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.

CONTACT DETAILS

Your contact details will not be stored with your questionnaire information. All contact details are stored separately in a secure password protected database and are not used for any other purpose

Your name, surname.....

Date you completed the questionnaire.....

Contents

1. BACKGROUND

The following questions ask about you, your relationships, your education and household and are important factors that may influence your health and well-being.

CHILDREN

Do you have any biological children? G227_CH

0 ○ No (*Please go to Q1.2*)

1 ○ Yes

What is/are your children's date(s) of birth?

Please list each of your children's sex and date of birth

	Male	Female	Date of Birth (day, month, year)
First child	G227_PCSX1		G227_PCDB1
Second child	G227_PCSX2		G227_PCDB2
Third child	G227_PCSX3		G227_PCDB3
Fourth child	G227_PCSX4		G227_PCDB4

1.2 Are you or is your partner currently pregnant? G227_SX63

○ No, *(Please go to 1.3)* 0 ○ Yes, I am pregnant 1 ○ Yes, my partner is pregnant 2

What is the expected due date of your baby? ..... G227_SX63_DAT

1.3 Are you and your partner trying for a baby at the moment? G227_SX125

○ No, please go to Q2 0 ○ Yes 1

When did you start trying? G227_SX125A

0 1. < 3 months ago

1 2. 3 to 6 months ago

2 3. 6 – 12 months ago

3 4. Longer than one year ago

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2. ACCOMMODATION

G227_DWEL

What type of accommodation do you live in? *(Please select one)*

1	1. A separate house
2	2. Semi-detached house/row or terrace house/townhouse etc
3	3. Flat/unit/apartment
4	4. "Granny" flat
5	5. Caravan, park home, boat
6	6. Aged care accommodation or nursing home
7	7. Homeless, temporary accommodation, improvised home, tent, sleeping out
8	8. Other *(please specify)* ..... G227_DWEL_OTH

The dwelling is: *(Please select one)*

G227_DWEL1

1	1. Owned outright
2	2. Owned with a mortgage
3	3. Being purchased under a rent/buy scheme
4	4. Being rented
5	5. Being occupied rent free
6	6. Being occupied under a life tenure scheme
7	7. None of the above

Who do you live with? *(Please select all that apply)*

1. I live alone — G227_OH37
2. With a partner — G227_OH24
3. My child/children/step children — G227_OH38
4. My parent(s)/step-parent(s)/in-laws — G227_OH39
5. Other relatives — G227_OH40
6. Friends — G227_OH41
7. Shared accommodation — G227_OH25
8. Other - please specify ..... G227_OH31 G227_OH31_OTH .....

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3. INCOME

Are you receiving any government benefits, pension or allowance? G227_BNF

0	○	No (*Please go to Q3.1)*
1	○	Yes
2	○	Prefer not say (*Please go to Q3.1)*

Which government benefits, pension or allowance are you receiving? *(Please select all that apply)*

○	Baby Bonus	G227_BN28
○	Carer Allowance (child)	G227_BN20
○	Carer Payment (child)	G227_BN22
○	Carer Allowance (adult)	G227_BN21
○	Carer Payment (adult)	G227_BN23
○	Child Care Benefit	G227_BN25
○	Child Care Rebate	G227_BN26
○	Crisis Payment	G227_BN31
○	Disability Support pensions	G227_BNF4
○	Family Tax Benefit Part A	G227_BN15
○	Family Tax Benefit Part B	G227_BN16
○	JET Child Care Fee	G227_BN27
○	Assistance Maternity Immunisation	G227_BN29
○	Mobility Allowance	G227_BN18
○	Newstart Allowance	G227_BN11
○	Parenting Payment	G227_BNF2
○	Remote area/zone allowance	G227_BN14
○	Rent Assistance	G227_BN17
○	Sickness Allowance	G227_BNF7
○	Workers comp	G227_BNF6
○	Other benefit - please specify:	G227_BNF9 & G227_BNF9_OTH

3.1. What is the total amount of YOUR usual salary/wage, before tax, per week or benefit payment per week (annual amount in brackets)? *(Please select one)*

G227_MON7_BT

0. No Income
1. $1-$199 ($1-$10,399)
2. $200-$299 ($10,400-$15,599)
3. $300-$399 ($15,600-$20,799)
4. $400-$599 ($20,800-$31,199)
5. $600-$799 ($31,200-$41,599)
6. $800-$999 ($41,600-$51,999)
7. $1,000-$1,249 ($52,000-$64,999)
8. $1,250-$1,499 ($65,000-$77,999)
9. $1,500-$1,999 ($78,000-$103,999)
10. $2,000-$2,499 ($104,000-$129,999)
11. $2,500-$2,999 ($130,000-$155,999)
12. $3,000-$3,499 ($156,000-$181,999)
13. $3,500-$3,999 ($182,000-$207,999)
14. $4,000-$4,999 ($208,000-$259,999)
15. $5,000 or more ($260,000 or more)

What is the total amount of YOUR HOUSEHOLD'S usual salary/wage, before tax, per week or benefit payment per week? (All adult income combined, annual amount in brackets) *(Please select one)*

G227_MON8_BT

0. No Income
1. $1-$199 ($1-$10,399)
2. $200-$299 ($10,400-$15,599)
3. $300-$399 ($15,600-$20,799)
4. $400-$599 ($20,800-$31,199)
5. $600-$799 ($31,200-$41,599)
6. $800-$999 ($41,600-$51,999)
7. $1,000-$1,249 ($52,000-$64,999)
8. $1,250-$1,499 ($65,000-$77,999)
9. $1,500-$1,999 ($78,000-$103,999)
10. $2,000-$2,499 ($104,000-$129,999)
11. $2,500-$2,999 ($130,000-$155,999)
12. $3,000-$3,499 ($156,000-$181,999)
13. $3,500-$3,999 ($182,000-$207,999)
14. $4,000-$4,999 ($208,000-$259,999)
15. $5,000 or more ($260,000 or more)
16. Don't know

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Do you currently have any of the following? (excluding Medicare) (*Please select all that apply*)

1. Private health insurance
2. Health care concession card
3. None
4. Other, please specify .....

G227_INS1
G227_INS3
G227_INS4
G227_INS5
G227_INS5_OTH

.....

4. EDUCATION

What is the highest level of education or training you have completed? *(Please select one)*

0. Did not go to school
1. Primary school
2. Secondary school (high school)
3. Apprentice
4. TAFE, college
5. Other training course
6. University undergraduate degree
7. University post graduate degree

G227_ED33

What is the highest year of high school you have completed? *(Please select one)*

0 1. Year 12 (or equivalent)
1 2. Year 11 (or equivalent)
2 3. Year 10 (or equivalent)
3 4. Year 9 (or equivalent)
4 5. Other - please specify .....

G227_ED34

G227_ED34_OTH

Are you currently studying or doing a course?

G227_ED35

○ No, (*please go to Q4.1)*
○ Yes – Studying full-time
○ Yes – Studying part-time

G227_ED89

1
2

Where are you studying?

0 1. University
1 2. TAFE/College
2 3. Vocational training (e.g. emergency services
3 4. Other, please specify .....

G227_ED36

G227_ED36_OTH

4.1 Did you take a gap year before or during your studies?

0 ○ No, (*please go to Q4.2)*
1 ○ Yes, When did you take it (after high school, after 1st year of studying) .....

G227_EGAP

G227_EGAPA

For how long (months).....

Where did you spend your gap year? .....

.....

G227_EGAP1
G227_EGAP2

4.2 How many years have you been in education? Please write down the number of years you spent at each stage of your education.

	Years
School education (primary and secondary)	G227_EDYR1
TAFE, Technical College	G227_EDYR2
Vocational training	G227_EDYR3
University - undergraduate	G227_EDYR4
University - postgraduate	G227_EDYR5
Other studies	G227_EDYR6 & G227_EDYR6_OTH

5. WORK

The following questions are about your work history, workplace environment and job satisfaction

What has been your <u>usual</u> occupation or job? G227_YJOB

.....

Which of the following describes your <u>current</u> employment situation? *(Please select one)*

G227_YWRK

0. Employed full-time (casual or permanent)
1. Employed part-time (casual or permanent)
2. Employed, but away from work (e.g. on long service leave)
3. Unemployed looking for full time work (Please go to Q5.1)
4. Unemployed looking for part time work (Please go to Q5.1)
5. Not in the labour force (not looking for work, unable to work) (Please to Q5.1)
6. Do paid casual work
7. Doing unpaid or voluntary work
8. Other G227_YWRK_OTH

What is your <u>current</u> occupation or job?

a. Job title..... G227_YEMP

b. Job description..... G227_YEMP1

G227_YLOC

c. Street address .....

For how many years or months have you worked in your <u>current</u> occupation or job?

a. Years..... G227_YYR

G227_YMON

b. Months.....

Industry: For your <u>current job</u> (the one you work the most hours in each week), what industry do you work in? *(Please select one)?*

G227_YIND

0. A - Agriculture, Forestry and Fishing
1. B - Mining
2. C - Manufacturing
3. D - Electricity, Gas, Water and Waste Services
4. E - Construction
5. F - Wholesale Trade
6. G - Retail Trade)
7. H - Accommodation and Food Services
8. I - Transport, Postal and Warehousing
9. J - Information Media and Telecommunications
10. K - Financial and Insurance Services
11. L - Rental, Hiring and Real Estate Services
12. M - Professional, Scientific and Technical Services
13. N - Administrative and Support Services
14. O - Public Administration and Safety
15. P - Education and Training
16. Q - Health Care and Social Assistance
17. R - Arts and Recreation Services
18. S - Other Services G227_YIND_OTH

How many hours per week do you usually work in all (<u>current</u>) jobs? *(Please select one)*

G227_YHRS

0. 1-15
1. 16-24
2. 25-34
3. 35-39
4. 40
5. 41-48
6. 49-55
7. More than 55

***5.1* Please list the main jobs that you have had in the last 5 years, starting from the most recent.** *(not including your current job)*

Occupation	Industry code (see above, A, B etc)	Approx number of years
G227_YEM1-9	G227_YIN1-9	G227_YJO1-9

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The following questions are about your working environment and job satisfaction.

How often do you get help or support from your colleagues?

G227_WSU1

4	○ Always
3	○ Often
2	○ Sometimes
1	○ Seldom
0	○ Never/hardly ever
9	○ Not relevant
10	○ Do not work *(please go to Q6)*

How often do you get help or support from your supervisors?

G227_WSU2

4	○ Always
3	○ Often
2	○ Sometimes
1	○ Seldom
0	○ Never/hardly ever
9	○ Not relevant

7Please indicate your response to the following statements:

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
The job allows me to make a lot of decisions on my own	☐	☐	☐	☐	☐ G227_WAD7
I can work at home sometimes	☐	☐	☐	☐	G227_WAD2
The job allows me to plan how I do my work	☐	☐	☐	☐	G227_WAD8
I can control the way I work	☐	☐	☐	☐	G227_WAD1
The job involves performing relatively simple tasks	☐	☐	☐	☐	G227_WAD9
The job requires that I engage in a large amount of thinking	☐	☐	☐	☐	G227_WAD10
I never seem to have enough time to get everything done at work	☐	☐	☐	☐	G227_WAD11
The job requires a lot of physical effort	☐	☐	☐	☐	G227_WAD12 ☐

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OREBRO Q8 Is your work heavy or monotonous? *Please indicate on the scale below* G227_WK1

Not at all									Extremely
1	2	3	4	5	6	7	8	9	10

Which of the following statements best describes the work that you do in your current job *(Please select one)* G227_WK2

1 ○ Sedentary occupation (e.g. secretary- where you spend most of your time sitting)

2 ○ Standing occupation (e.g. shop assistant, security guard spend most of your time standing/walking but not intense physical effort)

3 ○ Physical work (e.g. plumber, nurse - a job that requires some physical effort including handling of heavy objects and use of tools)

4 ○ Heavy manual work (e.g. bricklayer - a job that involves very vigorous physical activity including handling very heavy objects)

OREBRO Q17 If you take into consideration your work routines, management, salary, promotion possibilities and work mates, how satisfied are you with your job? *(Please select one)* G227_WSAT

Not satisfied at all									Completely satisfied
1	2	3	4	5	6	7	8	9	10

Now please think of your work experiences over the past 4 weeks (28 days). In the spaces provided below, write the number of days you spent in each of the following work situations.

In the past 4 weeks (28 days), how many days did you?

	Days
Miss an entire work day because of problems with your physical or mental health? *(Please include only days missed for your own health, not someone else's health.)*	G227_WMS1
Miss an entire work day for any other reason (including vacation).	G227_WMS2
Miss part of a work day because of problems with your physical or mental health? *(Please include only days missed for your own health, not someone else's health.)*	G227_WMS3
Miss part of a work day for any other reason (including vacation).	G227_WMS4
Come in early, go home late, or work on your day off?	G227_WMS5

About how many hours altogether did you work in the past 4 weeks (28 days)?

As a guide if you work for 8 hours on a typical working day then a:

5 day working week = 40 hour working week x 4 = 160 hours
4 day working week = 32 hour working week x 4 = 128 hours
3 day working week = 24 hour working week x 4 = 96 hours
2 day working week = 16 hour working week x 4 = 64 hours
1 day working week = 8 hour working week x 4 = 32 hours

G227_WHR

Number of hours worked in the past 4 weeks (28 days)? ..... hours

On a scale from 1 to 10 where 1 is the worst job performance any one could have at your job and 10 is the performance of a top worker:

	Worst performance 1	2	3	4	5	6	7	8	9	Top performance 10	
How would you rate the usual performance of most workers in a job similar to yours?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	G227_WPF1
How would you rate your usual job performance over the past year or two?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	G227_WPF2
How would you rate your overall job performance on the days you worked during the past 4 weeks (28 days)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	G227_WPF3

Bullying at work

Bullying takes place when one or more persons systematically and over time feel that they have been subjected to negative treatment from one or one or more persons, in a situation in which the person(s) exposed to the treatment has difficulty in defending themselves against them. If there has been a one or two times when you have had a conflicting situation with someone equally strong as you, this is not bullying.

