Dear HUNT participant

Thank you for taking part in this health study. We ask that you complete this questionnaire. Though some of the questions are similar to questions you have previously answered, it is important that you answer all the questions. The information will be used in research and preventative health care. Researchers will only have access to anonymous information; this means that the information cannot be traced back to the individual participants.

Please complete the questionnaire and send it in as soon as possible. Postage is paid.

Date completed 20___

Housing and Friends

Who do you live with? *(One or more Xs)*

No one	☐		
Parents	☐		
Spouse/partner	☐		
Other people over 18 years old	☐		
Other people under 18 years old	☐	Number of people under 18	

Are there any pets in your home?

Yes, cat ☐ Yes, dog ☐ Yes, other animals w/ fur/birds ☐ No ☐

Do you have friends that can help you when you need them? Yes ☐ No ☐

Do you have friends that you can speak to confidentially? Yes ☐ No ☐

Your Surroundings (neighbourhood/group of farms)

I feel a strong sense of community with the people who live here *(One X)*

Strongly agree	Somewhat agree	Not sure	Somewhat disagree	Strongly disagree
☐	☐	☐	☐	☐

We do not trust each other here *(One X)*

Strongly agree	Somewhat agree	Not sure	Somewhat disagree	Strongly disagree
☐	☐	☐	☐	☐

People like living here *(One X)*

Strongly agree	Somewhat agree	Not sure	Somewhat disagree	Strongly disagree
☐	☐	☐	☐	☐

Physical Activity

How much of your leisure time have you been physically active in the last year? *Weekly average for the year. Commute counts as leisure time.*

	Hours a week			
	None	**Less than 1**	1-2	3
Low physical activity *no sweat, not out of breath*	☐	☐	☐	☐
Vigorous physical activity *sweat, out of breath*	☐	☐	☐	☐

How many hours in total are you in front of a computer screen? *(Write 0 if you don't use a computer)*

Work ____ hours Leisure ____ hours

How many hours do you watch TV/video/DVD daily?

Less than 1 hour ☐ 1-3 hours ☐ 4-6 hours ☐ More than 6 hours ☐

Culture/Life Philosophy

How often <u>in the last 6 months</u> have you been to: *(One X per line)*

	More than 3 x /mo.	1-3 x /mo	1-6 x /6 mos.	Never
Museum/art exhibition	☐	☐	☐	☐
Concert, theatre, film	☐	☐	☐	☐
Church/chapel	☐	☐	☐	☐
Sports event	☐	☐	☐	☐

How many times <u>in the last 6 months</u> have you participated in the following: *(One X per line)*

	More than 1x /week	1x /week	1-3x /mo.	1-5x /6 mos.	Never
Association or club meeting/activity	☐	☐	☐	☐	☐
Music, singing, theatre	☐	☐	☐	☐	☐
Parish work	☐	☐	☐	☐	☐
Outdoor activities	☐	☐	☐	☐	☐
Dance	☐	☐	☐	☐	☐
Worked out, sports	☐	☐	☐	☐	☐

Which life philosophy is most like yours? (One X only)

Christian ☐ Atheistic ☐ Humanistic ☐ Other ☐

When something bad happens in my life, I think that it happened for a purpose.

No ☐ Yes ☐ Don't know ☐

I seek God's help when I need strength and solace.

Never ☐ Sometimes ☐ Often ☐

Personality

Describe yourself as you normally are:

	Yes	No
Are you a life of the party type person?	☐	☐
Are you mostly quiet and reserved when you are around other people?	☐	☐
Do you like meeting new people?	☐	☐
Do you like to have a lot of life and excitement around you?	☐	☐
Are you a relatively lively person?	☐	☐
Do you usually take the first step to make new friends?	☐	☐
Are you often worried?	☐	☐
Are your feelings easily hurt?	☐	☐
Do you often feel that you lose interest?	☐	☐
Do you have nervous problems?	☐	☐
Do you often feel tired and indifferent/unmotivated without reason?	☐	☐
Do you worry that terrible things might happen?	☐	☐

Headaches

Have you had headaches in the last year?

Yes ☐ No ☐

***If No, skip to* Respiratory Tract**

If Yes, what type of headache?

Migraine ☐ Other headache ☐

Average number of days a month with headaches:

Less than 1 day	1-6 days	7-14 days	More than 14 days
☐	☐	☐	☐

What is the average strength of your headaches?

Mild *(does not affect activity)* ☐

Moderate *(affects activity)* ☐

Strong *(hinders activity)* ☐

How long does the headache usually last?

Less than 4 hours ☐ 1-3 days ☐

4 hours – 1 day ☐ More than 3 days ☐

Are the headaches usually characterized by or accompanied by:

(One X per line)	Yes	No
Throbbing/thumping pain	☐	☐
Pressing pain	☐	☐
Pain on one side of the head (right or left)	☐	☐
Worsening with physical activity	☐	☐
Nausea and/or vomiting	☐	☐
Hypersensitivity to light and/or noise	☐	☐

Before or during the headache, have you had temporary: *(One X per line)*	Yes	No
Visual disturbances *(zigzag lines, flickering/flashing light, fogged vision)*	☐	☐
Numbness in half of your face or hand	☐	☐

Write the number of days you have been absent from work or school in the last month because of headaches ☐ days

Respiratory Tract

	Yes	No
Do you cough daily in periods of the year?	☐	☐
If Yes: **Do you usually bring up phlegm when coughing?**	☐	☐
Have you had a cough with phlegm for periods of at least 3 months during each of the last two years?	☐	☐
Do you have or have you had hayfever or nasal allergies?	☐	☐
If Yes: **Have you had hayfever/allergy symptoms in the last 12 months?**	☐	☐
In the last 12 months have you woken during the night because you were short of breath?	☐	☐

Muscles and Joints

In the last year, have you had pain or stiffness in muscles or joints that has lasted at least 3 consecutive months?

