



## 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.

~~I N C O R R E C T~~

CORRECT



**PART 1****SECTION A: BACKGROUND INFORMATION****A1. In which country:**

	Australia	Other	Please specify	Don't know	Office Use only
Were you born	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="text"/>
Was your mother born	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="text"/>
Was your father born	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="text"/>
Was your mother's mother born	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="text"/>
Was your mother's father born	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="text"/>
Was your father's mother born	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="text"/>
Was your father's father born	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="text"/>

**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  $\longrightarrow$   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)

- |  |  |
|--|--|
| <input type="checkbox"/> Gas ducted central heating                                  | <input type="checkbox"/> Reverse cycle air-conditioning  |
| <input type="checkbox"/> Coal or wood fire   | <input type="checkbox"/> Oil Heater  |
| <input type="checkbox"/> Gas room heater   | <input type="checkbox"/> Other (please specify) <input style="width: 150px; height: 20px;" type="text"/> |
| <input type="checkbox"/> Electric heater (e.g. radiator, fan or dimplex-type)        | <input type="checkbox"/> No heating  |
| <input type="checkbox"/> Other central heating (e.g. electric, hydronic, slab floor) |  |

**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?

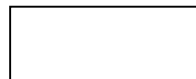
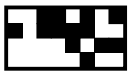
**B6b. Are the cats allowed indoors?**

- 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  Yes  Don't know **Please go to question B9**

Yes **B8a. How many dogs?**

**B8b. Are the dogs allowed indoors?**

- No  Yes **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?**

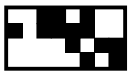
- No  Yes

**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
<b>C6.</b> Did your father smoke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>C7.</b> Did your mother smoke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>C8.</b> Was there a cat in your home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>C9.</b> Was there a dog in your home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>C10.</b> Did you have carpet (or a rug) covering the floor in your bedroom	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>C11.</b> As a child did you live on a farm that was run by your family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>C12.</b> 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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>C13.</b> As a child did you consume any farm milk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





**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?
- Yes, at least weekly → On average how much (per week) do you currently smoke?
- Yes, less than weekly → On average how much (per month) do you currently smoke?

**D1c.**

no. of cigarettes

no. of cigarettes

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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beer (full strength)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red wine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White wine (including sparkling wines)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fortified wines, port, sherry etc	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spirits, liqueurs, etc	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beer (full strength)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red wine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White wine (including sparkling wines)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fortified wines, port, sherry etc	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spirits, liqueurs, etc	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Total number of glasses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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

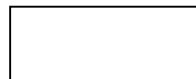
**E2. How many hours a day do you spend outdoors on a usual work and non-work day?**

*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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Time outdoors in winter	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>





	Constantly	Frequently	Seldom	Never	Don't know (never at home during working hours)
<b>E3.</b> 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>E4.</b> During working days (Monday to Friday), how often do heavy vehicles such as trucks or buses pass your house?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting, inactive in a public place (e.g. a theatre or a meeting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in the traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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

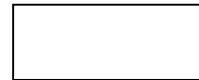
**F8a. How often does this occur?**

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

 More than 1 hour but less than 3 hours

 5 hours or more

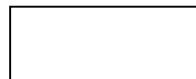
 Less than 1 hour

 More than 3 hours but less than 5 hours






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**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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat gravy, cream sauces or cheese sauces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Add butter, margarine, oil or sour cream to vegetables, rice, spaghetti	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat vegetables that are fried or roasted with fat or oil	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat meat pies, sausages, salami, burgers or bacon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat pastries, cakes, sweet biscuits or croissants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eat hot chips	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crisps, corn chips or nuts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cream	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More than a small serve of ice cream	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More than a small piece of cheese (exclude low fat cheese)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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?**

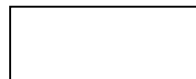
- Most or all of the fat                       Some of the fat                       None of the fat/I am vegetarian

**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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vegetables (fresh, canned, frozen)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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**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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fluoride dental paste	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental floss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tooth picks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mouth wash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being so restless that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

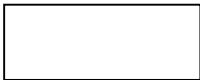
**H3. Over the last two weeks how often have you been bothered by the following problems?**

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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





### SECTION I: WOMEN'S HEALTH

11. 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

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

	No	Yes	If Yes: Age doctor diagnosed
Ovarian cyst/s	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> age in years
Polycystic ovaries or polycystic ovarian syndrome(PCOS)	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> age in years
Fibroids	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> age in years
Endometriosis	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> age in years

13. 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

14. 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?

