ADDITIONAL QUESTIONS TO THE TROMSØ HEALTH SURVEY 1986-87.

Cardiovascular heart and circulatory diseases, on which the surveys of the 1974 and 1979-80 focused, are a very varied category of diseases whose causes are still partly unknown. In Tromsø we are therefore trying to obtain a more complete description of factors which may be important for the course of these diseases, such as diet, psychological pressure, "stress", social conditions and the occurrence of disease in relatives. Such a description is also important in the search of factors that contribute to cancer, a group of diseases which also we try to combat in the coming years.

When you were called in, you received a questionnaire which you handed in at the survey. The present questionnaire asks for further information about your health and includes questions on various diseases and physical and psychological complaints. We have included questions on pregnancy, birth and menstruation.

In addition, we are interested in obtaining information on the public use of medical health services in order to find out how to improve the health service.

We hope that you will take the trouble to fill in yet another questionnaire and return it to "Tromsø Board of Health" in the enclosed envelope. All information will be treated with strict confidentiality If you have any comments regarding the survey, you may write them down in the space provided on the last page of the questionnaire.

Yours sincerely

Tromsø Board of Health

Department of medicine
University of Tromsø

GENERAL STATE OF HEALTH

How is your health?
Tick the box where "Yes" is appropriate.

		Yes
Very bad	12	☐ 1
Bad		☐ 2
Neither good nor bad, "middling"		☐ 3
Good		☐ 4
Excellent		☐ 5

ILLNESSES

Do you have, or have you had:
Tick "Yes" or "No" for each question.

		Yes	No
The skin disease psoriasis	13	☐	☐
Asthma	14	☐	☐
Allergic eczema	15	☐	☐
Hay fever	16	☐	☐
Chronic bronchitis	17	☐	☐
Gastric ulcer	18	☐	☐
Duodenal ulcer	19	☐	☐
Your appendix removed	20	☐	☐
An operation for a stomach ulcer	21	☐	☐
Chronic rheumatoid arthritis	22	☐	☐
Cancer	23	☐	☐
Epilepsy	24	☐	☐
Migraine	25	☐	☐

INFECTIONS

		Number / Yes	No
How many times in the last 6 months have you had infections like a cold, influenza (flu) diarrhoea/vomiting, or similar illnesses?	26	☐	
Have you had one of these infections in the past 14 days?	27	☐	☐

ILLNESSES IN PARENTS OR SIBLINGS

Tick for the relatives who have or have ever had any of the following illnesses:

		mother	father	brother	Sister
Cerebral stroke or brain haemorrhage	28	☐	☐	☐	☐
Diabetes	32	☐	☐	☐	☐
Rheumatoid arthritis	36	☐	☐	☐	☐
Cancer	40	☐	☐	☐	☐
Psoriasis	44	☐	☐	☐	☐
Gastric or duodenal ulcer	48	☐	☐	☐	☐
Asthma	52	☐	☐	☐	☐

		Yes	No
Tick if none of the relatives have or have had any of those illnesses	56	☐	☐

MEDICINES

		Yes	No
Have you during the last year used tablets/sprays or had injections for asthma or allergies?	60	☐	☐

Have you used any of the following medicines in the past 14 days?

		Yes	No
Painkillers	61	☐	☐
Antipyretic drugs (to reduce fever)	62	☐	☐
Eczema ointment	63	☐	☐
Blood pressure medicines	64	☐	☐
Heart medicines	65	☐	☐
Sleeping pills	66	☐	☐
Nerve tablets	67	☐	☐
Migraine drugs	68	☐	☐
Epilepsy drugs	69	☐	☐
Other medicines	70	☐	☐

CONTACT DUE TO OWN HEALTH OR ILLNESS

How many visits have you made during the past year due to your own health or illness?

Number of visits

- To a GP (general practitioner) ..... 71 ☐
- To a specialist (not hospital) ..... 72 ☐
- Emergency GP ..... 85 ☐
- Medical officer at work ..... 87 ☐
- Physiotherapist ..... 89 ☐
- Chiropractor ..... 81 ☐
- Alternative practitioner (homoeopath, foot zone therapist, etc.) .. 83 ☐
- Hospital outpatient department ..... 85 ☐

Number of hospital admissions in the past year . 87 ☐

DIET

How many slices of bread do you usually eat daily?
Tick the box where "Yes" is appropriate.

