



DASS-21 Q14 I was intolerant of anything that kept me from getting on with what I was doing G126_FL42	0	1	2	3
DASS-21 Q15 I felt I was close to panic G126_FL35	0	1	2	3
DASS-21 Q16 I was unable to become enthusiastic about anything G126_FL32	0	1	2	3
DASS-21 Q17 I felt I wasn't worth much as a person G126_FL31	0	1	2	3
DASS-21 Q18 I felt that I was rather touchy G126_FL21	0	1	2	3
DASS-21 Q19 I was aware of the action of my heart in the absence of physical exertion (eg. sense of heart rate increase, heart missing a beat) G126_FL18	0	1	2	3
DASS-21 Q20 I felt scared without any good reason) G126_FL19	0	1	2	3
DASS-21 Q21 I felt that life was meaningless G126_FL41	0	1	2	3


6.3 Have any of the following happened to you in the last year? (Please select all that apply)

- Serious illness or injury to yourself G126_ST12 = 1
- Serious illness or injury to a close relative G126_ST13 = 1
- Death of a close family member G126_ST14 = 1
- Death of a close family friend or relative G126_ST15 = 1
- Separation due to marital difficulties G126_ST16 = 1
- Broken off a steady relationship G126_ST17 = 1
- Serious problem with a close friend, neighbour or relative G126_ST18 = 1
- Unemployed/seeking work for more than one month G126_ST19 = 1
- Your own job loss (not voluntary) G126_ST7 = 1
- Major financial crisis G126_ST20 = 1
- Problems with police and court appearance G126_ST21 = 1
- Something valuable lost or stolen G126_ST22 = 1


This next section asks about your use of information technology (mobile phones, computers, television etc.)


11.1. The following questions are about how often and for how long you use these electronic devices. Please select your response for each item in each column.


		WEEKDAY (Mon – Fri)		WEEKEND (Sat – Sun)		Total
		On a typical Monday to Friday, how many days do you use this device? (Tick ONE only)	On each of these weekdays, for about how long do you use this device per day? (Tick ONE only)	On a typical Saturday to Sunday, how many days do you use this device? (Tick ONE only)	On each of these weekend days, for about how long do you use this device per day? (Tick ONE only)	What percent of your total weekly use of this device is for work purposes? (Tick ONE only)
Television 	G126_TVWD <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3 <input type="radio"/> 3 days = 4 <input type="radio"/> 4 days = 5 <input type="radio"/> 5 days = 6	G126_TVWDH <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16	G126_TVWE <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3	G126_TVWEH <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16	G126_TVWP <input type="radio"/> Do not use for work = 1 <input type="radio"/> about 25% = 2 <input type="radio"/> about 50% = 3 <input type="radio"/> about 75% = 4 <input type="radio"/> only use for work = 5	
	Desktop computer 	G126_DWD <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3 <input type="radio"/> 3 days = 4 <input type="radio"/> 4 days = 5 <input type="radio"/> 5 days = 6	G126_DWDH <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7	G126_DWE <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3	G126_DWEH <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6	G126_DWP <input type="radio"/> Do not use for work = 1 <input type="radio"/> about 25% = 2 <input type="radio"/> about 50% = 3 <input type="radio"/> about 75% = 4 <input type="radio"/> only use for work = 5

		<input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16		<input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16	
	WEEKDAY (Mon – Fri)		WEEKEND (Sat – Sun)		Total
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Laptop 	G126_LWD <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3 <input type="radio"/> 3 days = 4 <input type="radio"/> 4 days = 5 <input type="radio"/> 5 days = 6	G126_LWDH <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16	G126_LWE <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3	G126_LWEH <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16	G126_LWP <input type="radio"/> Do not use for work = 1 <input type="radio"/> about 25% = 2 <input type="radio"/> about 50% = 3 <input type="radio"/> about 75% = 4 <input type="radio"/> only use for work = 5
Tablet	G126_TWD <input type="radio"/> Do not use = 1	G126_TWDH <input type="radio"/> Do not use = 1	G126_TWE <input type="radio"/> Do not use = 1	G126_TWEH <input type="radio"/> Do not use = 1	G126_TWP <input type="radio"/> Do not use for work = 1