Have you been bullied at work?

- ○ NO
- ○ Yes, occasionally
- ○ Now and then
- ○ Once a week
- ○ Several times a week

G227_BU7 - Y/N
G227_BU7A - frequency

6. GENERAL HEALTH

SF-12 (version 2)

We realise that some of these questions may seem very personal, but all information that you provide us is helpful. As before, even if some questions seem remarkably similar, we need to ask you each and every one. Please answer them carefully and independently.

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. *For each of the following questions please mark the box that best describes your answer.*

SF12–Q1 (1) G227_OAL8	1 Excellent	2 Very good	3 Good	4 Fair	5 Poor
In general, would you say your health is?	☐	☐	☐	☐	☐

The following questions are about activities you might do during a typical day. Does your **health now limit you** in these activities? If so, how much?

(2)	1 Yes, limited a lot	2 Yes, limited a little	3 No, not limited at all
SF12–Q2 (a) **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐ G227_LI12 G227_LI14
SF12–Q3 (b) Climbing **several** flights of stairs	☐	☐	☐

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

(3)	1 All of the time	2 Most of the time	3 Some of the time	4 A little of the time	5 None of the time
SF12–Q4 (a) **Accomplished less** than you would like	☐	☐	☐	☐	☐ G227_LI22 G227_LI23
SF12–Q5 (b) Were limited in the **kind** of work or other activities	☐	☐	☐	☐	☐

During the past **4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

(4)	1 All of the time	2 Most of the time	3 Some of the time	4 A little of the time	5 None of the time
SF12–Q6 (a) **Accomplished less** than you would like	☐	☐	☐	☐	☐ G227_LI26 G227_LI27
SF12–Q7 (b) Did work of other activities **less carefully than usual**	☐	☐	☐	☐	☐

(5)	Not at all	A little bit	Moderately	Quite a bit	Extremely
SF12–Q8 During the **past 4 weeks**, how much did **pain** interfere with your normal work? (including both work outside the home and housework)	1	2	3	4	5

G227_PN2

These questions are about how you feel and how things have been with you **during the past 4 weeks.** For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**.

(6)	Not at all	A little bit	Moderately	Quite a bit	Extremely
SF12–Q9 Have you felt calm and peaceful?	1	2	3	4	5
SF12–Q10 Did you have a lot of energy?	☐	☐	☐	☐	☐
SF12–Q11 Have you felt downhearted and depressed?	☐	☐	☐	☐	☐

G227_FE23
G227_FE24
G227_FE25

(7)	All of the time	Most of the time	Some of the time	A little of the time	None of the time
SF12–Q12 During the past 4 weeks, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)?	1	2	3	4	5

G227_LI28

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

Absolutely calm and relaxed 0	1	2	3	4	5	6	7	8	9	**As tense and anxious as I have ever felt** 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

G227_LI36

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

Not at all 0	1	2	3	4	5	6	7	8	9	**Extremely** 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

G227_LI37

7. GENERAL MOOD AND WELLBEING.

Please read each statement and select a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

DASS - 21	Did not apply to me at all	Applied to me to some degree, or some of the time	Applied to me a considerable degree, or a good part of time	Applied to me very much, or most of the time	
DASS-21 Q1 I found it hard to wind down	0	1	2	3	G227_FL27
DASS-21 Q2 I was aware of dryness of my mouth	0	1	2	3	G227_FL15
DASS-21 Q3 I couldn't seem to experience any positive feeling at all	0	1	2	3	G227_FL13
DASS-21 Q4 I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion.)	0	1	2	3	G227_FL4
DASS-21 Q5 I found it difficult to work up the initiative to do things	0	1	2	3	G227_FL26
DASS-21 Q6 I tended to over-react to situations	0	1	2	3	G227_FL10
DASS-21 Q7 I experienced trembling (e.g. in the hands)	0	1	2	3	G227_FL39
DASS-21 Q8 I felt that I was using a lot of nervous energy	0	1	2	3	G227_FL22
DASS-21 Q9 I was worried about situations in which I might panic and make a fool of myself	0	1	2	3	G227_FL33
DASS-21 Q10 I felt that I had nothing to look forward to	0	1	2	3	G227_FL12
DASS-21 Q11 I found myself getting agitated	0	1	2	3	G227_FL40
DASS-21 Q12 I found it difficult to relax	0	1	2	3	G227_FL37
DASS-21 Q13 I felt down-hearted and blue	0	1	2	3	G227_FL25
DASS-21 Q14 I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3	G227_FL42

DASS - 21	Did not apply to me at all	Applied to me to some degree, or some of the time	Applied to me a considerable degree, or a good part of time	Applied to me very much, or most of the time	
DASS-21 Q15 I felt I was close to panic	0	1	2	3	G227_FL35
DASS-21 Q16 I was unable to become enthusiastic about anything	0	1	2	3	G227_FL32
DASS-21 Q17 I felt I wasn't worth much as a person	0	1	2	3	G227_FL31
DASS-21 Q18 I felt that I was rather touchy	0	1	2	3	G227_FL21
DASS-21 Q19 I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3	G227_FL18
DASS-21 Q20 I felt scared without any good reason)	0	1	2	3	G227_FL19
DASS-21 Q21 I felt that life was meaningless	0	1	2	3	G227_FL41

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

○ Serious illness or injury to yourself	G227_ST12
○ Serious illness or injury to a close relative	G227_ST13
○ Death of a close family member	G227_ST14
○ Death of a close family friend or relative	G227_ST15
○ Separation due to marital difficulties	G227_ST16
○ Broken off a steady relationship	G227_ST17
○ Serious problem with a close friend, neighbour or relative	G227_ST18
○ Unemployed/seeking work for more than one month	G227_ST19
○ Your own job loss (not voluntary)	G227_ST7
○ Major financial crisis	G227_ST20
○ Problems with police and court appearance	G227_ST21
○ Something valuable lost or stolen	G227_ST22

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The following questions are about your feelings in the past 4 weeks

G227_FL44-53

K10	All of the time	Most of the time	Some of the time	A little of the time	None of the time
1. In the past 4 weeks, about how often did you feel tired out for no good reason?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
2. (In the past 4 weeks,) about how often did you feel nervous?	☐	☐	☐	☐	☐
3. (In the past 4 weeks,) about how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
4. (In the past 4 weeks,) about how often did you feel hopeless?	☐	☐	☐	☐	☐
5. (In the past 4 weeks,) about how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
6. (In the past 4 weeks,) about how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
7. (In the past 4 weeks,) about how often did you feel depressed?	☐	☐	☐	☐	☐
8. (In the past 4 weeks,) about how often did you feel that everything was an effort?	☐	☐	☐	☐	☐
9. (In the past 4 weeks,) about how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
10. (In the past 4 weeks,) about how often did you feel worthless?	☐	☐	☐	☐	☐

This questionnaire asks about a number of different things that people sometimes do to hurt themselves. Please be sure to read each question carefully and respond honestly. Often, people who do these kinds of things to themselves keep it a secret, for a variety of reasons. However, honest responses to these questions will provide us with greater understanding and knowledge about these behaviors and the best way to help people. Please answer yes to a question only if you did the behaviour intentionally, or on purpose, to hurt yourself. Do not respond yes if you did something accidentally (e.g. you tripped and banged your head on accident). Also, please be assured that your responses are completely confidential.

Have you intentionally tried to hurt or harm yourself in anyway, e.g. cutting, burning or scratching yourself or banging your head?

G227_SHRM

○ 0 *No, Please go to Q8,* ○ 1 *Yes, Please continue with Q7.1*

(7.1) Have you ever intentionally (i.e., on purpose) cut or carved on your wrist, arms, or other area(s) of your body (without intending to kill yourself)? (Please select one):

G227_SHRM1

○ 0 O *(please go to Q7.2)* ○ 1 YES, if yes

How old were you when you first did this?	……..Years old
How many times have you done this?	……..Times
When was the last time you did this?	……Days ago ……..Months ago …… years ago

G227_SHRM1_yr	Cut - How old were you when you first did this? (years)
G227_SHRM1_n	Cut - How many times have you done this?
G227_SHRM1C	Cut - When was the last time you did this? (days/ months/ years ago)
G227_SHRM1C_mon	Cut - When was the last time you did this? (months prior)
G227_SHRM1C_yr	Cut - When was the last time you did this? (derived age in years)

(7.2) Have you ever intentionally (i.e., on purpose) burned yourself?

G227_SHRM2

○ 0 NO *(please go to Q7.3)* ○ 1 YES, if yes

How old were you when you first did this?	……..Years old
How many times have you done this?	……..Times
When was the last time you did this?	……Days ago ……..Months ago …… years ago

G227_SHRM2_yr	Burned - How old were you when you first did this? (years)
G227_SHRM2_n	Burned - How many times have you done this?
G227_SHRM2C	Burned - When was the last time you did this? (days/ months/ years ago)
G227_SHRM2C_mon	Burned - When was the last time you did this? (months prior)
G227_SHRM2C_yr	Burned - When was the last time you did this? (derived age in years)

(7.3) Have you ever intentionally (i.e., on purpose) severely scratched yourself, to the extent that scarring or bleeding occurred?

○ 0 NO *(please go to Q7.4)* 1 YES, if yes G227_SHRM3

How old were you when you first did this?	……..Years old
How many times have you done this?	……..Times
When was the last time you did this?	……Days ago ……..Months ago …… years ago

G227_SHRM3_yr	Scratched - How old were you when you first did this? (years)
G227_SHRM3_n	Scratched - How many times have you done this?
G227_SHRM3C	Scratched - When was the last time you did this? (days/ months/ years ago)
G227_SHRM3C_mon	Scratched - When was the last time you did this? (months prior)
G227_SHRM3C_yr	Scratched - When was the last time you did this? (derived age in years)

(7.4) Have you ever intentionally (i.e., on purpose) banged your head against something to the extent that it caused a bruise to appear.

○ 0 NO *(please go to Q8)* 1 YES, if yes G227_SHRM

How old were you when you first did this?	……..Years old
How many times have you done this?	……..Times
When was the last time you did this?	……Days ago ……..Months ago …… years ago

G227_SHRM4_yr	Banged head - How old were you when you first did this? (years)
G227_SHRM4_n	Banged head - How many times have you done this?
G227_SHRM4C	Banged head - When was the last time you did this? (days/ months/ years ago)
G227_SHRM4C_mon	Banged head - When was the last time you did this? (months prior)
G227_SHRM4C_yr	Banged head - When was the last time you did this? (derived age in years)

8. PHYSICAL PAIN

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) – Modified (4 questions in earlier sections)

OREBRO Q5 Please indicate the sites below in which you have had pain in the last month. *(Please select all that apply)*

○	Neck	G227_PN70
○	Left shoulder	G227_PN71
○	Right shoulder	G227_PN72
○	Left arm	G227_PN73
○	Right arm	G227_PN74
○	Upper back	G227_PN75
○	Lower back	G227_PN76
○	Left leg	G227_PN77
○	Right leg	G227_PN78
○	Other *(please state)*.....	G227_PN79 & G227_PN79_OTH
○	I have not had any pain in the last month *(If no pain please go to ***Q8.1***)*	G227_PN116

OREBRO Q6 How many days of work have you missed because of pain during the past 12 months? *(Please select one)*

0 days	1-2 days	3-7 days	8-14 days	13-30 days	1 month	2 months	3-6 months	6-12 month	G227_PN93
1	2	3	4	5	6	7	8	9	

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

			G2G227_WP
1	○	0 days	
2	○	1-2 days	
3	○	3-7 days	
4	○	8-14 days	
5	○	15-30 days)	
6	○	1 month	
7	○	2 months	
8	○	3-6 months	
9	○	6-12 months	
10	○	Over 1 year	

OREBRO Q9 How would you rate the pain you have had in the last week? *(Please select one)* G227_PN80

No Pain 0	1	2	3	4	5	6	7	8	9	Pain as bad as it could be 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

OREBRO Q10 In the past three months, on average, how bad was your pain on 0-10 scale *(Please sel* G227_PN81

No Pain 0	1	2	3	4	5	6	7	8	9	Pain as bad as it could be 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

OREBRO Q11 How often would you say that you have experienced pain episodes, on average, during the past three months? *(Please select one)*

G227_PN82

Never 0	1	2	3	4	5	6	7	8	9	Always 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

OREBRO Q12 Based on all things you do to cope, or deal with your pain, on an average day, how much are you able to decrease it? *(Please select one)*

G227_PN83

Can't decrease it all 0	1	2	3	4	5	6	7	8	9	Can decrease it completel **10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

OREBRO Q15 In your view, how large is the risk that your current pain may become persistent?

G227_PN84

No risk 0	1	2	3	4	5	6	7	8	9	Very large risk 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

OREBRO Q16 In your estimation, what are the chances that you will be working normal duties in 3 mo

G227_PN95A

No chance 0	1	2	3	4	5	6	7	8	9	Very large chance 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.

	Completely disagree 0	1	2	3	4	5	6	7	8	9	Completely agree 10
OREBRO Q18 Physical activity makes my pain worse	☐	☐	☐	☐	☐	☐	☐	☐	☐		
OREBRO Q19 An increase in pain is an indication that I should stop what I'm doing until the pain decreases	☐	☐	☐	☐	☐	☐	☐	☐	☐		
OREBRO Q20 I should not do my normal work with my present pain.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

G227_PN85

G227_PN86

G227_PN87

For the next 5 questions, please select the one number that best describes your current ability to participate in each of these activities.