Yes ☐ No ☐

If No, skip to question 30

If Yes,

Where have you had this pain or stiffness (One or more Xs)

Neck	☐	**FIGURE**
Shoulders	☐	
Upper back	☐	
Elbows	☐	
Lower back	☐	
Wrists/hands	☐	
Hips	☐	
Knees	☐	

Ankles/feet ☐

Have you had this pain/stiffness on both the right and left side of your body? Yes ☐ No ☐

Does this pain/stiffness hinder your daily activities?

	Yes	No
Work	☐	☐
Leisure	☐	☐

Have you had back surgery? Yes ☐ No ☐

If Yes,
Type of back surgery

- Prolapse/sciatica surgery ☐
- Fixation ☐
- Other ☐

Metabolism

Has it ever been verified that you have/have had:	Yes	No	If Yes, write age first time *Ex:* (45 yrs old)
Hypothyroidism (too low metabolism)	☐	☐	☐ yrs old
Hyperthyroidism (too high metabolism)	☐	☐	☐ yrs old
If Yes: Did you take Neo-Mercazole?	☐	☐	☐ yrs old
Have you had radioiodine treatment?	☐	☐	☐ yrs old

Abdomen

Have you had stomach pain or discomfort <u>in the last 12 months</u>?

Yes, much ☐ Yes, a little ☐ No, never ☐

If No, skip to question 34

If Yes:

	Yes	No
Is it localized in the upper stomach?	☐	☐
<u>In the last 3 months</u>, have you had this as often as 1 day a week for at least 3 weeks?	☐	☐
Is the pain/discomfort relieved by having a bowel movement?	☐	☐
Is the pain/discomfort related to more frequent or less frequent bowel movements than normal?	☐	☐
Is the pain/discomfort related to the stool being softer or harder than normal?	☐	☐
Do you have this pain/discomfort after eating?	☐	☐

To what degree have you had the following <u>in the last 12 months:</u>

	Never	A little	Much
Nausea	☐	☐	☐
Heartburn/acid regurgitation	☐	☐	☐
Diarrhoea	☐	☐	☐
Constipation	☐	☐	☐
Alternating constipation and diarrhoea	☐	☐	☐
Bloating	☐	☐	☐

How You Feel

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 feel tense or 'wound up'

Not at all ☐ From time to time, occasionally ☐ A lot of the time ☐ Most of the time ☐

I still enjoy the things I used to enjoy

Definitely as much ☐ Only a little ☐
Not quite so much ☐ Hardly at all ☐

I get a sort of frightened feeling as if something awful is about to happen

Very definitely and quite badly ☐ A little, but it doesn't worry me ☐
Yes, but not too badly ☐ Not at all ☐

I can laugh and see the funny side of things

As much as I always could ☐ Definitely not so much now ☐
Not quite so much now ☐ Not at all ☐

Worrying thoughts go through my mind

A great deal of the time ☐ Not too often ☐
A lot of the time ☐ Very little ☐

I feel cheerful

Never ☐ Sometimes ☐
Not often ☐ Most of the time ☐

I can sit at ease and feel relaxed

Definitely ☐ Not often ☐
Usually ☐ Not at all ☐

I feel as if I'm slowed down

Nearly all the time ☐ Sometimes ☐
Very often ☐ Not at all ☐

I get a sort of frightened feeling like 'butterflies' in the stomach

Not at all	☐	Quite often	☐
Occasionally	☐	Very often	☐

I have lost interest in my appearance

Definitely	☐	I may not take quite as much care	☐
I don't take as much care as I should	☐	I take just as much care as ever	☐

I feel restless as if I have to be on the move

Very much indeed	☐	Not very much	☐
Quite a lot	☐	Not at all	☐

I look forward with enjoyment to things

As much as I ever did	☐	Definitely less than I used to	☐
Rather less than I used to	☐	Hardly at all	☐

I get sudden feelings of panic

Very often indeed	☐	Not very often	☐
Quite often	☐	Not at all	☐

I can enjoy a good book or radio or TV programme

Often	☐	Not often	☐
Sometimes	☐	Very seldom	☐

Sleep

How often <u>in the last 3 months</u> have you:

	Seldom /never	Some-times	Several x a week
Snored loudly (bothersome)	☐	☐	☐
Stopped breathing when you were sleeping (**Sleep apnoea**)	☐	☐	☐
Had difficulty falling asleep at night	☐	☐	☐
Woken up repeatedly during the night	☐	☐	☐
Woken too early and couldn't get back to sleep	☐	☐	☐
Felt sleepy during the day	☐	☐	☐
Sweat while sleeping (night-time)	☐	☐	☐
Woken with a headache	☐	☐	☐
Felt an uncomfortable or pins and needles feeling in your legs	☐	☐	☐

Alcohol

If you do not drink alcohol, skip to question 54.

	Yes	No
Have you ever felt that you should reduce your alcohol intake?	☐	☐
Have other people ever criticised your use of alcohol?	☐	☐
Have you ever felt bad or guilty because of your use of alcohol?	☐	☐
Have you ever had a drink first thing in the morning as a pick-me-up or to calm your nerves or to cure a hangover?	☐	☐

Diet

How <u>many pieces of bread</u> do you usually eat?

