

(cross one option only)

1 ◯ Car	2 ◯ Motorbike
3 ◯ Public transport	4 ◯ Cycle
5 ◯ Walk	6 ◯ Not applicable

H2) Do you make regular journeys every day or most days either walking or cycling?

(cross one option only)

1 ◯ No	2 ◯ I walk
3 ◯ I cycle	4 ◯ Both

H3) Which of the following best describes your walking pace?

(cross one option only)

1 ◯ Slow	2 ◯ Steady average
3 ◯ Fairly brisk	4 ◯ Fast (at least 4 miles/hr)
5 ◯ Unable to walk	

H4) **If you cycle regularly**, how long do you spend cycling in an average week?

Hours/week ☐☐

1 ☐ I don't cycle regularly

H5)

a) Do you take part in physical activity (e.g. running, swimming, dancing, golf, tennis, squash, jogging, bowls)?

(cross one option only)

1 ◯ No	2 ◯ Occasionally (less than monthly)
3 ◯ Frequently (once a month or more)	

➡ **<u>If no or occasionally</u>, go to H6**

b) How many times do you take part in these activities on average?

	Times per week		Times per week
i) Summer	☐☐	**ii) Winter**	☐☐

H6) In a typical **week** during the past year, how many hours did you spend each week in the following activities? Please **round up to the nearest hour**, or write **00** in the boxes if you did not do this activity.

		1 Summer	2 Winter
a)	Walking to work, shopping or leisure	☐☐	☐☐
b)	Cycling, including to work and leisure	☐☐	☐☐
c)	Gardening, **light**. e.g. pruning, watering	☐☐	☐☐
d)	Gardening, **heavy** e.g. digging, mowing	☐☐	☐☐
e)	Physical exercise e.g. fitness, aerobics, sports	☐☐	☐☐
f)	DIY e.g. on house or car	☐☐	☐☐
g)	Household activities, **light**. e.g. cooking, washing up	☐☐	☐☐
h)	Household activities, **heavy** e.g. hoovering, cleaning windows	☐☐	☐☐

H7)

a) In a typical **week** in the **last year**, did you do any of these activities vigorously enough to cause breathlessness, sweating or a faster heartbeat?

(cross one option only)

1 ◯ Yes	2 ◯ No

➡ **<u>If no</u>, go to H9**

b) For how many **minutes** each week did you perform vigorous activity?

Minutes/week

☐☐☐

H8) In a typical weekday in the last year, how many flights of stairs did you climb?

Flights a day

☐☐

H9)

a) Compared with your activity level two years ago, are you doing?

(cross one option only)

1 ◯ More	2 ◯ Same
3 ◯ Less	

➡ **<u>If same</u>, go to H10**

b) **If you have selected more or less above**, please give a reason:

H10) Compared with other people your age, are you?

(cross one option only)

1 ◯ Much more active	2 ◯ More active
3 ◯ Similar	4 ◯ Less active
5 ◯ Much less active	

Section I

I1) On what date did you complete this questionnaire?

Day ☐☐ Month ☐☐ Year ☐☐☐☐

I2) Please give **your** date of birth

Day ☐☐ Month ☐☐ Year ☐☐☐☐

I3) Please give your **study child's** date of birth

Day ☐☐ Month ☐☐ Year ☐☐☐☐

Extra space for answering questions

Please clearly indicate the question number(s) your answer applies to.

Comments box

If you'd like to add a comment, please do so in the box below. Please sign at the bottom if you'd like a response

When completed, please send this questionnaire back in the freepost envelope provided or post to:
Freepost (RRXX-UUZG-HTLK)
Children of the 90s
Oakfield House
Oakfield Grove
Bristol BS8 2BN

THANK YOU VERY MUCH FOR YOUR HELP

1 ☐ For office use only