

## LIFE HABITS AND HEALTH AMONG MEN

Please use a biro/pen with blue or black ink.

Answer this way:  Make a small **cross** in the small boxes

Write clear **numbers** in the big boxes.

### WEIGHT

1. How much did you weigh at birth?

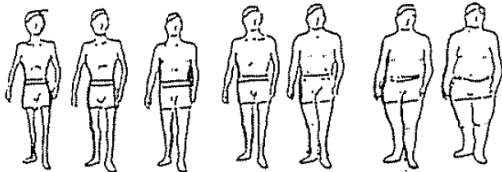
Less than 1500 grams	1500- 2499	2500- 3999	4000- 4999	Over 5000	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Were you born more than a month too early?

No  Yes

3. Are you a twin?  No  Yes

4. Which figure is most similar to your figure at the age of 10 years?



10 years

5. How tall were you at the age of 20?  cm

6. How much did you weigh at (in kilos):

20 yrs	30 yrs	40 yrs	50 yrs
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
60 yrs	70 yrs	80 yrs	Weight now
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

7. What are your measurements around your waist and hips?

Waist  cm Hips  Cm

8. What is your shoe size  collar size

9. Have you ever in your life lost 5 kg or more in less than 1 year? *If yes, why?*

No, never

Yes, due to dieting  times, Illness  times

more active  times, Other  times

10. If you ever dieted, what methods did you use?

<input type="checkbox"/> Weight watchers	<input type="checkbox"/> Less fat	<input type="checkbox"/> Fasting
<input type="checkbox"/> Fiber tablets	<input type="checkbox"/> Dieting powder <i>e.g. Nutrillett</i>	<input type="checkbox"/> Medicines <i>e.g. Obesedyl</i>
<input type="checkbox"/> Other		

### PHYSICAL ACTIVITY AND EXERCISE

11. Mark your level of physical activity **at different ages:**

<b>Work/occupation</b>	15 yrs	30 yrs	50 yrs	this yr
Mostly sitting down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down half the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mostly standing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mostly walking, min. lifting/carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mostly walking, sig. lifting /carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy manual labour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Walking/cycling</b>	15 yrs	30 yrs	50 yrs	this yr
Hardly ever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than 20 min/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20-40 minutes/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40-60 minutes/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-1.5 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 1.5 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Home/household work</b>	15 yrs	30 yrs	50 yrs	this yr
Less than 1 hour/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-2 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-4 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5-6 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7-8 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 8 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Leisure time

<b>Reading/watching TV</b>	15 yrs	30 yrs	50 yrs	this yr
Less than 1 hour/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-2 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-4 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5-6 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 6 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Exercise (excluding walking/cycling)

Less than 1 hour/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 hour/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2-3 hours/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4-5 hours/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 5 hours/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. How many hours in 24 hours do you usually...

Sleep  hours/24 hours Sit/lie down  hours/24 hours



FRUITS/BERRIES	Times per month			... week			... day		
	0	1-3	1-2	3-4	5-6	1	2	3+	
Orange/citrus fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Orange/grapefruit juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Apple/pear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Banana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Berries (fresh or frozen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Jam/marmalade/sauce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fruit fool/fruit soup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

CAKES/SWEETS ETC.	Times per month			... week			... day		
	0	1-3	1-2	3-4	5-6	1	2	3+	
Buns/cookies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Biscuits/wafers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cakes/pastries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Candy (not chocolate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ice cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chips/popcorn/cheese puffs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nuts/almonds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Salad dressing Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mayonnaise Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crème fraîche Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ketchup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

18. On average, how often do you eat fried food?

	times/mon	Rarely
Sausage/steak/pork chop <i>Fried in a pan</i>	<input type="checkbox"/>	<input type="checkbox"/>
Fish fried in a pan	<input type="checkbox"/>	<input type="checkbox"/>
Chicken/fillet/casserole <i>Fried in a pan</i>	<input type="checkbox"/>	<input type="checkbox"/>
Grilled/oven roasted chicken	<input type="checkbox"/>	<input type="checkbox"/>
Gravy/meat juice	<input type="checkbox"/>	<input type="checkbox"/>

19. What degree of browning do these foods usually have?

- Light brown       Brown  
 Dark brown       Charred

20. How often do you drink alcohol?

- I have never had alcohol  
 I stopped drinking alcohol at the age of  yrs

I usually drink	Times per month			... week			... day		
	Never	0-1	2-3	1-2	3-4	5-6	1	2	3+
Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beer (>3.5% alc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wine (>18% alc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirits (40% alc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. How much do you drink on each occasion?

Beer  cl    Wine  cl    Spirits  cl

1 can of beer=33/50 cl, bottle of wine/spirits=75 cl, 1 dl=10 cl

## DIETARY SUPPLEMENTS

22. Do you take vitamin, mineral or other supplements?

- Yes, regularly       Yes, sometimes       No

If yes, how much and since when?