Put an X for each type of bread

	0-4 pr week	*5-7 pr week*	*2-3 pr day*	*4-5 pr day*	*6 or more pr day*
White bread	☐	☐	☐	☐	☐
Wholemeal/ medium ground	☐	☐	☐	☐	☐
Multigrain wholemeal/ coarsely ground	☐	☐	☐	☐	☐

How often do you normally eat these meals?

(One X for each meal)

	Seldom/ never	**1-2 x a week**	**3-4 x a week**	**5-6 x a week**	**Every-day**
Breakfast	☐	☐	☐	☐	☐
Lunch	☐	☐	☐	☐	☐
Warm dinner	☐	☐	☐	☐	☐
Supper/ evening snack	☐	☐	☐	☐	☐
Other meal	☐	☐	☐	☐	☐
Midnight snack (24.00-06.00)	☐	☐	☐	☐	☐

What type of fat do you most often use? *(One X for each line)*

	Butter	Hard marg.	Soft/light margarine	Oils	Don't use
On bread	☐	☐	☐	☐	☐
For cooking	☐	☐	☐	☐	☐

Dental Health

Have you been to the dentist in the last 12 months? Yes ☐ No ☐

How would you say your dental health is?

Very bad	☐	Good	☐
Bad	☐	Very good	☐
OK	☐		

Is good dental health important to you?

Very much	☐	A little	☐
Much	☐	Svært lite	☐
Somewhat	☐		

Use of Non-Prescription Medicine

How often have you taken non-prescription medicine for the following problems in the last month:

	Seldom/ never	*1-3 x a week*	*4-6 x a week*	*Daily*
Heartburn/ acid regurgitation	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Headache	☐	☐	☐	☐
Pain in muscles/joints	☐	☐	☐	☐

Have you taken any of these non-prescription medicines at least once a week in the last month?

	Yes	No
Paracetamol, Paracet, Panodil, Pamol, Pinex, Perfalgan	☐	☐
Albyl E (500 mg), Aspirin, Globoid, Dispril	☐	☐
Ibuprofen, Ibux, Ibuprox, Ibumetin, Brufen	☐	☐
Naproxen, Naprosyn, Ledox	☐	☐
Other	☐	☐

How You Feel Now

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 ☐
- Somewhat in between ☐
- Somewhat tired and worn out ☐
- Tired and worn out ☐
- Very tired and worn out ☐

Additional Section Men 20-29

Employment

Is your work so physically demanding that you are often physically worn out after a day's work? *(Only one X)*

Yes, nearly always	☐	Seldom	☐
Quite often	☐	Never, or almost never	☐

Does your work require so much concentration and attention that you often feel worn out after a day's work? *(Only one X)*

Yes, nearly always	☐	Seldom	☐
Quite often	☐	Never, or almost never	☐

All things considered, how much do you enjoy your work? *(Only one X)*

A great deal	☐	Not much	☐
A fair amount	☐	Not at all	☐

Your Feelings in the Last 14 Days

In the last two weeks, have you: *(One X for each line)*

	No	A little	A good amount	Very much
Been continuously afraid and anxious	☐	☐	☐	☐
Felt tense and restless	☐	☐	☐	☐
Felt hopelessness when you think about the future	☐	☐	☐	☐
Felt down and sad	☐	☐	☐	☐
Worried too much about various things	☐	☐	☐	☐

Life Events

Have you experienced any of the following in the last 10 years? *(Put an X for each question)*

	No	Yes	
		Last 12 mos.	Earlier
Had problems at work or school?	☐	☐	☐
Had financial problems?	☐	☐	☐
Had problems or conflicts with family or friends?	☐	☐	☐
Had big problems in your love life?	☐	☐	☐
Been seriously ill or injured?	☐	☐	☐
Have those nearest you been seriously ill or injured?	☐	☐	☐

Eating Habits

Below are listed things that concern your eating habits. Put an X in the boxes according to how they apply to you. *(Put an X for each line)*

	Never	Seldom	Often	Always
When I first begin eating, it is difficult to stop.	☐	☐	☐	☐
I spend too much time thinking about food.	☐	☐	☐	☐
I feel that food controls my life.	☐	☐	☐	☐
I cut my food into small pieces.	☐	☐	☐	☐
I take longer than others to eat my meals.	☐	☐	☐	☐
Older people think I'm too thin.	☐	☐	☐	☐
I feel that others pressure me to eat.	☐	☐	☐	☐
I vomit after I have eaten.	☐	☐	☐	☐

Gambling

	Yes	No
Have you ever felt the need to gamble with continuously increasing amounts of money?	☐	☐
Have you ever had to lie to people who are important to you about how much you lost gambling?	☐	☐

Additional Section Women 20-29

Pregnancy and Birth Control

Not including pregnancies or post-natal periods, have you ever not menstruated for at least 6 months? Yes ☐ No ☐

If Yes,

How many times? ☐ times

Including all pregnancies, how many times have you been pregnant? ☐ times

Have you ever tried for <u>more than one year</u> to become pregnant? Yes ☐ No ☐

If Yes,

How old were you the first time you had problems becoming pregnant? ☐ yrs old

Do you use/take or have you used/taken:

	Now	Before, but not now	Never
Birth control pills	☐	☐	☐
Birth control patch	☐	☐	☐
Other hormone birth control *(Injection, vaginal ring, implant, IUD/coil)*	☐	☐	☐

If you have taken birth control pills: How old were you when you first began taking them? ☐ yrs old

How many years in total have you taken birth control pills?

