TAHS
Tasmanian Longitudinal Health Study

Follow up of the Tasmanian Longitudinal Health Study from first to sixth decade

STUDY BOOKLET

Participant ID:	☐☐☐☐
Family ID:	☐☐☐☐☐☐
Appointment Date:	☐☐ / ☐☐ / ☐☐☐☐ (Day / Month / Year)
Testing Scientist Number:	☐☐☐
Testing Centre ID:	☐☐
Barometric pressure (mmHg):	☐☐☐☐ ○ mmHg ○ hPa
Room temperature (Celsius):	☐☐.☐

QUESTIONNAIRE COMPLETION INSTRUCTIONS

Please answer each question the best you can. Please use a BLACK or DARK BLUE pen.

Please shade the circles or squares completely (do not tick or cross)

● ■

Write clearly within the boxes

A	B	C		1	2	3

Write clearly within each space

PLEASE WRITE IN CAPITAL LETTERS

- circles are provided where only one choice is permitted.
- squares indicate that multiple responses are permitted.

If you make a mistake, or want to change any of your shaded responses, please place a cross through the incorrect response ✖ and then shade the correct response ●

For written responses, please cross out your incorrect response and write your new response just above or below the one you have crossed out.

~~INCORRECT~~
CORRECT

PART 1

SECTION A: BACKGROUND INFORMATION

A1. In which country:

	Australia	Other	Please specify	Don't know	Office Use only
Were you born	○	○		○	
Was your mother born	○	○		○	
Was your father born	○	○		○	
Was your mother's mother born	○	○		○	
Was your mother's father born	○	○		○	
Was your father's mother born	○	○		○	
Was your father's father born	○	○		○	

A2. What is the highest educational or vocational qualification that you have completed?

- ○ Grade 1 to 6
- ○ Grade 7 to 9
- ○ Grade 10 or 11
- ○ Grade 12 or equivalent (e.g. Higher School Certificate)
- ○ Trade/Apprenticeship (e.g. hairdresser, electrician, plumber)
- ○ Certificate or Diploma (e.g. child care, technician etc)
- ○ University degree (e.g. Bachelor)
- ○ Higher University degree (e.g. Graduate Diploma, Masters, PhD)

A3. Are you currently employed (including self-employed)?

- ○ Yes → ○ Full time ○ Part time ○ Casual
- ○ No
- ○ No, studying
- ○ No, retired

A4. What is/was your main occupation?

- ○ Manager or administrator (e.g. magistrate, general manager, school principal, director of nursing)
- ○ Professional (e.g. scientist, nurse, allied health professional, teacher, artist)
- ○ Associate professional (e.g. technician, manager, police officer, small business owner)
- ○ Tradesperson or related worker (e.g. hairdresser, gardener, florist)
- ○ Advanced clerical or service worker (e.g. secretary, flight attendant, law clerk, personal assistant)
- ○ Intermediate clerical, sales, service worker (e.g. administration worker, child care worker, nursing assistant, hospitality worker)
- ○ Intermediate production or transport worker (e.g. machine operator, bus driver, sewing machinist)
- ○ Elementary clerical, sales or service worker (e.g. filing/mail clerk, parking inspector, sales assistant, housekeeper)
- ○ Labourer or related worker (e.g. cleaner, factory worker, farm hand, kitchen hand)
- ○ House person

A5. What is your usual work pattern?

- ○ Daytime - no shifts
- ○ Rotating shifts with nights
- ○ Rotating shifts without nights
- ○ Permanent nights
- ○ Other (please specify)

A6. What is your current marital status?

○ De facto ○ Divorced ○ Married ○ Never married ○ Separated but not divorced ○ Widowed

A7. What is your current postcode? ☐☐☐☐

SECTION B: HOME ENVIRONMENT AND PETS

B1. Which types of heating do you use at home? (Please choose **ALL** that apply)

☐ Gas ducted central heating
☐ Coal or wood fire
☐ Gas room heater
☐ Electric heater (e.g. radiator, fan or dimplex-type)
☐ Other central heating (e.g. electric, hydronic, slab floor)
☐ Reverse cycle air-conditioning
☐ Oil Heater
☐ Other (please specify)
☐ No heating

B2. What kind of stove do you mostly use for cooking?

○ Gas ○ Electric ○ Coal, coke or wood ○ Other (please specify)

B2a. Do you have an exhaust fan over the stove?

○ No → **Please go to question B3**
○ Yes

B2b. When cooking how often do you use the fan?

○ All of the time ○ Some of the time ○ None of the time

B2c. Does the fan take the fumes outside the house?

○ No ○ Yes

B3. Has there ever been mould or mildew on any surface, other than food, in your home?

○ No → **Please go to question B4**
○ Yes

B3a. Which rooms have been affected? (Please choose **ALL** that apply)

☐ Bathrooms ☐ Living rooms ☐ Your bedroom ☐ Kitchen ☐ Other bedrooms ☐ Any other area/s

B3b. Has there ever been mould or mildew on any surface, other than food, in your home in the last 12 months?

○ No ○ Yes

B4. How old is the mattress on your bed?

○ Less than 12 months old ○ 1 to 5 years old ○ More than 5 years old ○ Don't know ○ Not relevant (e.g. waterbed)

B5. Is there fitted carpet in the bedroom?

○ No → **Please go to question B6**
○ Yes

B5a. What is the age of the carpet?

○ Less than 12 months old ○ 1 to 5 years old ○ More than 5 years old ○ Don't know

B6. Do you keep or own any cats?

○ No → **Please go to question B7**
○ Yes → **B6a. How many cats?** ☐☐

B6b. Are the cats allowed indoors?

○ No → **Please go to question B7**
○ Yes

B6c. Are the cats allowed in the bedroom?

○ No ○ Yes

B7. Has there been a cat in the house in the last 12 months?
○ No ○ Yes ○ Don't know

B8. Do you keep or own any dogs?
○ No → **Please go to question B9**
○ Yes → **B8a. How many dogs?** ☐☐

B8b. Are the dogs allowed indoors?
○ No → **Please go to question B9**
○ Yes

B8c. Are the dogs allowed in the bedroom?
○ No ○ Yes

B9. Has there been a dog in the house in the last 12 months?
○ No ○ Yes ○ Don't know

SECTION C: CHILDHOOD ENVIRONMENT

C1. What term best describes the place you lived most of the time when you were under the age of five years?
○ Farm ○ Country town ○ Suburb of a city ○ Inner city ○ Don't know

C2. How many of your brothers, sisters or other children regularly slept in your bedroom before you were five years old, not including yourself?
☐☐

C3. Did you have a serious respiratory infection before the age of five years?
○ No ○ Yes ○ Don't know

C4. Did you go to school, pre-school, kindergarten, or a day care centre before the age of five years?
○ No ○ Yes

C5. At what age did you first attend a school, pre-school, kindergarten, or day care?
☐☐ age in years

	During the first year of your life?			When you were aged 1 to 4 years?			When you were aged 5 to 15 years?		
	No	Yes	Don't know	No	Yes	Don't know	No	Yes	Don't know
C6. Did your father smoke	○	○	○	○	○	○	○	○	○
C7. Did your mother smoke	○	○	○	○	○	○	○	○	○
C8. Was there a cat in your home	○	○	○	○	○	○	○	○	○
C9. Was there a dog in your home	○	○	○	○	○	○	○	○	○
C10. Did you have carpet (or a rug) covering the floor in your bedroom	○	○	○	○	○	○	○	○	○
C11. As a child did you live on a farm that was run by your family	○	○	○	○	○	○	○	○	○
C12. As a child did you have regular contact with farm animals e.g. horses, cows, pigs, sheep and/or poultry *(by regular contact we mean at least once a week playing, riding or cleaning the animals or the area that they are housed)*	○	○	○	○	○	○	○	○	○
C13. As a child did you consume any farm milk	○	○	○	○	○	○	○	○	○

C14 What was the main type of heating your home had when you were under the age of five years?
(Please choose **ALL** that apply)

- ☐ Gas ducted central heating
- ☐ Coal or wood fire
- ☐ Gas room heater
- ☐ Electric heater (e.g. radiator, fan or dimplex-type)
- ☐ Other central heating (e.g. electric, hydronic, slab floor)
- ☐ Reverse cycle air-conditioning
- ☐ Oil Heater
- ☐ Other (please specify)
- ☐ No heating

C15. When you were a child, how often did you eat vegetables that your family (or friends) had grown?

- ○ Never/rarely
- ○ Every week
- ○ Several times a week
- ○ Daily
- ○ Several times a day

C16. Currently, how often do you eat potatoes or vegetables that you (or your family or friends) have grown yourself?

- ○ Never
- ○ Rarely
- ○ Almost every week in summer/autumn season
- ○ Almost daily
- ○ Almost daily in summer/autumn season

SECTION D: SMOKING AND ALCOHOL USE

D1. In your lifetime, have you smoked at least 100 cigarettes or equal amounts of cigars, pipes or any tobacco product?

- ○ No → **Please go to question D2**
- ○ Yes

D1a. How old were you when you started smoking? ☐☐ age in years

D1b. Do you currently smoke (within the last 4 weeks)?

- ○ Not at all → **Please go to question D1d**
- ○ Yes, daily → On average how much (per day) do you currently smoke? **D1c.** ☐☐ no. of cigarettes
- ○ Yes, at least weekly → On average how much (per week) do you currently smoke? ☐☐ no. of cigarettes
- ○ Yes, less than weekly → On average how much (per month) do you currently smoke? ☐☐ no. of cigarettes

D1d. How old were you when you stopped smoking?

☐☐ age in years

D1e. On average, during periods when you smoked, how much did you smoke (total number of cigarettes or equivalent product)? *Provide the average number per day or per week or per month.*

☐☐ ○ Per day ○ Per week ○ Per month

D2. Not counting yourself, how many people in your household currently smoke regularly (most days of the week) inside the house?

☐☐ number of people

D3. On average, how many hours per day are you exposed to other people's tobacco smoke (home as well as outside home)?

☐☐ hours per day

D4. Over the last 12 months, how often did you drink beer, wine and/or spirits?

	Never	Less than once a month	1 to 3 times per month	1 day per week	2 days per week	3 days per week	4 days per week	5 days per week	6 days per week	Every day
Beer (low alcohol)	○	○	○	○	○	○	○	○	○	○
Beer (full strength)	○	○	○	○	○	○	○	○	○	○
Red wine	○	○	○	○	○	○	○	○	○	○
White wine (including sparkling wines)	○	○	○	○	○	○	○	○	○	○
Fortified wines, port, sherry etc	○	○	○	○	○	○	○	○	○	○
Spirits, liqueurs, etc	○	○	○	○	○	○	○	○	○	○

D5. Over the last 12 months, on days when you were drinking, how many glasses of beer, wine and/or spirits did you usually drink?

	1	2	3	4	5	6	7	8	9	10 or more
Beer (low alcohol)	○	○	○	○	○	○	○	○	○	○
Beer (full strength)	○	○	○	○	○	○	○	○	○	○
Red wine	○	○	○	○	○	○	○	○	○	○
White wine (including sparkling wines)	○	○	○	○	○	○	○	○	○	○
Fortified wines, port, sherry etc	○	○	○	○	○	○	○	○	○	○
Spirits, liqueurs, etc	○	○	○	○	○	○	○	○	○	○
Total number of glasses	○	○	○	○	○	○	○	○	○	○

D6. Over the last 12 months, what was the maximum number of glasses of beer, wine and/or spirits that you drank in 24 hours?

	1	2	3	4	5	6	7	8	9	10 or more
Total number of glasses	○	○	○	○	○	○	○	○	○	○

SECTION E: SUN EXPOSURE AND AIR POLLUTION

E1. If you went out in the sun without any protection in summer for 30 minutes during the middle of the day would you:
○ Just burn and not tan afterwards ○ Burn first and then tan afterwards ○ Not burn at all, just tan

E2. How many hours <u>a day</u> do you spend outdoors on a usual work and non-work day?
Include, for example, the time you spent in the garden, using public transport, walking outdoors, or any other work and non-work related outdoor activities.

If you are currently not working put '0' for a usual work day and fill in your time spent outdoors for a usual non-work day.

	Usual work day		Usual non-work day	
	Hours	Minutes	Hours	Minutes
Time outdoors in summer	☐☐	☐☐	☐☐	☐☐
Time outdoors in winter	☐☐	☐☐	☐☐	☐☐

	Constantly	Frequently	Seldom	Never	Don't know (never at home during working hours)
E3. During working days (Monday to Friday) is the traffic noise at home so intense that you would have to close the windows so you are not disturbed	○	○	○	○	○
E4. During working days (Monday to Friday), how often do heavy vehicles such as trucks or buses pass your house?	○	○	○	○	○

SECTION F: SLEEPINESS

F1. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive in a public place (e.g. a theatre or a meeting)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in the traffic	○	○	○	○

F2. Do you snore?

○ No → **Please go to question F5**

○ Yes

F2a. Your snoring is:

○ Slightly louder than breathing ○ Louder than talking

○ As loud as talking ○ Very loud - can be heard in adjacent rooms

F3. How often do you snore?

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

F4. Has your snoring ever bothered other people?

○ No ○ Yes

F5. Has anyone noticed that you stop breathing during your sleep?

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

F6. During your waking time, do you feel tired, fatigued, or not up to par?

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

F7. How often do you feel tired or fatigued after your sleep?

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

F8. Have you ever nodded off or fallen asleep while driving a vehicle?

○ No → **Please go to question F9**

○ Yes

F8a. How often does this occur?

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

F9. Do you have high blood pressure?

○ No ○ Yes ○ Don't know

SECTION G: PHYSICAL ACTIVITY AND DIET

Think about all the vigorous 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.

G1. During the last 7 days, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?

☐ days per week ○ No vigorous physical activities → **Please go to question G3**

G2. How much time did you usually spend doing vigorous physical activities on one of those days?

Hours ☐☐ Minutes ☐☐ ○ Don't know/Not sure

Think about all the moderate 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.

G3. During the last 7 days, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

☐ days per week ○ No moderate physical activities → **Please go to question G5**

G4. How much time did you usually spend doing moderate physical activities on one of those days?

Hours ☐☐ Minutes ☐☐ ○ Don't know/Not sure

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 have done solely for recreation, sport, exercise, or leisure.

G5. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?

☐ days per week ○ No walking → **Please go to question G7**

G6. How much time did you usually spend walking on one of those days?

Hours ☐☐ Minutes ☐☐ ○ Don't know/Not sure

This question is about the time you spent sitting on weekdays 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 or lying down to watch television.

G7. During the last 7 days, how much time did you spend sitting on a week day?

Hours ☐☐ Minutes ☐☐ ○ Don't know/Not sure

G8. During a normal week how many hours a day (24 hours) do you watch television?

○ Don't watch TV
○ Less than 1 hour
○ More than 1 hour but less than 3 hours
○ More than 3 hours but less than 5 hours
○ 5 hours or more

G9. How often do you:

	6+ times per week	3 to 5 times per week	1 to 2 times per week	Less than once a week	Never
Eat fried food with batter or breadcrumb coating	○	○	○	○	○
Eat gravy, cream sauces or cheese sauces	○	○	○	○	○
Add butter, margarine, oil or sour cream to vegetables, rice, spaghetti	○	○	○	○	○
Eat vegetables that are fried or roasted with fat or oil	○	○	○	○	○
Eat meat pies, sausages, salami, burgers or bacon	○	○	○	○	○
Eat pastries, cakes, sweet biscuits or croissants	○	○	○	○	○
Eat hot chips	○	○	○	○	○

G10. How is your meat usually cooked?

○ Fried ○ Grilled/roasted with added fat/oil ○ Eat meat occasionally or never
○ Stewed ○ Grilled/roasted without fat/oil

G11. How do you spread butter/margarine on bread?

○ Thickly ○ Medium ○ Thinly ○ Never use butter/margarine

G12. How often do you eat:

	6+ times per week	3 to 5 times per week	1 to 2 times per week	Less than once a week	Never
Chocolate or sweet snack bars	○	○	○	○	○
Crisps, corn chips or nuts	○	○	○	○	○
Cream	○	○	○	○	○
More than a small serve of ice cream	○	○	○	○	○
More than a small piece of cheese (exclude low fat cheese)	○	○	○	○	○

G13. What type of milk do you use on breakfast cereal or in cooking?

○ Cow ○ Goat ○ Soy

G13a. What form of milk in G13 do you consume?

○ Condensed or evaporated ○ Full cream ○ Full cream and reduced fat ○ Reduced fat ○ Skim

G14. How much skin on chicken do you eat?

○ Most or all of the skin ○ Some of the skin ○ None of the skin /I am vegetarian

G15. How much of the fat on meat do you eat?

○ Most or all of the fat ○ Some of the fat ○ None of the fat/I am vegetarian

G16. How many serves* do you usually eat each day of: *(*serve is what fits into the palm of your hand)*

	I don't eat fruit/ vegetables	Less than 1 serving per day	1 serving per day	2 servings per day	3 servings per day	4+ servings per day
Fruit (fresh, canned, frozen)	○	○	○	○	○	○
Vegetables (fresh, canned, frozen)	○	○	○	○	○	○

SECTION H: GENERAL HEALTH

H1. Which of the following dental hygiene tools do you use, and how often?

	Never/rarely	Once a week	Once a day	Twice a day	More than twice a day
Tooth brush	○	○	○	○	○
Fluoride dental paste	○	○	○	○	○
Dental floss	○	○	○	○	○
Tooth picks	○	○	○	○	○
Mouth wash	○	○	○	○	○

H2. Over the last two weeks how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Worrying too much about different things	○	○	○	○
Trouble relaxing	○	○	○	○
Being so restless that it is hard to sit still	○	○	○	○
Becoming easily annoyed or irritable	○	○	○	○
Feeling afraid as if something awful might happen	○	○	○	○

H3. Over the last two weeks how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed or hopeless	○	○	○	○
Trouble falling or staying asleep or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

H4. Has a doctor ever told you that you have/had any of the following conditions? (Please choose **ALL** that apply)

- ☐ Angina, heart attack or myocardial infarction
- ☐ Anxiety
- ☐ Cancer
- ☐ Celiac disease
- ☐ Crohn's disease/ulcerative colitis
- ☐ Depression
- ☐ Diabetes or high sugar levels in the blood or urine
- ☐ Gastro-oesophageal Reflux Disease (GORD)
- ☐ High blood pressure or Hypertension
- ☐ High levels of cholesterol/triglycerides
- ☐ Lupus/Systemic Lupus Erythematosus
- ☐ Multiple Sclerosis
- ☐ Other Psychiatric/mental health problems
- ☐ Rheumatoid arthritis
- ☐ Thyroid problems
- ☐ Transient ischemic attack (TIA) or a stroke
- ☐ Type 1 Diabetes Mellitus
- ☐ None of the above

SECTION I: WOMEN'S HEALTH

I1. Have you ever had a menstrual period?

○ No → **Please go to question I9**

○ Yes

I1a. Do you have regular periods?

○ Yes

○ No, they have never been regular

○ No, they have been irregular for a few months

○ No, my periods have now stopped

I1b. What is/was the usual interval between your periods?

○ Less than 24 days

○ 24 to 26 days

○ 27 to 29 days

○ 30 to 32 days

○ 33 to 35 days

○ More than 35 days

I2. Has a doctor ever told you that you have any of the following:

	No	Yes	If Yes: Age doctor diagnosed
Ovarian cyst/s	○	○	☐☐ age in years
Polycystic ovaries or polycystic ovarian syndrome(PCOS)	○	○	☐☐ age in years
Fibroids	○	○	☐☐ age in years
Endometriosis	○	○	☐☐ age in years

I3. Please fill in the date of the first day of your last period (or the year if you cannot remember the exact date) even if you are no longer menstruating.

☐☐ / ☐☐ / ☐☐☐☐

Day Month Year

I4. Have you had periods in the last 12 months?

○ No → **Please go to question I5**

○ Yes

I4a. How many periods have you had in the last 12 months? ☐☐ periods

I4b. Is your menstrual cycle often more than 35 days? *(Often = more than twice a year)*

○ No ○ Yes

I4c. Have your periods been irregular over the last 12 months?

○ No ○ Yes

I4d. For how long have your periods been irregular? ☐☐ months

I5. What statement best describes the reason you have not had a period in the last 12 months?

