BUSSELTON SURVEY 1994-95

QUESTIONNAIRE

THIS IS A MEDICAL RESEARCH SURVEY UNDERTAKEN BY THE BUSSELTON POPULATION MEDICAL RESEARCH FOUNDATION AND THE UNIVERSITY OF WESTERN AUSTRALIA. ALL INFORMATION WILL BE TREATED AS STRICTLY CONFIDENTIAL.

Please answer these questions at home and post back to us in the reply paid envelope. Please answer every question either with names, etc as in question 1, or with a tick, or with your answer as specified under the boxes eg. Times per week, as appropriate. Boxes marked "Office use only" should not be filled in, but the answer to the question should be printed on the dotted line provided.

BUSSELTON NUMBER

SURVEY NUMBER

Survey staff affix label

Office use only

Office use only

PLEASE PRINT

1. Surname

Other names

Address

Postcode

Telephone (Home) STD Code (Work) STD Code

2. Date of birth Day Month Year

3. Sex M F

4. a) Marital status

(Tick one box only)

Single

Married

Widowed

Divorced

Separated

Defacto
Please answer these questions at home and post back to us in the reply paid envelope. Please answer every question either with names, etc as in question 1, or with a tick \( \frac{1}{2} \) or with your answer as specified under the boxes eg. \( \frac{41}{1} \), as appropriate. Boxes marked "Office use only" should not be filled in, but the answer to the question should be printed on the dotted line provided.

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<th>BUSSELTON NUMBER</th>
<th>SURVEY NUMBER</th>
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**PLEASE PRINT**

1. **Surname**
   - Other names
   - Address
   - Postcode
   - Telephone (Home) STD Code
   - (Work) STD Code

2. **Date of birth**
   - Day
   - Month
   - Year

3. **Sex**
   - M
   - F

4. **a) Marital status**
   - **(Tick one box only)**
   - Single
   - Married
   - Widowed
   - Divorced
   - Separated
   - Defacto
26. (a) Have you in the past (for 6 months or more as an adult) drunk considerably more or considerably less alcohol than at present?

(Tick one box only)

Yes, considerably more

Yes, considerably less

Never changed much

If "never changed much" please go to next section on SMOKING.

(b) If there was a period of time when you drank increased quantities of alcohol, please state when.

\[
\begin{array}{c|c|c}
\text{Year} & \text{Year} \\
19 & 19 \\
\end{array}
\]

If there was a period of time when you drank decreased quantities of alcohol, please state when.

\[
\begin{array}{c|c|c}
\text{Year} & \text{Year} \\
19 & 19 \\
\end{array}
\]

27. If you now drink considerably less than before - what were the reasons for this change?

Own decision for health reasons

Own decision for other reasons

Doctor's advice

Media

28. How old were you when you stopped drinking alcohol OR significantly reduced the amount you drink.

The age you stopped drinking

\[
\begin{array}{c|c}
\text{Years} \\
\end{array}
\]

The age you reduced the amount you drink

\[
\begin{array}{c|c}
\text{Years} \\
\end{array}
\]
SMOKING HISTORY

29. Do you smoke?  

30. Have you ever smoked as much as seven cigarettes a week (or one cigar a week or one ounce of tobacco a month) for as long as a year?  

If NO please go to Question 38 on PASSIVE SMOKING.

31. How old were you when you started smoking regularly?

32. Do (did) you smoke manufactured cigarettes?

If YES

How many do (did) you smoke per day on weekdays?

How many do (did) you smoke per day at weekends?

33. Do (did) you smoke hand rolled cigarettes?

If YES

How much tobacco do (did) you usually smoke per week in this way?  

34. Do (did) you smoke a pipe?

If YES

How much pipe tobacco do (did) you usually smoke per week?

35. Do (did) you smoke cigars?

If YES

How many of these do (did) you smoke per week?

36. What brand of cigarettes do (did) you usually smoke (eg. Winfield Blue)?

37. For EX smokers:

How long is it since you gave up smoking?
Passive smoking:

38. How many people in your household currently smoke?

Yes  No

39. If you work outside the home are you exposed to tobacco smoke at work?

Yes  No

EXERCISE

40. How many hours each week do you usually spend at work doing:

Light activity (sitting, standing, slow walking)

Moderate activity (brisk walking, carrying)

Vigorous activity (heavy labour)

Hours per week

41. How many hours each week do you usually spend at home doing:

Light activity (washing, light cleaning)

Moderate activity (heavy cleaning, light gardening)

Vigorous activity (heavy gardening)

