Cardiovascular heart and circulatory diseases, on which the surveys of the 1974 and 1979-80 focused, are a very varied category of diseases whose causes are still partly unknown. In Tromsø we are therefore trying to obtain a more complete description of factors which may be important for the course of these diseases, such as diet, psychological pressure, “stress”, social conditions and the occurrence of disease in relatives. Such a description is also important in the search of factors that contribute to cancer, a group of diseases which also we try to combat in the coming years.

When you were called in, you received a questionnaire which you handed in at the survey. The present questionnaire asks for further information about your health and includes questions on various diseases and physical and psychological complaints. We have included questions on pregnancy, birth and menstruation.

In addition, we are interested in obtaining information on the public use of medical health services in order to find out how to improve the health service.

We hope that you will take the trouble to fill in yet another questionnaire and return it to "Tromsø Board of Health" in the enclosed envelope. All information will be treated with strict confidentiality If you have any comments regarding the survey, you may write them down in the space provided on the last page of the questionnaire.

Yours sincerely

Tromsø Board of Health       Department of medicine
University of Tromsø

---

**GENERAL STATE OF HEALTH**

How is your health?

- Tick the box where “Yes” is appropriate.
- Very bad ............................................... 12
- Bad ...................................................... 13
- Neither good nor bad, “middling” ............ 14
- Good ................................................... 15
- Excellent ............................................ 16

**ILLNESSES**

Do you have, or have you had:

- Tick “Yes” or “No” for each question.
- The skin disease psoriasis .................... 13
- Asthma ................................................. 14
- Allergic eczema .................................... 15
- Hay fever ............................................. 16
- Chronic bronchitis ............................... 17
- Gastric ulcer ....................................... 18
- Duodenal ulcer .................................... 19
- Your appendix removed ........................ 20
- An operation for a stomach ulcer .......... 21
- Chronic rheumatoid arthritis ................ 22
- Cancer ............................................... 23
- Epilepsy ............................................... 24
- Migraine .............................................. 25

**INFECTIONS**

How many times in the last 6 months have you had infections like a cold, influenza (flu) diarrhoea/vomiting, or similar illnesses? .... 26

Have you had one of these infections in the past 14 days? .......... 27

---

**ILLNESSES IN PARENTS OR SIBLINGS**

Tick for the relatives who have or have ever had any of the following illnesses:

- Cerebral stroke or brain haemorrhage ..... 28
- Diabetes .............................................. 32
- Rheumatoid arthritis ............................ 36
- Cancer ............................................... 40
- Psoriasis .............................................. 44
- Gastric or duodenal ulcer ...................... 48
- Asthma ............................................... 52

Tick if none of the relatives have or have had any of those illnesses .......... 56

---

**MEDICINES**

Have you during the last year used tablets/sprays or had injections for asthma or allergies? .......... 60

Have you used any of the following medicines in the past 14 days?

- Painkillers ......................................... 61
- Antipyretic drugs (to reduce fever) ........ 62
- Eczema ointment .................................. 63
- Blood pressure medicines ...................... 64
- Heart medicines ..................................... 65
- Sleeping pills ...................................... 66
- Nerve tablets ....................................... 67
- Migraine drugs ..................................... 68
- Epilepsy drugs ..................................... 69
- Other medicines .................................... 70
### CONTACT DUE TO OWN HEALTH OR ILLNESS

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>To a GP (general practitioner)</td>
<td>71</td>
</tr>
<tr>
<td>To a specialist (not hospital)</td>
<td>72</td>
</tr>
<tr>
<td>Emergency GP</td>
<td>85</td>
</tr>
<tr>
<td>Medical officer at work</td>
<td>87</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>89</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>81</td>
</tr>
<tr>
<td>Alternative practitioner (homeopath, foot zone therapist, etc.)</td>
<td>83</td>
</tr>
<tr>
<td>Hospital outpatient department</td>
<td>85</td>
</tr>
</tbody>
</table>

Number of hospital admissions in the past year | 87

### DIET

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many slices of bread do you usually eat daily?</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>What type of milk do you usually drink?</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>How many glasses/cups of milk do you usually drink daily?</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>How often do you eat cod/pollock or other lean fish for dinner or in a sandwich?</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>How often do you eat fatty fish such as herring, halibut, red fish, mackerel, salmon or trout for dinner or in a sandwich?</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Do you take cod liver oil regularly?</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>Do you usually eat breakfast daily?</td>
<td>94</td>
<td></td>
</tr>
</tbody>
</table>

### FISH

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you eat cod/pollock or other lean fish for dinner or in a sandwich?</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>How often do you eat fatty fish such as herring, halibut, red fish, mackerel, salmon or trout for dinner or in a sandwich?</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Do you take cod liver oil regularly?</td>
<td>93</td>
<td></td>
</tr>
</tbody>
</table>

### BREAKFAST

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you usually eat breakfast daily?</td>
<td>94</td>
<td></td>
</tr>
</tbody>
</table>

### DINNERS

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you eat meat for dinner?</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>How often do you use fat like butter, margarine, mayonnaise, etc. with your dinner?</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>Do you usually eat vegetables with your dinner?</td>
<td>97</td>
<td></td>
</tr>
</tbody>
</table>

### FRUIT

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you eat fruit?</td>
<td>98</td>
<td></td>
</tr>
</tbody>
</table>

### ALCOHOL

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you a teetotaller?</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>How often do you drink beer?</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>How often do you drink wine?</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>How often do you drink spirits?</td>
<td>102</td>
<td></td>
</tr>
<tr>
<td>Approximately how often have you during the last year consumed alcohol corresponding to at least 5 small bottles of beer, a bottle of wine, or 1/4 bottle of spirits?</td>
<td>103</td>
<td></td>
</tr>
</tbody>
</table>
**Change in Dietary Habits and Other Habits**

Have you changed any of the following habits during the last 5 years? (Tick once for each question)

- Dietary fat ........................................ 106
- Soya margarine or oil .......................... 107
- Skimmed or low fat milk ........................ 108
- Coffee intake .................................. 109
- Alcohol intake .................................. 110
- Physical activity ................................ 111

**Physical Activity**

How often do you take part in physical activity lasting at least 20 minutes, which makes you perspire or become breathless?

- Rarely or never .................................. 104
- Weekly .................................................
- Several times a week ............................
- Daily ....................................................

If you usually take part in this type of activity at least weekly, how much time do you spend exercising?

- Less than 30 minutes a week ................. 105
- Between 30 minutes and 1 hour a week ....
- Between 1 and 2 hours a week ..............
- More than 2 hours a week .................

**Marriage / Partner**

Are you married or partner? ................. 112

How old were you when you first married or moved in with a partner? .................. 113

**Household**

How many people live in your household? ........ 115

Is anyone in your household 10 years or younger? .......................... 117

Does anyone in your household need special care/assistance – other than the children? .... 118

**Schooling**

How many years education have you had? (including primary and secondary schools) 119

**Employment**

Have you had paid work the entire past year?

- Full-time work ................................ 121
- Part-time work .................................
- Unpaid work ..................................

How much house work do you normally do yourself?

- All or almost all ................................ 122
- At least half ........................................
- More than quarter ............................
- Less than quarter ............................

**Back and Joints Conditions**

During this last year have you suffered from back pain that has lasted longer than 4 weeks? 123

- If yes, does the pain improve when you move around? ..........................

Have you suffered from morning stiffness in your back lasting more than 30 minutes? 124

During the past 3 years have you suffered from pain in any of the following joints lasting more than 30 minutes?

- Knees .............................................. 125
- Elbows ..............................................
- Innermost finger joints ........................ 126
- Other joints ......................................

If yes, have you suffered from stiff joints in the morning lasting more than 30 minutes? 130

**Sleeplessness/ Loss of Consciousness**

Have you ever suffered from sleeplessness? 135

- If yes, what time of the year does it affect you most? Tick the box where "Yes" is appropriate.
  - No particular time .............................. 136
  - Especially during the polar night ........
  - Especially during the midnight sun season
  - Especially in spring and autumn .........

Have you at any time during the last 12 months suffered from tiredness that has affected your work performance? 137

Have you noticed sudden changes in your pulse rate of heartbeat in the past year? 139
### Reaction to Problems

If you have major personal problems, do you expect to get help and support from your spouse or family? ............................ 140

In the last year, have you for a long time felt a need to seek help with personal problems, without doing so? ............................ 141

During the past 2 weeks have you felt unable to cope with your problems? ............................

Tick the box where "Yes" is appropriate.

<table>
<thead>
<tr>
<th>Seldom or never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Nearly always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### The Remaining Section of the Questionnaire Applies to Women Only

#### Menstruation

How old were you when you started menstruating? ............................ 145

When did your last period start? ............................ 147

How many days usually pass from the first day of one period to the first day of your next period (the time lapsed between the start of two periods) ............................ 153

Do/ did you menstruate regularly? ............................ 155

Do you usually take painkillers during menstruation? ............................ 156

#### Pre-Menstrual Tension

Do you have any of the following complaints before your period:

- Are you depressed or irritable?
  - Tick the box where "Yes" is appropriate.
    | Hardly at all | Noticeably | Very much so |
    | Yes          | No         |             |
    | 1            | 2          | 3           |

- Are your breasts painful?
  - Tick the box where "Yes" is appropriate.
    | Hardly at all | Noticeably | Very much so |
    | Yes          | No         |             |
    | 1            | 2          | 3           |

- Do you have swollen hands/feet, put on weight, or feel bloated?
  - Tick the box where "Yes" is appropriate.
    | Hardly at all | Noticeably | Very much so |
    | Yes          | No         |             |
    | 1            | 2          | 3           |

### Pregnancy

How many children have given birth to? ............................ 163

How old were you when you got pregnant for the first time? ............................ 164

### Contraception

Do you use or have you ever used oral contraceptive pills or an intrauterine device? ............................ 166

If yes, for how many years altogether have you used:

- The pill? ............................ 167
- An intrauterine device? ............................ 169

How old were you when you started using:

- The pill? ............................ 171
- An intrauterine device? ............................ 173

If you have stopped taking the pill, did 6 months or more pass without menstruating without you being pregnant? ............................ 175

Did you have to stop taking the pill due to high blood pressure? ............................ 176

### Cervical Smear Test

How many times have you had a cervical smear test in the last 3 years? ............................ 177

How many years is it since you had your last cervical smear test? ............................ 178

Your comments: ............................ 179

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Thank you for the help! Remember to post the questionnaire today!

The Tromsø survey 1986-1987