Yes

- Less than 2 slices ..... 88 ☐ 1
- 2 - 4 slices ..... ☐ 2
- 5 – 6 slices ..... ☐ 3
- 7 – 12 slices ..... ☐ 4
- 13 or more slices ..... ☐ 5

What type of milk do you usually drink?
Tick the box where "Yes" is appropriate.

Yes

- Do not drink milk ..... 89 ☐ 1
- Full cream milk (ordinary or curdled) ..... ☐ 2
- Semi-skimmed milk ..... ☐ 3
- Skimmed milk (ordinary or curdled) ..... ☐ 4

How many glasses/cups of milk do you usually drink daily?

Yes

- Less than 1 glass/cup ..... 90 ☐ 1
- 1 – 2 glasses/cups ..... ☐ 2
- 3 – 4 glasses/cups ..... ☐ 3
- 5 or more glasses/cups ..... ☐ 4

FISH

How often do you eat cod/pollock or other lean fish for dinner or in a sandwich?
Tick the box where "Yes" is appropriate.

Yes

- Less than once a week ..... 91 ☐ 1
- Once a week ..... ☐ 2
- Twice a week ..... ☐ 3
- 3 or more times a week ..... ☐ 4

How often do you eat fatty fish such as herring, halibut, red fish, mackerel, salmon or trout for dinner or in a sandwich?
Tick the box where "Yes" is appropriate.

Yes

- Less than once a week ..... 92 ☐ 1
- Once a week ..... ☐ 2
- Twice a week ..... ☐ 3
- 3 or more times a week ..... ☐ 4

Do you take cod liver oil regularly?
Tick the box where "Yes" is appropriate.

Yes

- No ..... 93 ☐ 1
- During polar night ..... ☐ 2
- All year ..... ☐ 3

BREAKFAST

Yes No

Do you usually eat breakfast daily? ..... 94 ☐ ☐

DINNER

How often do you eat meat for dinner?
Tick the box where "Yes" is appropriate.

Yes

- Less than once a week ..... 95 ☐ 1
- Once or twice a week ..... ☐ 2
- 3 – 4 times a week ..... ☐ 3
- 5 or more times a week ..... ☐ 4

How often do you use fat like butter, margarine, mayonnaise, etc. with your dinner?
Tick the box where "Yes" is appropriate.

Yes

- Less than once a week ..... 96 ☐ 1
- Once or twice a week ..... ☐ 2
- 3 – 4 times a week ..... ☐ 3
- 5 or more times a week ..... ☐ 4

Yes No

Do you usually eat vegetables with your dinner? ..... 97 ☐ ☐

FRUIT

How often do you usually eat fruit?
Tick the box where "Yes" is appropriate.

Yes

- Less than once a week ..... 98 ☐ 1
- About once a week ..... ☐ 2
- 2 – 3 times a week ..... ☐ 3
- 4 – 5 times a week ..... ☐ 4
- More or less ..... ☐ 5

ALCOHOL

Yes No

Are you a teetotaller? ☐ ☐

If not,
- How often do you usually drink beer?
Tick the box where "Yes" is appropriate.

Yes

- Never or just a few times a year ..... 100 ☐ 1
- 1 – 2 times a month ..... ☐ 2
- About once a week ..... ☐ 3
- 2 – 3 times a week ..... ☐ 4
- More or less daily ..... ☐ 5

How often do you usually drink wine?
Tick the box where "Yes" is appropriate.

Yes

- Never or just a few times a year ..... 101 ☐ 1
- 1 – 2 times a month ..... ☐ 2
- About once a week ..... ☐ 3
- 2 – 3 times a week ..... ☐ 4
- More or less daily ..... ☐ 5

- How often do you usually drink spirits?
Tick the box where "Yes" is appropriate.

Yes

- Never or just a few times a year ..... 102 ☐ 1
- 1 – 2 times a month ..... ☐ 2
- About once a week ..... ☐ 3
- 2 – 3 times a week ..... ☐ 4
- More or less daily ..... ☐ 5

Approximately how often have you during the last year consumed alcohol corresponding to at least 5 small bottles of beer, a bottle of wine, or 1/4 bottle of spirits?
Tick the box where "Yes" is appropriate.