Less than 1 yr ☐ 1-3 yrs ☐ 4-10 yrs ☐ over 10 yrs ☐

Urinary Tract

Do you unintentionally leak urine? Yes ☐ No ☐

If No, skip to question 72

If Yes:

How often do you leak urine?

Less than once a month ☐ One or more times a week ☐

One or more times a month ☐ Every day/night ☐

How much urine usually leaks each time?

Drops ☐ Small amount ☐ Quite a lot ☐

	Yes	No
Do you leak urine when you cough, sneeze, laugh or lift something heavy?	☐	☐
When you leak urine is it accompanied by a sudden and strong urge to urinate?	☐	☐

How do you feel about having urinary incontinence?

Not a problem ☐ A great problem ☐

A slight problem ☐ A very great problem ☐

A moderate problem ☐

Employment

Is your work so physically demanding that you are often physically worn out after a day's work? *(Only one X)*

Yes, nearly always ☐ Seldom ☐

Quite often ☐ Never, or almost never ☐

Does your work require so much concentration and attention that you often feel worn out after a day's work? *(Only one X)*

Yes, nearly always ☐ Seldom ☐

Quite often ☐ Never, or almost never ☐

All things considered, how much do you enjoy your work? *(Only one X)*

A great deal ☐ Not much ☐

A fair amount ☐ Not at all ☐

Your Feelings in the Last 14 Days

In the last two weeks, have you: *(One X for each line)*

	No	A little	A good amount	Very much
Been continuously afraid and anxious	☐	☐	☐	☐
Felt tense and restless	☐	☐	☐	☐
Felt hopelessness when you think about the future	☐	☐	☐	☐
Felt down and sad	☐	☐	☐	☐
Worried too much about various things	☐	☐	☐	☐

Life Events

Have you experienced any of the following in the last 10 years? *(Put an X for each question)*

	No	Yes	
		Last 12 mos.	Earlier
Had problems at work or school?	☐	☐	☐
Had financial problems?	☐	☐	☐
Had problems or conflicts with family or friends?	☐	☐	☐
Had big problems in your love life?	☐	☐	☐
Been seriously ill or injured?	☐	☐	☐
Have those nearest you been seriously ill or injured?	☐	☐	☐

Eating Habits

Below are listed things that concern your eating habits. Put an X in the boxes according to how they apply to you. *(Put an X for each line)*

	Never	Seldom	Often	Always
When I first begin eating, it is difficult to stop.	☐	☐	☐	☐
I spend too much time thinking about food.	☐	☐	☐	☐
I feel that food controls my life.	☐	☐	☐	☐
I cut my food into small pieces.	☐	☐	☐	☐
I take longer than others to eat my meals.	☐	☐	☐	☐
Older people think I'm too thin.	☐	☐	☐	☐
I feel that others pressure me to eat.	☐	☐	☐	☐
I vomit after I have eaten.	☐	☐	☐	☐

Gambling

	Yes	No
Have you ever felt the need to gamble with continuously increasing amounts of money?	☐	☐
Have you ever had to lie to people who are important to you about how much you lost gambling?	☐	☐

Additional Section Men 30-69

Evaluating Your Job

Answer if you are or have been employed.

Respond to the following statements/questions about where you work.

There is a good collegiality at work.
Strongly agree ☐ Agree ☐
Disagree ☐ Strongly disagree ☐

My co-workers are there for me (support me).
Strongly agree ☐ Agree ☐
Disagree ☐ Strongly disagree ☐

I get along well with my co-workers.
Strongly agree ☐ Agree ☐
Disagree ☐ Strongly disagree ☐

Are you bullied/ harassed at work?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Does your job require you to work very fast?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Does your job require you to work very hard?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Does your job require too great a work effort?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Does your job require creativity?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Do you have the possibility to decide for yourself how to carry out your work?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Do you have the possibility to decide for yourself what should be done in your work?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

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

Leg Pain

	Yes	No
Do you have ulcer(s) on your toes, foot ankle that will not heal?	☐	☐
Do you have pain in one or both legs when you walk?	☐	☐

If Yes,
Where does it hurt the most?
Foot ☐ Leg ☐ Thigh ☐ Hip ☐

	Yes	No
Does the pain go away if you stand still a while?	☐	☐
Do you have pain in your legs when you are resting?	☐	☐
If Yes: **Is the pain worse when you lay in bed?**	☐	☐
Do you have less pain if you have your legs lower, such as over the edge of the bed?	☐	☐
Have you had pain in your legs continuously for more than 14 days?	☐	☐
Have you taken pain relievers because of pain in your legs?	☐	☐

Vision

Do you have any of the following eye conditions?	Yes	No
Cataract	☐	☐
Glaucoma (raised eye pressure)	☐	☐
Age-Related Macular Degeneration (retinal calcification)	☐	☐

Memory

Do you have problems with your memory?
No, none ☐ Yes, some ☐ Yes, a lot ☐

Has your memory changed since you were younger?

No ☐ Yes, some ☐ Yes, a lot ☐

Do you have trouble remembering:	Never	Sometimes	Often
Things that happened a few minutes ago?	☐	☐	☐
Other peoples' names?	☐	☐	☐
Dates?	☐	☐	☐
To do something you have planned to do?	☐	☐	☐
Things that happened a few days ago?	☐	☐	☐
Things that happened years ago?	☐	☐	☐
Enough to be able to follow along in a conversation?	☐	☐	☐

Urinary Tract

How often do you usually urinate during the day?

1-4 times ☐ 8-11 times ☐

5-7 times ☐ More than 11 times ☐

How many times do you get up during the night to urinate?

