



Children's Web-based Questionnaire

Lungehelseundersøkelsens Generasjonsstudie

*(Norwegian title used for ethics application
– translated «The lung health investigation's Generation Study»
Name chosen in order to be as similar as possible to
ECRHS/ RHINE name, translated "The lung health investigation")*

Consent form - for web version

The consent form is to be filled out by one of the parents of the participant

Please note:

- Participation in the study is voluntary.
- If you agree that your child participates in the study, please sign this consent form.
- Even if you agree to participating now, you can at any time and without giving a reason, withdraw your consent.

If you have any questions about the study, or wish to withdraw from the study you can contact the project coordinator NN, XX@XX, phone number XX

I _____ (name of parent) agree that
my child, _____ of whom I have legal custody,
may participate in this study.

- No
 Yes
-

Airways symptoms and allergic symptoms

1. Has this child had wheezing or whistling in his or her chest at any time **in the last 12 months?** No Yes

If answer is NO go to question 2, if YES:

- 1.1. Has this child been at all breathless when the wheezing noise was present? No Yes

- 1.2. Has this child had this wheezing or whistling when he or she did not have a cold? No Yes

2. Has this child woken up with a feeling of tightness in his or her chest at any time in the **last 12 months?** No Yes

3. Has this child been woken by an attack of shortness of breath at any time in the **last 12 months?** No Yes

4. Has this child been woken by an attack of coughing at any time in the **last 12 months?** No Yes

5. Has this child had an attack of asthma in the **last 12 months?** No Yes

6. Is this child currently taking any medicine for asthma? (including inhalers, aerosols or tablets)? No Yes

7. Does this child have any nasal allergies including hay fever? No Yes

8. What is the child's date of birth? (day/month/year) _____dd _____mm _____yyyy

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

10. Is this child a boy girl

11. Does this child have or has this child ever had asthma? No Yes

If answer is NO go to question 12, if YES:

- 11.1. Has this child ever had asthma diagnosed by a doctor? No Yes

- 11.2. How old were this child when he or she first experienced asthma symptoms? _____ years

- 11.3. How old were this child when he or she last experienced asthma symptoms? _____ years

11.4. In **the past 12 months**, how many days (or part days) of school have this child missed because of wheezing or asthma?

- None 1 - 5 days 6 - 10 days More than 10 days

12. Has this child been woken by an attack of shortness of breath at any time in **the last 3 days**? No Yes

13. Has this child been woken by an attack of coughing at any time in **the last 3 days**? No Yes

14. Has this child had wheezing or whistling in his or her chest in **the last 3 days**? No Yes

15. Has this child **ever** had wheezing or whistling in his or her chest? No Yes

If answer is NO go to question 16, if YES:

15.1. How old was this child when he or she first noticed wheezing or whistling in the chest? _____ years

16. Has this child ever experienced nasal symptoms such as nasal congestion, rhinorrhoea (runny nose) and/or sneezing attacks without having a cold? No Yes

If answer is NO go to question 17, if YES:

16.1. How old was this child when he or she experienced such nasal symptoms for the first time? _____ years

16.2. Has this child had such nasal symptoms in the last 12 months? No Yes

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

16.4. In which months of the year did this nose problem occur? (more than one answer is possible)

January / February

March / April

May / June.....

July / August.....

September / October.....

November / December.....

17. Has this child ever had eczema or any kind of skin allergy? No Yes

If answer is NO go to question 18, if YES:

17.1. How old were this child when he or she first had eczema or skin allergy? _____ years

18. Has this child ever had an itchy rash that was coming and going for at least 6 months? No Yes

If answer is NO go to question 19, if YES:

18.1. Has this child had this itchy rash in **the last 12 months**? No Yes

18.2. 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

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

Food Allergies

19. Has this child ever had an illness or trouble caused by eating
a particular food or foods? No Yes

If answer is NO go to question 20, if YES:

19.1. Has this child nearly always had the same illness or trouble after eating
this type of food? No Yes

If answer is NO go to question 20, if YES:

19.2. What type of food was this? [List up to 3]

Food 1 _____

Food 2 _____

Food 3 _____

19.3. Did this illness or trouble include:

19.3.1. a rash or itchy skin? No Yes

19.3.2. diarrhea or vomiting? No Yes

19.3.3. runny or stuffy nose? No Yes

19.3.4. severe headaches? No Yes

19.3.5. breathlessness? No Yes

Symptoms near animals, dusts or pollen

20. When this child is near animals, such as cats, dogs or horses, does he/she ever

- 20.1.** start to cough? No Yes
- 20.2.** start to wheeze? No Yes
- 20.3.** get a feeling of tightness in his or her chest? No Yes
- 20.4.** start to feel short of breath? No Yes
- 20.5.** get a runny or stuffy nose or start to sneeze? No Yes
- 20.6.** get itchy or watering eyes? No Yes

IF NO to all questions 20.1 -20.6 then go to question 22.

If YES to one or more of questions 20.1 -20.6:

21. Does this child have such symptoms when he/she is near a

- 21.1.** cat? No Yes
- 21.2.** dog? No Yes

22. When this child is in a dusty part of the house, or near pillows or duvets does he/she ever

- 22.1.** start to cough? No Yes
- 22.2.** start to wheeze? No Yes
- 22.3.** get a feeling of tightness in his or her chest? No Yes
- 22.4.** start to feel short of breath? No Yes
- 22.5.** get a runny or stuffy nose or start to sneeze? No Yes
- 22.6.** get itchy or watering eyes? No Yes

23. When this child is near trees, grass or flowers, or when there is a lot of pollen about, does he/she ever

- 23.1.** start to cough? No Yes
- 23.2.** start to wheeze? No Yes
- 23.3.** get a feeling of tightness in his or her chest? No Yes
- 23.4.** start to feel short of breath? No Yes
- 23.5.** get a runny or stuffy nose or start to sneeze? No Yes
- 23.6.** get itchy or watering eyes? No Yes

Childhood and family

24. What term best describes the place this child 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. What term best describes **the place this child's father 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. What term best describes **the place this child's mother 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. What term best describes the place this child's 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. How many persons, including this child, lived in his or her home when he or she was 5 years old? _____ persons

29. Did this child have a serious respiratory infection before the age of 5 years? No Yes Don't know

30. Did this child regularly share a bedroom before the age of 5 years? No Yes Don't know

31. At which age did this child first go to a Kindergarten, daycare facility or school? _____years

32. How old was this child's mother when he or she were born? _____years

33. How old was this child's father when he or she were born? _____years

34. Was this child delivered by Caesarean section? No Yes Don't know

35. Was this child born preterm (prior to the 37th week of pregnancy)? No Yes Don't know

36. Have this child been regularly exposed to tobacco smoke by other people in the last 12 months? (Regularly means at least once on most days or nights) No Yes

If answer is NO, then go to question 37. If YES:

36.1. How many hours per day, on average, is this child exposed to other people's tobacco smoke in the following locations?

36.1.1 at home _____Hours per day

36.1.2 elsewhere _____Hours per day

37. Did this child's father ever smoke regularly during his or her childhood? No Yes

38. Does this child's father smoke currently? No Yes

If answer is NO, continue with question 39, if YES:

38.1. Does this child's father smoke indoors? No Yes

39. Did this child's mother ever smoke regularly during his or her childhood? No Yes

40. Does this child's mother smoke currently? No Yes

If answer is NO, continue with question 41, if YES:

40.1. Does this child's mother smoke indoors? No Yes

41. Does this child have siblings? No Yes

If answer is NO, continue with question 44, if YES:

42. How many brothers does this child have? (Put 0 if you have none) _____number

If answer is "0", continue with Q43. If answer is 1 or more:

42.1. How many of these brothers have or have had asthma? _____number

42.2. How many of these brothers have or have had eczema, skin or nasal allergy or hay fever? _____number

43. How many sisters does this child have? (Put 0 if you have none) _____number

If answer is "0", continue with Q44,. If answer is 1 or more:

43.1. How many of these sisters have or have had asthma? _____number

43.2. How many of these sisters have or have had eczema, skin or nasal allergy or hay fever? _____number

44. Has this child's mother ever had asthma? No Yes Don't know

45. Has this child's mother ever had eczema, skin or nasal allergy or hay fever? No Yes Don't know

46. Has this child's father ever had asthma? No Yes Don't know

47. Has this child's father ever had eczema, skin or nasal allergy or hay fever? No Yes Don't know

48. Was there a cat in this child's home....

48.1. during his or her first year of life? No Yes Don't know

48.2. when this child were age 1 to 4 years? No Yes Don't know

48.3. when this child were age 5- 10 years? No Yes Don't know

49. Was there a dog in this child's home....

49.1. during his or her first year of life? No Yes Don't know

49.2. when this child were age 1 to 4 years? No Yes Don't know

49.3. when this child were age 5- 10 years? No Yes Don't know

50. What is the highest level of education this child's 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

51. What is the highest level of education this child's 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

52. In which type of accommodation does the child live most of the time? (tick one box only)

- 52.1. Detached house
- 52.2. Semi-detached or terraced house
- 52.3. Apartment
- 52.4. Other

Physical Activity

53. How often does the child do **strenuous** physical activity **outside of school** that makes him or her out of breath or sweat more than usual (like play team sport, hiking, dancing, swimming)?

- 53.1 Never
- 53.2 Less than once a month
- 53.3 At least once a month
- 53.4 1-3 times a week
- 53.5 4-6 times a week
- 53.6 Every day

If the child does strenuous physical activity at least once a week, continue with question 54. If you do less continue with question 55

54. About how many hours **a week** does the child do **strenuous** physical activity **outside of school** that make him or her out of breath or sweat more than usual?

