The Tromsø Health Survey

The main aim of the Tromsø Study is to improve our knowledge about cardiovascular diseases in order to aid prevention. The survey is also intended to improve our knowledge of cancer and other general conditions, such as allergies, muscle pains and mental conditions. We would therefore like you to answer some questions about factors that may be relevant for your risk of getting these and other illnesses.

This form is a part of the Health Survey, which has been approved by the Norwegian Data Inspectorate and the Regional Board of Research Ethics. The answers will only be used for research purposes and will be treated in strict confidence. The information you give us may later be stored along with information from other public health registers in accordance with the rules laid down by the Data Inspectorate and the Regional Board of Research Ethics.

If you are in doubt about what to answer, tick the box that you feel fits best.

The completed form should be sent to us in the enclosed pre-paid envelope.

Thank you in advance for helping us.

Yours sincerely,

Faculty of Medicine
University of Tromsø

National Health Screening Service

If you do not wish to answer the questionnaire, tick the box below and return the form. Then you will not receive reminders.

I do not wish to answer the questionnaire ....................................

Day Month Year

Date for filling in this form:..............................................

HOME

Who do you live with?
Tick once for each item and give the number .

<table>
<thead>
<tr>
<th>Spouse/partner</th>
<th>Yes</th>
<th>No</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other people over 18 years</th>
<th>Yes</th>
<th>No</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People under 18 years</th>
<th>Yes</th>
<th>No</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How many of the children attend day care/kindergarten? ....

What type of house do you live in?

<table>
<thead>
<tr>
<th>Villa/detached house</th>
<th>45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farm</td>
<td>46</td>
</tr>
<tr>
<td>Flat /apartment</td>
<td>47</td>
</tr>
<tr>
<td>Terraced /semi-detached house</td>
<td>48</td>
</tr>
<tr>
<td>Other</td>
<td>49</td>
</tr>
</tbody>
</table>

How big is your house? ..............................................

Approximately what year was your house built? ...........

Has your house been insulated after 1970?.............

Do you live on the lower ground floor/basement? .......

If "Yes", is the floor laid on concrete? .................

What is the main source of heat in your home?

<table>
<thead>
<tr>
<th>Electric heating</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wood-burning stove</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central heating system using:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Paraffin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have fitted carpets in the living room? .......

Is there a cat in your home? ....................................

Is there a dog in your home? ....................................

WORK

If you have paid or unpaid work, how would you describe your work?

<table>
<thead>
<tr>
<th>Mostly sedentary work?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g. office work, mounting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work that requires a lot of walking?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(e.g. shop assistant, light industrial work, teaching)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work that requires a lot of walking and lifting?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(e.g. postman, nursing, construction)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy manual work?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(e.g. forestry, heavy farm-work, heavy construction)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Can you decide yourself how your work should be organised?

<table>
<thead>
<tr>
<th>No, not at all</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>To a small extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, to a large extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, I decide myself</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Are you on call, do you work shifts or nights? .......

Do you do any of the following jobs (full- or part-time)?

Tick one box only for each item.

<table>
<thead>
<tr>
<th>Driver</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farmer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisherman</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CHILDHOOD/YOUTH

In which Norwegian municipality did you live at the age of 1 year?

- If you did not live in Norway, give country of residence instead of municipality.

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

| Very good | 29 |
| Good |    |
| Difficult |    |
| Very difficult |    |

How many of the first three years of your life

- did you live in a town/city? ....................................
- did your family have a cat or dog in the home? ....

How many of the first 15 years of your life

- did you live in a town/city? ....................................
- did your family have a cat or dog in the home? ....

How do you feel fits best.

The completed form should be sent to us in the enclosed pre-paid envelope.

Thank you in advance for helping us.

Yours sincerely,

Faculty of Medicine
University of Tromsø

National Health Screening Service

If you do not wish to answer the questionnaire, tick the box below and return the form. Then you will not receive reminders.

I do not wish to answer the questionnaire ....................................

Day Month Year

Date for filling in this form:..............................................
YOUR OWN ILLNESSES

Have you ever had:
Tick one box only for each item. Give your age at the time.
If you have had the condition several times, how old were you last time?