Hours per week

42. How many hours per week do you usually spend in physical leisure or sports activities:

Light activity (slow walking)

Moderate activity (brisk walking, slow cycling, golf)

Vigorous activity (running, aerobics, team sports)

Hours per week

43. Have you changed your exercise habits in the last five years?

Yes  No

44. If Yes, what was the reason for changing your exercise habits?

Own decision for health reasons

Own decision for other reasons

Doctor’s advice

Media
SLEEP

45. Do you snore?

(Tick one box for the most correct response)

- Never
- Hardly ever
- Occasionally
- Often
- Quite often
- Very often
- Always
- Don’t know

46. Has anyone told you that you stop breathing while you are asleep?

(Tick one box for the most correct response)

- Never
- Hardly ever
- Occasionally
- Often
- Quite often
- Very often
- Always
- Don’t know

47. Has anyone complained that you snore loudly?

(Tick one box for the most correct response)

- Never
- Hardly ever
- Occasionally
- Often
- Quite often
- Very often
- Always
- Don’t know
48. Do you fall asleep during the day, particularly if you are not busy?
   (Tick one box for the most correct response)
   Never
   Hardly ever
   Occasionally
   Often
   Quite often
   Very often
   Always
   Don’t know

RESPIRATORY SYMPTOMS

49. Breathlessness
   a) Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?

   b) Do you get short of breath walking with other people your own age on level ground?

   c) Do you have to stop for breath when walking at your own pace on level ground?

50. Cough
   a) Do you usually cough first thing in the morning?

   b) Do you usually cough during the day or at night?

   *If YES to a) or b:*

   c) Do you cough like this on most days for as much as three months each year?

51. Phlegm
   a) Do you usually bring up phlegm from your chest first thing in the morning?

   b) Do you usually bring up phlegm from your chest during the day or at night?

   *If YES to a) or b:*

   b) Do you bring up phlegm like this on most days for as much as three months each year?
52. Rhinitis / Hay fever
   a) Do you sneeze or get an itchy running nose?
      
      If YES

   b) Do you get this during any particular season?
      
      If, YES
      Spring
      Summer
      Autumn
      Winter

53. Wheeze
   a) Has your chest ever made a wheezing or whistling sound?

   b) If yes - in the last 12 months?

   c) If yes - in the last month?

54. Chest tightness
   a) Have you ever felt tight in the chest?

   b) If yes - in the last 12 months?

   c) If yes - in the last month?

PAST RESPIRATORY ILLNESSES
55. Has your doctor ever told you that you had....
   a) Bronchitis

   b) Pneumonia

   c) Pleurisy

   d) Asthma or bronchial asthma

   e) Other chest trouble
f) Hay fever

g) Allergic rhinitis

h) Sinusitis

CHEST PAIN

56. a) Have you ever had any pain or discomfort in your chest?  

b) Have you ever had any pressure or heaviness in your chest?  

   If no to both a) and b), go to question 57.

c) Do you get it when you walk up a hill or hurry?

d) Do you get it walking at ordinary pace on the level?

e) What do you do if you get it while you are walking?  
   (Tick one box only)
   
   Stop or slow down  
   Keep going

f) If you stand still what happens to it?  
   (Tick one box only)
   
   Relieved  
   Not relieved

g) How soon is it relieved?  
   (Tick one box only)
   
   More than 10 mins  
   10 mins or less

h) Where do you get this discomfort, pressure, heaviness or pain?  
   Mark all the places on the diagram with an 'X'

   LEFT

Office use only
i) Did you see a doctor because of this pain?

j) What did the doctor say it was? .................................................................

No 
Yes 
Office use only

57. a) Have you ever had a severe pain across the front of your chest, lasting 20 minutes or more?

If no, go to question 58.

b) Did you see the doctor because of that pain?

c) What did the doctor say it was? .................................................................

d) In which year did this happen?

19

58. Have you ever been told you have any of the following?

High blood pressure

No 
Yes 

Stroke

No 
Yes 

High cholesterol

No 
Yes 

High triglycerides

No 
Yes 

NEUROLOGICAL SYMPTOMS

59. a) In the last 12 months have you had any sudden feeling of numbness, tingling or loss of feeling in either arm, hand leg, foot or face?

If no, please go to question 60.

b) How long did the attack(s) usually last?

Usually less than an hour

From 1 to 24 hours

More than a day

56. a) During the past 12 months, have you had any sudden attacks of paralysis or loss of use of either arm, hand leg or foot?

