Canadian Partnership for Tomorrow Project

Projet de partenariat canadien Espoir pour demain

Health and Lifestyle Core Questionnaire For Women and Men

BC GENERATIONS PROJECT

Your time today builds a healthier tomorrow.

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L C V QA

13642

Directions For Completing This Questionnaire

The CORE QUESTIONNAIRE may take about 35 to 60 minutes to answer.
Please follow the directions carefully. You will be asked to skip certain questions that do not apply to you.

- We appreciate you completing the whole Questionnaire. However, if a question is not answered or left blank, it will mean that you prefer not to answer a question.
- Use a ballpoint pen, not a felt pen.
- Shade in the bubbles completely, like this: ●
- Write numbers in boxes like this: | 2 | 1 |

  If you are writing a single digit where there is more than one box, it does not matter which box you write the number in.
- If you make an error, put an X through the incorrect bubble like this:

Before starting the questionnaire please make sure to gather your prescription medications and a tape measure so these items are handy.

Please leave the booklet stapled together. The pages will be separated at the study centre.

If you are not sure how to answer a question, please feel free to contact us:

Atlantic Path:
Halifax Area 494-7284
Toll Free 1-877-285-7284
info@atlanticpath.ca

BC Generations Project:
Lower Mainland 604-675-8221
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1-877-263-2360
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Ontario Health Study:
1-866-606-0686
info@ontariohealthstudy.ca

The Tomorrow Project:
Toll Free 1-877-919-9292
Outside Canada call collect
1-403-476-2469
tomorrow@albertahealthservices.ca

DEMOGRAPHIC INFORMATION

DE01 What is your date of birth? DD / MM / YYYY

DE02 What is your sex? ○ Male ○ Female

FAMILY CHARACTERISTICS

FA01 What is your current marital status? Please choose the **ONE** status that best describes your current situation.

○ Married and/or living with a partner

○ Divorced

○ Widowed

○ Separated

○ Single, never married

FA02 How many **biological** siblings (brothers and sisters) do you have? Please include those who have died and half siblings (one common parent) but not step siblings or adopted siblings.

Brothers →
Sisters →
Don't know →

If "0" BROTHER AND "0" SISTER or "DON'T KNOW", SKIP TO FA05 (THIS PAGE)

FA03 How many of your biological siblings are, or were, older than you?
If you are part of a multiple birth (e.g. twins, triplets etc), please treat all of the siblings that were born with you as being the same age as you, regardless of the order in which you were actually born.

Siblings older than me

○ Don't know

FA04 Are you a twin or part of a multiple birth? Multiple births include twins, triplets, quadruplets, quintuplets, sextuplets, etc.

○ Yes

○ No

○ Don't know

FA05 Were you adopted?

○ Yes

○ No

○ Don't know

EDUCATION LEVEL

EL01 What is the highest level of education you have completed?

- ○ Elementary School
- ○ High School
- ○ Trade, technical or vocation school, apprenticeship training or technical CEGEP
- ○ Diploma from a community college, pre-university CEGEP or non-university certificate
- ○ University certificate below Bachelor's level
- ○ Bachelor's degree
- ○ Graduate degree (MSc, MBA, MD, PhD, etc.)
- ○ None → SKIP TO HEALTH STATUS - HS01 (NEXT PAGE)

EL02 What was your age when you completed this level of education?

☐☐ Age when you completed this level of education

○ Don't know

HEALTH STATUS

HS01 How would you rate your general health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

HS02 When was the last time you had a routine medical check-up, undertaken by a doctor or a nurse? A medical check-up is a physical exam that usually includes at least a blood pressure measurement and height and weight measurement.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS03 When was the last time you saw a dental professional, including a dentist or a hygienist?

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS04 When was the last time you had a fecal occult blood test or an FOBT?
A Fecal Occult Blood Test or FOBT is a test to check for blood in your stool, where you have a bowel movement and use a stick or a small brush to smear a small sample on a special card. It is usually collected at home for two or three days in a row.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS05 When was the last time you had a colonoscopy?
A colonoscopy is an exam where a long tube is used to examine the entire colon. Before the procedure is done, you are usually given a sedative.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS06 When was the last time you had a sigmoidoscopy?
A sigmoidoscopy is an exam where a flexible tube is inserted into the rectum and lower part of the large bowel to look for signs of cancer or other problems. The procedure does **not** usually require sedation.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS07 Have you ever had a polyp removed from your colon?
A polyp is an abnormal growth of tissue.

- ○ Yes
- ○ No
- ○ Don't know

WOMEN SKIP TO WOMEN'S HEALTH - WH01 (NEXT PAGE)

MEN'S HEALTH

MH01 When was the last time you had a PSA blood test?
A PSA test is a specific blood test ordered by a doctor to test men for prostate cancer.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

MH02 How many children have you fathered, including live births only?

☐☐ Children

- ○ Don't know

MEN SKIP TO PERSONNAL MEDICAL HISTORY - PM01 (PAGE 12)

WOMEN'S HEALTH

WH01 How old were you when you had your first menstrual period?

☐☐ Age at first menstrual period

○ Never had a menstrual period

○ Don't know

WH02 Have you ever used any hormonal contraceptives for any reason? Hormonal contraceptives include birth control pills, implants, patches, injections, and rings or intra-uterine devices that release female hormones.

○ Yes

○ No → SKIP TO WH05 (THIS PAGE)

○ Don't know →

WH03 How old were you when you started using hormonal contraceptives?

☐☐ Age when started using hormonal contraceptives

○ Don't know

WH04 **In total**, how many years or months did you use or have you been using hormonal contraceptives? Add up all the time that you used contraceptives even if you started and stopped several times.

☐☐ Years **OR** ☐☐ Months

○ Don't know

WH05 How many times have you been pregnant, including live births, stillbirths, spontaneous miscarriages or therapeutic abortions?

☐☐ Number of pregnancies

○ Never been pregnant → SKIP TO WH12 (NEXT PAGE)

○ Don't know →

WH06 How old were you when you first became pregnant?

☐☐ Age at first pregnancy

○ Don't know

WH07 Are you currently pregnant?

○ Yes → In what week are you? ☐☐ Weeks

If YES and it's your first pregnancy, SKIP TO WH12 (THIS PAGE)

○ No

○ Don't know

WH08 Of your pregnancies, how many went to 20 weeks or more? Please include all pregnancies, regardless of outcome.

☐☐ Pregnancies

○ Don't know

WH09 How many children have you given birth to, considering live births only?

☐☐ Live births

○ Don't know

WH10 How old were you when you last became pregnant?

