1 STATE OF HEALTH

For every section please mark only ONE statement, which describes the state of your health TODAY.

1.1 Mobility

I have no problem walking about
I have slight problems in walking about
I have moderate problems walking about
I have severe problems walking about
I am unable to walk about

1.2 Self-Care

I have no problems washing or dressing myself
I have slight problems washing or dressing myself
I have moderate problems washing or dressing myself
I have severe problems washing or dressing myself
I am unable to wash or dress myself

1.3 Usual activities

(I.e. work, studies, household chores, family or leisure activities)

I have no problem doing my usual activities
I have slight problems doing my usual activities
I have moderate problems doing my usual activities
I have severe problems doing my usual activities
I am unable to do my usual activities

1.4 Pain/Discomfort

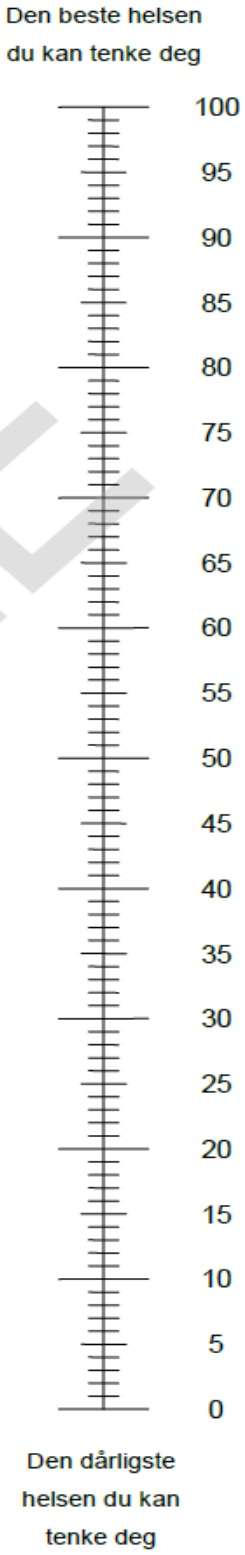
I have no pain or discomfort
I have slight pain or discomfort
I have moderate pain or discomfort
I have severe pain or discomfort
I have extreme pain or discomfort

1.5 Anxiety/Depression

I am not anxious or depressed
I am slightly anxious or depressed
I am moderately anxious or depressed
I am severely anxious or depressed
I am extremely anxious or depressed

We would like to know how good or bad your health is today. This scale is numbered from 0-100. 100 is the best health you can imagine while 0 is the worst health you can imagine. Please insert a number between 0 and 100 here.

1.6 Fill in a number between 0 and 100 which best describes your current state of health



2 CHILDHOOD/YOUTH AND AFFILIATION

2.1 Where did you live the greater part of your childhood?

(Tick once)

Tromsø

Troms, not Tromsø

Finnmark

Nordland

Norway, except Nordland, Troms, Finnmark

Abroad

2.2 How long have you lived in your current residence?

Number of years___

2.3 How was your family's financial situation during childhood?

Very good

Good

Difficult

Very difficult

2.4 What is the importance of religion in your life?

Very important

Somewhat important

No importance

2.5 What do you consider as your ethnic identity?

(Tick one or more)

Norwegian

Sami

Finnish/Kven

Other

2.6 How many siblings do you have/have you had?

Number of siblings

How many children do you have/ have you had?

Number of

2.7 Biological children
2.8 Adopted children
2.9 Step children
2.10 Foster children

2.11 Is your mother alive?
No Yes

If Yes, skip to 2.9.

If No:

2.11.1 What was your mother's age at death?
Age at death__

2.12 Is your father alive?
No Yes

If Yes, skip to 2.10.

If No:

2.12.1 What was your father's age at death?
Age at death__

What is the *highest completed education* of your parents and your domestic partner/spouse?

Primary and secondary school, up to 10 years

Vocational school/ High school minimum 3 years

College or University (Less than 4 years)

College or University (4 years or more)

2.13 Mother
2.14 Father
2.15 Spouse/domestic partner

3 WELLBEING

Below are three statements about your general wellbeing in life. Subsequently there are five statements concerning your perception and mastery of your own health. Show how much you agree or disagree with the statements by choosing the number on the rubric, which is most accurate for you.

Disagree completely Agree completely

1 2 3 4 5 6 7

3.1 In most ways my life is close to my ideal
3.2 The conditions of my life are excellent
3.3 I am satisfied with my life
3.4 I have a positive view of my future health
3.5 I can prevent serious diseases by living healthy
3.6 I know how to prevent the deterioration of my health
3.7 I can find solutions to new situations or problems with my health condition
3.8 After all, I am responsible for taking care of my health

Please indicate how well the following statements describe you or your family

Disagree completely Agree completely

1 2 3 4 5

3.9 I trust my judgments and decisions completely
3.10 I feel very happy with my family
3.11 The belief in myself gets me through difficult periods
3.12 My family is characterized by healthy cohesion
3.13 In difficult periods I have a tendency to find something good that helps me thrive and prosper
3.14 My family keeps an positive outlook on the future even in difficult periods

3.15 How would you evaluate your finances?

Very good

Good

Average

Difficult

Very difficult

4 WORK

4.1 What is your main occupation/activity?

(Tick once or more)

Works full-time

Works part-time

Housekeeping

Retired

Disability benefit recipient/work assessment allowance

Family income supplement

Unemployed

Student/military service

If Works full-time, Works part-time, Housekeeping, Retired, Student/military service, skip to 4.2

If Disability benefit recipient/work assessment allowance, Family income supplement, Unemployed:

4.1.1 For how long have you been without paid work?

3 months or less

4-6 months

7-12 months

1-2 years

3-5 years

6-9 years

10 years or more

4.2 I consider my occupation to have the following social status in society (if not currently employed, consider you latest occupation):

Very high social status

Fairly high social status

Neither high nor low social status

Fairly low social status

Very low status

If not Work full-time or Work part-time on 4.1 skip to 4.3

4.1.2 If working full-time or part-time, which of the following occupational fields describes your profession?

(Tick once)

Administrative leader or politician
Academic profession (at least 4 years of college or university education)
Work with shorter college or university education (1-3 years) and technicians
Office and customer service occupations
Sales-, service- and care professions
Agriculture, forestry or fisheries professions

Handyman, construction worker, skilled worker and the like
Process- and machine operator, transport worker or similar
Occupation with no formal educational requirements

4.1.2.1 Describe the workplace (department) where you were employed for the longest period of time the last 12 months (e.g. elementary school, hospital, bank)

Workplace: _____

4.1.2.2 Which occupation/title do/did you have at this workplace? (e.g. teacher, nurse)

Occupation: _____

4.1.4 If employed: On a scale from 0 to 10, how would you rate your job performance the past 7 days?

0 I have performed very poorly 10 I have performed excellently

If Work full-time or Work part-time on 4.1 skip to 5.1

If not Work full-time or Work part-time on 4.1:

4.1.3 Which of the following career fields best describes your last work?

(Tick once)

Administrative leader or politician
Academic profession (at least 4 years of college or university education)
Work with shorter college or university education (1-3 years) and technicians
Office and customer service occupations
Sales-, service- and care professions
Agriculture, forestry or fisheries professions
Handyman, construction worker, skilled worker and the like
Process- and machine operator, transport worker or similar
Occupation with no formal educational requirements

4.1.3.1 Describe the workplace (department) where you were employed for the longest period of time the last 12 months (e.g. elementary school, hospital, bank).

Workplace: _____

4.1.3.2 Which occupation/title do/did you have at this workplace? (e.g. teacher, nurse)

Occupation: _____

5 ILLNESS AND WORRIES

Have you had any of the following illnesses or worries?

No Yes Age first time

5.1 Have you had coronary artery bypass surgery?

5.2 Have you had percutaneous coronary intervention?

5.3 Do you have or have you had claudicatio intermittens?

If No on 5.1-5.3, skip to 5.4

If Yes on 5.1:

5.1.1 If you have had coronary artery bypass surgery - how old were you the first time?

Age first time___

If Yes on 5.2:

5.2.1 If you have had percutaneous coronary intervention - how old were you the first time?

Age first time___

If Yes on 5.3:

5.3.1 If you have had claudicatio intermittens - how old were you the first time?

Age first time___

Do you get pain in the calf when you are: No Yes

5.4 Walking?
5.5 Resting?

If No on 5.4 and 5.5, skip to 5.6:

If Yes on 5.4:

If you get pain in the calf while walking:

No Yes

5.4.1 Does the pain increase when you walk faster or uphill?
5.4.2 Does the pain disappear if you stop?

Do you get pain or discomfort in the chest when you walking?