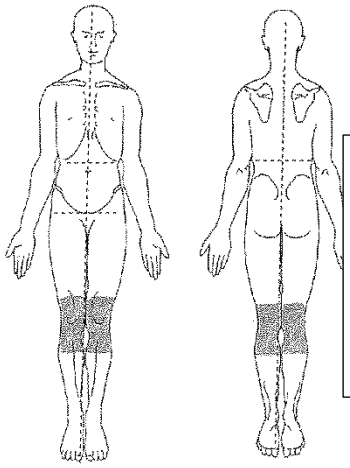
	Can't do it because of a pain problem										Can do it without pain being a problem
	0	1	2	3	4	5	6	7	8	9	10
OREBRO Q21 I can do light work for an hour	☐	☐	☐	☐	☐	☐	☐	☐			
OREBRO Q22 I can walk for an hour	☐	☐	☐	☐	☐	☐	☐	☐			
OREBRO Q23 I can do ordinary household chores	☐	☐	☐	☐	☐	☐	☐	☐			
OREBRO Q24 I can do the weekly shopping	☐	☐	☐	☐	☐	☐	☐	☐			
OREBRO Q25 I can sleep at night	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

G227_PN88
G227_PN89
G227_PN90
G227_PN91
G227_PN92

	0 No	**1 Yes**
(1) Is your pain work-related in that it was caused by your work?	☐	☐
(2) Is your pain work-related in that your pain developed outside of work but is made worse by work?	☐	☐
(3) Have you reported your pain to your employer?	☐	☐
(4) Have you claimed workers' compensation for your pain?	☐	☐

G227_WPN1
G227_WPN2
G227_WPN3
G227_WPN4

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



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

G227_PN101

0	○ Never *(please go to Q8.3)*
1	○ Monthly
2	○ Weekly
3	○ Daily
4	○ Always

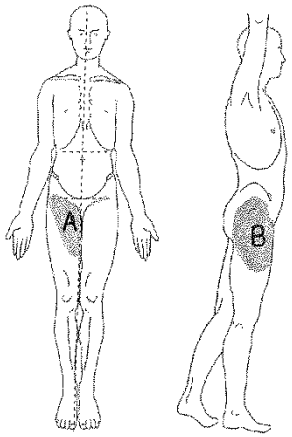
CODING VERSION

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

G227_PN101A-H

	None	Mild	Moderate	Severe	Extreme
KOOS P2 Twisting/pivoting on your knee	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
KOOS P3 Straightening knee fully	☐	☐	☐	☐	☐
KOOS P4 Bending knee fully	☐	☐	☐	☐	☐
KOOS P5 Walking on flat surface	☐	☐	☐	☐	☐
KOOS P6 Going up or down stairs	☐	☐	☐	☐	☐
KOOS P7 At night while in bed	☐	☐	☐	☐	☐
KOOS P8 Sitting or lying	☐	☐	☐	☐	☐
KOOS P9 Standing upright	☐	☐	☐	☐	☐

8.3 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 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)*

0 ○ Never
1 ○ Monthly
2 ○ Weekly
3 ○ Daily
4 ○ Always

G227_PN102A

HOOS P1 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)

0 ○ Never
1 ○ Monthly
2 ○ Weekly
3 ○ Daily
4 ○ Always

G227_PN102B

*(If "never' to both of the above two questions, please go to **Q8.4**)*

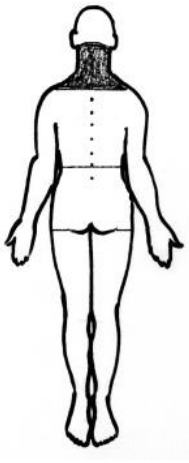
The following questions relate to the amount pain you have experienced in either hip in the last week. **For each situation please enter the amount of pain experienced in the last week during the following activities**. If both hips are painful, please answer with regard to the most painful hip.

G227_PN103A-I

	None	Mild	Moderate	Severe	Extreme
HOOS P2 Straightening your hip fully	☐ 0	☐ 1	2	3	4
HOOS P3 Bending your hip fully	☐	☐	☐	☐	☐
HOOS P4 Walking on a flat surface	☐	☐	☐	☐	☐
HOOS P5 Going up or down stairs	☐	☐	☐	☐	☐
HOOS P6 At night while in bed	☐	☐	☐	☐	☐
HOOS P7 Sitting or lying	☐	☐	☐	☐	☐
HOOS P8 Standing upright	☐	☐	☐	☐	☐
HOOS P9 Walking on a hard surface (asphalt, concrete, etc.)	☐	☐	☐	☐	☐
HOOS P10 Walking on an uneven surface	☐	☐	☐	☐	☐

Which of your hips was most painful? ☐ Left ☐ Right G227_PN102

8.4The following questions relate to pain you may have experienced in neck/shoulder. The diagram indicates the area where neck and shoulder pain is experienced.



Have you ever had neck/shoulder pain?

(Anywhere in the shaded area in the picture)

G227_PN9

0 ○ No *(Please go to Q8.5)*

1 ○ Yes

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

G227_PN11

0 ○ No

1 ○ Yes

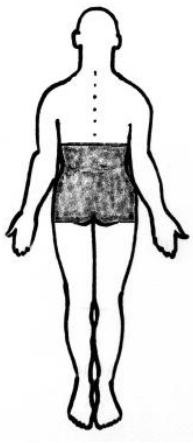
How would you rate the usual intensity neck/shoulder pain that you have had during the past month?

G227_PN11A

No Pain 0	1	2	3	4	5	6	7	8	9	Pain as bad as it could be 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	0 No	1 Yes
(a) In the past month, did you seek health professional advice or treatment for your neck/shoulder pain?	☐	☐
(b) In the past month, did you take medication to relieve your neck/shoulder pain?	☐	G227_PN104A
(c) In the past month, did your neck/shoulder pain interfere with your normal activities?	☐	G227_PN104B
(d) In the past month, did your neck/shoulder pain interfere with recreational physical activities (e.g. sport, walking, cycling etc.)	☐	G227_PN104C
(e) In the past month, did you miss work because of your neck/shoulder pain?	☐	G227_PN104D
(f) In the past month, did your neck/shoulder pain interfere with your work activities?	☐	G227_PN104E
(g) Has your present neck/shoulder pain lasted for more than 3 months continuously (it hurt more or less every day)?	☐	G227_PN104F
(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)?	☐	☐

8.5The following questions relate to pain you may have experienced in lower back. The diagram indicates the area where low back pain is experienced.



Have you ever had low back pain?
(Anywhere in the shaded area in the picture)

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

G227_PN38

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

0 ○ No
1 ○ Yes

G227_PN40

How would you rate the usual intensity of low back pain that you have had during the past month? G227_PN40A

No Pain 0	1	2	3	4	5	6	7	8	9	Pain as bad as it could be 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	0 **No**	1 **Yes**
(a) In the past month, did you seek health professional advice or treatment for your low back pain?	☐	☐
(b) In the past month, did you take medication to relieve your low back pain?	☐	☐
(c) In the past month, did your low back pain interfere with your normal activities?	☐	☐
(d) In the past month, did your low back pain interfere with recreational physical activities (e.g. sport, walking, cycling etc.)?	☐	☐
(e) In the past month, did you miss work because of your low back pain?	☐	☐
(f) In the past month, did your low back pain interfere with your work activities?	☐	☐
(g) Has your present low back pain lasted for more than 3 months continuously (it hurt more or less every day)?	☐	☐
(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)?	☐	☐

G227_PN105A
G227_PN105B
G227_PN105C
G227_PN105D
G227_PN105E
G227_PN105F
G227_PN41
G227_PN49

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)*	G227_RE34
1	○	Yes	

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

0	○	Never woken with wheezing	G227_RE36
1	○	Less than one night per week	
2	○	One or more nights per week	
3	○	Don't know	

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

0	○	No	G227_RE37
1	○	Yes	
2	○	Don't know	

Your chest sounded wheezy during or after exercise?

0	○	No	G227_RE8
1	○	Yes	
2	○	Don't know	

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

0	○	No	G227_AS1
1	○	Yes	
2	○	Don't know	

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

0	○	No	G227_AS2
1	○	Yes	
2	○	Don't know	
3	○	Never had asthma	

Do you still have asthma?

0	○	No	G227_AS16
1	○	Yes	
2	○	Don't have asthma *(Please go to 9.3)*	
3	○	Don't know	

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

0	○	No *(Please go to Q9.3)*	G227_AS67
1	○	Yes	

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

- ○ Ventolin – **G227_AS18**
- ○ Respolin – **G227_AS20**
- ○ Bricanyl - **G227_AS26**
- ○ QVAR – **G227_AS35**
- ○ Flixotide – **G227_AS39**
- ○ Pulmacort – **G227_AS41**
- ○ OXIS – **G227_AS50**
- ○ Serevent – **G227_AS52**
- ○ Singulaire – **G227_AS54**
- ○ Seretide – **G227_AS59**
- ○ Symbacort – **G227_AS61**
- ○ Prednisolone – **G227_AS63**
- ○ Other (please specify) **G227_AS65 & G227_AS65_OTH**

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

- ○ Viral infection – **G227_AS69**
- ○ Grass – **G227_AS70**
- ○ Pollen – **G227_AS71**
- ○ Animal – **G227_AS72**
- ○ Dust – **G227_AS73**
- ○ Other (please specify) **G227_AS75 & G227_AS75_OTH**
- ○ Don't know – **G227_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)*	G227_RE69
1	○	Yes	

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

0	○	No	G227_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	G227_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

G227_RE80-91

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

- 0 ○ No
- 1 ○ Yes

G227_RE24

What was the trigger/cause of these problems?

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

G227_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

G227_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
77	○	Don't know

G227_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
77	○	Don't know

G227_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

G227_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

G227_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

G227_CO21 - 32

What was the trigger/cause of these problems?

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

G227_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

G227_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

G227_RS1

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

0 ○ No
1 ○ Yes

G227_RS2

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

0 ○ No
1 ○ Yes

G227_RS3

Do you ever get short of breath at rest?

0 ○ No
1 ○ Yes

G227_RS4

Do you usually cough first thing in the morning?

0 ○ No
1 ○ Yes

G227_RS5

Do you usually cough during the day or at night?

0 ○ No
1 ○ Yes

G227_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

G227_RS7

CODING VERSION

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

0 ○ No
1 ○ Yes

G227_RS8

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

0 ○ No
1 ○ Yes

G227_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

G227_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

G227_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

G227_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

G227_RH6

Has this rash cleared completely during the last 12 months?

0 ○ No
1 ○ Yes

G227_RH5

Do you think that you have ever had eczema?

0 ○ No
1 ○ Yes
2 ○ Don't know

G227_RH7

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

0 ○ No
1 ○ Yes
77 ○ Don't know

G227_RH11

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

0 ○ No *(Please go to Q9.6)*
1 ○ Yes

G227_RH12

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

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

G227_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

G227_RH28-39

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

0 ○ No *(Please go to Q9.6)*
1 ○ Yes

G227_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

G227_FAL

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

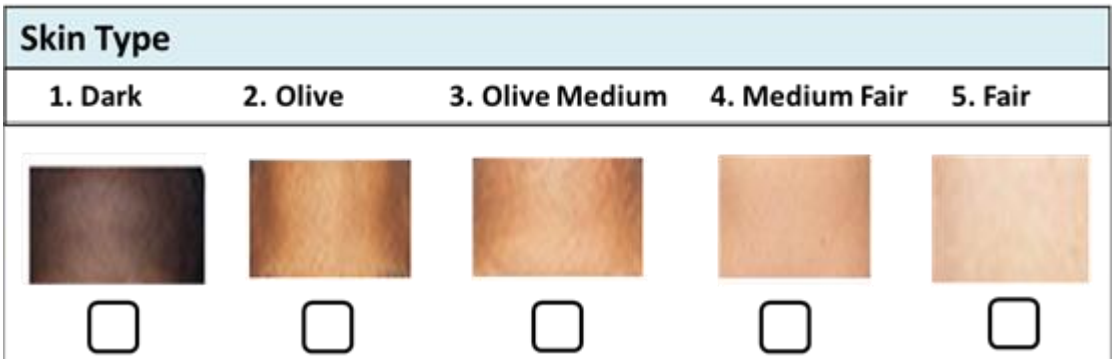
- ○ Peanut Products – **G227_FD1A**
- ○ Wheat/Yeast – **G227_FD2A**
- ○ Dairy – **G227_FD3A**
- ○ Fruit – **G227_FD4A**
- ○ Eggs – **G227_FD5A**
- ○ Seafood – **G227_FD6A**
- ○ Preservatives/Colouring – **G227_FD7A**
- ○ Other (please specify) - **G227_FD8A & G227_FD8A_OTH**

10. SUN EXPOSURE

We are interested in knowing details about time you spend outdoors and sun exposure.

Which of the following best describes your natural skin colour that is not exposed to the sun (e.g. on your underarm)? (Please mark only one response)

G227_UV1D



Imagine you spent 30 minutes in the sun in the middle of the day for the first time in summer. If you were not wearing sunscreen, would you (please mark only one response):

G227_UV2

- 3 ○ Get severe sunburn with blistering
- 2 ○ Have painful sunburn
- 1 ○ Get mildly burnt
- 0 ○ Not get sunburnt at all

After this initial reaction, would you get a tan?

G227_UV2A

- 0 ○ No
- 1 ○ Yes

Imagine you spent short periods of time in the sun every day over the summer (without sunscreen). How would your skin look at the end of summer?

G227_UV2B

- 3 ○ Very tanned
- 2 ○ Moderately tanned
- 1 ○ Lightly tanned
- 0 ○ No sun tan at all

How many bad sunburns with pain lasting longer than a day would you estimate you have had in your lifetime? (Please mark only one response)

G227_UV3

- 0 ○ None
- 1 ○ One
- 2 ○ 2-10
- 3 ○ More than 10

 CODING VERSION

In the **summer** on an **average work day**, how many hours do you spend **outdoors in the sun**? (Including sports, recreation, outdoor work and anything else done outside)

☐☐ **Hours** ☐☐ **Minutes**

G227_UV30S_HRS
G227_UV31S_MINS

In the **summer** on an average **non-working day**, how many hours do you spend **outdoors in the sun?** (Including sports, recreation, outdoor work and anything else done outside)

☐☐ **Hours** ☐☐ **Minutes**

G227_UV32S_HRS
G227_UV33S_MINS

In the **winter** on an **average work day**, how many hours do you spend **outdoors in the sun**? (Including sports, recreation, outdoor work and anything else done outside)

☐☐ **Hours** ☐☐ **Minutes**

G227_UV30W_HRS
G227_UV31W_MINS

In the **winter** on an **average non-working day**, how many hours do you spend **outdoors in the sun** (including sports, recreation, outdoor work and anything else done outside?)