If no, please go to question 61.
b) How long did the attack(s) usually last?
   Usually less than an hour
   From 1 to 24 hours
   More than a day

61. a) In the past 12 months have you had any sudden loss of eyesight or blurring of vision for a short period of time?
   If no, please go to question 62.
   Yes
   No

b) Was the loss of sight in one eye or both eyes?
   One eye affected
   Both eyes affected
   Not sure whether one or both eyes affected

c) How long did the attack(s) usually last?
   Usually less than an hour
   From 1 to 24 hours
   More than a day

62. a) In the last 12 months, have you had any attacks of changes in speech, loss of speech or inability to say words for more than 2 minutes?
   If no, please go to question 63.
   Yes
   No

b) How long did the attack(s) usually last?
   Usually less than an hour
   From 1 to 24 hours
   More than a day

63. a) During the past 12 months, have you had any spells of severe dizziness or light headedness, vertigo, difficulty walking or loss of balance?
   If no, please go to question 64.
   Yes
   No

b) How long did attack(s) usually last?
   Usually less than an hour
   From 1 to 24 hours
   More than a day
c) Did you see a doctor about any one of the above attack(s).

  No  Yes
  1    2

Office use only

d) What did the doctor say it was?

64. Have you ever been diagnosed as having any of the following:

   a) a transient ischaemic attack (TIA).

   b) a stroke.

   c) a cerebral thrombosis.

   d) a cerebral haemorrhage.

DIABETES

65. Has a doctor ever told you that you have diabetes or high blood sugar levels?

   If Yes - please state the year you were first told.

   No  Yes
   1    2

Year

66. Have you ever been given advice or treatment for diabetes or high blood sugar levels?

   If Yes - please state the year you were first given advice or treatment.

   Was this:

       (Please tick one or more boxes)

       No treatment

       Diet advice

       Tablets

       Insulin injections

INDIGESTION AND PEPITIC ULCERS

67. a) Do you now have repeated attacks of indigestion or abdominal pain?

   b) If no, have you had repeated attacks of indigestion or abdominal pain in the past?

68. a) Do you now suffer from heartburn?

   b) If no, have you suffered from heartburn in the past?
b) **Your maiden name (if applicable)**

Maiden name
Surname


c) **Please give full name of your husband / wife (if applicable).**

Surname
Other names


d) **Please state the year you married (if applicable).**

First marriage
Separation
Second marriage


e) **Your previous married names (if applicable)**

Previous Married 1st
Surname(s) 2nd


5. **Occupational history:**

a) **What is your current occupation?** .................................................................

b) **What industry do you work in?** ........................................................................


c) **How long have you been in this job?** ................................................................


d) **Do you now or have you ever worked in any job that exposed you to dust or fumes?**


e) **If Yes - please describe the job(s)?** (Please be as precise as possible)

Job (a) .........................................................................................................................

Job (b) .........................................................................................................................


f) **How long did you work in each job(s)?**

Job (a) .........................................................................................................................

Job (b) .........................................................................................................................


6. **In which country were you born?** ........................................................................


7. a) **If not born in Australia, in which year did you take up residence in Australia?**

b) **Including Australia, how many countries have you ever lived in?**

c) **Including Busselton, how many Australian postcodes have you lived in?**
69. Have you ever been told by a doctor that you had
   a) A duodenal ulcer?
   b) A gastric or stomach ulcer?
   c) A peptic ulcer?

70. If yes to a), b) or c), did your doctor ask for:
   a) A barium meal?
   b) A gastroscopy?
   c) None of the above?

71. When you had ulcer symptoms were you taking an anti-inflammatory drug for arthritis
    or other conditions?
    (Note: anti inflammatory drugs include aspirin, Brufen, Indocid, Naprosyn, Voltaren etc.)

72. Have any of the following blood relatives had a duodenal ulcer, gastric or stomach ulcer
    or peptic ulcer?
    a) brothers or sisters?
    b) mother or father?
    c) grandparents?

73. a) Have you recently been told by a doctor that you had reflux oesophagitis or hiatus
    hernia or oesophageal ulcers?

    b) If no, have you ever been told by a doctor that you had reflux oesophagitis or hiatus
    hernia or oesophageal ulcers?
74. What is your blood group?