No Yes

5.6 When walking up hills or stairs, or walking fast on level ground?
5.7 When walking at normal pace on level ground?

If No on 5.6 and 5.7, skip to 5.8.

If Yes on 5.6 or 5.7 or both:

5.6.1 If you get pain or discomfort in the chest when walking up hills or stairs, or walking fast on level ground, do you usually

Stop

Slow down

Carry on at the same pace

5.6.2 If you stop or slow down, does the pain disappear after

10 minutes or less

More than 10 minutes

5.8 Have you noticed sudden changes in your pulse or heart rhythm in the last year?

No Yes

5.9 Do you cough about daily for some periods of the year?

No Yes

If No, skip to 5.14.

If Yes:

If you cough about daily for some periods of the year

No Yes

5.9.1 Is your cough productive?

5.9.2 Have you had this kind of cough for as long as 3 months in each of the last two years?

Do you get breathless when

No Yes

5.10 Walking rapidly on level ground or up a moderate slope?
5.11 Walking calmly on level ground?
5.12 While washing or dressing?
5.13 At rest?

5.14 Do you have Crohn's disease/ulcerous colitis?

No Yes

5.15 Have you been infected with the liver virus hepatitis C?

No Yes Don't know

If No or Don't know, skip to 6.1.

If Yes:

5.15.1 Have you been treated for hepatitis C?

No Yes Don't know

6 MUSCULOSCELETAL PAIN

Have you during the last year suffered from pain and/or stiffness in muscles or joints in the following regions lasting for at least 3 consecutive months?

(Tick once for each line)

No complaint Little complaint Severe complaint

6.1 Neck, shoulder
6.2 Arms, hands
6.3 Upper part of your back
6.4 Lumbar regions
6.5 Hip, legs or feet
6.6 Other regions

Have you during the last 4 weeks suffered from pain and/or stiffness in muscles or joints in the following regions?

(Tick once for each line)

No complaint Little complaint Severe complaint

6.1 Neck, shoulder
6.2 Arms, hands
6.3 Upper part of your back
6.4 Lumbar regions
6.5 Hip, legs or feet
6.6 Other regions

7 HEADACHE

7.1 Have you been suffering from headache the last year?

No Yes

If No, skip to 8.1.

If Yes:

7.1.1 What kind of headache are you suffering from?

Migraine

Other headache

7.1.2 How many days per month do you suffer from headache?

Less than 1 day

1-6 days

7-14 days

More than 14 days

7.1.3 What is the normal intensity of your headache attacks?

Mild (do not hinder normal activity*)*

Moderate (hinder normal activity*)*

Strong *(block normal activity)*

7.1.4 What is the duration of your headache attacks generally?

Less than 4 hours

From 4 hours to 24 hours

1-3 days

More than 3 days

Is your headache generally characterized by or accompanied by

No Yes

7.1.5 Pounding/pulsatory pain?
7.1.6 Generally pressing/tightening pain?
7.1.7 Unilateral pain (left or right)?
7.1.8 Aggravated pain by physical activity?
7.1.9 Nausea and/or vomiting?
7.1.10 Light- and/or sound-sensitivity?

During or in the run up to your headache, do you have temporary:

No Yes

7.1.11 Visual disturbances?

7.1.12 Unilateral numbness in your face or hand?

7.1.13 Describe how many days you have been away from work or school during the last month due to headache?

Number of days in absence___

8 BOTHERS

8.1 How often have you been bothered by heartburn and/or acid regurgitation during the past three months?

Never Monthly Weekly Daily

If never, skip to 8.2.

If > never:

8.1.1 To what degree have you been troubled by heartburn and/or acid regurgitation?

Nothing Some A lot

8.1.2 For how long have you been troubled by heartburn and/or acid regurgitation?

Less than 3 months

3-5 months

6-12 months

More than 1 years

8.2 Did you ever fall last year?

No

Once

More than once

8.3 Are you afraid of falling?

Not at all

A bit

Very much

8.4 How have you experienced feelings of fatigue and exhaustion in the past week?

Mark on the line below the statement that most appropriate fits your experience with fatigue and exhaustion the past week

No problems with fatigue Close to a breaking point of fatigue and exhaustion

9 MEMORY

Please answer the questions below regarding your memory:

(Tick once for each line)

No Yes

9.1 Has your memory declined?
9.2 Do you often forget where you have placed your things?
9.3 Do you have difficulties finding common words in a conversation?
9.4 Do you have problems performing the daily tasks you used to master?
9.5 Have you been examined for memory problems?

If No on 9.1-9.4, skip to 10.1.

If Yes on one or more on 9.1-9.4:

9.1.1 Is your memory a problem in your daily life?

No Yes

10 INFERTILITY

10.1 Have you tried to conceive for more than one year without succeeding in becoming pregnant?

No Yes

If No, skip to 11.1.

If Yes:

If you have tried to conceive for more than one year without succeeding in becoming pregnant

No Yes Don't know

10.1.1 Was this due to conditions with yourself?
10.1.2 Was this due to conditions with your partner?
10.1.3 Have you received medical treatment for childlessness?

No Yes

If No, skip to 11.1.

If Yes:

If you or your partner has received treatment for childlessness, what type of treatment have you received?

Number of times

10.1.3.1 Have you received treatment for stimulation of ovulation?
10.1.3.2 Have you received treatment for stimulation of ovulation followed by artificial insemination (not husband/partner)?
10.1.3.3 Have you received artificial insemination (not husband/partner)?
10.1.3.4 Have you received invitrofertilisation (IVF/ICSI)?
10.1.3.5 Have you received other treatment modalities for childlessness?

How many children have you got in infertility treatment:

Number of children

10.1.3.6 At the university hospital of Northern Norway?
10.1.3.7 At other treatment institutions in Norway?
10.1.3.8 Abroad?

11 FAMILY AND FRIENDS

Tick the relatives which has or have had the following disease(s)

Mother Father Children Sibling(s) None of the closest relatives

11.1 Heart attack before the age of 60
11.2 Angina pectoris (Heart cramp)
11.3 Brain hemorrhage
11.4 Asthma
11.5 Diabetes
11.6 Psychological problems
11.7 Problems with substance abuse

12 SLEEP

How many days per week

(Tick the number of days) Number for days a week 0 1 2 3 4 5 6 7

12.1 Do you usually use more than 30 minutes to fall asleep?
12.2 Do you usually wake up for more than 30 minutes in the middle of the night?
12.3 Do you wake up 30 minutes earlier than you wished, without being able to go back to sleep again?
12.4 Have you not felt refreshed after sleep?
12.5 Felt so tired that it has affected your work, school or private life?
12.6 Have you been dissatisfied with your sleep?

12.7 If sleep problems, how long time?

Less than 1 week

1-3 weeks

1 months

2 months

3 months

4-6 months

7-12 months

1-5 years

6-10 years

More than 10 years

Do not have sleep problems

12.8 Do you usually work shifts or at night?

No Yes

When do you usually go to sleep?

12.9 On work days

00:30-24:00 (dropdown menu)

12.10 On non-work days

00:30-24:00 (dropdown menu)

For how long are you awake before you fall asleep?

12.11 On work days

Minutes_____

12.12 On non-work days

Minutes_____

What time do you usually wake up?

12.13 During work week

kl. 00:30-24:00 (dropdown menu)

12.14 During free days

kl. 00:30-24:00 (dropdown menu)

12.15 How often do you take naps at daytime?

Never or less often than once per month

Less than once per week

1-2 days per week

3-5 days per week

Every day or almost every day

If Never or less than once per month, skip to 12.16

If>Never or less than once per month:

12.15.1 If you take a nap, how long does it usually last?

Minutes___

12.16 Do you snore while sleeping?

Never or less than once per month

Less than once per week

1-2 nights per week

3-5 nights per week

Daily or almost daily

Don't know

12.17 Have you had breathing pauses (sleep apnea) at sleep?

Never or less than once per month

Less than once per week

1-2 nights per week

3-5 nights per week

Daily or almost daily

Don't know

How likely are you to doze off or fall asleep in the following situation?

