HUNT 2 Questionnaire 2

Women aged 20-69 years

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Thank you for taking part in this study!
We ask that you complete this questionnaire as well. The information will be used in research for preventive health care. Some of the questions are similar to questions you answered on the questionnaire that you completed at home and took with you when you attended the health examination. It is important that you answer all the questions on this questionnaire. The completed questionnaire should be returned in the enclosed pre-stamped envelope.
All information will be treated in strict confidence.

Yours sincerely,
Health Services in Nord-Trøndelag
The Norwegian Institute of Public Health
The National Health Screening Service

If you do not wish to answer the questionnaire, put an X here and return the form. As a result, you will not receive a reminder.

COMPLETION

Date of completion of the questionnaire: ___/___ 19___

GROWING UP

What town did you living in when you were 1 year old?
If you were not living in Norway, give the **country** instead of the town.

EMPLOYMENT

Present or previous work

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.)(Two answer columns: you and your spouse/partner)
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
Have not been gainfully employed

If your spouse/partner is or has been gainfully employed, please specify which occupational category his/her work falls under. (If not currently employed, give last occupation.)
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
Have not been gainfully employed

If you are not CURRENTLY gainfully employed or you do not do full-time housework, then go to HOUSING.

During the last 12 months, have you been on sick leave: <yes, no>
without a medical certificate
with a medical certificate

If YES: **How long altogether?**
One X only
2 weeks or less
2-8 weeks
More than 8 weeks

During the last 12 months, have you considered changing your career or job? <yes, no>

Is your work so physically demanding that you are often physically worn out after a day's work? *One X only*
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
Not much
Not at all

HOUSING

Who do you live with?
One X for each line and write in the number
Spouse/partner <yes, no>
Other people over the age of 18 <yes, no> Number ____
People below the age of 18 <yes, no> Number ____

How many of the children attend day care? Number ____

What type of housing do you live in? *One X only*
Single-family house/villa
Farm
Flat in block or terraced block of flats
Terraced house/2-4 family housing
Other accommodations

How large is your home? <Square metres ____>
Are there fitted carpets in the living room? <yes, no>
Are there fitted carpets in your bedroom? <yes, no>
Is there a cat in the home? <yes, no>
Is there a dog in the home <yes, no>
Are there other animals with fur or birds in the home? <yes, no>

FINANCES

Do you receive any of the following public welfare benefits? <yes, no>
Sick pay/rehabilitation benefits
Retraining benefits
Disability pension
Retirement/old age pension
Family income supplement
Unemployment benefits
Transitional benefits
Widow's pension
Other benefits

During the last year, has it at any time been difficult to meet the costs of food, transportation, housing and such? *One X only*
Yes, often
Yes, now and again
Yes, though seldom
No, never

FRIENDS

How many good friends do you have? Number ____
Count those with whom you can confidentially talk and who can help you when you are in need.
Do not include those with whom you live, but include other relatives.

Do you feel that you have enough good friends? <yes, no>

How often do you usually participate in social activities such as a sewing club, athletic club, political association, religious or other groups?
Never, or only a few times a year
1-2 times a month
About once a week
More than once a week

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WHERE YOU LIVE

Answer with regard to your environment, i.e. neighbourhood/group of farms. *One X for each statement*
<Strongly agree, Somewhat agree, Not sure, Somewhat disagree, Strongly disagree>
I feel a strong sense of community with the people who live here
Even if someone takes the initiative, no one participates in the things going on here
If I move from here, I will want to return
We do not trust each other here
If something has to be done here, it is easy to get people involved
It is difficult to get to know people here
There is a sense of unity here
Nobody bothers to take initiative here anymore
People like living here
People here can have major problems without the neighbours knowing anything about it
Somebody always takes the initiative to do what needs to be done here
People here don't talk much to each other

ILLNESS IN THE FAMILY

Put an X for the relatives who have or have had any of the following illnesses. If none of your relatives has had a particular disease, put an X in the box for Nobody on that line. (Possibly several Xs on each line)
<Mother, Father, Brother, Sister, Child, Nobody>
Stroke or cerebral haemorrhage
Heart attack before the age of 60
Asthma
Allergy
Cancer
High blood pressure
Mental health problems
Osteoporosis
Diabetes
Age when he/she got diabetes Years old ____

Do you have hay fever or nasal allergies? <yes, no>

USE OF HEALTH SERVICES

During the last 12 months, have you visited any of the following: <yes, no>
One X for each line
General practitioner (community doctor, private doctor, intern)
Company physician
Doctor at hospital (without being hospitalized)
Another doctor
Physiotherapist
Chiropractor
Homoeopath
Other treatment provider (naturopath, reflexologist, laying on of hands, healer, psychic, etc.)