CODING VERSION

<p>(e.g. iPad, Samsung Galaxy Tab, Kindle e-reader)</p> 	<ul style="list-style-type: none"> <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3 <input type="radio"/> 3 days = 4 <input type="radio"/> 4 days = 5 <input type="radio"/> 5 days = 6 	<ul style="list-style-type: none"> <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16 	<ul style="list-style-type: none"> <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3 	<ul style="list-style-type: none"> <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16 	<ul style="list-style-type: none"> <input type="radio"/> about 25% = 2 <input type="radio"/> about 50% = 3 <input type="radio"/> about 75% = 4 <input type="radio"/> only use for work = 5
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	On a typical Monday to Friday, how many days do you use this device? (Tick ONE only)	On each of these weekdays, for about how long do you use this device per day? (Tick ONE only)	On a typical Saturday to Sunday, how many days do you use this device? (Tick ONE only)	On each of these weekend days, for about how long do you use this device per day? (Tick ONE only)	What percent of your total weekly use of this device is for work purposes? (Tick ONE only)
<p>Mobile phone (i.e. smartphone or non-smartphone)</p> 	<p>G126_MWD</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3 <input type="radio"/> 3 days = 4 <input type="radio"/> 4 days = 5 <input type="radio"/> 5 days = 6 	<p>G126_MWDH</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16 	<p>G126_MWE</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3 	<p>G126_MWEH</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16 	<p>G126_MWP</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use for work = 1 <input type="radio"/> about 25% = 2 <input type="radio"/> about 50% = 3 <input type="radio"/> about 75% = 4 <input type="radio"/> only use for work = 5
<p>Electronic games</p>	<p>G126_NEWD</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3 <input type="radio"/> 3 days = 4 <input type="radio"/> 4 days = 5 <input type="radio"/> 5 days = 6 	<p>G126_NEWDH</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 	<p>G126_NEWE</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use = 1 <input type="radio"/> 1 day = 2 <input type="radio"/> 2 days = 3 	<p>G126_NEWEH</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use = 1 <input type="radio"/> 5 minutes = 2 <input type="radio"/> 15 minutes = 3 <input type="radio"/> 30 minutes = 4 <input type="radio"/> 1 hour = 5 <input type="radio"/> 2 hours = 6 <input type="radio"/> 3 hours = 7 <input type="radio"/> 4 hours = 8 	<p>G126_NEWP</p> <ul style="list-style-type: none"> <input type="radio"/> Do not use for work = 1 <input type="radio"/> about 25% = 2 <input type="radio"/> about 50% = 3 <input type="radio"/> about 75% = 4 <input type="radio"/> only use for work = 5

<p>(played sitting e.g. Xbox or PS3 console games and PSP or Nintendo DS handheld games)</p> 		<ul style="list-style-type: none"> <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16 		<ul style="list-style-type: none"> <input type="radio"/> 5 hours = 9 <input type="radio"/> 6 hours = 10 <input type="radio"/> 7 hours = 11 <input type="radio"/> 8 hours = 12 <input type="radio"/> 9 hours = 13 <input type="radio"/> 10 hours = 14 <input type="radio"/> 11 hours = 15 <input type="radio"/> 12 hours or more = 16 	
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The following questions are about your smoking history. It is important to know if you smoke/have ever smoked, or spend time with people who do.

12.1 Have you ever smoked cigarettes? G126_SM1

- No (*Please go Q12.6*) = 0
- Yes (*YES means more than 1 cigarette per day for a year, or 20 packs in a lifetime*) = 1

12.2 Do you currently smoke manufactured or hand-rolled cigarettes? G126_SM2

- No = 0
- Yes = 1

12.3 How many cigarettes per day do (did) you smoke? G126_SM4

- Less than one = 1
- 1-5 = 2
- 6-10 = 3
- 11-15 = 4
- 16-20 = 5
- More than 20 = 6

12.4 At what age did you start smoking regularly? G126_SM40**12.5 How old were you when you last stopped smoking? G126_SM6a****12.6 Over the past 3 years, have you lived for more than 6 months with anyone that smokes cigarettes/cigars? G126_SM42**

- No = 0
- Yes = 1

12.7 Are you exposed to tobacco smoke at work? G126_SM43

- No = 0
- Yes = 1
- I don't work = 2

12.8 Do you use electronic cigarettes or E-cigarettes, such as Ruyan or NJOY? G126_SM44

- No = 0
- Yes = 1

12.9 Do you use nicotine replacement therapy? G126_SM45

- No = 0
- Yes = 1

These are short questions on non-prescription drug use and alcohol and soft drink consumption

13.1 Have you ever tried or used the following drugs in the past 12 months, and if so, on average, how often?

	Never = 0	Only tried once = 1	Less than monthly = 2	About monthly = 3	About weekly = 4	Daily = 5	Don't know = 10
Marijuana/cannabis G126_DG1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin G126_DG17	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines (speed) G126_DG6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines (ice) G126_DG18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine G126_DG9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other G126_DG5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14.1. We are asking for information on the average amount of alcohol and the average amount of soft drinks you may consume. Please indicate how much of a certain drink you usually consume (eg Beer 2-4 cans, 1-2 times a week or sherry 0 = don't drink sherry, wine, 1 Glass, < 1 day a week, ie only occasionally).