Use the scale from 0-3 for each situation:

0= No chance of dosing

1= Slight chance of dozing

2= Moderate chance of dozing

3= High chance of dozing

Situation Likelihood of dozing off or fall asleep (0-3)

12.18 Sitting and reading
12.19 Watching TV
12.20 Sitting inactive in a public place (e.g. a theatre or meeting)
12.21 As a passenger in a car for an hour without break
12.22 Lying down to rest in the afternoon when circumstances permit
12.23 When you are sitting and talking to someone
12.24 When you are sitting quietly after lunch without alcohol
12.25 When you are in a car, while stopped for a few minutes in traffic

14 ABDOMEN

14.1 In the last 3 months, how often did you have discomfort or pain anywhere in your abdomen?

Never

Less than one day per month

One day a month

Two or three days a month

One day a week

More than one day a week

Every day

If Never, skip to 14.2.

If > Never and male, skip to 14.1.2.

If >Never and female:

PAIN IN ABDOMEN

14.1.1 Did this discomfort or pain occur only during your menstrual bleeding and not at other times?

No Yes I have not had menstrual bleedings the last 3 months

If Yes, skip to 14.2.

If No or I have not had menstrual bleedings the last 3 months:

PAIN IN ABDOMEN

14.1.2 Have you had this discomfort or pain 6 months or longer?

No Yes

If No, skip to 14.2.

If Yes:

PAIN IN ABDOMEN

Never or rarely Sometimes Often Most of the time Always

14.1.2.1 How often did this discomfort or pain get better or stop after you had a bowel movement?
14.1.2.2 When discomfort or pain started, did you have more frequent bowel movements?
14.1.2.3 When discomfort or pain started, did you have less frequent bowel movements?
14.1.2.4 When discomfort or pain started, were your stools (bowel movements) looser?
14.1.2.5 When discomfort or pain started, how often did you have harder stools?
14.1.2.6 In the last 3 months, how often did you have hard or lumpy stools?
14.1.2.7 In the last 3 months, how often did you have loose, mushy or watery stools?

14.2 How often do you usually have a bowel movement?

4 times a day or more often

1-3 times per day

4-6 times per week

1-3 times per week

Less than once per week

15 USE OF HEALTH SERVICES

15.1 For how long have you been going to your present GP?

Less than 1 year

1-2 years

3-4 years

More than 4 years

15.2 Did you have an appointment with your GP during the last 12 months?

No Yes

If No, skip to 15.3.

If Yes:

15.2.1 During your last appointment were you referred to

(Tick once or more)

Physiotherapist

Chiropractor

Psychiatrist/psychologist

Radiological investigation / imaging

Hospital outpatient clinic

Private practicing secondary care specialist

Other kinds of referral

Not referred

15.2.2 During the last 12 months, did you ask or want to be referred to radiological investigation or secondary care specialist, but was not referred by your GP?

Yes, once

Yes, several times

No, I was referred when I asked or wanted to be referred

No, referral was not relevant

If No, I was referred when I asked or wanted to be referred or No, referral was not relevant, skip to 15.3

If Yes:

15.2.2.1 The fact that you were not referred, did it affect your health in any way?

No Yes, temporarily Yes, permanent consequences

How often during the last year have you used the following internet-services for information and advice on health and disease issues?

Never Once A few times Often

15.3 Applications ("Apps") for smart phone or tablet

15.4 Search engines (like Google)

15.5 Social media (like Facebook or similar)

15.6 Video services (Like Youtube)

If Never on the entire previous, skip to 16.1.

If >Never:

Based on the information you found on the Internet – have you?

Never Once A few times Often

15.3.1 Decided to go to a doctor?
15.3.2 Decided not to go to a doctor?
15.3.3 Discussed the information with a doctor?
15.3.4 Changed your medication without consultation with a doctor?
15.3.5 Have you been unsure your diagnosis is correct?
15.3.6 Have you been unsure whether the treatment you have received is correct?
15.3.7 Have you decided to seek out complementary or alternative treatment?
15.3.8 Have you made lifestyle changes?
15.3.9 Have you felt anxiety?
15.3.10 Felt reassured?
15.3.11 Felt more knowledgeable?
15.3.12 Felt more confused?

16 COMPLIMENTARY AND ALTERNATIVE MEDICINE

16.1 Have you used herbal medicines during the last 12 months?

No Yes

16.2 Have you used meditation, yoga, qi gong or Tai Chi as self-treatment during the last 12 months?

No Yes

17 PAINKILLERS AND ANTIINFLAMMATORIC MEDICINES

17.1 Have you used analgesics and anti-inflammatory medication regularly in the past year? (i.e. acetylsalicylic acid, paracetamol, ibuprofen, diclofenac, naproxen)?

These include both over-the-counter and prescription only medicines, also including acetylsalicylic acid, which is used in low dosage as a blood thinning drug.

No Yes

If No, skip to 18.1.

If Yes:

Which analgesics and anti-inflammatory medication have your used the past year?

(Tick one or more)

17.1.1 «Baby» or low dose of Acetylsalicylic acid

(75 mg or 160 mg per tablet, i.e. Acetylsalicylic acid® i.e Albyl-E® Asasantin Retard®)

No Yes

17.1.2 Acetylsalicylic acid high dosage

(300-500 mg acetylsalicylic acid per tablet, i.e. Aspirin® Dispril® Globoid®)

No Yes

17.1.3 Paracetamol

(i.e. Pamol® Panodil® Paracet® Paracetamol® Pinex® Paracetduo®)

No Yes

17.1.4 Acetaminophen combined with med codeine phosphate/tramadol

(i.e. Paralgin forte® Codaxol® Paralgin major® Paralgin minor® Paramax Comp Vitabalans® Pinex Forte® Pinex Major® Trampalgin®)

No Yes

17.1.5 Fenazon

(i.e. Fanalgin® Fenazon-koffein® Fenazon-koffein sterke®)

No Yes

17.1.6 Ibuprofen etc.

(i.e. Brufen Retard® Burana® Ibumax® Ibumetin® Ibuprofen Ibuprox® Ibux® Orudis® Seractiv® Ketesse® Orodek®)

No Yes

17.1.7 Diclofenac etc.

(i.e. Cataflam® Diclofenac® DiclofenacKalium® Modifenac® Voltaren® Voltarol® Arthrotec® Toradol®)

No Yes

17.1.8 Naproxen

(i.e. Napren-E® Naproxen-E® Naproxen® Vimovo®)

No Yes

17.1.9 Other analgesics and anti-inflammatory medication

(I.e. Brexidol® Piroxicam® Meloxicam® Migea® Celebra® Dynastat® Arcoxia® Relifex®)

No Yes

If No on 17.1.1, skip to 18.1.

If Yes on 17.1.1:

17.1.1.1 Have you used "Baby" or low dose acetylsalicylic acid weekly or more often the past year?

No Yes

If No, skip to 18.1.

If Yes:

If you have used "Baby" or low dose acetylsalicylic acid regularly in the past year

17.1.1.1.1 How many days a week?

1

2-3

4-5

6+ days

17.1.1.1.2 How many tablets per week?

1-2

3-5

6-14

15+

17.1.1.1.3 For how long have you had this regular use?

Number of years__

If No on 17.1.2, skip to 18.1.

If Yes on 17.1.2:

17.1.2.1 Have you used high dose acetylsalicylic acid weekly or more often the past year?

No Yes

If No, skip to 18.1.

If Yes:

If you have used high dose acetylsalicylic acid weekly or more often the past year

17.1.2.1.1 How many days per week?

1

2-3

4-5

6+ days

17.1.2.1.2 How many tablets in total per week?

1-2

3-5

6-14

15+

17.1.2.1.3 For how long have you had this regular use?

Number of years__

If No on 17.1.3, skip to 18.1.

If Yes on 17.1.3:

17.1. 3.1 Have you used paracetamol weekly or more often the past year?

No Yes

If No, skip to 18.1.

If Yes:

If you have used paracetamol weekly or more often the past year

17.1.3.1.1 How many days per week?

1

2-3

4-5

6+ days

17.1.3.1.2 How many tablets in total per week?

1-2

3-5

6-14

15+

17.1.3.1.3 For how long have you had this regular use?

Number of years__

If No on 17.1.4, skip to 18.1.

If Yes on 17.1.4:

17.1.4.1 Have you used acetaminophen combined with med codeine phosphate /tramadol weekly or more often the past year?

No Yes

If No, skip to 18.1.

If Yes:

If you have used acetaminophen combined with med codeine phosphate /tramadol weekly or more often the past year

17.1.4.1.1 How many days per week?

1

2-3

4-5

6+ days

17.1.4.1.2 How many tablets in total per week?

1-2

3-5

6-14

15+

17.1.4.1.3 For how long have you had this regular use?

Number of years__

If No on 17.1.5, skip to 18.1.

If Yes on 17.1.5:

17.1.5.1 Have you used fenazon weekly or more often the past year?

No Yes

If No, skip to 18.1.

