



Tromsø



- part of The Tromsø Study



FILL OUT THE FORM IN THIS WAY:

The form would be read by machine, it is therefore important that you tick appropriately:

Correct

Wrong

Wrong

If you tick the wrong box, correct by filling the box like this

Write the numbers clearly 1 2 3 4 5 6 7 8 9 0

7 | 4 Correct

7 | 4 Wrong

Use only black or blue pen, do not use pencil or felt tip pen

1. DESCRIPTION OF YOUR HEALTH STATUS

Mark the statement that best fits your state of health today by ticking once in one of the boxes under each of the five groups below:

1.6 To allow you to show us how good or bad your state of health is we have made a scale (almost like a thermometer) where the best state of health you can imagine is marked 100 and the worst 0. We ask you to show your state of health by drawing a line from the box below to the point on the scale that best fits your state of health.

1.01 Mobility

- I have no problems in walking about
- I have little problems in walking about
- I am confined to bed

1.02 Self-care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

1.03 Usual activities (e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

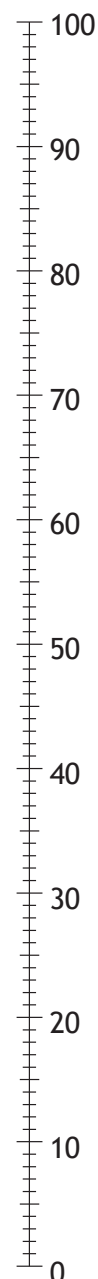
1.04 Pain and discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

1.05 Anxiety and depression

- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

Best imaginable health state



Best imaginable health state

Your own health state today

2. CHILDHOOD/YOUTH AND AFFILIATION

2.01 **Where did you live at the age of 1 year?**

- In Tromsø (with present municipal borders)
- In Troms, but not Tromsø
- In Finnmark
- In Nordland
- Another place in Norway
- Abroad

2.02 **How was your family's financial situation during your childhood?**

- Very good
- Good
- Difficult
- Very difficult

2.03 **What is the importance of religion in your life?**

- Very important
- Somewhat important
- Not important

2.07 **What was/is the highest completed education for your parents and your spouse/cohabitant?**
(Tick once for each column)

	Mother	Father	Spouse/ cohabitant
Primary 7-10 years, 1-2 years secondary school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocational school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High secondary school (A level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
College or university (less than 4 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
College or university (4 years or more)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.04 **What do you consider yourself as? (Tick for one or more alternatives)**

- Norwegian
- Sami ethnicity
- Kven/Finnish
- Another ethnicity

2.05 **How many siblings and children do you have/have you had?**

Number of siblings

Number of children

2.06 **Is your mother alive?**

- Yes No

If NO: her age when she died

Is your father alive?

- Yes No

If NO: his age when he died

3. WELL BEING AND LIVING CONDITIONS

3.01 Below are three statements about satisfaction with life as a whole. Then there are two statements about views on your own health. Show how you agree or disagree with each of the statements by ticking in the box for the number you think fits best for you. (tick once for each statement)

	Completely disagree	1	2	3	4	5	6	7	Completely agree
In most ways my life is close to my ideal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
My life conditions are excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I am satisfied with my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I have a positive view of my future health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
By living healthy, I can prevent serious diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3.02 Below are four statements concerning your current job conditions, or if you are not working now, the last job you had. (Tick once for each statement)

	Completely disagree	1	2	3	4	5	6	7	Completely agree
My work is tiring, physically or mentally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I have sufficient influence on when and how my work should be done	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I am being bullied or harassed at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I am being treated fairly at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3.03 I consider my occupation to have the following social status in the society (if you are not currently employed, think about your latest occupation)

- Very high status
- Fairly high status
- Middle status
- Fairly low status
- Very low status

3.04 Have you over a long period experienced any of the following? (Tick one or more for each line)

	No	Yes, as a child	Yes, as adult	Yes, last year
Been tormented, or threatened with violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been beaten, kicked at or victim of other types of violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Someone in your close family have used alcohol or drugs in such a way that it has caused you worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have experienced anything of the above, how much are you affected by that now?

- Not affected Affected to some extent Affected to a large extent

4. ILLNESS AND WORRIES

4.01 **Have you during the last month experienced any illness or injury?**

Yes No

If YES: have you during the same period?
(Tick once for each line)

	Yes	No
Been to a general practitioner	<input type="checkbox"/>	<input type="checkbox"/>
Been to a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>
Been to emergency department	<input type="checkbox"/>	<input type="checkbox"/>
Been admitted to a hospital	<input type="checkbox"/>	<input type="checkbox"/>
Been to an alternative practitioner (chiropractor, homeopath or similar)	<input type="checkbox"/>	<input type="checkbox"/>

4.02 **Have you noticed sudden changes in your pulse or heart rhythm in the last year?**

Yes No

4.03 **Do you become breathless in the following situations? (tick once for each question)**

	Yes	No
When you walk rapidly on level ground or up a moderate slope	<input type="checkbox"/>	<input type="checkbox"/>
When you walk calmly on level ground	<input type="checkbox"/>	<input type="checkbox"/>
While you are washing or dressing	<input type="checkbox"/>	<input type="checkbox"/>
At rest	<input type="checkbox"/>	<input type="checkbox"/>

4.04 **Do you cough about daily for some periods of the year?**

Yes No

If YES: Is the cough usually productive?

Yes No

Have you had this kind of cough for as long as 3 months in each of the last two years?

Yes No

4.05 **How often do you suffer from sleeplessness? (tick once)**

Never, or just a few times a year
 1-3 times a month
 Approximately once a week
 More than once a week

If you suffer from sleeplessness monthly or more often, what time of the year does it affect you most? (Put one or more ticks)

No special time
 Polar night time
 Midnight sun time
 Spring and autumn

4.06 **Have you had difficulty sleeping during the past couple of weeks?**

Not at all
 No more than usual
 Rather more than usual
 Much more than usual

4.07 **Have you during the last two weeks felt unhappy and depressed?**

Not at all
 No more than usual
 Rather more than usual
 Much more than usual

4.08 **Have you during the last two weeks felt unable to cope with your difficulties?**

Not at all
 No more than usual
 Rather more than usual
 Much more than usual

4.09 **Below, please answer a few questions about your memory: (tick once for each question)**

	Yes	No
Do you think that your memory has declined?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often forget where you have placed your things?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulties finding common words in a conversation?	<input type="checkbox"/>	<input type="checkbox"/>
Have you problems performing daily tasks you used to master?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been examined for memory problems?	<input type="checkbox"/>	<input type="checkbox"/>

If YES to at least one of the first four questions above: Is this a problem in your daily life?

Yes No

4.10 Have you during the last last year suffered from pain and/or stiffness in muscles or joints in your neck/shoulders lasting for at least 3 consecutive months?
(tick once for each line)

	No	A little	A lot
Neck, shoulder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms, hands.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper part of the back....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The lumbar region.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips, leg, feet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other places.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.11 Have you suffered from pain and/or stiffness in muscles or joints during the last 4 weeks

	No	A little	A lot
Neck, shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms, hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper part of the back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The lumbar region	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips, leg, feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.12 Have you ever had:

	Yes	No	Age last time
Fracture in the wrist/underarm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hip fracture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

4.13 Have you been diagnosed with arthrosis by a doctor?

Yes No

4.14 Do you have or have you ever had some of the following:

	Never	Little	Much
Nickel allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pollen allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.15 Have you ever experienced infertility for more than 1 year?

Yes No

If Yes: was it due to:

	Yes	No	Do not know
A condition concerning you?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A condition concerning your partner?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.16 To which degree have you had the following complaints during the last 12 months?

	Never	Little	Much
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/regurgitation....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alternating diarrhoea and constipation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloated stomach.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.17 If you have had abdominal pain or discomfort during the last year:

	Yes	No
Was it located in your upper stomach?.....	<input type="checkbox"/>	<input type="checkbox"/>
Were you bothered as often as once a week or more during the last 3 months?...	<input type="checkbox"/>	<input type="checkbox"/>
Became better after bowel movement?...	<input type="checkbox"/>	<input type="checkbox"/>
Are the symptoms related to more frequent or rare bowel movements than normally?	<input type="checkbox"/>	<input type="checkbox"/>
Are the symptoms related to more loose or hard stool than normally?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do the symptoms appear after a meal? ...	<input type="checkbox"/>	<input type="checkbox"/>

4.18 Have you ever had:

	Yes	No	Age last time
Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Ulcer surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

4.19 For women: Have you ever had a miscarriage?

Yes No Do not know
If Yes: number of times

4.20 For men: Have your partner ever had a miscarriage?

Yes No Do not know
If Yes: number of times

4.21 Is your diet gluten-free?

Yes No Do not know

4.22 Have you been diagnosed with Dermatitis Herpetiformis (DH)?

Yes No Do not know

4.23 Have you been diagnosed with coeliac disease, based on a biopsy from your intestine taken in an endoscopy examination?
 Yes No Do not know

4.24 Do you have your natural teeth?
 Yes No

4.25 How many amalgam tooth fillings do you have/have you had?
 0 1-5 6-10 10+

4.26 Have you been suffering from headache the last year?
 Yes No
If No: go to section 5, food habits

4.27 What kind of headache are you suffering from?
 Migraine Other headache

4.28 How many days per month do you suffer from headache?
 Less than one day
 1-6 days
 7-14 days
 More than 14 days

4.29 Is the headache usually:
 (tick one for each line)

	Yes	No
Pounding/pulsatory pain	<input type="checkbox"/>	<input type="checkbox"/>
Pressing/tightening pain	<input type="checkbox"/>	<input type="checkbox"/>
Unilateral pain (<i>right or left</i>)	<input type="checkbox"/>	<input type="checkbox"/>

4.30 What is the intensity of your headache?
 Mild (*do not hinder normal activity*)
 Moderate (*decrease normal activity*)
 Strong (*block normal activity*)

4.31 What is the duration of the headache usually?
 Less than 4 hours
 4 hours - 1 day
 1-3 days
 More than 3 days

4.32 If you suffer from headache, when during the year does it affect you most? (tick one or more)
 No special time
 Polar night time
 Midnight sun time
 Spring and/or Autumn

4.33 Before or during the headache, do you have a transient:

	Yes	No
Visual disturbances? (<i>flickering, blurred vision, flashes of light</i>).....	<input type="checkbox"/>	<input type="checkbox"/>
Unilateral numbness in your face or hand?	<input type="checkbox"/>	<input type="checkbox"/>
Deterioration by moderate physical Activity?	<input type="checkbox"/>	<input type="checkbox"/>
Nausea and/or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>

4.34 Describe how many days you have been away from work or school during the last month due to headache?
 Number of days

5. FOOD HABITS

5.01 How often do you usually eat the following? (tick once for each line)

	0-1 times per month	2-3 times per month	1-3 times per week	More than 3 times per week
Fresh water fish (<i>not farmed</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt water fish (<i>not farmed</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Farmed fish (<i>salmon, trout, char</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuna fish (<i>fresh or canned</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish bread spread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mussels, shells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The brown content in crabs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whale or seal meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pluck (liver/kidney/heart) from reindeer or elk/moose..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pluck (liver/kidney/heart) from ptarmigan/grouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.02 How many time during the year do/did you usually eat the following? (number of times)

	In adulthood	In childhood
Mølje (cod or pollack meat, liver, and roe)(<i>Number of times per year</i>) ...	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Gulls egg (<i>Number of eggs per year</i>)	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Reindeer meat (<i>Number of times per year</i>)	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Local mushroom and wild berries (<i>blueberries/lingonberries/cloudberries</i>) (<i>Number of times per year</i>)	<input style="width: 60px;" type="text"/>	<input style="width: 60px;" type="text"/>

5.03 How many times per month do you eat
canned (tinned) foods (from metal boxes)?

Number

5.04 Do you take vitamins and/or mineral
supplements?

Yes, daily Sometimes Never

5.05 How often do you eat?

	Never	1-3 times per month	1-3 times per week	4-6 times per week	1-2 times per day	3 times per day or more
Dark chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light chocolate/milk chocolate ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate cake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.06 If you eat chocolate, how much do you usually eat each time?

Compared with the size of a Kvikk-Lunsj sjokolade (*a chocolate brand in the market*) and describe how much do you eat in relation to it.

$\frac{1}{4}$	$\frac{1}{2}$	1	$1 \frac{1}{2}$	2	More than 2
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.07 How often do you drink
cocoa/hot chocolate?

	Never	1-3 times per month	1-3 times per week	4-6 times per week	1-2 times per day	3 times per day or more
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. ALCOHOL

6.01 How often have you in the last year:

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Not been able to stop drinking alcohol when you have started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failed to do what was normally expected of you because of drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needed a drink in the morning to get yourself going after a heavy drinking session?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had feeling of guilt or remorse after drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not been unable to remember what happened the night before because of your drinking?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Yes, but not in the last year	Yes, during the last year
6.02 Have you or someone else been injured because of your Drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. WEIGHT

<p>7.01 Have you involuntary lost weight during the last 6 months?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes: how many kilograms? <input style="width: 50px;" type="text"/></p>	<p>7.03 Are you satisfied with your present body weight?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7.02 Estimate your body weight when you were 25 years old:</p> <p>Number of kilograms <input style="width: 80px;" type="text"/></p>	<p>7.04 What weight would you be satisfied with (your "ideal" weight)?</p> <p>Number of kilograms <input style="width: 80px;" type="text"/></p>

8. SOLVENTS

<p>8.01 How many hours per week, do you do the following <u>leisure- or professional activities</u>:</p> <p>Automobile repair/paint, ceramic work, painting/solvents, hair dressing, glazier, electrician. (Put 0 if you do not engage in such leisure or professional activities)</p> <p>Number of hours per week on average: <input style="width: 50px;" type="text"/></p>	<p>8.02 Do you use hair color preparations</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes: How many times per year?.. <input style="width: 50px;" type="text"/></p>
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9. USE OF HEALTH SERVICES

9.01 **Have you ever experienced that disease has been inadequately examined or treated, and that this had serious consequences?**

- Yes, this has happened to me
 Yes, this has happened to a close relative
(child, parents, spouse)
 No

If Yes, where do you think the reason of the problem is? (tick once or more):

- With a general practitioner
 With an emergency medical doctor
 With a private practising specialist
 With a hospital doctor
 With another health personnel
 With an alternative practitioner
 with more than one person due to the failure of procedures and collaboration

9.02 **Have you ever felt persuaded to accept an examination or treatment that you do not want?**

- Yes No

If Yes, do you think this has had unfortunate health-related consequences?

- Yes No

9.03 **Have you ever complained about a treatment you have got?**

- Have never a reason for complaining
 Have considered complaining, but did not do that
 Have complained verbally
 Have complained in writing

9.04 **How long have you had your current general practitioner/other physician?**

- Less than 6 months
 6 to 12 months
 12 to 24 months
 More than 2 years

9.05 **At the last visit to the general practitioner, did the doctor(s) speak to you in a way so you understand them?** Answers to a scale from 0 to 10, where 0 = they were difficult to understand and 10 = they were always easy to understand

- 0 1 2 3 4 5 6 7 8 9 10

9.06 **How would you characterize the treatment or counselling, you got the last time you were with a doctor?** Answer on a scale from 0 to 10, where 0 = very bad treatment, and 10 = very good treatment

- 0 1 2 3 4 5 6 7 8 9 10

9.07 **Do you have during the last 12 months experienced that it has been difficult to be referred to special investigations (like X-ray or similar) or to specialized health service (private practising specialist or at hospital)?**

- Not applicable
 No problem
 Some problems
 Great problems

9.08 **Have you during the last 12 months experienced that it is difficult to be referred to physiotherapist, chiropractor or similar?**

- Not applicable
 No problem
 Some problems
 Great problems

9.09 **All in all, have you experienced that it is difficult or simply to be referred to specialized health services?**

- Not applicable
 Very difficult
 Somehow difficult
 Reasonably easy
 Very easy

9.10 Have you during the last 12 months been to examination or treatment in specialized health service?

Yes No

If Yes, did the doctor(s) speak to you so that you understood them? Answer on a scale from 0 to 10, where 0 = they were difficult to understand and 10 = they were always easy to understand

0 1 2 3 4 5 6 7 8 9 10

9.11 How would you characterize the treatment or advice you got last time you were with a specialist? Answer on a scale from 0 to 10, where 0 = very poor and 10 = very good

0 1 2 3 4 5 6 7 8 9 10

9.12 Have you ever before 2002 undergone an operation in hospital or specialist clinic?

Yes No

9.13 Have you during the last 12 months used herbal medicine, natural means or natural medicines?

Yes No

9.14 Have you during the last 12 months used meditation, yoga, qi gong or thai chi as own treatment?

Yes No

10. USE OF ANTIBIOTICS

10.01 Have you used antibiotics during the last 12 months? (all penicillin-like medicine in the form of tablets, syrups or injections)

Yes No Do not remember

If YES: What did you get the treatment for?

Have you taken many antibiotic treatments, tick for each treatment.

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5	Treatment 6
• Urinary tract infection (<i>bladder infection, cystitis</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Respiratory tract infection (<i>ear, sinus, throat or lung infection, bronchitis</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment duration: number of days						

How did you acquire the antibiotics for treatment?

Have you acquired many treatments, tick for each one.

With prescription from a doctor/dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Without contacting a doctor/without prescription:						
• Purchase from a pharmacy abroad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Purchase over the internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Remnants from earlier treatment at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• From family/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Other ways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.02 Do you have antibiotics at home?

Yes No

If YES: is this after an agreement with your doctor for treatment of chronic or frequently recurring disease?

Yes No

If No: how did you acquire this antibiotic? (Multiple ticks are possible)

- Purchased from a pharmacy abroad ...
- Purchased over the internet
- Remnants from earlier treatment
- From family/friends
- Other ways

10.03 Would you consider using antibiotics without consulting your doctor?

Yes No

If YES: which conditions would you treat in such situation? (multiple ticks are possible)

- Common cold
- Cough
- Bronchitis
- Sore throat
- Sinusitis
- Fever
- Influenza
- Ear infection
- Diarrhoea
- Urinary tract infection
- Other infections

11. YOUR CIRCADIAN RHYTHM

We will ask you some questions about your sleeping habits

II.01 Have you worked in a shift work schedule during the last 3 months?

Yes No

II.02 Number of days per week which you cannot freely choose when you sleep (e.g. work days)?

0 1 2 3 4 5 6 7

Then I go to bed at

I get ready to fall asleep at

Number of minutes I need to fall asleep

I wake up at

With help of: Alarm clock External stimulus (*noise, family members etc.*) By myself

Number of minutes I need to get up

II.03 Number of days per week which you can freely choose when you sleep (e.g. free days or holidays)

0 1 2 3 4 5 6 7

Then I go to bed at

I get ready to fall asleep at

Number of minutes I need to fall asleep

I wake up at

With help of: Alarm clock External stimulus (*noise, family members etc.*) By myself

Number of minutes I need to get up

12. SKIN AND DERMATOLOGY

12.01 How often do you usually take a shower or a bath? (tick once)

- 2 or more times daily
- 1 time daily
- 4-6 times per week
- 2-3 times per week
- Once a week
- Less than once a week

12.02 How often do you during a day usually wash your hands with soap? (tick once)

- 0 times
- 1-5 times
- 6-10 times
- 11-20 times
- More than 20 times

12.03 Have you ever taken any antibiotics (penicillin and similar medicines) because of a skin disease, for example infected eczema, acne, non-healing leg ulcers, recurrent abscess?

- Yes No

If Yes: How many times in average per year did you take antibiotics during the period you were most affected (tick once)

- 1-2 3-4 More than 4 times

12.04 Have you or have you ever had the following skin disorders? (tick once for each line)

- | | Yes | No |
|---|--------------------------|--------------------------|
| Psoriasis | <input type="checkbox"/> | <input type="checkbox"/> |
| Atopic eczema (children's eczema)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Recurrent hand eczema | <input type="checkbox"/> | <input type="checkbox"/> |
| Recurrent pimples/spots for several months | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg or foot ulcer that did not heal for 3-4 weeks | <input type="checkbox"/> | <input type="checkbox"/> |

If Yes for the question on leg and/or foot ulcer, do you have the ulcer today?

- Yes No

12.05 Have you often or always any of the following complaints? (tick once for each line)

- | | Yes | No |
|--|--------------------------|--------------------------|
| Swelling in the ankles or legs, particularly in the evenings | <input type="checkbox"/> | <input type="checkbox"/> |
| Varicose veins | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema (red, itchy rash) on your legs | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg pain when you walk, but is relieved when you stand still | <input type="checkbox"/> | <input type="checkbox"/> |

12.06 Have you ever had the following diagnoses by a physician? (tick once for each line)

- | | Yes | No |
|---------------------|--------------------------|--------------------------|
| Psoriasis | <input type="checkbox"/> | <input type="checkbox"/> |
| Atopic eczema | <input type="checkbox"/> | <input type="checkbox"/> |
| Rosacea | <input type="checkbox"/> | <input type="checkbox"/> |

12.07 Have you recurring large acne/abscesses that are tender/painful and often form scars in the following places? (tick once for each line)

- | | Yes | No |
|--------------------------------|--------------------------|--------------------------|
| Armpits | <input type="checkbox"/> | <input type="checkbox"/> |
| Under the breasts | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach groove/the navel | <input type="checkbox"/> | <input type="checkbox"/> |
| Around the genitalia | <input type="checkbox"/> | <input type="checkbox"/> |
| Around the anus | <input type="checkbox"/> | <input type="checkbox"/> |
| The groin | <input type="checkbox"/> | <input type="checkbox"/> |

If Yes: Have you ever visited a physician because of abscesses?

- Yes No

If Yes, did you get any of the following treatments? (tick once for each line)

- | | Yes | No |
|---|--------------------------|--------------------------|
| Antibiotic ointment | <input type="checkbox"/> | <input type="checkbox"/> |
| Antibiotic tablets | <input type="checkbox"/> | <input type="checkbox"/> |
| Surgical drainage | <input type="checkbox"/> | <input type="checkbox"/> |
| A larger surgical intervention including skin removal | <input type="checkbox"/> | <input type="checkbox"/> |
| Surgical laser treatment | <input type="checkbox"/> | <input type="checkbox"/> |

Follow-up questions



INFORMATION TO FOLLOW-UP QUESTIONS

The following pages with questions should not be answered by all. If you have answered yes to one or more of questions below, we ask you to move on to the follow-up questions on the topic or topics you have answered yes to. The first four topics are from the first questionnaire and the last question is from this form.

We have for the sake of simplicity highlighted topics with different colors so that you will find the questions that applies to you.

If you answered YES to that you have: long-term or recurrent pain that has lasted for 3 months or more, please answer the questions on page 19 and 20. The margin is marked with green.

If you answered YES to that you have undergone any surgery during the last 3 years, please answer the questions on page 21 and 22. The margin is marked with purple.

If you answered YES to that you're working outdoors at least 25% of the time, or in facilities with low temperature, such as warehouse/industrial halls, please answer the questions on page 23. The margin is marked with red.

If you answered YES to that you have used non-prescription pain relievers, please answer questions on page 24. The margin is marked with orange.

If you answered YES to that you have or have ever had skin problems (such as psoriasis, atopic eczema, non-healing leg or foot ulcer, recurrent hand eczema, acne or abscesses), please answer the questions on page 25. The margin is marked with yellow.

If you have answered **NO** to these five questions, you are finished with your answers. The questionnaire is to be returned in the reply envelope you were given at the survey. The postage is already paid.

Should you wish to give us written feedback on either the questionnaire or The Tromsø Survey in general, you are welcome to that on page 26.

Do you have any questions, please contact us by phone or by e-mail. You can find the contact information on the back of the form. **THANK YOU** for taking the time to the survey and to answer our questions.

13. FOLLOW-UP QUESTIONS ON PAIN

You answered in the first questionnaire that you have protracted or constantly recurrent pain that has lasted for 3 months or more. Here, we ask you to describe the pain a little closer.

13.01 **How long have you had this pain?**

Number of years months

13.02 **How often do you have this pain?**

- Every day Once a month or more
 Once a week or more Less than once a month

13.03 **Where does it hurt?** (Tick for all locations where you have protracted or constantly recurrent pain)

- | | |
|---|---|
| <input type="checkbox"/> Head/face | <input type="checkbox"/> Thigh/knee/leg |
| <input type="checkbox"/> Jaw/temporo-mandibular joint | <input type="checkbox"/> Ankle/foot |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Chest/breast |
| <input type="checkbox"/> Back | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Genitalia /reproductive organs |
| <input type="checkbox"/> Arm/elbow | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Other locations |
| <input type="checkbox"/> Hip | |

13.04 **What do you believe is the cause of the pain?** (Tick for all known causes)

- | | |
|--|--|
| <input type="checkbox"/> Accident /acute injury | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Long-term stress | <input type="checkbox"/> Angina pectoris |
| <input type="checkbox"/> Surgical intervention/operation | <input type="checkbox"/> Poor blood circulation |
| <input type="checkbox"/> Herniated disk (<i>prolapse</i>) /lumbago | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Whiplash | <input type="checkbox"/> Nerve damage/neuropathy |
| <input type="checkbox"/> Migraine/headache | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Herpes zoster |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Another cause (<i>describe below</i>) |
| <input type="checkbox"/> Bechterews syndrome | <input type="checkbox"/> Don't know |

Describe the other cause:

.....

13.05 **Which kind of treatment have you received for the pain?** (Tick for all types of pain treatments you have received)

- | | |
|---|---|
| <input type="checkbox"/> No treatment | <input type="checkbox"/> Psycho-educative/relaxation training/psychotherapy |
| <input type="checkbox"/> Analgesic medications | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Physiotherapy/chiropractic treatment | <input type="checkbox"/> Complimentary medicine
(<i>homeopathy, healing, aromatherapy, etc.</i>) |
| <input type="checkbox"/> Treatment at a pain clinic | <input type="checkbox"/> Another treatment |
| <input type="checkbox"/> Surgery | |

13.06 On a scale of 0 to 10, where 0 corresponds to no pain and 10 corresponds to the worst possible pain you can imagine:

How strong would you say that the pain usually is?.....

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable pain
	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	

How strong is the pain when it is in its strongest intense?.....

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable pain
	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	

To what degree does the pain interfere with your sleep?.....

No effect	0	1	2	3	4	5	6	7	8	9	10	Impossible to sleep
	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	

To what degree does the pain interfere with performing common activities at home and at work?.....

No effect	0	1	2	3	4	5	6	7	8	9	10	Can not do anything
	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	

14. FOLLOW-UP QUESTIONS ON SURGERY

In the first questionnaire you answered that you have undergone an operation during the last 3 years.

14.01 **How many times have you undergone surgery during the last 3 years?**

Number

Below, please describe the operation. If you have undergone several operations during the last 3 years, these questions concern the last surgery you underwent.

14.02 **Where in your body did you have surgery?**
(If you were operated simultaneously in several places in the body, tick more than once)

Surgery in the head/neck/back

- Head/face
- Neck/throat
- Back

Surgery in the chest

- Heart
- Lungs
- Breasts
- Another surgery in the chest region

Surgery in the stomach/pelvis

- Stomach/intestines
- Inguinal hernia
- Urinary tract/reproductive organs
- Gall bladder/biliary tract
- Another surgery in the stomach/pelvis

Surgery in the hip/legs

- Hip/thigh
- Knee/leg
- Ankle/foot
- Amputation

Surgery in the shoulder and arm

- Shoulder/overarm
- Elbow/underarm
- Hand
- Amputation

14.03 **Reason for the surgery:**

- Acute illness/trauma
- Planned non-cosmetic operation
- Planned cosmetic operation

14.04 **Where did you have the surgery?**

- Tromsø hospital
- Harstad hospital
- Other public hospital
- Private clinic

14.05 **How long time is it since you had surgery?**

Number of years Months

14.06 **Do you have reduced sensitivity in an area near the surgical scar?**

Yes No

14.07 **Are you hypersensitive to touch, heat or cold in an area near the surgical scar?**

Yes No

14.08 **Does slight touch from clothes, showering or similar cause discomfort/pain?**

Yes No

14.09 **If you had pain at the site of surgery before you had surgery, do you have the same type of pain now?**

Yes No



14.10

The pain at the site of surgery: Answer on a scale from 0 to 10, where 0=no pain and 10=worst pain you can imagine

	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable pain
How strong pain did you have at the site of surgery <u>before</u> you had surgery		<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable pain
How strong pain do you normally have at the site of surgery <u>now</u>		<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable pain
How strong pain do you normally have at the site of surgery when it is most intense		<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	



15. FOLLOW-UP QUESTIONS ABOUT WORK IN COLD ENVIRONMENT

In the first questionnaire you answered yes to that you work in cold environments. Here are some follow-up questions that we hope you will answer.

15.01 Do you feel cold at work?

- Yes, often
 Yes, sometimes
 No, never

15.02 For how long have you been exposed to cold air below 0°C during the last winter?

Leisure/hobbies (<i>hours/week</i>)	
Work (<i>hours/week</i>)	
Outdoors, with suitable clothing (<i>hours/week</i>)	
Outdoors, without suitable clothing (<i>hours/week</i>)	
Indoors, with no heating (<i>hours/week</i>)	
In cold, with wet clothing (<i>hours/week</i>)	
Contact with cold objects/tools (<i>hours/week</i>)	

15.03 What ambient temperature prevents you from:

	Under °C
Working outdoors	
Training outdoors	
Performing other activities outdoors	

15.04 Have you during the last 12 months had a frostbite with blisters, sores or skin injury?

- Yes No

If Yes, how many times?..... | |

15.05 Have you had itching and/or rash in relation to cold exposure?

- Yes No

15.06 Have you during the last 12 months been involved in an accident which required medical treatment where cold was an important factor?

	Yes	No
At work		
In leisure time		

15.07 Do you experience any of the following symptoms while you are in a cold environment? If so, at what temperature do the symptoms occur?

	Yes	No	Under °C
Breathing problems			
Wheezy breathing			
Mucus secretion from lungs			
Chest pain			
Disturbance in heart rhythm			
Impaired blood circulation in hands/feet			
Visual disturbance (<i>short term/transient</i>)			
Migraine (<i>short term/transient</i>)			
Fingers turning white (<i>short term/transient</i>)			
Fingers turning blue-red (<i>short term/transient</i>)			

15.08 How does a cold environments and cold-related symptoms influence your performance?

	Decrease	No effect	Improve
Concentration			
Memory			
Finger sensitivity (<i>feeling</i>)			
Finger skill (<i>motor</i>)			
Control of movement (<i>for example tremor</i>)			
Heavy physical work			
Long-lasting physical work			

16. USE OF NON-PRESCRIPTION PAINKILLERS MEDICATIONS

In the first questionnaire you answered that you had used non-prescription painkillers (analgesic) medications in the last 4 weeks. Here are some follow-up questions we hope you will answer.

