



FinHealth 2017 -study

NATIONAL HEALTH SURVEY

QUESTIONNAIRE 2

INSTRUCTIONS TO RESPONDENTS

You can fill in this questionnaire also in the Internet: <http://www.thl.fi/finterveys>.
Your study code (number) and password needed in the web questionnaire are at the right top corner of the invitation letter.

Tick the most suitable alternative or write the information required in the space given with a ballpoint pen. If possible do not use a pencil.

 If you make some marks to the answer box which you do not mean, please blacken the entire answer box.

You should only cross one best alternative for each question unless it is specifically stated that you may cross more than one.

Remember to answer all questions. Enter negative answers by choosing the 'no' alternative or by writing '0' (zero) in the space given.

EXAMPLE 1.

How do you find your current health status?

- excellent
- quite good
- average
- quite poor
- very poor

EXAMPLE 2.

What is your current height and weight?

height 1.6.5 cm

weight 6.2 kg



HEALTH

1. Have you during the last month (past 30 days) had the following symptoms or problems?

	Daily	Less frequently than daily	Not at all
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot, leg or ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot or cold flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath (halitosis or malodor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Have you during the past 12 months had toothache or other trouble related to your teeth or dentures?

- no
 yes

3. Over the past 12 months, have you noticed a wheezing or hissing sound when breathing?

- no (proceed to question 6)
 yes

4. While wheezing, did you experience shortness of breath (dyspnea) at the same time?

- no
 yes

5. Have you noticed a wheezing or hissing sound when you breathe even though you are not suffering from a common cold or a respiratory infection?

- no
 yes

6. Over the past 12 months, have you ever been awakened because your breathing became laboured?

- no
 yes

7. Over the past 12 months, have you ever been awakened because of shortness of breath?

- no
 yes

8. Over the past 12 months, have you ever been awakened because of a coughing fit?

- no
 yes

9. Have you had an asthma attack in the past 12 months?

- no
 yes

10. Do you currently take any asthma medications (nebulizer, inhaler or pills)?

- no
 yes





11. Symptoms related to indoor climate

	no	yes, over the past 12 months	yes, most recently over a year ago
Has the indoor air quality at your home ever caused you to have any symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the indoor air quality at your workplace ever caused you to have any symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever received medical care or been examined because of having symptoms that were suspected to be caused primarily by poor indoor air quality?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Over the past 12 months, have you required medical care for any of the following?

	no	yes
A traffic accident involving a motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>
Other traffic accident (e.g. on a bicycle)	<input type="checkbox"/>	<input type="checkbox"/>
Accident at work or elsewhere indoors	<input type="checkbox"/>	<input type="checkbox"/>
Accident outdoors (not on the way to or from work)	<input type="checkbox"/>	<input type="checkbox"/>
Accident on the way to or from work (if not traffic accident)	<input type="checkbox"/>	<input type="checkbox"/>
Accident at home indoors	<input type="checkbox"/>	<input type="checkbox"/>
Accident at home in the yard	<input type="checkbox"/>	<input type="checkbox"/>
Sporting accident indoors (fitness training or competitive sports)	<input type="checkbox"/>	<input type="checkbox"/>
Sporting accident outdoors (fitness training or competitive sports)	<input type="checkbox"/>	<input type="checkbox"/>
Other leisure-time accident indoors	<input type="checkbox"/>	<input type="checkbox"/>
Other leisure-time accident outdoors	<input type="checkbox"/>	<input type="checkbox"/>

13. Over the past 12 months, on how many days was it impossible or very difficult for you to cope with your daily tasks and duties because of the injuries caused by the accident?
(If none, answer 0.)

_____ days

14. Over the past 30 days, have you been absent from work/school because of a respiratory infection (a common cold, influenza, tonsillitis, maxillary sinusitis, pneumonia, etc.)?

- no
- yes

15. Over the past month, have you been absent from work/school because of stomach problems including diarrhoea and/or vomiting?

