English version, translated March 2014

UppStART:

Uppsala-Stockholm Assisted Reproductive Technique study

UppStART

Karolinska Institutet

English version, translated March 2014

Thank you for choosing to participate in the start-up trial! In this survey, we will ask you some questions about your and your partner's infertility problems, your health and your lifestyle. At the end of the questionnaire is your opportunity to provide your own comments. It takes about 30-45 minutes to complete the survey.

In about 4-6 weeks you will get a message that it is time to fill in questionnaire No. 2. This poll is quicker to fill in, as it just asksabout lifestyle issues and if you changed anything in the last month or since the IVF treatment was initiated. You are welcome to call our research nurse Radja Dawoud at 08-524 8232 4 if there is anything you wonder about.

To fill in the questionnaire: You respond by marking the answer you think is closest, or write your answer in the given boxes. You may need to scroll down sometimes to see the entire issue. When you are finished with all the questions we ask you to send in your answers with the enclosed postage-paid envelope.

First name:_____

Last name:_____

Personnummer:_____

ÅÅÅÅMMDDXXXX

pnr

Address:_____

Telephone and / or mobile number (IMPORTANT: to be able to reach you):_____

Email (IMPORTANT: to be able to reach you):_____

Partner's and last name:_____

Partner's personnummer:_____

ÅÅÅÅMMDDXXXX

You are a:

☐ Man (1)
☐ Woman (2)

Tick the clinic you are now visiting:

☐ Fertilitetsenheten, Huddinge (1)
☐ IVF-kliniken, St:Göran (2)
☐ Fertilitetscentrum (3)
☐ Carl von Linnés klinik (4)
☐ Reproduktionscentrum, Akademiska sjukhuset(5)
☐ Other clinic (6)

Q1 Do you live with someone?

☐ Yes (1)
☐ No (continue to Q3) (0)
☐ No comment (998)

Q1a With whom? Yes(1) No (0)

(More than 1 option can be chosen)

☐ Husband, wife, fiancé, partner
☐ Children
☐ Siblings
☐ Parents
☐ Friends
☐ Other

Q1b Enter quantity that you live with: (1-5, more than 5 (6))

Children _____
Siblings_____
Friends_____
Other_____

Q3 What is your current marital status?

☐ Single (1)
☐ Married/Partnership (2)
☐ Sambo (3)
☐ Särbo / live seperately (4)
☐ Separated/divorced (5)
☐ No Comment (999)

Q4 Do you have biological children?

☐ Yes (1)
☐ No (0) (continue to Q5)

Q4a How many biological children do you have?

Enter quantity 1-5, more than 5 (6)

_____

Q5 Do you have adopted children?

☐ Yesn (1)
☐ No (0) (continue to Q6)

Q5a How many adopted children do you have?

Enter quantity 1-5, more than 5 (6)

_____

Q6 What is the highest level of education you have achieved?

☐ Primary school (1)
☐ 1-2 years of high school education or equivalent(2)
☐ 3-4 years of high school education or equivalent(3)
☐ 1-3 years of post-secondary education (4)
☐ University degree or higher (5)
☐ Other (6)
☐ No comment (999)

Q7 Please indicate your current profession, or the last one you worked as:

_____

Q8 Which of the following describes your current situation best?

☐ Employed (1)
☐ Unemployed (2)
☐ Running your own business / work as a partner in business (3)
☐ On parental leave (4)
☐ Student (5)
☐ On a leave of absence (6)
☐ Homemaker (7)
☐ Early retirement due to disability or disease (receiving social benefits) (8)
☐ Sick leave (9)
☐ Other (10)

Q9 Have you ever done shift work (i.e. work at irregular times)?

☐ Yes, I currently do shift work
☐ Yes, I have done shift work in the past
☐ No (continue to Q10)
☐ I don't know
☐ No comment

Q9a What year did you last work shifts?

Enter year (1980 or before (1980), 1981-2013)

_____

Q11 Have you ever done night work (between the hours of 24.00 and 5.00)?

☐ Yes, I currently do night work (1)
☐ Yes, I have done night work in the past (2)
☐ No (continue to Q10) (3)
☐ I don't know (4)
☐ No comment (5)

Q11a What year did you last work nights?

Ange årtal
☐ 1980 eller tidigare (1980)
1981-2013 _____

Q12 Have you during the past year often had trouble due to one of the following at work? Yes(1) No(0)

(More than 1 option can be chosen)

☐ Work at a computer
☐ Awkward posture / work position
☐ Heavy labour
☐ Heat, cold, draft
☐ noise
☐ chemicals
☐ vibration
☐ other_____
☐ No (continue to Q13)

Q12a How often have you been bothered by (the options you ticked above) at work during this past year?

☐ Daily (1)
☐ At least 1 time per week (2)
☐ Less than 1 time per week (3)
☐ I don't know (4)
☐ No comment (999)

Q13 Have you had trouble sleeping in the past 12 months?

☐ Yes (1)
☐ No (0) (continue to Q14)
☐ I don't know (998)
☐ No comment (999)

Q13a How often have you had trouble sleeping on average over the past 12 months?

☐ A few nights per month (1)
☐ One night per week (2)
☐ A few nights per week (3)
☐ Every or almost every night (4)

Q14 If you think about the relationship between your work life and your personal life:

	Rarely/ Never(1)	Sometimes(2)	Often(3)	I don't know(4)	comment (5)
Do the demands of work affect your personal life negatively?					
Do the demands of your personal life affect your work negatively?					
Do you have trouble getting sufficient time for both your work and personal life?					

Below are questions about your treatment at the IVF clinic

INF1 Are you here because of your, your partners, or both of your infertility?

☐ Mine (1)
☐ Partner (2)
☐ Both (3)
☐ I don't know (998)
☐ No comment (999)

INF2 and INF3 to be answered only by women.

INF2 Which infertility problems do you have?

Yes (1) No (0)

(More than 1 option can be chosen)

☐ Fallopian tube obstruction
☐ Endometriosis
☐ PCOS (Polycystic Ovarian Syndrome)
☐ Ovulation disorders
☐ Chromosomal defect
☐ Unexplained cause
☐ Another reason, please explain_____
☐ I don't know
☐ No comment

INF3 Do you know of any infertility problems that your partner has? Yes(1) No(0)

(More than 1 option can be chosen)

- ☐ Defect or blockage in the reproductive system or reduced ejaculation (for example, because the testicles have dropped down into the scrotum or that one or both testicles are missing)
- ☐ Physical disease (such as high fever, kidney disease)
- ☐ infection (such as inflammation of the prostate, epididymis or testis)
- ☐ injury (such as testicular trauma)
- ☐ Testicular cancer
- ☐ Infertility caused by chemotherapy
- ☐ Disorders of metabolism,such as hemochromatosis
- ☐ Hormonal defect (testosterone deficiency)
- ☐ Varicoceles
- ☐ Chromosomal defect
- ☐ Unexplained reason
- ☐ Another reason, please explain
- ☐ I don't know
- ☐ No comment

INF4 and INF5 to be answered only by men.