(Tick one box only)

A 1
B 2
O 3
AB 4
Don't know 5

75. Have you ever donated blood?

76. Have you developed thickened bands or nodules in the palms of your hands or fingers?

77. At what age did you first notice these changes?

78. Have you noticed any difficulty straightening your fingers?

79. Are there any family members with this condition?

80. Have you ever had an operation for Dupuytren's contracture?

81. Has a doctor ever told you that you had carpal tunnel syndrome and/or trigger finger?

82. Do you have a history of hand injury?
THIS SECTION FOR WOMEN ONLY

83. How many months, in all, have you been on oral contraceptives ("The PILL")?

84. Are you on oral contraceptives now?

85. If yes-what type of oral contraceptive are you taking?

(Please specify)............................................................

86. a) Are you on hormone replacement therapy for menopausal symptoms now?
   b) Are you on hormone replacement therapy for other reasons (hysterectomy, premenstrual tension, irregular periods)

87. a) If yes - please specify brand, strength and number of tablets per day.
   Some women take one type of tablet, some take two types. Please describe whichever is applicable

   Tablet 1                        Tablet 2
   Brand ........................................ ..............................
   Strength ........................................ ..............................
   Number per day ........................................ ..............................

   Office use only

   Office use only.

   Office use only.

   Office use only.

88. How many times have you been pregnant?

89. How many of these pregnancies have resulted in the birth of a live child?
   Count twins etc as one

90. Are you pregnant now?

91. Have your periods stopped for good?

   If Yes - at what age?
92. Have you had a hysterectomy?

If Yes - at what age?

93. a) If you have been pregnant, did you have hypertension or pre-eclampsia or high blood pressure in your first pregnancy?

b) Have you had high blood pressure in subsequent pregnancies?

(i) Second pregnancy

(ii) Third pregnancy

(iii) Fourth pregnancy

(iv) Fifth pregnancy

END OF "WOMEN ONLY" SECTION
MEDICATIONS
To be answered by both men and women.

94. Please list all your current medications. (Include tablets, puffers, creams, patches, suppositories, ...)

a) Doctor prescribed drugs.  All medication boxes - office use only

b) Drugs bought from a pharmacy, without a prescription.

c) Medications, vitamins etc bought from a healthfood store or supermarket.
FAMILY INFORMATION

Please fill in the following family details as well as you can recall. For married women, please give married name and maiden name. Please give details of your children in the table on the following page.

Please tick the column marked * for all persons who are not a full blood relative, for example adoptees and step brothers, step sisters and step children.

<table>
<thead>
<tr>
<th>SURNAME</th>
<th>MAIDEN NAME</th>
<th>GIVEN NAMES</th>
<th>*</th>
<th>Date of birth</th>
<th>Country of birth</th>
<th>ASTHMA</th>
<th>DIABETES</th>
<th>HEARTILLNESS</th>
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25
Further family information - YOUR CHILDREN
Please tick the column marked * for all children who are not a full blood relative, for example adopted children and step children

<table>
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<tr>
<th>SURNAME</th>
<th>MAIDEN NAME</th>
<th>GIVEN NAMES</th>
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<th>Date of birth</th>
<th>Country of birth eg, Scotland, Italy, England</th>
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<th>DIABETES</th>
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THANKYOU VERY MUCH INDEED FOR TAKING THE TIME TO ANSWER THIS QUESTIONNAIRE!
8. a) How many years altogether have you lived in Busselton?
   
   b) Please list the years you were living in Busselton.
   
   19___ TO 19___
   19___ TO 19___

9. a) When was the last time you consulted a Doctor about your own health?

   *(Please tick the appropriate box)*
   
   Less than 3 months ago
   3 months to less than 6 months ago
   6 months to less than 12 months ago
   12 months or more ago
   Never / don't know

   b) Not including times that you went to an Outpatients Clinic or Casualty, how many times have you been admitted to hospital in the last 12 months?

   *(Please tick the appropriate box)*

   None
   One time
   Two times
   Three or more times

WEIGHT

10. Is your weight now different by more than 3 Kg (7lbs) compared with 12 months ago?

   *(Tick one box only)*

   No
   Gained
   Lost

   If you **gained** weight, please give reasons, if known.

   .................................................................
   Office use only

   If you **lost** weight, please give the reasons, if known.

   .................................................................
   Office use only
11. What did you weigh when you were 20 years old?