- no
- yes





ILLNESSES IN IMMEDIATE FAMILY

16. Has your father been diagnosed for

	no	yes	I don't know
Myocardial infarction when he was <u>under 60 years</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial infarction when he was <u>over 60 years</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke when he was <u>under 75 years</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated blood pressure, hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Has your mother been diagnosed for

	no	yes	I don't know
Myocardial infarction when she was <u>under 65 years</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial infarction when she was <u>over 65 years</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke when she was <u>under 75 years</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated blood pressure, hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WEIGHT

18. Do you consider yourself

- too thin
- a little too thin
- normal
- a little overweight
- too much overweight

19. In your opinion, what is your ideal weight? _____ kg

20. Have you ever seriously tried to lose weight? If so, how many times?

- I have never tried to lose weight (proceed to question 24)
- 1 to 2 times
- 3 to 5 times
- 6 times or more



21. What has been your best result when trying to lose weight?

- less than 2 kg
- 2-5 kg
- 6-10 kg
- more than 10 kg

22. Are you trying to lose weight at present?

- no (proceed to question 24)
- yes

23. Which methods are you currently using to lose weight? Choose one or more alternatives.

- diet
- exercise
- low calorie meal preparations
- weight-loss drugs
- other diet products (health foods etc.)
- other methods

PHYSICAL ACTIVITY

24. How much physical activity in total do you get at work and during commuting and leisure time? Think of the past 12 months. Take into account regular weekly physical activity that lasts at least 10 minutes at a time. Mark on as many rows as needed.

- Almost no regular weekly physical activity (proceed to question 26).

- Easy and peaceful aerobic exercise (=no sweating or faster breathing, e.g. leisurely walking)
on ___ days per week, total _____ hours _____ minutes per week

- Brisk and lively aerobic exercise (=some sweating and/or faster breathing, e.g. brisk walking)
on ___ days per week, total _____ hours _____ minutes per week

- Vigorous and strenuous aerobic exercise (=much sweating and/or faster breathing, e.g. jogging or running)
on ___ days per week, total _____ hours _____ minutes per week

25. During a normal week, how often do you exercise to maintain or improve your muscle strength? Gym workout, exercising at home, guided group exercise, ball games and and physically strenuous chores, for example. (If none, mark 0)

on ___ days a week



26. How often do you engage in the following (leisure time) activities?

Please give your answers separately for summer and winter. Choose one option on each row. If you never engage in the activity, please choose "Rarely or never".

SUMMER	Rarely or never	A few times a month	Once a week	Several times a week	Daily
Cleaning the house, maintenance, and repairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gardening and yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hunting, fishing, picking berries/mushrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing up stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking, Nordic walking, walking to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bicycling, spinning, bicycling to work, running errands by bicycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jogging, running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming, other water sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ball games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workout, muscle strengthening exercises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gymnastics, dancing, other group exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rollerblading, skating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WINTER	Rarely or never	A few times a month	Once a week	Several times a week	Daily
Cleaning the house, maintenance, and repairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gardening and yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking, Nordic walking, walking to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bicycling, spinning, bicycling to work, running errands by bicycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing up stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jogging, running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming, other water sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cross country skiing, alpine skiing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ball games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workout, muscle strengthening exercises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gymnastics, dancing, other group exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skating, rollerblading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



WORK AND WORKING ABILITY

27. Over the past 12 months, how many whole days have you been absent from work or unable to do your chores due to illness? (If none, please enter the number "0".)

_____ days

28. How well do the following propositions describe your current work? If you are not working, assess your last job.

	complete-ly agree	somewhat agree	neither agree nor disagree	somewhat disagree	complete-ly disa-gree
I can make many independent decisions in my job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I don't have enough time to get my work done	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. How would you evaluate your current work ability in terms of the physical demands of your work?

- very good
- fairly good
- average
- fairly poor
- very poor

30. How would you evaluate your current work ability in terms of the psychological demands of your work?

- very good
- fairly good
- average
- fairly poor
- very poor

31. In terms of your health, do you feel that you will be able to work in your current profession until retirement age? If you are not employed at present, please answer as for your most recent job.

