HUNT 2 Questionnaire 1

For people 20 years old and over, both sexes

Page 1

Page one is a personal invitation to the screening with information on where and when to attend. The participants were asked to fill in the questionnaire at home and bring it with them to their examination. The screening nurse at the examination location was to ensure that all questions on page two were filled in, explain misunderstandings if necessary and help participants complete and correct the questionnaire.

Page 2

This questionnaire is an important part of the Health Study. Here you will find questions about previous illnesses and other important conditions regarding your health. Please complete the form and take it with you to the health examination.

If any questions are not clear, leave them unanswered until you come to the examination where you can discuss them with the person on staff who examines you. All information you give will be treated in the strictest confidence.

Several places on this questionnaire we ask you to give your age when an illness occurred. If you do not know exactly how old you were, give the age that is closest to what you think may be correct.

When the results of the examination are available, there will be some people who need to be re-examined by their own doctor. If this is the case for you, you will be informed of this in a letter that we will send with your results. At the same time, your doctor will be sent your results. This is why in the section at the end of the questionnaire you are asked to give the name of your general practitioner, community doctor or health care centre where results are to be sent and possible follow-up examination are to be carried out.

Sincerely,
The Nord-Trøndelag Health Service - The State Health Examiners - The State Institute for Public Health

THIS IS ABOUT YOUR HEALTH

How is your health at the moment? (Put an X in only one box)
Poor
Not so good
Good
Very good

RESPIRATORY DISORDERS

Do you cough daily during periods of the year? <yes, no>

If YES, answer the next two questions.
Do you usually bring up phlegm when coughing? <yes, no>
Have you had a cough with phlegm for periods of at least 3 months during each of the last two years? <yes, no>

Have you had attacks of wheezing or breathlessness during the last 12 months? <yes, no>

Do you have or have you had asthma? <yes, no> Age first time ____

Do you use or have you used asthma medication? <yes, no>

CARDIOVASCULAR DISEASES, DIABETES

Have you had or do you have:
Myocardial infarction (heart attack) <yes, no> Age first time ____
Angina pectoris (chest pain) <yes, no> Age first time ____
Stroke/brain haemorrhage <yes, no> Age first time ____
Diabetes <yes, no> Age first time ____

What was the result the last time your blood pressure was measured? (Put an X in only one box)
Start or continue taking medicine for high blood pressure
Go in for a follow-up examination, but not take medicine
No follow-up examination and no medication necessary
Have never had blood pressure measured

Are you taking medication for high blood pressure? (Put an X in only one box)
Currently taking medication
Previously, but not now
Have never taken it

Has one or more of your parents or siblings had a myocardial infarction (heart attack) or angina pectoris (chest pains)? <yes, no, don't know>

METABOLISM

Have you ever had:
Hyperthyroidism (too high metabolism) <yes, no> Age first time ____
Hypothyroidism (too low metabolism) <yes, no> Age first time ____
Goitre <yes, no> Age first time ____
Other disease of the thyroid gland <yes, no> Age first time ____

Do you take or have you ever taken either of these medicines:

Thyroxin <yes, no> Age first time ____
NeoMercazole <yes, no> Age first time ____

Have you had a thyroid gland operation? <yes, no> Age first time ____

Have you had radioiodine treatment? <yes, no> Age first time ____

MUSCULOSKELETAL DISORDERS

During the last year, have you had pain and/or stiffness in your muscles and limbs that has lasted for at least 3 consecutive months? <yes, no>
If NO, go on to the next section.
If YES, answer the following questions:

Where did you have pain and/or stiffness? <yes, no>
Neck
Shoulders
Elbows
Wrists, hands
Chest/stomach
Upper part of back
Lumbar region
Hips
Knees
Ankles, feet

(If you had complaints in several areas for at least 3 months in the last year, put a circle around the yes-X for the complaint that lasted longest.)

How long did the pain and/or stiffness last? (Answer for the area where it lasted the longest)
If less than 1 year, give the number of months. ____ Number of months
If 1 year or more, give the number of years. ____ Number of years

Have these complaints reduced your ability to work during the last year? (Also applies to those working at home. Put an X in only one box.)
No, not significantly
To some degree
Significantly
Don't know

Have you been on sick leave due to these complaints during the last year? <yes, no, not working>

Have the complaints caused you to reduce your leisure activities? <yes, no>

Has a doctor ever said that you have/have had any of the following diseases? <yes, no>
Osteoporosis
Fibromyalgia (fibrositis/chronic pain syndrome)
Arthritis (rheumatoid arthritis)
Degenerative joint disease (osteoarthritis)
Bechterew's disease (AS)
Other long-term skeletal or muscular diseases

Have you ever had: <yes, no> Age last time ____

A fractured femur
A fractured wrist or forearm
Neck injury (whiplash)
Injury that led to hospitalisation

OTHER COMPLAINTS

To what degree have you had the following complaints in the last 12 months? <not at all, slightly, very much>
Nausea
Heartburn/ acid regurgitation
Diarrhoea
Constipation
Palpitations
Breathlessness

OTHER DISEASES

Do you have or have you ever had: <yes, no> Age first time ____
Epilepsy
Mental health problems for which you sought help
Cancer
Other long-term disease

EVERYDAY TASKS

Do you suffer from any long-term illness or injury of a physical or psychological nature that impairs your functioning in your everyday life? <yes, no>
(Long-term means at least one year.)
If YES, would you describe your impairment as slight, moderate or severe? <slight, moderate, severe>
Motor ability impairment
Vision impairment
Hearing impairment
Impairment due to physical illness
Impairment due to mental health problems