☐☐ Age at last pregnancy

○ Don't know

WH11 In **total**, how many months did you breastfeed or nurse your child or children for? Think about **all** the children you breastfed and the **total** number of months that you breastfed. Take the number of months that you breastfed each child and add them together. If you did not breastfeed any children, enter "0".

☐☐☐ Months

○ Don't know

WH12 Have you ever received hormone fertility treatment to help you get pregnant?

○ Yes

○ No

○ Don't know

WH13 Have you gone through menopause, meaning that your menstrual periods stopped for <u>at least one year</u> and did **not** restart?

○ Yes, natural menopause

○ Yes, other reasons (surgery, chemotherapy, medication)

○ No → SKIP TO WH15 (NEXT PAGE)

○ Don't know →

WH14 How old were you when your menstrual periods stopped for at least one year and did not restart?

☐☐ Age when menstrual periods stopped

○ Don't know

WH15 Have you ever used hormone replacement therapy (HRT) for any reason? Hormone replacement therapy includes progesterone and/or estrogen. It includes all forms such as patches, rings, creams and other topical forms prescribed by a doctor. It does not include thyroid hormone treatment or hormonal contraceptives and it does not include other 'natural' treatments that can be bought over the counter.

○ Yes
○ No → SKIP TO WH18 (THIS PAGE)
○ Don't know →

WH16 How old were you when you started using hormone replacement therapy?

☐☐ Age when started using hormone replacement therapy

○ Don't know

WH17 In **total**, for how many years or months did you use, or have you been using, hormone replacement therapy? Add up all the time that you used hormone replacement therapy even if you started and stopped several times.

☐☐ Years **OR** ☐☐ Months

○ Don't know

WH18 Have you ever had a hysterectomy (an operation to have your uterus or womb removed)?

○ Yes
○ No → SKIP TO WH20 (NEXT PAGE)
○ Don't know →

WH19 How old were you when you had your hysterectomy?

☐☐ Age at hysterectomy

○ Don't know

WH20 Have you ever had an operation to have your ovaries removed?

○ Yes
○ No → SKIP TO WH24 (THIS PAGE)
○ Don't know → SKIP TO WH24 (THIS PAGE)

WH21 Did you have one or both ovaries remove?

○ Both
○ One → SKIP TO WH23 (THIS PAGE)
○ Don't know → SKIP TO WH23 (THIS PAGE)

WH22 Were both of your ovaries removed at the same time?

○ Yes
○ No
○ Don't know

WH23 How old were you when you had the last surgery?

☐☐ Age at last surgery

○ Don't know

WH24 When was the last time you had a mammogram?
A mammogram is a low dose x-ray of the breast in a device that compresses and flattens the breast and is used as a screening test for breast cancer.

○ Less than 6 months ago
○ 6 months to less than 1 year ago
○ 1 year to less than 2 years ago
○ 2 years to less than 3 years ago
○ 3 or more years ago
○ Never
○ Don't know

WH25 When was the last time you had a Pap test or a smear test?
A Pap test (sometimes called a cervical smear) is a test performed by a doctor or a nurse where a sample of cells is taken from the cervix.

○ Less than 6 months ago
○ 6 months to less than 1 year ago
○ 1 year to less than 2 years ago
○ 2 years to less than 3 years ago
○ 3 or more years ago
○ Never
○ Don't know

PERSONAL MEDICAL HISTORY

PM01 Has a doctor ever told you that you had any of the following conditions? If yes, please provide your **age** when you were first diagnosed.

Condition	Diagnosed	Age at first Diagnosis
High blood pressure (hypertension, **not** including during pregnancy)	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Heart attack (myocardial infarction)	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Stroke	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Asthma	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Chronic obstructive pulmonary disease	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Major Depression	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Diabetes	○ Yes → ○ No ○ Don't know If yes, which **type** of diabetes was it? ○ Gestational diabetes **only** ○ Type 1 diabetes ○ Type 2 diabetes ○ Don't know	☐☐ ○ Don't know
Liver cirrhosis	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know

Condition	Diagnosed	Age at first Diagnosis
Chronic hepatitis	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Crohn's disease	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Ulcerative colitis	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Irritable bowel disease	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Eczema	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Lupus	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Psoriasis	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Multiple sclerosis	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Osteoporosis	○ Yes → ○ No ○ Don't know	☐☐ ○ Don't know
Arthritis	○ Yes → ○ No ○ Don't know If yes, which **type** of arthritis was it? ○ Rheumatoid arthritis ○ Osteoarthritis ○ Other (Please specify): ☐ ○ Don't know	☐☐ ○ Don't know

PM02 Has a doctor ever told you that you had cancer or a malignancy of any kind?

○ Yes
○ No → SKIP TO PM04 (PAGE 17)
○ Don't know →

PM03 What **type** of cancer was it and how **old** were you when the cancer was <u>first</u> diagnosed? If you have had cancer more than once, please select each one separately.

- First type of Cancer

Cancer type	**Age at first Diagnosis**	**Treatment**	**Type of treatment**
○ Bladder ○ Brain ○ Breast ○ Cervix ○ Colon ○ Esophagus ○ Kidney ○ Larynx ○ Leukemia ○ Liver ○ Lung and Bronchus ○ Lymphoma ○ Non-Hodgkin Lymphoma ○ Ovary ○ Pancreas ○ Prostate ○ Rectum ○ Skin ○ Stomach ○ Thyroid ○ Trachea ○ Uterus ○ Other Specify: [ ] ○ Don't know	[ ][ ] Age at first diagnosis ○ Don't know	Did you receive treatment for this cancer? ○ Yes → ○ No ○ Don't know	What type of treatment was it? **(Choose ALL that apply)** ○ Chemotherapy ○ Radiation ○ Surgery ○ Other Specify: [ ] ○ Don't know

- Second type of Cancer

Cancer type	Age at first Diagnosis	Treatment	Type of treatment
○ Bladder ○ Brain ○ Breast ○ Cervix ○ Colon ○ Esophagus ○ Kidney ○ Larynx ○ Leukemia ○ Liver ○ Lung and Bronchus ○ Lymphoma ○ Non-Hodgkin Lymphoma ○ Ovary ○ Pancreas ○ Prostate ○ Rectum ○ Skin ○ Stomach ○ Thyroid ○ Trachea ○ Uterus ○ Other Specify: [ ] ○ Don't know	[ ][ ] Age at first diagnosis ○ Don't know	Did you receive treatment for this cancer? ○ Yes → ○ No ○ Don't know	What type of treatment was it? **(Choose ALL that apply)** ○ Chemotherapy ○ Radiation ○ Surgery ○ Other Specify: [ ] ○ Don't know

- Third type of Cancer

Cancer type	Age at first Diagnosis	Treatment	Type of treatment
○ Bladder ○ Brain ○ Breast ○ Cervix ○ Colon ○ Esophagus ○ Kidney ○ Larynx ○ Leukemia ○ Liver ○ Lung and Bronchus ○ Lymphoma ○ Non-Hodgkin Lymphoma ○ Ovary ○ Pancreas ○ Prostate ○ Rectum ○ Skin ○ Stomach ○ Thyroid ○ Trachea ○ Uterus ○ Other Specify: [ ] ○ Don't know	[ ][ ] Age at first diagnosis ○ Don't know	Did you receive treatment for this cancer? ○ Yes → ○ No ○ Don't know	What type of treatment was it? **(Choose ALL that apply)** ○ Chemotherapy ○ Radiation ○ Surgery ○ Other Specify: [ ] ○ Don't know

PM04 Do you have or have you had any other **long-term health conditions**?