None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐ 5 or more

If you get up during the night to urinate, is this a problem for you?

Not a problem ☐ It's a problem ☐

Somewhat of a problem ☐ It's a very big problem ☐

Do you feel a sudden, compelling urge to urinate that is difficult to suppress?

Never ☐ Several times a week ☐

Monthly ☐ Daily ☐

<u>Over the past month</u>, how often have you had a sensation of not emptying your bladder completely after you finish urinating?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

<u>Over the past month</u>, how often have you had to urinate again less than 2 hours after you finished urinating?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

<u>Over the past month</u>, how often have you found you stopped and started again several times when you urinated?

Never ☐ 1 out of 3 times ☐ 2 av 3 ganger ☐

1 out of 5 times ☐ 1 av 2 ganger ☐ Nesten alltid ☐

<u>Over the last month</u>, how difficult have you found it to postpone urination?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

<u>Over the past month</u>, how often have you had a weak urinary stream?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

<u>Over the past month</u>, how often have you had to push or strain to begin urination?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

Do you unintentionally leak urine? Yes ☐ No ☐

(If No, skip to question about 93)

If Yes:

How often do you leak urine?

Less than once a month ☐ One or more times a week ☐

Several times a month ☐ Every day/night ☐

How much urine usually leaks each time?

Drops ☐ A small amount ☐ Quite a lot ☐

In which situations might you leak urine?

(You may X several answers)

When you cough, sneeze, lift something heavy ☐

When having a sudden urge to urinate ☐

Drops at end of or after urinating ☐

Drops all the time, independent of urinating ☐

How do you feel about having urinary incontinence?

Not a problem ☐ A great problem ☐

A slight problem ☐ A very great problem ☐

A moderate problem ☐

How old were you when you became incontinent? ☐ yrs old

Have you consulted a doctor Yes ☐ No ☐

because of urinary incontinence?

Additional Section Women 30-69

Menstruation, Birth Control and Pregnancy

Not including during pregnancy or post-natal period, have you ever not gotten a period for at least 6 months (premenopause)?
Yes ☐ No ☐

If Yes,
How many times? ☐ times

In total, how many times have you been pregnant? ☐ times

Have you ever tried for more than one year to become pregnant? **Yes** ☐ **No** ☐

If Yes,
How old were you the first time you tried to become pregnant? ☐ yrs old

	Yes	No
Have you ever received hormone treatment to become pregnant?	☐	☐
If Yes, **Have you received this treatment in the last 3 months?**	☐	☐

Do you use/take or have you used/taken:

	Now	Before, but not now	Never
Birth control pills	☐	☐	☐
Birth control patch	☐	☐	☐
Other hormone birth control *(injection, vaginal ring, implant, IUD/coil)*	☐	☐	☐

If you have taken birth control pills:
How old were you when you first began taking them? ☐ yrs old

How many years in total have you taken birth control pills?
Less than 1 yr ☐ 1-3 yrs ☐ 4-10 yrs ☐ Over 10 yrs ☐

Menopause

(If you are premenopausal, skip to 75)
Do you have/have you had hot flashes due to menopause?
During the day ☐ **During night** ☐ **Day and night** ☐ **Haven't had any** ☐

If you have had hot flashes, how would you describe them?
Very intense ☐ Moderately intense ☐ Hardly noticable ☐

Have you been to a doctor because of this? No ☐ Yes ☐

Have you ever taken/used medicine that contains oestrogen?	*Now*	*Previously*	*Never*
Tablets or patches *(prescribed by a doctor)*	☐	☐	☐
Creams or suppositories	☐	☐	☐

If you have taken/used prescription oestrogen:
How old were you when you began? ☐ yrs old

How old are/were you the last time you took/used it? ☐ yrs old

If you take/use or have taken/used oestrogen tablets or patches, why did you begin?
Alleviate menapausal symptoms ☐
Prevent osteoporosis ☐
Other ☐

If you have previously taken/used oestrogen tablets or patches, why did you stop?
No longer have/had symptoms ☐ Afraid of side effects ☐
Experienced bothersome side effects ☐ Other ☐

Operations/Radiation Therapy in the Lower Abdomen

Have you had both ovaries surgically removed?
No ☐ Yes ☐ Don't know ☐

If Yes,
How old were you then? ☐ yrs old

Have you had your womb surgically removed (hysterectomy)?
No ☐ Yes ☐ Don't know ☐

If Yes,
How old were you then? ☐ yrs old

Have you ever had radiation therapy in your pelvic region?
No ☐ Yes ☐ Don't know ☐

If Yes,
How old were you then? ☐ yrs old

Urinary Tract

How often do you usually urinate during the day?

1-4 times ☐ 8-11 times ☐

5-7 times ☐ over 11 times ☐

How many times do you get up during the night to urinate?

None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

If you get up during the night to urinate, is this a problem for you?

Not a problem ☐ It's a problem ☐

Somewhat of a problem ☐ It's a very big problem ☐

Do you feel a sudden, compelling urge to urinate that is difficult to suppress?

Never ☐ Several times a week ☐

Monthly ☐ Daily ☐

Do you unintentionally leak urine? Yes ☐ No ☐

If No, skip to question 84

If Yes:

How often do you leak urine?

Less than once a month ☐ One or more times a week ☐

One or more times a month ☐ Every day/night ☐

How much urine usually leaks each time?

Drops ☐ Small amount ☐ Quite a lot ☐

	Yes	No
Do you leak urine when you cough, sneeze, laugh or lift something heavy?	☐	☐
When you leak urine is it accompanied by a sudden and strong urge to urinate?	☐	☐

How do you feel about having urinary incontinence?

