# Health Survey

## Personal Invitation

<table>
<thead>
<tr>
<th>5.3 (Municipality)</th>
<th>9.3 (Business)</th>
<th>9.4 (Occupation)</th>
<th>14.7 (Mark)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. YOUR OWN HEALTH

1.1 What is your current state of health? (Tick one only)

<table>
<thead>
<tr>
<th>Poor</th>
<th>Not so good</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

1.2 Do you have, or have you had?:

- Asthma
- Hay fever
- Chronic bronchitis/emphysema
- Diabetes
- Osteoporosis
- Fibromyalgia/chronic pain syndrome
- Psychological problems for which you have sought help
- A heart attack
- Angina pectoris (heart cramp)
- Cerebral stroke/brain haemorrhage

1.3 Have you noticed attacks of sudden changes in your pulse or heart rhythm in the last year? [ ] Yes [ ] No

1.4 Do you get pain or discomfort in the chest when:

Walking up hills, stairs or walking fast on level ground? [ ] Stop? [ ] Slow down? [ ] Carry on at the same pace?

1.5 If you get such pain, do you usually:

[ ] Stop? [ ] Slow down? [ ] Carry on at the same pace?

1.6 If you stop, does the pain disappear within 10 minutes? [ ] Yes [ ] No

1.7 Can such pain occur even if you are at rest? [ ] Yes [ ] No

2. MUSCULAR AND SKELETAL COMPLAINTS

2.1 Have you suffered from pain and/or stiffness in muscles and joints during the last 4 weeks? (Give duration only if you have had problems)

<table>
<thead>
<tr>
<th>Neck/shoulders</th>
<th>Arms, hands</th>
<th>Upper part of your back</th>
<th>Lumbar region</th>
<th>Hips, legs, feet</th>
<th>Other places</th>
</tr>
</thead>
<tbody>
<tr>
<td>No complaint</td>
<td>Some complaint</td>
<td>Severe complaint</td>
<td>Duration</td>
<td>Up to 2 weeks</td>
<td>2 weeks or more</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age first time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

2.2 Have you ever had:

- Fracture in the wrist/forearm
- Hip fracture

3. OTHER COMPLAINTS

3.1 Below is a list of various problems. Have you experienced any of this during the last week (including today)? (Tick one for each complaint)

- Sudden fear without reason
- Felt afraid or anxious
- Faintness or dizziness
- Felt tense or upset
- Tend to blame yourself
- Sleeping problems
- Depressed, sad
- Feeling of being useless, worthless
- Feeling that everything is a struggle
- Feeling of hopelessness with regard to the future

4. USE OF HEALTH SERVICES

4.1 How many times in the last 12 months have you been to used: (Tick one for each line)

- General practitioner (GP)
- Medical officer at work
- Psychologist or psychiatrist (private or out-patient clinic)
- Other specialist (private or out-patient clinic)
- Emergency GP (private or public)
- Hospital admission
- Home nursing care
- Physiotherapist
- Chiropactor
- Dentist
- Alternative practitioner

5. CHILDHOOD/YOUTH AND AFFILIATION

5.1 How long altogether have you lived in the county? (Put 0 if less than half a year)

5.2 How long altogether have you lived in the municipality? (Put 0 if less than half a year)

5.3 Where did you live most of the time before the age of 16? (Tick one option and specify)

- Same municipality
- Another municipality in the county
- Another county in Norway
- Outside Norway

5.4 Have you moved within the last five years?

No [ ] Yes, one time [ ] Yes, more than once

6. BODY WEIGHT

6.1 Estimate your body weight when you were 25 years old: [ ] kg
7. FOOD AND BEVERAGES

7.1 How often do you usually eat these foods? (Tick once per line)

- Fruit, berries
- Cheese (all types)
- Potatoes
- Boiled vegetables
- Fresh vegetables/salad
- Fatty fish (e.g. salmon, trout, mackerel, herring)

7.2 What type of fat do you usually use? (Tick once per line)

- On bread: Don’t use, Butter, Hard margarine, Soft/light margarine, Oils, Other
- For cooking: Don’t use, Butter, Hard margarine, Soft/light margarine, Oils, Other

7.3 Do you use the following dietary supplements?

- Cod liver oil, fish oil capsules

7.4 How much of the following do you usually drink? (Tick once per line)

- Full milk, full-fat curdled milk, yoghurt
- Semi-skinned milk, semi-skimmed curdled milk, low-fat yoghurt
- Skimmed milk, skimmed curdled milk
- Extra semi-skimmed milk
- Juice
- Water
- Mineral water (e.g. Farris, Ramlesa etc)
- Cola-containing soft drink
- Other soda/soft drink

7.5 Do you usually drink soft drink: with sugar? 1, without sugar? 2

7.6 How many cups of coffee and tea do you drink daily? (Put 0 for the types you don’t drink daily)

- Filtered coffee
- Boiled coffee/coarsely ground coffee for brewing
- Other type of coffee

- Tea

7.7 Approximately how often have you during the last year consumed alcohol? (Do not count low-alcohol and alcohol-free beer)

- Never consumed alcohol
- Never consumed alcohol last year
- About 1 time a week
- 1.5 times a week
- 2-3 times a month
- About 1 time a month

7.8 When you drink alcohol, how many glasses or drinks do you normally drink?

7.9 Approximately how many times during the last year have you consumed alcohol equivalent to 5 glasses or drinks within 24 hours?

7.10 When you drink, do you normally drink: (Tick one or more)

- Beer
- Wine
- Spirits

8. SMOKING

8.1 How many hours a day do you normally spend in smoke-filled rooms? Number of total hours

8.2 Did any of the adults smoke at home while you were growing up?

8.3 Do you currently, or did you previously live together with a daily smoker after your 20th birthday?

8.4 Do you/did you smoke daily?

8.5 If you smoke daily now, do you smoke:

- Cigarettes
- Cigars/cigarillos
- A pipe

8.6 If you previously smoked daily, how long is it since you quit?

8.7 If you currently smoke, or have smoked previously:

- How many cigarettes do you or did you normally smoke per day?
- How old were you when you began daily smoking?
- How many years in all have you smoked daily?

9. EDUCATION AND WORK

9.1 How many years of education have you completed?

9.2 Do you currently have paid work?

9.3 Describe the activity at the workplace where you had paid work for the longest period in the last 12 months.

- Business: If retired, enter the former business and occupation. Also applies to 9.4

9.4 Which occupation/title have or had you at this workplace?

- Occupation: 

9.5 In your main occupation, do you work as self-employed, as an employee or family member without regular salary?

9.6 Do you believe that you are in danger of losing your current work or income within the next two years?

9.7 Do you receive any of the following benefits?

- Sickness benefit (are on sick leave)
- Old age pension, early retirement (AFP) or survivor pension
- Rehabilitation/reintegration benefit
- Disability pension (full or partial)
- Unemployment benefits during unemployment
- Social welfare benefits
- Transition benefit for single parents
11. FAMILY AND FRIENDS

11.1 Do you live with: Yes No
Spouse/partner?.................................

11.2 How many good friends do you have? Number of friends
Count the ones you can talk confidentially with and who can give you help when you need it. Do not count people you live with, but do include other relatives.

11.3 How much interest do people show for what you do? (Tick only once)
Great interest Some interest Little interest No interest Uncertain

11.4 How many associations, sport clubs, groups, religious communities or similar do you take part in? Number
(Write 0 if none)

11.5 Do you feel that you can influence what happening in your local community where you live? (Tick only once)
Yes, a lot Yes, some Yes, a little No Never

12. ILLNESS IN THE FAMILY

12.1 Have one or more of your parents or siblings had a heart attack (heart wound) or angina pectoris (heart cramp)? ......................... Yes No Don’t know

12.2 Tick for the relatives who have or have had any of the illnesses: (Tick for each line)
Cerebral stroke or brain haemorrhage ..........
Heart attack before age of 60 years
Asthma
Cancer
Diabetes

12.3 If any relatives have diabetes, at what age did they get diabetes (if for e.g. many siblings, consider the one who got it earliest in life):

13. USE OF MEDICINES

13.1 Do you use:
Blood pressure lowering drugs .......... Yes No Never
Cholesterol-lowering drugs .......... Yes No Never

13.2 How often have you during the last 4 weeks used the following medicines? (Tick once for each line)

13.3 For those medicines you have checked in points 13.1 and 13.2, and that you’ve used during the last 4 weeks:
State the name and the reason that you are taking/have taken it (disease or symptom): (Tick for each duration you have used the medicine)

14. THE REST OF THE FORM IS TO BE ANSWERED BY WOMEN ONLY

14.1 How old were you when you started menstruating? Age in years

14.2 If you no longer menstruating, how old were you when you stopped menstruating? Age in years

14.3 Are you pregnant at the moment?
Yes No Unable to tell Above fertile age

14.4 How many children have you given birth to? Number of children

14.5 Do you use, or have you ever used? (Tick once for each line)
Oral contraceptive pills/mini pill/contraceptive injection
Hormonal intrauterine device (IUD) (not ordinary IUD).
Estrogen (tablets or patches)
Estrogen (cream or suppositories)

14.6 If you use/have used prescription estrogen: How long have you used it? Number of years

14.7 If you use contraceptive pills, mini pill, contraceptive injection, hormonal IUD or estrogen, what brand do you use?