Type of alcoholic drink (amount)	On average how much of the following would you drink						Approximately how many times a week would you drink this amount?					
	0 = 0	1 = 1	2-4 = 2	5-9 = 3	10-15 = 4	>15 = 5	< 1 day a week = 1	1-2 days a week = 2	3-4 days a week = 3	5-6 days a week = 4	Every day = 5	
Beer (can)	G126_DK63	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G126_DK72	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic soda (can, bottle)	G126_DK64	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G126_DK73	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red wine (wine glass)	G126_DK65	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G126_DK74	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White wine, champagne (wine glass)	G126_DK66	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G126_DK75	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sherry, port (small wine glass)	G126_DK67	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G126_DK76	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirits (shot)	G126_DK68	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G126_DK77	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of soft drink (amount)	0	1	2-4	5-9	10-15	>15	< 1 day a week	1-2 days a week	3-4 days a week	5-6 days a week	Every day	
Fizzy drink eg. cola, lemonade (can, glass)	G126_DK69	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G126_DK78	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet fizzy drink eg. diet coke (can, glass)	G126_DK70	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G126_DK79	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy drink (eg. Redbull, V, Monster (can)	G126_DK71	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G126_DK80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following question is about your sleeping behaviour

Do you have a room-mate or partner? **G126_SL20A**

No = 0

Yes = 1

If you don't have a room-mate or partner, please go to Q16.1

15.1 If you have a room-mate or partner, ask him/her how often in the past month have you had:

PSQI (Partner Response)

	Not during the past month = 0	less than once a week = 1	Once or twice a week = 2	Three or more times a week = 3
(a) Loud snoring G126_SL21	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Long pauses between breaths while asleep G126_SL22	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Legs twitching and jerking while you sleep G126_SL23	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Episodes of disorientation or confusion during sleep G126_SL24	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Other restlessness while you sleep G126_SL25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please describe G126_SL25_OTH				

The following questions are about breathing difficulties and allergies

16.1 Have you wheezed in the last 12 months? G126_RE34

- No (*Please go to Q17.1*)
- Yes

16.2 In the last 12 months, how often on average has your sleep been disturbed due to wheezing? G126_RE36

- Never woken with wheezing
- Less than one night per week
- One or more nights per week
- Don't know

16.3 Wheezing ever been severe enough to limit your speech to only one or two words at a time between breaths? G126_RE37

- No
- Yes
- Don't know

16.4 Your chest sounded wheezy during or after exercise? G126_RE8

- No
- Yes
- Don't know

17.1 Do you think you have ever had asthma? G126_AS1

- No
- Yes
- Don't know

17.2 Has a doctor (GP, respiratory specialist) ever told you that you have asthma? G126_AS2

- No
- Yes
- Don't know
- Never had asthma

17.3 Do you still have asthma? G126_AS16

- No
- Yes
- Don't have asthma (*Please go to Q18.1*)
- Don't know

17.4 Have you taken/used any of the following asthma medications in the last 12 months?**G126_AS67**

- No (*Please go to Q17.5*)
- Yes

17.4a If yes, Please select all medications you have used in the last 12 months.

- Ventolin **G126_AS18**
- Respolin **G126_AS20**
- Bricanyl **G126_AS26**
- QVAR **G126_AS35**
- Flixotide **G126_AS39**
- Pulmacort **G126_AS41**
- OXIS **G126_AS50**
- Serevent **G126_AS52**
- Singulaire **G126_AS54**
- Seretide **G126_AS59**
- Symbacort **G126_AS61**
- Prednisolone **G126_AS63**
- Other (please specify) **G126_AS65 & G126_AS65_OTH**

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

- Viral infection **G126_AS69**
- Grass **G126_AS70**
- Pollen **G126_AS71**
- Animal **G126_AS72**
- Dust **G126_AS73**
- Other (please specify) **G126_AS75 & G126_AS75_OTH**
- Don't know **G126_AS74**

18.1 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? G126_RE69

- No *(Please go to Q19.1)*
- Yes

18.2 In the last 12 months, was this nose problem accompanied by itchy-watery eyes? G126_RE63

- No
- Yes

18.3 In the last 12 months, how many episodes of allergic nose problem have you had (including hay fever)? G126_HF3

- 1 to 2
- 3 to 12
- More than 12

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

- January G126_RE80
- February G126_RE81
- March G126_RE82
- April G126_RE83
- May G126_RE84
- June G126_RE85
- July G126_RE86
- August G126_RE87
- September G126_RE88
- October G126_RE89
- November G126_RE90
- December G126_RE91

18.5 Has a doctor (GP) ever told you that you have an allergic nose problem? G126_RE24

- No
- Yes

18.6 What was the trigger/cause of these problems?

- Grass **G126_HF7A**
- Pollen **G126_HF7B**
- Animal **G126_HF7C**
- Dust **G126_HF7E**
- Other *(Please specify)* **G126_HF7D & G126_HF7D_OTH**
- Don't know **G126_HF7F**

18.7 Have you taken/used any medication for an allergic nose problem (including hay fever) in the last 12 months? **G126_HF32**