If Yes:

If you have used fenazon weekly or more often the past year

17.1.5.1.1 How many days per week?

1

2-3

4-5

6+ days

17.1.5.1.2 How many tablets in total per week?

1-2

3-5

6-14

15+

17.1.5.1.3 For how long have you had this regular use?

Number of years__

If No on 17.1.6, skip to 18.1.

If Yes on 17.1.6:

17.1.6.1 Have you used ibuprofen etc. weekly or more often the past year?

No Yes

If No, skip to 18.1.

If Yes:

If you have used ibuprofen etc. weekly or more often the past year

17.1.6.1.1 How many days per week?

1

2-3

4-5

6+ days

17.1.6.1.2 How many tablets in total per week?

1-2

3-5

6-14

15+

17.1.6.1.3 For how long have you had this regular use?

Number of years__

If No on 17.1.7, skip to 18.1.

If Yes on 17.1.7:

17.1.7.1 Have you used diclofenac etc. weekly or more often the past year?

No Yes

If No, skip to 18.1.

If Yes:

If you have used diclofenac etc. weekly or more often the past year.

17.1.7.1.1 How many days per week?

1

2-3

4-5

6+ days

17.1.7.1.2 How many tablets in total per week?

1-2

3-5

6-14

15+

17.1.7.1.3 For how long have you had this regular use?

Number of years__

If No on 17.1.8, skip to 18.1.

If Yes on 17.1.8:

17.1.8.1 Have you used naproxen weekly or more often the past year?

No Yes

If No, skip to 18.1.

If Yes:

If you have used naproxen weekly or more often the past year?

17.1.8.1.1 How many days per week?

1

2-3

4-5

6+ days

17.1.8.1.2 How many tablets in total per week?

1-2

3-5

6-14

15+

17.1.8.1.3 For how long have you had this regular use?

Number of years__

If No on 17.1.9, skip to 18.1.

If Yes on 17.1.9:

17.1.9.1 Have you used other analgesics and anti-inflammatory medication weekly or more often the past year?

No Yes

If No, skip to 18.1.

If Yes:

If you have used other analgesics and anti-inflammatory medication weekly or more often the past year

17.1.9.1.1 How many days per week?

1

2-3

4-5

6+ days

17.1.9.1.2 How many tablets in total per week?

1-2

3-5

6-14

15+

17.1.9.1.3 For how long have you had this regular use?

Number of years__

18 MEDICINE INFORMATION

18.1 Have you used medicines (nonprescription and prescription) regularly during the last 4 weeks?

Do not include dietary supplements (vitamins, minerals, omega-3, herbs or other natural remedies)

No Yes

If No, skip to 19.1.

If Yes:

Think about the information you receive about your medicines from your general practitioner. Indicate whether you agree that you receive the following information

I receive information about… Strongly disagree Disagree Neutral Agree Strongly agree

18.1.1 The reason why I should take my medicines.
18.1.2 How I should take my medicines.
18.1.3 Which side effects I should be aware of.
18.1.4 How other medicines and/or food will/do influence my medicines.

Think about the information you receive about your medicines from your pharmacy. Indicate whether you agree that you receive the following information:

I receive information about… Strongly disagree Disagree Neutral Agree Strongly agree

18.1.5 The reason why I should take my medicines.
18.1.6 How I should take my medicines.
18.1.7 Which side effects I should be aware of.
18.1.8 How other medicines and/or food will/do influence my medicines.

18.1.9 Do you have help with your medicines?

No Yes

18.1.10 Regardless of whether you have help with your medicines or not, do you need more help?

I do not need any more help

I would like some more help

I would like a lot more help

18.1.11 Do you need more information about your medicines?

I do not want any more information

I would like some more information

I would like a lot more information

18.1.12 Generally, how would you describe the importance of your medicines?

Not important at all

Not very important

Important

Very important

18.1.13 Are you concerned about your medicines?

Not at all concerned

Concerned

Very concerned

If Not at all concerned, skip to 18.1.13.

If Concerned or Very concerned:

18.1.13.1 Please indicate which concerns you have about your medicines

(Tick once or more)

I am concerned about..

The long-term effects of these medicines

That these medicines would give me unpleasant side effects

That these medicines will disrupt my life

I will not be able to take my medicines correctly

Becoming too dependent on these medicines

That the medicines will become less effective if used regularly

That the medicines do more harm than good

The cost of my medicines

Other

Either because of forgetfulness, inconvenience or because they do not want to, it is common that people not always take the medicine they have been prescribed. The following questions concern your habits when taking *your* medicine.

18.1.14 How many times a week do you forget to take your medicines?

Less than once a week

Once a week

2-4 times a week

5 times a week or more

18.1.15 How many times a week do you decide to miss out your medicines?

Less than once a week

Once a week

2-4 times a week

5 times a week or more

19 PHYSICAL ACTIVITY

19.1 How often do you exercise?

(i.e. walking, skiing, swimming or training/sports)

Never

Less than once a week

Once a week

2-3 times a week

Approximately every day

If Never, skip to 20.1.

If >Never:

19.1.1 If you exercise - how hard do you exercise?

Easy - you do not become shortwinded or sweaty

You become shortwinded and sweaty

Hard - you become exhausted

19.1.2 For how long time do you exercise? (give an average)

Less than 15 minutes

15-29 minutes

30-60 minutes

More than 1 hour

20 FOOD HABITS

How often do you usually eat?

Tick once for each line

0-1 times per month 2-3 times per month 1-3 times per week More than 3 times per week

20.1 Fresh water fish (not farmed)
20.2 Salt water fish (not farmed)
20.3 Farmed fish (salmon, trout, char)
20.4 Tuna fish (fresh or canned)
20.5 Fish bread spread
20.6 Mussels, shells
20.7 Brown content in crabs
20.8 Meat from whale or seal
20.9 Pluck (liver/kidney/heart) from reindeer or elk/moose
20.10 Pluck (liver/kidney/heart) from ptarmigan/grouse
20.11 Tomatoes and tomato-based products (e.g. tomato, ketchup)

How many times per year do/did you usually eat

In adulthood: times per year In childhood: times per year

20.12 "Mølje" (cod or pollack meat, liver, and roe)
20.13 Seagulls' egg
20.14 Reindeer meat
20.15 Elk meat
20.16 Wild mushroom and wild berries (blueberries/lingonberries/cloudberries)

Do you use the following food supplements?

(Tick once for each line)

No Sometimes Daily during the winter season Daily

20.17 Cod liver oil or cod liver oil capsules
20.18 Omega 3 capsules (fish oil, seal oil)
20.19 Calsium tablets
20.20 Vitamin supplement with vitamin D

No Sometimes Only while travelling Daily

20.21 Milk acid bacteria/probiotics

21 LIGHT/SUN EXPOSURE

21.1 Have you been on holiday in the sun during the last two months?

No Yes

21.2 Do you use a solarium?

Yes, weekly Yes, sometimes Never

22 WEIGHT

22.1 What weight would you be satisfied with (your "ideal" weight)

(kg)___

22.2 Are you satisfied with your present body weight?

Yes No

22.3 Estimate your body weight when you were 25 years old

(kg)___

22.4 Have you involuntary lost weight during the last 6 months?

Yes No

If No, skip to 23.1 or 24.1 depending on your sex.

If Yes:

22.4.1 If you have involuntary lost weight during the last 6 months, how many kilos?

(kg)___

23 MENS HEALTH

23.1 Have you experienced any problems achieving an erection within the past 3 months?

No Yes

If No, skip to 23.2.

If Yes:

23.1.1 How do you rate your confidence that you could get and keep an erection?

Very low Low Moderate High Very high

23.1.2 When you had erections with sexual stimulation, how often were your erections hard enough for penetration?

Almost never or never A few times (much less than half the time) Sometimes (about half the time) Most times (Much more than half the time) Almost always or always

23.1.3 During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?

Almost never or never A few times (much less than half the time) Sometimes (about half the time) Most times (Much more than half the time) Almost always or always

23.1.4 During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Extremely difficult Very difficult Difficult Slightly difficult Not difficult

23.1.5 When you attempted sexual intercourse, how often was it satisfactory for you?

Almost never or never A few times (much less than half the time) Sometimes (about half the time) Most times (Much more than half the time) Almost always or always

23.2 Have any of your partners had a spontaneous abortion after becoming pregnant with you?

No Yes Don't know

If No or Don't know, skip to 25.1.