Have you been hospitalized during the last 5 years? <yes, no>

ALCOHOL

If you are a non-drinker, go to DIET
One X for each question

Have you ever felt that you should reduce your alcohol intake? <yes, no>

Have other people ever criticised your use of alcohol? <yes, no>

Have you ever felt bad or guilty because of your use of alcohol? <yes, no>

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? <yes, no>

DIET

How many meals do you usually eat a day (dinner and meals with bread)? Number ____

How many days a week do you have a warm dinner? Number ____

What kind of bread (bought or homemade) do you usually eat? *No more than two Xs*
The bread type is most like… <White, White multigrain (finely ground), Wholemeal (medium ground), Multigrain wholemeal (coarsely ground), Crispbread>

What kind of fat is usually used in your household?
One X for cooking and one X for bread < For cooking, On bread>
Do not use butter or margarine
Dairy butter
Hard margarine
Soft margarine
Butter/margarine blend
Low fat margarine
Oils

USE OF MEDICINE

During the last 12 months, have you taken any medicines daily or almost daily? <yes, no>

If YES,
Indicate for how many months you used the following medicines:
Write 0 if you have not used these medicines. No. of months ____
Analgesics (pain relief medicine)
Sleep medicine
Sedatives
Medicine for depression
Allergy medicine
Asthma medicine
Heart medicine (not blood pressure medicine)
Other medicine
Dietary supplements:
Iron tablets
Vitamin supplements
Cod liver oil/fish oil

How often have you taken tranquilizers/sedatives or sleep medication in the last month?
Daily
Weekly, but not every day
Not as often as every week
Never

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HEADACHES

Have you had headaches in the last 12 months?
Yes, in attacks (migraines)
Yes, other types of headaches
No
Number of headaches in the last 12 months ____

If NO, go to MUSCULOSKELETAL CONDITIONS

About how many days per month do you have a headache?
Less than 7 days
7 to 14 days
More than 14 days

How long do the headaches last each time?
Less than 4 hours
4 hours - 3 days
More than 3 days

How often is the headache characterised by or accompanied by:
One X for each line <Seldom or never, Now and again, Often>
Throbbing, thumping pain
Pressing pain
Pain on one side of the head, always the same side
Pain on one side of the head, alternating left and right sides
Pain in entire head
Nausea
Hypersensitivity to light and/or noise
Worsening with physical activity
Visual disturbance before onset of headache

How many tablets/suppositories of these medicines have you used altogether in the last month?
Put 0 of you have not used any of these medicines
Cafergot
Anervan
Imigran

MUSCULOSKELETAL CONDITIONS

Have you had discomfort (pain, aching) in your muscles/limbs in the last month? <yes, no>

If YES,
Where did you have the discomfort (one or more Xs) **and for about how many days altogether were you troubled?** Number of days ____
Discomfort/pain (put an X):
Neck
Shoulders/upper arms
Upper back
Elbows
Lower back
Wrists/hands
Hips
Knees

Ankles/feet

If there are several Xs, put a **ring** around the X for **the area that bothered you the most.**

Did the discomfort (pain, aching) hinder you in carrying out your everyday activities in the last month? <yes, no>
At work
During leisure time

VISION *1st version sent out had VISION section instead of LEG PAIN section*

Have you ever had any of the following eye conditions? <Yes, No, Don't know>
Cataract
Glaucoma (raised eye pressure)

Do you wear glasses? <yes, no>

Do you wear contact lenses? <yes, no>

Are you able to read small print (such as this text): <yes, no>
without glasses/contact lenses/magnifying glass
with glasses/contact lenses/magnifying glass

Are you able to see quite far: <Yes, No, Don't know>
without glasses/contact lenses
with glasses/contact lenses

If you wear glasses or contact lenses, is this because:
Shortsightedness/myopia (minus glasses)
Farsightedness/hyperopia (plus glasses)
Old age (reading glasses)