- No *(Please go to Q19.1)*
- Yes

18.7a 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
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>

19.1 Do you think that you have ever had an allergic reaction in the eyes (including hay fever)? **G126_CO1**

- No
- Yes
- Don't know

19.2 Has a doctor (GP, respiratory specialist) ever told you that you had an allergic reaction in the eyes (including hay fever)? **G126_CO2**

- No
- Yes
- Don't know

19.3 In the last 12 months, have you suffered from an allergic reaction in the eyes (including hay fever)? G126_CO4

- No (Please go to Q20.1)
- Yes

19.4 In the last 12 months, how many episodes of allergic reaction in the eyes have you had (including hay fever)? G126_CO5

- 1 to 2
- 3 to 12
- More than 12

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

- January G126_CO21
- February G126_CO22
- March G126_CO23
- April G126_CO24
- May G126_CO25
- June G126_CO26
- July G126_CO27
- August G126_CO28
- September G126_CO29
- October G126_CO30
- November G126_CO31
- December G126_CO32

19.6 What was the trigger/cause of these problems?

- Grass G126_CO6A
- Pollen G126_CO6B
- Animal G126_CO6C
- Dust G126_CO6E
- Other (Please specify) G126_CO6D& G126_CO6D_OTH
- Don't know G126_CO6F

19.7 Have you taken/used any medication for an allergic eye reaction (including hay fever) in the last 12 months? G126_CO48

- No (Please go to Q20.1)
- Yes

19.7a 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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

20.1 Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? G126_RS1

- No
 Yes

20.2 Do you get short of breath walking with other people your own age on level ground? G126_RS2

- No
 Yes

20.3 Do you have to stop for breath when walking at your own pace on level ground? G126_RS3

- No
 Yes

20.4 Do you ever get short of breath at rest? G126_RS4

- No
 Yes

20.5 Do you usually cough first thing in the morning? G126_RS5

- No
 Yes

20.6 Do you usually cough during the day or at night? G126_RS6

- No
 Yes

If yes to either,

20.7 Do you cough like this on most days for as much as three months each year? G126_RS7

- No
 Yes

21.1 Do you usually bring up phlegm from your chest first thing in the morning? G126_RS8

- No
- Yes

21.2 Do you usually bring up phlegm from your chest during the day or at night? G126_RS9

- No
- Yes

If yes to either,

21.3 Do you bring up phlegm like this on most days for as much as three months each year? G126_RS10

- No
- Yes

22.1 Have you ever had eczema or an itchy rash which was coming and going for at least 12 months? G126_RH1

- No (*Please go to Q22.5*)
- Yes

22.2 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? G126_RH3

- No
- Yes

22.3 In the last 12 months, how often, on average, have you been kept awake at night by this itchy rash? G126_RH6

- Never in the last 12 months
- Less than one night per week
- One or more nights per week

22.4 Has this rash cleared completely during the last 12 months? G126_RH5

- No
- Yes

22.5 Do you think that you have ever had eczema? G126_RH7

- No
- Yes
- Don't know

22.6 Has a doctor (GP, respiratory specialist) ever told you that you have eczema? G126_RH11

- No
- Yes
- Don't know

22.7 In the last 12 months, have you suffered from eczema? G126_RH12

- No (*Please go to Q23.1*)
- Yes

22.8 In the last 12 months, how many episodes of eczema have you had? G126_RH13

- 1 to 2
- 3 to 12
- More than 12

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

- January G126_RH28
- February G126_RH29
- March G126_RH30
- April G126_RH31
- May G126_RH32
- June G126_RH33
- July G126_RH34
- August G126_RH35
- September G126_RH36
- October G126_RH37
- November G126_RH38
- December G126_RH39

22.10 Have you taken/used any medication for eczema in the last 12 months? G126_RH49

- No (*Please go to Q23.1*)
- Yes

22.10a 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
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>

23.1 Do you have any food allergies? G126_FAL

- No (*Please go to Q24.1*)
- Yes

23.1a If yes, please tick all foods that you are allergic to

- Peanut Products **G126_FD1A**
- Wheat/Yeast **G126_FD2A**
- Dairy **G126_FD3A**
- Fruit **G126_FD4A**
- Eggs **G126_FD5A**
- Seafood **G126_FD6A**
- Preservatives/Colouring **G126_FD7A**
- Other (please specify) **G126_FD8A & G126_FD8A_OTH**

The following questions are about aches or pains in your muscles, bones or joints, including neck, back, hip or knee pain.

Örebro Musculoskeletal Pain Questionnaire (ÖMPQ) – Short

OREBRO Q5 24.1 Please indicate the sites below in which you have had pain in the last month.