If Yes:

23.2.1 In total, how many spontaneous abortions have your partner(s) had after being pregnant with you?

Number of times__

24 WOMENS HEALTH

24.1 Have you ever had a spontaneous abortion?

No Yes Don't know

If No or Don't know, skip to 24.2.

If Yes:

24.1.1 How many spontaneous abortions have you had?

Number of times__

MENSTURATION

24.2 Do you still menstruate?

No Yes

If Yes, skip to 24.3.

If No:

24.2.1 If you do not have natural menstruation, why did it stop?

(Tick once)

It stopped by itself

Uterus surgery

Both Ovaries were removed

Hormonal intrauterine device

Other reason (e.g. radiation, chemo therapy)

24.2.2 If you do not have natural menstruation, how old were you when it stopped?

Age ___

24.3 Have you during your lifetime been bothered by menstrual pain?

No Yes

If No, skip to 24.4.

If Yes on 24.3 + No on 24.2:

How old were you when the pain was most bothersome?

24.3.1 from age_

24.3.2 to age _

24.3.3 How long did the pain usually last at that time?

Less than one day

1 day

2 days

3 days

4 days

More than 4 days

24.3.4 On a scale from 0 to 10, where 0 is no pain at all, while 10 is the most severe pain imaginable, how strong was the pain usually at that time?

No pain at all 0 1 2 3 4 5 6 7 8 9 10 Most severe pain imaginable

24.3.5 Were you sometimes away from school or work because of menstrual pain?

Never Sometimes Often Most of the time

If Yes on 24.3 + Yes on 24.2:

24.3.6 If you still menstruate - How long does the pain usually last?

Less than one day

1 day

2 days

3 days

4 days

More than 4 days

24.3.4 On a scale from 0 to 10, where 0 is no pain at all while 10 is the most severe pain imaginable, how strong was the pain usually at that time?

No pain at all 0 1 2 3 4 5 6 7 8 9 10 Most severe pain imaginable

24.3.8 Are you sometimes away from school or work because of menstrual pain?

Never Sometimes Often Most of the time

HORMONAL CONTRACEPTIVES

24.4 Do you use now, or have you ever used hormonal contraceptives (incl. oral contraceptive pills, mini-pills, birth control patch, intrauterine birth control products, and implants)?

No Yes, previously Yes, now

If No, skip to 24.5

If Yes, previously on 24.4:

24.4.1 Age first time you used hormonal contraceptives

Age first time use __

24.4.2 Age last time you used hormonal contraceptives

Alder last time use __

24.4.3 In total, how many years have you used hormonal contraceptives?

Number of years__

If Yes, now on 24.4:

24.4.1 Age first time you used hormonal contraceptives

Age first time use __

24.4.3 In total, how many years have you used hormonal contraceptives?

Number of years__

24.4.5 If you use hormonal contraceptives now - which brand do you currently use?

Oral contraceptive pills (Loette Microgynon Oralcon Marvelon Mercilon Yasmin Yasminelle Yaz Zoely Synfase Qlaira)

Mini-pills (Conludag Cerazette)

Birth control patch (Evra)

Implants (Depo-Provera, Nexplanon)

Intrauterine birth control products, implants (Jaydess, Mirena, NuvaRing)

USE OF SEX HORMONES

24.5 Do you use now or have ever used estrogens to treat climacteric problems or for any other reason (tablets/patches/vaginal ring/tablets/creams)?

No Yes, previously Yes, now

If No, skip to 24.6.

If Yes, previously 24.5:

24.5.1 Age first time you used estrogens

Age first time use __

24.5.2 Age last time you used estrogens

Age last time use __

24.5.3 In total, how many years have you used estrogens?

Number of years__

If Yes, now on 24.5:

24.5.1 Age first time you used estrogens

Age first time use __

24.5.3 In total, how many years have you used estrogens?

Number of years__

24.5.4 If you use estrogens now- which brand do you use?

Patches (Evorel Estalis Estradot Sequidot)

Tablets (Activelle Cliovelle Eviana Indivina Novofem Trisekvens Progynova Livial)

Ovesterin tablets

Vaginal ring/Vaginal tablet (Estring Vagifem)

Ovesterin vaginal crème, Ovesterin vagitories

24.6 Did you or do you have hot flushes during the climacteric period?

Yes, definitely Yes, sometimes No, not much No, not at all

24.7 Did you or do you suffer from night sweats during the climacteric period?

Yes, definitely Yes, sometimes No, not much No, not at all

VAGINAL BULGE

24.8 Can you feel a bulge from or in the vagina?

Genital prolapse is a condition you can feel from or in the vagina.

Not at all

A little

Moderately

A lot

If Not at all, skip to 25.1.

If A little, Moderately or A lot:

VAGINAL BULGE

Not at all A little Moderately A lot

24.8.1 Do you have a bulge in your vagina that worsens during the course of the day?
24.8.2 How much do you think your prolapse problem affects your life?
24.8.3 Does your prolapse affect your physical activities (e.g. going for a walk, run, sport, gym etc.)?
24.8.4 Do you have to strain in order to empty your bladder?
24.8.5 Does your prolapse affect your sexual life? (a vaginal bulge which gets in the way of sex)

24.8.6 If necessary, can you push up the prolapse with your fingers?

Never

Occasionally

Often

Always

24.8.7 Do you feel completely empty after having had defecation?

Always

Most of the time

Quite often

Usually not

24.8.8 Have you visited a medical doctor for your prolapse?

No Yes

25 SEXUAL HEALTH

25.1 Have you been sexually active during the last 12 months?

No Yes

25.2 What is your total number of sexual partners? (Put in 0 if you have not had a sex partner)

Number of sexual partners __

25.3 Have you ever practised oral sex? (performed on partner and/or received)

No Yes

If No, skip to 26.1.

If Yes:

25.3.1 Have you practised oral sex during the last 12 months?

No Yes

26 URINATING PROBLEMS

26.1 Have you experienced problems urinating the past month?

(i.e. weak urinary stream, a sensation of not being able to empty your bladder or abnormal high frequency of bathroom visits)

No Yes

If No, skip to 27.1.

If Yes:

URINATING PROBLEMS

Not at all Less than 1 in 5 times Less than half the time About half the time More than half the time Almost always

26.1.1 How often have you had the sensation of not emptying your bladder?
26.1.2 How often have you had to urinate less than every two hours?
26.1.3 How often have you found you stopped and started again several times when you urinated?
26.1.4 How often have you found it difficult to postpone urination?
26.1.5 How often have you had a weak urinary stream?
26.1.6 How often have you had to strain to start urination?
26.1.7 How many times did you typically get up at night to urinate?

27 INCONTINENCE

27.1 How often do you leak urine?
(Tick once)

Never

About once a week or less often

Two or three times a week

About once a day

Several times a day

All the time

If Never, skip to 28.1.

If >Never:

URINARY INCONTINENCE

27.1.1 How much urine do you usually leak?
(Tick once)

None

A small amount

A moderate amount

A large amount

27.1.2 Overall, how much does leaking urine interfere with your everyday life?
Please ring a number between 0 (not at all) and 10 (a great deal)

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

27.1.3 When does urine leak?
(Tick once or more)

Never – urine does not leak

Leaks before you can get to the toilet.

Leaks when you cough or sneeze.

Leaks when you are asleep.

Leaks when you are physically active/exercising.

Leaks when you have finished urinating and are dressed.

Leaks for no obvious reason.

Leaks all the time.

27.1.4 Have you sought any help for urinary incontinence

No Yes

28 ANXIETY AND DEPRESSION

Below you find a list of different situations. Have you experienced some of them in the last week (including today)?

(Tick once for each complaint)

	No complaint	Little complaint	Pretty much	Very much

28.1 Sudden fear without apparent reason
28. Felt afraid or anxious
28.3 Faintness or dizziness
28.4 Felt tense or upset
28.5 Easily blamed yourself
28.6 Sleeping problems
28.7 Depressed or sad
28.8 Felt useless, worthless
28.9 Felt that everything is a struggle
28.10 Felt hopelessness with regard to the future

Tick the box beside the reply that is closest to how you have been feeling in the past week. Don't think too long over your replies: your immediate is best.

28.11 I feel tense or 'wound up'.

Most of the time

A lot of the time

From time to time, occasionally

Not at all

28.12 I still enjoy the things I used to enjoy.

Definitely as much

Not quite so much

Only a little

Hardly at all

28.13 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

28.14 I can laugh and see the funny side of things.

As much as I always could

Not quite as much now

Definitely not so much now

Not at all

28.15 Worrying thoughts go through my mind.

A great deal of the time

A lot of the time

From time to time, but not too often

Only occasionally

28.16 I feel cheerful.

Not at all

Not often

Sometimes

Most of the time

28.I can sit at ease and feel relaxed.