- I am already retired
- no
- probably no
- probably yes
- yes

USING HEALTH CARE SERVICES

32. Over the past 12 months, how many times have you been to a doctor's appointment because of your own condition?

(not a dentist) (Mark 0 if not at all.)

_____ times

33. Over the past 12 months, how many times have you been to a public health nurse's, nurse's or occupational health nurse's appointment, or they have visited you at home because of your own condition?

(Mark 0 if not at all.)

_____ times



34. Have you been in physiotherapy on a doctor's referral during the past 12 months?

- no
 yes

35. Which of the following do you primarily contact when in need of medical attention? (Choose only one option)

- The health centre
 A private clinic
 Occupational health care
 Student health care
 A hospital outpatient clinic
 Other

36. Evaluate your experiences in your primary care facility in the past 12 months (not including dental care).

	Always	Usually	Some-times	Never	Not applicable
I was able to get contact to the unit without difficulty	<input type="checkbox"/>				
I had access to care without undue delay	<input type="checkbox"/>				
I had access to examinations (laboratory tests, X ray imaging, ultrasound scans, etc.) without undue delay	<input type="checkbox"/>				
The health care personnel listened to what I had to say	<input type="checkbox"/>				
Everything was explained to me intelligibly	<input type="checkbox"/>				
The care personnel allowed me to participate in decision making regarding my care and the necessary examinations as much as I wanted to	<input type="checkbox"/>				
The visit was beneficial	<input type="checkbox"/>				
Communication between my care unit and other health care units was fluent	<input type="checkbox"/>				
Traveling to the care unit was difficult	<input type="checkbox"/>				
High fees have made it more difficult for me to get care	<input type="checkbox"/>				

37. When was the last time you had a health examination? For ex. in occupational health care, to get a driving license, or at maternity clinic.

- during the last 6 months
 6 months - 1 year ago
 1 year - 5 years ago
 over 5 years ago
 never

38. Has your risk of diabetes been assessed during the past 12 months with e.g. a diabetes risk test, Omahoitopolut.fi-calculator or a blood glucose measurement?

- no
 yes

39. Has your risk of heart disease been assessed during the past 12 months with e.g. the FINRISK calculator or Omahoitopolut.fi-calculator?

- no
 yes

40. Do you usually go to a dentist:

- regularly for a check-up
 only when you have toothache or some other trouble
 never



41. When was the last time you visited a dentist?

- during the past 12 months
- 1 to 2 years ago
- 3 to 5 years ago
- over 5 years ago
- I have never visited a dentist

42. Have the following circumstances prevented you from getting the dentist's treatment you want?

	no	yes
Queuing to get treatment	<input type="checkbox"/>	<input type="checkbox"/>
Poor means of transportation to the place of treatment	<input type="checkbox"/>	<input type="checkbox"/>
Excessively high service charges and prices	<input type="checkbox"/>	<input type="checkbox"/>

43. Over the past 12 months, how many times have you visited... (Mark 0 if not at all.)

A dentist at a health centre _____

A dentist at a private clinic _____

Other dentist (the Student Health Services, military, university, hospital, etc.) _____

A dental technician _____

A dental hygienist or dental assistant at a health centre _____

A dental hygienist or dental assistant at a private clinic _____

Other dental health care _____

44. Have you used any health services because of mental health problems in the past 12 months?

- no
- yes

45. Have you used any health or social services because of problems related to alcohol use in the past 12 months?

- no
- yes, because of my own problems related to alcohol use
- yes, because of somebody else's problems related to alcohol use

46. Did you get vaccinated against the flu for the season starting autumn 2016 and ending in the spring 2017?

- yes
- no
- I can't remember

47. Have you ever taken any of the following vaccinations, and paid for them yourself?
Please enter here only the vaccinations you have purchased yourself. Do not enter details about vaccinations that are included in the national vaccination programme or offered to you by your occupational health care for free.

	no	yes	I don't remember
Tick-borne encephalitis (TBE) vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Combined hepatitis A and B vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicella vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other vaccine, you have purchased yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROVIDING ASSISTANCE

48. Do you need and do you get help for your everyday activities due to your impaired functional capacity?

- I do not need help and do not get it
- I would need help but do not get it
- I get help, but not enough
- I get enough help
- I get more help than I need

49. Do you yourself regularly help someone, who does not live in your household, who has limited functional capacity or is ill?