(Please select all that apply)

- Neck G126_PN106 = 1
- Left shoulder G126_PN107 = 1
- Right shoulder G126_PN108 = 1
- Left arm G126_PN109 = 1
- Right arm G126_PN110 = 1
- Upper back G126_PN111 = 1
- Lower back G126_PN112 = 1
- Left leg G126_PN113 = 1
- Right leg G126_PN114 = 1
- Other *(please state)* G126_PN115 = 1 & G126_PN115_OTH.....
- I have not had any pain in the last month G126_PN116 = 1 *(If no pain please go to section 25.1)*

OREBRO Q7 24.2 How long have you had your current pain problem? *(Please select one)* G126_WPN6

- 0 days = 1
- 1-2 days = 2
- 3-7 days = 3
- 8-14 days = 4
- 15-30 days = 5
- 1 month = 6
- 2 months = 7
- 3-6 months = 8
- 6-12 months = 9
- Over 1 year = 10

OREBRO Q9 24.3 How would you rate the pain you have had in the last week? *(Please select one)*
G126_PN80

No Pain 0 = 0	1 = 1	2 = 2	3 = 3	4 = 4	5 = 5	6 = 6	7 = 7	8 = 8	9 = 9	Pain as bad as it could be 10 = 10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CODING VERSION**OREBRO Q13 24.4** How tense or anxious have you felt in the past week? *(Please select one)* G126_LI36

Absolutely calm and relaxed 0 = 0	1 = 1	2 = 2	3 = 3	4 = 4	5 = 5	6 = 6	7 = 7	8 = 8	9 = 9	As tense and anxious as I have ever felt 10 = 10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OREBRO Q14 24.5 How much have you been bothered by feeling depressed in the past week? *(Please select one)* G126_LI37

Not at all 0 = 0	1 = 1	2 = 2	3 = 3	4 = 4	5 = 5	6 = 6	7 = 7	8 = 8	9 = 9	Extremely 10 = 10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For the next 2 questions, please select the one number that best describes your current ability to participate in each of these activities.

OREBRO Q21 24.6 I can do light work for an hour. G126_PN88

Can't do it because of a pain problem 0 = 0	1=1	2=2	3=3	4=4	5=5	6=6	7=7	8=8	9=9	Can do it without pain being a problem 10=10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OREBRO Q25 24.7 I can sleep at night. G126_PN92

Can't do it because of a pain problem 0 = 0	1=1	2=2	3=3	4=4	5=5	6=6	7=7	8=8	9=9	Can do it without pain being a problem 10=10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CODING VERSION

Here are some of the things that other people have told us about their pain. For each statement, select one number from 0 to 10 to say how much physical activities, such as bending, lifting, walking or driving, would affect your pain.

OREBRO Q19 24.8 An increase in pain is an indication that I should stop what I'm doing until the pain decreases. [G126_PN86](#)

Completely disagree 0=0	1=1	2=2	3=3	4=4	5=5	6=6	7=7	8=8	9=9	Completely agree 10=10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OREBRO Q20 24.9 I should not do my normal work with my present pain. [G126_PN87](#)

Completely disagree 0=0	1=1	2=2	3=3	4=4	5=5	6=6	7=7	8=8	9=9	Completely agree 10=10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OREBRO Q15 24.10 In your view, how large is the risk that your current pain may become persistent? [G126_PN84](#)

No risk 0=0	1=1	2=2	3=3	4=4	5=5	6=6	7=7	8=8	9=9	Very large risk 10=10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

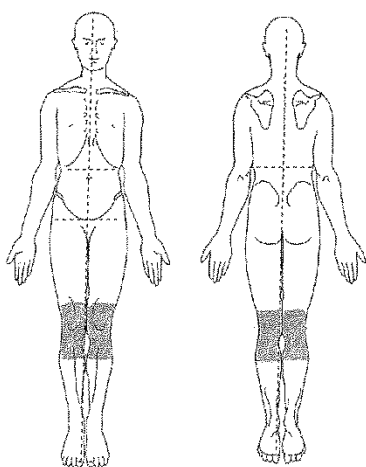
OREBRO Q16 24.11 In your estimation, what are the chances that you will be working normal duties in 3 months? [G126_PN95A](#)

No chance 0=0	1=1	2=2	3=3	4=4	5=5	6=6	7=7	8=8	9=9	Very large chance 10=10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25.0

	No = 0	Yes = 1
(1) Is your pain work-related in that it was caused by your work? G126_WPN1	<input type="checkbox"/>	<input type="checkbox"/>
(2) Is your pain work-related in that your pain developed outside of work but is made worse by work? G126_WPN2	<input type="checkbox"/>	<input type="checkbox"/>
(3) Have you reported your pain to your employer? G126_WPN3	<input type="checkbox"/>	<input type="checkbox"/>
(4) Have you claimed workers' compensation for your pain? G126_WPN4	<input type="checkbox"/>	<input type="checkbox"/>

The following questions relate to pain you may have experienced in your knee.