Yes

- Not at all the past year ..... 103 ☐ 1
- A few times ..... ☐ 2
- Once or twice a month ..... ☐ 3
- 3 or more times a week ..... ☐ 4

PHYSICAL ACTIVITY

How often do you take part in physical activity lasting at least 20 minutes, which makes you perspire or become breathless?
Tick the box where "Yes" is appropriate.

		Yes
Rarely or never	104	☐ 1
Weekly		☐ 2
Several times a week		☐ 3
Daily		☐ 4

If you usually take part in this type of activity at least weekly, how much time do you spend exercising?
Tick the box where "Yes" is appropriate.

		Yes
Less than 30 minutes a week	105	☐ 1
Between 30 minutes and 1 hour a week		☐ 2
Between 1 and 2 hours a week		☐ 3
More than 2 hours a week		☐ 4

CHANGE IN DIETARY HABITS AND OTHER HABITS

Have you changed any of the following habits during the last 5 years: (Tick once for each question)

		Now use more	As before	Less
Dietary fat	106	☐	☐	☐
Soya margarine or oil	107	☐	☐	☐
Skimmed or low fat milk	108	☐	☐	☐
Coffee intake	109	☐	☐	☐
Alcohol intake	110	☐	☐	☐
Physical activity	111	☐	☐	☐

MARRIAGE / PARTNER

		Yes	No
Are you married or partner	112	☐	☐

How old were you when you first married or Moved in with a partner? 113 ☐ years

HOUSEHOLD

How many people live in your household? 115 ☐ Number

		Yes	No
Is anyone in your household 10 years or younger?	117	☐	☐
Does anyone in your household need special care/assistance – other than the children?	118	☐	☐

SCHOOLING

How many years education have you had? (including primary and secondary schools) 119 ☐ years

EMPLOYMENT

Have you had paid work the entire past year?
Tick the box where "Yes" is appropriate.

		Yes
Full-time work	121	☐ 1
Part-time work		☐ 2
Unpaid work		☐ 3

How much house work do you normally do yourself?
Tick the box where "Yes" is appropriate.

All or almost all	122	☐ 1
At least half		☐ 2
More than quarter		☐ 3
Less than quarter		☐ 4

BACK AND JOINTS CONDITIONS

		Yes	No
During this last year have you suffered from back pain that has lasted longer than 4 weeks?	123	☐	☐
If yes, does the pain improve when you move around?	124	☐	☐
Have you suffered from morning stiffness in your back lasting more than 30 minutes?	125	☐	☐

During the past 3 years have you suffered from pain in any of the following joints lasting more than 30 minutes?

		Yes	No
Knees	126	☐	☐
Elbows	127	☐	☐
Innermost finger joints	128	☐	☐
Other joints	129	☐	☐

		Yes	No
If yes, have you suffered from stiff joints in the morning lasting more than 30 minutes?	130	☐	☐

NECK, HEAD AND SHOULDER COMPLAINTS

How often do you suffer from headache?
Tick the box where "Yes" is appropriate.

		Yes
Rarely of never	131	☐ 1
Once or more a month		☐ 2
Once or more a week		☐ 3
Daily		☐ 4

How often do you suffer pain in the neck or shoulder?
Tick the box where "Yes" is appropriate.

		Yes
Rarely of never	132	☐ 1
Once or more a month		☐ 2
Once or more a week		☐ 3
Daily		☐ 4

Do the pains in your head, neck or shoulder reduce your ability to work?
Tick the box where "Yes" is appropriate.

		Yes
Little or no effect	133	☐ 1
To some degree		☐ 2
To a large degree		☐ 3
Cannot do ordinary work		☐ 4

		Yes	No
Have your back, shoulder, and/or neck ever been x-rayed?	134	☐	☐

SLEEPLESSNESS/ LOSS OF CONSCIOUSNESS

		Yes	No
Have you ever suffered from sleeplessness?	135	☐	☐

If yes, what time of the year does it affect you most? Tick the box where "Yes" is appropriate.

		Yes
No particular time	136	☐ 1
Especially during the polar night		☐ 2
Especially during the midnight sun season		☐ 3
Especially in spring and autumn		☐ 4

		Yes	No
Have you at any time during the last 12 months suffered from tiredness that has affected your work performance?	137	☐	☐
Have you suffered from sudden loss of consciousness in the past year?	138	☐	☐
Have you noticed sudden changes in your pulse rate of heartbeat in the past year?	139	☐	☐

REACTION TO PROBLEMS

If you have major personal problems, do you expect to get help and support from your spouse or family? ..... 140 — Yes ☐ No ☐

In the last year, have you for a long time felt a need to seek help with personal problems, without doing so? ..... 141 — Yes ☐ No ☐

During the past 2 weeks have you felt unable to cope with your problems?
Tick the box where "Yes" is appropriate.
- Seldom or never ..... 142 — Yes ☐ 1
- Sometimes ..... ☐ 2
- Often ..... ☐ 3
- Nearly always ..... ☐ 4

During the past 2 weeks have you felt unhappy or depressed?
Tick the box where "Yes" is appropriate.
- Seldom or never ..... 143 — Yes ☐ 1
- Sometimes ..... ☐ 2
- Often ..... ☐ 3
- Nearly always ..... ☐ 4

Do you ever feel lonely?
Tick the box where "Yes" is appropriate.
- Very often ..... 144 — Yes ☐ 1
- Sometimes ..... ☐ 2
- Rarely or never ..... ☐ 3

THE REMAINING SECTION OF THE QUESTIONNAIRE APPLIES TO WOMEN ONLY

MENSTRUATION

How old were you when you started menstruating? ..... 145 — ☐ years

When did your last period start? ..... 147 — day / month / year

How many days usually pass from the first day of one period to the first day of your next period (the time lapsed between the start of two periods) ..... 153 — ☐ days

Do/ did you menstruate regularly? ..... 155 — Yes ☐ No ☐

Do you usually take painkillers during menstruation? ..... 156 — Yes ☐ No ☐

PRE-MENSTRUAL TENSION

Do you have any of the following complaints before your period:
- Are you depressed or irritable?
Tick the box where "Yes" is appropriate.
  - Hardly at all ..... 157 — Yes ☐ 1
  - Noticeably ..... ☐ 2
  - Very much so ..... ☐ 3
- Are your breasts painful?
Tick the box where "Yes" is appropriate.
  - Hardly at all ..... 158 — Yes ☐ 1
  - Noticeably ..... ☐ 2
  - Very much so ..... ☐ 3
- Do you have swollen hands/feet, put on weight, or feel bloated?
Tick the box where "Yes" is appropriate.
  - Hardly at all ..... 159 — Yes ☐ 1
  - Noticeably ..... ☐ 2
  - Very much so ..... ☐ 3

Do the complaints disappear when you get your period? ..... 160 — Yes ☐ No ☐

For these complaints, do you use?
- diuretics? ..... 161 — Yes ☐ No ☐
- other medications? ..... 162 — ☐ ☐

PREGNANY

How many children have given birth to? .... 163 — number ☐

How old were you when you got pregnant for the first time? ..... 164 — ☐ years

CONTRACEPTION

Do you use or have you ever used oral contraceptive pills or an intrauterine device? ..... 166 — Yes ☐ No ☐

If yes, for how many years altogether have you used:
- The pill? ..... 167 — ☐ years
- An intrauterine device? ..... 169 — ☐ years

How old were you when you started using:
- The pill? ..... 171 — ☐ years
- An intrauterine device? ..... 173 — ☐ years

If you have stopped taking the pill, did 6 months or more pass without menstruating without you being pregnant? 175 — Yes ☐ No ☐

Did you have to stop taking the pill due to high blood pressure? ..... 176 — Yes ☐ No ☐

CERVICAL SMEAR TEST

How many times have you had a cervical smear test in the last 3 years? ..... 177 — Number of tests ☐

How many years is it since you had your last cervical smear test? ..... 178 — ☐ years

Your comments: 179

Thank you for the help! Remember to post the questionnaire today!

The Tromsø survey 1986-1987