- 54.1. Less than 1 hour
- 54.2. 1-2 hours
- 54.3. 3-4 hours
- 54.4. 5-6 hours
- 54.5. More than 6 hours

55. About how many hours **a day** does the child do **non-strenuous** physical activity **outside of school** (walking, riding the bike slowly)

- 55.1. Less than 1 hour
- 55.2. 1-2 hours

55.3. 3-4 hours

55.4. 5-6 hours

55.5. More than 6 hours

56. About how many hours does the child usually spend **per day**

56.1. at the computer?hours per day

56.2. at the playstation/game console?hours per day

56.3. in front of the televisionhours per day

Sleep

57. At what time does the child usually get into bed to sleep on **weekdays**?(e.g. 21:30) _____:_____

58. At what time does the child usually wake up from sleep on **weekdays**? (e.g. 7:00) _____:_____

59. At what time does the child usually get into bed to sleep on **weekends**? _____:_____

60. At what time does the child usually wake up from sleep on **weekends**? _____:_____

61. On average, how long does it take for the child to fall asleep after turning out the lights? _____hours _____minutes

62. On average, how often does the child wake up during the night?

62.1. Never or less often than once per night

62.2. 1-2 times per night

62.3. 3-5 times per night

62.4. More than 5 times per night

63. If the child wake up at night:

63.1. Does the child fall asleep right away again

63.2. Does it take a few minutes to fall asleep again

63.3. Does the child have trouble falling asleep again

General health

64. How tall is this child? _____ cm

65. How much does this child weigh? _____ kg

66. Has this child ever visited a hospital casualty department or emergency room (for any reason, apart from accidents and injuries)? No Yes

If answer is NO, continue with question 67, if YES:

66.1. Was this due to breathing problems at least once? No Yes

67. Has this child ever spent a night in hospital (for any reason, apart from accidents and injuries)? No Yes

If answer is NO, continue with question 68, if YES:

67.1. Was this due to breathing problems at least once? No Yes

68. How often does this child usually brush his or her teeth? (*tick one box only*)

2 times/day or more	Once daily	Less than daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

69. Has a doctor or health professional ever said that this child have diabetes? No Yes Don't know

If answer is NO, continue with question 70, if YES:

69.1. Does this child get any treatment for this disease? No Yes Don't know

70. Has a doctor or health professional ever said that this child have a heart disease or a heart malformation? No Yes Don't know

If answer is NO, continue with question 71, if YES:

70.1. Does this child get any treatment for this disease? No Yes Don't know

71. Has a doctor or health professional ever said that this child have another disease? No Yes Don't know

If answer is NO, continue with question 72, if YES:

71.1. Which disease? _____

71.2. Does this child get any treatment for this disease? No Yes Don't know

72. Have this child had one of the following diseases?

72.1. Otitis Media No Yes Don't know

- 72.2. Tonsillitis No Yes Don't know
- 72.3. Appendicitis No Yes Don't know
- 72.4. Pneumonia No Yes Don't know
- 72.5. Meningitis No Yes Don't know

73. Did this child's mother ever suffer from any of the following?

MOTHER

- 73.1. Chronic bronchitis, emphysema and/or COPD No Yes Don't know
- 73.2. Heart disease/Myocardial infarction No Yes Don't know
- 73.3. Hypertension No Yes Don't know
- 73.4. Diabetes No Yes Don't know
- 73.5. High blood fats/High cholesterol No Yes Don't know
- 73.6. Cancer No Yes Don't know
- 73.7. Inflammatory bowel disease (Chron's disease/Colitis ulcerosa) No Yes Don't know

74. Did this child's father ever suffer from any of the following?

FATHER

- 74.1. Chronic bronchitis, emphysema and/or COPD No Yes Don't know
- 74.2. Heart disease/Myocardial infarction No Yes Don't know
- 74.3. Hypertension No Yes Don't know
- 74.4. Diabetes No Yes Don't know
- 74.5. High blood fats/High cholesterol No Yes Don't know
- 74.6. Cancer No Yes Don't know
- 74.7. Inflammatory bowel disease (Crohn's disease/Colitis ulcerosa) No Yes Don't know

Food and drinks

75. How often does this child eat or drink the following:

	Never	Rarely	Several times a month	Several times a week	Daily
75.1. Meat or sausage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.2. Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.3. Cod oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.4. Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.5. Raw vegetables, salad, vegetable juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.6. Potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.7. Potatoes or vegetables you or your family have cultivated yourselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.8. Olive oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.9. Citrus fruit or citrus fruit juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.10. Any fruit (except citrus fruit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.11. Milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.12. Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.13. Dark (not white) bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.14. Food heated in plastic container in microwave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

76. The questionnaire are filled in by

76.1. This child's mother

76.2. This child's father

76.3. Another guardian

76.4. Any comment: _____

The questionnaire is finished.

Thank you very much for participation in this survey!