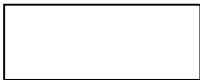
- No     Yes

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

15. 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)





16. 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 17
- Yes

16a. How old were you when these symptoms started?

		years
--	--	-------

16b. How old were you when you last experienced these symptoms?  
*(If you currently have these symptoms please give your current age)*

		years	<input type="radio"/> Currently having symptoms
--	--	-------	---

16c. 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

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

- No → Please go to question 18
- Yes

17a. How old were you when you first took hormonal treatments for the menopause?

		years
--	--	-------

17b. 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

17c. At the time you started this medication, were you experiencing hot flushes/flashes/night sweats?

- No
- Yes

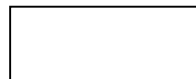
17d. How old were you when you last took hormonal treatments for the menopause?  
*(If you currently take hormonal contraceptives please give your current age)*

		years	<input type="radio"/> Currently taking hormonal treatments for the menopause
--	--	-------	--

17e. 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	<input type="radio"/>	<input type="radio"/>	<table border="1" style="display: inline-table;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> years		
Patches	<input type="radio"/>	<input type="radio"/>	<table border="1" style="display: inline-table;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> years		
Vaginal preparations	<input type="radio"/>	<input type="radio"/>	<table border="1" style="display: inline-table;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> years		





18. 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 19

Yes

18a. How old were you when you first took hormonal contraceptives?

years

18b. Were your periods irregular before you started taking hormonal contraceptives?

No

Yes

18c. 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

Irregular periods

Contraception

Painful periods

Endometriosis

Polycystic ovarian syndrome

Heavy menstrual bleeding

18d. 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

18e. 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	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> years
Patches	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> years
Vaginal ring	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> years
Injections/implants	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> years
Coil impregnated with hormones	<input type="radio"/>	<input type="radio"/>	<input type="text"/> <input type="text"/> years

19. Have you ever been pregnant in the past?

No

Yes

110. How many live births have you had?

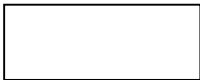
(enter zero if none)

111. 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?**

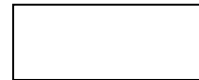
No

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



# SECTION M: FOOD ALLERGY

M1. Have you ever had any food allergies?

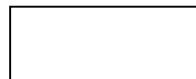
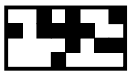
No → Please go to Section N

Yes → Please complete the Food Allergy table below

## FOOD ALLERGY TABLE

	<input type="checkbox"/> Peanut	<input type="checkbox"/> Tree nut (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Fish	<input type="checkbox"/> Cow's milk	<input type="checkbox"/> Egg	<input type="checkbox"/> Wheat	<input type="checkbox"/> Sesame	<input type="checkbox"/> Other (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>
What foods are you allergic to? (Please choose <b>ALL</b> that apply)									
Was the allergy confirmed by a doctor?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
At what age did you develop the allergy?	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> years	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> years	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> years	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> years	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> years	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> years	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> years	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> years	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> years
What was the reaction? (Please choose <b>ALL</b> that apply)	<input type="checkbox"/> A rash or itchy skin <input type="checkbox"/> Diarrhoea or vomiting <input type="checkbox"/> Runny or stuffy nose <input type="checkbox"/> Severe headaches <input type="checkbox"/> Breathless <input type="checkbox"/> Other reaction (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>	<input type="checkbox"/> A rash or itchy skin <input type="checkbox"/> Diarrhoea or vomiting <input type="checkbox"/> Runny or stuffy nose <input type="checkbox"/> Severe headaches <input type="checkbox"/> Breathless <input type="checkbox"/> Other reaction (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>	<input type="checkbox"/> A rash or itchy skin <input type="checkbox"/> Diarrhoea or vomiting <input type="checkbox"/> Runny or stuffy nose <input type="checkbox"/> Severe headaches <input type="checkbox"/> Breathless <input type="checkbox"/> Other reaction (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>	<input type="checkbox"/> A rash or itchy skin <input type="checkbox"/> Diarrhoea or vomiting <input type="checkbox"/> Runny or stuffy nose <input type="checkbox"/> Severe headaches <input type="checkbox"/> Breathless <input type="checkbox"/> Other reaction (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>	<input type="checkbox"/> A rash or itchy skin <input type="checkbox"/> Diarrhoea or vomiting <input type="checkbox"/> Runny or stuffy nose <input type="checkbox"/> Severe headaches <input type="checkbox"/> Breathless <input type="checkbox"/> Other reaction (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>	<input type="checkbox"/> A rash or itchy skin <input type="checkbox"/> Diarrhoea or vomiting <input type="checkbox"/> Runny or stuffy nose <input type="checkbox"/> Severe headaches <input type="checkbox"/> Breathless <input type="checkbox"/> Other reaction (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>	<input type="checkbox"/> A rash or itchy skin <input type="checkbox"/> Diarrhoea or vomiting <input type="checkbox"/> Runny or stuffy nose <input type="checkbox"/> Severe headaches <input type="checkbox"/> Breathless <input type="checkbox"/> Other reaction (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>	<input type="checkbox"/> A rash or itchy skin <input type="checkbox"/> Diarrhoea or vomiting <input type="checkbox"/> Runny or stuffy nose <input type="checkbox"/> Severe headaches <input type="checkbox"/> Breathless <input type="checkbox"/> Other reaction (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>	<input type="checkbox"/> A rash or itchy skin <input type="checkbox"/> Diarrhoea or vomiting <input type="checkbox"/> Runny or stuffy nose <input type="checkbox"/> Severe headaches <input type="checkbox"/> Breathless <input type="checkbox"/> Other reaction (specify) <span style="border: 1px solid black; display: inline-block; width: 60px; height: 20px; vertical-align: middle;"></span>
Are you still allergic to it?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Have you been prescribed an EpiPen/Anapen?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No