KOOS P1 25.1 How often do you experience knee pain in the shaded area marked on the diagram? G126_PN100

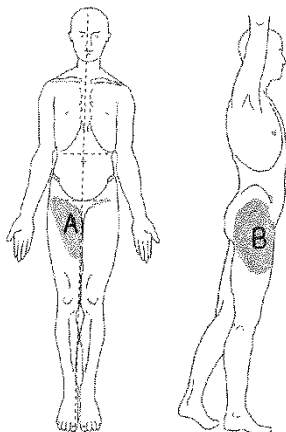
- Never (Please go to Q26.1) = 0
- Monthly = 1
- Weekly = 2
- Daily = 3
- Always = 4

25.2 The following questions relate to the amount pain you have experienced in either knee in the last month. **For each situation please enter the amount of pain experienced in the last month during the following activities.** If both knees are painful, please answer with regard to the most painful knee.

	None = 0	Mild = 1	Moderate = 2	Severe = 3	Extreme = 4
KOOS P2 Twisting/pivoting on your knee G126_PN101a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KOOS P3 Straightening knee fully G126_PN101b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KOOS P4 Bending knee fully G126_PN101c	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KOOS P5 Walking on flat surface G126_PN101d	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KOOS P6 Going up or down stairs G126_PN101e	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KOOS P7 At night while in bed G126_PN101f	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KOOS P8 Sitting or lying G126_PN101g	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

KOOS P9 Standing upright G126_PN101h	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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The following questions relate to pain you may have experienced in your hip. The diagram indicates two areas of the hip in which people commonly experience pain



HOOS P1 26.1 How often do you experience hip pain in the shaded area marked A on the diagram? (The diagram shows the right hip but your pain can be in either hip) G126_PN102A

- Never = 0
- Monthly = 1
- Weekly = 2
- Daily = 3
- Always = 4

HOOS P1 26.2 How often do you experience hip pain in the shaded area marked B on the diagram? (The diagram shows the right hip but your pain can be in either hip) G126_PN102B

- Never = 0
- Monthly = 1
- Weekly = 2
- Daily = 3
- Always = 4

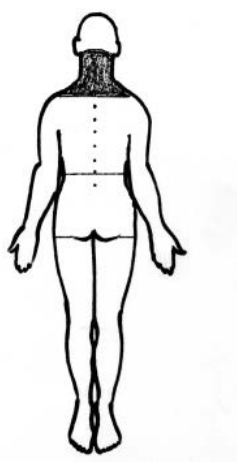
(If "never" to both of the above two questions, please go to 27.1)

26.3 The following questions relate to the amount pain you have experienced in either hip in the last month. For each situation please enter the amount of pain experienced in the last month during the following activities. If both hips are painful, please answer with regard to the most painful hip.

	None = 0	Mild = 1	Moderate = 2	Severe = 3	Extreme = 4
HOOS P2 Straightening your hip fully G126_PN103a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOOS P3 Bending your hip fully G126_PN103b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOOS P4 Walking on a flat surface G126_PN103c	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOOS P5 Going up or down stairs) G126_PN103d	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOOS P6 At night while in bed G126_PN103e	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOOS P7 Sitting or lying G126_PN103f	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOOS P8 Standing upright G126_PN103g	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOOS P9 Walking on a hard surface (asphalt, concrete, etc.) G126_PN103h	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOOS P10 Walking on an uneven surface G126_PN103i	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions relate to pain you may have experienced in neck/shoulder. The diagram indicates the area where neck and shoulder pain is experienced.



27.1 Have you ever had neck/shoulder pain? [G126_PN9](#)

(Anywhere in the shaded area in the picture)

- No (Please go to Q28.1) = 0
- Yes = 1

27.2 Has your neck/shoulder been painful at any time in the last month?

[G126_PN11](#)

- No = 0
- Yes = 1

27.3 How would you rate the neck/shoulder pain that you have had during the past month?

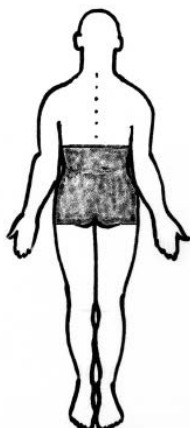
[G126_PN11A](#)

No Pain 0 = 0	1 = 1	2 = 2	3 = 3	4 = 4	5 = 5	6 = 6	7 = 7	8 = 8	9 = 9	Pain as bad as it could be 10 = 10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27.4	No = 0	Yes = 1
(a) In the past month, did you seek health professional advice or treatment for your neck/shoulder pain? G126_PN104a	<input type="checkbox"/>	<input type="checkbox"/>
(b) In the past month, did you take medication to relieve your neck/shoulder pain? G126_PN104b	<input type="checkbox"/>	<input type="checkbox"/>