☐☐ **Hours** ☐☐ **Minutes**

G227_UV32W_HRS
G227_UV33W_MINS

When outdoors in the sun, how much of the time do you

	Never	**seldom**	**half of the time**	**usually**	**always**	**cannot judge**
Wear a hat with a brim or a visor?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Wear sunglasses?	☐	☐	☐	☐	☐	☐

G227_UV5
G227_UV6

11. EYES

What is the main reason you wear sunglasses? (Please mark only one response)

- ○ Protection from eye disease
- ○ Driving
- ○ Medical condition/doctor's advice
- ○ Glare
- ○ Sport
- ○ Fashion/looks cool
- ○ School requirement
- ○ Influenced by family member
- ○ ~~Don't wear sunglasses~~
- ○ Other - please specify .....

G227_UV27a
G227_UV27b
G227_UV27c
G227_UV27d
G227_UV27e
G227_UV27f
G227_UV27g
G227_UV27h
G227_UV27i & G227_UV27i_OTH

What is the main reason you do NOT wear sunglasses? (Please mark only one response)

- ○ Inconvenient
- ○ Uncomfortable
- ○ Decreases vision
- ○ Wears prescription glasses
- ○ Expensive
- ○ Not fashionable
- ○ Not necessary
- ○ Forget to
- ○ Don't have any
- ○ Other - please specify .....

G227_UV28a
G227_UV28b
G227_UV28c
G227_UV28d
G227_UV28e
G227_UV28f
G227_UV28g
G227_UV28i
G227_UV28j
G227_UV28h & G227_UV28h_OTH

Have you <u>ever</u> worn (or needed to wear) glasses/spectacles and/or contact lenses for your vision?

0 ○ No *(please go to Q11.1)* G227_GLSE
1 ○ Yes

What age did you start wearing them? ..... G227_GLS1 ..... *Age in years*

Do you <u>currently</u> wear (or need to wear) glasses/spectacles and/or contact lenses for your vision?

0 ○ No ..... *(please specify why)* G227_GLS & G227_GLS_NOTE
1 ○ Yes

If yes, do you use: 1 ☐ Contact lenses 2 ☐ Glasses/spectacles 3 ☐ Both

G227_GLS2

***11.1* Has a doctor ever told you that you have any of the following problems with your eyes? (Select all that apply)**

- ○ Diabetes related eye disease
- ○ Injury or trauma resulting in loss of vision
- ○ Macular degeneration
- ○ Glaucoma
- ○ Cataract
- ○ Dry eye syndrome
- ○ Other serious eye condition. Please specify: .....
- ○ None of the above

G227_EY19
G227_EY27
G227_EY18
G227_EYE7
G227_EYE8
G227_EY10
G227_EY29 & G227_EY29_OTH

Do you currently use artificial tear eye drops or gel?

0 ○ No
1 ○ Yes

G227_E130

For the past three months or longer, have you had dry eyes? (This is described as a foreign body sensation with itching and burning, sandy feeling, not related to allergy)

0 ○ No
1 ○ Yes

G227_E131

Have you had any eye surgeries?

0 ○ No
1 ○ Yes

G227_EY28 &
G227_EY28_OTH

If yes, please specify ……

……

……

12. PHYSICAL ACTIVITY

The following questions relate to how physically active you are.

The following questions will ask you about the time you spent being physically active in the last 7 days. Please answer each question, even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

12.1 Think about all the **vigorous physical activities** that you did in the last 7 days. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

During the last 7 days, on how many days did you do **vigorous physical activities** like heavy lifting, digging, aerobics, or fast bicycling? G227_AY1

0 ○ No vigorous activities *(Please go to Q12.2)*

1 ○ Yes (how many **days per week**?) G227_AY2

How much time did you usually spend doing **vigorous** physical activities on one of those days?

Hours per day G227_AY3 **Minutes per day** G227_AY4

12.2 Think about all the **moderate physical activities** that you did in the last 7 days. Moderate activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

During the last 7 days, on how many days did you do **moderate physical activities** like carrying light loads, bicy G227_AY5 pace, or doubles tennis? Do not include walking.

0 ○ No moderate activities *(Please go to Q12.3)*

1 ○ Yes (how many **days per week**?) G227_AY6

How much time did you usually spend doing **moderate** physical activities on one of those days?

Hours per day G227_AY7 **Minutes per day** G227_AY8

12.3 Think about the time you spent **walking** in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

During the last 7 days, on how many days did you **walk** for at least 10 minutes at a time? G227_AY9

0 ○ No walking (*Please go to Q12.4)*

1 ○ Yes (how many **days per week**?) G227_AY10

How much time did you usually spend **walking** on one of those days?

Hours per day G227_AY11 **Minutes per day** G227_AY12

12.4 This question is about the time you spent **sitting on weekdays and weekends** during the last 7 days. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting to watch television.

During the last 7 days, how much time did you spend **sitting** on a **week day**?

Hours per day G227_SIT1 **Minutes per day** G227_SIT2

During the last 7 days, how much time did you spend **sitting** on a **weekend** day?

Hours per day G227_SIT3 **Minutes per day** G227_SIT4

During the last 7 days what proportion (stated as a %) of your typical work day was spent doing the following? *(This involves only your work day, and does not include travel to and from work, or what you did in your leisure time - note: the sum of all activities should total 100%)*

..... 1. Sitting (including driving) G227_WK6

..... 2. Standing G227_WK7

..... 3. Walking G227_WK8

..... 4. Heavy labour or physically demanding tasks G227_WK9

13 TECHNOLOGY USE

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

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**
	Over a typical Monday to Friday,on **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)	Over a typical Saturday to Sunday, on **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 	○ Do not use ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use ○ 1 day ○ 2 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use for work ○ about 25% ○ about 50% ○ about 75% ○ only use for work

G227_TVWD	tv - number of weekdays used
G227_TVWDH	tv - number of hours used per weekday
G227_TVWE	tv - number of weekend days used
G227_TVWEH	tv - number of hours used per weekend day
G227_TVWP	tv - total weekly use for work purposes

CODING VERSION

	WEEKDAY (Mon – Fri)		**WEEKEND (Sat – Sun)**		**Total**
	Over a typical Monday to Friday,on **how many days do you use this device?**	On each of these weekdays, for about **how long do you use this device per day?**	Over a typical Saturday to Sunday, on **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)
Desktop computer 	○ Do not use ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use ○ 1 day ○ 2 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use for work ○ about 25% ○ about 50% ○ about 75% ○ only use for work

G227_DWD	desktop computer - number of weekdays used
G227_DWDH	desktop computer - number of hours used per weekday
G227_DWE	desktop computer - number of weekend days used
G227_DWEH	desktop computer - number of hours used per weekend day
G227_DWP	desktop computer - total weekly use for work purposes

CODING VERSION

	WEEKDAY (Mon – Fri)		**WEEKEND (Sat – Sun)**		**Total**
	Over a typical Monday to Friday,on **how many days do you use this device?**	On each of these weekdays, for about **how long do you use this device per day?**	Over a typical Saturday to Sunday, on **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)
Laptop 	○ Do not use ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use ○ 1 day ○ 2 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use for work ○ about 25% ○ about 50% ○ about 75% ○ only use for work

G227_LWD	laptop - number of weekdays used
G227_LWDH	laptop - number of hours used per weekday
G227_LWE	laptop - number of weekend days used
G227_LWEH	laptop - number of hours used per weekend day
G227_LWP	laptop - total weekly use for work purposes

CODING VERSION

	WEEKDAY (Mon – Fri)		**WEEKEND (Sat – Sun)**		**Total**
	Over a typical Monday to Friday,on **how many days do you use this device?**	On each of these weekdays, for about **how long do you use this device per day?**	Over a typical Saturday to Sunday, on **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)
Tablet (e.g. iPad, Samsung Galaxy Tab, Kindle e-reader) 	○ Do not use ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use ○ 1 day ○ 2 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use for work ○ about 25% ○ about 50% ○ about 75% ○ only use for work

G227_TWD	tablet - number of weekdays used
G227_TWDH	tablet - number of hours used per weekday
G227_TWE	tablet - number of weekend days used
G227_TWEH	tablet - number of hours used per weekend day
G227_TWP	tablet - total weekly use for work purposes

CODING VERSION

	WEEKDAY (Mon – Fri)		**WEEKEND (Sat – Sun)**		**Total**
	Over a typical Monday to Friday,on **how many days do you use this device?**	On each of these weekdays, for about **how long do you use this device per day?**	Over a typical Saturday to Sunday, on **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)
Mobile phone (i.e. smartphone or non-smartphone) 	○ Do not use ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use ○ 1 day ○ 2 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use for work ○ about 25% ○ about 50% ○ about 75% ○ only use for work

G227_MWD	mobile - number of weekdays used
G227_MWDH	mobile - number of hours used per weekday
G227_MWE	mobile- number of weekend days used
G227_MWEH	mobile - number of hours used per weekend day
G227_MWP	mobile - total weekly use for work purposes

	WEEKDAY (Mon – Fri)		**WEEKEND (Sat – Sun)**		**Total**
	Over a typical Monday to Friday,on **how many days do you use this device?**	On each of these weekdays, for about **how long do you use this device per day?**	Over a typical Saturday to Sunday, on **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)
Non-active electronic games (played sitting e.g. Xbox or PS3 console games and PSP or Nintendo DS handheld games) 	○ Do not use ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use ○ 1 day ○ 2 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use for work ○ about 25% ○ about 50% ○ about 75% ○ only use for work

G227_NEWD	Non-active electronic games - number of weekdays used
G227_NEWDH	Non-active electronic games - number of hours used per weekday
G227_NEWE	Non-active electronic games - number of weekend days used
G227_NEWEH	Non-active electronic games - number of hours used per weekend day
G227_NEWP	Non-active electronic games - total weekly use for work purposes

	WEEKDAY (Mon – Fri)		WEEKEND (Sat – Sun)		Total
	Over a typical Monday to Friday, on **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)	Over a typical Saturday to Sunday, on **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)
Active electronic games (played actively and moving about e.g. Xbox Kinect, Wii, PS3 Move) 	○ Do not use ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use ○ 1 day ○ 2 days	○ Do not use ○ 5 minutes ○ 15 minutes ○ 30 minutes ○ 1 hour ○ 2 hours ○ 3 hours ○ 4 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11 hours ○ 12 hours or more	○ Do not use for work ○ about 25% ○ about 50% ○ about 75% ○ only use for work

G227_AEWD	Active electronic games - number of weekdays used
G227_AEWDH	Active electronic games - number of hours used per weekday
G227_AEWE	Active electronic games - number of weekend days used
G227_AEWEH	Active electronic games - number of hours used per weekend day
G227_AEWP	Active electronic games - total weekly use for work purposes

G227_MO14

How old were you when you got your first mobile phone? ……. *Age in years*

☐ I have never had a mobile phone.

G227_MO15

14. SLEEP

The following questions are about how you sleep and the quality of your sleep.

Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

It is important that you answer each question as best you can.

Situation	Chance of dozing (0-3)			
G227_EPW1-8	would never doze	slight chance of dozing	moderate chance of dozing	high chance of dozing
ESS Q1 (1) Sitting and reading	0	1	2	3
ESS Q2 (2) Watching TV	0	1	2	3
ESS Q3 (3) Sitting inactive in a public place (e.g. a theatre or a meeting)	0	1	2	3
ESS Q4 (4) As a passenger in a car for an hour without a break	0	1	2	3
ESS Q5 (5) Lying down to rest in the afternoon when circumstances permit	0	1	2	3
ESS Q6 (6) Sitting and talking to someone	0	1	2	3
ESS Q7 (7) Sitting quietly after lunch without alcohol	0	1	2	3
ESS Q8 (8) In a car, while stopped for a few minutes in the traffic	0	1	2	3

Pittsburgh Sleep Symptom Questionnaire – Insomnia (PSSQ_I)

Instructions: Below is a list of common sleep complaints. During the past month, how many nights, or days per week, have you had, or been told you had, the following symptoms? If you have experienced any of these symptoms, please indicate how long it has lasted - in weeks, months or years.