○ Because I have been taking treatments (hormonal IUD, contraceptive implants, chemotherapy)

○ Menopause

○ Ovaries removed

○ Womb removed

○ Other (please specify) ☐

I6. Some women experience hot flushes, flashes and/or night sweats around the time of the menopause, even when they are having menstrual cycles. Have you ever had either of these symptoms at a time which could be related to the menopause?

○ No → **Please go to question I7**

○ Yes

I6a. How old were you when these symptoms started?

☐☐ years

I6b. How old were you when you last experienced these symptoms?
(If you currently have these symptoms please give your current age)

☐☐ years ○ Currently having symptoms

I6c. How often have you had hot flushes/night sweats in the past 6 months?

○ Never

○ Less than once a week

○ More than once a week, but not every day

○ Every day

I7. Have you ever taken hormonal treatment for the menopause (tablets, cream, patches, vaginal creams or vaginal pessaries)?

○ No → **Please go to question I8**

○ Yes

I7a. How old were you when you first took hormonal treatments for the menopause?

☐☐ years

I7b. At the time you started taking hormonal treatment for the menopause, how often were your periods?

○ I had not had period in the previous 12 months

○ I had at least one period in the previous 12 months, but my cycles had become irregular

○ My periods were regular during the previous 12 months

I7c. At the time you started this medication, were you experiencing hot flushes/flashes/night sweats?

○ No

○ Yes

I7d. How old were you when you last took hormonal treatments for the menopause?
(If you currently take hormonal contraceptives please give your current age)

☐☐ years ○ Currently taking hormonal treatments for the menopause

I7e. How long in total have you taken/did you take the following types of hormonal treatments for the menopause?
(If you have taken them on and off for some time intervals please provide an estimate of the total number of years taken)

	Ever used		Years used
	No	Yes	
Oral preparations	○	○	☐☐ years
Patches	○	○	☐☐ years
Vaginal preparations	○	○	☐☐ years

I8. Have you ever taken hormonal contraceptives (e.g. the pill, patches, injections, implants, coil impregnated with hormone e.g. Mirena)?

○ No → **Please go to question I9**

○ Yes

I8a. How old were you when you first took hormonal contraceptives?

☐☐ years

I8b. Were your periods irregular before you started taking hormonal contraceptives?

○ No

○ Yes

I8c. Which of the following reasons were the main reasons for taking the hormonal contraceptives (e.g. the pill, hormonal coil)? (Please choose **ALL** that apply)

☐ Acne
☐ Contraception
☐ Endometriosis
☐ Heavy menstrual bleeding
☐ Irregular periods
☐ Painful periods
☐ Polycystic ovarian syndrome

I8d. How old were you when you last took hormonal contraceptives?
(If you currently take hormonal contraceptives please give your current age)

☐☐ years ○ Currently taking hormonal contraceptives

I8e. How long in total have you/did you take the following types of hormonal contraceptives?
(If you have taken them on and off for some time intervals please provide an estimate of the total number of years taken)

	Ever used		Years used
	No	Yes	
Tablets	○	○	☐☐ years
Patches	○	○	☐☐ years
Vaginal ring	○	○	☐☐ years
Injections/implants	○	○	☐☐ years
Coil impregnated with hormones	○	○	☐☐ years

I9. Have you ever been pregnant in the past?

○ No

○ Yes

I10. How many live births have you had?

☐☐ (enter zero if none)

I11. How many miscarriages or abortions have you had?

☐☐ (enter zero if none)

Thank you for your help with Part 1 of the questionnaire

PART 2

SECTION J: ECZEMA

J1. Have you ever had eczema or any kind of skin allergy?

○ No ⟶ **Please go to question J2**

○ Yes

J1a. Was this eczema or skin allergy confirmed by a doctor?

○ No

○ Yes

J2. Have you ever had an itchy rash that was coming and going for at least 6 months?

○ No ⟶ **Please go to question J3**

○ Yes

J2a. How old were you when you first had this itchy rash?

☐☐ age in years

J2b. Have you had this itchy rash in the last 12 months?

○ No

○ Yes

J2c. Has this rash at any time affected any of the following places: (Please choose **ALL** that apply)

☐ Folds of the elbows

☐ Behind the knees

☐ In front of the ankles

☐ Under the buttocks

☐ Around the neck, ears or eyes

☐ None of the above

J3. Have you used any medicines including creams and ointments for rash or eczema during the last 12 months?

○ No

○ Yes

SECTION K: HAY FEVER AND RHINOSINUSITIS

K1. Have you ever had hay fever or nasal allergies (that is sneezing, running or blocked nose when you do not have a cold or the flu)?

○ No ⟶ **Please go to question K2**

○ Yes

K1a. Have you had this problem in the last 12 months?

○ No

○ Yes

K1b. Was this problem accompanied by itchy or watery eyes?

○ No

○ Yes

K1c. How old were you when you first had hay fever or nasal allergies?

☐☐ age in years

K2. Has your nose been blocked for more than 12 weeks during the last 12 months?
- ○ No
- ○ Yes

K3. Have you had pain or pressure around the forehead, nose or eyes for more than 12 weeks during the last 12 months?
- ○ No
- ○ Yes

K4. Have you had discoloured nasal discharge or discoloured mucus in the throat for more than 12 weeks during the last 12 months?
- ○ No
- ○ Yes

K5. Has your sense of smell been reduced or absent for more than 12 weeks during the last 12 months?
- ○ No
- ○ Yes

K6. Has a doctor ever told you that you have chronic sinusitis?
- ○ No
- ○ Yes

SECTION L: SYMPTOMS OF ALLERGY

L1. When you are near animals, such as cats, dogs, or horses; near feathers, including pillows, quilts or doonas; or in a dusty part of the house, do you ever: (Please choose **ALL** that apply)
- ☐ Start to cough
- ☐ Start to wheeze
- ☐ Get a feeling of tightness in the chest
- ☐ Start to feel short of breath
- ☐ Get a runny or stuffy nose or start to sneeze
- ☐ Get itchy or watery eyes
- ☐ None of the above

L2. When you are near trees, grass or flowers, or when there is a lot of pollen about, do you ever:
(Please choose **ALL** that apply)
- ☐ Start to cough
- ☐ Start to wheeze
- ☐ Get a feeling of tightness in the chest
- ☐ Start to feel short of breath
- ☐ Get a runny or stuffy nose or start to sneeze
- ☐ Get itchy or watery eyes
- ☐ None of the above

L2a. *If yes to any of the above* - At which time of the year does this happen? (Please choose **ALL** that apply)
- ☐ Winter
- ☐ Spring
- ☐ Summer
- ☐ Autumn

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SECTION M: FOOD ALLERGY

M1. Have you ever had any food allergies?

