

One hour for the research

An examination where everybody's life experience help us to a better knowledge of the cause of cancer and the connection between lifestyle and health

You can help out in the fight against cancer

One hour of your life

One hour, maybe a little longer, is what we ask you to give to the research. We will ask questions about lifestyle and health, questions that never can be solved by sampling or test on animals, but only through careful answers from many individuals.

Is your contribution meaningful? Our answer is Yes, it is invaluable. The contribution from every individual is equally important.

Our aim is to get reliable knowledge of how to keep or improve ones health. We want to get away from the existing situation with unsecure, often contradictory health directions and constant larm reports.

It is a long and difficult process that can take several years. But we hope that you shall be able to feel satisfaction over your contribution to such a development. You do that by inform us of your experiences, by answering this questionnaire.

Good luck in your efforts to remember and answer.

Many thanks for your co-operation.

**

This is how you fill in the questionnaire:

As the questionnaire is read by machines, we rather see that you use a pencil with black or blue colour. Please mark your answer with a cross within the box beside the answering alternative that you find fitting.

Example

If you have made a mistake and wish to change your answer, you should fill the wrong box completely and put the cross in the right box

Example

We kindly ask you to give your fully National Registration Number. Only questionnaires with correct National Registration Numbers can be considered and contribute to the research. The information about your National Registration Number, as well as your answer, will be completely inaccessible for others than the researchers.

Which is your completely National Registration Number?

-

Which year/years did you attend the National march for the Swedish Cancer Society?

1991 1993 1995 1997

How do you consider that your condition is/was compared to persons of the same age and sex?

	Much worse	A little worse	Equal	A little better	Much better
Now	<input type="checkbox"/>				
When you were 10-16 years	<input type="checkbox"/>				

How much do/did you exercise compared to persons of the same age and sex?

	Much less	A little less	Equal	A little more	Much more
Now	<input type="checkbox"/>				
When you were 10-16 years	<input type="checkbox"/>				

How much daily exercise have you got *per week* during the last 12 months, e.g. by walking and/or biking to work, by weekly cleaning, gardening or the alike?

Less than 1 hours 1-2 hours 3-4 hours
 5-6 hours More than 6 hours

How much time per week, in average, during the last 12 months have you devoted to athletics/exercise/sports/outdoor life?

		Hours per week					
		0	0-1	2	3	4	5 or more
Light exercise, like taking a walk	Summer	<input type="checkbox"/>					
	Winter	<input type="checkbox"/>					
Strenuous exercise, like speedy walk, jogging or swimming	Summer	<input type="checkbox"/>					
	Winter	<input type="checkbox"/>					
Hard training or competition	Summer	<input type="checkbox"/>					
	Winter	<input type="checkbox"/>					

How much have you been training or exercising in your different ages?

	Times per week				
	Never	Less than 1	Approx. 1	2-3 times	More than 3
As a teenager	<input type="checkbox"/>				
20-29 years	<input type="checkbox"/>				
30-49 years	<input type="checkbox"/>				
50 years or older	<input type="checkbox"/>				

How physically demanding has your daily work/occupation been during the past 12 months?

- Light, mostly sedentary Light, but I have moved a little
 Rather strenuous Very strenuous

If you have marked any of the alternatives on the lower row, please specify in which way you have moved/strained yourself. Mark one or more alternatives.

- Locomotion, like walking, running, biking, climbing or swimming
 Muscle power, like lifting, bending, shooting, squeezing or twisting
 Other type of strain

How much did you move yourself at work and during leisure time 10 years ago?

- Much less than now Less than now Just as much as now
 More than now Much more than now

How physically active are you on an ordinary day-and-night weekday?

In the table below there are 9 levels (degrees) of strains. In order to understand what each level means there are examples of activities that are just that strenuous. Try to estimate how long time during 24 hours that you totally devote to each level. Start with level A and state the time with one cross per level.

How long time of per day/night do you devote to such that are just as strenuous as	Minutes							
	0-4	5-9	10-19	20-39	40-89	90-179	180-359	360-720
A) Sleep, rest					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Sit in the bathtub, sit and listen on music, watch TV	<input type="checkbox"/>							
C) Office work, knit, sew, sit in a meeting	<input type="checkbox"/>							
D) Make the bed, ironing, washing up by hand	<input type="checkbox"/>							
E) Bowling, drive bus/tractor, workshop, fix the car, dance waltz/foxtrot	<input type="checkbox"/>							
F) Quick walk, horse ride, sweep the pavement	<input type="checkbox"/>							
G) Paint the house, carry and staple wood, ski/slalom	<input type="checkbox"/>							
H) Roadwork, cut the lawn with manual lawn mower, shovel snow	<input type="checkbox"/>							
I) How long time per day/night do you devote to such that is more strenuous than level H?	<input type="checkbox"/>							

Here we ask you to fill in your body measures.