Not a problem ☐ A great problem ☐

A slight problem ☐ A very great problem ☐

A moderate problem ☐

How old were you when you became incontinent? ☐ yrs old

Have you consulted a doctor because of urinary incontinence? Yes ☐ No ☐

Have you ever been treated for urinary incontinence? *(Several Xs possible here)*

No, I have never had urinary incontinence ☐

No, I had urinary incontinence, but became better on its own ☐

Yes ☐

If Yes, what type of treatment?

Operation ☐ Medicine ☐

Pelvic floor exercises ☐ Other ☐

Bowel Movements

Have you had uncontrollable flatulence <u>in the last month</u>?

Never/seldom ☐ Weekly ☐ Daily ☐

Have you leaked stool (faecal incontinence) in the last month?

Never/seldom ☐ Weekly ☐ Daily ☐

If you answered Yes to one of the above questions, does faecal incontinence affect your daily life?

Never/seldom ☐ Weekly ☐ Daily ☐

Are you able to hold back the stool for 15 minutes after you first feel the urge to evacuate your bowels? Yes ☐ No ☐

Evaluating Your Job

Answer if you are or have been employed.

Respond to the following statements/questions about where you work.

There is a good collegiality at work.

Strongly agree ☐ Agree ☐

Disagree ☐ Strongly disagree ☐

My co-workers are there for me (support me).

Strongly agree ☐ Agree ☐

Disagree ☐ Strongly disagree ☐

I get along well with my co-workers.

Strongly agree ☐ Agree ☐

Disagree ☐ Strongly disagree ☐

Are you bullied/ harassed at work?

Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Does your job require you to work very fast?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Does your job require you to work very hard?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Does your job require too great a work effort?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Does your job require creativity?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Do you have the possibility to decide for yourself how to carry out your work?
Yes, often ☐ Yes, sometimes ☐
No, seldom ☐ No, could say never ☐

Do you have the possibility to decide for yourself what should be done in your work?
Yes, often ☐ Yes, sometimes ☐

Leg Pain

	Yes	No
Do you have ulcer(s) on your toes, foot ankle that will not heal?	☐	☐
Do you have pain in one or both legs when you walk?	☐	☐

If Yes,
Where does it hurt the most?
Foot ☐ Leg ☐ Thigh ☐ Hip ☐

	Yes	No
Does the pain go away if you stand still a while?	☐	☐
Do you have pain in your legs when you are resting?	☐	☐
If Yes: **Is the pain worse when you lay in bed?**	☐	☐
Do you have less pain if you have your legs lower, such as over the edge of the bed?	☐	☐
Have you had pain in your legs continuously for more than 14 days?	☐	☐
Have you taken pain relievers because of pain in your legs?	☐	☐

Vision

Do you have any of the following eye conditions?	Yes	No
Cataract	☐	☐
Glaucoma (raised eye pressure)	☐	☐
Age-Related Macular Degeneration (retinal calcification)	☐	☐

Memory

Do you have problems with your memory?
No, none ☐ Yes, some ☐ Yes, a lot ☐

Has your memory changed since you were younger?
No ☐ Yes, some ☐ Yes, a lot ☐

Do you have trouble remembering:	Never	Sometimes	Often
Things that happened a few minutes ago?	☐	☐	☐
Other peoples' names?	☐	☐	☐
Dates?	☐	☐	☐
To do something you have planned to do?	☐	☐	☐
Things that happened a few days ago?	☐	☐	☐
Things that happened years ago?	☐	☐	☐
Enough to be able to follow along in a conversation?	☐	☐	☐

Eating Disorders

Place a circle around the number that best describes your eating habits during the last month.

Are you satisfied with your eating habits?
Very satisfied 1 2 3 4 5 6 7 Very disatisfied

Have you eaten to comfort yourself or because you were unhappy?
Not at all 1 2 3 4 5 6 7 Every-day

Have you felt guilty about eating?

Not at all 1 2 3 4 5 6 7 Every-day

Have you felt that it was necessary for you to use a strict diet or other eating rituals to control your eating?

Not at all 1 2 3 4 5 6 7 Every-day

Have you felt that you are too fat?

Not at all 1 2 3 4 5 6 7 Every-day

Additional Section Men 70+

Leg Pain

	Yes	No
Do you have ulcer(s) on your toes, foot ankle that will not heal?	☐	☐
Do you have pain in one or both legs when you walk?	☐	☐

If Yes,
Where does it hurt the most?
Foot ☐ Leg ☐ Thigh ☐ Hip ☐

	Yes	No
Does the pain go away if you stand still a while?	☐	☐
Do you have pain in your legs when you are resting?	☐	☐
If Yes: **Is the pain worse when you lay in bed?**	☐	☐
Do you have less pain if you have your legs lower, such as over the edge of the bed?	☐	☐
Have you had pain in your legs continuously for more than 14 days?	☐	☐
Have you taken pain relievers because of pain in your legs?	☐	☐

Activities of Daily Life

Can you do the following daily tasks without the help of others?

	Yes	No
Walk around indoors on the same floor	☐	☐
Go to the toilet	☐	☐
Wash yourself	☐	☐
Take a bath or shower	☐	☐
Dress and undress yourself	☐	☐
Go to bed and get up	☐	☐
Eat	☐	☐

Other Daily Tasks

Do you have a driver's licence? Yes ☐ No ☐

If Yes,
Do you still drive a car? Yes ☐ No ☐

Can you do the following daily tasks without the help of others?