○ Yes
○ No → SKIP TO PRESCRIBED MEDICATION - ME01 (NEXT PAGE)
○ Don't know →

Please list these long-term conditions.

Long term condition 1:
Long term condition 2:
Long term condition 3:
Long term condition 4:
Long term condition 5:
Long term condition 6:
Long term condition 7:
Long term condition 8:
Long term condition 9:
Long term condition 10:

PRESCRIBED MEDICATION

ME01 Are you <u>currently</u> taking any medications prescribed by a doctor and dispensed by a pharmacist? Prescription medication could include such things as insulin, nicotine patches, birth control (pills, patches or injections) and other hormonal therapies.

- ○ Yes
- ○ No → SKIP TO FAMILY MEDICAL HISTORY - FM01 (NEXT PAGE)
- ○ Don't know → SKIP TO FAMILY MEDICAL HISTORY - FM01 (NEXT PAGE)

For **each** prescribed medication that you are currently taking, please write down the name of the medication and the drug identification number (DIN).

If you have access to the bottles and containers, write down the name of each medication and DIN from the label. The DIN is an 8 digit number that should be printed on the label that is attached to the container by the pharmacist. It is NOT the prescription number.

Medication	Name of the Medication	Drug Identification Number (DIN)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

FAMILY HEALTH HISTORY

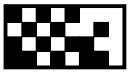
For your family health history, please **ONLY** include **immediate blood relatives**, including your mother, father, children, full and half brothers and sisters. Do not include relatives by marriage, stepbrothers and stepsisters, parents by adoption, stepchildren or adopted children.

FM01 Have any of your **immediate blood relatives** ever been diagnosed by a medical doctor with any of the following long-term health conditions?

	Health Condition			
Mother	Heart attack (myocardial infarction)	○ Yes	○ No	○ Don't know
	Stroke	○ Yes	○ No	○ Don't know
	Diabetes	○ Yes	○ No	○ Don't know
	Chronic obstructive pulmonary disease	○ Yes	○ No	○ Don't know
	High blood pressure	○ Yes	○ No	○ Don't know
	Asthma	○ Yes	○ No	○ Don't know
	Major Depression	○ Yes	○ No	○ Don't know
	Liver cirrhosis	○ Yes	○ No	○ Don't know
	Chronic hepatitis	○ Yes	○ No	○ Don't know
	Crohn's disease	○ Yes	○ No	○ Don't know
	Ulcerative colitis	○ Yes	○ No	○ Don't know
	Irritable bowel disease	○ Yes	○ No	○ Don't know
	Eczema	○ Yes	○ No	○ Don't know
	Lupus	○ Yes	○ No	○ Don't know
	Psoriasis	○ Yes	○ No	○ Don't know
	Multiple sclerosis	○ Yes	○ No	○ Don't know
	Osteoporosis	○ Yes	○ No	○ Don't know
	Arthritis	○ Yes	○ No	○ Don't know

Father	Heart attack (myocardial infarction)	○ Yes	○ No	○ Don't know
	Stroke	○ Yes	○ No	○ Don't know
	Diabetes	○ Yes	○ No	○ Don't know
	Chronic obstructive pulmonary disease	○ Yes	○ No	○ Don't know
	High blood pressure	○ Yes	○ No	○ Don't know
	Asthma	○ Yes	○ No	○ Don't know
	Major Depression	○ Yes	○ No	○ Don't know
	Liver cirrhosis	○ Yes	○ No	○ Don't know
	Chronic hepatitis	○ Yes	○ No	○ Don't know
	Crohn's disease	○ Yes	○ No	○ Don't know
	Ulcerative colitis	○ Yes	○ No	○ Don't know
	Irritable bowel disease	○ Yes	○ No	○ Don't know
	Eczema	○ Yes	○ No	○ Don't know
	Lupus	○ Yes	○ No	○ Don't know
	Psoriasis	○ Yes	○ No	○ Don't know
	Multiple sclerosis	○ Yes	○ No	○ Don't know
	Osteoporosis	○ Yes	○ No	○ Don't know
	Arthritis	○ Yes	○ No	○ Don't know

Siblings ○ I do not have any siblings	Heart attack (myocardial infarction) ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Stroke ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Diabetes ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Chronic obstructive pulmonary disease ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	High blood pressure ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Asthma ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Major Depression ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Liver cirrhosis ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Chronic hepatitis ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Crohn's disease ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Ulcerative colitis ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Irritable bowel disease ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Eczema ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Lupus ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Psoriasis ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Multiple sclerosis ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Osteoporosis ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐
	Arthritis ○ Yes ○ No ○ Don't know	If yes, # of siblings ☐☐



Children ○ I do not have any children	Heart attack (myocardial infarction) ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Stroke ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Diabetes ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Chronic obstructive pulmonary disease ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	High blood pressure ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Asthma ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Major Depression ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Liver cirrhosis ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Chronic hepatitis ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Crohn's disease ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Ulcerative colitis ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Irritable bowel disease ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Eczema ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Lupus ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Psoriasis ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Multiple sclerosis ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Osteoporosis ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐
	Arthritis ○ Yes ○ No ○ Don't know	If yes, # of children ☐☐

FM02 Have any of your **immediate blood relatives**, including your mother, father, children, full and half brothers and sisters ever been diagnosed with cancer?

- ○ Yes
- ○ No → SKIP TO SLEEP PATTERN - SP01 (PAGE 28)
- ○ Don't know → SKIP TO SLEEP PATTERN - SP01 (PAGE 28)

FM03 Has your **biological** mother ever been diagnosed with cancer?

- ○ Yes
- ○ No → SKIP TO FM05 (NEXT PAGE)
- ○ Don't know → SKIP TO FM05 (NEXT PAGE)

FM04 Which of the following **types** of cancer was your mother diagnosed with? Choose **ALL** that apply.

