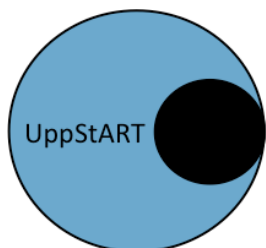


UppStART:

Uppsala-Stockholm Assisted Reproductive Technique study

Web Questionnaire 2



It takes a few minutes and can provide enormous opportunities for research to improve conditions for IVF treatment.

www.ki.se/meb/uppstart

Ett samarbete mellan



**Karolinska
Institutet**



UPPSALA
UNIVERSITET

Fertilitetsenheten,
Huddinge sjukhus

KAROLINSKA
Universitetssjukhuset



IVF-kliniken®



Carl von Linné Kliniken



AKADEMISKA
SJUKHUSET

Finansierat utav:

EU- FP7-HEALTH-2010 collaborative project on Integrated research on Developmental determinants of Aging and Longevity

Strategiska forskningsprogrammet I Epidemiologi (Young Scholar Awards)

Vetenskapsrådet

Axel and Signe Lagermans Stiftelse

Thank you for participating in the UppSTART study and for that you have filled in the first online survey. The purpose of this online survey is to study whether, and if so how, your lifestyle habits have changed since you and / or your partner started treatment for infertility. At the end of the questionnaire is your opportunity to provide your own comments. It takes about 10-30 minutes to complete the survey (depending on your answers).

You respond by marking the answer you think is closest, or write your answers in the specified boxes. When you are finished with all the questions we ask you to submit your answers in the enclosed reply envelope.

You are welcome to call our research nurse Radja Dawoud on 08-524 8232 4 if there is anything you wonder about

personnummer:

(ÅÅÅÅMMDDXXXX)

You are a:

- Man
- Woman

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	No	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, specificity: _____				
No health problems				

Cancer: Woman

H7 Please indicate which body part with cancer or cancer type you have:

(More than 1 option can be chosen)

- 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
- No

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

Cancer: Man

H8 Specify which body part with cancer or cancer type you have:

(More than 1 option can be chosen)

- 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:_____

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

- Yes
- No

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

H9 Has a doctor diagnosed you with asthma?

- Yes
- No
- I don't know
- No comment

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

- Yes
- No
- I don't know
- No comment

H8c Has a doctor made the diagnosis of hayfever or other allergic rhinitis?

- Yes
- No
- I don't know
- No comment

H9d Upplever du att du har någon av följande allergier?

(Fler alternativ kan kryssas)

Do you feel that you have any of the following allergies?

(More than 1 option can be chosen)

- Pollen
- Fur
- Mites
- Bee or wasp
- Contact allergy
- No, none of the above
- I don't know
- No comment

H10 Har du regelbundet tagit några värktabletter de senaste 3 månaderna?

- Alvedon, panodil
- Ipren, ibuprofen
- Voltaren, diclofenac

- Naproxen
- Citodon
- Treo, acetylsalisyra, trombyl
- Other, specify: (7)_____

H11 Do you take any other medicine / drug currently?

H12 Since beginning IVF treatment, have you felt any anxiety / depression?

- I am not anxious or depressed
- I am or have been anxious or depressed to some extent
- I am or have been highly anxious or depressed
- I don't know
- No comment
- No change since IVF treatment started

Q13 Have you had trouble sleeping?

- yes
- No
- I don't know
- No comment

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

	No change since the IVF treatment was initiated	Rarely/ Never	Sometimes	Often	I don't know	No comment
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?						

The next questions are about your experiences, feelings or thoughts then IVF treatment started. For each question, you must 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.

H13 How often have you:

	No change since last	Never	Rarely	Quite often	Very often	I don't know/ no comment
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?						

	No change since last	Never	Rarely	Quite often	Very often	I don't know/ no comment
Felt that the problems have become so numerous that you could not overcome them?						

Consider how you have felt since the IVF treatment started and answer the questions below concerning thoughts and feelings about your and your partner's 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	Pretty much	A little	Not at all
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				

	Very much	Pretty much	A little	Not at all
Your financial condition				

Expectations of fertility treatments

COMP3 I have sought investigations and treatment. . .

	Very important	Less important	Not important
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..

	Very important	Less important	Not important
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			

	Very important	Less important	Not important
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	Less important	Not important
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	Maybe	No	I don't know
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	Sometimes	Often	Very often
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	Sometimes	Often	Very often
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
- Yes, sometimes
- No, never

COMP10 Do you talk to others about. . .

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

THESE QUESTIONS CONCERN YOUR HABITS SINCE YOUR IVF TREATMENT BEGAN

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

Breakfast

- Every day
- Several times per week
- One time per week
- Rarely or never
- No change since IVF treatment started

Lunch

- Every day
- Several times per week
- One time per week
- Rarely or never
- No change since IVF treatment started

Dinner

- Every day
- Several times per week
- One time per week
- Rarely or never
- No change since IVF treatment started

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

- 4 times per day or more
- 3 times per day
- 1-2 times per day
- A few times per week
- Rarely or never
- No change since IVF treatment started
- I don't know
- No comment

M4 Enter the quantity and how often you drank the following beverages (coffee, tea and chocolate drink) on average since IVF treatment started.

Select the cup size representing the amount you usually drink

Coffee

- about 1 dl
- about 2 dl
- about 3 dl
- I do not drink coffee

Te

- about 1 dl
- about 2 dl
- about 3 dl
- I do not drink tea

Chokladdyck

- about 1 dl
- about 2 dl
- about 3 dl
- I do not drink chockladdyck

No change since IVF treatment began ([Go to question M7](#))

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

	Times per day	Times per week
Kaffe	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6
Te	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6
Chokladdyck	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6

M5 If you have indicated that you drink coffee, what type of coffee do you drink most often?

(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?

(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?

(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
- 50cl
- 1,5l
- Another amount: _____
- I do not drink these types of beverages ([Go to question M8](#))
- No change since IVF treatment started ([Go to question 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)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6

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	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6

- I do not drink cola (Continue to M9)
- No change since IVF treatment started (Continue to M9)

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

- about 250 ml
- about 60 ml
- other, specify: _____
- Never drink sports drink (Continue to M10)
- No change since IVF treatment started (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	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6

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

- about 25 cl
- about 50 cl
- other, specify: _____
- I never drink enrgy drinks (Continue to M11)
- No change since IVF treatment started (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	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6

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

	Times per day	Times per week
Choklad	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6

- Other, speficy: _____
- I do not each chocolate (continue to M12)
- No change since IVF treatment started (continue to M12)

M11a How much chocolate do you eat normally a time?

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
- 25-49 g
- 50-99 g
- 100-199 g
- More than 200g
- I don't know
- No comment

M11b Which of the following types of chocolate do you eat normally?

(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
- Yes, sometimes
- No (Continue to M13)
- No change since IVF treatment started (Continue to M13)

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	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Folic acid	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Iron	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
A-vitamin	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
B-vitamin	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
C-vitamin	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
D-vitamin	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
E-vitamin	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Calcium	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Zinc	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Magnesium	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Vitamin B-complex	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods

Beta-carotene	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Q10	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Antioxidanter (e.g Bio-Antioxidant or Antioxidant Plus)	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Selenium	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods
Other suppliments. Specify:	<input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> In periods

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

M13 Have you used any of the following products on a weekly basis since the IVF treatment began?

(Fler alternativ kan kryssas)

(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, Valeriana)
- 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
- No change since IVF treatment started (Continue to M14)

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

- Every day
- A few times per week
- A few times per month
- In periods

Indicate for each product ticked above:

M14 Have you received any of the following treatments since IVF treatment began?

(More than 1 option can be chosen)

- Physiotherapy
- water aerobics
- professional massage
- chiropractic treatment
- Naprapathic therapy
- Acupuncture
- reflexology
- homeopathy, chinese medicine
- Anthroposophic medicine
- healing, crystal therapy
- No, none of the above (Go to Q)

M14a How often did you get the treatment you checked in question M14 since the IVF treatment began?

- A few times
- A few times per month
- A few times per week

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
- sit / stand
- sit / stand / walk partially
- stand / walk mostly
- hard labour
- No change since I last completed this survey
- No comment

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

- sit / stand
- light activity (walking 30 min per day)
- moderate activity (cycling, cleaning up more than 30 minute per day)

English translation June 2014

- sports/cycling/physical labour more than 60 minutes per day
- No change since IVF treatment began
- no comment

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

- No change since IVF treatment began ([Go to FS1](#))

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

SÖMN

FS4 When do you usually get up and go to bed vardag/arbetsdag

weekday/work days

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

And wake up at _____

weekend/ non-work day

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

And wake up at _____

FS4 How long do you sleep at night on a weekday / workday?

- No change since IVF treatment started
- Enter the number of hours _____

FS5 FS5 How long do you sleep at night on a weekend day / non-work day??

- No change since IVF treatment started
- Enter the number of hours _____

MOB1 Do you use a mobile phone at least one time per week since IVF treatment began?

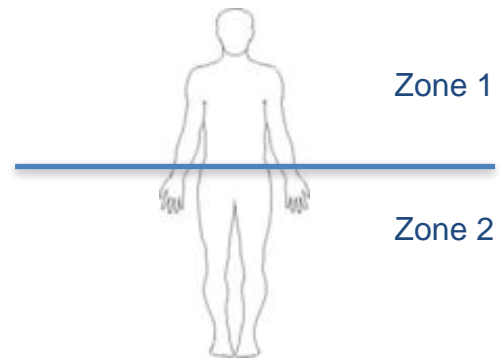
- Yes
- No (Continue to R1)
- No change since IVF treatment started (Go to question R1)
- I don't know
- No comment

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

- Less than 5 minutes
- 5 to 29 minutes
- 30 to 59 minutes
- 1 to 3 hours
- 4 to 6 hours
- 6 hours or more

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
- Zone 2
- I do not carry my mobile phone near my body



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

The following section applies your alcohol and tobacco habits since your IVF treatment began. If your tobacco habits have not changed since you last responded to the survey tick below the "no change since last time."

R1 Have you smoked since your IVF treatment began?

- Yes
- No (continue to SN1)
- No change since IVF treatment started ([Go to SN1](#))
- I don't know
- No comment

R3 Estimate how much you smok on average per day since IVF treatment started?

- Less than 1 cigarette per day
- 1-5 cigarettes per day
- 6-10 cigarettes per day
- 11-20 cigarettes per day
- More than 20 cigarettes per day
- I don't know
- No comment

SN1 Have you used snuff since your IVF treatment began?

- Yes
- No (Continue to ALK1)
- No comment

SN1 Har du snusat sedan din IVF behandling inleddes?

- Ja
- Nej ([Go to question ALK1](#))
- No change since IVF treatment started ([Go to question ALK1](#))
- Vill ej svara

SN2 How many cans per week?

Enter the number of cans

ALK1 Select the alcoholic beverages you drank at least 1 time per week or per month, since your IVF treatment began:

(Fler alternativ kan kryssas)

(More than 1 option can be chosen)

- 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)
- Spiritis / hard liquor
- I drink alcoholic beverages less than than 1 time per month or not at all
- I do not drink alcohol (Continue to HAR1)
- No change since IVF treatment started (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 Have you coloured or highlighted your hair since your IVF treatment began?

- Yes, I dye my hair
- Yes, I hightlight my hair
- Yes, I both dye and highlight my hair
- No, neither (Continue to BAD1)
- No change since IVF treatment started (Continue to BAD1)
- I don't know/No comment

HAR2 Did you use:

(More than 1 option can be chosen)

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

HAR5 What hair coloring products do you use?

(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
- 2-4 months ago
- 5-12 months ago
- More than 1 year ago
- I don't know
- No comment

BAD1 How often have you taken a sauna in the since IVF treatment began?

- 1 time per week
- 2-3 times per month
- 1 time per month
- Rarely
- Never
- No change since IVF treatment started
- I don't know
- No comment

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

- 1 time per week
- 2-3 times per month
- 1 time per month
- Rarely
- Never
- No change since IVF treatment started
- I don't know
- No comment

SOL1 How many times have you been sunbathing per week since your IVF treatment began?

- 1-5 times
- 6-15 times
- 16-30 times
- More than 30 times
- I do not go tanning (continue to last question)
- No change since IVF treatment started (continue to last question)
- I don't know
- No comment

SOL2 How long did you tan each time?

- 5-15 minute
- 16-30 minute
- 30 minutes - 1 hour
- 1-3 hour
- More than 3 hours

FINAL QUESTIONS

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.

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					

AVS5 Please explain your rating:

AVS3 Did you receive assistance in filling out the questionnaire?

- Yes
- No

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!