INF4 Which infertility problems do you have? Yes(1) No(0)

(More than 1 option can be chosen)

- ☐ Defect or blockage in the reproductive system or reduced ejaculation (for example, because the testicles have dropped down into the scrotum or that one or both testicles are missing)
- ☐ Physical disease (such as high fever, kidney disease)
- ☐ infection (such as inflammation of the prostate, epididymis or testis)
- ☐ injury (such as testicular trauma)
- ☐ Testicular cancer
- ☐ Infertility caused by chemotherapy
- ☐ Disorders of metabolism, such as hemochromatosis
- ☐ Hormonal defect (testosterone deficiency)
- ☐ Varicoceles
- ☐ Chromosomal disorder
- ☐ Unexplained reason
- ☐ Another reason, please explain
- ☐ I don't know
- ☐ No comment

INF5 Do you know of any infertility problems that your partner has?

Yes(1) No(0)

(More than 1 option can be chosen)

- ☐ Fallopian tube obstruction
- ☐ Endometriosis
- ☐ PCOS (Polycystic Ovarian Syndrome)
- ☐ Ovulation disorders
- ☐ Chromosomal defects
- ☐ Unexplained cause
- ☐ Another reason, please explain_____
- ☐ I don't know
- ☐ No comment

The following questions are to be answered by both women and men

INF6 Is this the first time you are seeking treatment for infertility??

- ☐ Yes (1) (continue to INF7)
- ☐ No (0)
- ☐ No comment (999)

INF6a How many times have you been treated before for infertility?

The number refers to how many treatments you received in the past whether it was artificial insemination, hormone stimulation, IVF/ICSI with fresh or frozen embryos or otherwise)

Enter number _____

INF6b What was the last infertility treatment you had? Yes(1) No(0)

(More than 1 option can be chosen)

- ☐ Artificial insemination
- ☐ In vitro fertilization, IVF
- ☐ Intracytoplasmic sperm injection, ICSI
- ☐ In vitro fertilization with a donor egg
- ☐ Hormone treatment only (stimulated ovulation with hormone pills or hormone injections)
- ☐ Other, please specifiy which drugs or treatment____
- ☐ I don't know
- ☐ No comment

} Continue to INF7

INF6c and 6d to be answered only by women:

INF6c Did you use your partner's or a donor's sperm?

- ☐ Partner(1)
- ☐ Donor (2)
- ☐ Others (e.g. expartner) (3)

INF6d Did you use you eggs or a donor's eggs?

- ☐ My own (1)

☐ Donor (2)

INF6e and 6f to be answered only by men:

INF6e Did you use your sperm or donor sperm?

☐ My own (1)
☐ Donor (2)

INF6f Did you use your partner's or a donor's eggs?

☐ Partners (1)
☐ Donor (2)
☐ Others (e.g. expartner) (3)

INF7 How often do you / did you have sexual intercourse per month during the last 3 months when you and your partner are trying to conceive?

☐ 1 to 4 times per month (1)
☐ 5 to 8 times per month (2)
☐ 9 to 12 times per month (3)
☐ More than 12 times per month (4)
☐ I don't know (998)
☐ No comment (999)

INF8 How long have you been trying to get pregnant?

☐ 1 to 3 months (1)
☐ 4 to 12 months (2)
☐ More than 1 year. If so, the number of years and (3) months_____
☐ I don't know (998)
☐ No comment (999)

INF9 What treatment will you and your partner to get at this clinic? Yes(1) No(0)

(More than 1 option can be chosen)

☐ Artificial insemination
☐ In vitro fertilization, IVF
☐ Intracytoplasmic sperm injection, ICSI
☐ In vitro fertilization with a donor egg
☐ Hormone treatment only (stimulated ovulation with hormone pills or hormone injections)
☐ Other, please specifiy which drugs or treatment____

INF9a and 9b to be answered only by women:

INF9a Will your partner's or a donor's sperm be used??

☐ Partners (1)
☐ Donor (2)

INF9b Will your eggs or a donor's eggs be used?

☐ My own (1)
☐ Donor (2)

INF9c and 9d to be answered by only men:

INF9c Will your sperm or a donor's sperm be used??

☐ My own (1)
☐ Donor (2)

INF9d Will your partner's eggs or a donor's eggs be used??

☐ Partners (1)
☐ Donor (2)

To be answered only by women.

Men continue to INF14

INF10 Have you ever been pregnant?

☐ Yes (1)
☐ No (0) (continue to INF12)

INF10a How long did it take for you to become pregnant last time?

☐ 1 to 3 months (1)
☐ 4 to 12 months (2)
☐ More than 1 year (3) (Specify number of years)

_____

☐ I was not trying to become pregnant (4)
☐ I don't know (998)
☐ No comment (999)

INF10b How did you become pregnant last time?

☐ Intercourse (without treatment) (1) (continue to INF11)
☐ Artificial insemination (2)
☐ In vitro fertilization, IVF (3)
☐ Intracytoplasmic sperm injection, ICSI (4)
☐ In vitro fertilization with a donor egg (5)
☐ Hormone treatment only (stimulated ovulation with hormone pills or hormone injections) (6)

Continue to INF10c

☐ Other, please specifiy which drugs or treatment (7) ____

INF10c Did you use your partner's sperm or a donor's sperm?

☐ Partners (1)
☐ Donor (2)
☐ Others (e.g. expartner) (3)

INF10d Did you use your eggs or a donor's eggs?

☐ My own (1)
☐ Donor (2)

INF11 How many times have you been pregnant?

Enter number of times (1-8, more than 8 (9))

_____

INF11a How many times have you given birth?

Enter number of times (1-8, more than 8 (9))

_____

INF11c Have you ever had a miscarriage?

☐ Yes (1)
☐ No (0) (continue to INF12)

INF11d How many times have you had a miscarriage?

Enter number of times *(1-12)*_____

INF11e Please indicate, to the extent of your knowledge, if your miscarriage(s) were before or after week 12:

Miscarriage number	Before week 12	After week 12

INF12 Have you ever had an abortion?

☐ Yes (1)
☐ No (2) (continue to INF13)

INF12a How many times have you had an abortion?

Enter number of times (1-8, more than 8 (9))

_____

INF13 Have you ever had an ectopic pregnancy??

☐ Yes (1)
☐ No (2) (continue to INF14)

INF13a When did you last have an ectopic pregnancy?

Enter year_____

INF14 INF14 Has anyone in your immediate family had infertility problems?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

INF14a Who is / are your closest family / relatives have had infertility problems?

Yes(1) No(0)

☐ Mother
☐ Father
☐ Sister
☐ Brother
☐ Half-sister (maternal side)
☐ Half-sister (paternal side)
☐ Half-brother (maternal side)
☐ Half-brother (paternal side)
☐ Aunt (mother's sister)
☐ Aunt (father's sister)
☐ Other_____

To be answered only by women.
Men continue to H1.

K1 How old were you when you got your first period?

Specify age (Younger than 10 (1), 2-12, older than 20 (13)) _____

K2 Have you had periods in the past year?

☐ Yes (1)(continue to K3)
☐ No (0)

K2a What is the reason that you have not had your period?

☐ Hormonal dysfunction (for example, anovulation)(1)
☐ Medication (2)
☐ Contraception (3)
☐ Gynecological surgery (4)
☐ Intensive physical training (5)
☐ Anorexia / eating disorder (6)
☐ Pregnancy (7)
☐ Other, specify (8): _____
☐ I don't know (998)
☐ No comment (999)

K3 Do you have regular periods?

Regular periods means that you have your period every month and that you can predict the beginning of your period within a 5 day window.

☐ Yes (1)
☐ No (2) (continue to K5)
☐ I don't know (998)
☐ No comment (999)

K4 How many days usually go between periods?

A cycle is the number of days from the first day of a menstrual period to the first day of next month's menstruation. . Example: if your periods usually begin the same day and it is four weeks, then the cycle length of 28 days.

Menstrual cycle length in days:

_____

☐ I don't know
☐ No comment

K5 You have indicated that you have irregular periods. How many days usually go between one period and the menstrual period, as the most and which the least??

A cycle is the number of days from the first day of a menstrual period to the first day of next month's menstruation. . Example: if your periods usually begin the same day and it is four weeks, then the cycle length of 28 days

Enter the number of days in the shortest cycle:

_____

Enter the number of days in the longest cycle:

_____

☐ I don't know
☐ No comment

The shortest cycle (1)
The longest cycle (2)

K6 Have you ever used any of the following birth control? Yes(1) No(2)

(More than 1 option can be chosen)

☐ Mini pill
☐ Combination pill (regular oral contraceptives)
☐ P - injection
☐ Hormonal IUD hormonal (intrauterine device)
☐ IUD copper (intrauterine device)
☐ P - implant
☐ Other _____
☐ No
☐ I don't know
☐ No comment

K6a How long in total have you been taking the birth control you have ticked? If you have ticked more fill in the number of years for each variety in the box below

Number of years (1)

_____

☐ Less than 1 year (2)

K7 Have you ever undergone any of the following gynecological surgical procedures (except cesarean)? Yes(1) No(0)

(More than 1 option can be chosen)

☐ Surgery on the cervix
☐ Removal of an ovary
☐ Laproscopy (for reasons other than above)
☐ Surgical abortion
☐ Chemical abortion
☐ Complications in pregnancy
☐ Scraping (uterus)
☐ Appendectomy
☐ Another operation
☐ No
☐ I don't know
☐ No comment

Continue to K8

7a How old were you when you had this surgery?

Enter age

K8 Have you been diagnosed with uterine fibroids (ie, fibroids in the uterus)?

☐ Yes (1)

☐ No (0) (continue to K9)
☐ I don't know (998)
☐ No comment (999)

K8a Have you received treatment for uterine fibroids?

☐ Yes, surgery (1)
☐ Yes, another treatment (2)
☐ No (3)
☐ I don't know (998)
☐ No comment (999)

K9 Have you been diagnosed with endometriosis?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

K10 Have you been diagnosed with polycystic ovarian syndrome (PCO/PCOS)?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

K11 Do you think you have abnormal hair growth on various body parts, i.e.on the upper lip, chin, tummy, or thighs?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

K12 Do you suffer from severe period pains?

☐ Yes (1)
☐ No (0) (continue to K13)
☐ I don't know (998)
☐ No comment (999)

K12a Do you regularly one of the following things because of the pain?

Yes(1) No(0)

(More than 1 option can be chosen)

☐ I take time off of work
☐ I take painkillers
☐ I take contraceptives (p-pillar)
☐ No
☐ I don't know
☐ No comment

K13 Do you feel pain during sex?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

K14 Do you suffer from pain in the pelvis during the period between two menstrual cycles?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

K15 Have you gotten the cervical cancer vaccine?

☐ Gardasil (1)
☐ Cervarix (2)
☐ Cannot remember the name (3)
☐ No (4)
☐ I don't know (998)
☐ No comment (999)

Continue to H1

K15a How old were you when you got the vaccine for cervical cancer?

Enter age (1) _____
☐ Cannot remember (2)

K15b Have you undergone the complete vaccination schedule against cervical cancer, with three doses?

☐ Full treatment (1)
☐ Currently undergoing treatment (2)
☐ Did not complete treatment (fewer than 3 doses) (3)
☐ No (4)
☐ I don't know (998)
☐ No comment (999)

These questions are about issues that affect your health

H1 Enter your height and weight in whole numbers, round up to the nearest centimeter / kilogram.

Height in centimeters:_____

Weight in kilograms:_____

H2 How much did you weigh when you were born?

☐ Enter weight in grams (1) _____
☐ I don't know (998)
☐ No comment (999)

H3 In what gestational week were you born?

☐ Week (1)_____
☐ I don't know (998)
☐ No comment (999)

H4 Do you know if you were born premature, ie before 37 weeks of pregnancy?