<table>
<thead>
<tr>
<th>Illness</th>
<th>Yes</th>
<th>No</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip fracture</td>
<td></td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Wrist/forearm fracture</td>
<td></td>
<td></td>
<td>72</td>
</tr>
<tr>
<td>Whiplash</td>
<td></td>
<td></td>
<td>75</td>
</tr>
<tr>
<td>Injury requiring hospital admission</td>
<td></td>
<td></td>
<td>78</td>
</tr>
<tr>
<td>Gastric ulcer</td>
<td></td>
<td></td>
<td>81</td>
</tr>
<tr>
<td>Duodenal ulcer</td>
<td></td>
<td></td>
<td>84</td>
</tr>
<tr>
<td>Gastric/duodenal ulcer surgery</td>
<td></td>
<td></td>
<td>87</td>
</tr>
<tr>
<td>Neck surgery</td>
<td></td>
<td></td>
<td>90</td>
</tr>
</tbody>
</table>

Have you ever had, or do you still have:
Tick one box only for each item.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psoriasis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fibromyalgia/fibrositis/chronic pain syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological problems for which you have sought help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy and hypersensitivity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atopic eczema (e.g. childhood eczema)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand eczema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hay fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food allergy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other hypersensitivity (not allergy)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How many times have you had a cold, influenza (flu), vomiting/diarrhoea, or similar in the last six months? times

Have you had this in the last 14 days? times

ILLNESS IN THE FAMILY

Tick for the relatives who have or have ever had any of the following diseases:
Tick "None" if none of your relatives have had the disease.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Mother</th>
<th>Father</th>
<th>Brother</th>
<th>Sister</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral stroke or brain haemorrhage</td>
<td></td>
<td>113</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart attack before age 60</td>
<td>119</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>125</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>131</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastric/duodenal ulcer</td>
<td>137</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>143</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological problems</td>
<td>149</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy</td>
<td>155</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>161</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- age when they got diabetes 167

SYMPTOMS

Do you cough about daily for some periods of the year? Yes No
If "Yes":
Is your cough 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

Have you had episodes of wheezing in your chest? Yes No
If "Yes", has this occurred:
Tick one box only for each item.

At night Yes No
In connection with respiratory infections Yes No
In connection with physical exertion Yes No
In connection with very cold weather Yes No

Have you noticed sudden changes in your pulse or heart rhythm in the last year? Yes No

How often do you suffer from sleeplessness?
Never, or just a few times a year Yes No
1-2 times a month Yes No
Approximately once a week Yes No
More than once a week Yes No

If you suffer from sleeplessness, what time of the year does it affect you most?
No particular time of year Yes No
Especially during the polar night Yes No
Especially during the midnight sun season Yes No
Especially in spring and summer Yes No

Have you in the last year suffered from sleeplessness to the extent that it has affected your ability to work? Yes No

How often do you suffer from headaches?
Rarely or never Yes No
Once or more a month Yes No
Once or more a week Yes No
Daily Yes No

Does the thought of getting a serious illness ever worry you?
Not at all Yes No
Only a little Yes No
Some Yes No
Very much Yes No

USE OF HEALTH SERVICES

How many visits have you made during the past year due to your own health or illness:
Tick 0 if you have not had such contact Number of times

To a general practitioner (GP)/Emergency GP 191
To a psychologist or psychiatrist 300
To an other medical specialist (not at a hospital) 301
To a hospital out-patient clinic 303
Admitted to a hospital 289
To a medical officer at work 291
To a physiotherapist 293
To a chiropractor 299
To an acupuncturist 299
To a dentist 297
To an alternative practitioner (homeopath, foot zone therapist, etc.) 299
To a healer, faith healer, clairvoyant 299
**MEDICATION AND DIETARY SUPPLEMENTS**

Have you for any length of time in the past year used any of the following medicines or dietary supplements daily or almost daily? Indicate how many months you have used them.

Put **0** for items you have **not used**.