- no (proceed to question 53)
- yes

50. What kind of assistance do you provide, and to whom?

For each line choose everybody whom you help

	I don't	Yes, my own or my spouse's parents or grandparents	Yes, my children or grandchildren	Yes, other people (other relative, neighbour, etc.)
activities of daily living (getting dressed, bathing, taking medicines, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
house and garden work (cooking, cleaning, snow removal etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
health-related errands (visits to the health care centre, outpatient clinic, or pharmacy, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
shopping, banking and other similar matters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
counselling and advice (by phone, face to face)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
maintaining social relationships, alleviating loneliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
arranging services and benefits (e.g. Care Allowances and other benefits, living arrangements)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
financial support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



51. Over the past 12 months, how often have you provided assistance to this person/these persons? Please choose only one alternative on each line.

	never	less often than once a month	1-3 times in month	1-3 in week	every day or most days
my own or my spouse's parents or grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
my children or grandchildren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other persons (other relative, neighbour, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

52. Are you a formally appointed informal caregiver of a person who is not a member of your household?

- no
- yes

53. Do you regularly provide assistance to a person who is a member of your household and has limited functional capacity, or is ill, and could otherwise not cope at home?

- no (proceed to question 56)
- yes, my spouse or cohabitant
- yes, my child or grandchild
- yes, my own or my spouse's parents
- yes, my own or my spouse's grandparents
- some other person

54. How much assistance do you provide?

- I provide assistance daily in most activities and/or am always present to monitor the situation
- I provide assistance daily in some activities, but I do not need to be present all the time
- I provide assistance in some activities during the week, but not daily
- I provide assistance less often than once a week

55. Are you a formally appointed informal caregiver for this person?

- no
- yes

56. Have you ever been an informal caregiver?

- no
- yes

QUALITY OF LIFE

When answering questions number 57 to 59, think about your life in **the last two weeks**.

57. How would you rate your quality of life?

- Very poor
- Poor
- Neither poor nor good
- Good
- Very good

58. How satisfied are you with?

	very dissatisfied	dissatisfied	neither satisfied nor dissatisfied	satisfied	very satisfied
your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your ability to perform your daily living activities yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
your personal relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the conditions of your living place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





59. Do you have

	Not at all	A little	Moderately	Mostly	Completely
enough energy for everyday life	<input type="checkbox"/>				
enough money to meet your needs	<input type="checkbox"/>				

SOCIAL RELATIONSHIPS

60. How often are you in contact with your friends and relatives who do not live in the same household with you?

	Daily or almost daily	1-3 times a week	1-3 times a month	less than once a month	never
meeting in person	<input type="checkbox"/>				
by phone	<input type="checkbox"/>				
over the Internet (e.g. e-mail, chat, Skype, Facebook)	<input type="checkbox"/>				

61. Estimate your possibilities to get help from people close to you when you need help or support. You may choose more than one option per row.

	husband, wife, partner	some other relative	close friend	close fellow worker	close neighbour	some-one else close	no one
Who do you think really cares about you no matter what happened to you?	<input type="checkbox"/>						
From whom do you get practical help when needed?	<input type="checkbox"/>						

62. Do you currently have a close friend with whom you can talk confidentially about almost any issues concerning yourself?

- I don't have any close friends
- I have one close friend
- I have two close friends
- I have several close friends

63. Do you agree with the following statements?

	Absolutely agree	Some-what agree	Some-what disagree	Absolutely disagree
it is better not to trust anyone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
most people make friends because they think friends can be useful for their purposes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
most people would not want to go through the trouble to help other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





64. How much do you trust the following? On a scale from "I do not trust them at all" to "I trust them completely", choose the option that best describes your opinion.

