BUSELTON POPULATION STUDIES 1981

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.

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

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**PLEASE PRINT**

1. **Surname**
2. **Address**
3. **Date of birth**
4. **Sex:** Male 1 Female 2
5. **MARITAL STATUS:**
   - Single 1
   - Married 2
   - Widowed 3
   - Divorced 4
   - Separated 5
   - Defacto 6
   - (b) Please give full name of your husband/wife:
5. **Your maiden name please (if applicable):**
6. **Your previous married name (if applicable):**
7. **In which country were you born?**
8. **Are you right handed 1 left handed 2 ambidextrous 3**
9. **Do you eat a special diet?**
   - low sugar or starch 1
   - low animal fat 2
   - vegetarian 3
   - low salt 4
   - other, specify, 5
9. **Do you eat daily Bran 1 Vegetables 2 Fruit 4**
10. **How many cups of TEA do you drink daily?**
11. **How many cans of COKE do you drink daily?**
12. **How many cans of COCA-COLA, PEPSI COLA, TAB do you drink daily?**

**10.**
   - (a) Are you now on treatment for high blood pressure?
   - Diet 1 Exercise 2 Medication 4 please specify
   - No 1 Yes 2

**11.**
   - (a) How many days a week do you exercise?
   - 0 1 2 3 4 5 6 7
   - No 1 Yes 2
   - (b) Do you get out of breath when exercising?
12. (a) Have you ever had THYROID disease or GOITRE?  
(b) If YES, what year was it diagnosed?

13. (a) Have you ever had DIABETES?  
(b) If YES, what year was diabetes first found?  
(c) Have you ever had treatment for diabetes?  
(d) If YES, were you ever treated by special diet?  
   insulin injections?  
Prescribed tablets? Please specify.

14. Which of the following blood relatives have had diabetes or sugar trouble? (Please circle)
   Father  Brother  Son  Mother  Sister  Daughter  Other, specify

15. Has your weight changed by more than 7 lbs (3 kgs) in the last 12 months?  
   No 1  Gained  2  Lost  3
   If gained give reason, if known
   (e.g., water retention, illness)
   If lost give reason, if known
   (e.g., diet, illness)

16. Have you ever been treated for  
(a) A malignant mole or melanoma?  
(b) Another type of skin cancer?  
(c) Pre-cancerous skin growths or “sunspots”?  
   (Often treated by freezing or ointments)

17. When you have bare skin exposed to the sun for one half hour or more in summer (October-March) do you use a sun screen lotion or cream?
   Never 1  
   on less than one half of such occasions 2  
   on more than one half of such occasions 3

18. Are you a non-drinker  1  drinker  2  ex-drinker  3
   If a drinker how much of the following do you drink per week?
   Beer  750 ml bottles  stubbles/cans
   Beer  glasses pony, glasses middy, glasses schooner
   Wine  bottles OR  glasses (3-4 ozs)
   Spirits  No. of nips (1 oz) Sherry, Port, Muscat  glasses (2-3 ozs)

19. Do you snore?  
   No 1  Yes 2
   Is it a problem to you?  
   No 1  Yes 2
   Is it a problem to your spouse?  
   No 1  Yes 2

20. On average how many hours sleep do you get each night?
   Hours...

21. Have you ever had a reaction to a bee sting that was more than a small amount of swelling around the sting? (This would include fainting, wheezing, or rash on other parts of the body)  
   No 1  Yes 2
22. Circle the appropriate number for a to g.
   a. Have you ever had any pain or discomfort in your chest? No 1 Yes 2
   b. Have you ever had any pressure or heaviness in your chest? No 1 Yes 2
   c. Do you get this when you walk up hill or hurry? No 1 Yes 2
   d. Do you get it walking at ordinary pace on the level? No 1 Yes 2
   e. What do you do if you get it while you are walking? Stop 1 Slow 2 Keep Going 3
   f. If you stand still, what happens to it? Relieved 1 Not Relieved 2
   g. How soon is it relieved? 10 mins or less 1 More than 10 mins 2
   h. Where to get this discomfort, pressure, heaviness or pain? LEFT
   Mark all the places on the diagram with an "X".

   i. Did you see a doctor because of this pain? No 1 Yes 2
   j. What did the doctor say it was? ..........................................................

23. a. Have you ever had a severe pain across the front of your chest, lasting half an hour or more? No 1 Yes 2
   b. Did you see the doctor because of that pain? No 1 Yes 2
   c. What did the doctor say it was? ..........................................................

24. Do you smoke cigarettes at all now? No 1 Yes 2

25. Have you ever smoked at least one cigarette per day for as long as one month? No 1 Yes 2
   If NO, go straight to question 27.

26. 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? No 1 Yes 2
   If YES, please answer questions c, d, e, below.
   If NO, please answer question f below.
   c. How many cigarettes do you smoke per day now? ................................ cigarettes
   d. Do you usually roll your own cigarettes? No 1 Yes 2
   e. If not, what brand do you usually smoke? e.g. Craven Mild
   ........................................................................................................
   f. How long is it since you last smoked at least one cigarette per day?
   .............................................................................................. months
   .............................................................................................. years

27. Do you now smoke a pipe or cigars? No 1 Pipe only 2 Cigars only 3 Pipe and cigars 4

28. Have you ever had
   (a) wheezing or tightness in the chest? No 1 Yes 2
   (b) cough at night? No 1 Yes 2
   (c) SHORTNESS OF BREATH when hurrying on level ground or walking up a slight hill? No 1 Yes 2
   (d) SHORTNESS OF BREATH when walking with people of your own age on level ground? No 1 Yes 2
   (e) Do you have to stop for breath when walking at your own pace on level ground? No 1 Yes 2
   (f) Are you ever short of breath when you are resting? No 1 Yes 2
29. In the last three years have you had cough with phlegm
(a) first thing in the morning? No 1 Yes 2
(b) during the day? No 1 Yes 2
(c) on most days for as much as 3 months in each year? No 1 Yes 2
(d) In the last three years have you had cough with phlegm lasting 3 weeks or more? No 1 Yes 2
(e) If YES, have you had more than one such period of cough with phlegm in the last 3 years? No 1 Yes 2

IF NO TO QUESTIONS 28 AND 29, PLEASE GO TO QUESTION 31

30. (a) Circle the month(s) of the year when the symptoms in questions 28 and 29 are or were PRESENT

JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC

(b) Circle the month(s) of the year when the symptoms in questions 28 and 29 are or were WORST

JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC

(c) At what age did the symptoms in questions 28 and 29 start? Age

(d) Are they still present? No 1 Yes 2

(e) If not still present, at what age did they stop? Age

(f) How many days have you lost from work or school because of symptoms in Questions 28 and 29?

In the last year? ............................................ days

In the last 10 years? ............................................ days

31. Have you ever had long-lasting or frequent:
(a) blockage of the nose, nasal stuffiness? No 1 Yes 2

(b) water discharge from the nose? No 1 Yes 2

(c) sneezing, or itching of the nose, roof of mouth or throat? No 1 Yes 2

(d) any (a), (b) or (c) with headache? No 1 Yes 2

(e) any (a), (b) or (c) with excessive fatigue or depression? No 1 Yes 2

(f) itching and/or redness of eyes? No 1 Yes 2

32. (a) Circle the month(s) of the year when the symptoms in Question 31 are or were PRESENT

JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC

(b) Circle the month(s) of the year when the symptoms in Question 31 are or were WORST

JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC

(c) At what age did the symptoms in question 31 start? Age

(d) Are they still present? No 1 Yes 2

(e) If not still present, at what age did they stop? Age

(f) How many days have you lost from work or school because of symptoms in question 31?

In the last year? ............................................ days

In the last 10 years? ............................................ days

If you answered YES to any of questions 21, 28, 29 or 31 would you please complete an additional very small questionnaire when you return this one? THANK YOU

33. Has a doctor ever told you that you had (please circle)

Bronchitis Pneumonia Pleurisy Bronchial asthma/asthma

Other chest complaints, please specify ............................................

Hay Fever Allergic rhinitis Sinusitis
34. **Question 34 WOMEN only.**

(a) How many months in all have you been on oral contraceptives ("The PILL")? If none, write none.  

........................................ months  

No 1  Yes 2  

(b) Are you on oral contraceptives now?  

No 1  Yes 2  

(c) Are you on hormone treatment (oestrogen) for change of life or menopause now?  

No 1  Yes 2  

(d) How many times have you been pregnant?  

........................................ times  

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

........................................ pregnancies  

No 1  Yes 2  Maybe 3  

(f) Are you pregnant now?  

No 1  Yes 2  Maybe 3  

(g) Have your periods stopped for good?  

Age........................................  

No 1  Yes 2  

(h) If YES, at what age?  

(i) If YES, have you had a hysterectomy?  

No 1  Yes 2  

35. (a) Did you attend any of the previous adult surveys in Busselton?  

No 1  Yes 2  

(b) Who is your usual doctor? ........................................  

No 1  Yes 2  

(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  

36. Have any of your immediate family (grandparents, parents, brother, sister, child, aunt, uncle, etc.) died from a heart attack under the age of 65 years?  

If YES, please list:  

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<th>SURNAME</th>
<th>GIVEN NAMES</th>
<th>BLOOD RELATIONSHIP</th>
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No 1  Yes 2  

37. Have any other members of your family attended any Adult Busselton Surveys?  

If YES, please specify:  

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No 1  Yes 2  

5  

B0  

13  

20  

27  

34  

41  

48  

55  

62  

69  

76
Certain diseases affect people from some families more than others. These questions are designed to determine which families might be at greater risk from such diseases.

Please fill the following family details as well as you can recall. For married women, please give married name and maiden name. It would be helpful if you could please indicate adopted children with an "X" next to date of birth column.

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<tr>
<th>SURNAME</th>
<th>MAIDEN NAME</th>
<th>GIVEN NAMES</th>
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<th>Country of birth e.g. Scotland, Italy, England</th>
<th>If deceased year of death or age at death</th>
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THANK YOU VERY MUCH FOR YOUR CO-OPERATION