Lungehelseundersøkelsens Generasjonsstudie

– translated «The lung health investigation's Generation Study"
Name chosen in order to be as similar as possible to

Airways symptoms and allergic symptoms

1. Have you had wheezing or whistling in your chest at any time **in the last 12 months?** ☐No ☐Yes

If NO go to question 2, if YES:

1.1. Have you been at all breathless when the wheezing noise was present? ..... ☐No ☐Yes

1.2. Have you had this wheezing or whistling when you did not have a cold?..... ☐No ☐Yes

2. Have you woken up with a feeling of tightness in your chest at any time **in the last 12 months?** ..... ☐No ☐Yes

3. Have you been woken by an attack of shortness of breath at any time **in the last 12 months?** ..... ☐No ☐Yes

4. Have you been woken by an attack of coughing at any time **in the last 12 months?**... ☐No ☐Yes

5. Have you had an attack of asthma **in the last 12 months**? ..... ☐No ☐Yes

6. Are you currently taking any medicine (including inhalers, aerosols or tablets) for asthma?..... ☐No ☐Yes

7. Do you have any nasal allergies including hay fever?..... ☐No ☐Yes

8. What is your date of birth? (day/month/year) ..... ____dd ____mm_____yyyy

9. What is today's date? (day/month/year) ..... ____dd ____mm _____yyyy

10. Gender ☐Man ☐Woman

11. How tall are you? ..... _____cm

12. How much do you weigh? ..... _____ kg

13. In recent years, have you been troubled by a protracted cough?..... ☐No ☐Yes

14. Do you usually bring up phlegm or do you have phlegm in your lungs which you have difficulty bringing up? ☐No ☐Yes

If NO to question 13 and 14 go to question 15, if YES:

14.1. Do you cough or bring up phlegm in this way almost every day for at least three months every year? ..... ☐No ☐Yes

14.2. Have you had periods of this kind for at least two years in a row? ☐No ☐Yes

15. Do you have or have you ever had asthma?..... ☐No ☐Yes

If NO go to question 16, if YES:

15.1. Have you ever had asthma diagnosed by a doctor?..... ☐No ☐Yes

15.2. How old were you when you first experienced asthma symptoms? _____years

15.3. How old were you when you last experienced asthma symptoms?..... _____years

16. Has a doctor ever told you that you have chronic obstructive pulmonary disease (COPD)? ☐No ☐Yes

17. Have you been woken by an attack of shortness of breath at any time in **the last 3 days**? ☐No ☐Yes

18. Have you been woken by an attack of coughing at any time in **the last 3 days**? ☐No ☐Yes

19. Have you had wheezing or whistling in your chest in **the last 3 days**? ☐No ☐Yes

20. Have you **ever** had wheezing or whistling in your chest? ☐No ☐Yes

If NO go to question 21, if YES:

20.1 How old were you when you first noticed wheezing or whistling in your chest? ..... _____ years

21. Have you ever experienced nasal symptoms such as nasal congestion, rhinorrhoea (runny nose) and/or sneezing attacks without having a cold? ☐No ☐Yes

If No go to question 22, if YES:

21.1. How old were you when you experienced such nasal symptoms for the first time? _____ years

21.2. Have you had such nasal symptoms in **the last 12 months**?..... ☐No ☐Yes

21.3. Has this nose problem been accompanied by itchy or watery eyes? ☐No ☐Yes

21.4. In which months of the year did this nose problem occur?

January / February ..... ☐

March / April ..... ☐

May / June..... ☐

July / August ..... ☐

September / October..... ☐

November / December…… ☐

22. Have you ever had eczema or any kind of skin allergy? ☐No ☐Yes

If NO go to question 23,if YES:

22.1. How old were you when you first had eczema or skin allergy? _____ years

23. Have you ever had an itchy rash that was coming and going for at least 6 months? ☐No ☐Yes

If NO go to question 24, if YES:

23.1. Have you had this itchy rash in **the last 12 months**? ☐No ☐Yes

23.2. Has this itchy rash at any time affected any of the following places:
the folds of the elbows, behind the knees, in front of the ankles, under the buttocks or around the neck, ears or eyes? ☐No ☐Yes

23.3. Has this itchy rash affected your hands at any time in **the last 12 months?** ☐No ☐Yes

24. Have you ever had an illness or truoble caused by eating **a particular** food or foods? ☐No ☐Yes

If NO go to question 25, if YES:

24.1. Have you nearly always had the same illness or trouble after eating this type of food? ☐No ☐Yes

If NO go to question 25, if YES:

24.2. What type of food was this (*list up to three foods*)?

_____

24.3. Did this illness or truoble include:

24.3.1. a rash or itchy skin? ☐No ☐Yes

24.3.2. diarrhea or vomiting? ☐No ☐Yes

24.3.3. runny or stuffy nose? ☐No ☐Yes

24.3.4. severe headaches? ☐No ☐Yes

24.3.5. breathlessness? ☐No ☐Yes

24.4. How soon after eating this food did/do you get the first sympoms?

Less than half an hour	½ - 1 hour	1-2 hours	2-4 hours	More than 4 hours
☐	☐	☐	☐	☐

24.5. How old were you when you **first** had this attack? _____years

24.6. How old were you when you **last** had this attack? _____years

Smoking habits

25. Do you smoke? (this applies even if you only smoke the odd cigarette/cigar or pipe every week) ☐No ☐Yes

26. Did you smoke previously?..... ☐No ☐Yes

If NO to question 25 and 26 go to question 27, if YES:

26.1. How much do or did you smoke? *(give an average)*

Cigarettes/day	Cigars/week	Pkts pipe tobacco/week

26.2. How old were you when you started smoking? _____ years

26.3. For how long have you smoked? (applies to both smokers and ex-smokers) _____ years

26.4. If you are an ex- smoker, how old were you when you stopped smoking? _____years

27. Do you use moist snuff, nicotine patches, or other products containing nicotine? ☐No ☐Yes

28. Did you use moist snuff, nicotine patches, or other products containing nicotine previously? ☐No ☐Yes

If NO to question 27 and 28 go to question 30, if YES:

29. What kind of nicotine-containing product do /did you use?

29.1. Moist Snuff ☐No ☐Yes

If you use/have used moist snuff:

29.1.1. How old were you when you started using moist snuff? _____ years

29.1.2. For how long have you been using moist snuff? (applies to both current users and past users) _____ years

29.1.3. If you did use moist snuff previously, how old were you when you stopped using it? _____ years

29.2. Nicotine patches/ gum /tablets ☐No ☐Yes

If you have been using nicotine patches/gum/tablets:

29.2.1. For how long have you used nicotine patches/gum/tablets: _____ months

Childhood and family

30. What term best describes **the place you lived most of the time before the age of 5 years**? (tick one box only)

Farm with livestock	Farm without livestock	Village in rural area	Small town	Suburb of city	Inner city
☐	☐	☐	☐	☐	☐

30.1. What term best describes the place **your father** lived as a child? (tick one box only)

Farm with livestock	Farm without livestock	Village in rural area	Small town	Suburb of city	Inner city	Don't know
☐	☐	☐	☐	☐	☐	☐

30.2. What term best describes the place **your mother** lived as a child? (tick one box only)

Farm with livestock	Farm without livestock	Village in rural area	Small town	Suburb of city	Inner city	Don't know
☐	☐	☐	☐	☐	☐	☐

30.3. What term best describes the place **your grandparents'** lived as a child? (tick one box for each grandparent)

	Farm	Village in rural area	Small town	Inner city	Don't know
Father's father	☐	☐	☐	☐	☐
Father's mother	☐	☐	☐	☐	☐
Mother's father	☐	☐	☐	☐	☐
Mother's mother	☐	☐	☐	☐	☐

31. How many persons, including yourself, lived in your home when you were 5 years old (where you lived most of the time)? (number)……

32. Did you have a serious respiratory infection before the age of five years?....☐No ☐ Yes ☐ Don't know

33. Did your father ever smoke regularly during your childhood? .....☐No ☐ Yes ☐ Don't know

34. Did your mother ever smoke regularly during your childhood? .....☐No ☐ Yes ☐ Don't know

If NO / DON'T KNOW go to question 35, if YES:

34.1. Did your mother smoke when she was pregnant with you? ☐No ☐ Yes ☐ Don't know

35. Did other people (other than parents) smoke regularly at home during your childhood?..... ☐No ☐ Yes ☐ Don't know

36. How often did you take cod liver oil when you were a child? (tick one box only)

Never	Rarely	Every week	Daily
☐	☐	☐	☐

37. How often did you eat fresh fruits and berries when you were a child? (tick one box only)

Never	Rarely	Every week	Almost daily	Almost daily in the autumn season
☐	☐	☐	☐	☐

38. How often did you eat potatoes or vegetables that **you or your family had cultivated** when you were a child? (tick one box only)

Never	Rarely	Almost weekly in the growing season	Almost daily in the growing season
☐	☐	☐	☐

39. Was there a cat in your home?

39.1. During your first year of life ☐No ☐ Yes ☐ Don't know

39.2. When you were aged 1 to 4 years ☐No ☐ Yes ☐ Don't know

39.3. When you were aged 5- 15 years ☐No ☐ Yes ☐ Don't know

40. Was there a dog in your home?

40.1. During your first year of life ☐No ☐ Yes ☐ Don't know

40.2. When you were aged 1 to 4 years ☐No ☐ Yes ☐ Don't know

40.3. When you were aged 5- 15 years ☐No ☐ Yes ☐ Don't know

41. What was the highest level of education your mother has/had? (tick one box only)

Primary school (up to the minimum school leaving age)..... ☐

Secondary school / technical school (past the minimum age)..... ☐

College or university ..... ☐

42. What was the highest level of education your father has/had? (tick one box only)

Primary school (up to the minimum school leaving age)..... ☐

Secondary school / technical school (past the minimum age)..... ☐

College or university ..... ☐

43. Did your biological parents ever suffer from any of the following:

	Mother (tick box if YES)	Father (tick box if YES)
Asthma	☐	☐
Chronich bronchitis, emphysema and/or COPD	☐	☐
Heart disease	☐	☐
Hypertension	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Cancer	☐	☐

44. Do you have any biological children? ☐No ☐ Yes

If NONE go to question 45, if you have (had) biological children:

44.1. How many children? NUMBER_____

44.2. Please write the years when your biological children were born, and tick "YES" if they have had any of the following:

	Year of birth	Girl/ boy	Asthma before 10 years	Asthma after 10 years	Hayfever/ Rhinitis	Atopic eczema/ skin allergies
Child 1						
Child 2						
Child 3						
Child 4						
Child 5						
Child 6						

Education and occupation

45. Please mark the educational level which best describes your level: *(tick one box only)*)

Primary school ..... ☐

Secondary school/technical school..... ☐

College or University ..... ☐

46. Which is your current or most recent work or occupation?

Employed	Self- employed	Homemaker	Student	Unemployed	Other
☐	☐	☐	☐	☐	☐

47. Do you currently have /have you ever had paid work?..... ☐No ☐Yes

*Please **do not** include occupations of shorter duration than three months.*

*Please **do** include part time jobs of 20 or more hours per week.*

If NO go to question 54, if YES:

48. Which is your current or most recent work or occupation? *(please use capital letters)*

.....

48.1. How many years have you worked / did you work in this occupation? .....years

49. Does being at your current workplace ever cause breathing problems (chest tightness, wheezing, coughing)? ☐No ☐Yes

50. In your current job, are you regularly exposed to vapours, gas, dust or fumes? ☐No ☐Yes

51. Have you ever changed job because the job affected your breathing?..... ☐No ☐Yes

52. Have you ever changed job because of hay fever or nasal symptom?..... ☐No ☐Yes

53. Have you ever changed job because of eczema or skin disease?..... ☐No ☐Yes

In-door environment

54. Do you keep a cat? ☐No ☐Yes

If NO go to 55,if YES:

54.1. Is your cat (are your cats) allowed inside the house? ☐No ☐Yes

54.2. Is your cat (are your cats) allowed in the bedroom? ☐No ☐Yes

55. Do you keep a dog? ☐No ☐Yes

If NO go to question 56, if YES:

55.1. Is your dog (are your dogs) allowed inside the house? ☐No ☐Yes

55.2. Is your dog (are your dogs) allowed in your bedroom? ☐No ☐Yes

56. In which type of accommodation do you live? *(tick one box only)*

Detached house ☐

Semidetached or terraced house ☐

Apartment ☐

Other ☐

57. When did you move to your current home?..... Year_____

58. Have you ever moved house because of breathing problems?..... ☐No ☐Yes

59. When was your present home built?..... Year _____

60. Does tobacco smoking take place in your present home? *(tick one box only)*

Yes, every day	Yes, frequently 1-4 times/week	Yes, sometimes 1-3 times/month	No, never
☐	☐	☐	☐