(c) In the past month, did your neck/shoulder pain interfere with your normal activities? G126_PN104c	<input type="checkbox"/>	<input type="checkbox"/>
(d) In the past month, did your neck/shoulder pain interfere with recreational physical activities (e.g. sport, walking, cycling etc.) G126_PN104d	<input type="checkbox"/>	<input type="checkbox"/>
(e) In the past month, did you miss work because of your neck/shoulder pain? G126_PN104e	<input type="checkbox"/>	<input type="checkbox"/>
(f) In the past month, did your neck/shoulder pain interfere with your work activities? G126_PN104f	<input type="checkbox"/>	<input type="checkbox"/>
(g) Has your present neck/shoulder pain lasted for more than 3 months continuously (it hurt more or less every day)? G126_PN12	<input type="checkbox"/>	<input type="checkbox"/>
(h) Has your present neck/shoulder pain lasted for more than 3 months off and on (it hurt at least once a week but not every day)? G126_PN50	<input type="checkbox"/>	<input type="checkbox"/>

The following questions relate to pain you may have experienced in lower back. The diagram indicates the area where low back pain is experienced.



28.1 Have you ever had low back pain? G126_PN38

(Anywhere in the shaded area in the picture)

- No (Please go to Q29) = 0
- Yes = 1

28.2 Has your low back been painful at any time in the last month?

G126_PN40

- No = 0
- Yes = 1

28.3 How would you rate the usual intensity of low back pain that you have had during the past month? G126_PN40A

No Pain 0 = 0	1 = 1	2 = 2	3 = 3	4 = 4	5 = 5	6 = 6	7 = 7	8 = 8	9 = 9	Pain as bad as it could be 10 = 10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28.4	No = 0	Yes = 1
(a) In the past month, did you seek health professional advice or treatment for your low back pain? G126_PN105a	<input type="checkbox"/>	<input type="checkbox"/>
(b) In the past month, did you take medication to relieve your low back pain? G126_PN105b	<input type="checkbox"/>	<input type="checkbox"/>
(c) In the past month, did your low back pain interfere with your normal activities? G126_PN105c	<input type="checkbox"/>	<input type="checkbox"/>
(d) In the past month, did your low back pain interfere with recreational physical activities (e.g. sport, walking, cycling etc.)? G126_PN105d	<input type="checkbox"/>	<input type="checkbox"/>
(e) In the past month, did you miss work because of your low back pain? G126_PN105e	<input type="checkbox"/>	<input type="checkbox"/>
(f) In the past month, did your low back pain interfere with your work activities? G126_PN105f	<input type="checkbox"/>	<input type="checkbox"/>
(g) Has your present low back pain lasted for more than 3 months continuously (it hurt more or less every day)? G126_PN41	<input type="checkbox"/>	<input type="checkbox"/>
(h) Has your present low back pain lasted for more than 3 months off and on (it hurt at least once a week but not every day)? G126_PN49	<input type="checkbox"/>	<input type="checkbox"/>

29. For men, this is the end of the Questionnaire, thank you for completing the questionnaire.

The following questions are **for women only** and are about menopause and sleep.

29.1 Are you G126_MEN1

- Pre-menopausal (*still having regular periods*) =0
- Menopausal (*had a period within the last year but periods are irregular*) =1
- Post-menopausal (*last period was more than a year ago*) =2
- Don't know=3

29.2 What was the date of the first day of your last period (approx OK)? DD /MM / YYYY G126_MEN2
G126_MENDT (quality of the date variable)

29.3 Have you used hormonal contraception in the last 3 months? G126_MEN3

- No (*Please go to Q29.4*) =0
- Yes=1

29.3a If yes, Pill, implanon, injection, mirena other, please specify
G126_MEN3A, G126_MEN3B, G126_MEN3E, G126_MEN3C, G126_MEN3D, G126_MEN3D_PTH (describe other)

.....

29.4 Have you used hormone replacement therapy (HRT) in the last 3 months? G126_MEN4

- No=0
- Yes=1

29.5 Have you had a Hysterectomy? G126_MEN5

- No (*Please go to Q 29.6*) =0
- Yes=1

29.5a If yes, at what age G126_MEN5a

- < 30 years=1
- 30 to 40=2
- 41 to 50=3
- 51 to 60=4
- > 60=5

29.6 Have you had a bilateral oophorectomy? (both your ovaries removed) G126_MEN6

- No (*Please go to Q29.7*) =0
- Yes=1

29.6a If yes, at what age G126_MEN6a.....