	I do not trust them at all			I trust them completely		
public health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
public social services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
courts of law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
the police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
decisionmaking in your municipality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
people in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

65. How often do you practice the following activities on an average?

	every day or during most days	once or twice a week	once or twice a month	once or a few times a year	less frequently or never
club or society activities (including posts of trust in society)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
theatre, movies, concerts, art exhibitions, sport competitions etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
studying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
church or other religious activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
exercise, hunting, fishing, gardening or other outdoor activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
handicrafts, playing music, singing, photographing, painting, collecting (e.g. stamps)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

66. Over the past 12 months, have you been forced to limit or completely give up an important hobby/leisure time activity?

- no (proceed to question 68)
- yes

67. Why have you been forced to limit or completely give up an important hobby/leisure time activity in the past 12 months?

	no	yes
impaired health or functional capacity	<input type="checkbox"/>	<input type="checkbox"/>
transportation-related problem	<input type="checkbox"/>	<input type="checkbox"/>
financial problems	<input type="checkbox"/>	<input type="checkbox"/>
lack of time	<input type="checkbox"/>	<input type="checkbox"/>
other	<input type="checkbox"/>	<input type="checkbox"/>





SMOKING

The following questions only apply to people who smoke currently or have previously smoked regularly. If you have quit smoking, think about your smoking before quitting. If you have never smoked regularly, please go directly to question number 74.

68. Is it difficult for you to refrain from smoking in places where smoking is banned?

- yes
 no

70. Do you usually have a habit of smoking more frequently in the first hours after waking than at other times of day?

- yes
 no

69. Which cigarette is the most difficult for you to give up?

- the first of the morning
 some other cigarette

71. Do you smoke even when you are so ill that you have to stay in bed for most of the day?

- yes
 no
 I can't say

The next questions only apply to people who are currently smoking. If you don't currently smoke, please go to question 74.

72. Would you be willing to quit smoking?

not at all willing					very willing				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10

73. If you were to try to quit smoking, do you believe that you could completely give up smoking?

not at all confident					very confident				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10

NUTRITION

74. Which of the following describe your food choices?

It is important for me...	not important at all	not very important	can't say	fairly important	very important
that my diet contains a large proportion of meat products	<input type="checkbox"/>				
that the food I eat has very little additives	<input type="checkbox"/>				
to choose low-fat foods	<input type="checkbox"/>				
to favor high-fiber foods	<input type="checkbox"/>				
to avoid very salty foods	<input type="checkbox"/>				
to follow a low-carbohydrate diet	<input type="checkbox"/>				
to eat many vegetables, fruits or berries	<input type="checkbox"/>				
that food gives me comfort when I'm depressed or feel stressed	<input type="checkbox"/>				





75. How often do you add salt to your food at the table?

- never
- usually when the food does not taste salty enough
- almost always

77. Do you consider ready meals (microwave meals, frozen food) more or less salty than home-made food?

- more salty
- as salty
- less salty

76. When you eat outside the home, how salty is the food compared to home-made food?

- more salty
- as salty
- less salty

78. What kind of salt do you mostly use at home? (Choose only one option)

- ordinary iodized table salt (e.g. Jozo)
- non-iodized sea salt, rose salt, fleur de sel
- low-sodium salt (e.g. Pansuola, Seltin)
- aromatic salt, herbal salt (e.g. Herbamare)
- we do not use salt at home

LIFESTYLE CHANGE RECOMMENDATIONS

79. Has any of the following people recommended you for health reasons in the past 12 months to You may choose several alternatives on each row.

	no one	doctor or dentist	a public health nurse, or some other health care professional	family member	someone else
exercise more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
change your eating habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
reduce consumption of alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
quit smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SLEEP

80. What time do you usually go to bed (to prepare to sleep)?

On workdays or weekdays at ____ : ____ (e.g. 22 : 30)

On days off or weekends at ____ : ____ (e.g. 23 : 20)

81. What time do you usually get up from bed (without going back again)?

On workdays or weekdays at ____ : ____ (e.g. 07 : 15)

On days off or weekends at ____ : ____ (e.g. 10 : 30)





82. There are so-called "morning people" (early to rise, early to bed) and "evening people" (late to rise, late to bed). Which are you?

