

Participant
Stickers

The Fenland Study General Questionnaire

**Please try to answer
all the questions**

**If you have any
queries, please ask
one of the staff**

**Your answers will be
treated as confidential
and will only be used
for medical research**

This study is supported by the Medical Research Council

A5.

<i>(Please tick box)</i>	Yes	No
1. Has your doctor ever told you that you have heart trouble?		
2. Have you ever had any pain or discomfort in your chest? <i>If no, proceed to question 7. If yes please answer the next question</i>		
3. Do you experience this discomfort when you walk uphill or hurry?		
4. Do you experience this discomfort when you walk at an ordinary pace on the level?		
5. What do you do if you experience this discomfort while walking?	<input type="checkbox"/> Stop or slow down	
	<input type="checkbox"/> Carry on	
6. If you stand still, what happens to this discomfort?	<input type="checkbox"/> It goes away	
	<input type="checkbox"/> It remains the same or gets worse	
7. Do you often feel faint or have spells of severe dizziness?		
8. Has a doctor ever told you that your blood pressure was too high?		
9. If you have been told that your blood pressure was too high, are you now on treatment?		
10. Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise or might be made worse by exercise?		
11. Are you pregnant?		
12. Is there any reason you know of that means you should not follow an activity programme even if you wanted to?		

For women only

A6. How old were you when you had your first menstrual period?

Don't know
 I have never had a period

A7. Are you still having menstrual periods?

Yes No

If NO, how old were you when you stopped having your periods (i.e. your age at menopause)?

Section B: Smoking and Drinking

B1. Smoking

(please tick box)	Yes	No
Have you ever smoked? <i>If no please go to B2 on the next page</i>		
Do you smoke now?		
At what age did you start smoking <i>Please enter age in years</i>		
If you have stopped smoking in which year did you quit		
How much do you or did you smoke a day on average?		
Number of cigarettes a day		
Number of cheroots a day		
Number of cigars a day		
Amount in grams of tobacco in a week		

B2. Alcoholic Drink

How often do you usually have an alcoholic drink of any kind?

Please tick one box for each line	Yes	No
Do you <u>ever</u> drink alcohol? If you answered no, please go to section C on the next page'		
Do you usually drink every day?		
Do you usually drink almost every day?		
Do you usually drink 3 to 4 times a week?		
Do you usually drink 1 to 2 times a week?		
Do you usually drink about once a fortnight?		
Do you usually drink about once a month?		
Do you usually drink less often than once a month?		

B3. How many units of alcohol do you consume in an average week?

1 unit is equivalent to: ½ pint of beer
 1 glass of wine
 1 single measure of spirits
 1 glass of sherry

Type of alcohol	Units per week
Beer, lager or cider	
Wine	
Spirits	
Fortified wine (sherry, Cinzano, Campari)	

Section C. Occupation.

C1. What is your current work status?

	Yes	No
In work - full time i.e. more than 30 hours per week		
Part time work i.e. less than 30 hours per week		
Keeping house		
Wholly retired from work		
Waiting to start a new job already obtained		
Unemployed and looking for work		
Out of work as temporarily sick		
Permanently sick or disabled		
If other please specify		

Please could you give us some details about your present or your last job?

Please tick only one box per question

C2. Employee or self employed

Do (did) you work as an employee or are (were) you self-employed?

	Please tick one box
Employee	
Self-employed with employees	
Self-employed / freelance without employees (go to question C5)	

C3. Number of employees

For employees: indicate below how many people work (worked) for your employer at the place where you work (worked)

For self-employed: indicate below how many people you employ (employed)

	Please tick one box
1 to 24 people	
25 or more people	

C4. Supervisory status

Do (did) you supervise any other employees

A supervisor or foreman is responsible for overseeing the work of other employees on a day to day basis.

Please tick one box	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

C5. Occupation type

Please tick one box which **best** describes the sort of work you do. If you are not working now, please tick a box to show what you did in your last job.

	Please tick one box	Office use
Modern professional occupations such as: teacher – nurse – social worker – welfare officer – artist – police officer (sergeant or above) – musician – software designer	<input type="checkbox"/>	1
Clerical and intermediate occupations such as: office clerk – secretary – personal assistant – clerical worker – call centre agent – nursing auxiliary – nursery nurse	<input type="checkbox"/>	2
Senior managers or administrators (usually responsible for planning, organising and co-ordinating work and for finance)	<input type="checkbox"/>	3
Technical and craft occupations such as: motor mechanic – fitter – inspector – plumber – printer – tool maker – electrician – gardener – train driver	<input type="checkbox"/>	4
Semi-routine manual and service occupations such as: postal worker – machine operative – security guard – caretaker – farm worker – catering assistant – receptionist – sales assistant	<input type="checkbox"/>	5
Routine manual and service occupations such as: HGV driver – van driver – cleaner – porter – packer – sewing machinist – messenger – labourer – waiter/waitress – bar staff	<input type="checkbox"/>	6
Middle or junior managers such as: office managers – retail manager – bank manager – restaurant manager – warehouse manager – publican	<input type="checkbox"/>	7
Traditional professional occupations such as: accountant – solicitor – medical practitioner – scientist – civil/mechanical engineer	<input type="checkbox"/>	8

C6. Do you have any of the following qualifications? (tick all applicable)

School Leaving certificate		GCE A Level, AS level, Highers		Secretarial College Exams	
CSE		Technical College exams, City & Guilds		Teaching Diploma, HNC, NVQ	
GCE O level or GCSE		HND GNVQ		University Degree	
Matriculation		Completed Apprenticeship		Trade Certificates	
Other Please describe				None	

C7. At what age did you finish full time education?

Years

C8. What is your total combined household income?

< £20,000		£20,000- £40,000		> £40,000	
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C9. How many people are there in your household?
(including children)

C10. Do you own a car or van?

Yes No

C11. Do you own or rent your own home?

Own it/buying it Yes No

Rent it Yes No

C12. What is your marital status? (tick the box which is most applicable)

	Please tick one box only
Single	
Married or living as married	
Widowed	
Separated	
Divorced	

Section D: Dietary patterns

For the following questions please tick the box which is **most** true

D1. How often do you usually eat breakfast?

Never or rarely

1-2 times per week

3-5 times per week

More than 5 times per week

D2. When eating your main meal at home, how often do you usually eat?

Home delivery or take-away meals

Never or rarely

1-2 times per week

3-5 times per week

More than 5 times per week

Ready-made meals/prepared foods

Never or rarely

1-2 times per week

3-5 times per week

More than 5 times per week

Home cooked meals

Never or rarely

1-2 times per week

3-5 times per week

More than 5 times per week

D3. On average, how often do you eat a meal outside of the home (restaurants, pubs, fast-food outlets, etc)?

Less than once a week	<input type="checkbox"/>
Once a week	<input type="checkbox"/>
2-4 times a week	<input type="checkbox"/>
5-6 times a week	<input type="checkbox"/>
Once a day	<input type="checkbox"/>
More than once a day	<input type="checkbox"/>

D4. How often do you eat your meal while watching television or video?

Less than once a week	<input type="checkbox"/>
Once a week	<input type="checkbox"/>
2-4 times a week	<input type="checkbox"/>
5-6 times a week	<input type="checkbox"/>
Once a day	<input type="checkbox"/>
More than once a day	<input type="checkbox"/>

D5. Apart from meals, how often do you eat snack foods while watching television?

Never or rarely	<input type="checkbox"/>
Occasionally	<input type="checkbox"/>
Usually	<input type="checkbox"/>
Always	<input type="checkbox"/>

D6.

We are interested in how often you had snacks or drinks while watching TV in the last 4 weeks in addition to your usual meals. Only think of snacks in addition to your breakfast, lunch or dinner.

Please tick (✓) **one** box only per line.

	<p style="text-align: center;">In the last 4 weeks, on average, how often did you have the following snacks or drinks <u>while watching TV</u> in addition to your breakfast, lunch or dinner?</p>									
	None	1 to 2 times a week	3 to 4 times a week	5 to 6 times a week	Once a day	2 times a day	3 times a day	4 times a day	5 times a day	More than 5 times a day
Savoury snacks (crisps, salted nuts,...)	<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"/>	<input type="checkbox"/>
Sweets, chocolate(s) (bars), cakes, biscuits	<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"/>	<input type="checkbox"/>
Ice cream, chocolate mousse	<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"/>	<input type="checkbox"/>
Yoghurt, rice pudding	<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"/>	<input type="checkbox"/>
Soda (coke,...)	<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"/>	<input type="checkbox"/>
Alcoholic drinks (beer, wine, 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"/>	<input type="checkbox"/>
Fruit 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squash	<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"/>	<input type="checkbox"/>
Milk, milkshake, hot 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea or coffee	<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"/>	<input type="checkbox"/>
Other: _____ _____	<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"/>	<input type="checkbox"/>

D7. Eating patterns:

In the table below, describe the meals or snacks you **usually** eat during a 24hour period.

Tick the boxes that best describe what you eat and when. You may tick more than one box per line.

Time you eat or drink	Main meal cooked dish e.g. meat with potatoes, pizza, lasagne, fish and chips, burgers, fried breakfast	Light meal e.g. porridge, cereal, toast, sandwiches, soup, salad, omelette	Snack e.g. biscuit, cake, fruit, sweets, chocolate, crisps, nuts, ice cream	Drink only snack e.g. drinks with some milk or sugar in; not low calorie drinks or water
6-8 a.m.				
8-10 a.m.				
10-12 a.m.				
12-2 p.m.				
2-4 p.m.				
4-6 p.m.				
6-8 p.m.				
8-10 p.m.				
10-12 p.m.				
0-2 a.m.				
2-4 a.m.				
4-6 a.m.				

D8. Special diets

Please tick to show if you are **currently** on any of the following special diets

Type of diet	Yes, for less than 6 months	Yes, for 6 months or longer
"Weight Watchers"		
"Slimmers World"		
Low fat diet		
Low carbohydrate diet e.g. "Atkins Diet"		
Vegetarian		
Vegan		
Kosher		
Halal		
Other (please describe)		

Section E. Self perceived health status

Mark with a in the one box that best describes your answer.

E1. Overall, how would you rate your health during the past 4 weeks?

Excellent	Very good	Good	Fair	Poor	Very poor
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

E2. During the past 4 weeks, how much did physical health problems limit your usual physical activities (walking, climbing stairs)?

Not at all	Very little	Somewhat	Quite a lot	Could not do physical activities
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

E3. During the past 4 weeks, how much difficulty did you have doing your daily work, both inside and outside the home, because of your physical health?

Not at all	Very little	Somewhat	Quite a lot	Could not do daily work
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

E4. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very severe
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

E5. During the past 4 weeks, how much energy did you have?

Very much	Quite a bit	Some	A little	None
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

E6. During the past 4 weeks, how much did your physical health or emotional problems limit your usual social activities with family or friends?

Not at all	Very little	Somewhat	Quite a lot	Could not do social activities
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

E7. During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

Not at all	Slightly	Moderately	Quite a lot	Extremely
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

E8. During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, studies, or other daily activities?



















Not at all	Very little	Somewhat	Quite a lot	Could not do daily activities
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

E9. Think about what time you went to sleep and you got up in the last 4 weeks. If you had variable sleeping patterns (e.g. you did "shift work"), please record the average time you went to bed and got up on weekdays and on weekend days.

	In the past 4 weeks	
	At what time did you go to sleep?	At what time did you get up?
Week day	____ (pm <input type="checkbox"/> / am <input type="checkbox"/>)	____ (am <input type="checkbox"/> / pm <input type="checkbox"/>)
Weekend day	____ (pm <input type="checkbox"/> / am <input type="checkbox"/>)	____ (am <input type="checkbox"/> / pm <input type="checkbox"/>)

E10

Which of the diagrams shown below best depicts your body outline at a given age and that of your parents when they were middle aged?

Mother in middle age										
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Age 10	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Age 20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yourself	Age 30	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Age 40	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Currently		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Father in middle age										
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Approximately how much did you weigh when you were about 20 years old?

Section F: Ethnic origin

Tick one box only

2001 census ethnicity classification

<i>White</i>		
A	British	<input type="checkbox"/>
B	Irish	<input type="checkbox"/>
C	Any other white background	<input type="checkbox"/>

<i>Mixed</i>		
D	White & Black Caribbean	<input type="checkbox"/>
E	White and Black African	<input type="checkbox"/>
F	White and Asian	<input type="checkbox"/>
G	Any other mixed background	<input type="checkbox"/>

<i>Asian or Asian British</i>		
H	Indian	<input type="checkbox"/>
J	Pakistani	<input type="checkbox"/>
K	Bangladeshi	<input type="checkbox"/>
L	Any other Asian background	<input type="checkbox"/>

<i>Black or Black British</i>		
M	Caribbean	<input type="checkbox"/>
N	African	<input type="checkbox"/>
P	Any other Black background	<input type="checkbox"/>

<i>Other ethnic category</i>		
R	Chinese	<input type="checkbox"/>
S	Any other ethnic category	<input type="checkbox"/>

<i>Not stated</i>		
Z	Not stated	<input type="checkbox"/>

Thank you for completing this questionnaire.