29.7 When you were in your 20s and 30s, how many days were there on average from the beginning of one period to the beginning of the next one? G126_MEN7

- Less than 20 days =0
- 20 – 25 days=1
- 26 – 31 days (approximately normal) =2
- 32 - 40 days=3
- More than 40 days=4
- Not sure=5

29.8 For the past 6 months, how many days were there on average from the beginning of one period to the beginning of the next one? G126_MEN8

- Less than 20 days =0
- 20 – 25 days=1
- 26 – 31 days=2
- 32 - 40 days=3
- More than 40 days=4
- Not sure=5
- Don't have periods=6

29.9 In the past 6 months, have you ever had a time of 60 or more days of no bleeding (i.e. you've skipped 2 or more periods)? G126_MEN9

- No=0
- Yes=1
- No periods in the last 6 months =2

29.10 Have you ever consulted a healthcare professional about symptoms of menopause? G126_MEN10

- No=0
- Yes=1
- Don't have menopausal symptoms=2

29.11 During the past 2 weeks, how often have you experienced hot flushes or night sweats? G126_MEN11

- Not at all=0
- 1 – 5 days=1
- 6 – 8 days=2
- 9 – 13 days=3
- Every day=4

29.12

(a) On average, how many hot flushes do you experience per day?	G126_MEN11A
(b) On average, how many hot flushes/night sweats do you experience per night?	G126_MEN11B
(c) On average, how many times do you get woken up at night by hot flushes/night sweats	G126_MEN11C
(d) For how many month/years have you experienced hot flushes/night sweats MONTHS	G126_MEN11D
YEARS	G126_MEN11E

29.13 Have you taken any medication (prescription or non-prescription) in the last 6 months to treat any of your menopausal symptoms? G126_MEN12

- No (Please go to Q30) =0
 Yes (Please list below) =1

29.13a Type of medication
G126_MEN13

30. Please circle one number to the right of each phrase to describe how much **DURING THE PAST WEEK** hot flushes have **INTERFERED** with each aspect of your life. Higher numbers indicate more interference with your life. If you are not experiencing hot flushes or if hot flushes do not interfere with these aspects of your life, please select zero to the right of each questions. **HFRDIS**

	Do not interfere	1	2	3	4	5	6	7	8	9	10	Completely interfere
HFRDIS Q1 1. Work (work outside the home and housework) G126_MEN14A	0	1	2	3	4	5	6	7	8	9	10	
HFRDIS Q2 2. Social activities (time spent with family, friends, etc.) G126_MEN14B	0	1	2	3	4	5	6	7	8	9	10	
HFRDIS Q3 3. Leisure activities (time spent relaxing, doing hobbies, etc.) G126_MEN14C	0	1	2	3	4	5	6	7	8	9	10	
HFRDIS Q4 4. Sleep G126_MEN14D	0	1	2	3	4	5	6	7	8	9	10	
HFRDIS Q5 5. Mood G126_MEN14E	0	1	2	3	4	5	6	7	8	9	10	
HFRDIS Q6 6. Concentration G126_MEN14F	0	1	2	3	4	5	6	7	8	9	10	
HFRDIS Q7 7. Relaxation with others G126_MEN14G	0	1	2	3	4	5	6	7	8	9	10	

HFRDIS Q8 8. Sexuality G126_MEN14H	0	1	2	3	4	5	6	7	8	9	10
HFRDIS Q9 9. Enjoyment of life G126_MEN14I	0	1	2	3	4	5	6	7	8	9	10
HFRDIS Q10 10. Overall quality of life G126_MEN14J	0	1	2	3	4	5	6	7	8	9	10

The following questions provide a brief measure of **menopause symptoms**.

31. Please indicate the extent to which you are bothered at the moment by any of these symptoms by placing a tick in the appropriate box: GCS

	Not at all (0)	A little (1)	Quite a bit (2)	Extremely (3)
GCS Q1 1. Heart beating quickly or strongly G126_MEN15A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q2 2. Feeling tense or nervous G126_MEN15B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q3 3. Difficulty in sleeping G126_MEN15C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q4 4. Excitable G126_MEN15D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q5 5. Attacks of anxiety, panic G126_MEN15E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q6 6. Difficulty in concentrating G126_MEN15F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q7 7. Feeling tired or lacking in energy G126_MEN15G	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q8 8. Loss of interest in most things G126_MEN15H	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q9 9. Feeling unhappy or depressed G126_MEN15I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q10 10. Crying spells G126_MEN15J	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q11 11. Irritability G126_MEN15K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q12 12. Feeling dizzy or faint G126_MEN15L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q13 13. Pressure or tightness in head G126_MEN15M	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q14 14. Parts of body feel numb G126_MEN15N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q15 15. Headaches G126_MEN15O	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q16 16. Muscle and joint pains G126_MEN15P	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GCS Q17 17. Loss of feeling in hands or feet G126_MEN15Q	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q18 18. Breathing difficulties G126_MEN15R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q19 19. Hot flushes G126_MEN15S	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q20 20. Sweating at night G126_MEN15T	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GCS Q21 21. Loss of interest in sex G126_MEN15U	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31a When are hot flushes/night sweats most bothersome to you? **G126_MEN16**

- Daytime=**1**
- Nighttime=**2**
- Both daytime and night time=**3**
- I am not bothered by these symptoms =**4**

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE