CODING VERSION

The Raine Study Gen2_27 year follow up

Thank you for completing this questionnaire.

The purpose of this questionnaire is to collect background information about you that may be related to your general health and well being

Please complete all the questions.

Please use a pen to complete the questionnaire

All your responses are confidential and will be de-identified. Your responses will be entered and kept in a secure database and only used for analyses as part of a large de-identified amalgamated database. This questionnaire will have your contact details removed. It will then be stored with all other Raine Study information in our secure storage facilities.

If you have any questions please contact the Raine Study, telephone 6488 6952, mobile 0447 863944, email: rainestudy@uwa.edu.au.

9. ASTHMA AND ALLERGY

The following questions are about breathing difficulties and allergies

10.1 Have you wheezed in the last 12 months?

0	○	No *(Please go to Q9.2)*
1	○	Yes

Y27_RE34

In the last 12 months, how often on average has your sleep been disturbed due to wheezing?

0	○	Never woken with wheezing
1	○	Less than one night per week
2	○	One or more nights per week
3	○	Don't know

Y27_RE36

Wheezing ever been severe enough to limit your speech to only one or two words at a time between breaths?

0	○	No
1	○	Yes
2	○	Don't know

Y27_RE37

Your chest sounded wheezy during or after exercise?

0	○	No
1	○	Yes
2	○	Don't know

Y27_RE8

***9.2* Do you think you have ever had asthma?**

0	○	No
1	○	Yes
2	○	Don't know

Y27_AS1

Has a doctor (GP, respiratory specialist) ever told you that you have asthma?

0	○	No
1	○	Yes
2	○	Don't know
3	○	Never had asthma

Y27_AS2

Do you still have asthma?

0	○	No
1	○	Yes
2	○	Don't have asthma *(Please go to 9.3)*
3	○	Don't know

Y27_AS16

Have you taken/used any of the following asthma medications in the last 12 months?

0	○	No *(Please go to Q9.3)*
1	○	Yes

Y27_AS67

If yes, Please select all medications you have used in the last 12 months.

- ○ Ventolin – **Y27_AS18**
- ○ Respolin – **Y27_AS20**
- ○ Bricanyl - **Y27_AS26**
- ○ QVAR – **Y27_AS35**
- ○ Flixotide – **Y27_AS39**
- ○ Pulmacort – **Y27_AS41**
- ○ OXIS – **Y27_AS50**
- ○ Serevent – **Y27_AS52**
- ○ Singulaire – **Y27_AS54**
- ○ Seretide – **Y27_AS59**
- ○ Symbacort – **Y27_AS61**
- ○ Prednisolone – **Y27_AS63**
- ○ Other (please specify) ..... Y27_AS65 & Y27_AS65A .....

What triggers your asthma? (*Please select all that apply)*

- ○ Viral infection – **Y27_AS69**
- ○ Grass – **Y27_AS70**
- ○ Pollen – **Y27_AS71**
- ○ Animal – **Y27_AS72**
- ○ Dust – **Y27_AS73**
- ○ Other (please specify) ..... Y27_AS75 & Y27_AS75A .....
- ○ Don't know – **Y27_AS74**

***9.3*In the last 12 months, have you had a problem with sneezing or a runny or blocked nose (including hay fever) when you DID NOT have a cold or flu?**

0	○	No *(Please go to Q9.4)*	Y27_RE69
1	○	Yes	

In the last 12 months, was this nose problem accompanied by itchy-watery eyes?

0	○	No	Y27_RE63
1	○	Yes	

In the last 12 months, how many episodes of allergic nose problem have you had (including hay fever)?

0	○	1 to 2	Y27_HF3
1	○	3 to 12	
2	○	More than 12	

In which of the last 12 months did this problem occur? *(Please select all that apply)*

- ○ January
- ○ February
- ○ March
- ○ April
- ○ May
- ○ June
- ○ July
- ○ August
- ○ September
- ○ October
- ○ November
- ○ December

Y27_RE80-91

Has a doctor (GP) ever told you that you have an allergic nose problem?

0 ○ No
1 ○ Yes

Y27_RE24

What was the trigger/cause of these problems?

- ○ Grass
- ○ Pollen
- ○ Animal
- ○ Dust
- ○ Other *(Please specify)*.....
- ○ Don't know

Y27_HF7A-F

Have you taken/used any medication for an allergic nose problem (including hay fever) in the last 12 months?

0 ○ No *(Please go to Q9.4)*
1 ○ Yes

Y27_HF32

If yes, please list the medication(s) below and indicate whether it was prescribed by a doctor.

Name of medication	Prescribed by Doctor	Not prescribed by Doctor
----------	☐	☐
----------	☐	☐
----------	☐	☐
	☐	☐

***9.4* Do you think that you have ever had an allergic reaction in the eyes (including hay fever)?**

0	○	No
1	○	Yes
2	○	Don't know

Y27_CO1

19.2 Has a doctor (GP, respiratory specialist) ever told you that you had an allergic reaction in the eyes (including hay fever)?