**SECTION N: RESPIRATORY SYMPTOMS****N1. Have you, at anytime in your life, suffered from attacks of asthma or 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	<input type="radio"/>	<input type="radio"/>
Had an attack of shortness of breath after exercise	<input type="radio"/>	<input type="radio"/>
Woken due to a feeling of tightness in your chest	<input type="radio"/>	<input type="radio"/>
Been woken at night by an attack of shortness of breath	<input type="radio"/>	<input type="radio"/>

**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

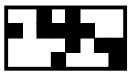
**O2. During the last month, do you or have you been told you snort or gasp in sleep?**

- 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





**Q3. During the last month, do you or have you been told you choke or stop breathing in sleep?**

- No → Please go to question Q4
- Don't know
- Yes

**Q3a. 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

**Q4. During the last month, have you had excessive sleepiness during the day?**

- No
- Yes

**Q5. Has your doctor ever told you that you have or had obstructive sleep apnoea?**

- No → Please go to question Q6
- Yes

**Q5a. How old were you when you were told you had obstructive sleep apnoea?**   age in years

**Q5b. How old were you when you had your first overnight sleep study?**   age in years

**Q5c. 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

**Q6. 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

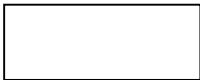
**P3b. Do you bring up this phlegm on most days for at least three months of each year?**

- 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?**

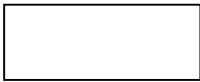
No

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.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> number
2.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> number
3.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When dressing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking on level ground	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hurrying on level ground	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking up stairs or up hills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Active sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please specify) <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you answered Yes to ANY statements in question R7 → Please go to question R9

If you answered No to ALL 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?

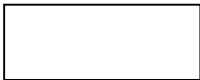
- No asthma in the past 12 months
- Asthma symptoms in the past 12 months but not in the last month
- Asthma symptoms in the last month, but not frequent (less than once per week)
- Frequent (once per week or more but not daily) in the last 1 month
- Persistent (daily)

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Last 1 month	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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

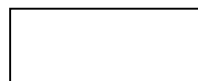
|

**R24a. In the last 12 months?**

No

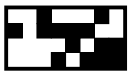
Yes



**SECTION 5: 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?	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
b) Which type of inhaler device?	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
c) Strength/dose per puff (mcg)?	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
d) Are you currently using this medication?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
e) How long have you been using this medication?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	<input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	<input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	<input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years
f) <b>In the last 12 months, how have you used them:</b>				
When needed - Average number of puffs per month	<input type="text"/> <input type="text"/> <input type="text"/> (puff/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/mth)
In short courses - Number of courses in last 12 months	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)
- Average number of puffs per day during flare-up	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)
- Average number of days of flare-up	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)
Continuously - Average number of puffs per day	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)
Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all
g) <b>In the last month, how have you used them:</b>				
When needed - Average number of puffs per month	<input type="text"/> <input type="text"/> <input type="text"/> (puff/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/mth)
In short courses - Number of courses in last 12 months	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)
- Average number of puffs per day during flare-up	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)
- Average number of days of flare-up	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)
Continuously - Average number of puffs per day	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)	<input type="text"/> <input type="text"/> <input type="text"/> (puff/day)
Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all
h) Is this medication the same type as prescribed by your doctor?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
i) Are you taking this medication at the same dose as prescribed by your doctor?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
j) If No to h) or i) why not the same: (Please choose <b>ALL</b> that apply)	<input type="checkbox"/> Cost <input type="checkbox"/> Side effects <input type="checkbox"/> Symptoms resolved <input type="checkbox"/> Forget to take <input type="checkbox"/> Other (specify) <input type="text"/>	<input type="checkbox"/> Cost <input type="checkbox"/> Side effects <input type="checkbox"/> Symptoms resolved <input type="checkbox"/> Forget to take <input type="checkbox"/> Other (specify) <input type="text"/>	<input type="checkbox"/> Cost <input type="checkbox"/> Side effects <input type="checkbox"/> Symptoms resolved <input type="checkbox"/> Forget to take <input type="checkbox"/> Other (specify) <input type="text"/>	<input type="checkbox"/> Cost <input type="checkbox"/> Side effects <input type="checkbox"/> Symptoms resolved <input type="checkbox"/> Forget to take <input type="checkbox"/> Other (specify) <input type="text"/>





**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  $\longrightarrow$  Please go to question S3  Yes  $\longrightarrow$  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?	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
b) Strength/dose per tablet (mg)?	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
c) Are you currently using this medication?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
d) How long have you been using this medication?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	<input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	<input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	<input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years
e) <u>In the last 12 months</u> , how have you used them:				
When needed				
- Average number of tablets per month	<input type="text"/> <input type="text"/> <input type="text"/> (tab/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/mth)
In short courses				
- Number of courses in last 12 months	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)
- Average number of tablets per day during flare-up	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)
- Average number of days of flare-up	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)
Continuously				
- Average number of tablets per day	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)
Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all
f) <u>In the last month</u> , how have you used them:				
When needed				
- Average number of tablets per month	<input type="text"/> <input type="text"/> <input type="text"/> (tab/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/mth)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/mth)
In short courses				
- Number of courses in last 12 months	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)	<input type="text"/> <input type="text"/> <input type="text"/> (number)
- Average number of tablets per day during flare-up	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)
- Average number of days of flare-up	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)	<input type="text"/> <input type="text"/> <input type="text"/> (days)
Continuously				
- Average number of tablets per day	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)	<input type="text"/> <input type="text"/> <input type="text"/> (tab/day)
Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all	<input type="radio"/> Not at all
g) Is this medication the same type as prescribed by your doctor?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
h) Are you taking this medication at the same dose as prescribed by your doctor?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
i) If No to g) or h) why not the same: (Please choose <b>ALL</b> that apply)	<input type="checkbox"/> Cost <input type="checkbox"/> Side effects <input type="checkbox"/> Symptoms resolved <input type="checkbox"/> Forget to take <input type="checkbox"/> Other (specify) <input type="text"/>	<input type="checkbox"/> Cost <input type="checkbox"/> Side effects <input type="checkbox"/> Symptoms resolved <input type="checkbox"/> Forget to take <input type="checkbox"/> Other (specify) <input type="text"/>	<input type="checkbox"/> Cost <input type="checkbox"/> Side effects <input type="checkbox"/> Symptoms resolved <input type="checkbox"/> Forget to take <input type="checkbox"/> Other (specify) <input type="text"/>	<input type="checkbox"/> Cost <input type="checkbox"/> Side effects <input type="checkbox"/> Symptoms resolved <input type="checkbox"/> Forget to take <input type="checkbox"/> Other (specify) <input type="text"/>







[Empty box]

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?

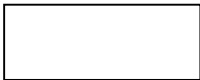
- No
- Yes (please specify) [Empty box]

**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.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> hours
Medication 2.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> hours
Medication 3.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> 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.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> hours
Medication 2.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> hours
Medication 3.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> 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.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> hours
Medication 2.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> hours
Medication 3.	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> 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

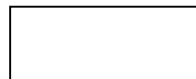
T7c. At what age did you have this reaction?