	Yes	No
Prepare warm meals	☐	☐
Do light housework (ex: wash dishes)	☐	☐
Do heavier housework (ex: wash floors)	☐	☐
Wash clothes	☐	☐
Do the shopping	☐	☐
Pay bills	☐	☐
Take medicines	☐	☐
Go out	☐	☐
Take the bus	☐	☐

Memory

Do you have problems with your memory?
No, none ☐ Yes, some ☐ Yes, a lot ☐

Has your memory changed since you were younger?
No ☐ Yes, some ☐ Yes, a lot ☐

Do you have trouble remembering:	Never	Sometimes	Often
Things that happened a few minutes ago?	☐	☐	☐
Other peoples' names?	☐	☐	☐
Dates?	☐	☐	☐
To do something you have planned to do?	☐	☐	☐
Things that happened a few days ago?	☐	☐	☐
Things that happened years ago?	☐	☐	☐
Enough to be able to follow along in a conversation?	☐	☐	☐

Falls

Have you fallen and hurt yourself in the last year? No ☐ Yes ☐

If Yes,
Where did it happen? Indoors ☐ Outdoors ☐

	Yes	No
Have you been to a doctor in the last year because of an injury caused by a fall?	☐	☐
Have you been admitted to hospital in the last year because of an injury	☐	☐

caused by a fall?

Have you fallen in the last 3 months? ☐ ☐

Do you have problems with your balance? ☐ ☐

Use of Health Services

	Yes	No
Have you had home care help in the last 12 months?	☐	☐
If Yes, **Do you have enough home care help?**	☐	☐
Have you received home nursing care in the last 12 months?	☐	☐
If Yes, **Do you receive enough home nursing care?**	☐	☐
Have you been admitted to a nursing home in the last 12 months?		

Vision

Do you have any of the following eye conditions?	Yes	No
Cataract	☐	☐
Glaucoma (raised eye pressure)	☐	☐
Age-Related Macular Degeneration (retinal calcification)	☐	☐

Urinary Tract

How often do you usually urinate during the day?

1-4 times ☐ 8-11 times ☐

5-7 times ☐ More than 11 times ☐

How many times do you get up during the night to urinate?

None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

If you get up during the night to urinate, is this a problem for you?

Not a problem ☐ It's a problem ☐

Somewhat of a problem ☐ It's a very big problem ☐

Do you feel a sudden, compelling urge to urinate that is difficult to suppress?

Never ☐ Several times a week ☐

Monthly ☐ Daily ☐

Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

Over the past month, how often have you found you stopped and started again several times when you urinated?

Never ☐ 1 out of 3 times ☐ 2 av 3 ganger ☐

1 out of 5 times ☐ 1 av 2 ganger ☐ Nesten alltid ☐

Over the last month, how difficult have you found it to postpone urination?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

Over the past month, how often have you had a weak urinary stream?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

Over the past month, how often have you had to push or strain to begin urination?

Never ☐ 1 out of 3 times ☐ 2 out of 3 times ☐

1 out of 5 times ☐ 1 out of 2 times ☐ Almost always ☐

Do you unintentionally leak urine? Yes ☐ No ☐

If No, skip to question about 89

If Yes:

How often do you leak urine?

Less than once a month ☐ One or more times a week ☐

Several times a month ☐ Every day/night ☐

How much urine usually leaks each time?

Drops ☐ Small amounts ☐ Quite a lot ☐

In which situations might you leak urine?

(You may X several answers)

When you cough, sneeze, lift something heavy ☐

When having a sudden urge to urinate ☐

Drops at end of or after urinating ☐

Drops all the time, independent of urinating ☐

How do you feel about having urinary incontinence?

Not a problem ☐

A slight problem ☐

A moderate problem ☐

A great problem ☐

A very great problem ☐

How old were you when you became incontinent? ☐ yrs old

Have you consulted a doctor because of urinary incontinence? Yes ☐ No ☐

Additional Section Women 70+

Pregnancy, Children and Hormone Therapy

In total, how many times have you been pregnant? ☐ times

Have you ever tried for <u>more than one year</u> to become pregnant? Yes ☐ No ☐

If Yes,
How old were you the first time you had problems becoming pregnant? ☐ yrs old

Do you have/have you had hot flashes due to menopause?
During the day ☐ **During night** ☐ **Day and night** ☐ **Haven't had any** ☐

If you have had hot flashes, how would you describe them?
Very intense ☐ Moderately intense ☐ Hardly noticable ☐

Have you been to a doctor because of this? No ☐ Yes ☐

Have you ever taken/used medicine that contains oestrogen?	*Now*	*Previously*	*Never*
Tablets or patches *(prescribed by a doctor)*	☐	☐	☐
Cream or suppositories	☐	☐	☐

If you have taken/used prescription oestrogen:
How old were you when you began? ☐ yrs old

How old are/were you the last time you took/used it? ☐ yrs old

If you take/use or have taken/used oestrogen tablets or patches, why did you begin?
Alleviate menapausal symptoms ☐
Prevent osteoporosis ☐
Other ☐

If you have previously taken/used oestrogen tablets or patches, why did you stop?
No longer have/had symptoms ☐ Afraid of side effects ☐
Experienced bothersome side effects ☐ Other ☐

Operations/Radiation Therapy in the Lower Abdomen

Have you had both ovaries surgically removed?
No ☐ Yes ☐ Don't know ☐

If Yes,
How old were you then? ☐ yrs old

Have you had your womb surgically removed (hysterectomy)?
No ☐ Yes ☐ Don't know ☐

If Yes,
How old were you then? ☐ yrs old

Have you ever had radiation therapy in your pelvic region?
No ☐ Yes ☐ Don't know ☐

