

LIFE HABITS AND HEALTH AMONG MEN

Please use a biro/pen with blue or black ink.

Answer this way: Make a small **cross** in the small boxes

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 Write clear **numbers** in the big boxes.

WEIGHT

1. How much did you weigh at birth?

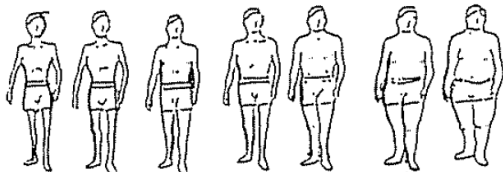
Less than 1500 grams	1500- 2499	2500- 3999	4000- 4999	Over 5000	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Were you born more than a month too early?

No Yes

3. Are you a twin? No Yes

4. Which figure is most similar to your figure at the age of 10 years?



10 years

5. How tall were you at the age of 20?

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 cm

6. How much did you weigh at (in kilos):

20 yrs	30 yrs	40 yrs	50 yrs																
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60 yrs	70 yrs	80 yrs	Weight now																
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7. What are your measurements around your waist and hips?

Waist

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 cm Hips

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 Cm

8. What is your shoe size

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 collar size

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9. Have you ever in your life lost 5 kg or more in less than 1 year? *If yes, why?*

No, never

Yes, due to dieting

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 times, Illness

--	--

 times

more active

--	--

 times, Other

--	--

 times

10. If you ever dieted, what methods did you use?

Weight watchers Less fat Fasting

Fiber tablets Dieting powder Medicines

e.g. Nutrillett *e.g. Obesedyl*

Other

PHYSICAL ACTIVITY AND EXERCISE

11. Mark your level of physical activity **at different ages:**

<u>Work/occupation</u>	15 yrs	30 yrs	50 yrs	this yr
Mostly sitting down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down half the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mostly standing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mostly walking, min. lifting/carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mostly walking, sig. lifting /carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy manual labour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>Walking/cycling</u>	15 yrs	30 yrs	50 yrs	this yr
Hardly ever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than 20 min/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20-40 minutes/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40-60 minutes/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-1.5 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 1.5 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>Home/household work</u>	15 yrs	30 yrs	50 yrs	this yr
Less than 1 hour/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-2 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-4 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5-6 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7-8 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 8 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>Leisure time</u>	15 yrs	30 yrs	50 yrs	this yr
<u>Reading/watching TV</u>	15 yrs	30 yrs	50 yrs	this yr
Less than 1 hour/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-2 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-4 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5-6 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 6 hours/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>Exercise</u> (excluding walking/cycling)	15 yrs	30 yrs	50 yrs	this yr
Less than 1 hour/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 hour/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2-3 hours/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4-5 hours/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 5 hours/week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. How many hours in 24 hours do you usually...
 Sleep

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 hours/24 hours Sit/lie down

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 hours/24 hours

FRUITS/BERRIES	Times per month			... week			... day		
	0	1-3	1-2	3-4	5-6	1	2	3+	
Orange/citrus fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Orange/grapefruit juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Apple/pear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Banana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Berries (fresh or frozen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Jam/marmalade/sauce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fruit fool/fruit soup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

CAKES/SWEETS ETC.	Times per month			... week			... day		
	0	1-3	1-2	3-4	5-6	1	2	3+	
Buns/cookies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Biscuits/wafers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cakes/pastries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Candy (not chocolate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ice cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chips/popcorn/cheese puffs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nuts/almonds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Salad dressing Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mayonnaise Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crème fraîche Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ketchup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

18. On average, how often do you eat fried food?

	times/mon	Rarely
Sausage/steak/pork chop <i>Fried in a pan</i>	<input type="checkbox"/>	<input type="checkbox"/>
Fish fried in a pan	<input type="checkbox"/>	<input type="checkbox"/>
Chicken/fillet/casserole <i>Fried in a pan</i>	<input type="checkbox"/>	<input type="checkbox"/>
Grilled/oven roasted chicken	<input type="checkbox"/>	<input type="checkbox"/>
Gravy/meat juice	<input type="checkbox"/>	<input type="checkbox"/>

19. What degree of browning do these foods usually have?

- Light brown Brown
 Dark brown Charred

20. How often do you drink alcohol?

- I have never had alcohol
 I stopped drinking alcohol at the age of yrs

I usually drink	Times per month			... week			... day		
	Never	0-1	2-3	1-2	3-4	5-6	1	2	3+
Beer, class II (2.25-3.5% alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beer, class III (>3.5% alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. How much do you drink on each occasion?

Beer cl Wine cl Spirits cl

1 can of beer=33/50 cl, bottle of wine/spirits=75 cl, 1 dl=10 cl

DIETARY SUPPLEMENTS

22. Do you take vitamin, mineral or other supplements?

- Yes, regularly Yes, sometimes No

If yes, how much and since when?