○ No ⟶ **Please go to Section N**

○ Yes ⟶ **Please complete the Food Allergy table below**

FOOD ALLERGY TABLE

What foods are you allergic to? *(Please choose* ***ALL*** *that apply)*	☐ Peanut	☐ Tree nut (specify)	☐ Shellfish	☐ Fish	☐ Cow's milk	☐ Egg	☐ Wheat	☐ Sesame	☐ Other (specify)
Was the allergy confirmed by a doctor?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
At what age did you develop the allergy?	years	years	years	years	years	years	years	years	years
What was the reaction? *(Please choose* ***ALL*** *that apply)*	☐ A rash or itchy skin ☐ Diarrhoea or vomiting ☐ Runny or stuffy nose ☐ Severe headaches ☐ Breathless ☐ Other reaction (specify)	☐ A rash or itchy skin ☐ Diarrhoea or vomiting ☐ Runny or stuffy nose ☐ Severe headaches ☐ Breathless ☐ Other reaction (specify)	☐ A rash or itchy skin ☐ Diarrhoea or vomiting ☐ Runny or stuffy nose ☐ Severe headaches ☐ Breathless ☐ Other reaction (specify)	☐ A rash or itchy skin ☐ Diarrhoea or vomiting ☐ Runny or stuffy nose ☐ Severe headaches ☐ Breathless ☐ Other reaction (specify)	☐ A rash or itchy skin ☐ Diarrhoea or vomiting ☐ Runny or stuffy nose ☐ Severe headaches ☐ Breathless ☐ Other reaction (specify)	☐ A rash or itchy skin ☐ Diarrhoea or vomiting ☐ Runny or stuffy nose ☐ Severe headaches ☐ Breathless ☐ Other reaction (specify)	☐ A rash or itchy skin ☐ Diarrhoea or vomiting ☐ Runny or stuffy nose ☐ Severe headaches ☐ Breathless ☐ Other reaction (specify)	☐ A rash or itchy skin ☐ Diarrhoea or vomiting ☐ Runny or stuffy nose ☐ Severe headaches ☐ Breathless ☐ Other reaction (specify)	☐ A rash or itchy skin ☐ Diarrhoea or vomiting ☐ Runny or stuffy nose ☐ Severe headaches ☐ Breathless ☐ Other reaction (specify)
Are you still allergic to it?	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
Have you been prescribed an Epipen/Anapen?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

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SECTION N: RESPIRATORY SYMPTOMS

N1. Have you, at anytime in your life, suffered from attacks of asthma of wheezy breathing?
(Regard asthma and wheezy breathing as being much the same thing for this question.)

○ No → **Please go to question N2**
○ Yes

N1a. How old were you when you had your first attack of asthma or wheezy breathing?

☐☐ age in years

N1b. How old were you when you had your most recent attack of asthma or wheezy breathing?

☐☐ age in years

N1c. Have you had an attack of asthma or wheezy breathing in the last 12 months?
○ No ○ Yes

N1d. Have you taken any medicines including inhalers or tablets for asthma or wheezy breathing in the last 12 months?
○ No ○ Yes

N2. Have you had wheezing or whistling in your chest in the last 12 months?
(Wheezing means a whistling sound, however high or low pitched and however faint.)

○ No → **Please go to question N3**
○ Yes

N2a. Have you been at all breathless when the wheezing noise was present?
○ No ○ Yes

N2b. Have you had this wheezing or whistling when you did not have a cold?
○ No ○ Yes

N3. Have you, at any time in the last 12 months?

	No	Yes
Had an attack of shortness of breath at rest	○	○
Had an attack of shortness of breath after exercise	○	○
Woken due to a feeling of tightness in your chest	○	○
Been woken at night by an attack of shortness of breath	○	○

SECTION O: SNORING AND SLEEPINESS

O1. During the last month, do you or have you been told you snore loudly in sleep?

○ No → **Please go to question O2**
○ Don't know
○ Yes

O1a. On average, how often?

○ Rarely, less than once a week ○ 1 to 2 times per week ○ 3 to 4 times per week
○ 5 to 7 times per week ○ Don't know

O2. During the last month, do you or have you been told you snort or gasp in sleep?

○ No → **Please go to question O3**
○ Don't know
○ Yes

O2a. On average, how often?

○ Rarely, less than once a week ○ 1 to 2 times per week ○ 3 to 4 times per week
○ 5 to 7 times per week ○ Don't know

O3. During the last month, do you or have you been told you choke or stop breathing in sleep?
- ○ No → **Please go to question O4**
- ○ Don't know
- ○ Yes

O3a. On average, how often?
- ○ Rarely, less than once a week
- ○ 1 to 2 times per week
- ○ 3 to 4 times per week
- ○ 5 to 7 times per week
- ○ Don't know

O4. During the last month, have you had excessive sleepiness during the day?
○ No ○ Yes

O5. Has your doctor ever told you that you have or had obstructive sleep apnoea?
- ○ No → **Please go to question O6**
- ○ Yes

O5a. How old were you when you were told you had obstructive sleep apnoea? ☐☐ age in years

O5b. How old were you when you had your first overnight sleep study? ☐☐ age in years

O5c. Are you currently being treated for obstructive sleep apnoea with any of the following?
(Please choose **ALL** that apply)
☐ CPAP ☐ Surgery ☐ Weight loss ☐ Oral splint ☐ Positional device ☐ Other

O6. How many hours in 24 do you sleep? ☐☐ hours

SECTION P: COUGH AND PHLEGM

P1. Have you at any time in your life suffered from attacks of bronchitis or attacks of cough with sputum (phlegm) in the chest ("loose" or "rattly" cough)?
- ○ No → **Please go to question P2**
- ○ Yes

P1a. How long is it since the last attack?
- ○ Within the last 6 months
- ○ Within the last year but longer than the last 6 months
- ○ Less or equal to 2 years but more than 1 year
- ○ More than 2 years

P1b. At what age did these attacks begin? ☐☐ age in years

P2. Do you usually cough when you do not have a cold?
- ○ No → **Please go to question P3**
- ○ Yes

P2a. Are there months in which you cough on most days?
- ○ No → **Please go to question P3**
- ○ Yes

P2b. Do you cough on most days for at least three months of each year?
○ No ○ Yes

P2c. For how many years have you had this cough?
○ Less than 2 years ○ 2 to 5 years ○ More than 5 years

P3. Do you usually have phlegm in your chest when you do not have a cold?
- ○ No → **Please go to question P4**
- ○ Yes

P3a. Are there months in which you have phlegm in your chest on most days?
- ○ No → **Please go to question P4**
- ○ Yes

P3b. Do you bring up this phlegm on most days for at least three months of each year?
○ No ○ Yes

P3c. For how many years have you had this phlegm?
○ Less than 2 years ○ 2 to 5 years ○ More than 5 years

P4. Have you, at anytime in your life, suffered from cough with phlegm in the chest (with or without a cold)?

○ No ⟶ **Please go to question Q1**

○ Yes

P4a. Have you had this cough with phlegm on most days for at least three months and for two years in a row?

○ No

○ Yes

SECTION Q: CHEST COLDS AND CHEST ILLNESSES

Q1. If you get a cold, does it usually go to your chest? *(Usually means more than half of the time)*

○ No

○ Yes

○ Do not get colds

Q2. During the past three years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?