Under 18  Over 18





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**SECTION U: LABORATORY DATA SHEET****U1. SKIN PRICK TEST DATA**

	1st diam	2nd diam		1st diam	2nd diam		1st diam	2nd diam
Negative control	<input type="text"/>	<input type="text"/>	Penicillium	<input type="text"/>	<input type="text"/>	Peanut	<input type="text"/>	<input type="text"/>
House dust mite	<input type="text"/>	<input type="text"/>	Aspergillus	<input type="text"/>	<input type="text"/>	Shellfish	<input type="text"/>	<input type="text"/>
Cat	<input type="text"/>	<input type="text"/>	Rye grass	<input type="text"/>	<input type="text"/>	Cow's milk	<input type="text"/>	<input type="text"/>
Hormodendrum	<input type="text"/>	<input type="text"/>	Mixed grasses	<input type="text"/>	<input type="text"/>	Positive control	<input type="text"/>	<input type="text"/>
Alternaria	<input type="text"/>	<input type="text"/>	Egg white	<input type="text"/>	<input type="text"/>			

**ANTHROPOMETRIC DATA**

U2. Height (cm): Range 00-300 cm	<input type="text"/>	<input type="text"/>	<input type="text"/>	cm		
U3. Weight (kg): Range 00-200.0 kg	<input type="text"/>	<input type="text"/>	<input type="text"/>	kg		
U4. Neck measurements (cm): Range 00-70.0 cm	1. <input type="text"/>	<input type="text"/>	cm	2. <input type="text"/>	<input type="text"/>	cm
U5. Waist measurements (cm): Range 00-200.0 cm	1. <input type="text"/>	<input type="text"/>	cm	2. <input type="text"/>	<input type="text"/>	cm
U6. Hip measurements (cm): Range 00-200.0 cm	1. <input type="text"/>	<input type="text"/>	cm	2. <input type="text"/>	<input type="text"/>	cm

**SPIROMETRY****Pre-Bronchodilator****Blow 1****Blow 2****Blow 3**

U7. FVC (litres) Range 00-10.00 L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U8. FEV <sub>1</sub> (litres) Range 00-10.00 L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U9. FEV <sub>1</sub> /FVC (%) Range 00-100%	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**SPIROMETRY****Post-Bronchodilator****Blow 1****Blow 2****Blow 3**

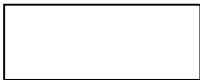
U10. FVC (litres) Range 00-10.00 L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U11. FEV <sub>1</sub> (litres) Range 00-10.00 L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U12. FEV <sub>1</sub> /FVC (%) Range 00-100%	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**SPIROMETRY****BEST Values Pre and Post BD****Pre-BD****Post-BD**

U13. FVC (litres) Range 00-10.00 L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U14. FEV <sub>1</sub> (litres) Range 00-10.00 L	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U15. FEV <sub>1</sub> /FVC (%) Range 00-100%	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U16. PEF (litres/sec) Range 00-20.00 L/sec	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U17. FEF <sub>25-75%</sub> (litres/sec) Range 00-10.00 L/sec	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U18. FEF <sub>50%</sub> (litres/sec) Range 00-10.00 L/sec	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
U19. FIF <sub>50%</sub> (litres/sec) Range 00-10.00 L/sec	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

U34. ApneaLink Test Results:

No Data → Please go to question U33

	Result		Result
a) AHI	<input type="text"/> <input type="text"/> <input type="text"/> e/hr	f) Average saturation	<input type="text"/> <input type="text"/> %
b) RI (Risk Indicator)	<input type="text"/> <input type="text"/> <input type="text"/>	g) Lowest saturation	<input type="text"/> <input type="text"/> %
c) Apnea Index	<input type="text"/> <input type="text"/> <input type="text"/> e/hr	h) Baseline saturation	<input type="text"/> <input type="text"/> %
d) Hypopnea Index	<input type="text"/> <input type="text"/> <input type="text"/> e/hr	i) Cumulative time saturation ≤ 90%	<input type="text"/> <input type="text"/> <input type="text"/> mins
e) ODI (Oxygen desaturation index)	<input type="text"/> <input type="text"/> <input type="text"/> e/hr	j) CSR probable	<input type="radio"/> Yes <input type="radio"/> No

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

No  Yes → Please complete a Technical Observation CRF