☐ Yes (1)
☐ No (2)
☐ I don't know (998)
☐ No comment (999)

H5 Please tick if you have or have had any of the following health problems and what year it started, and if you take any medication for it:

(More than 1 option can be chosen)

	Yes (1)	No (0)	Year	Medication
Diabetes Type I				
Diabetes Type II				
Gestational Diabetes				
Heart disease				
Cancer (continue to H7 for women, H8 for men)				
High blood pressure / hypertension				
Depression				
Hyperthyroidism (overactive thyroid)				
Hypothyroidism (underactive thyroid)				
Allergies				
Asthma (continue to H9)				
Systemic lupus erythematosus, SLE				
Inflammatory bowel disease (i.e. ulcerative colitis, Crohn's disease,)				
Cystic fibrosis				
Chronic bronchitis				
Kidney disease				
Liver disease				
Anemia				
Pneumonia				

Blood transfusions				
Seizures (i.e. epileptic)				
Chronic muscle pain / joint pain				
Reflux, Heartburn				
Disorders of the gallbladder				
Headache (e.g. migraines)				
Sweating at night and hot flashes				
Appendicitis				
Other, specificy:_____				
No health problems				

For the following questions, answer for those conditions you have ticked above

H5a Are you cured of your problem now?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

Cancer: Women

H7 Please indicate which body part with cancer or cancer type you have/had and enter the year in which it started next to cancer type:

(More than 1 option can be chosen)

Year

☐ Ovarian _____
☐ Cervical_____
☐ Uterine_____
☐ Airway/lung_____
☐ breast_____
☐ stomach_____
☐ gallbladder_____
☐ liver_____
☐ esophagus_____
☐ skin_____
☐ bladder_____
☐ oral cavity, pharynx _____
☐ Kidney (Wilm's tumor) _____
☐ cancer of the nervous system (eg brain) ___
☐ leukemia _____
☐ lymphoma and multiple myeloma _____
☐ other, specify: _____

H7a Are you taking any medication or presently being treated for your cancer?

☐ Yes (1)
☐ No (0)

H7b What is / are the medications you are taking regarding your cancer?

H7c Are you cured of your cancer now?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

H7d How long have you had/did you have cancer?

☐ 1-2 years (1)
☐ 2-4 years (2)
☐ More than 4 years (3)
☐ 1-7 days (4)
☐ 1-4 weeks (5)
☐ 1-6 months (6)
☐ 6-12 months (7)

Cancer: Man

H8 Specify which body part with cancer or cancer type you have/had and enter the year in which it started next to the type of cancer:

(More than 1 option can be chosen)

YEAR

☐ testicular/_____
☐ penal_____
☐ prostate_____
☐ airway/lung_____
☐ stomach_____
☐ colon/rectal _____
☐ oral cavity/ pharynx_____
☐ bladder_____
☐ gall bladder_____
☐ esophogus_____
☐ liver_____
☐ skin (melanoma and other types) ____
☐ Kidney (Wilm's tumor) _____
☐ Cancer of the nervous system (eg brain) __
☐ Leukemia_____
☐ Lymphoma and multiple myeloma _____
☐ Other, specify:_____ _____

H8c Are you cured of your cancer now?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

H8d How long have you had/did you have cancer?

☐ 1-2 years (1)
☐ 2-4 years (2)
☐ More than 4 years (3)
☐ 1-7 days (4)
☐ 1-4 weeks (5)
☐ 1-6 months (6)
☐ 6-12 months (7)

H8a Are you taking any medication or presently being treated for your cancer?

☐ Yes (1)
☐ No (0)

H8b What is / are the medications you are taking regarding your cancer?

Asthma and Allergy

H9b Do you have / have had hay asthma?

H9 Has a doctor diagnosed you with asthma?

☐ Yes (1)
☐ No (2)
☐ I don't know (998)
☐ No comment (999)

H9a At what age were you diagnosed with asthma?

_____

☐ I don't know (998)
☐ No comment (999)

Are you taking any medication at present for your asthma??

☐ Yes (1)
☐ No (0)

Specify which medications you are taking your current asthma:

_____

Are you cured of your problem now? (asthma)

☐ Yes (11)
☐ No (12)
☐ I don't know (998)
☐ No comment (999)

How long have you had / did you have asthma?

☐ 1-2 year (1)
☐ 2-4 year (2)

☐ More than 4 years (3)

☐ 1-7 days (4)
☐ 1-4 weeks (5)
☐ 1-6 months (6)
☐ 6-12 months (7)

H9b Do you have / have had hay fever or another allergic rhinitis?

☐ Yes (1)
☐ No (0)
☐ I don't know (998)
☐ No comment (999)

H9c Has a doctor made the diagnosis of hayfever or other allergic rhinitis?

☐ Yes (1)
☐ No (0)

H9d **Do you feel that you have any of the following allergies?** Yes(1) No (0)
(More than 1 option can be chosen)

☐ Pollen
☐ Fur
☐ Mites
☐ Bee or wasp
☐ Contact allergy
☐ No, none of the above
☐ I don't know (998)
☐ No comment (999)

How long have you had / did you have allergy?

☐ 1-2 year (1)
☐ 2-4 year (2)

☐ More than 4 years (3)

☐ 1-7 days (4)
☐ 1-4 weeks (5)
☐ 1-6 months (6)
☐ 6-12 months (7)

H10 Have you regularly taken any painkillers in the last last 3 months?

❑ Alvedon, panodil (1)
❑ Ipren, ibuprofen (2)
❑ Voltaren, diclofenac (3)
❑ Naproxen (4)
❑ Citodon (5)
❑ Treo, acetylsalisyra, trombyl (6)
❑ Other, specify: (7)_____
❑ I have taken no painkillers (8)

H11 Do you take any other medicine / drug currently?

❑ I take no other medication
Yes(1) No (0)

The next questions are about your experiences, feelings and thoughts during the last three months. For each question, you may specify how often you have experienced, felt or thought a certain way. Some questions may seem similar but try to treat each issue separately. Answering why every question without any further consideration. Do not try to figure out how often you felt a certain way, try instead appreciate what seems to be the most reasonable for you according to the answer choices.

H12 Have you during the past year felt any anxiety / depression?

☐ I am not anxious or depressed (1)
☐ I am or have been anxious or depressed to some extent (2)
☐ I am or have been highly anxious or depressed (3)
☐ I don't know (998)
☐ No comment (999)

H13 How often have you:

	Never(1)	Rarely(2)	Quite often(3)	Very often(4)	Don't know(998) No comment(999)
Become upset about something that happened unexpectedly?					
Felt that you had no control over the important factors in your life?					
Felt nervous and stressed?					
Felt that you could not handle everything that needs to be done?					
Become angry about things that have happened and that were beyond your control?					
Felt confident in your ability to handle your personal problems?					
Thought that things have developed that you wanted?					
Felt that you had control of irritating moments in your life?					
Felt that you had control over things?					
Felt that the problems have become so numerous that you could not overcome them?					

The following questions relate to the stress related to your / your infertility and childlessness

Select an option on each line.

1= Strongly Disagree 5= Strongly agree

COMP1 Consequences for you of the childlessness

	1	2	3	4	5
My life has been affected significantly					
My life has been complicated because of the fertility problem					
Infertility means for me a great source of anxiety and stress.					

What are the consequences of childlessness for your marriage / relationship?

	1	2	3	4	5
Brought us closer					
Strengthened our relationship					
Caused crisis in our relationship					
Caused thoughts of divorce					

COMP2 To what extent has the fertility problem negatively affected the following aspects of your life?

	Very much(1)	Pretty much(2)	A little(3)	Not at all(4)
your marriage/partnership				
Your sex life				
Your relationship with your family				
Your relationship with your partner's family				
Your relationship with your friends				
Your relationship with your colleagues				
Your relationship with other peoples children				
Your relationship with pregnant women				
your physical health				
Your mental health				
Your finanical condition				

Expectations of fertility treatments

COMP3 I have sought investigations and treatment. . .

	Very important(1)	Less important(2)	Not important(3)
to find the cause of our childlessness			
to get pregnant			
to have (another) child			
As a last resort to have children			
for my own reason			
for my husband's/partners reason			
because fertility treatment has worked			
Other, specify:			

COMP4 I wish that the staff at the fertility clinic..

	important(1)	important(2)	important(3)
Inform us on the results of our tests			
informs us about the different treatment options relevant for us			
informs us about the possibilities of adoption			
asks us how we are feeling emotionally			
shows us understanding			
gives us written information about our treatment			
gives a pamphlet about the emotional consequences of childlessness			
refers us to associations for childless people			
Other, specify:			

Some childless couples wishing to fertility clinic offered courses or support groups for involuntarily childless. Some couples would like to be featured conversations with a psychologist or sexologist.

COMP5 How important is it for you to. . .

	Very important(1)	Less important(2)	Not important(3)
a. participate in a course about childlessness			
b. participate in a support group			
c. talk to a psychologist			
d. talk to a sexologist			
e. other, specify:			

COMP6 If I was offered one of the options above, I would. . .

	Yes (1)	Maybe (2)	No (3)	I don't know(4)
a. participate in a course about childlessness				
b. participate in a support group				
c. talk to a psychologist				
d. talk to a sexologist				
e. other, specify:				

The ability to handle the problem of infertility is individual. What do you do to manage the problem?

COMP7 I. . .

	Never(1)	Sometimes(2)	Often(3)	Very often(4)
avoid being with pregnant women or children				
leave when people are talking about pregnancies and children				
try to keep my feelings to myself				
turn to work or substitute activity to take my mind off things				
think about the different ways to become parents (e.g. different treatment options, adoption, fostering)				
Have a close relationship with other people's children				
take a break from trying to have (another) child				
let my feelings out somehow				
accept sympathy and understanding from someone				
ask other childless people for advice				
ask a relative or friend for advice				
read or watch TV about childlessness				
live a healthy life				
use humour				

COMP8 I . . .

	Never(1)	Sometimes(2)	Often(3)	Very often(4)
hope a miracle will happen				
feel that the only thing I can do is to wait				
try to forget the everything about the childlessness				
have fantasies and wishes about how things might turn out				
avoid to read or to hear about childlessness				
have grown as a person in a good way				
try to analyse the problem in order to understand it better				
think about the fertility problem in a positive light				
find my marriage/partnership even more valuable now				
find other life goals				
pray (to God, for example)				
believe there is a meaning with our difficulties with having children				

Infertility - how open are you? The following questions are about how you converse with your partner and others about childlessness and of the infertility investigations and treatments you undergo.

COMP9 Do you find it difficult to talk about you childlessness with your partner?

☐ Yes, always (1)
☐ Yes, sometimes (2)
☐ No, never (3)

COMP10 Do you to talk to others about. . .

	No, not to anyone (1)	Yes, only to people I am close with (2)	Yes, to most people I know (3)
That you cannot have children?			
The reason why you are childless?			
Your fertiliyt tests?			
What kind of treatment you are trying?			
Your feelings about being childless?			
How tests and treatments affect you emotionally?			

S1 How old were you when you had sexual intercourse for the first time??

Enter age: _____

S2 Have you ever been told that you have any of the following sexually transmitted diseases?
Yes(1) No(0)

(More than 1 option can be chosen)

☐ Chlamydia
☐ Herpes
☐ Gonnrhea
☐ Genital warts
☐ Candida (yeast infection)
☐ Trichomonas
☐ Another illness, specify:_____
☐ No
☐ I don't know
☐ No comment

THESE QUESTIONS ARE REGARDING YOUR EATING HABITS FOR THE LAST 3 MONTHS

M1 How often do you eat or drink something at the following meals??

Breakfast

☐ Every day (1)
☐ Several times per week (2)
☐ One time per week (3)
☐ Rarely or never (4)

Lunch

☐ Every day (1)
☐ Several times per week (2)
☐ One time per week (3)
☐ Rarely or never (4)

Dinner

☐ Every day (1)
☐ Several times per week (2)
☐ One time per week (3)
☐ Rarely or never (4)

M2 How often do you eat snacks (or cakes/fikabröd)?

☐ 4 times per day or more (1)
☐ 3 times per day (2)
☐ 1-2 times per day (3)
☐ A few times per week (4)
☐ Rarely or never (5)
☐ I don't know (998)
☐ No comment (999)

M3 Are you:

☐ Vegetarian (1)
☐ Vegan (2)
☐ Vegetarian and eat only fish (3)
☐ Vegetarian och eat only white meat (eg fish and chicken) (4)
☐ Have no special diet (6)
☐ I don't know (998)
☐ No comment (999)

M4 Enter the quantity and how often you drank the following beverages (coffee, tea and chocolate drink) on average over the past 3 months.

Select the cup size representing the amount you usually drink

Coffee

☐ about 1 dl (1)
☐ about 2 dl (2)
☐ about 3 dl (3)
☐ I never drink te (4)

Tea
☐ about 1 dl (1)
☐ about 2 dl (2)
☐ about 3 dl (3)
☐ I never drink coffee (4)

Chokladdryck
☐ about 1 dl (1)
☐ about 2 dl (2)
☐ about 3 dl (3)
☐ I never drink chokladdryck (4)

M4a Fill in either "per day" or "per a week" which ever best meets your intake.