16.01 What types of non-prescription painkiller medications have you used?

Paracetamol: (*Pamol, Panodil, Paracet, Paracetamol, Pinex*)

- Not used
- Less than every week
- Every week, but not daily
- daily

How much you take usually daily when you use the medications? (number of tablets, suppositories)

Acetylsalicylates (*Aspirin, Dispril, Globoid*)

- Not used
- Less than every week
- Every week, but not daily
- Daily

How much you take usually daily when you use the medications? (number of tablets)

Ibuprofen: (*Ibumetin, Ibuprofen, Ibuprox, Ibox*)

- Not used
- Less than every week
- Every week, but not daily
- Daily

How much you take usually daily when you use the medications? (number of tablets, suppositories)

Naproxen: (*Ledox, Naproxen*)

- Not used
- Less than every week
- Every week, but not daily
- Daily

How much you take usually daily when you use the medications? (number of tablets)

Phenazone with caffeine: (*Antineuralgica, Fanalgin, Fenazon-koffein, Fenazon-koffein sterke*)

- Not used
- Less than every week
- Every week, but not daily
- daily

How much you take usually daily when you use the medications? (number of tablets)

16.02 For which complains do you use non-prescription painkiller drugs? (multiple ticks are possible)

- Headache
- Menstrual pain
- Migraine
- Back pain
- Muscle/joint pain
- Tooth pain
- Other

16.03 Do you think you have experienced side effects of some of the medications? (tick once for each line)

	Yes	No
Paracetamol	<input type="checkbox"/>	<input type="checkbox"/>
Acetylsalicylates	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Naproxen	<input type="checkbox"/>	<input type="checkbox"/>
Phenazone with caffeine	<input type="checkbox"/>	<input type="checkbox"/>

16.04 Where do you use to buy such medications?

- Pharmacy
- Grocery
- Patrol stations
- Abroad
- Internet

16.05 Do you combine the treatment with the use of prescribed pain-relief medications?

- Yes
- No

17. FOLLOW-UP QUESTIONS ABOUT SKIN DISEASES

On page 15 in this questionnaire you answered that you have or have had a skin disease. Here are some follow-up questions we hope you will answer.

Answer on a scale from 0 to 10, where 0 corresponds to no symptoms and 10 correspond to worst imaginable complaints. If you answered YES to that you have or have had:

		No complaint												Worst imaginable complaints
		0	1	2	3	4	5	6	7	8	9	10		
17.01	Psoriasis													
	· How much are you affected by your psoriasis today?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	· How much are you affected by your psoriasis when it is most severe?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17.02	Atopic eczema													
	· How much are you affected by your atopic eczema today?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	· How much are you affected by your atopic eczema when it is most severe?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17.03	Hand eczema													
	· How much are you affected by your hand eczema today?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	· How much are you affected by your hand eczema when it is most severe?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17.04	Acne													
	· How much are you affected by your acne today?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	· How much are you affected by your acne when it is most severe?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17.05	Abscesses													
	· How much are you affected by your abscesses today?	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	· How much are you affected by your abscesses when it is most severe? ..	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17.06	Here is a list of factors that might trigger or exacerbate abscesses, tick for what you think apply to you:													
		Yes	No											
	Stress/psychological strain	<input type="checkbox"/>	<input type="checkbox"/>											
	Narrow/tight clothing	<input type="checkbox"/>	<input type="checkbox"/>											
	Menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>											
	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>											
	Other	<input type="checkbox"/>	<input type="checkbox"/>											
17.07	How many episodes of abscesses do you usually have per year? (tick once)													
	<input type="checkbox"/> 0-1	<input type="checkbox"/> 4-6												
	<input type="checkbox"/> 2-3	<input type="checkbox"/> More than 6												
17.08	How old were you when you got abscesses for the first time?													
	<input type="checkbox"/> 0-12 years	<input type="checkbox"/> 26-35 years												
	<input type="checkbox"/> 13-19 years	<input type="checkbox"/> 36-50 years												
	<input type="checkbox"/> 20-25 years	<input type="checkbox"/> Older than 50 years												
17.09	If you no longer have abscesses, how old were you when it disappeared?													
	<input type="checkbox"/> 0-12 years	<input type="checkbox"/> 26-35 years												
	<input type="checkbox"/> 13-19 years	<input type="checkbox"/> 36-50 years												
	<input type="checkbox"/> 20-25 years	<input type="checkbox"/> Older than 50 years												

Thank you for your help





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