During the past month …	**Never** 0	**Do not Know** 10	**Rarely**, less than once per week 1	**Sometimes**, 1-2 times per week 2	**Frequently** 3-4 times per week 3	**Always**, 5-7 times per week 4	**How long has the symptom lasted** (number of weeks, months or years)
PSSQ_I Q1 1. Difficulty falling asleep	☐	☐	☐	☐	☐	☐	☐ weeks 1 ☐ months 2 ☐ years 3
PSSQ_I Q2 2. Difficulty staying asleep	☐	☐	☐	☐	☐	☐	☐ weeks ☐ months ☐ years
PSSQ_I Q3 3. Frequent awakenings from sleep	☐	☐	☐	☐	☐	☐	☐ weeks ☐ months ☐ years
PSSQ_I Q4 4. Feeling that your sleep is not sound	☐	☐	☐	☐	☐	☐	☐ weeks ☐ months ☐ years
PSSQ_I Q5 5. Feeling that your sleep is unrefreshing	☐	☐	☐	☐	☐	☐	☐ weeks ☐ months ☐ years

If you checked "never", or "do not know' for **all of these symptoms**, YOU MAY STOP answering this question and go to Q14.1

If you checked "rarely" to "always" for **any of these symptoms** please continue with questions 6 to 13

CODING VERSION

				How long has the symptom lasted?		
		Indicator of "Freq" or "Always"	**Indicator of ">= 4 weeks"**	**Weeks**	**Months**	**Years**
1. Difficulty falling asleep	G227_PSSQ1	G227_PSSQ1_01	G227_PSSQA_01	G227_PSSQA1_1	G227_PSSQA1_2	G227_PSSQA1_3
2. Difficulty staying asleep	G227_PSSQ2	G227_PSSQ2_01	G227_PSSQB_01	G227_PSSQB2_1	G227_PSSQB2_2	G227_PSSQB2_3
3. Frequent awakenings from sleep	G227_PSSQ3			G227_PSSQC3_1	G227_PSSQC3_2	G227_PSSQC3_3
4. Feeling that your sleep is not sound	G227_PSSQ4			G227_PSSQD4_1	G227_PSSQD4_2	G227_PSSQD4_3
5. Feeling that your sleep is unrefreshing	G227_PSSQ5	G227_PSSQ5_01	G227_PSSQE_01	G227_PSSQE5_1	G227_PSSQE5_2	G227_PSSQE5_3

	How long has the symptom lasted? Number of weeks/months/years	**How long has symptom (difficulty falling asleep) lasted - weeks/months/years**
1. Difficulty falling asleep	G227_PSSQA1	G227_PSSQA
2. Difficulty staying asleep	G227_PSSQB2	G227_PSSQB
3. Frequent awakenings from sleep		
4. Feeling that your sleep is not sound		
5. Feeling that your sleep is unrefreshing	G227_PSSQE5	G227_PSSQE

CODING VERSION

Instructions: If you have experienced **any** sleep symptoms **during the past month** please circle the appropriate number to let us know how your sleep is affecting your daily life

G227_PSSQ6 - 13

During the past month	Not all	A little bit	Moderately	Quite a bit	Extremely
PSSQ_I Q6 6. How much do your sleep problems bother you?	0	1	2	3	4
PSSQ_I Q7 7. Have your sleep difficulties affected your work?	0	1	2	3	4
PSSQ_I Q8 8. Have your sleep difficulties affected your social life?	0	1	2	3	4
PSSQ_I Q9 9. Have your sleep difficulties affected other important parts of your life?	0	1	2	3	4
PSSQ_I Q10 10. Have your sleep difficulties made you feel irritable?	0	1	2	3	4
PSSQ_I Q11 11. Have your sleep problems caused you to have trouble concentrating?	0	1	2	3	4
PSSQ_I Q12 12. Have your sleep difficulties made you feel fatigued?	0	1	2	3	4
PSSQ_I Q13 13. How sleepy do you feel during the day?	0	1	2	3	4

CODING VERSION

Please choose the correct response to each question

Berlin questionnaire

14.1

Berlin Q1 1. Do you

G227_BERQ1

1 ○ Yes
0 ○ No *(Please go to Q5*)*
77 ○ Don't know *(Please go to Q5*)*

If you snore

Berlin Q2 2. Your snoring is:

G227_BERQ2

1 ○ Slightly louder than breathing
2 ○ As loud as talking
3 ○ Louder than talking
4 ○ Very loud; can be heard in adjacent rooms

Berlin Q3 3. How often do you snore?

G227_BERQ3

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1-2 times a month
5 ○ Never or nearly never

Berlin Q4 4. Has your snoring ever bothered other people?

G227_BERQ4

1 ○ Yes
0 ○ No
77 ○ Don't know

Berlin Q5 5. Has anyone noticed that you quit breathing during your sleep?

G227_BERQ5

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1- 2 times a month
5 ○ Never or nearly never

Berlin Q6 6. How often do you feel tired or fatigued after your sleep?

G227_BERQ6

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1-2 times a month
5 ○ Never or nearly never

Berlin Q7 7. During your wake time, do you feel tired, fatigued, or not up to par?

G227_BERQ7

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1-2 times a month
5 ○ Never or nearly never

Berlin Q8 8. Have you ever nodded off or fallen asleep while driving a vehicle?

G227_BERQ8

1 ○ Yes
0 ○ No *(Please go to Q10*)*

If yes

Berlin Q9 9. how often does this occur?

G227_BERQ9

1 ○ Nearly every day
2 ○ 3-4 times a week
3 ○ 1-2 times a week
4 ○ 1-2 times a month
5 ○ Never or nearly never

Berlin Q10 10. Do you have high blood pressure?

G227_BERQ10

1 ○ Yes
0 ○ No
77 ○ Don't know

These questions relate to your sleep over the past month
The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

Pittsburgh Sleep Quality Index (PSQI)

PSQI Q1 (1) During the past month, what time have you usually gone to bed at night?

[BED TIME] 00:00 (24 hr clock) ..... G227_BED .....

PSQI Q2 (2) During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

[NUMBER OF MINUTES] ..... G227_SL1 .....

PSQI Q3 (3) During the past month, what time have you usually gotten up in the morning?

[GETTING UP TIME] 00:00 (24 hr clock) ..... G227_WAKE .....

PSQI Q4 (4) During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

[HOURS OF SLEEP PER NIGHT] *decimal points*..... G227_SL2A .....

For each of the remaining questions, check the one best response. Please answer all questions

(5) During the past month, how often have you had trouble sleeping because you … G227_SL6-14

	Not during the past month	less than once week	Once or twice a week	Three or more times a week
PSQI Q5a (a) Cannot get to sleep within 30 minutes	☐ 0 ☐	☐ 1 ☐	☐ 2 ☐	☐ 3 ☐
PSQI Q5b (b) Wake up in the middle of the night or early morning				
PSQI Q5c (c) Have to get up to use the bathroom	☐	☐	☐	☐
PSQI Q5d (d) Cannot breathe comfortably	☐	☐	☐	☐
PSQI Q5e (e) Cough or snore loudly	☐	☐	☐	☐
PSQI Q5f (f) Feel too cold	☐	☐	☐	☐
PSQI Q5g (g) Feel too hot	☐	☐	☐	☐
PSQI Q5h (h) Had bad dreams	☐	☐	☐	☐
PSQI Q5i (i) Have pain	☐	☐	☐	☐
PSQI Q5j (j) Other reason(s), please describe		G227_SL15 & G227_SL15_NOTE		
How often during the past month have you had trouble sleeping because of this	☐	☐	☐	☐

PSQI Q6 (6) During the past month, how would you rate your sleep quality overall G227_SL16

0 Very good 1 Fairly good 2 Fairly bad 3 Very bad

PSQI Q7 (7) During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?

G227_SL17

0 ○ Not during the past month
1 ○ Less than once a week
2 ○ Once or twice a week
3 ○ Three or more times a week

PSQI Q8 (8) During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity

G227_SL18A

0 ○ Not during the past month
1 ○ Less than once a week
2 ○ Once or twice a week
3 ○ Three or more times a week

PSQI Q9 (9) During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

G227_SL19

0 ○ No problem at all
1 ○ Only a very slight problem
2 ○ Somewhat of a problem
3 ○ A very big problem

PSQI Q10 (10) Do you have a bed partner or roor G227_SL20

0 ○ No bed partner or roommate
1 ○ Partner/roommate in other room
2 ○ Partner in same room, but not same bed
3 ○ Partner in same bed

(11) During the past month, how many times per night do you wake up?

G227_SL18

0 ○ Never
1 ○ Less than once a week
2 ○ 1-6 times per week
3 ○ 1-2 times per night
4 ○ 3-5 times per night
5 ○ More than 5 times per night

15. EATING HABITS and WEIGHT

Do you know how much you weigh?

0 ○ No — G227_W1

1 ○ Yes → What is your current weight? ……KG ……..g — G227_W2

Are you worried about your weight?

0 ○ No, not at all — G227_W3

1 ○ A little

2 ○ Moderately

3 ○ Very

Do you consider yourself to be:

0 ○ Underweight — G227 W4

1 ○ Normal weight

2 ○ A bit overweight

3 ○ Very overweight

The following questions are concerned with the past 4 weeks only (28 days)

Please answer all of the questions

n how many days, in the past 4 weeks:

Please mark one response for each item	0 days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
1. Have you been trying hard to eat less to change your shape or weight? (even if you haven't been able to do so)	0	1	2	3	4	5	6
2. Have you gone for 8 or more waking hours without eating anything in order to influence your shape or weight?	☐	☐	☐	☐	☐	☐	
3. Have you tried to avoid eating foods that you like in order to influence your shape or weight?	☐	☐	☐	☐	☐	☐	
4. Have you tried to follow definite rules regarding your eating in order to influence your shape or weight; for example, a calorie limit, a set amount of food, or rules about what or when you should eat?	☐	☐	☐	☐	☐	☐	
5. Has thinking about <u>food or its calorie content</u> made it difficult to concentrate on things you are interested in; for example, read, watch TV, follow a conversation?	☐	☐	☐	☐	☐	☐	
6. Have you been afraid of losing control over eating?	☐	☐	☐	☐	☐	☐	
7. Have you eaten in secret (do not count binge eating)?	☐	☐	☐	☐	☐	☐	
8. Have you had a definite fear that you might gain weight or become fat?	☐	☐	☐	☐	☐	☐	
9. Have you felt fat?	☐	☐	☐	☐	☐	☐	
10. Have you had a strong desire to lose weight?	☐	☐	☐	☐	☐	☐	

G227_W8

G227_W35

G227_W9

G227_W10

G227_W11

G227_W12

G227_W15

G227_W16

G227_W38

G227_W39

11. Have there been times when you felt that you'd eaten what other people would regard as an unusually large amount of food given the circumstances?	0 NO, *go to Q 12*	1 *go t*	G227_W14
11a. How many such episodes have you had over the past four weeks?			G227_W14A
11b. During these episodes, did you have a sense of having lost control over your eating (of not being able to stop eating or of not being able to control how much or what you ate)?	☐ NO, *go to Q 12*	☐ *go t*	G227_W54
11c. If so, for how many of the above episodes did you experience this sense of loss of control?			G227_W54A
12. Have you made yourself sick (vomit) as a means of controlling your shape or weight?	☐ NO, *go to Q 13*	☐ *go t*	G227_W17
12a. How many times have you done this over the past four weeks?			G227_W17A
13. Have you taken laxatives as a means of controlling your shape or weight?	☐ NO, *go to Q 14*	☐ *go t*	G227_W55
13a. How many times have you done this over the past four weeks?			G227_W55A
14. Have you exercised hard as a means of controlling your shape or weight?	☐ NO, *go to Q 15*	☐ *go t*	G227_W19
14a. How many days have you done this over the past four weeks?			G227_W19A
14b. For how long for each day (on average)?			G227_W19B

	Not at all		**Slightly**		**Moderately**	**Markedly**	
15. Has your **weight** influenced how you think about (judge) yourself as a person?	☐0	☐1	☐2	☐3	☐4	☐5	G227_W45
16. Has your **shape** influenced how you think about (judge) yourself as a person?	☐0	☐1	☐2	☐3	☐4	☐5	G227_W56

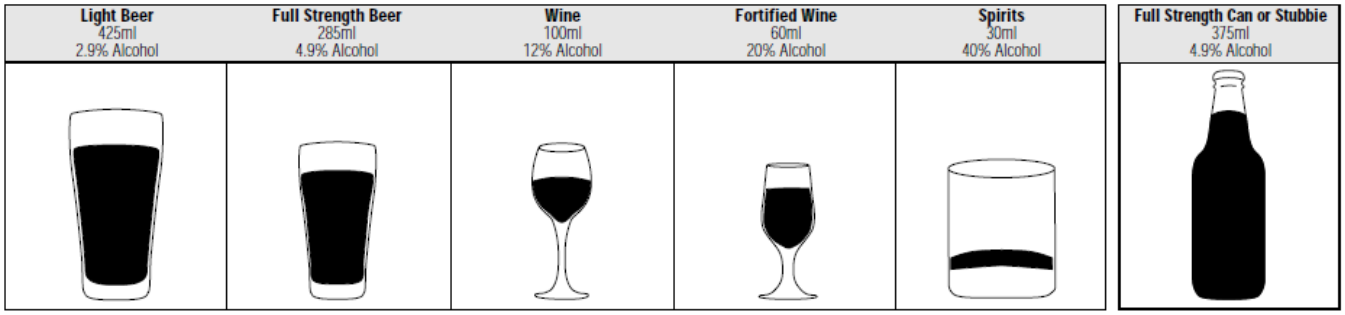
16. ALCOHOLIC, NON-ALCOHOLIC and ENERGY DRINKS

We would like to know how often and how much of the following drinks you usually consume. When answering these questions please answer in number of glasses, cans, cups, stubbies etc. To assist you, below each type of drink is the type of measurement. Please fill in every line (tick NEVER if you don't consume the type of drink). Please indicate the number of drinks you usually consume for the time selected. E.g you drink water every day, and usually **6** glasses per day

	How often	**Average Number**
Water (250 ml glass)	G227_DK1	G227_DK19
Fizzy drink (e.g cola, lemonade) can or glass	G227_DK2	G227_DK20
Diet fizzy drink (e.g. Diet cola, diet lemonade) can or glass	G227_DK3	G227_DK21
Energy drink (e.g Redbull, V, Monster) can	G227_DK4	G227_DK22
Diet energy drink (can)	G227_DK5	G227_DK23
Tea (cup)	G227_DK6	G227_DK24
Herbal tea (cup)	G227_DK7	G227_DK25
Green tea (cup)	G227_DK8	G227_DK26
Instant coffee (cup)	G227_DK9	G227_DK27
Ground coffee (ie filter coffee, cappuccino, flat white) cup, mug	G227_DK10	G227_DK28
Beer (can stubby)	G227_DK11	G227_DK29
Alcoholic soda (eg alcopop, cruiser, UDL)	G227_DK12	G227_DK30
Red wine (wine glass)	G227_DK13	G227_DK31
White wine, champagne (wine glass)	G227_DK14	G227_DK32
Sherry, port (small wine glass 30 ml)	G227_DK15	G227_DK33
Vodka (shots)	G227_DK16	G227_DK34
Whiskey (30 mL)	G227_DK17	G227_DK35
Other spirits (shots)	G227_DK18	G227_DK36
Milk full fat (250 ml glass)	G227_DK55	G227_DK59
Milk (hi lo, skim or any other type) 250 ml glass	G227_DK56	G227_DK60
Non cows milk (eg soy, almond, coconut) 250 ml glass	G227_DK57	G227_DK61
Flavoured milk (eg ice coffee, choc chill) box or bottle	G227_DK58	G227_DK62

We would like to ask you some questions about your alcohol consumption.

16.2 Please answer the following questions in terms of standard drinks. The following gives you an idea of one standard drink. A full strength can or stubby, and a can or bottle of alcoholic soda is 1.5 standard drinks.



*The guide above contains examples of **one standard drink**.*

A full strength can or stubbie contains ***one and a half standard drinks***.