○ No ⟶ **Please go to question Q3**

○ Yes

Q2a. Did you produce phlegm with any of the chest illnesses?

○ No

○ Yes

Q2b. In the last three years, how many such illnesses, with increased phlegm, did you have which lasted a week or more? *(if none enter zero)*

☐☐ number of illnesses

Q3. Have you ever had Pneumonia?

○ No ⟶ **Please go to question Q4**

○ Yes

Q3a. Was this confirmed by a doctor?

○ No

○ Yes

Q3b. At what age did you first have it?

☐☐ age in years

Q3c. How many times have you had it?

☐☐ number of times

Q3d. Have you ever been hospitalised for Pneumonia?

○ No

○ Yes

Q4. Have you ever been hospitalised for any other chest illness? ○ No ○ Yes

If Yes, please specify diagnosis (see Code Sheet)	Office Use only	Age at first occurrence	Number of occurrences
1.	☐☐	☐☐ years	☐☐ number
2.	☐☐	☐☐ years	☐☐ number
3.	☐☐	☐☐ years	☐☐ number

SECTION R: ASTHMA

R1. Have you ever had asthma?
- ○ No → **Please go to Section S**
- ○ Yes

R2. How old were you when you had your first symptoms of asthma? ☐☐ age in years

R3. Was this confirmed by a doctor?
- ○ No → **Please go to question R4**
- ○ Yes

R3a. How old were you when this was confirmed? ☐☐ age in years

R4. How old were you when you had your most recent symptoms of asthma? ☐☐ age in years

R5. Have you been woken from your sleep by your asthma?

Last 12 months: ○ No ○ Yes

Last 1 month: ○ No ○ Yes → **R5a. How many nights were you woken from sleep by your asthma in the last week?** ☐ number of nights

R6. Have you had asthma symptoms when you wake in the morning?

Last 12 months: ○ No ○ Yes

Last 1 month: ○ No ○ Yes → **R6a. How many mornings in the last week?** ☐ number of mornings

R7. Have you been limited in any of the following activities because of asthma?

	Last 12 months		Last 1 month	
	No	**Yes**	**No**	**Yes**
All activities	○	○	○	○
When dressing	○	○	○	○
Walking on level ground	○	○	○	○
Hurrying on level ground	○	○	○	○
Walking up stairs or up hills	○	○	○	○
Active sports	○	○	○	○
Other (please specify) ☐	○	○	○	○

If you answered Yes to <u>ANY</u> statements in question R7 → Please go to question R9
If you answered No to <u>ALL</u> statements in question R7 → Please answer question R8 before continuing

R8. Would you agree or disagree with the following statement:

My asthma has not limited any of my activities:

Last 12 months: ○ Agree ○ Disagree

Last 1 month: ○ Agree ○ Disagree

R9. How frequent have your asthma symptoms (of any severity) been?
- ○ No asthma in the past 12 months
- ○ Asthma symptoms in the past 12 months but not in the last month
- ○ Asthma symptoms in the last month, but not frequent (less than once per week)
- ○ Frequent (once per week or more but not daily) in the last 1 month
- ○ Persistent (daily)

R10. How frequent have your asthma attacks/flare ups been over the past 12 months?

An "attack" or "flare up" of asthma is a period of time when asthma symptoms are worse or more frequent than usual. One could have asthma symptoms regularly or intermittently without getting attacks or flare-ups.

○ None in the past 12 months ○ 3 or less in the past 12 months ○ 4 or more but less than monthly
○ More than monthly in the last 12 months ○ More than weekly or persistent ○ Not sure

R11. Have you had an episode of asthma which has made you unable to speak or severe enough to limit your speech to only 1 or 2 words between breaths?

Last 12 months: ○ No ○ Yes
Last 1 month: ○ No ○ Yes

R12. On average, how would you rate the severity of your asthma?

	Not severe at all	Mild	Moderate	Severe	Not sure
Last 12 months	○	○	○	○	○
Last 1 month	○	○	○	○	○

R13. Have you lost any days from work, school or usual activities because of your asthma?

Last 12 months: ○ No ○ Yes → **R13a. How many?** ☐☐☐ days

Last 1 month: ○ No ○ Yes → **R13b. How many?** ☐☐ days

R14. Have you had an attack or symptoms of asthma that was so bad, you needed to call your general practitioner, ambulance, emergency locum or 24 hour clinic?

Last 12 months: ○ No ○ Yes → **R14a. How many?** ☐☐☐ number

Last 1 month: ○ No ○ Yes → **R14b. How many?** ☐☐ number

R15. Have you had an attack or symptoms of asthma that was so bad you had to go to a hospital emergency or casualty department?

Last 12 months: ○ No ○ Yes → **R15a. How many?** ☐☐☐ number

Last 1 month: ○ No ○ Yes → **R15b. How many?** ☐☐ number

R16. Have you ever been admitted to a hospital because of your asthma?

○ No → **Please go to question R17**
○ Yes

R16a. In the past 12 months?

○ No → **Please go to question R17**
○ Yes

R16b. How many times in the last 12 months? ☐☐ number

R16c. How many times in the last 1 month? ☐☐ number

R17. Have you ever had an attack or symptoms of asthma that resulted in an admission to a hospital intensive care unit?

○ No ○ Yes

R18. How frequently have you seen the following health professionals for your asthma in the last 12 months?
(enter zero if not at all)

1) **General Practitioner** *(number of times in the last 12 months)* ☐☐ number
2) **Respiratory specialist** *(number of times in the last 12 months)* ☐☐ number
3) **Nurse/Asthma educator** *(number of times in the last 12 months)* ☐☐ number
4) **Pharmacist** *(number of times in the last 12 months)* ☐☐ number

R19. Have you ever been given a demonstration on the correct use of your metered dose inhaler?

○ No → **Please go to question R20**

○ Yes

R19a. In the last 12 months?

○ No

○ Yes

R20. Has your doctor ever checked your inhaler technique?

○ No → **Please go to question R21**

○ Yes

R20a. In the last 12 months?

○ No

○ Yes

R21. Do you have written instructions from your doctor on how to manage your asthma if it gets worse or if you have an attack?

○ No → **Please go to question R22**

○ Yes

R21a. In the last 12 months?

○ No

○ Yes

R22. Has your doctor given you a verbal plan telling you how to manage your asthma if it gets worse or if you have an attack?

○ No → **Please go to question R23**

○ Yes

R22a. In the last 12 months?

○ No

○ Yes

R23. Do you have a peak flow meter of your own?

○ No → **Please go to question R24**

○ Yes

R23a. How often have you used it in the last 3 months?

○ Never

○ Some days

○ Most days

R24. Has your doctor ever measured your breathing in his/her surgery (including peak flows/spirometry/bronchodilator response)?

○ No → **Please go to Section S**

○ Yes

R24a. In the last 12 months?