61. Have any of the following been identified in your home in **the last 12 months:**

61.1. Water leakage or water damage indoors in walls, floor or ceilings?..... ☐No ☐Yes

61.2. Bubbles or yellow discoloration on plastic floor covering, or black discoloration of parquet floor? ..... ☐No ☐Yes

61.3. Visible mould growth indoors on walls, floor or ceilings..... ☐No ☐Yes

62. Have you seen any signs of damp, water leakage or mould in your home at any time **in the last 10 years**? ..... ☐No ☐Yes

63. Have you noticed the odour of mould or mildew (not from food) in your home at any time **in the last 12 months**?..... ☐No ☐Yes

General health

64. Have you had a course of antibiotics in **the last 12 months**?..... ☐No ☐Yes
(*i.e. Apocillin, Azitromax, Imacillin) LIST the three most commonly used antibiotics in your country*

64.1. If YES, how many courses of antibiotics..... (number) _____

65. Have you had a course of antibiotics in **the last 14 days**?..... ☐No ☐Yes

66. Does your gum bleed when you brush your teeth? *(tick one box only)*

Always	Often	Sometimes	Rarely	Never
☐	☐	☐	☐	☐

67. How often do you usually brush your teeth? *(tick one box only)*

2 times/day or more	Once daily	Less than daily
☐	☐	☐

68. How frequently do you exercise? *(give an average, tick one box only)*

Never	Less than once a week	Once a week	2-3 times a week	Almost every day
☐	☐	☐	☐	☐

If you do such exercise as frequently as one or more times a week:

68.1. How hard do you push yourself? *(tick one box only)*

I take it easy without breaking into a sweat or losing my breath..... ☐
I push myself so hard that I lose my breath and break into a sweat..... ☐
I push myself to near-exhaustion..... ☐

68.2. How long does each session last? *(give an average, tick one box only)*

Less than 15 minutes ..... ☐
16-30 minutes ..... ☐

30 minutes to 1 hour ..... ☐

More than 1 hour ..... ☐

Sleep and daytime symptoms

69. How often has it occurred **in the last months** *(circle one number for each question):*

1: *Never or almost never*	**2**: *Less than once a week*	**3**: *Once or twice a week*	**4**: *3- 5 nights/days a week*	**5**: *Almost every day or night*

69.1. ... that you snore loudly and disturbingly?.....	1	2	3	4	5
69.2. ...that you have heartburn or belching when you have gone to bed?	1	2	3	4	5
69.3. ... that you have difficulty in getting to sleep at night?...	1	2	3	4	5
69.4. ... that you wake up repeatedly during the night?.....	1	2	3	4	5
69.5. ... that you perspire heavily during the night?	1	2	3	4	5
69.6. ... that you feel drowsy in the daytime?	1	2	3	4	5
69.7. ...that you wake up too early and have difficulty In getting to sleep again?.....	1	2	3	4	5

70. How long time do you usually sleep per night? _____Hours _____Minutes

Other diseases

71. Has a doctor or health professional ever told you that you have?

71.1. Diabetes? ☐No ☐Yes

If NO go to question 71.2, if YES:

71.1.1. How old were you when you were diagnosed with diabetes? _____years

71.1.2. What treatment are you currently using for diabetes? *(tick one box only)*

Insulin	Tablets	Both insulin and tablets	Only diet
☐	☐	☐	☐

71.1.3. Which type of diabetes do/did you have:

☐ Type 1 ☐ Type 2 ☐ Only in pregnancy ☐ Don't know

71.2. Psoriasis? ☐No ☐Yes

If NO go to question 71.3, if YES::

71.2.1. How old were you when you were diagnosed with psoriasis? _____years

71.3. Bechterew's disease? ☐No ☐Yes

If NO go to question 71.4, if YES:

71.3.1. How old were you when you were diagnosed with Bechterew's disease? _____years

71.4. Rheumatiod arthritis? ☐No ☐Yes

If NO go to question 71.5, if YES:

71.4.1. How old were you when you were diagnosed with rheumatoid arthritis? _____years

71.5. Ulcerous Colitis? ☐No ☐Yes

If NO go to question 71.6, if YES:

71.5.1. How old were you when the disease started? ……. _____years

71.6. Crohn's disease? ☐No ☐Yes

If NO go to question 71.7, if YES:

71.6.1. How old were you when the disease started? …… _____years

71.7. Sleep apnea? ☐No ☐Yes

If NO go to question 71.8, if YES:

71.7.1. How old were you when you were diagnosed with sleep apnea? _____years

71.7.2. What treatment are you currently using for sleep apnea? (more than one box may apply)

CPAP	Oral appliance (bite splint)	Other
☐	☐	☐

71.8. Hypertension (high blood pressure)? ☐No ☐Yes

If NO go to question 71.9, if YES:

71.8.1. How old were you when you were diagnosed with hypertension (high blood pressure)? _____years

71.8.2. Are you currently taking any medication for hypertension (high blood pressure)? ☐No ☐Yes

71.9. Heart infarction or angina pectoris? ☐No ☐Yes

If NO go to question 72, if YES:

71.9.1. Have you ever been treated in hospital because of heart infarction or angina pectoris? ☐No ☐Yes

If NO go to question 72, if YES:

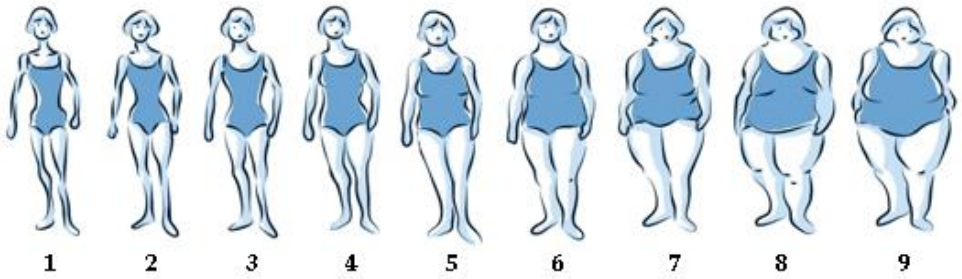
71.9.2. How old were you when you were treated in hospital (for the first time) for heart infarction or angina pectoris? _____years

Body shape

72. Gender: ☐Man ☐Woman

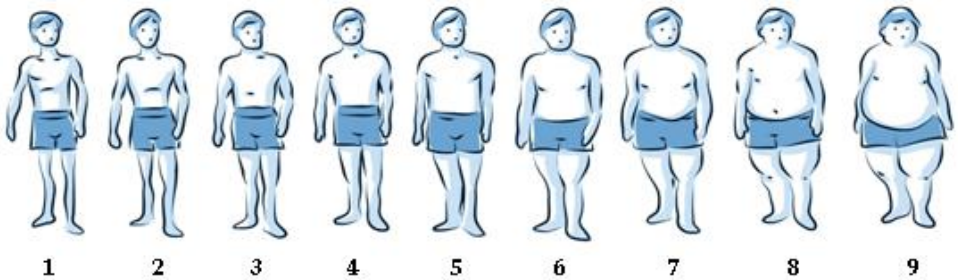
What picture best describes your body shape at each age
(tick one box only for each age/ period you have reached)

72.1. WOMEN



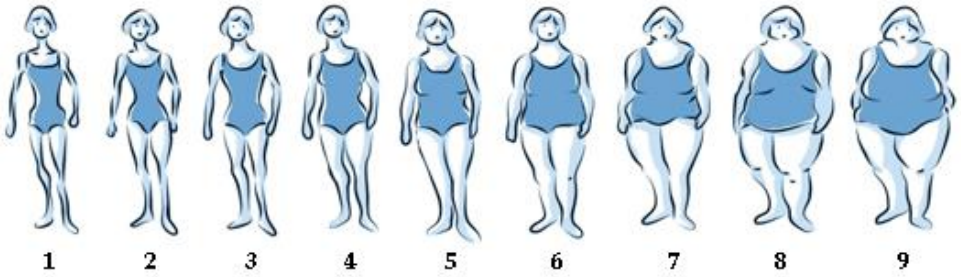
Current	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 8 years	☐	☐	☐	☐	☐	☐	☐	☐	☐
At first menstruation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 20	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 30	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 45	☐	☐	☐	☐	☐	☐	☐	☐	☐