G227_AH40 - 49

	Never	Monthly or less	2-4 times a month	2-3 times a week,	4 or more times a week
How often do you have a drink containing alcohol?	0 Go to Q17	1	2	3	4
	1 or 2	**3 or 4**	**5 or 6**	**7 to 9**	**10 or more**
How many standard drinks do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐
	Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
How often do you have six or more standard drinks on one occasion?	☐	☐	☐	☐	☐
How often during the last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐
How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐
How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐
Have you or someone else been injured because of your drinking?	☐	☐	☐	☐	☐
Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	☐	☐	☐	☐	☐

In the last year, have you drunk more than you meant to?

0	○	No	G227_AH50
1	○	Yes	

Have you felt you wanted or needed to cut down on your drinking in the last year?

0		No	G227_AH51
1		Yes	

17. SMOKING

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 smoke.

17.1 Have you ever smoked cigarettes (including roll ups)?

0	○	No *(Please go Q17.7)*	G227_SM1
1	○	Yes	

17.2 Have you smoked any cigarettes (including hand rolled) in the past 30 days?

0	○	No	G227_SM2
1	○	Yes (Please go to Q17.3)	

If No, How old were you when you last stopped smoking..... G227_SM6A

How many cigarettes per day did you smoke?

0	○	Less than one	G227_SM9
1	○	1-5	
2	○	6-10	
3	○	11-15	
4	○	16-20	
5	○	More than 20	

(Please go to Q17.7)

17.3 How many cigarettes per day do you currently smoke?

0	○	Less than one	G227_SM4
1	○	1-5	
2	○	6-10	
3	○	11-15	
4	○	16-20	
5	○	More than 20	

17.4 At what age did you start smoking regularly? ..... G227_SM40 **.....**

17.5 In the last year, have you ever smoked more than you meant to?

0	○	No	G227_SM46
1	○	Yes	

17.6 Have you felt you wanted or needed to cut down on your smoking in the last year?

0	○	No	G227_SM47
1	○	Yes	

17.7 Over the past 3 years, have you lived for more than 6 months with anyone that smokes cigarettes/cigars?

0	○	No	G227_SM42
1	○	Yes	

17.8 Are you currently exposed to tobacco smoke at home?

0	○	No, *please go to Q17.9*	G227_SM41
1	○	Yes	

If Yes, how long have you been exposed to tobacco smoke at home

…….years ……..months G227_SM41_yr G227_SM41_Mon

17.9 Are you exposed to tobacco smoke at work?

0	○	No, please go to Q17.10	G227_SM43
1	○	Yes	
2	○	I don't work, please go to Q17.10	

If Yes, how long have you been exposed to tobacco smoke at work

…….years ……..months G227_SM43_yr G227_SM43_Mon

17.10 Do you currently use electronic cigarettes or E-cigarettes, such as Ruyan or NJOY?

0	○	No	G227_SM44
1	○	Yes	

17.11 Do you currently use nicotine replacement therapy?

0	○	No	G227_SM45
1	○	Yes	

18. DRUG USE

18.1 Have you ever tried or used the following drugs for <u>non-medicinal purposes</u> in the past 12 months, and if so, on average, how often?

Marijuana/cannabis	G227_DG1
Opioids (heroin morphine, pethidine)	G227_DG17
Amphetamines (speed, ecstasy, diet pills)	G227_DG6
Ritalin	G227_DG19
Methamphetamines (ice)	G227_DG18
Other Methamphetamines (MDMA, molly)	G227_DG20
Cocaine HCl (powder cocaine, coke)	G227_DG9
GHB (liquid ecstasy, liquid G, blue nitro, fantasy)	G227_DG11
Freebase cocaine (crack)	G227_DG21
Nitrous (laughing gas)	G227_DG8
Other inhalants (glue, petrol, solvents)	G227_DG2
Hallucinogens (LSD, acid, mushrooms, Ketamine,)	G227_DG16
Sedatives or sleeping pills e.g. Valium, Rohypnol (**for recreational use**)	G227_DG14
Painkiller/analgesics e.g. panadeine forte, nurofen plus (**for recreational use**).	G227_DG3
Methadone/Buprenorphine	G227_DG10
Other, please list	G227_DG5_OTH1
	G227_DG5_OTH1_com
	G227_DG5_OTH2
	G227_DG5_OTH2_com
	G227_DG5_OTH3
	G227_DG5_OTH3_com

18.2 In the last year, have you ever smoked more marijuana than you meant to?

0	○	No, don't smoke marijuana (*please go to Q18.4*)
1	○	No
2	○	Yes

G227_DG22

18.3 Have you felt you wanted or needed to cut down on your marijuana smoking in the last year?

0	○	No
1	○	Yes

G227_DG22A

18.4 In the last year, have you ever used other drugs more than you meant to?

0	○	No, don't use drugs *(please go to Q19)*
1	○	No
2	○	Yes

G227_DG23

18.5 Have you felt you wanted or needed to cut down on your use of other drugs in the last year?

0	○	No
1	○	Yes

G227_DG23A

19. MEDICATIONS

The following questions are about your health and medical history, doctor-prescribed medications, over-the-counter medications or supplements you may take.

Do you currently take medication(s) prescribed by a doctor?

G227_PMED

0	○	No *(Please go to Q19.1)*
1	○	Yes, If yes, please list all **PRESCRIBED** medications you currently take, e.g. Coversyl, Lipitor, mini pill,

Medication	Condition medication addresses	Dose in mgs	Frequency e.g. daily, twice a day	How long have you been taking this medication at th current dose? In years or months

19.1 Antibiotics and probiotics

Have you taken any antibiotic tablets or intravenous (through the vein) antibiotics within *the last 3 months*?

- ○ No *(Please go to Q19.2)* G227_ATB
- ○ Yes

If yes, please list the name of the antibiotic (e.g. penicillin), duration of course (e.g. 7 days) and approximately how long ago you took them (e.g. 1 month ago).

Name of antibiotic	Duration (e.g. 7 days)	How long ago did you take them

If yes, please identify the condition that the antibiotics were used to treat**;**

- ○ Respiratory tract infection (bronchitis or pneumonia) G227_ATB2
- ○ Sinusitis
- ○ Urinary tract infection
- ○ Skin infection (or cellulitis)
- ○ Acne
- ○ Ear infection (or otitis media or otitis externa)
- ○ Gastroenteritis
- ○ Sexually transmitted infection (e.g. chlamydia or gonorrhea)
- ○ Other, *Please specify* ‘ .....

19.2 Over the counter medications

Have you taken any non-prescription medications in the last 3 months? (e.g. paracetomol, ibuprofen, aspirin etc)

G227_CMED

- ○ No *(Please go to Q19.3)*
- ○ Yes, please list

Medication	Condition medication addresses	Dose in mgs	Frequency e.g. daily, twice a day	When did you last have this medication

19.3 Have you taken any pro-biotics (e.g. Yakult, Inner Health Plus, kambucha, kefir etc) within *the last 3 months*?

G227_PRB

- ○ No *(Please go to Q19.4)*
- ○ Yes

If yes, please specify the total number of days in the last 3 months that you have taken probiotics;

Name of substance or supplement (or product)	How much	Frequency (e.g. daily, weekly)	When did you last consume any probiotics (e.g. 2 weeks ago)

19.4 Vitamins, supplements or other substances

Do you currently take supplements or substances (e.g. anabolic agents, peptides, beta-blockers, stimulants) that have not been prescribed by a doctor for the purpose of:

Enhancing your performance in an important area of your life such as work, study, or sport (e.g. anabolic agents, peptides, beta-blockers, stimulants)?

G227_SUP1

○ No *(Please go to **b**)* ◯ Yes *(Please complete **a**)*

a. Name of substance or supplement (or product)	Dose in mgs	Frequency (e.g. daily, weekly)	How long have you been taking this substance or supplement (yrs and mnths)?

Losing weight (e.g. diuretics, stimulants)?

G227_SUP2

○ No *(Please go to **c**)* ◯ Yes *(Please complete **b**)*

b. Name of substance or supplement (or product)	Dose in mgs	Frequency (e.g. daily, weekly)	How long have you been taking this substance or supplement (yrs and mnths)?

Building muscles (e.g. growth hormones, steroids, protein powder, creatine, pre-workout)?

G227_SUP3

○ No *(Please go to **d**)* ◯ Yes *(Please complete **c**)*

c. Name of substance or supplement (or product)	Dose in mgs	Frequency (e.g. daily, weekly)	How long have you been taking this substance or supplement (yrs and mnths)?

Improving your general health or well-being (e.g. fish oil, calcium, VitB, VitC etc)

G227_SUP4

○ No *(Please go to **Q20**)* ◯ Yes *(Please complete **d**)*

d. Name of substance or supplement (or product)	Dose in mgs	Frequency (e.g. daily, weekly)	How long have you been taking this substance or supplement (yrs and mnths)?

20. MEDICAL HISTORY

*** 20*** We are interested in knowing your recent medical history and any major illness you may have had over the last 5 years?

ENDOCRINE DISEASE: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Polycystic ovary syndrome
- ○ Endometriosis
- ○ Osteoporosis
- ○ Kidney disease
- ○ Thyroid disease
- ○ None of the above

G227_ENDO

NEUROLOGICAL CONDITIONS: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Alzheimer's disease
- ○ Vascular dementia (Multi-infarct dementia)
- ○ Parkinson's disease
- ○ Attention Deficit (Hyperactivity) Disorder
- ○ Anxiety disorder (including Post Traumatic Stress Disorder)
- ○ Bipolar disorder
- ○ Schizophrenia
- ○ Epilepsy
- ○ Chronic Fatigue (ME)
- ○ None of the above

G227_NEURO

DEPRESSION: Have you ever been told by a doctor that you have depression?

- ○ No
- ○ Yes

G227_DEPR

ALLERGIES AND RESPIRATORY DISEASE: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Asthma or bronchial asthma
- ○ Eczema
- ○ Bronchitis
- ○ Chronic obstructive pulmonary disease (COPD)
- ○ Hay fever or allergic rhinitis
- ○ Pleurisy
- ○ Pneumonia
- ○ Sinusitis
- ○ None of the above

G227_ALLR

AUTOIMMUNE DISEASE – Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Ankylosing Spondylitis
- ○ Multiple sclerosis
- ○ SLE (lupus)
- ○ None of the above

G227_AUIM

DIABETES: Has a doctor ever diagnosed you with diabetes?

- ○ No *(Please go to Sleep problems)*
- ○ Yes - please enter year diagnosed (e.g. 2010) .....

G227_DIAB & G227_DIABY

What kind of diabetes were you diagnosed with?

- ○ Type 1 diabetes (also known as insulin dependent diabetes)
- ○ Type 2 diabetes (also known as non-insulin dependent diabetes)

G227_DIAB12

SLEEP PROBLEMS: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Obstructive sleep apnoea
- ○ Narcolepsy
- ○ Loud or disruptive snoring
- ○ Insomnia disorder
- ○ Excessive (too much) sleepiness
- ○ Restless legs or periodic leg movements of sleep
- ○ None of the above

G227_SLPP

GASTROINTESTINAL DISORDERS: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Stomach (gastric) or duodenal ulcer
- ○ Colon cancer
- ○ Colonic polyps
- ○ Coeliac disease
- ○ Gastro-oesophageal reflux disease
- ○ Hiatus Hernia
- ○ Crohn's disease
- ○ Ulcerative colitis (or proctitis)
- ○ Irritable bowel syndrome
- ○ Diverticular disease
- ○ Gallstones
- ○ Haemorrhoids
- ○ Other (please specify)……
- ○ None of the above

G227_GASTR

GASTROINTESTINAL DISORDERS: Have you ever had surgery on your gastrointestinal tract? *(Please select all that apply)*

- ○ No
- ○ Cholecystectomy (removal of gall bag/gall bladder)
- ○ Appendicectomy (removal of appendix)
- ○ Colectomy (removal of part of the colon)
- ○ Lap or gastric banding
- ○ Gastric bypass surgery
- ○ Other (please specify)…….

G227_GASTR1

CARDIOVASCULAR DISEASE: Has a health professional ever diagnosed you with any of the following conditions in the past five years? *(Please select all that apply)*

- ○ Angina
- ○ Claudication (problems with blood supply to your legs that causes pain on walking)
- ○ High blood pressure
- ○ High cholesterol
- ○ Implant or cardiac pacemaker
- ○ Myocardial infarction/ Heart attack
- ○ Transient ischaemic attack (TIA)
- ○ Stroke
- ○ Carotid surgery (endarterectomy or stent)
- ○ Coronary angioplasty or stent
- ○ Coronary bypass
- ○ None of the above

G227_CVD

In the last 5 years, have you been diagnosed with cancer?

- ○ No *(Please go to Other medical conditions)*
- ○ Yes

G227_CANC

In the last 5 years, what type of cancer(s) were you diagnosed with?
(Please select all that apply)

- ○ Breast Cancer
- ○ Prostate Cancer
- ○ Skin Cancer
- ○ Bowel Cancer
- ○ Lung Cancer
- ○ Blood cancer
- ○ Lymphoma
- ○ Other, *Please specify* ' .....

G227_CAN

OTHER MEDICAL CONDITIONS: Has a health professional ever diagnosed you with any of the following conditions in the past five years?? *(Please select all that apply)*

- ○ Chronic ear infection
- ○ Ménières Disease
- ○ Trauma to the head or neck
- ○ Anaemia
- ○ Arthritis
- ○ Migraine
- ○ Headache
- ○ Cirrhosis of the liver
- ○ Fatty liver
- ○ Poliomyelitis
- ○ Urinary tract infection
- ○ Other major medical condition(s) – please list below
- ○ No other major medical conditions

G227_OTHM

Please list any other major medical condition(s) that you have been diagnosed with in the last 5 years.

Name of condition

Accidents, injuries, hospital admissions

In the past 5 years, have you had any accidents or injuries which required you to go to a doctor (GP), hospital or clinic?