- absolutely a "morning person"
- more "morning" than "evening person"
- more "evening" than "morning person"
- absolutely an "evening person"

83. Do you snore when sleeping?
(Ask others if you are not sure)

- No
- Yes, once a month or more rarely
- Yes, during 1 to 2 nights a week
- Yes, during 3 to 5 nights a week
- Yes, every night or nearly every night
- Don't know

84. Have you noticed (or have others noticed) respiratory arrests when you sleep?

- Never or more rarely than once a month
- More rarely than once a week
- From 1 to 2 nights a week
- From 3 to 5 nights a week
- Each or nearly each night
- Don't know

85. How many times a night do you need to get up to urinate?

- None
- Once
- Twice
- 3 to 4 times
- 5 times, or more
- I can't say

86. How much do the following things change for you according to different seasons?

	no change	changes somewhat	changes clearly	considerable variation
duration of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
social activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mood (general feeling of well-being)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
energy to do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

87. If you have experienced any of the above mentioned changes according to different seasons, how much of a problem is it for you?

- I haven't experienced any seasonal variation
- I have experienced seasonal variation, but it is not a problem
- a slight problem
- a moderate problem
- a significant problem
- a serious problem

MOOD

88. Have you recently been able to concentrate on what you're doing?

- better than usual
- same as usual
- less than usual
- much less than usual

94. Have you recently been able to enjoy your normal day to day activities?

- more so than usual
- same as usual
- less so than usual
- much less than usual

89. Have you recently lost much sleep over worry?

- not at all
- no more than usual
- rather more than usual
- much more than usual

95. Have you recently been able to face up to your problems?

- more so than usual
- same as usual
- less so than usual
- much less than usual

90. Have you recently felt that you are playing a useful part in things?

- more so than usual
- same as usual
- less so than usual
- much less than usual

96. Have you recently been feeling unhappy or depressed?

- not at all
- no more than usual
- rather more than usual
- much more than usual

91. Have you recently felt capable of making decisions about things?

- more so than usual
- same as usual
- less so than usual
- much less than usual

97. Have you recently been losing confidence in yourself?

- not at all
- no more than usual
- rather more than usual
- much more than usual

92. Have you recently felt constantly under strain?

- not at all
- no more than usual
- rather more than usual
- much more than usual

98. Have you recently been thinking of yourself as a worthless person?

- not at all
- no more than usual
- rather more than usual
- much more than usual

93. Have you recently felt you couldn't overcome your difficulties?

- not at all
- no more than usual
- rather more than usual
- much more than usual

99. Have you recently been feeling reasonably happy, all things considered?

- more so than usual
- same as usual
- less so than usual
- much less than usual



100. The following contains a group of sequences of four to five propositions. Read each sequence of propositions carefully through and choose in each sequence the one proposition that best describes your current situation.

- I do not feel low-spirited or sad
- I feel low-spirited and sad
- I feel low-spirited and I cannot get rid of the feeling
- I feel so sad or unhappy that it hurts
- I feel so sad or unhappy that I can't bear it anymore

- I don't feel particularly guilty
- I feel bad or unworthy a good part of the time
- I feel quite guilty
- I feel bad or unworthy practically all the time now
- I feel as though I am very bad or worthless

- I do not have an especially hopeless view of my future
- My future feels hopeless to me
- I feel that I have nothing to expect from the future
- I feel that I can never get rid of my worries
- My future feels hopeless to me, and I can't believe that things could change for the better

- I am not disappointed in myself
- I am disappointed in myself
- I do not like myself
- I detest myself
- I hate myself

- I do not feel particularly unsatisfied
- I feel bored most of the time
- I no longer enjoy things the way I used to
- I can't get satisfaction from anything anymore
- I am unsatisfied with everything