- ○ Bladder
- ○ Brain
- ○ Breast
- ○ Cervix
- ○ Colon
- ○ Esophagus
- ○ Kidney
- ○ Larynx
- ○ Leukemia
- ○ Liver
- ○ Lung and Bronchus
- ○ Lymphoma
- ○ Non-Hodgkin Lymphoma
- ○ Ovary
- ○ Pancreas
- ○ Rectum
- ○ Skin
- ○ Stomach
- ○ Thyroid
- ○ Trachea
- ○ Uterus
- ○ Other; Specify: _____
- ○ Don't Know

FM05 Has your **biological** father ever been diagnosed with cancer?

- ○ Yes
- ○ No → SKIP TO FM07 (NEXT PAGE)
- ○ Don't know → SKIP TO FM07 (NEXT PAGE)

FM06 Which of the following **types** of cancer was your father diagnosed with? Choose **ALL** that apply.

- ○ Bladder
- ○ Brain
- ○ Breast
- ○ Colon
- ○ Esophagus
- ○ Kidney
- ○ Larynx
- ○ Leukemia
- ○ Liver
- ○ Lung and Bronchus
- ○ Lymphoma
- ○ Non-Hodgkin Lymphoma
- ○ Pancreas
- ○ Prostate
- ○ Rectum
- ○ Skin
- ○ Stomach
- ○ Thyroid
- ○ Trachea
- ○ Other; Specify: _____
- ○ Don't Know

FM07 Have any of your **biological** siblings ever been diagnosed with cancer?

○ Yes → If yes, how many siblings ☐☐

○ Don't know

○ No

○ I do not have any siblings

○ Don't know

FM08 Have any of your **biological** children ever been diagnosed with cancer?

○ Yes → If yes, how many children ☐☐

○ Don't know

○ No

○ I do not have any children

○ Don't know

IF "NO" FOR FM07 AND FM08 **OR**
IF "DON'T HAVE SIBLINGS AND CHILDREN" **OR**
IF, "DON'T KNOW" FOR FM07 AND FM08

SKIP TO SLEEP PATTERN - SP01 (PAGE 28)

FM09 For your biological siblings and children, please indicate how many siblings and children have been diagnosed with each of the cancer types listed below. Enter "0" if none of your siblings or children has been diagnosed with a particular type of cancer.

Cancer type	Number siblings diagnosed	Number children diagnosed
Bladder	☐☐ Number siblings	☐☐ Number children
Brain	☐☐ Number siblings	☐☐ Number children
Breast	☐☐ Number siblings	☐☐ Number children
Cervix	☐☐ Number siblings	☐☐ Number children
Colon	☐☐ Number siblings	☐☐ Number children
Esophagus	☐☐ Number siblings	☐☐ Number children
Kidney	☐☐ Number siblings	☐☐ Number children
Larynx	☐☐ Number siblings	☐☐ Number children
Leukemia	☐☐ Number siblings	☐☐ Number children
Liver	☐☐ Number siblings	☐☐ Number children
Lung and Bronchus	☐☐ Number siblings	☐☐ Number children
Lymphoma	☐☐ Number siblings	☐☐ Number children
Non-Hodgkin Lymphoma	☐☐ Number siblings	☐☐ Number children
Ovary	☐☐ Number siblings	☐☐ Number children
Pancreas	☐☐ Number siblings	☐☐ Number children
Prostate	☐☐ Number siblings	☐☐ Number children
Rectum	☐☐ Number siblings	☐☐ Number children

Cancer type	Number siblings diagnosed	Number children diagnosed
Skin	☐☐ Number siblings	☐☐ Number children
Stomach	☐☐ Number siblings	☐☐ Number children
Thyroid	☐☐ Number siblings	☐☐ Number children
Trachea	☐☐ Number siblings	☐☐ Number children
Uterus	☐☐ Number siblings	☐☐ Number children
Other	☐☐ Number siblings Specify the cancer type	☐☐ Number children Specify the cancer type
Don't Know	☐☐ Number siblings	☐☐ Number children

SLEEP PATTERN

SP01 On average, how many hours per day do you usually sleep, including naps? A day refers to a 24 hour period. Please think of the total amount of unbroken sleep.

☐☐ Hours **AND** ☐☐ Minutes

○ Don't know

SP02 How often do you have trouble going to sleep or staying asleep?

○ None of the time
○ A little of the time
○ Some of the time
○ Most of the time
○ All the time
○ Don't know

SP03 On average, how much light enters your room while you are sleeping?

○ Virtually no light
○ Some light
○ A lot of light
○ Don't know

SUNLIGHT

SU01 In the past 12 months, how many times have you used artificial tanning equipment such as a tanning bed, sunlamp or tanning light for any reason, including medical reasons?

- ○ Never
- ○ 1 to 4 times
- ○ 5 to 9 times
- ○ 10 to 14 times
- ○ 15 to 19 times
- ○ 20 to 24 times
- ○ 25 or more times
- ○ Don't know

SU02 After several months of not being in the sun, if you then went out in the sun during the summer in the middle of the day without sunscreen or protective clothing for one hour, which one of these would happen to your skin? If you do not go out in the sun, make your best guess of what would happen if you did.

- ○ A severe sunburn with blistering
- ○ A painful sunburn for a few days followed by peeling
- ○ Mildly burnt followed by tanning
- ○ Darker/brown without any sunburn
- ○ There would be no change
- ○ Other

SU03 What is your natural hair colour? If your hair is now grey, please select the colour of your hair before it turned grey. Choose **ONE** only.

- ○ Blonde
- ○ Red
- ○ Light brown
- ○ Dark brown
- ○ Black

SU04 What your natural eye colour? Choose **ONE** only.

- ○ Amber
- ○ Blue
- ○ Brown
- ○ Grey
- ○ Green
- ○ Hazel
- ○ Red (Albino)

FOOD CONSUMED IN A TYPICAL DAY

The next few questions ask about food you eat in a typical day. Since diet is a very important area, we will ask more about this in the future. Today we will ask only a few basic questions.

FC01 In a typical day, how many total servings of vegetables do you eat? A serving of fresh, frozen, canned or cooked leafy vegetables is about 1/2 cup or 125 ml.

☐☐ Servings/day

○ None

○ Don't know

FC02 In a typical day, how many total servings of fruit (not including fruit juice) do you eat? A serving is about 1/2 cup or 125 ml of fresh, frozen or canned fruit.

☐☐ Servings/day

○ None

○ Don't know

FC03 In a typical day, how many total servings of 100% fruit or vegetable juice do you drink? This includes mixtures of fruit and vegetable juice, but not fruit drinks or fruit cocktails. A serving of fruit or vegetable juice is about 1/2 cup or 125 ml.

☐☐ Servings/day

○ None

○ Don't know

ALCOHOL USE

AU01 Have you ever consumed alcohol?

- ○ Yes
- ○ No → SKIP TO TOBACCO USE - TU01 (PAGE 33)
- ○ Don't know → SKIP TO TOBACCO USE - TU01 (PAGE 33)

AU02 On average, over the last year, how often did you drink alcohol?

- ○ 6 to 7 times a week
- ○ 4 to 5 times a week
- ○ 2 to 3 times a week
- ○ Once a week
- ○ 2 to 3 times a month → SKIP TO AU05 (NEXT PAGE)
- ○ About once a month → SKIP TO AU05 (NEXT PAGE)
- ○ Less than monthly → SKIP TO AU05 (NEXT PAGE)
- ○ Never → SKIP TO TOBACCO USE - TU01 (PAGE 33)
- ○ Don't know → SKIP TO TOBACCO USE - TU01 (PAGE 33)

AU03 On average, how many drinks do you have during a typical week?

A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle of can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43mL) of liquor.

	Drink(s) per week		
Red Wine		○ None	○ Don't know
White Wine		○ None	○ Don't know
Beer		○ None	○ Don't know
Liquor/Spirits		○ None	○ Don't know
Other Alcohol		○ None	○ Don't know

AU04 During a typical week, do you drink alcohol mostly on weekend (or non working) days?

- ○ Yes
- ○ No

MEN ONLY, WOMEN SKIP TO AU06

AU05 During the past 12 months, how often did you have five or more drinks at the same sitting or occasion?

- ○ 6 to 7 times a week
- ○ 4 to 5 times a week
- ○ 2 to 3 times a week
- ○ Once a week
- ○ 2 to 3 times a month
- ○ About once a month
- ○ 6 to 11 times a year
- ○ 1 to 5 times a year
- ○ Never
- ○ Don't know

WOMEN ONLY, MEN SKIP TO TOBACCO USE - TU01 (NEXT PAGE)

AU06 During the past 12 months, how often did you have four or more drinks at the same sitting or occasion?

- ○ 6 to 7 times a week
- ○ 4 to 5 times a week
- ○ 2 to 3 times a week
- ○ Once a week
- ○ 2 to 3 times a month
- ○ About once a month
- ○ 6 to 11 times a year
- ○ 1 to 5 times a year
- ○ Never
- ○ Don't know

TOBACCO USE

This section is about tobacco. The first questions are about **CIGARETTE SMOKING**. The term "cigarette" refers to cigarettes that are bought ready-made as well as those you roll yourself. Do not include cigars, cigarillos or pipes when you answer these first questions about cigarettes.

In this section, **read the directions and follow the arrows carefully**. There are different "paths" for non-smokers, daily smokers, and occasional smokers.

TU01 Have you smoked at least 100 cigarettes in your life? (About 4 - 5 packs)

- ○ Yes → SKIP TO TU03 (THIS PAGE)
- ○ No
- ○ Don't know

TU02 Have you ever smoked a whole cigarette?

- ○ Yes
- ○ No → SKIP TO TU16 (PAGE 35)
- ○ Don't know →

TU03 At what age did you smoke your first whole cigarette?

☐☐ Age

TU04 At the present time, do you smoke cigarettes daily, occasionally, or not at all?

- ○ Daily (At least one cigarette every day for the past 30 days) → GO TO TU05 (THIS PAGE)
- ○ Occasionally (At least one cigarette in the past 30 days, but not every day) → GO TO TU09 (NEXT PAGE)
- ○ Not at all (You did not smoke at all in the past 30 days) → GO TO TU11 (NEXT PAGE)

TU05 At what age did you begin smoking cigarettes daily?

☐☐ Age

TU06 How many cigarettes do you smoke each day now?

- ○ 1 - 5 cigarettes
- ○ 6 - 10 cigarettes
- ○ 11 - 15 cigarettes
- ○ 16 - 20 cigarettes
- ○ 21 - 25 cigarettes
- ○ 26+ cigarettes → If 26+, how many? ☐☐

TU07 For how many total years have you smoked daily?

TU08 During the total years that you have smoked daily, about how many cigarettes per day have you usually smoked? (If your smoking pattern has changed over the years, make your best guess of the average number of cigarettes you have smoked per day)

○ 1 - 5 cigarettes ○ 16 - 20 cigarettes

○ 6 - 10 cigarettes ○ 21 - 25 cigarettes

○ 11 - 15 cigarettes ○ 26+ cigarettes → If 26+, how many? | | |

→ If **you currently smoke <u>daily</u>** SKIP TO TU16 (NEXT PAGE)

TU09 On how many of the last 30 days did you smoke at least one cigarette?

○ 1 - 5 days ○ 11 - 20 days

○ 6 - 10 days ○ 21 - 29 days

TU10 On the days that you smoked, how many cigarettes did you usually smoke?

○ 1 - 5 cigarettes ○ 16 - 20 cigarettes

○ 6 - 10 cigarettes ○ 21 - 25 cigarettes

○ 11 - 15 cigarettes ○ 26+ cigarettes

TU11 Have you ever smoked cigarettes daily? (At least one cigarette a day for 30 days in a row)

○ Yes

○ No → SKIP TO TU16 (NEXT PAGE)

○ Don't know →

TU12 At what age did you begin to smoke daily?

Age

TU13 When you smoked daily, how many cigarettes did you usually smoke each day?

○ 1 - 5 cigarettes ○ 16 - 20 cigarettes

○ 6 - 10 cigarettes ○ 21 - 25 cigarettes

○ 11 - 15 cigarettes ○ 26+ cigarettes → If 26+, how many? ☐☐

TU14 For how many total years did you smoke daily?

☐☐ Years

TU15 When did you stop smoking cigarettes daily?

○ Less than 1 year ago ○ More than 5 years ago

○ 1 to 2 years ago ○ Don't know

○ 3 to 5 years ago

→ **Everyone answers the last questions.**

TU16 **In your lifetime**, have you ever used other types of tobacco on a regular basis and for a period of at least six months?

○ Yes

○ No → SKIP TO ENVIRONMENTAL TOBACCO SMOKE - ET01 (PAGE 37)

○ Don't know →

TU17 What other types of products listed below have you ever used on a regular basis and for a period of at least six months?

Cigars	○ Yes ○ No ○ Don't know
Small cigars (cigarillos)	○ Yes ○ No ○ Don't know
Tobacco pipes	○ Yes ○ No ○ Don't know
Chewing tobacco or snuff	○ Yes ○ No ○ Don't know
Nicotine patches	○ Yes ○ No ○ Don't know
Nicotine gum	○ Yes ○ No ○ Don't know
Betel nut	○ Yes ○ No ○ Don't know
Paan	○ Yes ○ No ○ Don't know
Sheesha	○ Yes ○ No ○ Don't know
Other, specify ☐	○ Yes ○ No ○ Don't know

TU18 Do you currently use any other types of products listed below?

Cigars	○ Yes ○ No ○ Don't know
Small cigars (cigarillos)	○ Yes ○ No ○ Don't know
Tobacco pipes	○ Yes ○ No ○ Don't know
Chewing tobacco or snuff	○ Yes ○ No ○ Don't know
Nicotine patches	○ Yes ○ No ○ Don't know
Nicotine gum	○ Yes ○ No ○ Don't know
Betel nut	○ Yes ○ No ○ Don't know
Paan	○ Yes ○ No ○ Don't know
Sheesha	○ Yes ○ No ○ Don't know
Other, specify	○ Yes ○ No ○ Don't know

ENVIRONMENTAL TOBACCO SMOKE

ET01 From birth until the age of 18, how many years did you live with a person who smoked cigarettes, cigars or pipes **inside your home**?

☐☐ Years

○ None

○ Don't know

ET02 As an adult, from age 18 years to now, how many years did you live with a person who smoked cigarettes, cigars or pipes **inside your home**?

☐☐ Years

○ None

○ Don't know

ET03 At home, how often are you usually exposed to other people's tobacco smoke **inside your home**?

○ Every day

○ Almost every day

○ At least once a week

○ At least once a month

○ Less than once a month

○ Never

○ Don't know

ET04 During leisure time **outside of your home**, how often are you usually exposed to other people's tobacco smoke?

○ Every day

○ Almost every day

○ At least once a week

○ At least once a month

○ Less than once a month

○ Never

○ Don't know

ET05 As an adult, from age 18 years to now, how many years did you regularly **work** in an environment where other people smoked cigarettes, cigars or pipes in your presence?

☐☐ Years

○ None

○ Don't know

ET06 **At work**, how often are you usually exposed to other people's tobacco smoke?

- ○ Every day
- ○ Almost every day
- ○ At least once a week
- ○ At least once a month
- ○ Less than once a month
- ○ Never
- ○ Don't know

PHYSICAL ACTIVITY

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

PA01 During the **last 7 days**, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling?

☐ days per week

○ No vigorous physical activities → SKIP TO PA03 (THIS PAGE)

PA02 How much time did you usually spend doing **vigorous** physical activities on one of those days?

☐☐ hours per day AND ☐☐ minutes per day

○ Don't know/Not sure

Think about all the **moderate** activities that you did in the **last 7 days**. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

PA03 During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

☐ days per week

○ No moderate physical activities → SKIP TO PA05 (NEXT PAGE)

PA04 How much time did you usually spend doing **moderate** physical activities on one of those days?

☐☐ hours per day AND ☐☐ minutes per day

○ Don't know/Not sure

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

PA05 During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time?

☐ days per week

○ No walking → SKIP TO PA07 (THIS PAGE)

PA06 How much time did you usually spend **walking** on one of those days?

☐☐ hours per day AND ☐☐ minutes per day

○ Don't know/Not sure

The last questions are about the time you spent **sitting** on weekdays and weekend days during the **last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

PA07 During the **last 7 days**, how much time did you spend **sitting** on a **week day**?

☐☐ hours per day AND ☐☐ minutes per day

○ Don't know/Not sure

PA08 During the **last 7 days**, how much time did you spend **sitting** on a **weekend day**?

☐☐ hours per day AND ☐☐ minutes per day

○ Don't know/Not sure

ETHNIC BACKGROUND

EB01 What is your ethnic background and the ethnic background of your biological parents? Choose **ALL** that apply.

Ethnic background	You	Mother	Father
Aboriginal (e.g. First Nations, Métis, Inuit)	○	○	○
Arab (e.g Egypt, Iraq, Jordan, Lebanon)	○	○	○
Black (African or Caribbean descent)	○	○	○
East Asian (e.g. China, Japan, Korea, Taiwan)	○	○	○
Filipino	○	○	○
Jewish	○	○	○
Latin American/Hispanic	○	○	○
South Asian (e.g. India, Sri Lanka, Pakistan, Bangladesh)	○	○	○
Southeast Asian (e.g. Malaysia, Indonesia, Viet Nam)	○	○	○
West Asian (e.g. Turkey, Iran, Afghanistan)	○	○	○
White (European descent)	○	○	○
Other ethnic group not listed above	○	○	○

EB02 In what country were you and your **biological** parents and grandparents born? Choose only **ONE** per person.

Country of birth	**You**	**Mother**	**Father**	**Mother's mother**	**Mother's father**	**Father's Mother**	**Father's Father**
Canada	○	○	○	○	○	○	○
China	○	○	○	○	○	○	○
France	○	○	○	○	○	○	○
Germany	○	○	○	○	○	○	○
Greece	○	○	○	○	○	○	○
India	○	○	○	○	○	○	○
Islamic Republic of Iran	○	○	○	○	○	○	○
Ireland	○	○	○	○	○	○	○
Italy	○	○	○	○	○	○	○
Jamaica	○	○	○	○	○	○	○
Republic of Korea	○	○	○	○	○	○	○
Philippines	○	○	○	○	○	○	○
Poland	○	○	○	○	○	○	○
Portugal	○	○	○	○	○	○	○
Russian Federation	○	○	○	○	○	○	○
Ukraine	○	○	○	○	○	○	○
United Kingdom	○	○	○	○	○	○	○
United States	○	○	○	○	○	○	○
Viet Nam	○	○	○	○	○	○	○
Other country	○ please specify ☐	○ please specify ☐	○ please specify ☐	○ please specify ☐	○ please specify ☐	○ please specify ☐	○ please specify ☐
Don't know	○	○	○	○	○	○	○

IF YOU WERE BORN IN CANADA SKIP TO RESIDENCE - RE01 (THIS PAGE)

EB03 How old were you when you first came to Canada to live?

☐☐ Age when you first came to Canada to live

○ Don't know

RESIDENCE

RE01 What is your current village/town/city?

RE02 What is your current postal code?

☐☐☐ ☐☐☐

RE03 How old were you when you started living in the dwelling where you live now?

☐☐ Age when started living at current location

○ Don't know

RE04 Throughout your life to date, is the dwelling that you live in now the one where you have lived for the **longest period of time**?

○ Yes

○ No

○ Don't know

LANGUAGES

LS01 What is the language that you first learned at home in childhood and can still understand? Choose **ALL** that apply if more than one language was learned at the same time.

- ○ English
- ○ French
- ○ Arabic
- ○ Aboriginal Language(s)
- ○ Bengali
- ○ Cantonese
- ○ Danish
- ○ Dutch
- ○ Farsi/Persian
- ○ Finnish
- ○ Gaelic
- ○ German
- ○ Greek
- ○ Hindi
- ○ Hungarian
- ○ Icelandic
- ○ Italian
- ○ Korean
- ○ Mandarin
- ○ Norwegian
- ○ Polish
- ○ Portuguese
- ○ Punjabi
- ○ Russian
- ○ Spanish
- ○ Swedish
- ○ Tagalog/Filipino
- ○ Tamil
- ○ Ukrainian
- ○ Urdu
- ○ Vietnamese
- ○ Welsh
- ○ Other, please specify:

WORKING STATUS

WS01 Which of the following best describes your current employment status?
Choose **ALL** that apply
Full time means 30 hours or more per week. Part time means less than 30 hours per week.

- ○ Full-time employed/self-employed
- ○ Part-time employed/self-employed
- ○ Retired
- ○ Looking after home and/or family
- ○ unable to work because of sickness or disability
- ○ Unemployed
- ○ Doing unpaid or voluntary work
- ○ Student

IF EMPLOYED OR SELF-EMPLOYED (FULL-TIME OR PART-TIME), GO TO WS02,

OTHERWISE, SKIP TO WS07 (NEXT PAGE)

WS02 What is currently your main job title, meaning the job at which you work the most hours? Give as full a description as you can (e.g. office clerk, factory worker, forestry technician)

[ ]

○ Don't know

WS03 What kind of business, industry or service do you work in?

[ ]

○ Don't know

WS04 How old were you when you started working at your current job?

[ ][ ] Age when you started working at current job

○ Don't know

WS05 Which one of following **best describes** your working schedule in your current job?
A night shift is work during the early hours of the morning, after midnight. An evening shift is work during the evening ending at or before midnight.
Choose **ONE** only

- ○ Regular daytime schedule or shift
- ○ Regular evening shift
- ○ Regular night shift
- ○ Rotating shift, changing periodically from days to evenings or to nights
- ○ Split shift, consisting of two or more distinct periods each day
- ○ Irregular schedule, or on call
- ○ Other, Specify [ ]

WS06 Is your <u>current</u> job the one you have worked in for the longest time (most number of years)?

○ Yes → SKIP TO HOUSEHOLD INCOME - HI01 (NEXT PAGE)

○ No

WS07 What was the title of the main job that you held for the **longest time**, meaning the one at which you worked the most hours?
Refer to the jobs that you did when you were employed by someone else, or when you were self-employed. Give as full a description as you can (e.g. office clerk, factory worker, forestry technician.)

○ Don't know

WS08 What kind of business, industry or service did you work in for the **longest time** (most number of years)?

○ Don't know

WS09 Which one of the following **best describes** your working schedule for the job that you held for the **longest time**? A night shift is work during the early hours of the morning, after midnight. An evening shift is work during the evening ending at or before midnight. Choose **ONE** only

○ Regular daytime schedule or shift

○ Regular evening shift

○ Regular night shift

○ Rotating shift, changing periodically from days to evenings or to nights

○ Split shift, consisting of two or more distinct periods each day

○ Irregular schedule, or on call

○ Other, Specify

HOUSEHOLD INCOME

The next question asks for your household income. We understand that this information is very private but the question is important because it helps to determine whether the study includes a wide range of participants.

HI01 What is the approximate total household income (from all sources) before taxes last year? Please include the total income including salaries, pensions and allowances.

- ○ Less than $10, 000
- ○ $10, 000 - $24, 999
- ○ $25, 000 - $49, 999
- ○ $50, 000 - $74, 999
- ○ $75, 000 - $99, 999
- ○ $100, 000 - $149, 999
- ○ $150, 000 - $199, 999
- ○ $200, 000 or more
- ○ Don't know
- ○ Prefer not to answer

HI02 How many individuals does that income support, including children, parents and other persons living in your home and outside your home?

☐☐ Individuals

○ Don't know

HI03 How many **adults (age 18 or older)** including yourself are currently living in your household?

☐☐ Adults

HI04 How many **children (under 18 years of age)** are currently living in your household?

☐☐ Children

ANTHROPOMETRIC MEASUREMENTS

AM01 Do you regard yourself as being left or right-handed, or ambidextrous?
An ambidextrous person is able to use either hand with equal dexterity.

- ○ Left
- ○ Right
- ○ Ambidextrous

AM02 Are you able to stand without assistance?

- ○ Yes
- ○ No → IF you are UNABLE TO STAND WITHOUT ASSISTANCE, this is the end of the questionnaire. Thank you for taking the time to complete this survey.

Date of completion of the questionnaire: DD / MM / YYYY

ANTHROPOMETRIC MEASUREMENTS

In this part of the survey, we need you to take measurements of your height, weight, waist and buttocks. All measures should be taken twice.

Height

- Remove your shoes and any headwear (e.g., hair clips, hat);
- Stand up straight against a wall with your feet together, and your heels, buttocks and shoulder blades touching the wall;
- Look straight ahead and lay a hardcover book flat on top of your head;
- Use a pencil to make a mark on the wall in line with the bottom edge of the book;
- Measure the distance between the floor and the mark;
- Repeat the measurement. The two measurements should be within a half inch (or one centimetre) of each other. If not, take a third measurement and record the closest two measurements.
- Record your height feet and inches (or centimetres).

AM03 First Measurement ☐ feet ☐ inches **OR** ☐ centimetres

AM04 Second Measurement ☐ feet ☐ inches **OR** ☐ centimetres

Weight

- Adjust your scale to zero;
- Weigh yourself with your clothes off, or wear light clothing. Remember to remove your shoes.
- Step on the scale. Make sure both feet are fully on the scale.
- Weigh yourself twice. The two weights should be within one pound (or one kilogram) of each other. If not, weigh yourself a third time and record the closer of the two measurements.
- Record your weight in pounds (or kilograms Example: 72.2).

AM05 First Measurement ☐ pounds **OR** ☐ kilograms

AM06 Second Measurement ☐ pounds **OR** ☐ kilograms

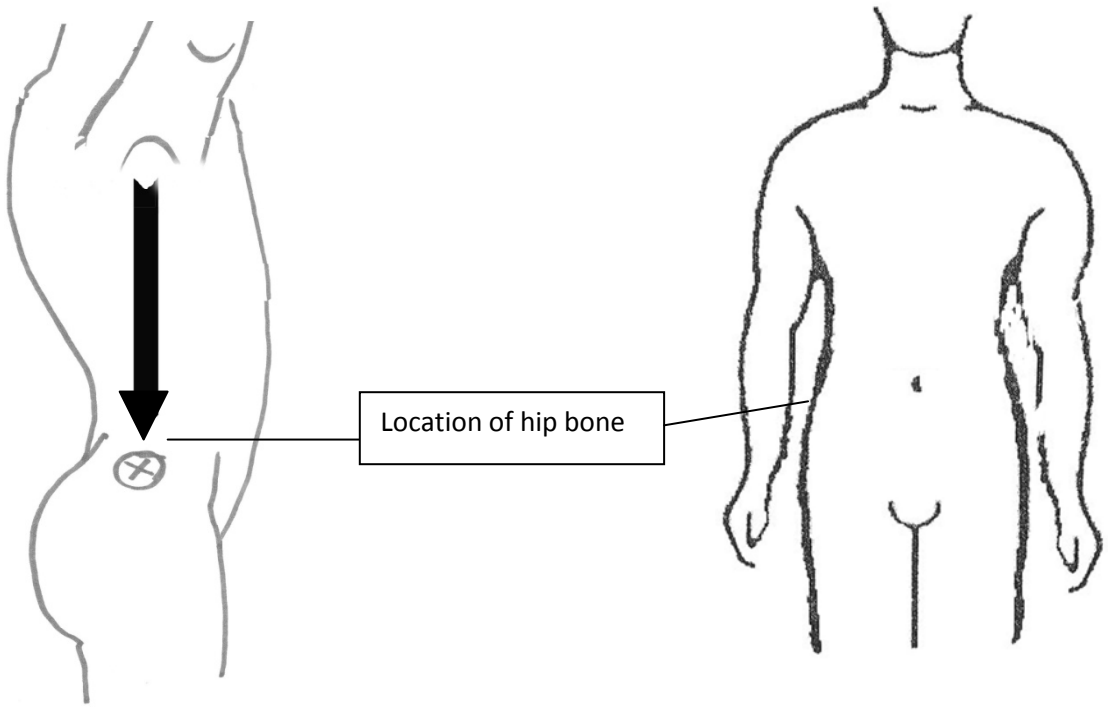
WAIST AND HIPS

Take the next set of measurements ideally unclothed or in loose fitting underwear

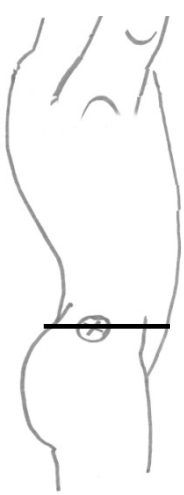
1. Stand in front of a mirror to help position the measuring tool correctly.
2. Pull the measuring tool tight enough that it does not slide, but not too tight to indent the skin;
3. Record the measurement in inches (or centimetres).

Waist

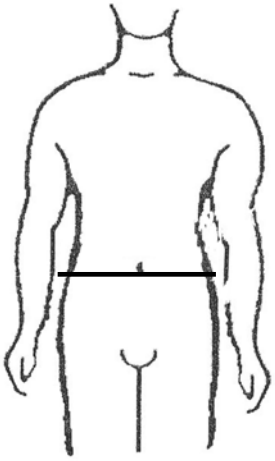
- This measurement is taken at a specific spot found along your side. To find the spot simply place your thumb under your armpit, then slide your thumb straight down until you find the hip bone. (see diagram)



- Place your measuring tool over that spot where your thumb found the bone, then wrap the measuring tool around your middle.



Wrap the measuring tape around your middle



- Look in the mirror and turn in a circle to ensure the measuring tool is level all around and not twisted at any point. Take the measurement, EVEN IF THIS IS NOT YOUR USUSAL WAISTLINE.

- Measure twice. The two measurements should be within a half inch (or one centimetre) of each other. If they are not, take a third measurement and record the closest two measurements.

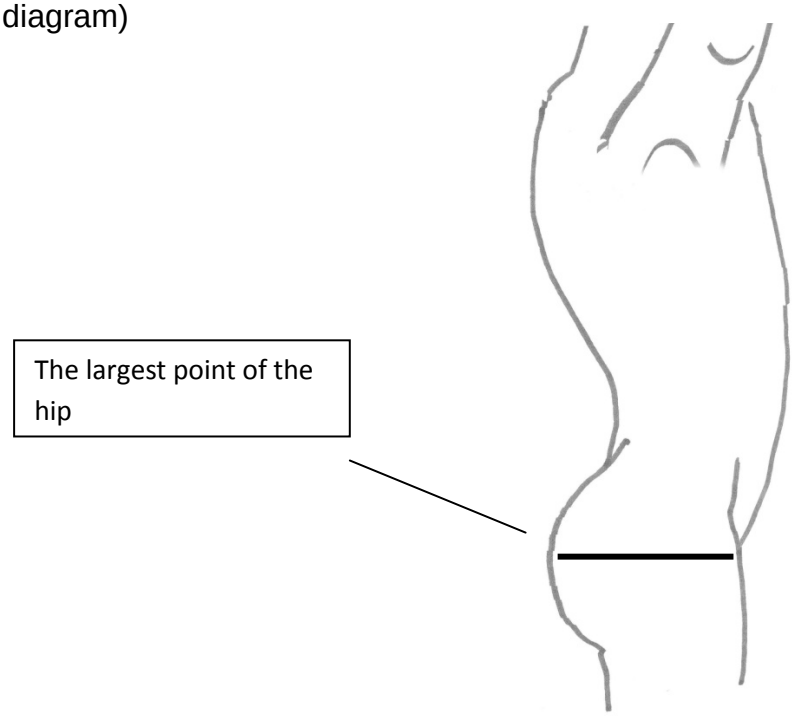
- Record your measurement to the nearest inch (or centimetre).

AM07 First Measurement ☐ inches **OR** ☐ centimetres

AM08 Second Measurement ☐ inches **OR** ☐ centimetres

Hips

- Stand in profile to a mirror with your feet shoulder width apart.
- Look for the largest point of your buttocks and place the measuring tool at that position. (See diagram)



- Now turn in a full circle in front of the mirror to be certain the measuring tool is level all the way around your body. Take the measurement.
- Measure twice. The two measurements should be within a half inch (or one centimetre) of each other. If not, take a third measurement and record the closest two measurements.
- Record the size of your buttocks to the nearest inch (or centimetre).

AM09 First Measurement ☐ inches **OR** ☐ centimetres

AM10 Second Measurement ☐ inches **OR** ☐ centimetres

This is the end of the questionnaire!

We plan to contact you periodically to request additional information related to important risk factors such as diet, environmental exposures and psychosocial factors.

Thank you for taking the time to complete this questionnaire.