- ○ No *(Please go to Q20.1)*
- ○ Yes

G227_HOSP

Please describe the accident, the injury and any treatment (e.g. Broke leg playing football) and list every accident or injury separately, giving as much detail as possible

Injury	How did it happen?	When did it happen?	Treatment
Sprained wrist	Fell down stairs	2 years ago	Physiotherapy

20.1 In the past 5 years, have you been admitted to a hospital or day surgery?

- ○ No *(Please go to **Q20.2**)*
- ○ Yes

G227 AE

Please list each admission separately, giving as much detail as possible.

Date	Which hospital	Reason for admission
October 2015	Hollywood	Knee arthroscopy

20.2 Approximately how many times have you seen the following health professionals about your health in the last 12 months?

G227_HPR1-14

		0	1	2	3	4	5	6-10	11 +
GP or family doctor		☐	☐	☐	☐	☐	☐	☐	☐
Accident and Emergency		☐	☐	☐	☐	☐	☐	☐	☐
Hospital outpatient (department or clinic)		☐	☐	☐	☐	☐	☐	☐	☐
Private medical specialist		☐	☐	☐	☐	☐	☐	☐	☐
Dentist, dental therapist, orthodontist		☐	☐	☐	☐	☐	☐	☐	☐
Optician/optometrist		☐	☐	☐	☐	☐	☐	☐	☐
Dietician/nutritionist		☐	☐	☐	☐	☐	☐	☐	☐
Physiotherapist		☐	☐	☐	☐	☐	☐	☐	☐
Occupational therapist (OT)		☐	☐	☐	☐	☐	☐	☐	☐
Speech therapist		☐	☐	☐	☐	☐	☐	☐	☐
Psychologist/psychiatrist		☐	☐	☐	☐	☐	☐	☐	☐
Podiatrist		☐	☐	☐	☐	☐	☐	☐	☐
Chiropractor		☐	☐	☐	☐	☐	☐	☐	☐
Alternative therapist e.g. iridologist		☐	☐	☐	☐	☐	☐	☐	☐

When did you last visit the dentist? Why did you visit the dentist?

- ○ In the last 6 months
- ○ Between 6 months and a year ago
- ○ Over a year ago

G227_DENT1

- ○ Never

Why did you visit the dentist?

- ○ Check up with no treatment
- ○ Check up with scale and clean
- ○ Check up with minor treatment (e.g. Small filling)
- ○ Check up with follow-up treatment (e.g. Large filling, crown)
- ○ Ongoing long-term treatment
- ○ To see the hygienist (scale and polish)
- ○ Emergency

G227_DENT2

21. RELATIONSHIPS

21.1 What is your current relationship status? *(Please mark only one response)*

0	○ Single and not in a relationship
1	○ In a relationship but NOT living together
2	○ In a relationship AND living together
3	○ Married (in a registered marriage)

G227_PTNR1

What is your current marital status? *(Please select one)*

0	○ Never married
1	○ Married
2	○ Widowed
3	○ Divorced
4	○ Separated
5	○ De Facto

G227_MAR

Is your primary partner male or female?

0	○ No primary partner (Please go to Q21.1)
1	○ Male
2	○ Female
3	○ Other, please specify ……

G227_P6
G227_P6_OTH

How long have you been with your primary partner?

G227_P10_WK
G227_P10_MON
G227_P10_YR

…….. weeks ……..months……years ☐ don't know

21.1 Which of these statements best describes you? (Please mark only one response)

0	○	I have felt attracted only to females, never to males
1	○	I have felt attracted more often to females and at least once to a male
2	○	I am about equally attracted to females and males
3	○	I have felt attracted more often to males and at least once to a female
4	○	I have felt attracted only to males, never to females
5	○	I have never felt attracted to anyone at all

G227_SX11

What do you identify as: (Please mark only one response)

0	○	Heterosexual
1	○	Gay/Lesbian
2	○	Bisexual
3	○	Not sure
4	○	Other - please specify ……

G227_SX94
G227_SX94_OTH

Do you identify as: (Please mark only one response)

0	○	Female
1	○	Male
2	○	Transgender female
3	○	Transgender male
4	○	Nonbinary
5	○	Other - please specify ……

G227_SX123
G227_SX123_OTH

Regarding your sexual experiences

How old were you when you first had an experience of:

	Haven't	Under 14	14to18	18to20	20to25	over 25
Deep kissing	☐	☐	☐	☐	☐	
Touching a partner's genitals with your hands	☐	☐	☐	☐	☐	
Being touched on your genitals by a partner's hand	☐	☐	☐	☐	☐	
Giving oral sex	☐	☐	☐	☐	☐	
Receiving oral sex	☐	☐	☐	☐	☐	
Penis-vaginal intercourse	☐	☐	☐	☐	☐	
Anal intercourse (giving or receiving)	☐	☐	☐	☐	☐	

G227_SX13
G227_SX14
G227_SX15
G227_SX16
G227_SX17
G227_SX119
G227_SX120

Over the last year, with how many partners have you had oral sex, or vaginal or anal intercourse? *(Please mark only one response)*

0	○	Have not had a sexual partner *(Please go to ***Q21.3***)*
1	○	Have not had a sexual partner in the last year
2	○	1 person
3	○	2 people
4	○	3 people
5	○	4 people
6	○	5-10 people
7	○	11 or more people

G227_SX95

Over the last year, have your partners been

0	○	Male only
1	○	Female only
2	○	Male and female

G227_PTNR2

Over your LIFETIME, have your partners been:

0	○	Male only
1	○	Female only
2	○	Male and female

G227_PTNR3

In the last year, have you ever had oral sex or vaginal/anal intercourse when you didn't want to?

0	○	No *(Please go to Q21.2)*
1	○	Yes

G227_SX23

What were the reasons for this? (Please mark all responses that apply)

- ○ Had been drinking at the time
- ○ Was high at the time
- ○ Partner thought I should
- ○ Friends thought I should
- ○ Felt I could not say no
- ○ Other reason - please specify ……

G227_SX23
G227_SX24
G227_SX25
G227_SX26
G227_SX27
G227_SX96
G227_SX28
G227_SX28_OTH

21.2 CONTRACEPTION AND PREGNANCY

What kind(s) of contraception do you or your partner use? *(Please mark all that apply)*

○ Male condoms	G227_PTNR4A
○ Female condoms	G227_PTNR4B
○ Diaphragm	G227_PTNR4C
○ Oral contraceptive pill (please give the name: _	G227_PTNR4D & G227_PTNR4D_NOTE
○ Coil	G227_PTNR4E
○ Injection (Depo Provera)	G227_PTNR4F
○ Implant (e.g. Implanon)	G227_PTNR4G
○ Inter uterine device (IUD, Ring)	G227_PTNR4H
○ Sterilisation (vasectomy, tubal ligation)	G227_PTNR4I
○ Contraceptive vaginal ring	G227_PTNR4J
○ Other (please specify) ……	G227_PTNR4K & G227_PTNR4K_OTH

Why do you, or why does your partner use this contraceptive? *(Please mark* all *responses that apply)*

○ To prevent pregnancy	G227_PTNR5A
○ To prevent sexually transmitted infections	G227_PTNR5B
○ For painful periods	G227_PTNR5C
○ For heavy periods	G227_PTNR5D
○ For another reason - please specify ……	G227_PTNR5E & G227_PTNR5E_OTH

Have you ever had (or caused) a pregnancy?

0	No *(Please go to ***Q21.3**)*	G227_SX62
77	Don't know	
1	Yes	

How did the pregnancy(ies) end? (all that apply)

	How did the pregnancy (ies) end?	Number
Livebirth	G227_SX98_i	G227_SX98
Stillbirth	G227_SX99_i	G227_SX99
Miscarriage	G227_SX100_i	G227_SX100
Ectopic pregnancy	G227_SX126_i	G227_SX126
Abortion/termination	G227_SX101_i	G227_SX101

Was the last pregnancy

0	○	Planned
1	○	Unplanned but wanted
2	○	Unplanned and unwanted

G227_SX102

***21.3* How much would you like to become a parent sometime soon?**

0	○	I am already a parent
1	○	I really want to be a parent soon
2	○	It would be nice to be a parent soon
3	○	I don't care if I do or don't become a parent soon
4	○	I would prefer not to be a parent soon
5	○	I really don't want to be a parent soon

G227_SX61

21.4 SEXUALLY TRANSMITTED DISEASE

In your opinion how likely is it that you might catch a sexually transmissible infection?

0	○	Never
1	○	Very unlikely
2	○	Unlikely
3	○	Likely
4	○	Very likely

G227_SX80

Have you ever been diagnosed with a sexually transmissible infection?

0	○	No *(Please go to Q22)*
1	○	Yes

G227_SX30

Which genital or sexually transmitted infections have you been diagnosed with and at what age?
(Please mark all responses that apply)

		AGE in years
Candidiasis/Thrush	G227_SI1	G227_SI13
Chlamydia	G227_SI2	G227_SI14
Genital herpes	G227_SI3	G227_SI15
Genital warts	G227_SI4	G227_SI16
Gonorrhoea	G227_SI5	G227_SI17
Hepatitis B	G227_SI6	G227_SI18
HIV/AIDS	G227_SI7	G227_SI19
Pubic lice/crabs	G227_SI8	G227_SI20
Syphilis	G227_SI9	G227_SI21
Bacterial vaginosis	G227_SI11	G227_SI23
Hepatitis C	G227_SI12	G227_SI24
Other - please specify	G227_SI10	G227_SI22
	G227_SI10_OTH	G227_SI22_OTH

22. DRIVING

Do you have a drivers' license?

0	○ No *(Please go to **Q23***)*	G227_DRV
1	○ No, but drive	
2	○ Yes	

When did you get your drivers' license?

(Date on back of license) Month…… Year…….. G227_DRV_MON G227_DRV_YR

We would like to get an accurate estimate of how many km you drive in a typical week, to help with this it may be helpful to think of the places you drive to in a typical week e.g. work, sport, beach, shops, friends, family, etc. This table is to assist you calculate the total km's to complete the question below*

Place	Times per week	KM estimate	= total KM
e.g. home to work	5	10	50 km

In a typical week, how many km do you generally drive? Total km G227_DRV_KM

	Never	Hardly ever	Occasionally	Quite often	Frequently	Nearly all the time
How often do you drive without a seatbelt?	0	1	2	3	4	5
How often do you drive after drinking too much?	☐	☐	☐	☐	☐	☐
How often do you exceed the speed limit by at least 20kph	☐	☐	☐	☐	☐	☐
How often do you text while driving?	☐	☐	☐	☐	☐	☐
How often do you talk on the phone on a hands free system while driving?	☐	☐	☐	☐	☐	☐
How often do you talk on the phone while driving?	☐	☐	☐	☐	☐	☐
How often do you become angry with other drivers and indicate hostility?	☐	☐	☐	☐	☐	☐

G227_DRV5-11

How many car accidents have you <u>ever</u> had while driving a car?

G227 SL70

.....

How many car accidents have you ever had because you <u>felt sleepy or fell asleep</u> behind the wheel of a car?

G227_SL71

.....

How many 'near miss' car accidents have you <u>ever</u> had <u>due to sleepiness</u>?

G227_SL69

.....

Have you <u>ever</u> fallen asleep whilst you were behind the wheel?

0	○	No *(Please go to next section)*
1	○	Yes

G227_SL67

Has this occurred:

0	○	Only once
1	○	2-5 times
2	○	6-20 times
3	○	21-100 times
4	○	More than 100 times
77	○	Not sure

G227_SL68

23. HEARING

The following questions are about your hearing, including questions on noisy activities (leisure and work), tinnitus (noises in your ears), hyperacusis (intolerance to sound) and dizziness.

23.1 How would you rate your hearing? G227_EAR5

Very good	Good	Average	Poor	Very Poor
4	3	2	1	0

Do you have trouble hearing when there is background noise? G227_EAR6

- 0 ○ No
- 1 ○ Yes

Do any members of your family or close friends ever say they think you have a hearing loss? G227_EAR7

- 0 ○ No
- 1 ○ Yes

Thinking of your current lifestyle and leisure activities, how would you describe the risk of it leading to [a] degree of permanent hearing loss? G227_EAR8

- 0 ○ No risk of hearing loss
- 1 ○ A very small risk of hearing loss
- 2 ○ A small risk of hearing loss
- 3 ○ A medium risk of hearing loss
- 4 ○ A large risk of hearing loss
- 5 ○ A very large risk of hearing loss
- 77 ○ Don't know

If you have a hearing impairment, does it affect your daily life and activities? G227_EAR9

- 0 ○ I don't have a hearing impairment
- 1 ○ Not at all
- 2 ○ Occasionally
- 3 ○ Frequently
- 4 ○ Constantly

Do you use a hearing aid or other hearing device? G227_EAR10 & G227_EAR10_OTH

- 0 ○ No
- 1 ○ Hearing aid in one ear
- 2 ○ Hearing aid in both ears
- 3 ○ Cochlear implant
- 4 ○ Bone Anchored Hearing Aid (BAHA)
- 5 ○ Other, please describe: …….

G227_EAR11B – 16B

How often are you involved in these activities?

G227_EAR11A – 16A	More than once a week	Once a week	Once a month	Once every 3 to 6 months	Less than once a year	Never	Do you usually wear hearing protection during these activities?	
							Yes	No
Attend a live sporting event	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ 1	☐ 0
Visit a pub or registered club e.g. RSL club	☐	☐	☐	☐	☐	☐	☐	☐
Attend a fitness class set to music e.g. aerobics, spin	☐	☐	☐	☐	☐	☐	☐	☐
Go to a concert or live music venue	☐	☐	☐	☐	☐	☐	☐	☐
Go to a night club or dance-music venue	☐	☐	☐	☐	☐	☐	☐	☐
Use of DIY equipment e.g. electric saw, lawnmowers, drills	☐	☐	☐	☐	☐	☐	☐	☐

If you do any of the activities above, on average, how long would you do each activity?