Definitely

Usually

Not often

Not at all

28.18 I feel as if I am slowed down.

Nearly all the time

Very often

Sometimes

Not at all

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

Not at all

Occasionally

Quite often

Very often

28.20 I have lost interest in my appearance.

Definitely

I don’t take as much care as I should

I may not take as much as ever

I take just as much care as ever

28.21 I feel restless as I have to be on the move.

Very much indeed

Quite a lot

Not very much

Not at all

28.22 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

28.23 I get sudden feelings of panic.

Very much indeed

Quite often

Not very often

Not at all

28.24 I can enjoy a good book or radio or TV program.

Often

Sometimes

Not often

Very seldom

29 WORRIES

Specify how typical or characteristic the following statement is for you

(Tick once for each statement, from 1=Not typical to 5= Very typical)

Not typical	Somewhat typical			Very typical
1	2	3	4	5

29.1 I worry all the time

29.2 Many situations make me worry

29.3 I am always worrying about something

30 Mental Trauma

Have you ever experienced one of the following events?

(Tick once or more for each line)

	No, have not experienced	Yes, before 18 years old	Yes, after 18 years old	Yes, the last year
30.1 A life-threatening illness or a serious accident (for example, fire, work accident, or car accident)				
30.2 Been exposed to violence (for example, hit, kicked, beaten, robbed, or threatened with a firearm)				
30.3 Been exposed to sexual abuse, i. e. sexual actions against your will				
30.4 Been called negative things, marginalized, threatened or bullied by schoolmates, fellow students, or coworkers over a longer period				
30.5 Witnessed someone close to you being exposed to violence or sexual abuse (for example, hit, kicked, beaten, robbed, or threatened with a firearm				
30.6 Experienced something else that was frightening, dangerous, or violent (for example, natural disaster, war, terror attack, held captive)				
30.7 Death of a close one and difficulty accepting the loss, yearning for the deceased, and intense emotional pain related to the loss.				
30.8 Received painful medical treatment when in hospital due to sickness or serious injury.				
30.9 Received painful medical treatmentat at the dentist.				
30.10 That someone close to you had a life-threatening illness or was exposed to a serious accident.				
30.11 Failure of care in childhood, i.e. not having received the necessary of food, clothing, protection and care/love from parents/caregivers				

No Yes

If No on all 30.1-30.11, skip to 31.1

If Yes on at least one of 30.1-30.11:

30.1.1 Do you still think a lot about what happened?

No Yes

31 ALCOHOL

31.1 Have you been drinking alcoholic beverages during the last year?

No Yes

If No, skip to 31.1.1.15.

If Yes:

As exact as you can, give an estimate of your alcohol habits. Keep the past year in mind when filling in.

31.1.1-*31.1.8.2*

9. Alkoholholdige drikker

Svar enten pr. måned eller pr. uke. Merk at porsjonsenhetene er forskjellige, 1/5 liter tilsvarer ett glass (2 dl), mens 1/3 liter tilsvarer 0,33 liter glassflaske/boks.

	Gang pr. måned			eller	Gang pr. uke					Mengde pr. gang						
	Aldri/ sjelden	1	2	3	1	2-3	4-5	6-7								
Øl, sterk øl, pils	☐	☐	☐	☐	☐	☐	☐	☐	(liter)	1/3 ☐	½ ☐	1 ☐	2 ☐	3 ☐	4+ ☐	
Lettøl	☐	☐	☐	☐	☐	☐	☐	☐	(liter)	1/3 ☐	½ ☐	1 ☐	2 ☐	3 ☐	4+ ☐	
Rusbrus, Cider m/alkohol	☐	☐	☐	☐	☐	☐	☐	☐	(liter)	1/5 ☐	1/3 ☐	½ ☐	1 ☐	1½ ☐	2+ ☐	
Rødvin	☐	☐	☐	☐	☐	☐	☐	☐	(vinglass)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6+ ☐	
Hvitvin	☐	☐	☐	☐	☐	☐	☐	☐	(vinglass)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6+ ☐	
Hetvin (portvin, sherry o.l.)	☐	☐	☐	☐	☐	☐	☐	☐	(1 glass = 4cl)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6+ ☐	
Brennevin, likør	☐	☐	☐	☐	☐	☐	☐	☐	(1 dram = 4cl)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6+ ☐	
Blandede drinker, cocktail	☐	☐	☐	☐	☐	☐	☐	☐	(drink)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6+ ☐	

How often the past year have you:

Never Less than monthly Monthly Weekly Daily

31.1.1.9 Not been able to stop drinking alcohol when first started?
31.1.1.10 Failed to do what was normally expected from you because of drinking?
31.1.1.11 Needed alcohol in the morning to get yourself going after a heavy drinking session?
31.1.1.12 Had a feeling of guilt or remorse after drinking?
31.1.1.13 Been unable to remember what happened the night before because you had been drinking?
31.1.1.14 Drunk so much that you felt highly intoxicated (drunk)?

How often the past year have you:

Never Yes, but not during the past year Yes, during the past year

31.1.1.15 Have you or someone else been injured because of your drinking?
31.1.1.16 Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

32 DRUG USE

32.1 Do/did you use drugs other than alcohol (for example cannabis, amphetamines, cocaine, heroin, hallucinogens, solvents, GHB)?

No Yes, now Yes, previously

If No skip to 32.2.

If Yes, now Yes, previously:

32.1.1 If you do/did use drugs other than alcohol (for example cannabis, amphetamines, cocaine, heroin, hallucinogens, solvents, GHB) - how old were you the first time?

Age first time ___

32.1.2 During the last 12 months, how often did you use other drugs than alcohol (for example cannabis, amphetamines, cocaine, heroin, hallucinogens, solvents, GHB)?

No use the last 12 months

Once a month or less often

2-4 times a month

2-3 times a week

4 times a week or more often

32.2 Do/did you use prescription drugs for recreational use (for example calming pills, sleeping pills, pain-relievers, ADHD-medication)?

No Yes, now Yes, previously

If No skip to 33.1.

If Yes, now or Yes, previously

32.2.1 If you do/did use prescription drugs for recreational use (for example calming pills, sleeping pills, pain-relievers, ADHD-medication) - how old were you the first time?

Age first time use ___

32.2.2 During the last 12 months, how often did you use prescription drugs for recreational use (for example calming pills, sleeping pills, pain-relievers, ADHD-medication)?

No use last 12 months

Once a month or less often

2-4 times a month

2-3 times a week

4 times a week or more often

33 SMOKE AND SNUFF

DAILY SMOKING

33.1 Do you/did you smoke daily?

Never Yes, now Yes, previously

If Never, skip to 33.2

If Yes, now or Yes, previously

DAILY SMOKING

33.1.1 How old were you when you began smoking daily?

Age__

33.1.2 How many years in all have you smoked daily?

Number of years__

33.1.3 How many cigarettes do you or did you usually smoke per day?

Number of cigarettes ____

If Yes, previously on 33.1:

33.1.4 If you previously smoked daily, how long is it since you stopped?

Number of years__

OCCASIONAL SMOKING

33.2 Do you smoke, or have you smoked sometimes, but not daily?

Never Yes, now Yes, previously

If Never, skip to 33.3.

If Yes, now or Yes, previously:

OCCASIONAL SMOKING

33.2.1 How many cigarettes do you or did you usually smoke per day?

Number of cigarettes__

DAILY USE OF SNUFF

33.3 Have you used or do you use snuff or chewing tobacco?

Never Yes, now Yes, previously

If Never, skip to 33.4.

If Yes, now or Yes, previously?

