Thank you for coming to this examination.

Please complete this questionnaire. The information will be used in a major research project about factors that have a bearing on your health.

Answer to the best of your abilities. Place a cross next to one multiple choice option only (unless otherwise specified). Please return the completed questionnaire in the enclosed pre-stamped envelope.

All information will be treated in the strictest confidence.

Yours sincerely,

The National Mass Radiography Service
The County Medical Officer
Municipal Health Council
The Norwegian Institute of Public Health
The Institute of Applied Social Research/
The Institute of Social Research

EXERCISE

By exercise we mean going for walks, skiing, swimming and working out/sports.

How often do you exercise?
(on the average)
Never
Less than once a week
Once a week
2-3 times a week
Nearly every day

If you exercise as often as once or several times a week:
How hard do you exercise?
(average)
I take it easy, I don’t get out of breath or break a sweat
I push myself until I’m out of breath and break into a sweat
I practically exhaust myself

For how long do you exercise each time?
(average)
Less than 15 minutes
16 - 30 minutes
30 minutes - 1 hour
More than 1 hour
SALT

How often do you eat salt-cured meats or salt-cured fish/herring for dinner?
Never or less than once a month
1 - 2 times a month
Up to once a week
Up to twice a week
More than twice a week

How often do you put extra salt on your dinner?
Rarely or never
Occasionally
Often
Always or almost always

SMOKING HABITS

Do you currently smoke daily? <yes, no>

If YES, which of the following do you smoke DAILY: <yes, no>
Cigarettes?
Pipe?
Cigars (or cheroots/cigarillos)?

If you do NOT currently smoke CIGARETTES daily, have you ever smoked CIGARETTES daily? <yes, no>

If you answered YES, how long ago did you stop smoking cigarettes daily?
Less than 3 months ago
3 months - 1 year ago
1 - 5 years ago
More than 5 years ago

If you currently smoke CIGARETTES daily or have previously done so, how many cigarettes do you smoke or did you smoke a day? (Give the number per day, including hand rolled cigarettes) <number>

To be answered by those who smoke every day now or have done so in the past: (applies to cigarette, pipe and cigar smokers)

How old were you when you started smoking daily? <years>

For how many years have you been smoking daily? <years>
ALCOHOL CONSUMPTION

How often did you drink alcohol (beer, wine or spirits) during the LAST 14 DAYS?
I did not drink alcohol, though I am not a non-drinker
I drank alcohol 1 - 4 times
I drank alcohol 5 - 10 times
I drank alcohol more than 10 times
I am a non-drinker, I never drink alcohol

If you drank alcohol during the past 14 days, did it make you feel intoxicated on any occasion? <yes, no>

Have there been periods in your life when you drank excessively or too much?
No
Not sure, maybe
Yes

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HOUSING

Do you live alone or with others?
Put an X next to those you live with. (You may put an X next to more than one answer.)
Live alone
Spouse or domestic partner
Parents or parents-in-law
Other adults
Child/children under 5 years old
Child/children between 6 - 15 years old
Child/children over 15 years old

Are you a full-time resident at an institution? <yes, no>
(nursing home, retirement home or similar institution)

EDUCATION

What is your educational background? *
Only specify highest level achieved.
7 years primary school or less
Middle school
9 years compulsory primary and lower secondary school
10 years primary and lower secondary school
One or two years at upper secondary school
General Certificate of Education, commercial college or sixth form college
College or university, less than 4 years
College or university, 4 years or more

If you have completed any other forms of full-time education, how many years did you study? <years>
Write number of years here ________
* Differences in school systems complicate translation to English. Details for comparison can be found in the file Education systems in UK, Norway and USA.

**EMPLOYMENT**

If you are or have been gainfully employed, please specify which of the following categories your occupation best falls under. (If you are not currently employed give your last occupation)

If your spouse/partner is or has been gainfully employed, please specify which occupational category his/her work falls under. (If he/she has not been gainfully employed, then put an X in the last box) <yourself, spouse>
- Semi-skilled, unskilled worker
- Skilled worker, artisan, foreman
- Non-professional occupation (shop, office, public service)
- Lower professional occupation (e.g. nurse, technician, teacher)
- Management position in public or private enterprise
- Farmer or forest owner
- Fisherman
- Self-employed professional (e.g. dentist, lawyer)
- Self-employed businessperson (industry, transport, trade)
- Has not been gainfully employed (due to, for example, full-time housework, studies, disability pension)

If you are employed (this also applies to full-time housework), please answer the following questions:

**Is your work so physically demanding that you are often physically worn out after a day's work?**
- Yes, nearly always
- Quite often
- Seldom
- Never or almost never

**Does your work require so much concentration and attention that you often feel worn out after a day's work?**
- Yes, nearly always
- Quite often
- Seldom
- Never, or almost never

**All things considered, how much do you enjoy your work?**
- A great deal
- A fair amount
- It's OK
- Not much
- Not at all
If you are a farmer or a self-employed businessman/woman of some other type, do you have any regular employees?
No regular employees
1 - 2 regular employees
3 - 10 regular employees
More than 10 regular employees

HOW DO YOU FEEL?
Thinking about your life at the moment, would you say that you are by and large satisfied with life, or that you are mostly dissatisfied with your life?
(Put an X in only one box)
Very satisfied
Satisfied
Somewhat satisfied
Neither satisfied nor dissatisfied
Somewhat dissatisfied
Dissatisfied
Very dissatisfied

Do you feel, for the most part, strong and fit or tired and worn out?
Very strong and fit
Strong and fit
Somewhat strong and fit
Somewhere in between
Somewhat tired and worn out
Tired and worn out
Very tired and worn out

MEDICINE/AILMENTS
Do you normally: <yes, no>
Cough in the morning
Expectorate phlegm from your chest in the morning?

How often have you taken analgesics (pain relief medicine) during the last month?
Daily
Weekly, but not every day
Not as often as every week
Never
How often have you taken tranquilizers/sedatives or sleep medication during the last month?
Daily
Weekly, but not every day
Not as often as every week
Never

During the last month, have you suffered from nervousness (felt irritable, anxious, tense or restless)?
Almost all the time
Often
Sometimes
Never

During the last month, have you had any problems falling asleep or sleep disorders?
Almost every night
Often
Sometimes
Never

Do you by and large feel calm and good?
Almost all the time
Often
Sometimes
Never

FRIENDS/HELP
If you became ill and were bedridden for an extended period of time, how likely is it that you would receive the necessary help and support from family, friends or neighbours?
Extremely likely
Rather likely
Uncertain
Unlikely
Highly unlikely

Do you often feel lonely?
Very often
Often
Sometimes
Very rarely
Never
WHAT TYPE OF PERSON ARE YOU?

Do you have a tendency to take your duties more seriously than most people?
Yes, that's exactly the way I am
Yes, for the most part
Sometimes
No, usually not
No, on the contrary

Have you, during the last year, felt that you have pressured yourself or
continuously pushed yourself? <yes, no, don't know>

Do you feel that you are constantly short of time, even in your everyday tasks?
Always, or almost always
Sometimes
Never

Would you say you are usually cheerful or downhearted?
Very downhearted
Downhearted
Somewhat downhearted
Some of both
Somewhat cheerful
Cheerful
Very cheerful

WHAT DO YOU CONSIDER TO BE IMPORTANT

Do you think it is important to try to be satisfied with what one has?
This is especially important
This is important
Yes and no
This is not so important
This is of no importance whatsoever

Do you think it is important to be able to lower your expectations of yourself?
This is especially important
This is important
Yes and no
This is not so important
This is of no importance whatsoever

Do you think it is important to be cheerful at all times?
This is especially important
This is important
Sometimes
This is not so important
This is of no importance whatsoever
Thank you very much for the help you have given us by answering this questionnaire.

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