How old were you the first time that you were prescribed glasses or contact lenses? Years old ____

LEG PAIN ***2ND version sent out had LEG PAIN section instead of VISION***

Do you have ulcer(s) on your toes, foot or ankle that will not heal? <yes, no>

Do you have pain in one or both legs when you walk? <yes, no>

Have you seen a doctor because of pain in your legs? <yes, no>

If you answered NO to the above questions, then skip to MENSTRUATION

Can you walk further than 50 metres? <yes, no>

Does the pain go away if you stand still a while? <yes, no>

Do you have to sit down so that the pain passes? <yes, no>

Where does it hurt the most?
Foot
Leg
Thigh
Hip

Do you have pain in your legs when you are resting? <yes, no>

Is the pain worse when you lay in bed? <yes, no>

Is your sleep disturbed because of the pain? <yes, no>

Do you have less pain when you elevate your legs? <yes, no>

Do you have less pain if you have your legs lower, such as over the edge of the bed? <yes, no>

Does it lessen the pain if you get up and walk a little? <yes, no>

MENSTRUATION

Do you still menstruate? <yes, no>

If NO,
How old were you when you stopped menstruating? Years old ____

Are you pregnant at the moment? <Yes, No, Don't know>

Do you use an IUD (coil, loop) now? <yes, no>

When did you last menstruate? <Day, Month, Year>
If you don't remember the day, just write the month and year.
If you only remember the year, write the year.

Your menstruation cycle in the last 12 months
Have your periods been regular during the last year? <Yes, No, Unsure>
Regular means the periods lasted about as long each time with about the same time between them.

How many days did your period last the last time you had your period? Number of days ____

How many days did you not bleed between your last period and the one before that? Number of days ____

Have your periods stopped for more than 3 months during the last year without you being pregnant? <yes, no>

If YES,
For how many months in a row did you not get your period? Number of months ____

If YES,
Did you consult a doctor? <yes, no>

Previous menstruation cycles (i.e. before the last 12 months)
Did your periods ever stop without you being pregnant? <yes, no>

If YES,
For how long and how many times did this happen? *Put an X for several answers if applicable.*
<Once, Twice, More often>
3-6 months
6-12 months
More than a year

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OPERATIONS IN THE LOWER ABDOMEN

Have you ever had lower abdominal surgery? <Yes, No, Don't know>

If YES,
place an X **for each operation**: <Yes, No, Don't know>
Removal of part of or only one ovary
Removal of both ovaries

If you had both ovaries removed, how old were you at the time of the surgery? Years old ____

Operation for endometriosis <Yes, No, Don't know>
Tubal ligation (tubes tied) <Yes, No, Don't know>
D&C (in hospital) <Yes, No, Don't know>
Removal of the womb (hysterectomy) <Yes, No, Don't know>

If you had a hysterectomy, how old were you at the time of the surgery? Years old ____

CONTRACEPTIVE PILLS

Have you ever used contraceptive pills, including mini-pills? <yes, no>

If YES,
How old were you the first time you took contraceptive pills? Years old ____

For how long did you take contraceptive pills altogether? Years ____
If less than 1 year, number of months Months ____

Are you still taking contraceptive pills? <yes, no>

Which brand do you take? _____

HORMONE TREATMENT

Not including contraceptive pills
Have you ever taken medicines that contain oestrogen? Common names of such medicines are Cyclabil, Estraderm, Kliogest, Oversterin, Progynova, Trisekvens
Tablets or patches <Now, Previously, Never>
Cream or suppositories <Now, Previously, Never>

If YES,
How old were you the first time that you were prescribed oestrogen, and for about how many years did you use oestrogen?
(Your age/Number of years)

Tablets or patches <Now, Previously, Never>
Cream or suppositories <Now, Previously, Never>

If you are currently using oestrogen, what is the name of the product? _____

PROBLEMS BECOMING PREGNANT

Have you ever tried for more than a year to become pregnant? <yes, no>

If YES,
How old were you the first time you tried to become pregnant? Years old ____

Have you ever consulted a doctor because you had problems becoming pregnant? <yes, no>

PREGNANCY, BIRTHS AND BREASTFEEDING

How many times altogether have you been pregnant?
*Include **all** pregnancies: miscarriages and abortions as well as births (including stillbirths) Times* ____