DAILY USE OF SNUFF

33.3.1 How old were you when you began using snuff or chewing tobacco?

Age__

33.3.2 How many years in all have you used snuff or chewing tobacco?

Number of years____

33.3.3 If you use or have used snuff - how many portions do/did you take in a week?

Number of portions ____

If Yes, previously on 33.3:

DAILY USE OF SNUFF

33.3.4 If you used snuff daily previously, how many years since you stopped?

Number of years__

OCCASIONAL SNUFF USE

33.4 Do you use, or have you used snuff sometimes, but not daily?

Never Yes, now Yes, previously

If Never, skip to 34.1

If Yes, now or Yes, previously:

OCCASIONAL SNUFF USE

33.4.1 How many portions did you/do you usually take in a week?

Number of portions____

3 NOISE

How sensitive are you to noise? Tick next to the statement that best fits

34.1 I am sensitive to noise

Agree strongly

Quite agree

Agree slightly

Disagree slightly

Quite disagree

Disagree strongly

34.2 Do you have a hearing loss (one/both ears)?

No Yes

34.3 During the last 12 months, did you experience ringing in your ears lasting more than 5 minutes?

No Yes

If No skip to 34.4:

If Yes:

RINGING IN THE EARS

34.3.1 How frequently do you have ringing in your ears?

(Tick once)

Less frequently than every week

Each week, but not every day

Each day, but not all the time

Most of the time

34.3.2 How long do the periods with ringing usually last?

(Tick once)

A few minutes

10 minutes- 1 hour

Longer than 1 hour

34.3.3 Some people do not care about the sound, for others it feels very troublesome to have ringing in their ears. Please, indicate how bothered you are by the ringing in your ears. (0 Not bothered, 10 Worst imaginable pain)

0 Not bothered 10 Worst imaginable pain

Over the past 12 months or so, when you are at home, how much are you bothered, disturbed, or annoyed by the following sources of noise?

(Tick once for each line)

Not at all Slightly Moderately Very Extremely

34.4 Road traffic
34.5 Helicopter
34.6 Aircraft
34.7 Boat/ship/port
34.8 Building and construction work
34.9 Industrial and business activity
34.10 Neighbour/others outside your home
34.11 Others inside your home (e.g. who plays loud music, snoring partner, child who wakes up screaming at night etc.)
34.12 Other noise source

34.13 How many years in total have you worked in noisy locations where it has been necessary to shout to be heard?

Number of years___

If not Work full-time or Work part-time on 4.1, skip to 35.1

If Work full-time or Work part-time on 4.1:

34.13.1 Over the past 12 months, how much have you been bothered (by music, people talking, ventilation plant, machinery, equipment etc.) that has been disturbing your work?

Not at all

Slightly

Moderately

Very

Extremely

35 ORAL HEALTH

Next are questions concerning how your teeth and general dental health affect you in everyday life. First you will find questions regarding bothers with your teeth or dentures.

BOTHERS WITH TEETH/DENTURES

Every or nearly every day Once or twice a week Once or twice a month Less than once a month
Never affected

During the past 6 months:

35.1 During the past 6 months, how often have problems with your mouth and teeth caused you any difficulty with eating and enjoying food?

35.2 During the past 6 months, how often have problems with your mouth and teeth caused you any difficulty with speaking and pronouncing clearly?

35.3 During the past 6 months, how often have problems with your mouth and teeth caused you any difficulty with cleaning your teeth?

35.4 During the past 6 months, how often have problems with your mouth and teeth caused you any difficulty with sleeping and relaxing?

35.5 During the past 6 months, how often would you say that these ailments have made it difficult smiling and showing teeth without embarrassment?

35.6 During the past 6 months, how often would you say that these ailments have made it difficult maintaining usual emotional state?

35.7 During the past 6 months, how often would you say that these ailments have made it difficult enjoying contact with other people?

35.8 During the past 6 months, how often would you say that these ailments have made it difficult carrying out major work and a social role?

35.9 How often do you usually brush your teeth?

Once a week or less often

A couple of times every week

Once a day

Twice a day or more often

35.10 Do you go regularly to the dentist / dental care?

Yes, at least once a year

Yes, every year

Yes, every second year

Yes, with longer intervals than 2 years

No, only for acute problems

No, never goes

Do you use some of these oral hygiene products- and if so how often?

	Never/rarely	A couple of times every month	A couple of times every week	Daily

35.11 Fluoride toothpaste
35.12 Floss, interdental brushes and/or tooth-sticks
35.13 Fluoride tablets
35.14 Fluoride mouth rinse (Flux,Fluorid mouth rinse, Nycodent)
35.15 Antibacterial mouth rinse (Listerine, Corsodyl, Klorhexidin)?

Next are questions on how you experience a visit to the dentist. To what degree would you feel anxious in connection with a visit to the dentist?

Not anxious Slightly anxious Fairly anxious Very anxious Extremely anxious

35.16 If you went to your dentist for treatment tomorrow, how would you feel?
35.17 If you were sitting in the waiting room (waiting for treatment), how would you feel?
35.18 If you were about to have a tooth drilled, how would you feel?
35.19 If you were about to have your teeth scaled and polished, how would you feel?
35.20 If you were about to have a local anaesthetic injection in your gum, above an upper back tooth, how would you feel
?

36 SKIN AND DERMATOLOGY

Do you have, or have you had any of the following skin and dermatology diseases?

No Yes

36.1 Psoriasis
36.2 Psoriasis arthritis
36.3 Atopic eczema (children's eczema, atopic dermatitis)
36.4 Recurring hand eczema
36.5 Recurring large, painfull, lumps or abscesses which often heal with a scar in your armpits, groins or under your breasts (disease called hidradenitis suppurativa)

If Yes on 36.1:

PSORIASIS
36.1.1 Have you ever been diagnosed with psoriasis by a doctor?
No Yes

36.1.2 Have you had a psoriasis rash within the last 12 months?
No Yes

If Yes on 36.2:

36.1.2.1 Which description best describes/ described your psoriasis rash over the last 12 months?
(Tick once)

Sudden outbreak of tiny spots (less than one cm) spread over the entire body

Patches on the elbows/ knees/ scalp that appear sometimes

Patches on the elbows/ knees/ scalp that are almost always there

Patches on the elbows/ knees/ scalp that are almost always there, but also some patches on the torso/ upper body

Outbreaks of psoriasis rash on larger areas of the body occasionally

Psoriasis rash on larger area of the body, which are almost always present

If Yes on 36.2:

Psoriasis arthritis

36.2. Have you had symptoms of psoriasis arthritis within the last 12 months?

No Yes

If Yes on 36.3:

Atopic eczema (children's eczema, atopic dermatitis)

36.3.1 Have you had atopic eczema (atopic dermatitis) rash within the last 12 months?

No Yes

If Yes on 36.4:

Recurring hand eczema

36.4.1 Have you had a hand eczema rash within the last 12 months?

No Yes

If Yes on 36.5:

PAINFULL LUMPS (HIDRADRENITIS)

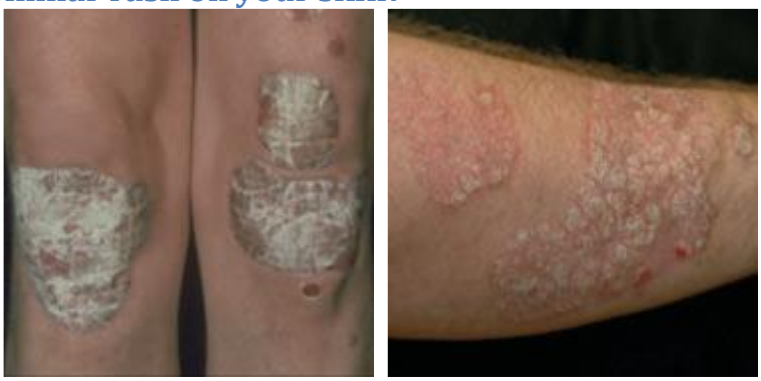
36.5.1 Have you had outbreaks/ symptoms of hidradenitis within the last 12 months?

No Yes

Do you have, or have you had:

(Tick once or more)

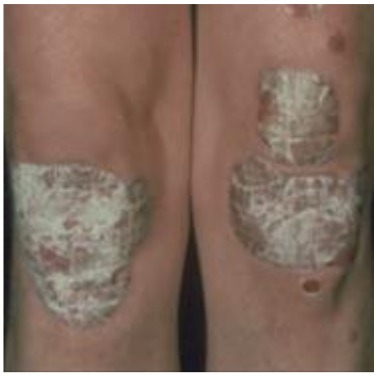
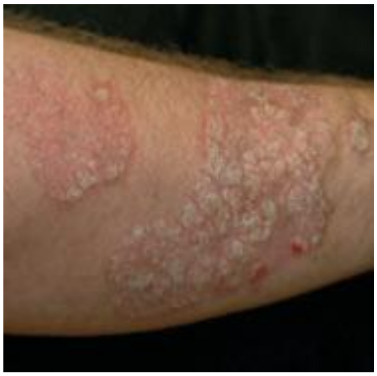
36.6 Similar rash on your skin?



No Yes

If No, skip to 36.7.