MEN continue after this section

TO BE ANSWERED BY WOMEN ONLY

How many children have you had? <_____ Number of children>
(Put 0 if you have had no children)

If you have had children, answer these questions:
How old were you when you had your first child? <Age _____>
How old were you when you had your last child? <Age _____>
(Do not answer if you have only had one child)

How old were you when you started menstruating? <Age ____>
(Put 0 if you have never menstruated)

Continue to the next section

SMOKING

Did any of the adults where you grew up smoke indoors? <yes, no>

After you were 20 years old, do you live or have you lived with a daily smoker(s)? <yes, no>

How long are you usually in a smoky room each day? <Number of hours ____>
(Put 0 if you are not usually in a smoky room)

Do you smoke? <yes, no>
Daily cigarette smoker?
Daily cigar/cigarillo smoker?
Daily pipe smoker?
Have never smoked daily (Put an X) □

If you previously smoked, how long has it been since you stopped? <Number of years ____>

If you, now or previously, smoke(d) daily, answer these questions:

How many cigarettes do you or did you usually smoke daily? <Number of cigarettes - ____>
How old were you when you started smoking? <Age ____>
How many years in total have you smoked daily? <Number of years ____>

COFFEE/TEA/ALCOHOL

How many cups of coffee/tea do you drink daily? <Number of cups ____>
(Put 0 if you do not drink coffee/tea daily)
Brewed coffee
Other coffee
Tea

Concerning alcohol, are you a non-drinker? <yes, no>

How many times a month do you normally drink alcohol? <Number of times ____> (Do not include low-alcohol beer. Put 0 if less than once a month.)

How many glasses of beer, wine or spirits do you usually drink in the course of two weeks? (Do not include low-alcohol beer. Put 0 if less than once a month.)

Beer <Number of glasses ____>
Wine <Number of glasses ____>
Spirits <Number of glasses ____>

PHYSICAL ACTIVITY

DURING LEISURE TIME

How much of your leisure time have you been physically active during the last year? (Think of a weekly average for the year. Your commute to work counts as leisure time.)
<Hours per week: None, Less than 1, 1-2, 3 or more>
Low physical activity (no sweating/not out of breath)
Vigorous physical activity (sweating/out of breath)

AT WORK

(For both paid or unpaid work)
How would you describe your work? (Put an X in only one box)
Mostly sedentary work (e.g. at a desk, on an assembly line)
Much walking at work (e.g. delivery work, light industrial work, teaching)
Much walking or lifting at work (e.g. postman, nurse, construction work)
Heavy physical work (e.g. forestry work, heavy agricultural work, heavy construction work)

HOW DO YOU FEEL?

In the last two weeks, have you felt: <no, a little, a good amount, very much>
Confident and calm?
Happy and optimistic?
Have you felt:
Nervous and restless?
Troubled by anxiety?
Irritable?
Down/depressed?
Lonely?

Read each item below and place an X next to the reply that comes closest to how you have been feeling **in the past week** (only one X per item). Do not take too long over your replies; your immediate reaction to each item will probably be more accurate than a long, thought-out response.

I still enjoy the things I used to enjoy
Definitely as much
Not quite so much
Only a little
Hardly at all

I get a sort of frightened feeling as if something awful is about to happen
Very definitely and quite badly
Yes, but not too badly
A little, but it doesn't worry me
Not at all

I can laugh and see the funny side of things
As much as I always could
Not quite so much now
Definitely not so much now
Not at all

Worrying thoughts go through my mind
A great deal of the time
A lot of the time
Not too often
Very little

I feel cheerful
Never
Not often
Sometimes
Most of the time

I can sit at ease and feel relaxed
Definitely
Usually
Not often
Not at all

I feel as if I'm slowed down
Nearly all the time
Very often
Sometimes
Not at all

I get a sort of frightened feeling like 'butterflies' in the stomach
Not at all
Occasionally
Quite often
Very often

I have lost interest in my appearance
Definitely
I don't take as much care as I should
I may not take quite as much care
I take just as much care as ever

I feel restless as if I have to be on the move
Very much indeed
Quite a lot
Not very much
Not at all

I look forward with enjoyment to things
As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all

I get sudden feelings of panic
Very often indeed
Quite often
Not very often
Not at all

I can enjoy a good book or radio or television programme
Often
Sometimes
Not often
Very seldom

EDUCATION

What is your highest level of education?

Primary school 7-10 years, continuation school, folk high school
High school, intermediate school, vocational school, 1-2 years high school
University qualifying examination, junior college, A levels
University or other post-secondary education, less than 4 years
University/college, 4 years or more

WORK

What kind of work do you currently do? (One or more Xs)
Paid work
Self-employed
Full-time housework
Student, military service
Unemployed, laid off
Retired/on Social Security

How many hours of paid work do you have a week? <Number of hours ____ >

Do you work shifts, at night, or on call? <yes, no>

IN GENERAL

Thinking about your life at the moment, would you say that you by and large are satisfied with life, or are you mostly dissatisfied?

(Put an X in only one box)
Very satisfied
Satisfied
Somewhat satisfied
Neither satisfied nor dissatisfied
Somewhat dissatisfied
Dissatisfied
Very dissatisfied

Which general practitioner would you prefer to be referred to if this health survey indicates that you should undergo a more thorough examination?
Write the doctor's name here_____

Thank you for completing this questionnaire!
And once again, Welcome to the examination!