Multivitamins	<input type="text"/>	tablets per week	<input type="text"/>	yr
Vitamin C	<input type="text"/>	"	<input type="text"/>	yr
Vitamin E	<input type="text"/>	"	<input type="text"/>	yr
Vitamin B <sub>6</sub>	<input type="text"/>	"	<input type="text"/>	yr
Calcium	<input type="text"/>	"	<input type="text"/>	yr
Fish oil	<input type="text"/>	capsules per week	<input type="text"/>	yr

23. Which of the following do you usually take?

- Enomdan     Vitamineral     Vitaplex     Omnibionta  
 Ginseng     Vit B-complex     Selenium     Folic Acid  
 Gerimax     Beta-carotene     Q10     Oxigard  
 Protector     Magnesium     Zinc     Chromium  
 Esbericum     Hyperforce     Cernitol     Curbicin  
 Echinacea     Garlic tablets     Ginseng     Other

## HEALTH

24. How would you describe your general health?

- Very good    Good    Neither good/ nor bad    Bad    Very bad

25. Have you had any of the following diseases?

State **what year** you had the first diagnosis

- High blood pressure    yr 19   
 High cholesterol    yr 19   
 Blood clot (deep) in the leg    yr 19   
 Angina    yr 19   
 Heart attack    yr 19   
 Stroke    yr 19   
 Diabetes    yr 19   
 Fracture of the wrist/vertebra/femur    yr 19   
 Kidney stone    yr 19   
 Gallstone    yr 19   
 Cataract surgery    yr 19   
 Urinary problems    yr 19

26. Has any of your parents or siblings had:

	No	Yes, Mother	Father	Siblings	Don't know
	How many				
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

Before 60 years old

27. These questions concern urination over the **past month**.

	Never	Less than every 5 <sup>th</sup> time	Less than every other time	About half of the time	More than half of the time	Almost never
How often have you had the feeling of not being able to empty your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often have you had to urinate within 2 hours after a previous visit to the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is urination not in a continuous flow?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is it hard to hold in urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have a weak urine stream?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often must you apply pressure to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. How often do you normally go to the toilet each night?

	Never	1 time	2 times	3 times	4 times	5+
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. If you had to live with the way you urinate as you do today, how would that feel?

	Very good	Good	Acceptable	Neither good or bad	Fairly bad	Very bad	Terrible
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICINE, SMOKING ETC.**

30. Have you used any of the following medicines?  
If yes, **how much and how long?**

Aspirin (ex. Magnecyl, Bamy, Dispril, Aspirin, Alka-Seltzer, Treo, Albyl, Bamycor, Trombyl)

No  Yes  tabl/wk, from yr 19

Para-acetylamino-phenol (ex. Alvedon, Panodil, Citadon, Curadon, Distalgesic, Lemsip, Panocod, Reliv)

No  Yes  tabl/wk, from yr 19

Medication for sleeping disorders

No  Yes  tabl/wk, from yr 19

Cortisone tablets  No  Yes  course

Cortisone in inhalation form (t.ex. Pulmicort, Becotide, Flutide)

No  Yes, now  Yes, in total  yr

31. Have you taken medicine for prostate problems?

No  
 Yes, Proscar  
 from  Yrs of age, in total  yrs

Yes: Peripress, Alfadil, Xatral, Hytrinex, Sinalfa  
 from  years old, total  yrs

32. Have you smoked cigarettes regularly at some time?

No, I have never smoked cigarettes  
 Yes, I started smoking when I was  yrs  
 still smoking  stopped smoking for

Number of cigarettes per day at each age

15-20 yr	21-30 yr	31-40 yr	41-50 yr	51-60 yr	This year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

33. Do you use snuff or smoke a pipe regularly?

No  Yes, I have used snuff  
 Yes, I have smoked a pipe.

34. How often do you feel very angry?

Times/day  Times/week  Seldom  Never

**OTHER QUESTIONS**

35. Where did you grow up?

In a big city/suburb  In a medium-sized city  
 In a small town/community  In the countryside

36. How many whole/half siblings do you have?

Sisters  Brothers

37. How many siblings were born to your mother before you?

She had  children before me

38. What education/schools have you gone to?

Compulsory school  Secondary school  
 Junior secondary school  University/college  
 Vocational/Boys' school  Other training

39. What is your current marital status?

Single  Married/living with partner  Divorced  Widower

40. What is your current employment status?

Full-time  Part-time  Unemployed  
 Studying  Disability  Retired

**It is good if you can go through and check that the questions are answered as fully as possible.**

Would you like to help further research by providing a blood sample for future genetic studies of protective factors?  Yes  No

Would you allow researchers - if you become ill - to study cells in tissue samples taken during routine diagnostic or treatment?  Yes  No

Can we call you if we need to ask further questions?  Yes  No

Your phone nr  -   
 Area code

**THANK YOU FOR YOUR PARTICIPATION !**