Multivitamins	<input type="text"/>	tablets per week	<input type="text"/>	yr
Vitamin C	<input type="text"/>	"	<input type="text"/>	yr
Vitamin E	<input type="text"/>	"	<input type="text"/>	yr
Vitamin B ₆	<input type="text"/>	"	<input type="text"/>	yr
Calcium	<input type="text"/>	"	<input type="text"/>	yr
Fish oil	<input type="text"/>	capsules per week	<input type="text"/>	yr

23. Which of the following do you usually take?

- Enomdan Vitamineral Vitaplex Omnibionta
 Ginseng Vit B-complex Selenium Folic Acid
 Gerimax Beta-carotene Q10 Oxigard
 Protector Magnesium Zinc Chromium
 Esbericum Hyperiforce Cernitol Curbicin
 Echinacea Garlic tablets Ginseng Other

HEALTH

24. How would you describe your general health?

- Very good Good Neither good/ nor bad Bad Very bad

25. Have you had any of the following diseases?

State **what year** you had the first diagnosis

- High blood pressure yr 19
 High cholesterol yr 19
 Blood clot (deep) in the leg yr 19
 Angina yr 19
 Heart attack yr 19
 Stroke yr 19
 Diabetes yr 19
 Fracture of the wrist/vertebra/femur yr 19
 Kidney stone yr 19
 Gallstone yr 19
 Cataract surgery yr 19
 Urinary problems yr 19

26. Has any of your parents or siblings had:

	No	Yes, Mother Father Siblings			Don't know
		How many			
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

Before 60 years old

27. These questions concern urination over the **past month**.

	Never	Less than every 5 th time	Less than every other time	About half of the time	More than half of the time	Almost never
How often have you had the feeling of not being able to empty your bladder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often have you had to urinate within 2 hours after a previous visit to the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is urination not in a continuous flow?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is it hard to hold in urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have a weak urine stream?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often must you apply pressure to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. How often do you normally go to the toilet each night?

	Never	1 time	2 times	3 times	4 times	5+
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. If you had to live with the way you urinate as you do today, how would that feel?

	Very good	Good	Acceptable	Neither good or bad	Fairly bad	Very bad	Terrible
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICINE, SMOKING ETC.

30. Have you used any of the following medicines?
If yes, **how much and how long**?

Acetylsalicylic acid (ex. *Magnecyl, Bamyl, Dispril, Aspirin, Alka-Seltzer, Treo, Albyl, Bamycor, Trombyl*)

No Yes tabl/wk, from yr 19

Paracetamol (ex. *Alvedon, Panodil, Citadon, Curadon, Distalgesic, Lemsip, Panocod, Reliv*)

No Yes tabl/wk, from yr 19

Medication for sleeping disorders

No Yes tabl/wk, from yr 19

Cortisone tablets No Yes course

Cortisone in inhalation form (t.ex. *Pulmicort, Becotide, Flutide*)

No Yes, now Yes, in total yr

31. Have you taken medicine for prostate problems?

No
 Yes, *Proscar*
from Yrs of age, in total yrs

Yes: *Peripress, Alfadil, Xatral, Hytrinex, Sinalfa*
from years old, total yrs

32. Have you smoked cigarettes regularly at some time?

No, I have never smoked cigarettes
 Yes, I started smoking when I was yrs
 still smoking stopped smoking for

Number of cigarettes per day at each age

15-20 yr	21-30 yr	31-40 yr	41-50 yr	51-60 yr	This year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

33. Do you use snuff or smoke a pipe regularly?

No Yes, I have used snuff
 Yes, I have smoked a pipe.

34. How often do you feel very angry?

Times/day Times/week Seldom Never

OTHER QUESTIONS

35. Where did you grow up?

In a big city/suburb In a medium-sized city
 In a small town/community In the countryside

36. How many whole/half siblings do you have? Sisters

Brothers

37. How many children did your mother give birth to before you?

She had children before me

38. What education/schools have you gone to?

Compulsory school Secondary school
 Junior secondary school University/college
 Vocational/Boys' school Other training

39. What is your current marital status?

Single Married/living with partner Divorced Widower

40. What is your current employment status?

Full-time Part-time Unemployed
 Studying Disability pension Retired

It is good if you can go through and check that the questions are answered as fully as possible.

Would you like to help further research by providing a blood sample for future genetic studies of protective factors? Yes No

Would you allow researchers - if you become ill - to study cells in tissue samples taken during routine diagnostic or treatment? Yes No

Can we call you if we need to ask further questions? Yes No

Your phone nr -
Area code

THANK YOU FOR YOUR PARTICIPATION !