Preferably use a measuring-tape for measuring hip and waist.

Example:
If you weigh 84 kg
you first write 84
on top with figures

	Present weight	Weight at 20 years	Weight at 50 years
	□□□ kg	□□□ kg	□□□ kg
0	□□□	□□□	□□□
1	□□□	□□□	□□□
2	□□□	□□□	□□□
3	□□□	□□□	□□□
4	□□□	□□□	□□□
5	□□□	□□□	□□□
6	□□□	□□□	□□□
7	□□□	□□□	□□□
8	□□□	□□□	□□□
9	□□□	□□□	□□□

	Length	Hip	Waist
	□□□ cm	□□□ cm	□□□ cm
0	□□□	□□□	□□□
1	□□□	□□□	□□□
2	□□□	□□□	□□□
3	□□□	□□□	□□□
4	□□□	□□□	□□□
5	□□□	□□□	□□□
6	□□□	□□□	□□□
7	□□□	□□□	□□□
8	□□□	□□□	□□□
9	□□□	□□□	□□□

Do not know Do not know

Which was your birthweight?

- Less than 1500 grams 1500-2499 2500-4000
 Over 4000 Do not know

Have you ever lost 5 kg or more in less than a year?

Women should disregard weight changes in connection with pregnancy.

- No Yes

If Yes, how much and how many times?

- Between 5 and 10 kg 1 2 3 4 5 times or more
 More than 10 kg 1 2 3 4 5 times or more

Please do not forget to fill in your National Registration number on page 2. Only questionnaires with correct National Registration Numbers can be considered and contribute to the research.

Did you know that...

the occurrence of different cancer diseases varies a lot – in some cases hundredfold – between different countries? Furthermore there are considerable differences within Sweden. Therefore it is important to have some knowledge of your background.

Which is yours and your biological parents' place of origin?

	<u>Me</u>	<u>Mother</u>	<u>Father</u>		<u>Me</u>	<u>Mother</u>	<u>Father</u>
Sweden	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Norway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baltic country	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Denmark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Turkey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Germany	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Greece	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hungary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iraq	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	North America	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iran	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	South America	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Former Yugo- slavia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Africa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lebanon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Do not know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you were born outside Sweden, since which age have you mainly been living in Sweden?

<input type="checkbox"/> Before 5 years of age	<input type="checkbox"/> 5-14 years of age	<input type="checkbox"/> 15-19 years of age
<input type="checkbox"/> 20-29 years of age	<input type="checkbox"/> 30-50 years of age	<input type="checkbox"/> After 50 years of age

How many brothers and sisters do you have?

Even count half-brothers/sisters and brothers/sisters that have passed away.

<input type="checkbox"/> None	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> More than 9	

How many of your brothers/sisters were born before you?

<input type="checkbox"/> None	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> More than 9	

Where were you mainly brought up?

<input type="checkbox"/> In a big city (or suburb)	<input type="checkbox"/> Medium-sized city
<input type="checkbox"/> Small town/village	<input type="checkbox"/> In the countryside

Which type of child care/nursery school have you gone to?

Mark one or more alternatives

<input type="checkbox"/> Day nursery (daghem)
<input type="checkbox"/> Nursery school, preschool, kindergarten, other care with many children
<input type="checkbox"/> None of those types

If you have gone to a Day nursery, how old were you when you started?

<input type="checkbox"/> Younger than 1 year	<input type="checkbox"/> 1-2 years	<input type="checkbox"/> 3-4 years	<input type="checkbox"/> Older than 4 years
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Which is presently your mainly occupation?

- Paid fulltime work
- Paid parttime work
- Run your own business
- Unpaid homework, e.g. housewife/houseman
- Unemployed
- Retired
- Sickness pension/long-term sick leave
- Student
- Other

Which working hours do you have?

- Day time
- Daytime + on call
- Mostly evening/nights
- Two shift
- Three-Five shift
- Other
- Do not work

How is your work?

If you do not work – how is your daily occupation?

	Seldom/ never	Some- times	Often	Always/ almost always
Do you have to work very fast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have to work very hard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have too much to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have enough of time to catch up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you allowed to learn new things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are the demands on you contradictory?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does it demand skilfulness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does it demand ingenuity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have freedom to decide <u>what</u> is to be done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have freedom to decide <u>how</u> it is to be done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does it mean that you do the same thing over and over again?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which educations/schools do you have or are in now?

- Elementary school/Comprehensive school/Compulsory school
- Vocational school
- 2-year Upper secondary school
- University/Highschool
- Junior secondary school
- Girls' school
- 3 or 4-year Upper secondary school
- Other education

Have you ever...

... smoked cigarettes daily during more than 6 months? No Yes

... taken snuff regularly (at least once a week during more than 6 months)? No Yes

...smoked pipe regularly (at least once a week during more than 6 months)? No Yes

Did you know that...

you are just now contributing to one of the largest epidemiological research studies that have ever been made? The aim of the epidemiological research is to get knowledge about the cause of different diseases in order to concentrate on preventive measures. During the history preventive measures- rather than treatment – have been the most successful way to improve our health and prolong the life.

How much have you smoked/taken snuff in different ages?

Age	Cigarettes per day						
	0	1-5	6-10	11-15	16-20	21-30	More than 30
Now	<input type="checkbox"/>						
10-14	<input type="checkbox"/>						
15-19	<input type="checkbox"/>						
20-29	<input type="checkbox"/>						
30-39	<input type="checkbox"/>						
40-49	<input type="checkbox"/>						
50-59	<input type="checkbox"/>						
60 or older	<input type="checkbox"/>						

Age	Pipe smoking		Amount of snuffboxes per week				
	No	Yes	0	Less than 1	1-2	3-7	More than 7
Now	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10-14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15-19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20-29	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30-39	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40-49	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50-59	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60 or older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much are you/have been exposed to other persons' tobacco smoke?

		Exposure level			
		Not at all	A little	Average	A lot
Now	at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	during leisure time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 years ago	at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	during leisure time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do you estimate your health?

Very good Good Neither good or bad
 Bad Very bad

How often do you have trouble with...

	Never/ seldom	Some- times	Often	Always/ almost always
...chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... palpitation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... breathlessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... headache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... stomach ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... muscle pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... joint pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... backache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... faint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you been treated by a doctor for some of the following diseases?

	No	Yes	Do not know
Allergic skinproblems (atopic dermatitis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergic nasal catarrh (hay fever)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne (pimples)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact eczema (e.g. nickel allergy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina pectoris?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lipid disturbance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina pectoris in your legs (claudication)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist fracture as adult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes detected before 30 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes detected after 30 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis (MS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn´s disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

You surely know that...

the laboratory research have made fantastic progress in the understanding of how healthy cells transform to cancer cells. But did you know that almost all knowledge about the external causes to cancer in man comes from epidemiological research? The disclosure that smoking causes cancer is one example. With this epidemiological study we want to reveal new connections that may lead to a better health.

Have you ever visited any of the following parts of the world?

Asia

Max. 4 weeks 5 weeks to 1 year More than 1 year

Africa

Max. 4 weeks 5 weeks to 1 year More than 1 year

South America, Mexico, Central America

Max. 4 weeks 5 weeks to 1 year More than 1 year

Are you vaccinated against...

... yellow fever? *(is being done before going to parts of South America and Africa)*

No Yes Do not know

... Japanese B encephalitis? *(is being done before going to Southeast Asia)*

No Yes Do not know

... rabies?

No Yes Do not know

... tick born encephalitis, also called TBE? *(is being done on persons living on the Swedish east coast, especially the islands in the Stockholm area)*

No Yes Do not know

...jaundice (hepatitis B)?

No Yes Do not know

How many times in your life have you had gamma globulin injections, e.g. before going abroad?

Never 1-5 times 6-10 times
 More than 10 times Do not know

How many times in life have you been treated with penicillin or other antibiotics?

Never 1-2 times
 3-10 times More than 10 times Do not know

If Yes, how long was the longest cure of penicillin or other antibiotics that you were treated with?

Less than 2 weeks 2-4 weeks
 5 weeks up to half a year More than half a year Do not know

How often, in average, have you taken a sunbath outdoors the past years?

Never Less than 5 hours per year
 5-14 hours per year 15-29 hours per year
 30-60 hours per year More than 60 hours per year

Do you usually go on sun vacation to southern countries?

Never Occasionally
 Every or every second year Several times per year

In former times I took a sunbath...

Less Just as much More

Do you easily get a tan?

No, I seldom get a tan No, I get a tan slowly
 Yes, relatively easy Yes, definitely

Do you use sun lotion when spending time outdoors in the summertime?

Never Sometimes Almost always

Do you usually get red/burnt by the sun?

(Red means flare that doesn't hurt; burnt means pain, painful flush and/or blisters)

Never Seldom Often

If you have been red/burnt, how often has this happened?

	Never/ almost never	Some years	Almost every year
Burnt several times during one and the same year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burnt occasional time during one and the same year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red but not burnt several times during one and the same year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red but not burnt occasional times during one and the same year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Did you get burnt in the sun as a child?

Never Sometimes Often Do not know

What is/has been your natural hair colour?

Dark brown/black Light brown Blonde/yellow Red

Have you ever taken a sunbath in a solarium?

No Yes

If yes, how many times per year have you taken a sunbath in a solarium in your different ages. Mark one cross for each age.

	Times per year						
	0	1-5	6-10	11-20	21-30	31-50	over 50
Up to 15 years	<input type="checkbox"/>						
15-19 years	<input type="checkbox"/>						
20-29 years	<input type="checkbox"/>						
30-39 years	<input type="checkbox"/>						
40-49 years	<input type="checkbox"/>						
50 years and older	<input type="checkbox"/>						

How often do you feel...

	Seldom/ never	Some- times	Often	Always/ almost always
... sad, low-spirited, depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... lonely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... worried, tensed or anxious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... satisfied with your day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... very healthy and full of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have something of the following happened to you during the past 12 months? How did it influence you?

	Influenced me				
	No	Yes	Not so much	Considerably	Strongly negative
Sickness/emergency/death (relative/friend)	<input type="checkbox"/>				
Divorce/separation	<input type="checkbox"/>				
Got unemployed	<input type="checkbox"/>				

Have you got someone/ones that you can...

... share interests/experiences with?	<input type="checkbox"/> No	<input type="checkbox"/> Doubtful	<input type="checkbox"/> Yes
... turn to with daily problems?	<input type="checkbox"/> No	<input type="checkbox"/> Doubtful	<input type="checkbox"/> Yes
... be familiar with?	<input type="checkbox"/> No	<input type="checkbox"/> Doubtful	<input type="checkbox"/> Yes

How many persons live in your household except yourself?

<input type="checkbox"/> Nobody	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<input type="checkbox"/> 4-5	<input type="checkbox"/> 6-7	<input type="checkbox"/> More than 7	

Do you have pets at home?

<input type="checkbox"/> No	<input type="checkbox"/> Yes <i>If Yes, what kind?</i>		
	<input type="checkbox"/> Dog	<input type="checkbox"/> Cat	<input type="checkbox"/> Bird
	<input type="checkbox"/> Rodent (e.g. hamster, rabbit)	<input type="checkbox"/> Other	

Did you know that...

many persons are considered suffering from chronic fatigue in our modern society? Nobody knows for sure how this may affect the health in the short and the long run. In this study we make a serious effort to find this out.

How is your sleep?

<input type="checkbox"/> Good	<input type="checkbox"/> Rather good	<input type="checkbox"/> Neither good or bad
<input type="checkbox"/> Rather bad	<input type="checkbox"/> Bad	

How many hours, approximately, per night...

	Less than 5	5	6	7	8	9 or more
...do you <i>consider</i> that you need to sleep?	<input type="checkbox"/>					
... do you <i>usually</i> sleep during a <i>weekday night</i> ?	<input type="checkbox"/>					
... do you <i>usually</i> sleep when you are <i>off duty</i> ?	<input type="checkbox"/>					

The following questions are regarding your sleep during the past 12 months.
Please choose one alternative per row.

Have you...	Never	Seldom	Some- times	Mostly	Always	Do not know
... had problems to fall asleep?	<input type="checkbox"/>					
... waken up and have had problems to fall asleep again?	<input type="checkbox"/>					
...snored severely?	<input type="checkbox"/>					
... had a restless sleep?	<input type="checkbox"/>					
... had nightmares?	<input type="checkbox"/>					
... had problems waking up?	<input type="checkbox"/>					
... not been thoroughly rested at awakening?	<input type="checkbox"/>					
... woke up fatigued?	<input type="checkbox"/>					
... woke up too early?	<input type="checkbox"/>					
... been sleepy during the day?	<input type="checkbox"/>					
... fell asleep (dropped off) during the day?	<input type="checkbox"/>					
... taken a nap during the day?	<input type="checkbox"/>					
... used sleeping pills?	<input type="checkbox"/>					

Did you know that...

we in Sweden are the most frequent users of mobile telephones in the whole world? This study will give us unique possibilities to disperse the uncertainty around ev. health effects caused by mobile telephones.

Have you regularly (at least twice a month) spoken in a mobile telephone?

We do not mean a wireless telephone only used in your home or a car telephone with outer antenna.

Yes No, If No, go to the next page.

If Yes, which nets have you used?

	Not used mobile tel.	GSM (070)	NMT 900 (010)	NMT 450 (010)	Both GSM and NMT	Do not know
Before 1985	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
1985-92	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
After 1992	<input type="checkbox"/>					

How many years, totally, have use used mobile telephone?

Less than 1 year 1-5 years 6-10 years More than 10 years

How often, in average, do/did you use mobile telephone?

Less than once a week A few calls per week
 Less than 10 minutes/day 10-29 minutes/day
 30 minutes – 1 hour/day More than 1 hour/day

Towards which ear do you usually hold the mobile telephone when you speak?

Right Left Alternately right and left

How much do you drink/eat of the following:

Mark one alternative per row (7+ means 7 times or more)

Glasses per day (1 glass= 2 dl)

	0	1	2	3	4	5	6	7+
Light/mini milk	<input type="checkbox"/>							
Medium milk	<input type="checkbox"/>							
Standard milk	<input type="checkbox"/>							
Light sour milk/ light yoghurt	<input type="checkbox"/>							
Sour milk/yoghurt	<input type="checkbox"/>							
Juice/soft drink	<input type="checkbox"/>							
Light beer	<input type="checkbox"/>							

Cups per day (1 cup=1,5 dl)

	0	1	2	3	4	5	6	7+
Tea	<input type="checkbox"/>							
Coffee	<input type="checkbox"/>							

Bits/spoons per day

	0	1	2	3	4	5	6	7+
Sugar/honey	<input type="checkbox"/>							

Tablespoons per day

	0	1	2	3	4	5	6	7+
Cottage cheese/curd	<input type="checkbox"/>							

	Slices per day							
	0	1	2	3	4	5	6	7+
Cheese	<input type="checkbox"/>							
Light cheese	<input type="checkbox"/>							
Crispbread	<input type="checkbox"/>							
White bread/loaf	<input type="checkbox"/>							
Coarse rye bread/ wholemeal bread	<input type="checkbox"/>							
Bread with butter/ margarine	<input type="checkbox"/>							

How do you usually butter a slice of bread?

- Rather thick Thin
 Very thin No fat at all

Which types of cooking fat do you usually use?

Mark one or more alternatives for sandwich, then for cooking

	Sandwich	Cooking
Butter	<input type="checkbox"/>	<input type="checkbox"/>
Bregott	<input type="checkbox"/>	<input type="checkbox"/>
Sandwich margarine(e.g. Flora)	<input type="checkbox"/>	<input type="checkbox"/>
Light margarine (e.g. Lätta)	<input type="checkbox"/>	<input type="checkbox"/>
Cooking margarine (e.g. Milda)	<input type="checkbox"/>	<input type="checkbox"/>
Olive oil	<input type="checkbox"/>	<input type="checkbox"/>
Rape oil		<input type="checkbox"/>
Cooking oil (e.g. maize-, sunflower oil)		<input type="checkbox"/>
Liquid margarine		<input type="checkbox"/>
I do not use cooking fat	<input type="checkbox"/>	<input type="checkbox"/>

How often, in average, do you eat the following?

Mark only one alternative per row.

Corn	Times/month		Times/week			Times/day		
	0	1-3	1-2	3-4	5-6	1	2	3+
Oatmeal porridge	<input type="checkbox"/>							
Other porridge/gruel	<input type="checkbox"/>							
Flakes/muesli	<input type="checkbox"/>							
Spaghetti/macaroni	<input type="checkbox"/>							
Pancakes	<input type="checkbox"/>							
Pizza	<input type="checkbox"/>							
Rice	<input type="checkbox"/>							
Wheat or oat bran	<input type="checkbox"/>							

Meat	Times/month		Times/week			Times/day		
	0	1-3	1-2	3-4	5-6	1	2	3+
Minced meat dishes (e.g. meatballs, ham- burger, mincemeat sauce)	<input type="checkbox"/>							
Pork (whole/casserole)	<input type="checkbox"/>							
Beef/veal (whole/casserole)	<input type="checkbox"/>							
Sausage (fried/grilled, boiled)	<input type="checkbox"/>							
Black pudding	<input type="checkbox"/>							
Liver/kidney	<input type="checkbox"/>							
Liverpaste	<input type="checkbox"/>							
Meat- or sausage on sandwich	<input type="checkbox"/>							

Did you know that...

good eating habits – according to new esteems – probably should reduce cancer occurrence with 1/3?

And furthermore protect against many other diseases? To be able to give safer advise regarding healthy food we kindly ask you to fill in this part exactly accurately.

Bird/fish/egg	Times/month		Times/week			Times/day		
	0	1-3	1-2	3-4	5-6	1	2	3+
Chicken/other bird	<input type="checkbox"/>							
Herring/Baltic herring/ mackerel	<input type="checkbox"/>							
Salmon/lavaret/char	<input type="checkbox"/>							
Cod/coalfish/fish finger	<input type="checkbox"/>							
Caviar	<input type="checkbox"/>							
Shellfish (shrimps/ crayfish)	<input type="checkbox"/>							
Egg/omelet	<input type="checkbox"/>							

Potato/carrots	Times/month		Times/week			Times/day		
	0	1-3	1-2	3-4	5-6	1	2	3+
Boiled potato	<input type="checkbox"/>							
Fried potato	<input type="checkbox"/>							
French fried potatoes	<input type="checkbox"/>							
Carrots	<input type="checkbox"/>							

Vegetables	Times/month		Times/week			Times/day		
	0	1-3	1-2	3-4	5-6	1	2	3+
Lettuce/iceberg lettuce	<input type="checkbox"/>							
Cabbage/red cabbage/ lettuce cabbage	<input type="checkbox"/>							
Cauliflower	<input type="checkbox"/>							
Broccoli/Brussels sprouts	<input type="checkbox"/>							
Tomato/tomato juice	<input type="checkbox"/>							
Paprika (sweet pepper)	<input type="checkbox"/>							
Spinach/whitebeet	<input type="checkbox"/>							
Green peas	<input type="checkbox"/>							
Onion/leek	<input type="checkbox"/>							
Garlic	<input type="checkbox"/>							
Mixed vegetables	<input type="checkbox"/>							
Pea soup/beans/lentils	<input type="checkbox"/>							

Fruit/berries	Times/month		Times/week			Times/day		
	0	1-3	1-2	3-4	5-6	1	2	3+
Orange/citrus fruit/juice	<input type="checkbox"/>							
Apple/Pear	<input type="checkbox"/>							
Banana	<input type="checkbox"/>							
Berries (fresh or frozen)	<input type="checkbox"/>							
Other fruit	<input type="checkbox"/>							
Jam/marmalade/mash	<input type="checkbox"/>							
Stewed fruit/fruit soup	<input type="checkbox"/>							

Other	Times/month		Times/week			Times/day		
	0	1-3	1-2	3-4	5-6	1	2	3+
Coffee bread (buns, cookies)	<input type="checkbox"/>							
Biscuits/wafers/rusk	<input type="checkbox"/>							
Cakes and pastries	<input type="checkbox"/>							
Chocolate/chocolate bar	<input type="checkbox"/>							
Sweets (not chocolate)	<input type="checkbox"/>							
Ice cream	<input type="checkbox"/>							
Chips/popcorn/cheese snacks	<input type="checkbox"/>							
Nuts/almond	<input type="checkbox"/>							
Dressing	<input type="checkbox"/>							
Mayonnaise	<input type="checkbox"/>							
Cream/crème fraiche	<input type="checkbox"/>							
Ketchup	<input type="checkbox"/>							

It is easy to forget one row by mistake. Please check that you have marked one cross on every row.

Fried food	Times/month		Times/week			Times/day		
	0	1-3	1-2	3-4	5-6	1	2	3+
Sausage/beef/pork chop fried in frying pan	<input type="checkbox"/>							
Fish fried in frying pan	<input type="checkbox"/>							
Chicken fried in frying pan	<input type="checkbox"/>							
Grilled/roasted chicken	<input type="checkbox"/>							
Gravy/sauce of gravy	<input type="checkbox"/>							

How often do you usually drink alcohol?

Only mark one alternative per row

	Never	Times/month		Times/week			Times/day		
		0-1	1-3	1-2	3-4	5-6	1	2	3+
Medium strong beer	<input type="checkbox"/>								
Strong beer	<input type="checkbox"/>								
White wine	<input type="checkbox"/>								
Red wine	<input type="checkbox"/>								
Dessert wine	<input type="checkbox"/>								
Liquor	<input type="checkbox"/>								

How much do you usually drink on every occasion?

Beer	<input type="checkbox"/> Less than 33 cl	<input type="checkbox"/> 33-50 cl	<input type="checkbox"/> 50-200 cl
	<input type="checkbox"/> 200-400 cl	<input type="checkbox"/> More than 400 cl (8-10 cans)	
Wine	<input type="checkbox"/> 1 glass	<input type="checkbox"/> 2-3 glasses	
	<input type="checkbox"/> ½ - 1 bottle	<input type="checkbox"/> More than 1 bottle	
Liquor	<input type="checkbox"/> 6 cl or less	<input type="checkbox"/> 7-12 cl	<input type="checkbox"/> 13-18 cl
	<input type="checkbox"/> 19-37 cl	<input type="checkbox"/> More than 37 cl	

If you drink alcohol, is it in connection to a meal?

Never Seldom Sometimes Often Always

Do you take vitamins, minerals or other supplements?

No Yes, the whole year Yes, parts of the year

If Yes, what do you usually take? How long have you been taken it?

Mark with a cross on every row.

	Never	Less than 1 year	1-5 years	More than 5 years
Vitamins without minerals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins with minerals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calcium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C-vitamin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B-vitamins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-vitamin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q 10 (antioxidant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxigard (antioxidant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beta-carotene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish oil products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Everything seems to indicate that it is possible to prevent disease by changing the habits of living. But to get a better knowledge of this, scientific studies are necessary. We plan to start that kind of research study within a couple of years and therefore ask if you would be interested to participate. This is only an application of interest; we will send a new inquiry before the study starts, together with detailed information about the habits of living that we believe may improve the health and prevent diseases.

Would you like to be contacted and eventually take part in the planned research study?

- Yes, I would like to
 Yes, maybe
 No

Did you know that...

different painkillers have shown to protect against several cancer diseases in animal experiments? Nobody knows if they have the same positive effect in man, but that is something we would like to find out. Therefore we kindly ask you to answer the following questions as accurately as possible.

How much acetylsalicylic acid have you taken, in average?

(e.g. Magnecyl, Bamyl, Dispril, Aspirin, Alka-Seltzer, Treo, Albyl, Bamycod, Reumyl, Trombyl)

	State the amount of tablets per month					
	0	1-5	6-10	11-20	21-30	More than 30
During the last year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Five years ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ten years ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much paracetamol have you taken, in average?

(e.g. Alvedon, Panodil, Citodon, Curadon, Distalgesic, Lemsip, Panocod, Reliv)

	State the amount of tablets per month					
	0	1-5	6-10	11-20	21-30	More than 30
During the last year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Five years ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ten years ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much indomethacin have you taken, in average?

(e.g. Indomee, Confortid, Indometacin). State the amount of capsules per month.

	0	1-5	6-10	11-20	21-30	More than 30
During the last year	<input type="checkbox"/>					
Five years ago	<input type="checkbox"/>					
Ten years ago	<input type="checkbox"/>					

Mark with a cross if you have taken any/some of the following painkillers and anti-inflammatory drugs:

- | | | | |
|------------------------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Alganex | <input type="checkbox"/> Alpoxen | <input type="checkbox"/> Ardinex | <input type="checkbox"/> Brexidol |
| <input type="checkbox"/> Brufen | <input type="checkbox"/> Diklofenak | <input type="checkbox"/> Felden | <input type="checkbox"/> Ibumetin |
| <input type="checkbox"/> Ipren | <input type="checkbox"/> Ketoprefen | <input type="checkbox"/> Miranax | <input type="checkbox"/> Mobic |
| <input type="checkbox"/> Naprosyn | <input type="checkbox"/> Naproxen | <input type="checkbox"/> Nurofen | <input type="checkbox"/> Orudis |
| <input type="checkbox"/> Prolixana | <input type="checkbox"/> Pronaxen | <input type="checkbox"/> Relifex | <input type="checkbox"/> Voltaren |

If you have marked any/some of those drugs, how many tablets or capsules have you taken per month totally?

	0	1-5	6-10	11-20	21-30	More than 30
During the last year	<input type="checkbox"/>					

Five years ago

Ten years ago

Have you during any period been on the following medication...

	No	Yes, but have stopped	Yes, taking now	Do not know
... cortisone tablets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... cortisone inhalator (e.g. Pulmicort, Becotide, Flutide)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you are a male you shall stop here. Please read the information on the next page how to further contribute to the research. If you are a female, you still have 2 pages to answer.

ONLY FOR THE FEMALES

How old were you at your first menstruation?

Younger than 11 years 11-12 13-14
 15-16 17 or older Do not know

Do you still have menstrual flow?

Yes No, they ceased (spontaneously or after operation) when I was
 under 40 years 40-44 45-49
 50-54 55-59 Younger than 11 years

How many children have you given birth to? Do not count miscarriage.