72.2. MEN



Current	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 8 years	☐	☐	☐	☐	☐	☐	☐	☐	☐
At voice break	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 20	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 30	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 45	☐	☐	☐	☐	☐	☐	☐	☐	☐

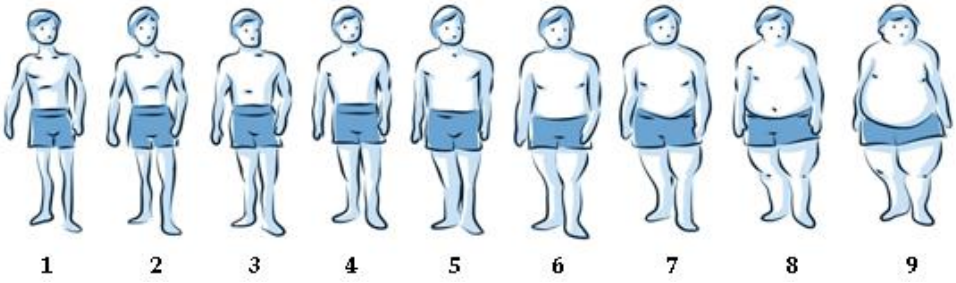
73. What picture best describes the body shape of your biological mother at



Don't know

Age 30	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 45	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

74. What picture best the body shape of your biological father at



Don't know

Age 30	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age 45	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Food and drinks

75. How many days each week do you usually eat/ drink the following:

	Never	Rarely	1 day a week	2 days a week	3 days a week	4 days a week	5 days a week	6 days a week	7 days a week
Meat or sausage	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐	☐	☐	☐	☐	☐
Raw vegetables, salad, vegetable juice	☐	☐	☐	☐	☐	☐	☐	☐	☐
Potatoes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Potatoes or vegetables you or your family have cultivated yourselves	☐	☐	☐	☐	☐	☐	☐	☐	☐
Olive oil	☐	☐	☐	☐	☐	☐	☐	☐	☐
Citrus fruit or citrus fruit juice	☐	☐	☐	☐	☐	☐	☐	☐	☐
Any fruit (except citrus fruit)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Milk (not including milk you have in tea or coffe)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐	☒	☐	☐	☐	☐
Dark (not white) bread	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food heated in plastic container in microwave	☐	☐	☐	☐	☐	☐	☐	☐	☐
Unpasteurized milk?	☐	☐	☐	☐	☐	☐	☐	☐	☐
Beer or wine	☐	☐	☐	☐	☐	☐	☐	☐	☐
Naturally fermented foods	☐	☐	☐	☐	☐	☐	☐	☐	☐

76. To collect data on outdoor exposures in places you have lived, we would like to ask for your address history. Some countries provide address information through registries, others do not.

Which country do you live in?

If you live in NORWAY, SWEDEN, DENMARK or SWITZERLAND:

Your country provides address history through registries.
Thank you for participation in this survey.

If you live in AUSTRALIA, ICELAND, SPAIN, or ESTONIA:

76.1. We would like to know where you have lived since January 1990.
Please give the address, including postcode, of all homes you have lived in **for at least one year since 1990, starting with your current address**

House number	**Street name**	**City**	**Postcode**	**Moved in**	**Lived there until (YEAR)**
					current

Norwegian consent form
To be signed before submitting the *postal* questionnaire

Respondent number

Project title	Project number
The Lung Health Investigation's Generation study	

Project leader

Department/hospital

Participation in the study is voluntary. If you want to participate, you have to sign this consent form. If you agree to participate, you can at any time and without giving a reason, withdraw your consent. Further, this will not have any consequences for your future contact with the health care system.

If you want to withdraw, or have any questions about the study, you can contact the project leader.

I would like to participate in this study

Name in capitals

Date	Signed
__ __ /__ __ / 20 __ __	

Thank you for your help!

Consent form - translation for web:

Participation in the study is voluntary. If you want to participate, you have to sign this consent form by ticking ‘yes’ at the bottom of this page. If you agree to participate, you can at any time and without giving a reason, withdraw your consent. Further, this will not have any consequences for your future contact with the health care system.

If you want to withdraw, or have any questions about the study, you can contact the project leader.

I would like to participate in this study: