BUSSELTON POPULATION STUDIES 1978

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

Please answer these questions at home and bring this form with you when you come to the Survey.

Instructions
1. Please complete the blank spaces.
2. Circle the appropriate number beside the correct answer.
3. Boxes are for office use only.

1. PLEASE PRINT: OTHER NAMES

SURNAME

ADDRESS

POST CODE

2. DATE OF BIRTH

3. SEX: Male Female

4. a. MARITAL STATUS: Circle the appropriate number.
   Single 1 Married 2 Widowed 3
   Divorced 4 Separated 5 Defacto 6
   b. PLEASE GIVE FULL NAME OF YOUR HUSBAND/WIFE:

   c. YOUR MAIDEN NAME PLEASE
   (If Applicable)

   d. PREVIOUS MARRIED NAME
   (If Applicable)

5. WHAT IS YOUR PRESENT OCCUPATION?

6. IN WHICH COUNTRY WERE YOU BORN?

7. WHICH OF THE FOLLOWING DO YOU THINK MOST ACCURATELY DESCRIBES YOUR ANCESTRAL HERITAGE? Circle the appropriate number.
   English 01 E. European 05 Scandinavian 09
   Scottish 02 W. European 06 Asian 10
   Irish 03 N. European 07 African 11
   Welsh 04 S. European 08 Aboriginal 12

8. a. DO YOU PLAY ACTIVE SPORT? Circle the appropriate number for a. and b.
   Never 1 1-3 times per week 3
   Less than once a week 2 4-7 times per week 4
   b. DOES YOUR WORK INVOLVE YOU PERSPIRING OR GETTING OUT OF BREATH?
   Regularly 1 Occasionally 2 Rarely 3

9. PLEASE LIST ANY MEDICINES, TABLETS, MIXTURES OR INJECTIONS THAT YOU TAKE REGULARLY.

10. a. HOW MANY TIMES A YEAR ON AVERAGE DO YOU SUFFER FROM INFLUENZA (FLU) OR COLD?
    times

   b. IN WHICH YEAR WERE YOU LAST VACCINATED FOR FLU? 19
For Questions 11 to 32 inclusive, please circle the appropriate number in response to Yes/No.

11. a. HAVE YOU EVER HAD A RASH ON YOUR FACE OR NECK? No 1 Yes 2
   b. IF YES, WAS IT CAUSED BY EXCESSIVE EXPOSURE TO THE SUN? No 1 Yes 2

12. DO YOU SUNBURN EASILY AND SEVERELY? No 1 Yes 2

13. DO YOUR HANDS-go BLUE AND WHITE IN THE COLD? No 1 Yes 2

14. HAVE YOU EVER HAD FITS (EPILEPSY)? No 1 Yes 2

15. HAVE YOU EVER BEEN CONCERNED BY EXCESSIVE HAIR LOSS OR BALDNESS? No 1 Yes 2

16. HAVE YOU EVER BEEN TOLD BY A DOCTOR YOU HAVE PSORIASIS? No 1 Yes 2

17. HAVE YOU EVER HAD ANY SKIN DISEASE? No 1 Yes 2

18. HAVE YOU EVER BEEN TOLD BY A DOCTOR YOU HAVE RHEUMATOID ARTHRITIS OR OTHER FORM OF ARTHRITIS? No 1 Yes 2

19. ARE THE JOINTS IN YOUR FINGERS AND HANDS MORE "STIFF IN THE MORNINGS?"
   IF SO, HOW LONG DOES IT TAKE TO WEAR OFF? __________ hours □

20. HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE KERATOSIS? (Painful inflammation of the eyes) No 1 Yes 2

21. DO YOU SUFFER FROM DRYNESS OF THE EYES? No 1 Yes 2

22. HAVE YOU EVER BEEN TREATED FOR SKIN CANCER? No 1 Yes 2

23. HAVE YOU EVER BEEN TREATED FOR ANY OTHER TYPE OF CANCER? No 1 Yes 2

24. DO YOU HAVE ANY UNEXPLAINED PATCHES OF PALE SKIN? No 1 Yes 2

25. DO YOU SUFFER FROM ANY OF THE FOLLOWING ALLERGIC CONDITIONS?
   - Asthma No 1 Yes 2
   - Hay Fever No 1 Yes 2
   - Eczema No 1 Yes 2
   - Hives (urticaria) No 1 Yes 2
   - Abnormal reactions to vaccines or drugs (e.g. Penicillin) No 1 Yes 2

   If so how do you react? ____________________________________________________________________________

   - Allergies to foods, pets, etc.

   If so, please specify ____________________________________________________________________________

26 a. DO YOU SUFFER FROM ANY OF THE FOLLOWING INFECTIONS RECURRENTLY? (i.e. more than one episode per year).

   If so HOW LONG DO THE INFECTIONS NORMALLY LAST?
   - Chest Infections: a) Bronchitis No 1 Yes 2
   b) Pneumonia No 1 Yes 2
   c) Pleurisy No 1 Yes 2
   - Sinus infections No 1 Yes 2
   - Ear infections No 1 Yes 2
   - Skin infections (e.g. boils, carbuncles) No 1 Yes 2
   - Throat infections No 1 Yes 2
   - Kidney infections No 1 Yes 2
   - Bladder infections No 1 Yes 2

   b. DO YOU NORMALLY REQUIRE MORE THAN ONE COURSE OF ANTIBIOTICS TO CLEAR THESE INFECTIONS? No 1 Yes 2

Days

No 1 Yes 2
No 1 Yes 2
No 1 Yes 2
No 1 Yes 2
No 1 Yes 2
No 1 Yes 2
No 1 Yes 2
No 1 Yes 2
No 1 Yes 2
27. HAVE YOU HAD ANY OF THE FOLLOWING DISEASES MORE THAN ONCE?
If yes, please indicate by circling the appropriate number.
- Glandular Fever
- Measles
- German Measles (Rubella)
- Chicken Pox
- Shingles
- Mumps
- Infectious Hepatitis (Jaundice)

28. DO YOU SUFFER FROM ANY OF THE FOLLOWING?
If yes, please circle the appropriate number.
- Cold sores
- Mouth ulcers
- Warts
- Oral thrush
- Vaginal thrush
- Ring worm
- Tinea (athletes foot)

29. HAVE YOU EVER BEEN TREATED FOR ANAEMIA?
IF SO, WHAT TREATMENT DID YOU RECEIVE?

30. HAVE YOU EVER BEEN TREATED FOR THYROID DISEASE?
If yes, please indicate by circling the appropriate number.
- Neck operation
- Radio-active iodine
- Tablets

31. HAS ANY MEMBER OF YOUR FAMILY HAD THYROID DISEASE?

32. a. DO YOU EAT A SPECIAL DIET?
Circle the appropriate number.

b. IF YES, INDICATE WHICH OF THE FOLLOWING:
- Low sugar or starch
- Low animal fat
- Vegetarian
- Low salt
- Other

33. a. ARE YOU NOW ON TREATMENT FOR HIGH BLOOD PRESSURE?

b. IF YES, PLEASE NAME PRESENT TREATMENTS:

34. a. HAVE YOU EVER HAD ANY PAIN OR DISCOMFORT IN YOUR CHEST?

b. HAVE YOU EVER HAD ANY PRESSURE OR HEAVINESS IN YOUR CHEST?

C. DO YOU GET THIS WHEN YOU WALK UP 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?

F. IF YOU STAND STILL, WHAT HAPPENS TO IT?

G. HOW SOON IS IT RELIEVED?

H. WHERE DO YOU GET THIS DISCOMFORT, PRESSURE, HEAVINESS OR PAIN?

I. DID YOU SEE A DOCTOR BECAUSE OF THIS PAIN?

J. WHAT DID THE DOCTOR SAY IT WAS?
35. HAVE YOU EVER HAD A SEVERE PAIN ACROSS THE FRONT OF YOUR CHEST, LASTING HALF AN HOUR OR MORE?
   a. Yes 2
   b. No 1
   c. 

36. HAVE YOU SUFFERED FROM LOW BACK PAIN OF ANY TYPE?
   a. HOW MANY ATTACKS OF PAIN HAVE YOU HAD?
   b. HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST ATTACK OF BACK PAIN?
   c. HOW OFTEN ON THE AVERAGE DO YOU GET BACK PAIN?
      Circle the appropriate number:
      Continually present 1 At least once a month 4
      Every day 2 At least once a year 5
      At least once a week 3 Less than once a year 6
   d. DOES THE PAIN RESULT IN IMPAIRED ABILITY TO BEND YOUR BACK?
   e. DOES THE BACK PAIN EVER AWAKEN YOU AT NIGHT?
      If yes, HOW OFTEN DOES THIS OCCUR?
      Most nights 1 Once a month 3
      Once a week 2 Less than once a month 4
   f. DO YOU A WAKE IN THE MORNING WITH SIGNIFICANT STIFFNESS IN YOUR BACK?
      If yes, HOW LONG DOES IT LAST?........hours
   g. IS THE BACK PAIN WORSE IN THE MORNING OR EVENING?
   h. WHAT IS THE EFFECT OF EXERCISE OR ACTIVITY ON THE BACK PAIN?
      Morning 1 Evening 2 No difference 3

37. HAVE YOU EVER HAD SUGAR IN YOUR URINE?
   a. Yes 2
   b. No 1

38. HAVE YOU EVER HAD DIABETES?
   a. Yes 2
   b. No 1
   c. 

39. HAS YOUR WEIGHT CHANGED BY MORE THAN 7 POUNDS (3.2 kg) IN THE LAST 12 MONTHS?
   a. GAINED 7LB OR MORE
   b. LOST 7LB OR MORE
   Circle appropriate number:
   No 1
   GAINED 1
   LOST 2
40. WHICH OF THESE DIRECT BLOOD RELATIVES EVER HAD DIABETES?

<table>
<thead>
<tr>
<th>Father</th>
<th>Brother</th>
<th>Son</th>
<th>Mother</th>
<th>Sister</th>
<th>Daughter</th>
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41. HAVE YOU EVER DRUNK ALCOHOL-CONTAINING BEVERAGES MORE FREQUENTLY THAN ONCE PER MONTH?

- No 1
- Yes 2

42. a. DO YOU EVER DRINK ALCOHOL - CONTAINING BEVERAGES OF ANY TYPE NOW?

Circle the number beside the correct reply:

- If no, go straight to question 43.

b. HOW FREQUENTLY DO YOU USUALLY DRINK ALCOHOL - CONTAINING BEVERAGES?

- Every day
- 1-4 times per month
- 5-7 times per week
- Less than once per month
- 1-4 times per week

- 76

c. HOW MUCH ALCOHOL DO YOU DRINK IN AN AVERAGE WEEK?

Write the details in the table below. If last week was an average week, write what you drank last week. If none, write none:

<table>
<thead>
<tr>
<th>DAY</th>
<th>BEVERAGE</th>
<th>TYPE</th>
<th>AMOUNT</th>
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<tbody>
<tr>
<td>Monday</td>
<td>Beer</td>
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<td>Wine</td>
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<td>Spirits</td>
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<td>Thursday</td>
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<td>Spirits</td>
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As far as possible use the following description of amounts:

- **Beer:**
  - Can, bottle, stubby, pony, middy, schooner, pot, pint,
  - small glass (7oz or less)
  - medium glass (8-11oz)
  - large glass (12oz or more)

- **Wine:**
  - small glass (3oz or less)
  - medium glass (4oz)
  - large glass (5oz or more)

- **Spirits:**
  - half nip (1/2oz)
  - nip (1oz)
  - double nip (2oz)

43. DO YOU SMOKE CIGARETTES AT ALL NOW?

Circle the number beside the correct answer:

- No 1
- Yes 2

44. HAVE YOU EVER SMOKED AT LEAST ONE CIGARETTE PER DAY FOR AS LONG AS ONE MONTH?

- No 1
- Yes 2

45. a. HOW OLD WERE YOU WHEN YOU FIRST BEGAN TO SMOKE AT LEAST ONE CIGARETTE PER DAY?

Age

b. DO YOU NOW SMOKE AT LEAST ONE CIGARETTE PER DAY?

- Yes, please answer question c below.
- No, please answer question d below.

c. HOW MANY CIGARETTES DO YOU SMOKE PER DAY NOW?

- cigarettes

- ounces tobacco

d. HOW LONG AGO IS IT SINCE YOU LAST SMOKED AT LEAST ONE CIGARETTE PER DAY?

- months

- years
46. DO YOU NOW SMOKE A PIPE OR CIGARS?

Circle the appropriate number:
- No 1
- Cigars only 3
- A pipe only 2
- A pipe and cigars 4

QUESTION 47 - WOMEN ONLY

47. a. HOW MANY MONTHS IN ALL HAVE YOU BEEN ON ORAL CONTRACEPTIVES ('THE PILL')? If none, write none: ........................................ months

b. ARE YOU ON ORAL CONTRACEPTIVES NOW? No 1 Yes 2

c. HOW MANY TIMES HAVE YOU BEEN PREGNANT? ........................................ times

d. HOW MANY OF THESE PREGNANCIES HAVE RESULTED IN THE BIRTH OF A LIVE CHILD? (Count twins etc. as one) ........................................ pregnancies

e. ARE YOU PREGNANT NOW? No 1 Yes 2

f. HAVE YOUR PERIODS STOPPED FOR GOOD? No 1 Yes 2

If yes, AT WHAT AGE? Age ........................................

48. a. DID YOU ATTEND ANY OF THE PREVIOUS ADULT SURVEYS IN BUSSELTON? No 1 Yes 2

b. WHO IS YOUR USUAL DOCTOR? ........................................

c. DO YOU WANT US TO SEND A COPY OF YOUR RESULTS TO YOUR OWN DOCTOR AS WELL AS TO YOU? No 1 Yes 2

49. Certain diseases affect people from some countries more than others. These questions are designed to determine the country to which your ancestry is most closely associated.

Please fill the following family details as well as you can recall. For married women, please give married name and maiden name in brackets. It would be helpful if you would please indicate adopted children with an "X".

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<th>Name</th>
<th>Date of Birth</th>
<th>Country of Birth</th>
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Thank you very much for your co-operation.