0	○	No
1	○	Yes
2	○	Don't know

Y27_CO2

In the last 12 months, have you suffered from an allergic reaction in the eyes (including hay fever)?

0	○	No *(Please go to **Q9.5**)*
1	○	Yes

Y27_CO4

In the last 12 months, how many episodes of allergic reaction in the eyes have you had (including hay fever)?

0	○	1 to 2
1	○	3 to 12
2	○	More than 12

Y27_CO5

In which of the last 12 months did this problem occur? *(Please select all those applicable)*

- ○ January
- ○ February
- ○ March
- ○ April
- ○ May
- ○ June
- ○ July
- ○ August
- ○ September
- ○ October
- ○ November
- ○ December

Y27_CO21 - 32

What was the trigger/cause of these problems?

- ○ Grass
- ○ Pollen
- ○ Animal
- ○ Dust
- ○ Other *(Please specify)*.....
- ○ Don't know

Y27_CO6A-F

Have you taken/used any medication for an allergic eye reaction (including hay fever) in the last 12 months?

0 ○ No *(Please go to Q9.5)*
1 ○ Yes

Y27_CO48

If yes, please list the medication(s) below and indicate whether it was prescribed by a doctor.

Name of medication	Prescribed by Doctor	Not prescribed by Doctor
----------	☐	☐
----------	☐	☐
----------	☐	☐
----------	☐	☐

***9.5* Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?**

0 ○ No
1 ○ Yes

Y27_RS1

Do you get short of breath walking with other people your own age on level ground?

0 ○ No
1 ○ Yes

Y27_RS2

Do you have to stop for breath when walking at your own pace on level ground?

0 ○ No
1 ○ Yes

Y27_RS3

Do you ever get short of breath at rest?

0 ○ No
1 ○ Yes

Y27_RS4

Do you usually cough first thing in the morning?

0 ○ No
1 ○ Yes

Y27_RS5

Do you usually cough during the day or at night?

0 ○ No
1 ○ Yes

Y27_RS6

If yes to either,

Do you cough like this on most days for as much as three months each year?

0 ○ No
1 ○ Yes

Y27_RS7

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Do you usually bring up phlegm from your chest first thing in the morning?

0 ○ No
1 ○ Yes

Y27_RS8

Do you usually bring up phlegm from your chest during the day or at night?

0 ○ No
1 ○ Yes

Y27_RS9

If yes to either,

Do you bring up phlegm like this on most days for as much as three months each year?

0 ○ No
1 ○ Yes

Y27_RS10

Have you ever had eczema or an itchy rash which was coming and going for at least 12 months?

0 ○ No *(Please go to **Q9.6**)*
1 ○ Yes

Y27_RH1

Has this eczema/itchy rash at any time affected any one of the following places – the folds of the elbows, behind the knees, in front of the ankles, under the buttocks or around the neck, ears or eyes?

0 ○ No
1 ○ Yes

Y27_RH3

In the last 12 months, how often, on average, have you been kept awake at night by this itchy rash?

0 ○ Never in the last 12 months
1 ○ Less than one night per week
2 ○ One or more nights per week

Y27_RH6

Has this rash cleared completely during the last 12 months?

0 ○ No
1 ○ Yes

Y27_RH5

Do you think that you have ever had eczema?

0 ○ No
1 ○ Yes
2 ○ Don't know

Y27_RH7

Has a doctor (GP, respiratory specialist) ever told you that you have eczema?

0 ○ No
1 ○ Yes
2 ○ Don't know

Y27_RH11

In the last 12 months, have you suffered from eczema?

0 ○ No *(Please go to Q9.6)*
1 ○ Yes

Y27_RH12

In the last 12 months, how many episodes of eczema have you had?

0 ○ 1 to 2
1 ○ 3 to 12
2 ○ More than 12

Y27_RH13

In which of the last 12 months did this problem occur? *(Please select all those applicable)*

- ○ January
- ○ February
- ○ March
- ○ April
- ○ May
- ○ June
- ○ July
- ○ August
- ○ September
- ○ October
- ○ November
- ○ December

Y27_RH28-39

Have you taken/used any medication for eczema in the last 12 months?

0 ○ No *(Please go to Q9.6)*
1 ○ Yes

Y27_RH49

If yes, please list the medication(s) below and indicate whether it was prescribed by a doctor.

Name of medication	Prescribed by Doctor	Not prescribed by Doctor
----------	☐	☐
----------	☐	☐
----------	☐	☐
	☐	☐

***9.6* Do you have any food allergies?**

0 ○ No *(Please go to Q10)*
1 ○ Yes

Y27_FAL

If yes, please tick all foods that you are allergic to

- ○ Peanut Products – FD1A
- ○ Wheat/Yeast – FD2A
- ○ Dairy – FD3A
- ○ Fruit – FD4A
- ○ Eggs –FD5A
- ○ Seafood – FD6A
- ○ Preservatives/Colouring – FD7A
- ○ Other (please specify) .....

Y27_FD8A & Y27_FD8Aa

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