○ No

○ Yes

SECTION S: MEDICINES AND INHALERS (see Medication Code List)

S1. Have you used any inhaled medicines to help your breathing in the last 12 months?
○ No → **Please go to question S2** ○ Yes → **Please continue with the questions below**

Which have been used in the last 12 months?	Medication 1	Medication 2	Medication 3	Medication 4
a) Which one?				
b) Which type of inhaler device?				
c) Strength/dose per puff (mcg)?				
d) Are you currently using this medication?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
e) How long have you been using this medication?	○ Days ○ Months ○ Years	○ Days ○ Months ○ Years	○ Days ○ Months ○ Years	○ Days ○ Months ○ Years
f) In the last 12 months, how have you used them:				
When needed - *Average number of puffs per month*	(puff/mth)	(puff/mth)	(puff/mth)	(puff/mth)
In short courses - *Number of courses in last 12 months*	(number)	(number)	(number)	(number)
- *Average number of puffs per day during flare-up*	(puff/day)	(puff/day)	(puff/day)	(puff/day)
- *Average number of days of flare-up*	(days)	(days)	(days)	(days)
Continuously - *Average number of puffs per day*	(puff/day)	(puff/day)	(puff/day)	(puff/day)
Not at all	○ Not at all	○ Not at all	○ Not at all	○ Not at all
g) In the last month, how have you used them:				
When needed - *Average number of puffs per month*	(puff/mth)	(puff/mth)	(puff/mth)	(puff/mth)
In short courses - *Number of courses in last 12 months*	(number)	(number)	(number)	(number)
- *Average number of puffs per day during flare-up*	(puff/day)	(puff/day)	(puff/day)	(puff/day)
- *Average number of days of flare-up*	(days)	(days)	(days)	(days)
Continuously - *Average number of puffs per day*	(puff/day)	(puff/day)	(puff/day)	(puff/day)
Not at all	○ Not at all	○ Not at all	○ Not at all	○ Not at all
h) Is this medication the same type as prescribed by your doctor?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
i) Are you taking this medication at the same dose as prescribed by your doctor?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
j) If No to h) or i) why not the same: *(Please choose **ALL** that apply)*	☐ Cost ☐ Side effects ☐ Symptoms resolved ☐ Forget to take ☐ Other (specify)	☐ Cost ☐ Side effects ☐ Symptoms resolved ☐ Forget to take ☐ Other (specify)	☐ Cost ☐ Side effects ☐ Symptoms resolved ☐ Forget to take ☐ Other (specify)	☐ Cost ☐ Side effects ☐ Symptoms resolved ☐ Forget to take ☐ Other (specify)

S2. Have you used any pills, capsules, tablets or medicines, other than inhaled medicines to help your breathing at any time in the last 12 months?

○ No → **Please go to question S3** ○ Yes → **Please continue with the questions below**

Which have been used in the last 12 months?	Medication 1	Medication 2	Medication 3	Medication 4
a) Which one?				
b) Strength/dose per tablet (mg)?				
c) Are you currently using this medication?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
d) How long have you been using this medication?	○ Days ○ Months ○ Years	○ Days ○ Months ○ Years	○ Days ○ Months ○ Years	○ Days ○ Months ○ Years
e) In the last 12 months, how have you used them:				
When needed - *Average number of tablets per month*	(tab/mth)	(tab/mth)	(tab/mth)	(tab/mth)
In short courses - *Number of courses in last 12 months*	(number)	(number)	(number)	(number)
- *Average number of tablets per day during flare-up*	(tab/day)	(tab/day)	(tab/day)	(tab/day)
- *Average number of days of flare-up*	(days)	(days)	(days)	(days)
Continuously - *Average number of tablets per day*	(tab/day)	(tab/day)	(tab/day)	(tab/day)
Not at all	○ Not at all	○ Not at all	○ Not at all	○ Not at all
f) In the last month, how have you used them:				
When needed - *Average number of tablets per month*	(tab/mth)	(tab/mth)	(tab/mth)	(tab/mth)
In short courses - *Number of courses in last 12 months*	(number)	(number)	(number)	(number)
- *Average number of tablets per day during flare-up*	(tab/day)	(tab/day)	(tab/day)	(tab/day)
- *Average number of days of flare-up*	(days)	(days)	(days)	(days)
Continuously - *Average number of tablets per day*	(tab/day)	(tab/day)	(tab/day)	(tab/day)
Not at all	○ Not at all	○ Not at all	○ Not at all	○ Not at all
g) Is this medication the same type as prescribed by your doctor?	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
h) Are you taking this medication at the same dose as prescribed by your doctor?	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know	○ Yes ○ No ○ Don't know
i) If No to g) or h) why not the same: *(Please choose **ALL** that apply)*	☐ Cost ☐ Side effects ☐ Symptoms resolved ☐ Forget to take ☐ Other (specify)	☐ Cost ☐ Side effects ☐ Symptoms resolved ☐ Forget to take ☐ Other (specify)	☐ Cost ☐ Side effects ☐ Symptoms resolved ☐ Forget to take ☐ Other (specify)	☐ Cost ☐ Side effects ☐ Symptoms resolved ☐ Forget to take ☐ Other (specify)

S3. Have you ever used inhaled steroids to help your breathing?

○ No → **Please go to question S4**

○ Yes

S3a. At what age did you start using inhaled steroids? ☐☐ years

S3b. In the past 5 years, how many months would you have used inhaled steroids on most days? ☐☐ months

S4. Have you ever been prescribed home oxygen therapy?

○ No → **Please go to question S5**

○ Yes

S4a. Are you currently using oxygen therapy at home?

○ No ○ Yes

S4b. For how many years have you been using oxygen therapy at home? ☐☐ years

S4c. How have you used oxygen therapy during the last month?

1) **For relief of symptoms or when needed** ○ No ○ Yes
2) **For flare-ups or attacks** ○ No ○ Yes
3) **Regularly, on a daily basis** ○ No ○ Yes

S5. Have you ever had an influenza vaccination?

○ No → **Please go to question S6**

○ Yes

S5a. Have you been vaccinated for influenza in the last 12 months?

○ No ○ Yes

S6. Have you ever had a pneumonia vaccination?

○ No → **Please go to question S7**

○ Yes

S6a. Have you been vaccinated for pneumonia in the last 5 years?

○ No ○ Yes

S7. Have you ever been vaccinated or desensitised for allergy?

○ No → **Please go to question S8**

○ Yes

S7a. Have you been vaccinated for allergy in the last 12 months?

○ No ○ Yes

S8. Have you had any other injections to help your breathing at any time in the last 12 months?

○ No ○ Yes (please specify) ☐

SECTION T: SCREENING QUESTIONNAIRE FOR LAB TESTING

T1. Have you used a puffer or inhaler in the last 24 hours? ○ No ○ Yes

If Yes, what inhaler(s) did you use and how many hours ago was the last dose taken?	Office Use only	Number of hours
Inhaler 1.	☐☐	☐☐☐ hours
Inhaler 2.	☐☐	☐☐☐ hours
Inhaler 3.	☐☐	☐☐☐ hours

T2. Have you taken any medication for breathing (other than inhalers) in the last 24 hours? ○ No ○ Yes

If Yes, which medication(s) did you take and how many hours ago was the last dose taken?	Office Use only	Number of hours
Medication 1.		hours
Medication 2.		hours
Medication 3.		hours

T3. Have you had a cigarette (or any other tobacco product) in the last 24 hours?
○ No → **Please go to question T4**
○ Yes
T3a. How many hours ago was your last smoke? hours

T4. Have you taken an antihistamine (a medication for allergy including hay fever) or cough medicine in the last 72 hours?
○ No ○ Yes

If Yes, which medication(s) did you take and how many hours ago was the last dose taken?	Office Use only	Number of hours
Medication 1.		hours
Medication 2.		hours
Medication 3.		hours

T5. Have you taken any medication for high blood pressure or a heart condition, or used eye drops to treat glaucoma in the last 72 hours? ○ No ○ Yes

If Yes, which medication(s) did you take and how many hours ago was the last dose taken?	Office Use only	Number of hours
Medication 1.		hours
Medication 2.		hours
Medication 3.		hours

T6. Have you had a respiratory infection in the last 3 weeks?
○ No → **Please go to question T7**
○ Yes
T6a. How many days ago did it end? days

T7. Have you ever had an anaphylactic reaction or been treated with an Epipen?
○ No → **Please go to Section U**
○ Yes
T7a. Were you admitted to hospital for this anaphylaxis?
○ No ○ Yes
T7b. Did you react to any of the following: (Please choose **ALL** that apply)

☐ Alternaria	☐ Cow's milk	☐ House dust mite	☐ Penicillium
☐ Aspergillus	☐ Egg	☐ Mixed grasses	☐ Rye grass
☐ Cat	☐ Hormodendrum	☐ Peanut	☐ Shellfish

T7c At what age did you have this reaction?
○ Under 18 ○ Over 18

SECTION U: LABORATORY DATA SHEET

U1. SKIN PRICK TEST DATA

	1st diam	2nd diam		1st diam	2nd diam		1st diam	2nd diam
Negative control			Penicillium			Peanut		
House dust mite			Aspergillus			Shellfish		
Cat			Rye grass			Cow's milk		
Hormodendrum			Mixed grasses			Positive control		
Alternaria			Egg white					

ANTHROPOMETRIC DATA

U2. Height (cm): Range 00-300 cm — ___.___ cm

U3. Weight (kg): Range 00-200.0 kg — ___.___ kg

U4. Neck measurements (cm): Range 00-70.0 cm — 1. ___.___ cm 2. ___.___ cm

U5. Waist measurements (cm): Range 00-200.0 cm — 1. ___.___ cm 2. ___.___ cm

U6. Hip measurements (cm): Range 00-200.0 cm — 1. ___.___ cm 2. ___.___ cm

SPIROMETRY
Pre-Bronchodilator

		Blow 1	Blow 2	Blow 3
U7.	FVC (litres) Range 00-10.00 L	___.___	___.___	___.___
U8.	FEV_1 (litres) Range 00-10.00 L	___.___	___.___	___.___
U9.	FEV_1/FVC (%) Range 00-100%	___.___	___.___	___.___

SPIROMETRY
Post-Bronchodilator

		Blow 1	Blow 2	Blow 3
U10.	FVC (litres) Range 00-10.00 L	___.___	___.___	___.___
U11.	FEV_1 (litres) Range 00-10.00 L	___.___	___.___	___.___
U12.	FEV_1/FVC (%) Range 00-100%	___.___	___.___	___.___

SPIROMETRY
BEST Values Pre and Post BD

		Pre-BD	Post-BD
U13.	FVC (litres) Range 00-10.00 L	___.___	___.___
U14.	FEV_1 (litres) Range 00-10.00 L	___.___	___.___
U15.	FEV_1/FVC (%) Range 00-100%	___.___	___.___
U16.	PEF (litres/sec) Range 00-20.00 L/sec	___.___	___.___
U17.	$FEF_{25-75\%}$ (litres/sec) Range 00-10.00 L/sec	___.___	___.___
U18.	$FEF_{50\%}$ (litres/sec) Range 00-10.00 L/sec	___.___	___.___
U19.	$FIF_{50\%}$ (litres/sec) Range 00-10.00 L/sec	___.___	___.___

HB AND COHB

U20. Hb Concentration g/dl ☐☐.☐

U21. COHb % ☐☐.☐

SINGLE BREATH DLCO (post-BD)

		Measurement 1	Measurement 2
U22.	**DLCO (uncorrected)** (ml/min/mmHg)	☐☐.☐☐	☐☐.☐☐
U23.	**DLCO (corrected)** (ml/min/mmHg)	☐☐.☐☐	☐☐.☐☐
U24.	**VA (litres)**	☐.☐☐	☐.☐☐
U25.	**DLCO/VA (uncorrected)** (ml/min/mmHg/L)	☐☐.☐☐	☐☐.☐☐
U26.	**DLCO/VA (corrected)** (ml/min/mmHg/L)	☐☐.☐☐	☐☐.☐☐
U27.	**Inspiratory VC (L)**	☐☐.☐☐	☐☐.☐☐

APNEALINK STUDY

Instructions: Complete 1 form for each Home ApneaLink test attempted.

U28. Date of test ☐☐ / ☐☐ / ☐☐☐☐ (Day / Month / Year)

U29. Serial Number of ApneaLink ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐

U30. Serial Number of Pulse Oximetry ☐☐☐ ☐☐☐ ☐☐☐

U31. Recording Duration: ☐☐ Hours ☐☐ Minutes

U32. Evaluation Period Duration: ☐☐ Hours ☐☐ Minutes

If evaluation period is less than 4 hours the study must be repeated

U33. Please indicate why evaluation period is less than 4 hours.

- ○ UNK, slept 4 or more
- ○ Unable to sleep due to AL - complete question U33
- ○ Subject unsure if device was working or set-up correctly - complete question U33
- ○ Normally sleeps less than 4 hours
- ○ Unable to sleep unrelated to AL
- ○ Other (please specify) - consider completing question U33

U34. ApneaLink Test Results:

○ No Data ⟶ **Please go to question U33**

		Result			Result	
a)	**AHI**	☐☐☐	e/hr	**f)** **Average saturation**	☐☐	%
b)	**RI** (Risk Indicator)	☐☐☐		**g)** **Lowest saturation**	☐☐	%
c)	**Apnea Index**	☐☐☐	e/hr	**h)** **Baseline saturation**	☐☐	%
d)	**Hypopnea Index**	☐☐☐	e/hr	**i)** **Cumulative time saturation ≤ 90%**	☐☐☐	mins
e)	**ODI** (Oxygen desaturation index)	☐☐☐	e/hr	**j)** **CSR probable**	○ Yes ○ No	

U35. Were there any hardware, software, technical or user interface problems related to the ApneaLink?

○ No ○ Yes ⟶ **Please complete a Technical Observation CRF**