How many children have you had? No. of children ____

Fill in below for each child (the first 7) information on year of birth, the approximate number of months you breastfed each child and the number of months you did not menstruate after the birth (also write this information for stillbirths and for children who died later in life)

Child	Year of birth	Number of months breastfed	Number of months without a period
1			
2			
3			
4			
5			
6			
7			

URINARY INCONTINENCE

Do you unintentionally leak urine at least twice a month? <yes, no>

If NO, go to CALCIUM INTAKE AND DIETARY SUPPLEMENTS

How often do you leak urine?
Less than once a month
One or more times a month
One or more times a week
Everyday and/or night

How much urine usually leaks each time?
Drops or not much
Small amount
Quite a lot

Do you leak urine when you cough, sneeze, laugh or lift something heavy? <yes, no>

When you leak urine is it accompanied by a sudden and strong urge to urinate? <yes, no>

Have you consulted a doctor because of urinary incontinence? <yes, no>

How do you feel about having urinary incontinence? *One X only*
Not a problem
A slight problem
A moderate problem
A great problem
A very great problem

CALCIUM INTAKE AND DIETARY SUPPLEMENTS

How many glasses of milk (all kinds, including drinking yoghurt) do you usually drink daily? *One X only*
None
Less than one
1-2 glasses
3 or more

How many slices of bread with white cheese do you usually eat daily? *One X only*
None
Less than one
1-2 slices
3 or more

Do you usually take these dietary supplements? <yes, no>
Vitamin D supplement
Calcium tablets or bone meal

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MOOD AND WELLBEING

One X for each line

How you have felt in the last month?
<Never, Sometimes, Quite often, Mostly>
in a good mood
in a bad mood

Are you quick to understand that something is funny?
Very slow
Quite slow
Quite quick
Very quick

Do you agree that there is something irresponsible about people who constantly try to be funny?
No, not at all
To some extent
Quite agree

Yes, absolutely

Are you a cheerful person?
No, not at all
To some extent
Quite cheerful
Yes, absolutely

TEMPER

Put an X by the answer that best describes you in regards to the two statements below:

I express my anger, and other people know that I am angry.
Almost never
Sometimes
Quite often
Almost always

I boil with anger, but I don't show it to others.
Almost never
Sometimes
Quite often
Almost always

REST AND RELAXATION

How many hours do you usually spend lying down during a 24 hour period?

Night-time sleep, Number of hours ____

Afternoon rest, Number of hours ____

How many hours do you usually spend sitting down during a 24 hour period?
Work, mealtimes, TV, car, etc., Number of hours ____

How often do you suffer from insomnia?
Never or a few times a year
1-2 times a month
About once a week
More than once a week

During the last year, have you been troubled by insomnia to such a degree that it affected your work? <yes, no>

Have you had difficulty falling asleep in the last month? *One X only*
Almost every night
Often
Now and again
Never

During the last month, have you woken too early and not been able to get back to sleep? *One X only*
Almost every night
Often
Now and again

Never

During the last month, have you felt nervous (irritable, anxious, tense or restless)**?**
Almost all the time
Often
Now and again
Never

HOW YOU FELT

During your life, have there been periods of 2 consecutive weeks or more when you: <yes, no>
Felt depressed, sad and down
Had appetite problems or ate too little
Felt weak (adynamic) or lacked extra energy
Really reproached yourself and felt worthless
Had problems concentrating or had difficulty making decisions
Had at least three of the above mentioned problems simultaneously

HOW YOU SEE YOURSELF

People see themselves in different ways. For each statement, put an X to indicate how much or how little you agree with it. *One X for each line*
<Strongly agree, Agree, Disagree, Strongly disagree>
I have a positive opinion of myself.
I feel really useless at times.
I feel that I do not have much to be proud of.
I feel that I am a valuable person, at least equal to others.

Do you feel that you have a meaningful life? <yes, no>

Do you feel that you live life to its fullest? <yes, no>

HOW YOU FEEL

Put an X in the square by the answer that best describes your feelings **last week**. *One X only*

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

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

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

Place the completed questionnaire in the enclosed reply envelope and post it as soon as possible!
The postage is paid.

Many thanks for your help!