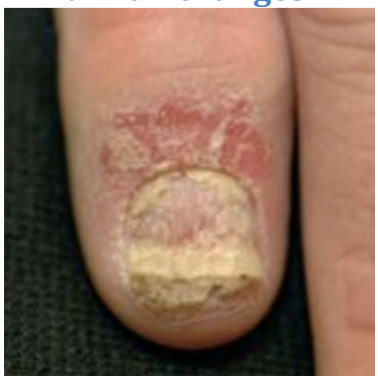
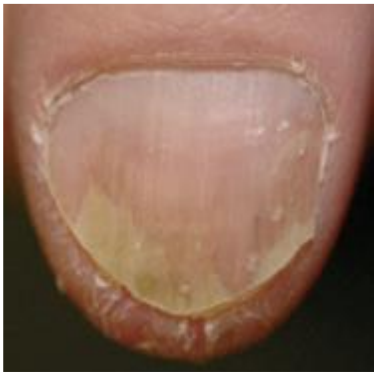
If Yes:

36.6.1 Have you had a similar rash within the last 12 months?

No Yes

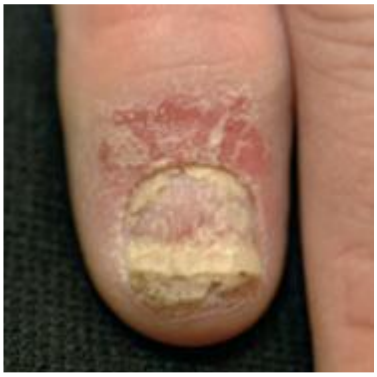
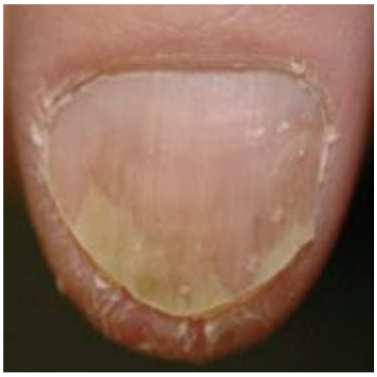
36.7 Similar nail changes?

No Yes

If No, skip to 36.8.

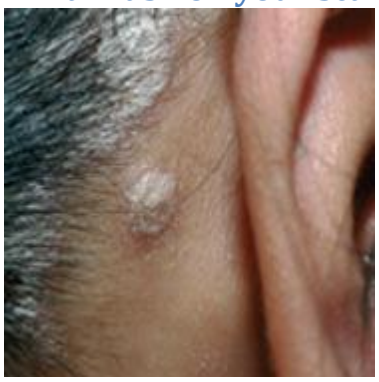
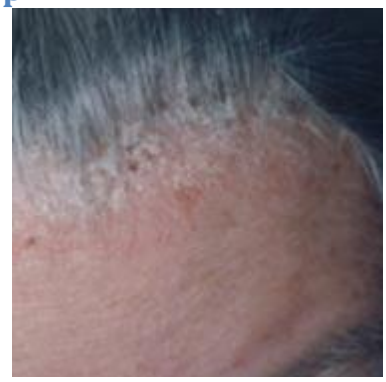
If Yes:

36.7.1 Have you had similar nail changes within the last 12 months?

No Yes

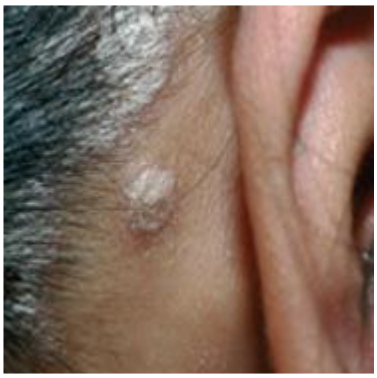
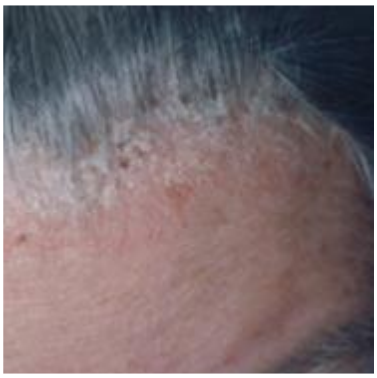
36.8 Similar rash on your scalp?

No Yes

If No, skip to 36.9.

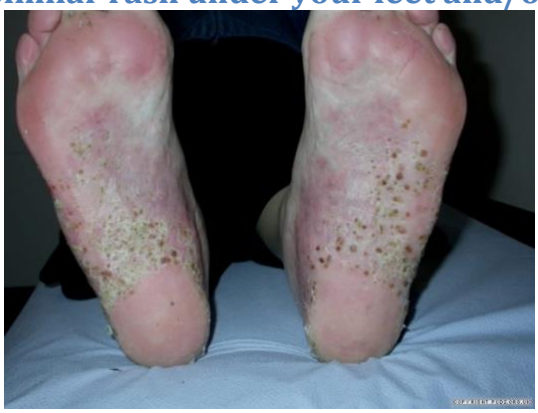
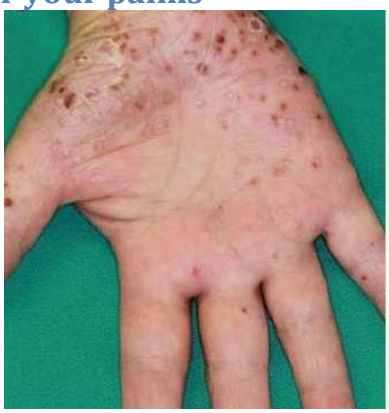
If Yes:

36.8.1 Have you had a similar rash within the last 12 months?

No Yes

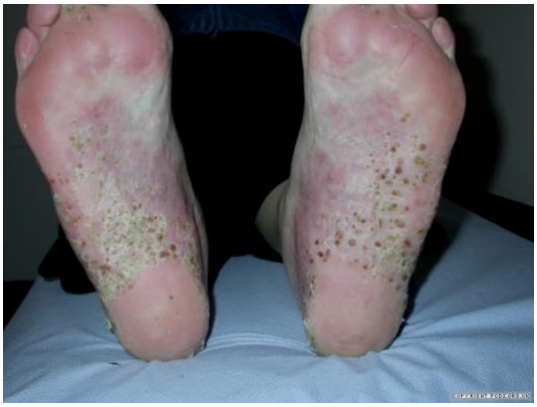
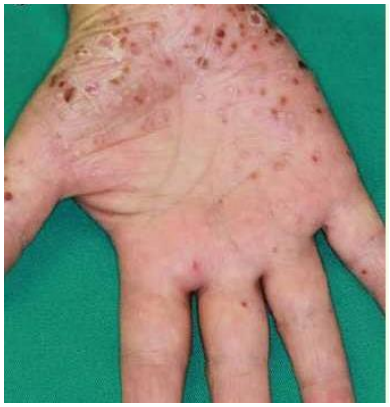
36.9 Similar rash under your feet and/or your palms

No Yes

If No, skip to 36.10.

If Yes:

36.9.1 Have you had a similar rash within the last 12 months?

No Yes

36.10 Have you had a rash or redness/irritation in your groin area, between your buttocks or under your arms which have lasted for more than 2 weeks at a time?

No Yes

37 TRAVEL AND ILLNESS

37.1 Please specify the number of travels you have performed during the past 12 months outside the Nordic countries with a duration of >1 week.

(Put in 0 if you do not have any travels of >1 week outside the Nordic countries in the past 12 months)

Number of travels in dropdown menu (1-20 travels)

If Travels=0 skip to 38.1

If Travels >0:

For each travel outside the Nordic countries with a duration of >1 week, tick the country you visited the longest, if you had diarrhoea during your stay and if you had a hospital admission and how many times:

For reise 1-20:

37.1.1 Countries

Dropdown menu countries (200 countries)

37.1.2 Diarrhoea

No Yes

37.1.3 Number of hospital admissions

(Put in 0 if you were not admitted to a hospital in connection with your travel)

Number of times__

If number of times hospital admission =0, skip to 38.1.

If number of times hospital admission >0:

For each hospital admission in a country outside the Nordic countries during the past 12 months please specify in which country, what month and for how long you were hospitalized

37.1.3.1 Country

Dropdown menu countries alphabetical (200 countries)

37.1.3.2 Month hospitalized

(e.g March 2015)

37.1.3.3 Duration of hospitalization

Number of days__

38 ANTIBIOTICS BOUGHT ABROAD

38.1 Have you bougth antibiotics abroad during the last 12 months (penicillin-like medicine to treat infection)?

No Yes

If No, questioner completed

If Yes:

38.1.1 How did you acquire it?

Prescription from doctor/dentist

From a pharmacy, without prescription?