[Blank spaces for pounds, stones, and kilograms]

OR

DIET

12. a) Do you eat a special diet?

b) If Yes - please indicate which of the following:
   (Tick one box only)
   Low sugar or starch
   Low animal fat
   Low salt
   Vegetarian
   Other, please specify ........................................

c) How often do you add salt to your food after it is cooked?
   (Tick one box only)
   Rarely or never
   Sometimes
   Almost always or always

d) How many of the following do you drink per day?
   Cups of tea per day
   Cups of coffee per day
   Cans of soft drink per day
13. How much milk do you estimate that you consume each week, including milk on cereals, in drinks and in cooking?

   a) Full cream milk
   b) Skim milk
   c) Low fat milk

14. How much of the following dairy products do you usually have in a week?

   a) Yoghurt - plain or flavoured
   b) Low fat yoghurt - plain or flavoured
   c) Cream
   d) Ice-cream

   b) How much cheese do you estimate that you eat weekly? (500 grams = approx. 1 lb)

15. a) How many eggs do you eat weekly?

   b) How many times a week do you eat red meat (hot, cold, in sandwiches etc)

   c) Do you eat liver or kidney each week?

   d) How many times a week do you eat fish

16. a) How many times per week do you eat oranges or grapefruit or drink juice from them?

   b) How many pieces of other kinds of fresh fruit do you eat each week?

   c) How many times per week do you eat potatoes with your meal?

   d) How many times per week do you eat other cooked vegetables with your meal?

   e) How many different kinds of these other vegetables do you usually eat with one such meal?

   f) How many times per week do you eat salads?
17. a) Which of the following do you regularly use as a spread:

- butter
- table or cooking margarine
- polyunsaturated margarine

b) Which of the following is/are regularly used in your cooking:

- butter
- table or cooking margarine
- polyunsaturated margarine polyunsaturated oils
- other fats or oils

18. a) Which bread do you prefer to use:

- white bread
- wholemeal bread
- other

b) How many slices of bread do you usually eat per week?

c) Do you regularly eat bran (unprocessed, Albran, etc...)?

19. a) Between meals, do you usually have any of the following:

- cakes, biscuits, pastries
- potato crisps or similar snacks
- soft drinks or cordials
- ice cream or similar iced confections
- sweets or chocolates
b) Do you eat these between meal snacks?

during the morning

during the afternoon

after the evening meal

c) How many teaspoonfuls of sugar do you have in one week in drinks and on cereals?

d) How many teaspoonfuls of honey do you have in one week in drinks and on cereals?

20. Have you substantially changed your pattern of eating in the last 5 years

21. If Yes - what was the reason for this change?

Own decision for health reasons

Own decision for other reasons

Doctor’s advice

Media
22. In the last 6 months did you drink any alcohol?

If Yes - how often?  
(Tick one box only)  
Every day  
A few times a week  
Once a week or less  
Once a month or less

23. If No:

a) Have you ever drunk alcohol?

If you do not drink alcohol now and have not in the past please go to the section on SMOKING on page 11.

b) If you used to drink alcohol how often did you drink?  
(Tick one box only)  
Every day  
A few times a week  
Once a week or less  
Once a month or less

24. How old were you when you first started to drink alcohol?

If you currently drink alcohol please fill in the table on the next page. If you do not currently drink alcohol please go to question 26 in this section.

THE FOLLOWING DIAGRAM SHOULDBE REFERRED TO WHEN FILLING IN THE LAST COLUMN  
(amount of standard drinks)
25. If you currently drink alcohol: (If not please go to question 26).
Please list **what type** of alcohol and the **amount** you drank on each day of last week, below.

<table>
<thead>
<tr>
<th>Day</th>
<th>BEVERAGE</th>
<th>TYPE</th>
<th>Amount in standard drinks</th>
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<tbody>
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<td>Monday</td>
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**THE BUSSELTON POPULATION MEDICAL RESEARCH FOUNDATION (INC.)**

**POPULATION RE-SURVEY DATA RECORD 1994-1995**

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☐ ECG

☐ HAND EXAMINATION

ARE THERE PALPABLE BANDS OR NODULES IN ANY OF THE FOLLOWING RIGHT OR LEFT HANDS?

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<th>MIDDLE FINGER</th>
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COMMENTS:
# Anthropomorphic Measurements

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</tr>
<tr>
<td>cm</td>
<td>Kg</td>
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**Skinfolds:**
- Triceps
  - mm
- Subscapular
  - mm
- Biceps
  - mm
- Iliac Crest
  - mm
- Supraspinale
  - mm
- Abdominal
  - mm
- Thigh
  - mm
- Calf
  - mm

**Circumferences:**
- Arm
  - Relaxed
    - cm
  - Flexed
    - cm
- Neck
  - cm
- Waist
  - cm
- Hip
  - cm
- Calf
  - cm

**Bone Measurements:**
- Humerus
  - cm
- Femur
  - cm