If Yes,
How old were you then? ☐ yrs old

Urinary Tract

How often do you usually urinate during the day?
1-4 times ☐ 8-11 times ☐
5-7 times ☐ over 11 times ☐

How many times do you get up during the night to urinate?
None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

If you get up during the night to urinate, is this a problem for you?
Not a problem ☐ It's a problem ☐
Somewhat of a problem ☐ It's a very big problem ☐

Do you feel a sudden, compelling urge to urinate that is difficult to suppress?
Never ☐ Several times a week ☐
Monthly ☐ Daily ☐

Do you unintentionally leak urine? Yes ☐ No ☐

If No, skip to question 79
If Yes:
How often do you leak urine?
Less than once a month ☐ One or more times a week ☐

One or more times a month ☐ Every day/night ☐

How much urine usually leaks each time?
Drops ☐ Small amount ☐ Quite a lot ☐

	Yes	No
Do you leak urine when you cough, sneeze, laugh or lift something heavy?	☐	☐
When you leak urine is it accompanied by a sudden and strong urge to urinate?	☐	☐

How do you feel about having urinary incontinence?
Not a problem ☐ A great problem ☐
A slight problem ☐ A very great problem ☐
A moderate problem ☐

How old were you when you became incontinent? ☐ yrs old
Have you consulted a doctor because of urinary incontinence? Yes ☐ No ☐

Have you ever been treated for urinary incontinence? *(Several Xs possible here)*
No, I have never had urinary incontinence ☐
No, I had urinary incontinence, but became better on its own ☐
Yes ☐

If Yes, what type of treatment?
Operation ☐ Medicine ☐
Pelvic floor exercises ☐ Other ☐

Bowel Movements

Have you had uncontrollable flatulence <u>in the last month</u>?
Never/seldom ☐ Weekly ☐ Daily ☐

Have you leaked stool (faecal incontinence) in the last month?
Never/seldom ☐ Weekly ☐ Daily ☐

If you answered Yes to one of the above questions, does faecal incontinence affect your daily life?
Never/seldom ☐ Weekly ☐ Daily ☐

Are you able to hold back the stool for 15 minutes after you first feel the urge to evacuate your bowels? Yes ☐ No ☐

Leg Pain

	Yes	No
Do you have ulcer(s) on your toes, foot ankle that will not heal?	☐	☐
Do you have pain in one or both legs when you walk?	☐	☐

If Yes,
Where does it hurt the most?
Foot ☐ Leg ☐ Thigh ☐ Hip ☐

	Yes	No
Does the pain go away if you stand still a while?	☐	☐
Do you have pain in your legs when you are resting?	☐	☐
If Yes: **Is the pain worse when you lay in bed?**	☐	☐
Do you have less pain if you have your legs lower, such as over the edge of the bed?	☐	☐
Have you had pain in your legs continuously for <u>more than 14 days</u>?	☐	☐
Have you taken pain relievers because of pain in your legs?	☐	☐

Activities of Daily Life

Can you do the following daily tasks without the help of others?

	Yes	No
Walk around indoors on the same floor	☐	☐
Go to the toilet	☐	☐
Wash yourself	☐	☐
Take a bath or shower	☐	☐
Dress and undress yourself	☐	☐
Go to bed and get up	☐	☐
Eat	☐	☐

Other Daily Tasks

Do you have a driver's licence? Yes ☐ No ☐
If Yes,
Do you still drive? Yes ☐ No ☐

Can you do the following daily tasks without the help of others?
Yes No

Prepare warm meals	☐	☐
Do light housework (ex: wash dishes)	☐	☐
Do heavier housework (ex: wash floors)	☐	☐
Wash clothes	☐	☐
Do the shopping	☐	☐
Pay bills	☐	☐
Take medicines	☐	☐
Go out	☐	☐
Take the bus	☐	☐

Memory

Do you have problems with your memory?
No, none ☐ Yes, some ☐ Yes, a lot ☐

Has your memory changed since you were younger?
No ☐ Yes, some ☐ Yes, a lot ☐

Do you have trouble remembering:	Never	Sometimes	Often
Things that happened a few minutes ago?	☐	☐	☐
Other peoples' names?	☐	☐	☐
Dates?	☐	☐	☐
To do something you have planned to do?	☐	☐	☐
Things that happened a few days ago?	☐	☐	☐
Things that happened years ago?	☐	☐	☐
Enough to be able to follow along in a conversation?	☐	☐	☐

Falls

Have you fallen and hurt yourself in the last year? No ☐ Yes ☐

If Yes, Where did it happen? Indoors ☐ Outdoors ☐

	Yes	No
Have you been to a doctor <u>in the last year</u> because of an injury caused by a fall?	☐	☐
Have you been admitted to hospital <u>in the last year</u> because of an injury caused by a fall?	☐	☐
Have you fallen <u>in the last 3 months</u>?	☐	☐
Do you have problems with your balance?	☐	☐

Use of Health Services

	Yes	No
Have you had home care help <u>in the last 12 months</u>?	☐	☐
***If Yes,* Do you have enough home care help?**	☐	☐
Have you received home nursing care <u>in the last 12 months</u>?	☐	☐
***If Yes,* Do you receive enough home nursing care?**	☐	☐
Have you been admitted to a nursing home <u>in the last 12 months</u>?		

Vision

Do you have any of the following eye conditions?	Yes	No
Cataract	☐	☐
Glaucoma (raised eye pressure)	☐	☐
Age-Related Macular Degeneration (retinal calcification)	☐	☐