	Times per day	Times per week
Kaffe	☐ 1 (1) ☐ 2 (2) ☐ 3 (3) ☐ 4 (4) ☐ 5+ (5)	☐ 1-2 (1) ☐ 3-4 (2) ☐ 5-6 (3)
Te	☐ 1 (1) ☐ 2 (2) ☐ 3 (3) ☐ 4 (4) ☐ 5+ (5)	☐ 1-2 (1) ☐ 3-4 (2) ☐ 5-6 (3)
Chokladdryck	☐ 1 (1) ☐ 2 (2) ☐ 3 (3) ☐ 4 (4) ☐ 5+ (5)	☐ 1-2 (1) ☐ 3-4 (2) ☐ 5-6 (3)

M5 If you have indicated that you drink coffee, what type of coffee do you drink most often?
Yes(1) No(0)

(More than 1 option can be chosen)

☐ Drip coffee / brewed
☐ Automatic machine
☐ Espresso (including caffe latte, cappuccino, nespresso)
☐ Instant coffee (Nescafé)
☐ Boiled/ percolator/ coffee press
☐ Caffeine free / decaffeinated
☐ Other coffee
☐ I don't know
☐ No comment

M5a What do you have in your coffee?

Yes(1) No(0)

(More than 1 option can be chosen)

☐ A splash of milk or cream
☐ A lot of milk or cream (e.g. latte, café au lait)
☐ Sugar, syrup
☐ sweetener
☐ Nothing
☐ I don't know
☐ No comment

M6 If you have indicated that you drink tea, what kind of tea do you drink most often?
(More than 1 option can be chosen)

☐ Black tea (t ex Earl Grey, Sun Tea, Yellow label)
☐ Green tea
☐ Red tea (rooibos)
☐ Herbal tea (such as chamomile)
☐ Other tea
☐ I don't know
☐ No comment

M6a What do you have in your tea?

Yes(1) No(0)

(More than 1 option can be chosen)

☐ Milk, cream
☐ Sugar, honey
☐ Sweetener
☐ Nothing
☐ I don't know
☐ No comment

M7 For soda (not cola), cider, table drink and lemonade select the cup size that you usually drink:

☐ 33cl (1)
☐ 50cl (2)
☐ 1,5l (3)
☐ I do not drink these types of beverages (4)
(Continue to M8)

M7a Fill in either "per day" or "per a week" for which best meets your intake of soda (not cola), cider, table drink and lemonade juice

On average over the last 3 months

	Times per day	Times per week
soda, cider, table drink and lemonade / (Läsk, cider, måltids-dryck, saft)	☐ 1 (1) ☐ 2 (2) ☐ 3 (3) ☐ 4 (4) ☐ 5+ (5)	☐ 1-2 (6) ☐ 3-4 (7) ☐ 5-6 (8)

☐ I don't know (998)
☐ No comment (999)

☐ Other, specify (9):_____

M8 If you drink cola drinks (eg Coca-Cola, Pepsi, etc.) fill in either "per day" or "per a week", whichever best meets your intake of cola drinks (eg Coca-Cola, Pepsi, etc.)..

On average over the last 3 months

	Times per day	Times per week
Cola	☐ 1 (1) ☐ 2 (2) ☐ 3 (3) ☐ 4 (4) ☐ 5+ (5)	☐ 1-2 (6) ☐ 3-4 (7) ☐ 5-6 (8)

☐ I don't know (998)
☐ No comment (999)

☐ Other, specify (9):_____

M9 Sports Drinks: Select the size that is the amount you usually drink

☐ about 250 ml (1)
☐ about 60 ml (2)
☐ other, specify (3): _____
☐ Never drink sports drink (4)(Continue to M10)

M9a Fill in either "per day" or "per a week", that which best meets your intake..

On average over the last 3 months

	Times per day	Times per week
Sports Drink	☐ 1 (1) ☐ 2 (2) ☐ 3 (3) ☐ 4 (4) ☐ 5+ (5)	☐ 1-2 (6) ☐ 3-4 (7) ☐ 5-6 (8)

☐ I don't know (998)
☐ No comment (999)

☐ Other, specify (9):

_____

M10 If you drink energy drinks, select the volume that you usually drink

☐ about 25 cl (1)
☐ about 50 cl (2)
☐ other, specify (3): _____
☐ I never drink engry drinks (4) (Continue to M11)

M10a Fill in either "per day" or "per a week", that which best meets your intake.

On average over the last 3 months

	Times per day	Times per week
Energy Drink	☐ 1 (1) ☐ 2 (2) ☐ 3 (3) ☐ 4 (4) ☐ 5+ (5)	☐ 1-2 (6) ☐ 3-4 (7) ☐ 5-6 (8)

☐ I don't know (998)
☐ No comment (999)

☐ Other, specify (9):

_____

M11 How often do you eat chocolate?

Fill in either "per day" or "per a week", that which best meets your intake.

On average over the last 3 months

	Times per day	Times per week
Choklad	☐ 1 (1) ☐ 2 (2) ☐ 3 (3) ☐ 4 (4) ☐ 5+ (5)	☐ 1-2 (6) ☐ 3-4 (7) ☐ 5-6 (8)

☐ Other, speficy (9):

_____

☐ I do not each chocolate (10) (continue to M12)

M11a How much chocolate do you eat normally a time? Yes(1) No(0)

1 large chocolate bar corresponds to 200 g. 1 snickers or daim corresponds to 50 g. 1 praline equivalent to 10 g.

☐ Less than 25 g (1)
☐ 25-49 g (2)
☐ 50-99 g (3)
☐ 100-199 g (4)
☐ 200g or more (5)
☐ I don't know/No comment (999)

M11b Which of the following types of chocolate do you eat normally? Yes(1) No(0)

(More than 1 option can be chosen)

☐ Snickers, Daim, Japp and similar
☐ Milk chocolate
☐ Dark chocolate (about 70%)
☐ Dark chocolate (about 85%)
☐ White chocolate
☐ I don't know/No comment

M12 Do you take vitamins, minerals or other supplements?

☐ Yes, regularly (1)
☐ Yes, sometimes (2)
☐ No (3) (Continue to M13)
☐ I don't know (998)
☐ No comment (999)

M12a For those supplements you have taken in the last 3 months, select from the list how often you take them.

On average over the last 3 months

Multivitamins and minerals	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Folic acid	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Iron	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
A-vitamin	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
B-vitamin	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
C-vitamin	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
D-vitamin	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
E-vitamin	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Calcium	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Zinc	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Magnesium	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Vitamin B-complex	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Beta-carotene	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Q10	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Antioxidanter (e.g Bio-Anti-oxidant orAntioxidant Plus)	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Selenium	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)
Other suppliments. Specify:	☐ Every day (1) ☐ A few times per week (2) ☐ A few times per month (3) ☐ In periods (4)

M12b Iron

Enter the daily amount of iron in grams

_____

OR Enter the weekly amount of iron in grams

M12c Folic Acid

Enter the daily amount of folic acid in grams

OR Enter the weekly amount of folic acid in grams

M12d zinc

Enter the daily amount of zinc in grams

OR Enter the weekly amount of zinc in grams

M13 Have you used any of the following products on a weekly basis for the last 3 months? Yes(1) No(0)

(More than 1 option can be chosen)

- ☐ Chinese herbs
- ☐ Peruvian "ginseng" capsules (such as maca, Lepidium meyenii)
- ☐ Royal jelly capsules
- ☐ Omega-3 (for example ACO Omega 3, Omega Max, Friggs Eskimo 3, Pikasol)
- ☐ Ginkgo Biloba (for example Bio-Biloba, Ginkomax, Gink-Yo, Proginko, Seredrin)
- ☐ Echinacea (for example Echinagard, Echinaforce, Esberitox)
- ☐ Ginseng (for example Gericomplex, Ginsana)
- ☐ Kan Jang
- ☐ Chi San
- ☐ Rose root
- ☐ Valerian root (for example Valeriana forte, Valeriena)
- ☐ St John's Wort (for example Esbericum, Movina, Neurokan)
- ☐ Lactobacilli
- ☐ Garlic products (for example Kwai, Kyolic)
- ☐ No, none of the above (Continue to M14)
- ☐ I don't know
- ☐ No comment

M13a How often do you take the products you have ticked in question M13?

Indicate for each product ticked above.

- ☐ Every day (1)
- ☐ A few times per week (2)
- ☐ A few times per month (3)
- ☐ In periods (4)

M14 Have you received any of the following treatments in the last 3 months? Yes(1) No(0)

(More than 1 option can be chosen)

- ☐ Physiotherapy
- ☐ water aerobics
- ☐ professional massage
- ☐ chiropractic treatment
- ☐ Naprapathic therapy
- ☐ Acupunture
- ☐ reflexology
- ☐ homeopathy, chinese medicine
- ☐ Anthroposophic medicine
- ☐ healing, crystal therapy
- ☐ No, none of the above
- ☐ Another treatment

specify:_____

M14a How often did you get the treatment you checked in question M14 in the last 3 months?

- ☐ A few times per month (2)
- ☐ A few times per week (3)
- ☐ A few times per year (4)

Indicate for each treatment ticked above.

FS1 Mark your average daily physical activity at work / during the daytime in the last 14 days:

- ☐ Sit / lie (1)
- ☐ sit / stand (2)
- ☐ sit / stand / walk partially (3)
- ☐ stand / walk mostly (4)
- ☐ hard labour (5)
- ☐ I don't know (998)
- ☐ No comment (999)

FS2 Mark your average daily physical activity in your leisure time / in the evening in the last 14 days:

- ☐ sit / stand (1)
- ☐ light activity (walking 30 min per day) (2)
- ☐ moderate activity (cycling, cleaning up more than 30 minute per day) (3)
- ☐ sports/cycling/physical labour more than 60 minutes per day (4)
- ☐ I don't know (998)
- ☐ No comment (999)

FS3 How much time (in hours) per week on average have you in the last 3 months dedicated to sports / exercise / sports / outdoor activities?

	0 (1)	0-1 (2)	2 (3)	3 (4)	4 (5)	5 or more hours(6)
Every day exercise (e.g. making beds, washing dishes, playing musical instruments, knitting/crochetting)						
Light exercise (e.g. painting/wallpapering, easy walking, riding, golf, swimming, ping-pong)						
Strenuous exercise (e.g. jogging, dancing, tennis, scuba						

	0 (1)	0-1 (2)	2 (3)	3 (4)	4 (5)	5 or more hours(6)
diving, skating, skiing)						
Hard training or competition (e.g. fast running more than 10 mintes, martial arts, orienteering, squash, rock climbing)						

FS4 When do you usually get up and go to bed? weekday/work days
I go to bed (turn off the light) at _____
And wake up at (1-24) _____

Holiday/ non-work day

I go to bed (turn off the light) at _____
And wake up at _____

MOB1 Do you use a mobile phone at least one time per week?

☐ Yes (1)
☐ No (0) (Continue to R1)
☐ I don't know (998)
☐ No comment (999)

MOB2 How many years have you used a mobile phone at least once a week?

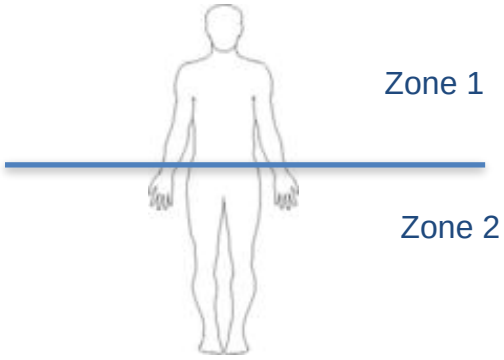
☐ Less than 2 years (1)
☐ 2 to 5 years (2)
☐ More than 5 years (3)
☐ I have never used a mobile phone at least once a week (4)

MOB3 How much time per week, currently, do you use your cell phone to make calls with?

☐ Less than 5 minutes (1)
☐ 5 to 29 minutes (2)
☐ 30 to 59 minutes (3)
☐ 1 to 3 hours (4)
☐ 4 to 6 hours (5)
☐ 6 hours or more (6)

MOB4 If you keep your mobile phone on your person, mark which zone where you keep it closest. If you typically carry cell phone in a purse, select which part of the body your purse is held closest to.

☐ Zone 1 (1)
☐ Zone 2 (2)
☐ I do not carry my mobile phone near my body (3)



The diagram is divided into zone 1L above the navel; and Zone 2: below the navel.

R1 Have you smoked regularly for more than 1 year or a total of more than 100 cigarettes in your lifetime?

☐ Yes (1)
☐ No (0)(continue to SN1)
☐ I don't know (998)
☐ No comment (999)

R2 How old were you when you started smoking?

Start age: _____

50 or more yers (43)

R3 Estimate how much you smoked on average per day from the time you started smoking?

☐ Less than 1 cigarette per day (1)
☐ 1-5 cigarettes per day (2)
☐ 6-10 cigarettes per day (3)
☐ 11-20 cigarettes per day (4)
☐ More than 20 cigarettes per day (5)
☐ I don't know (998)
☐ No comment (999)

R4 Estimate how long you smoked altogether during your lifetime. If you stopped and started again, add together the time.

☐ All together less than 1 year.(1)
☐ All together 1 to 2 years (2)
☐ All together 3 to 5 years (3)
☐ All together 5 to 10 years (4)

☐ All together more than 10 years (5)
☐ I don't know (998)
☐ No comment (999)

R5 Do you smoke daily now?

☐ Yes (1)(Continue to R6)
☐ No (0)
☐ Vill ej svara (999)

R5a When did you stop smoking?

☐ Less than 1 month ago (1)
☐ 1- 3 months ago (2)
☐ 4-12 months ago (3)
☐ More than 1 year ago (4)
☐ I don't know (998)
☐ No comment (999)

R6 How much do you smoke on average per day now?

☐ Less than 1 cigarette per day (1)
☐ 1-5 cigarettes per day (2)
☐ 6-10 cigarettes per day (3)
☐ 11-20 cigarettes per day (4)
☐ More than 20 cigarettes per day (5)
☐ I don't know (998)
☐ No comment (999)

SN1 Do you use snuff currently?

☐ Yes (1)
☐ No (0) (Continue to ALK1)
☐ No comment (999)

SN2 How many cans per week?

Enter the number of cans (1-30)

_____

SN3 How long have you used snuff?

Enter the number of years 0-12, more than 12 (13)

_____

Enter number of months 0-12, more than 12 (13)

_____

ALK1 Select the alcoholic beverages you drank at least 1 time a month last 3 months:

Yes(1) No(0)

(More than 1 option can be chosen)

☐ Folköl (Class II, 2.25 – 3.5%) (1)
☐ Starköl (Class III, more than 3.6%) (2)
☐ Wine (Red or white) (3)
☐ Fortified wine (eg sherry, port, madeira, vermouth, Campari, etc) (4)
☐ Spiritis / hard liquor (5)
☐ I drink alcoholic beverages less than than 1 time per month or not at all (6)
☐ I do not drink alcohol (Continue to HAR1)
☐ I don't know
☐ No comment

ALK2 How much of each beverage do you usually drink? Enter either the number of drinks per week or per month.

	Per week	Per month	I don't know	No comment
Folköl (Class II, 2.25 – 3.5%)				
Starköl (Class III, more than 3.6%)				
Wine (Red or white)				
Fortified wine (eg sherry, port, madeira, vermouth, Campari, etc)				
Spirits / hard liquor				
I drink alcoholic beverages less than than 1 time per month or not at all				

HAR1 Do you dye or highlight your hair?

☐ Yes, I dye my hair (1)
☐ Yes, I hightlight my hair (2)
☐ Yes, I both dye and highlight my hair (3)
☐ No, neither (4) (Continue to BAD1)
☐ I don't know/No comment (999)

HAR2 Do you use: Yes(1) No(0)

(More than 1 option can be chosen)

☐ Permanent colour
☐ Toner
☐ Henna
☐ Other, specify:_____

HAR3 If you dye your hair, how often do you do it?

☐ 1 to 2 times per month, or more often (1)
☐ 1 time every 2 months (2)
☐ 1-2 times per year (3)
☐ 1-3 times per year or less (4)
☐ Other (5)

HAR4 If you highlight your hair, how often do you do it?

☐ 1 to 2 times per month, or more often (1)
☐ 1 time every 2 months (2)
☐ 1-2 times per year (3)
☐ 1-3 times per year or less (4)
☐ Other (5)

HAR5 What hair coloring products do you use?

Yes(1) No(0)

(More than 1 option can be chosen)

☐ Loreal (for example Casting, Excellence Creme)
☐ Schwarzkopf (for example Soyance, Brilliance, Essential colors, Country colors)
☐ Garnier (for example Nutrisse, Herba shine, Nordic essentials)
☐ Wella (for example Viva)
☐ Poly Palette
☐ Jane Mood
☐ Scandinavian Care
☐ Syoss
☐ Henna
☐ It's the hair stylist's choice
☐ Other, specify: _____

HAR6 When did you colour your hair last?

☐ 1 month ago or less (1)
☐ 2-4 months ago (2)
☐ 5-12 months ago (3)
☐ More than 1 year ago (4)
☐ I don't know (998)
☐ No comment (999)

BAD1 How often have you taken a sauna in the last three months?

☐ 1 time per week (1)
☐ 2-3 times per month (2)
☐ 1 time per month (3)
☐ Rarely (4)
☐ Never (5)
☐ I don't know (998)
☐ No comment (999)

BAD2 How often did you take a hot bath during the last three months?

☐ 1 time per week (1)
☐ 2-3 times per month (2)
☐ 1 time per month (3)
☐ Rarely (4)
☐ Never (5)
☐ I don't know (998)
☐ No comment (999)

SOL1 During the past year, how often have go tanning per week (including summer and / or winter)?

☐ 1-5 times (1)
☐ 6-15 times (2)
☐ 16-30 times (3)
☐ More than 30 times (4)
☐ I do not go tanning (5) (continue to last question)
☐ I don't know (998)
☐ No comment (999)

SOL2 How long did you tan each time?

☐ 5-15 minute (1)
☐ 16-30 minute (2)
☐ 30 minutes - 1 hour (3)
☐ 1-3 hour (4)
☐ More than 3 hours (5)

FINAL QUESTIONS

AVS1 We now want to ask a few questions about how you felt about completing the survey.

Select the option that best matches how you experienced the questionnaire

	Not at all(1)	Disagree (2)	Neither agreeor disagree (3)	Mostly agree (4)	Completely agree (5)
The questionnaire was easy to fill in					
The questions were relevant					

AVS2 If you were to give an overall grade for the survey, based on easiness for the user, instructions and how the questions were asked, how would you rate the questionnaire? Enter your rating on a scale from 1 to 5 where 1 is worst and 5 is best.

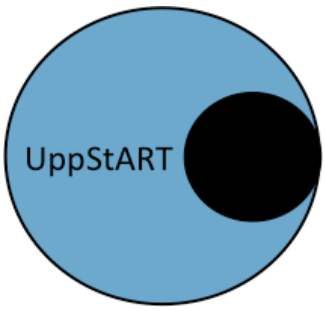
	1	2	3	4	5
User rating					

AVS3 Did you receive assistance in filling out the questionnaire?

☐ Yes (1)
☐ No (0)

If you have received help to answer the questionnaire indicate who has helped you!

AVS4 If you have any other comments about the survey, please write them in the box below.



THANK YOU SO MUCH FOR YOUR PARTICIPATION!