THE MOBILE CLINIC

QUESTIONNAIRE

Study location

This questionnaire concerns topics on your health status. Use a cross to indicate your answer in the boxes given. Ignore the numbers in the boxes and next to them, they are used only in the further data processing.

For example, if you are currently working in your occupation (Q9), draw a cross in the 'YES' box, if you are not working, draw a cross in the 'NO' box. If necessary, use the "further information" (Q62) or write a clarification in the answer space. Bring the form with you to the check-up. If you have difficulties in filling out the form, you can ask for help at the examination site. It is extremely important for the examining physician to receive the information you provide. All data will be processed in full confidence.

Do not eat or drink anything F O U R hours before the examination. Please, fill in the questionnaire carefully and in clear CAPITAL LETTERS. Do your best to answer every question.

1. **Family name**
2. **All first names**
3. **Gender:** 1 Male 2 Female

   Phone number (during office hours)
4. **Date of birth** Social security number
5. **Address**
6. **Place of birth**
7. **Marital status:**

   1 single 2 married 3 widow 4 divorced or separated
8. **Occupation**
9. **Are you currently working in your occupation?** No Yes

   If not, when did you leave your latest work? Year
10. **Occupational class**

1. Agriculture and forestry
2. Industry and mining etc.
3. Office work etc.
4. Transport and traffic
5. Commerce
6. Services
7. Upper management and administrative work
8. Housewives
9. Students, pupils
10. Other

Strenousness of work

1. Very light
2. Light
3. Normal
4. Heavy
5. Very heavy

11. Present/latest employer

12. Are you completely or partially disabled for work? Yes No

Disability/invalidity degree (with 5% precision)

If farmer, total cultivated area (in hectares)

13. Do you feel healthy at present? Yes No

14. Which diseases do you suffer from now and which have you suffered from? Put a cross to indicate each disease you have). If the illness you suffer from cannot be found in the list below, please indicate your condition on the following page.

1. Tuberculosis (Lung disease)
2. Heart disease

-Valvular disease

-Heart failure

-Angina pectoris

-Myocardial infarction

-Congenital heart disease

-other or no specified information

3. High blood pressure
4. Anemia
5. Diabetes mellitus
6. Kidney disease
7. Thyroid enlargement (Goiter)
8. Overactivity of the Thyroid gland (Hyperthyroidism)
9. Hypothyroidism
10. Lung cancer
11. Other cancer
12. Tonsillitis
13. Rheumatic fever
14. Rheumatoid arthritis
15. Disorders of calcium metabolism
16. Skin diseases or sexually acquired diseases
17. Epilepsy, Epileptic fits
18. Accidents and injuries, war injuries
19. Mental or psychic disorders
20. Hemorrhoids
21. Pancreatitis
22. Gout
23. Hypertrophic prostate
24. Urinary bladder or renal infection

25. Lung or bronchial infection

Other diseases?

Which?

15. Have you been treated in a tuberculosis sanitarium? Yes No

16. Have you been treated in a hospital for a week or longer? Which hospital? Why? (Giving birth excluded) Yes No

Use the numbers indicated in Q14 in regards to the reason for treatment, e.g. Valvular disease should be marked with number 2.

Hospital Reason Year

When did you last receive a doctor prescribed medicine against a tape worm?

Have you ever had an ulcer? Currently Weeks ago

17. Have you taken any medicines during the past three months?

Yes No

If yes, which ones?

18. Have you taken any iron medication or tonics during the past three months?

Yes No

19. How many analgesic tablets or powder portions have you taken during the past two weeks? Tablets Powder

20. Do you often use analgesic drugs? Yes No

If yes, for how long? Years

21. Have you had a gall bladder or a kidney x-ray taken in the past two years?

Yes No

22. Have you had thyroid surgery? Yes No Year

23. Have you received radioiodine treatment? Yes No

Once Twice More Year

24. Is iodized salt used in your household? Yes No

25. Do you suffer from chronic coughing (over two weeks)? No Yes

26. Do you often have infections in the airways? No Yes

27. Do you smoke cigarettes? 1 None 2 less than 15 a day 3 more than 15 a day

Cigars? Yes

Pipe? Yes

Have you quit smoking? 1 less than a year ago 2 1-9 years ago 3 more than 10 years ago

28. Do you discharge blood when defecating? No Yes

29. Has your urine been noted to contain sugar? No Yes

30. How many times per night do you get up to urinate? 1 0-1 times 2 2 or more times

31. Have you noticed the amount of your urine to increase recently? No Yes

32. Do you feel thirsty more often than usual? No Yes

33. Does your mouth often feel dry? No Yes

34. Does your skin constantly feel itchy? No Yes

35. Have you had persistent abscesses or blemishes? No Yes

36. Have you had wounds that have healed slower than usual? No Yes

37. Do you constantly feel tired? No Yes

If yes, is it specifically after eating? No Yes

38. Has your appetite increased recently? No Yes

39. Has your appetite decreased recently? No Yes

40. Have you lost a considerable amount of weight recently? No Yes

41. Have you gained a considerable amount of weight recently? No Yes

42. Do you enjoy staying in cool temperatures? No Yes

warm temperatures? No Yes

43. Do you suffer from excessive sweating? No Yes

44. When sleeping, do you use more cover than previously? No Yes

less cover than previously? No Yes

45. Do you tolerate Sauna less than previously? No Yes

46. Have you become nervous recently? No Yes

47. Do you suffer from recurring diarrhea? No Yes

48. Do you have diarrhea at night? No Yes

49. Do you feel out of breath faster than previously? No Yes

50. Do you often have palpitation? No Yes

51. Do you have palpitation when at rest? No Yes

52. Do you have constant tremorof hands or fingers? No Yes

53. Do you have chest pains during exertion? No Yes

54. Do you have leg pain during exertion? No Yes

55. Do you have leg pain at night? No Yes

56. Do you repeatedly suffer from hand spasms? No Yes

57. Do you have burning or itching sensations when urinating? No Yes

58. Do you suffer from continuos headaches? No Yes

59. Have any of your relatives suffered from diabetes?

Which relative/s?

How many of your children?

Father?

Mother?

How many brothers?

How many sisters?

Grandfather/s?

Grandmother/s?

How many aunts?

How many uncles?

How many cousins?

60. Do you exercise during your leisure time? No Yes

If yes, how often? 1 Daily 2 Weekly 3 Less frequently

61. Do you currently feel healthy? 1 Yes 2 No 3 Fairly

62. Further information:

Below you can specify your previous answers. If you found some sections of the form to be unclear or difficult to answer, please indicate these sections below.

63. Go through the form one more time and ensure you have answered all of the questions!

Only for women

64. Are you currently pregnant? No Yes

65. Do you menstruate at present? No Yes

66. Is your menstrual flow heavier than usual? No Yes

67. Do you have itchiness in your reproductive organs? No Yes

68. How many times have you given birth? Number of times

69. Have you given birth to children whose birth weight was over 4500 grams
No Yes

70. Have you given birth to any premature babies? No Yes

71. Have you had a uterine prolapse? No Yes

72. Have you suffered from any other defects or injuries to your uterus?
No Yes

What?

Only for men

73. Have you completed your military service? No Yes

Service fitness class (recorded in the military passport)

If not A 1, provide the LTO number (in the military passport)