None 1 2 3 4 5
 6 7 8 9 More than 9

How old were you when you first child was born?

Under 20 years 20-24 25-29
 30-34 35-39 40 years or older

Have you ever been treated for childlessness?

No Yes

If Yes, which treatment did you get?

Operation Hormone stimulation (of ovulation)
 Other treatment

Have you ever used contraceptive pill? (Do not count so called minipill)

No Yes, If Yes, during how long time totally
 Less than 1 year 1-4 5-9 10 years or more

Hormone treatment (oestrogen) is usually given against different problems in menopause, or to prevent disease.

Have you at anytime had hormone treatment?

No Yes

If Yes, which type and during how long time totally?

Oestrogen without gestagen
(Progynon, Promarit/Premarina, Estraderm)
 Less than 1 year 1-4 5-9 10 years or more

Oestrogen together with gestagen
(combinations like e.g. Kliogest, Trisekvens, Cyclabil, Estracomb, or in separate preparations)

Less than 1 year 1-4 5-9 10 years or more

If you have used oestrogen, have you stopped completely with hormone treatment?

No

Yes, in that case when?

During the past year

1-5 years ago

More than 5 years ago

Now you have completed the questionnaire. Please check your answers. On the following pages you can find more information. When you have read it, please put the questionnaire in the addressed envelope. In every ICA-shop there are special boxes where you can leave your answer. If you prefer to post it, you will have to stamp it yourself.

What does the body's own defence mean?

In many cases there are known causes for a disease – take smoking as an example. How come that not everybody who smoke are subjects for severe illness? Are there inherent protectors in the cells of the body, and is it only the persons who miss those that get ill? Is it possible in the future to find persons who have less protection against the damaging substance in the tobacco?

To get an answer to this and other questions regarding collaboration between external factors (except tobacco, e.g. exercise and food) and the body's defence, you have to study the cell's "control-gear", that is their DNA. The body's DNA can be extracted from a simple blood sample.

We therefore ask you if you are willing to leave a blood sample on some future occasion. We can already inform that only a small group of all willing will be contacted. In order to compare how those who are getting ill differs from the healthy ones, we would in the future even want the possibility to study the cells in tissue from the ill. The sample will be taken in connection with diagnosis or treatment.

As it may take several years before there are enough cases of illness to compare the ill and the healthy, the blood samples have to be saved. To facilitate the analyses the researchers will immediately start to extract DNA. The DNA will be placed in locked freezers without access for unauthorized persons.

DNA compose, as you may know, the genetic make-up. Even though researchers today from the genetic make-up's chemical composition are unable to get a picture of the individual, a lot of people find it unpleasant that the researchers have access to the genetic code. To guarantee that information will not be abused, all future analyses will be examined and approved by the Ethic Committee at the Karolinska Institute in Stockholm.

If you would like to take part in this examination we would like you to take a stand to the following:

- Are you willing to leave a blood sample if you are asked?
- Do you allow that the researcher – if you would get ill in the future – study cells that is taken in connection with diagnosis or treatment?
- Do you allow that the researchers save your DNA for examinations of further protective genes in the future (after duly approval from the Ethic Committee)?

*If you find that you can answer Yes on those questions and want to contribute to the research on the body's own protection mechanisms against pathogenic factors, you mark **box A on the backpage**.*

Can drugs cause illness in a long run?

Drugs may influence the health both in a short and a long run.

The information about medication that you just gave in the questionnaire can be more valuable if we, in addition, can have the knowledge of your future medication. This is possible as the pharmacies already – via computer systems – leave information to Socialstyrelsen after approval from the owner of the prescription. This information can be used for research.

Do you give your consent that information of your present or ev. future prescriptions of the following drugs may be registered continuously by Socialstyrelsen for the research project which you are taking part in?

- | | | |
|---------------------------|-----------------------------|------------------------------|
| Painkillers | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cortisone | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| P-pill | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Other hormone preparation | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

*If you have answered Yes on any of those questions, please mark with a cross in box **B on the backpage**.*

I have read the questions on the former page.

A *Yes, I would like to contribute to the research of the body's own protection mechanisms and am willing to leave a blood sample.*

B *Yes, I consent that present and ev. future drug prescriptions of the marked drugs may be registered continuously by Socialstyrelsen for the research project.*

If you have put a cross in any of the boxes above, we also ask you to put a cross in the box on the flap of the addressed envelope. Then we can quickly identify the questionnaires from those who in this way furthermore wish to contribute to the research.