- I make decisions as easily as before
- I am less certain and try to delay making decisions
- I have difficulties in making decisions
- I can no longer make decisions at all

101. Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks.

	none of the time	rarely	some of the time	often	all of the time
I've been feeling optimistic about the future	<input type="checkbox"/>				
I've been feeling useful	<input type="checkbox"/>				
I've been feeling relaxed	<input type="checkbox"/>				
I've been feeling interested in other people	<input type="checkbox"/>				
I've had energy to spare	<input type="checkbox"/>				
I've been dealing with problems well	<input type="checkbox"/>				
I've been thinking clearly	<input type="checkbox"/>				
I've been feeling good about myself	<input type="checkbox"/>				
I've been feeling close to other people	<input type="checkbox"/>				
I've been feeling confident	<input type="checkbox"/>				
I've been able to make up my own mind about things	<input type="checkbox"/>				
I've been feeling loved	<input type="checkbox"/>				
I've been interested in new things	<input type="checkbox"/>				
I've been feeling cheerful	<input type="checkbox"/>				

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SEXUAL AND REPRODUCTIVE HEALTH (These questions apply to men and women)

102. Have there been time periods when you have attempted to have a child but have not succeeded or it took over 12 months to succeed?

- I don't know, because we or I have never tried to have a baby
- no
- yes, most recently _____ years ago

103. Have you been examined because of infertility or sought treatment because of it?

Please consider both yourself and your spouse or partner.

- no (proceed to question 106)
- yes, most recently _____ years ago

104. Have you or your spouse or partner received any of the following fertility treatments (please include also interrupted treatment periods that did not result in embryo transfer, for example):

	no	yes
hormone therapy (ovulation induction, OI)	<input type="checkbox"/>	<input type="checkbox"/>
intrauterine insemination (IUI)	<input type="checkbox"/>	<input type="checkbox"/>
in vitro fertilization (IVF), micro injection therapy (ICSI), or similar	<input type="checkbox"/>	<input type="checkbox"/>
frozen embryo transfer (FET)	<input type="checkbox"/>	<input type="checkbox"/>
some other treatment	<input type="checkbox"/>	<input type="checkbox"/>

105. Did you succeed in having a child/children due to the treatments?

- no, because we only had the examinations, not the treatments
- no, we did not get a biological child/children despite the treatments
- yes

106. In the future, do you wish to have (more) children?

- no
- yes, but it is not yet/no longer an issue for us, or is not possible
- yes, we are hoping or trying to conceive
- I am, or my spouse or partner is currently pregnant
- I can't say

107. Have you had sex in the past 12 months?

- only with a man or men
- only with a woman or women
- with a man or men and a woman or women
- I have not had sex in the past 12 months (please proceed to question 111)



108. Over the past 12 months, have you engaged in the following (you can choose more than one option)?

- vaginal intercourse
- anal intercourse
- oral sex (if you have had only oral sex without sexual intercourse, please proceed to question 111)
- none of the above (please proceed to question 111)

109. Over the past 12 months, with how many partners have you had sexual intercourse

With _____ person/people

110. Which method are you currently using, or have used in the past 12 months? (Please include also the methods used by your partner. You can choose more than one option.)

- oral contraceptive pills
- a contraceptive vaginal ring or patch
- an intrauterine device
- condoms
- postcoital contraception ("morning-after pills")
- sterilization (yours or your partners)
- some other method
- none, we do not want to use contraceptives (trying to become pregnant, religious beliefs, etc.)
- none, because there is no need (e.g. becoming pregnant is not possible)

111. Have you attended the following examinations

	yes, in the past 12 months	yes, in the past 1 to 5 years	yes, over 5 years ago	never
HIV test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women: mammography (X-ray of the breasts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women: ultrasonic examination of the breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women: cervix cancer screening (PAP smear)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women: a gynaecological examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Men: PSA blood test to screen prostate cancer or enlargement of the prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THANK YOU FOR YOUR ANSWERS!