**Medicines**
- Painkillers ................................................................. 215 months
- Sleeping pills ............................................................. months
- Tranquilizers .............................................................. months
- Antidepressants .......................................................... months
- Allergy drugs ............................................................ months
- Asthma drugs ............................................................. months

**Dietary supplements**
- Iron tablets ............................................................. 122 months
- Calcium tablets or bonemeal ......................................... months
- Vitamin D supplements ................................................ months
- Other vitamin supplements ........................................... 333 months
- Cod liver oil or fish oil capsules ................................... months

Have you in the last 14 days used the following medicines or dietary supplements? **Tick one box only for each item.**

**Medicines**  
- Painkillers ............................................................... 237  
- Antipyretic drugs (to reduce fever) ..................................  
- Migraine drugs ...........................................................  
- Eczema cream/ointment ................................................  
- Heart medicines (not blood pressure) ..............................  
- Cholesterol lowering drugs .........................................  
- Sleeping pills ............................................................  
- Tranquilizers .............................................................  
- Antidepressants ..........................................................  
- Other drugs for nervous conditions .............................. 247  
- Antacids .................................................................... 247  
- Gastric ulcer drugs .....................................................  
- Insulin .........................................................................  
- Diabetes tablets ..........................................................  
- Drugs for hypothyroidism (Thyroxine) ..........................  
- Cortisone tablets ..........................................................  
- Other medicine(s) ....................................................... 252  

**Dietary supplements**
- Iron tablets ...............................................................  
- Calcium tablets or bonemeal .........................................  
- Vitamin D supplements ................................................  
- Other vitamin supplements ........................................... 267  
- Cod liver oil or fish oil capsules ...................................  

**FOOD HABITS**

If you use butter or margarine on your bread, how many slices does a small catering portion normally cover? By this, we mean the portion packs served on planes, in cafés, etc. (10-12g)

A catering portion is enough for about .............................. 265 slices

What kind of fat is normally used in **cooking** (not on the bread) in your home?
- Butter .................................................................. 266  
- Hard margarine .........................................................  
- Soft margarine ............................................................  
- Butter/margarine blend ................................................  
- Oils ................................................................. 270  

What kind of bread (bought or home-made) do you usually eat? **Tick one or two boxes!**
- The bread I eat is most similar to:  
  - White bread ..........................................................  
  - Light textured ..........................................................  
  - Ordinary brown .......................................................  
  - Coarse brown ..........................................................  
  - Crisp bread ............................................................  

The bread I eat is most similar to:  
- White bread ..........................................................  
- Light textured ..........................................................  
- Ordinary brown .......................................................  
- Coarse brown ..........................................................  
- Crisp bread ............................................................  

How much (in **number** of glasses, cups, potatoes or slices) do you usually eat or drink **daily** of the following foodstuffs? **Tick one box for each foodstuff.**

<table>
<thead>
<tr>
<th>Foodstuff</th>
<th>Less than 1</th>
<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
<th>More than 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full milk (ordinary or curdled) (glasses)</td>
<td>265</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-skimmed milk (ordinary or curdled) (glasses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skimmed milk (ordinary or curdled) (glasses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tea (cups)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange juice (glasses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potatoes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slices of bread in total (incl. crisp-bread)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Slices of bread with:  
  - fish (e.g. mackerel in tomato sauce)   |           |     |     |     |             |
  - lean meat (e.g. ham)                  |           |     |     |     |             |
  - fat meat (e.g. salami)                |           |     |     |     |             |
  - cheese (e.g. Gouda/ Norvegia)          |           |     |     |     |             |
  - brown cheese                         |           |     |     |     |             |
  - smoked cod caviare                   |           |     |     |     |             |
  - jam and other sweet spreads           |           |     |     |     |             |

How many **times per week** do you normally eat the following foodstuffs? **Tick a box for all foodstuffs listed.**

<table>
<thead>
<tr>
<th>Foodstuff</th>
<th>Never</th>
<th>Less than 1</th>
<th>1-2</th>
<th>3-4</th>
<th>4-5</th>
<th>Almost daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yoghurt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boiled or fried egg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breakfast cereal/ oat meal, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Dinner with  
  - unprocessed meat                   |       |             |     |     |     |              |
  - sausage/meatballs                   |       |             |     |     |     |              |
  - fatty fish (e.g. salmon/redfish)     |       |             |     |     |     |              |
  - lean fish (e.g. cod)                |       |             |     |     |     |              |
  - fishballs/fishpudding/fishcakes     |       |             |     |     |     |              |
  - vegetables                           |       |             |     |     |     |              |
  - Mayonnaise, remoulade                |       |             |     |     |     |              |
  - Carrots                              |       |             |     |     |     |              |
  - Cauliflower/cabbage/ broccoli       |       |             |     |     |     |              |
  - Apples/pears                         |       |             |     |     |     |              |
  - Oranges, mandarins                  |       |             |     |     |     |              |
  - Sweetened soft drinks               |       |             |     |     |     |              |
  - Sugar-free ("Light") soft drinks    |       |             |     |     |     |              |
  - Chocolate                            |       |             |     |     |     |              |
  - Waffles, cakes, etc.                |       |             |     |     |     |              |

**FRIENDS**

How many good friends do you have whom you can talk good confidentially with and who give you help when you need it? 266 friends

Do not count people you live with, but do include other relatives!

