

## LIFE HABITS AND HEALTH AMONG WOMEN

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

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

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

### WEIGHT

1. How much did you weigh at birth?

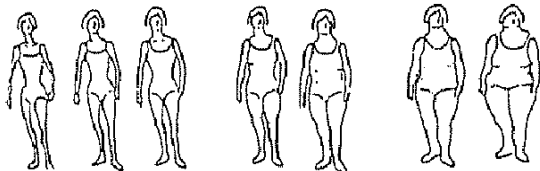
Less than 1500 grams	1500- 2499	2500- 3999	4000- 4999	Over 5000	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

No  Yes

3. Are you a twin?  No  Yes

4. How was your figure at 10 years of age?



10 years

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

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

20 yrs	30 yrs	40 yrs	50 yrs
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
60 yrs	70 yrs	80 yrs	Weight now
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

7. What are your measures around waist and hips?

Waist  cm Hips  cm

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

No, never  Yes, after pregnancy

Yes, due to dieting  times, illness  times  
more active  times, Other  times

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

Weight watchers  Less fat  Fasting  
 Fibre tablets  Dieting powder *e.g. Nutrillett*  Medicines *e.g. Obesedyl*  
 Other

### PHYSICAL ACTIVITY AND EXERCISE

10. Mark your level of physical activity at different ages:

Home/householdwork	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"/>

Walking/cycling	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"/>

Work/occupation	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"/>

### Leisure time

Watching TV/reading	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"/>

### Exercise

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"/>

11. How many hours in 24 hours do you usually...

Sleep  hours/24 hours Sit/lie down  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/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 and cakes	<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/rusks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gateau/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"/>	
Sweets (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"/>	<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"/>	<input type="checkbox"/>	
Crème fraiche 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"/>	<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"/>	

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

	Rarely	
Sausage/steak/pork chop <i>Fried in a pan</i>	<input type="checkbox"/> times/mon	<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/roasted chicken	<input type="checkbox"/>	<input type="checkbox"/>
Gravy/meat-juice	<input type="checkbox"/>	<input type="checkbox"/>

18. What degree of browning do these courses usually have?

- Light brown       Brown  
 Dark brown       Charred

19. How often do you drink alcohol?

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

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"/>

20. 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

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

- Yes, regularly       Yes, sometimes       No

*If yes, how much and since when?*

Multivitamins <i>With minerals</i>	<input type="text"/>	tablets per week	<input type="text"/>	yr
Multivitamins <i>Without minerals</i>	<input type="text"/>	"	<input type="text"/>	yr
Vitamin C	<input type="text"/>	"	<input type="text"/>	yr
Vitamin E	<input type="text"/>	"	<input type="text"/>	yr
Vitamin B <sub>6</sub>	<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

22. Which of the following do you usually take?

- Ginseng     Vit B-complex     Selenium     Folic acid  
 Gerimax     Beta-carotene     Zinc     Oxigard  
 Protector     Magnesium     Q10     Remifemin

## WOMEN'S HEALTH

23. How old were you when your period started?

yrs       don't know

24. How many children have you had?  children

Your age at the birth of the first child  yrs

25. Were you ever treated for infertility?

- Yes,  operation,  hormonal stimulation,  other  
 No

26. Have you ever used contraceptive pills or injections? **How long?** *Don't include so called mini-pills*

- Yes, from  yrs of age, total  yrs  
 No, I have never used contraceptive pills/injections

27. Do you still have menstrual bleedings?

- Yes, "natural"       Yes, due to hormonal treatment  
 No, they ceased when I was  yrs  
 The bleedings ceased naturally  
 because my ovaries were removed surgically  
 because my womb was removed surgically

28. Have you taken hormones (estrogen) at menopause or later? *If yes, how long?*

- Yes, to ease hot flushes, sweating  
from  yrs of age, total  yrs       Use now  
 Yes, to ease dryness in the vagina.  
from  yrs of age, total  yrs       Use now  
 No, I have never received hormonal treatment.

**HEALTH**

29. Have you had any of the following diseases?

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

- Benign lump in the breast yr 19
- High blood pressure yr 19
- High cholesterol yr 19
- Thrombosis (deep) in the leg yr 19
- Angina pectoris yr 19
- Myocardial infarction yr 19
- Stroke yr 19
- Diabetes yr 19
- Fracture of the wrist/vertebra/femur yr 19
- Asthma yr 19
- Surgery of cataract
- Kidney stone yr 19
- Gallstone yr 19
- Articular rheumatism yr 19

30. Have you regularly (at least 1 tabl/week) used any of the following medicines?

If yes, **how much and from what year**?

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

- No  Yes  Tabl/Week from 19

Paracetamol (e.g. Alvedon, Panodil, Citadon, Curadon, Distalgesic, Lemsip, Panocod, Reliv)

- No  Yes  Tabl/Week from 19

Indometacin (e.g. Indoméé, Confortid, Indometacin)

- No  Yes  Capsul/Week from 19

Medication for sleeping disorders

- No  Yes  Tabl/Month from 19

Cortisone tablets  No  Yes  courses

Cortisone for inhaling (e.g. Pulmicort, Becotide, Flutide)

- No,  Yes, using now,  Yes, for  yrs

31. Has any of your parents or siblings had:

	No	Yes, M/r	F/r	Sibling number	Don't know
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
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"/>
Coronary before the age of 60	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

**OTHER QUESTIONS**

32. Did you ever smoke cigarettes regularly?

- No, I have never smoked cigarettes
- Yes, I started smoking when I was  yrs
  - still smoking
  - stopped smoking  Yrs ago

Number of cigarettes per day at different ages

- 15-20 yrs  21-30 yrs  31-40 yrs  41-50 yrs  51-60 yrs  this yr

33. Did you ever use snuff regularly?

- No  Yes

34. Where did you grow up?

- In a city /suburb  In a medium-sized city
- In a smaller town/community  In the country

35. How many whole/half siblings do you have?

- Sisters  Brothers

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

- She gave birth to  children before

37. What education/schools have you attended?

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

38. Do you live alone?

- No, there are  persons in the household
- Yes, I live alone since 19

39. What is your present occupation?

- Full-time work  Part-time work  Housewife
- Retired  Disability pension  Unemployed

*It is good if you can go through and check that the questions have been answered as completely as possible.*

Would you be willing to help the research further by giving a blood sample for future studies of hereditary protective factors?  Yes  No

Were you to get ill - would you allow the researchers to study cells in a tissue sample taken in connection with a routine diagnosis or treatment?  Yes  No

Can we call you if there is anything further we might need to know?  Yes  No

Your phone number  -  Area code

**MANY THANKS FOR YOUR PARTICIPATION !**