G227_EAR11C – 16C	Never attend	Less than an hour	Between 1 – 3 hours	Between 3 – 5 hours	Between 5-8 hours	More than 8 hours
Attend a live sporting event	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Visit a pub or registered club e.g. RSL club	☐	☐	☐	☐	☐	☐
Attend a fitness class set to music e.g. aerobics, spin	☐	☐	☐	☐	☐	☐
Go to a concert or live music venue	☐	☐	☐	☐	☐	☐
Go to a night club or dance-music venue	☐	☐	☐	☐	☐	☐
Use DIY equipment e.g. electric saw, lawnmowers, drills	☐	☐	☐	☐	☐	☐

23.2 Have you worked in a place where it was so noisy that you had to raise your voice to be heard by others? G227_EAR17

0 ○ No ---> please go to Q23.3

1 ○ Yes

If yes, did you wear hearing protection? G227_EAR18

0 ☐ Never 1 ☐ Occasionally 2 ☐ Frequently 3 ☐ Always

How long have you worked at a noisy workplace? G227_EAR19

0 ☐ Less than 6 months 1 ☐ 6-12 months 2 ☐ 1-2 years 3 ☐ 3 + years

During your time at a noisy workplace, how many days per week would you be exposed to an environment that was so noisy that you had to raise your voice to be heard by others? G227_EAR20

0 ☐ 1 or less per week 1 ☐ 2-3 days per week 2 ☐ 3-4 days per week 3 ☐ Everyday

Thinking about your average day, how long would you spent in a workplace so noisy you had to raise your voice? G227_EAR21

0 ☐ Less than 1 hour 1 ☐ 1-3 hours 2 ☐ 3-5 hours 3 ☐ 5-8 hours 4 ☐ More than 8 hours

23.3 Do you ever experience ringing or buzzing in your ears (i.e. tinnitus)? G227_EAR22

0 ○ Never, please go to Q23.4

1 ○ Occasionally

2 ○ Sometimes

3 ○ Often

4 ○ Always

77 ○ Unsure, please go to Q23.4

What is the frequency of your tinnitus? G227_EAR2

0 ☐ Intermittent 1 ☐ Constant

What is the nature of your tinnitus? G227_EAR2

0 ☐ Ringing or hissing 1 ☐ Roaring 2 ☐ Pulsing 3 ☐ Other

How often does tinnitus affect your daily life and activities? G227_EAR25

G ☐ Not at all 1 ☐ Occasionally 2 ☐ Frequently 3 ☐ Constantly

23.4 Do you consider yourself <u>sensitive or intolerant to everyday sounds</u> (hyperacusis)?

0 ○ No, please go to Q23.5
1 ○ Yes

G227_EAR26

Is it possible for you to concentrate on a task if it is not completely quiet around you?

0 ☐ No 1 ☐ Yes, most of the time 2 ☐ Yes

G227_EAR27

Are you sensitive to any of these sounds? *(Select all that apply)* G227_EAR28A – 28G

☐ Noise ☐ Paper ☐ Talk ☐ Music ☐ Clatter ☐ Mechanical and monotonous sounds ☐ Other

How do you feel when you are exposed to these sounds? *(Select all that apply)* G227_EAR29A – 29G

☐ Tense ☐ Afraid ☐ Pain ☐ Angry ☐ Vague ☐ Irritated ☐ Other

If you are intolerant to some sound, how often does it affect your daily life and activities?

0 ☐ Not at all 1 ☐ Occasionally 2 ☐ Frequently 3 ☐ Constantly

G227_EAR30

23.5 Do you experience any <u>imbalance or dizziness</u>?

0 ○ No, please go to Q24
1 ○ Yes

G227_EAR31

What is the nature of your imbalance or dizziness? (Select all that apply) G227_EAR32A – EAR32D

○ Spinning or sensation of movement
○ Light-headedness
○ Unsteadiness on feet
○ Other, please describe:

How often do you experience this imbalance or dizziness? G227_EAR33

0 ☐ Daily 1 ☐ Weekly 2 ☐ Monthly 3 ☐ Less frequently than monthly

How long do the specific episodes of imbalance or dizziness last?

G227_EAR34

0 ○ Seconds to less than 2 minutes
1 ○ 2 to 20 minutes
2 ○ Over 20 minutes to hours
3 ○ Hours to days

How long do the after-effects of feeling unwell or off-colour last?

G227_EAR35

0 ☐ No after-effects | 1 ☐ Minutes | 2 ☐ Hours | 3 ☐ Days

Do you suffer from any of the following symptoms for more than 20 minutes that you associate with your dizziness or imbalance? *(Select all that apply.)*

G227_EAR36 – EAR42
G227_EAR42_OTH

○ Fullness (blockage) in the ears
○ Tinnitus
○ Reduced hearing
○ Nausea
○ Vomiting
○ None of these
○ Other, please describe: ……

Does your dizziness or imbalance occur when: *(Select all that apply)*

G227_EAR43 – EAR53

☐ Sitting ☐ Straining ☐ Looking up to a high shelf
☐ Walking ☐ Bending down ☐ Lying down and rolling over to one
☐ Sneezing ☐ Hearing a loud noise ☐ Standing up
☐ None of these ☐ Other, please describe: ……

G227_EAR53_OTH

……

How often does your dizziness or imbalance affect your daily life and activities?

G227_EAR54

0 ☐ Not at all | 1 ☐ Occasionally | 2 ☐ Frequently | 3 ☐ Constantly

24. TATTOOS

The following questions are about tattoos

Do you have, or ever had, a tattoo or tattoos? G227_TATT1A

0 ○ No ⇨ Do you think you will get a tattoo 0 No 1 Yes 2 not sure

G227_TATT1 ⇨ *Thank you for completing the tattoo questions*

1 ○ Yes, *please complete the following questions*

How many tattoos do you have?

0	○	One
1	○	Two
2	○	Three to five
3	○	Six to ten
4	○	More than 10

G227_TATT2

What type of tattoo(s) do you have? *(Select all that apply)*

○ Professional
○ Amateur
○ Permanent makeup

G227_TATT3A – TATT3C

Please indicate all areas where you have a tattoo(s), and the approximate size of the tattoo(s). If you have more than one tattoo in one area, please indicate the size of the largest tattoo.

Sizes are:

Small the size of a bankcard or smaller	**Medium** approximately the size of an Iphone	**Large** the size of an Ipad or larger
 	 	 

	Small	**Medium**	**Large**	**What are the main colours in your tattoo(s)?**				
	Bankcard size	Iphone size	Ipad size	Black	Red	Blue	Green	other
Trunk	☐	☐	☐	☐	☐	☐	☐	☐
Arms	☐	☐	☐	☐	☐	☐	☐	☐
Legs	☐	☐	☐	☐	☐	☐	☐	☐
Head/neck	☐	☐	☐	☐	☐	☐	☐	☐

G227_TATT4A – TATT4D

G227_TATT5A_BL/R/BU/G/O – TATT5D_BL/R/BU/G/O

Do you have any history of experiencing an adverse tattoo reaction?

(An adverse tattoo reaction is any skin sign or symptom that differs or goes beyond from what you would consider a normal part of tattooing or tattoo healing, such as persistent redness, itching, rash, irritation, swelling, scarring, infection, disfigurement, raising, and photosensitivity. Please also describe any more general reactions related to your tattoo, such as dizziness, headache, nausea and fever.)

G227_TATT6

0	○ No	→ *Thank you for completing this questionnaire*
1	○ Yes	→ *Please complete the following questions*

Please describe the adverse reaction(s) in your own words: ……G227_TATT6_COM…..

……

When did the adverse reaction(s) begin? …….. **days/weeks/months* after tattoo placement**

G227_TATT6B
G227_TATT6C

** Please cross out what is not applicable*

What is the main colour of ink of the tattoo that caused the adverse reaction(s)?

G227_TATT7 & TATT7_OTH

0	○ Black
1	○ Red
2	○ Blue
3	○ Green
4	○ Other: ……

How long did the adverse reaction(s) persist?

G227_TATT8

0	○ Less than 4 weeks
1	○ 1 to 4 months
2	○ Longer than 4 months

****MEN, for you, this is the end of the questionnaire****

Thank you for completing it.

Women, please complete the next questions relating to menstruation.

For women, the following are questions relating to menstruation,

25. FOR WOMEN ONLY - MENSTRUATION

How often do you usually have a menstrual period? (If you are currently pregnant answer this referring to when you were not pregnant)? (Please mark only one response)

0
1
2
3
4

- ○ Never *(please go to Q25.1)*
- ○ Very irregularly
- ○ Less than once per month
- ○ Every month
- ○ More than once per month

G227_PER1

Using the scale below where 0 is the least pain and 10 is the worst pain, how would you describe the worst pain you commonly experience during your menstrual cycle?

0 (None)	2	3	4	5	6	7	8	9	10 (Unbearable)
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

G227_PER2

25.1 Pelvic pain

G227_PER3 – PER5

	No	yes	not applicable
Do you regularly experience pelvic pain that is not during your period?	☐	☐	☐
Do you regularly experience pain during intercourse?	☐	☐	☐
Do you regularly take medication for cramps or pelvic pain?	☐	☐	☐

25.2 These questions ask for details about your period. Periods can be different from month to month. Please make sure you read all of the options. For this questionnaire, period refers to any bleeding that you have from your vagina, even if it is irregular.

Some of the questions may sound similar. Just read through each question carefully and give your best answer.

You may have other medical problems that could affect your answers. Please try to focus on questions and answers ONLY as they relate to your period.

During the past month, did you have ANY bleeding?

G227_PER6

○ No *(please go to Q12)*

○ Yes *(please continue to Q1)*

1. During the past month, how would you describe your periods?

G227_PER7

Very Light	Light	Moderate	Heavy	Very Heavy
☐	☐	☐	☐	☐

*Instructions for questions **2, 3, and 4**.*
"High absorbency" sanitary products mean any type of tampon or a pad that is NOT a thin pantyliner.
"Soaked" means completely or almost completely stained and filled with blood.

2. On your heaviest day of bleeding during the past month, how many high absorbency sanitary products did you soak (either completely or almost completely)?

G227_PER8

0	1-4	5-8	9-12	13-16	More than 16
☐	☐	☐	☐	☐	☐

3. During the past month, how often did you need to wear either an incontinence brief or more than one high absorbency sanitary product (either more than one pad, a pad and a tampon, more than one tampon) at a time to contain your bleeding?

G227_PER9

Never	1-3 times	4-6 times	7-10 times	11 times or greater
☐	☐	☐	☐	☐

4. During the past month, how many times have you had an episode of bleeding that soaked through your "outer" clothes (pants, skirt, dress)?

G227_PER10

Never	1-3 times	4-6 times	Greater than 6 times
☐	☐	☐	☐

5. During the past month, how many times did you need to get out of bed in the middle of night (or during sleep hours) to change your sanitary products?

G227_PER11

Never	1-3 times	4-6 times	7-10 times	11 times or greater
☐	☐	☐	☐	☐

6. During the past month, how many times did you pass blood clots (clumps of blood)?

G227_PER12

Never	1-3 times	4-6 times	Greater than 6 times
☐	☐	☐	☐

7. During the past month, how often did passing blood clots (clumps of blood) stain your clothing?

G227_PER13

Never	1-3 times	4-6 times	Greater than 6 times
☐	☐	☐	☐

8. Please fill in the following statement about pain related to your period. During the past month, my period was associated with…

G227_PER14

No pain	Slight pain	Moderate pain	Severe pain
☐	☐	☐	☐

9. During the past month, how many weeks did your periods last?

G227_PER15

- ○ 1 week or less out of 4 week
- ○ More than 1 week, less than 2 weeks out of 4 weeks
- ○ More than 2 weeks, less than 3 weeks out of 4 weeks
- ○ More than 3 weeks out of 4 weeks

10. During the past month, on how many days do you think your work at your job suffered because you were bleeding?

G227_PER16

- ○ I am currently not working outside of the home
- ○ Never, my bleeding does not affect my work.
- ○ 1-3 days
- ○ 4-8 days
- ○ 9-12 days
- ○ 13 days or more

11. During the past month, on how many days did you miss work because you were bleeding?

- ○ I am currently not working outside of the home
- ○ Never, my bleeding does not affect my work schedule
- ○ 1-3 days
- ○ 4-8 days
- ○ 9-12 days
- ○ 13 days or more

G227_PER17

***12*. During the past month, on how many days did you avoid family activities (grocery shopping, household chores) when you thought you would be bleeding?**

- ○ Never
- ○ 1-3 days
- ○ 4-8 days
- ○ 9-12 days
- ○ 13 days or more

G227_PER18

13. During the past month, when would you carry sanitary products (pads, tampons) with you (in your pocket, in your bag)?

- ○ Every day, in case I had any bleeding
- ○ On the days when I had bleeding and on days when I guessed that I might have bleeding
- ○ Only on the days that I had bleeding

G227_PER19

14. During the past month, on how many days did you avoid social activities (such as getting together with friends, going shopping for fun, going sight-seeing) when you thought you would be bleeding?

Never	1-3 days	4-8 days	9-12 days	13 days or more
☐	☐	☐	☐	☐

G227_PER20

5. During the past month, on how many days did you plan your activities (work, social, or family) based on whether or not there was a bathroom nearby?

Never	1-3 days	4-8 days	9-12 days	13 days or more
☐	☐	☐	☐	☐

G227_PER21

16. During the past month, on how many days did you bring extra clothes with you (to work, out shopping) in case you had staining from your period?

Never	1-3 days	4-6 days	Greater than 6 days
☐	☐	☐	☐

G227_PER22

17. During the past month, on how many days did you choose what to wear based on whether or not you were bleeding?

Never	1-3 days	4-8 days	9-12 days	13 days or more	
☐	☐	☐	☐	☐	G227_PER23

18. On a scale of 0-10, with 0 being no concern at all and 10 being extremely concerned, please rate your overall concern about bleeding staining your clothes.

0 (no concern)	2	3	4	5	6	7	8	9	10 (extremely concerned)	
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	G227_PER24

19. During the past month, would you say that your period start date was…

Completely predictable	Somewhat predictable	Not at all predictable	
☐	☐	☐	G227_PER25

20. During the past month, would you say that your period end date was…

Completely predictable	Somewhat predictable	Not at all predictable	
☐	☐	☐	G227_PER26

End of Questions

Thank you for completing the questionnaire.

The Raine Study