How many of these good friends do you have contact with at least once a month? 261

Do you feel you have enough good friends? 263  
- Yes  
- No

How often do you normally take part in organised gatherings, e.g. sewing circles, sports clubs, political meetings, religious or other associations?
- Never, or just a few times a year 264  
- 1-2 times a month 264  
- Approximately once a week 264  
- More than once a week 264
**ALCOHOL**

How often do you usually drink: 
- beer? 
- wine? 
- spirits?

Never, or just a few times a year ........................................... 1
1-2 times a month ................................................................. 2
About once a week ............................................................... 3
2-3 times a week ................................................................. 4
More or less daily ................................................................. 5

Approximately how often during the last year have you consumed alcohol corresponding to at least 5 small bottles of beer, a bottle of wine, or 1/4 bottle of spirits?
- Not at all the last year .......................................................... 1
- A few times ................................................................. 2
- 1-2 times a month .............................................................. 3
- 1-2 times a week .............................................................. 4
- 3 or more times a week ..................................................... 5

For approximately how many years has your alcohol consumption been as you described above? ............... 312 years

**TO BE ANSWERED BY WOMEN ONLY**

**MENSTRUATION**

How old were you when you started menstruating? ................................................................ 326 years
If you no longer menstruate, how old were you when you stopped menstruating? ......................... 328 years

Apart from pregnancy and after giving birth, have you ever stopped having menstruation for 6 months or more? 
- Yes ☐ 
- No ☐

If "Yes", how many times? ....................................................... 331 times

If you still menstruate or are pregnant: 
- day/month/year

Do you usually use painkillers to relieve period pains? 
- Yes ☐ 
- No ☐

**PREGNANCY**

How many children have you given birth to? ............... 349 children

Are you pregnant at the moment? 
- Yes ☐ 
- No ☐ 
- Don't know ☐

Have you during pregnancy had high blood pressure and/or proteinuria? 
- Yes ☐ 
- No ☐

If "Yes", during which pregnancy? 
- First Pregnancy
- Later Pregnancy

If you have given birth, fill in for each child the year of birth and approximately how many months you breastfed the child.

<table>
<thead>
<tr>
<th>Child</th>
<th>Year of birth:</th>
<th>Number of months breastfed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>348</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>356</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>364</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>372</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>382</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>396</td>
<td></td>
</tr>
</tbody>
</table>

**WEIGHT REDUCTION**

About how many times have you deliberately tried to lose weight? Write 0 if you never have.
- before age 20 .............................................................. 314 times
- later ................................................................................ 316 times

If you have lost weight deliberately, about how many kilos have you ever lost at the most?
- before age 20 .............................................................. 318 kg
- later ................................................................................ 320 kg

What weight would you be satisfied with (your "ideal weight")? .................................................. 322 kg

**URINARY INCONTINENCE**

How often do you suffer from urinary incontinence?
- Never .............................................................................. 325 Yes
- Not more than once a month ........................................... 326 Yes
- Two or more times a month ......................................... 327 Yes
- Once a week or more .................................................. 328 Yes

**CONTRACEPTION AND ESTROGEN**

Do you use, or have you ever used:
- Oral contraceptive pills (incl. minipill) ...372
- Hormonal intrauterine device ....................
- Estrogen (tablets or patches) ............. 374
- Estrogen (cream or suppositories) ............

If you use oral contraceptive pills, hormonal intrauterine device, or estrogen, what brand do you currently use?

If you use or have ever used oral contraceptive pills:
- Age when you started to take the pill? .......... 386 years
- Age when you stopped? ............................... 386 years
- How many years in total have you taken the pill? .... 382 years
- How many years did you take the pill before your first delivery? .......................... 384 years
- If you have given birth, how many years did you take the pill before your first delivery? .......................... 384 years
- If you have stopped taking the pill: 
  - Age when you stopped? ............................... 386 years

Your comments:

Thank you for the help! Remember to mail the form today!

The Tromsø Health Survey