



Ernst Omevåg

Airways 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. Do you have any nasal allergies including hay fever?/...../.....

9. What is today's date?/...../.....

10. Are you male or female Male Female

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 go to question 18, if YES:

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

If NO go to question 18, if YES:

16. Have you had periods of this kind for at least two years in a row? NO YES

If NO go to question 18, if YES:

17. How old were you when these problems began? years

Smoking habits

18. Are you a smoker (*this applies even if you only smoke the odd cigarette/cigar or pipe every week*)? No Yes

19. Are you an ex-smoker?

If NO to question 18 and 19 go to question 20, if YES:

19.1 Smoke/smokedcigarettes/day
.....cigars/week
.....pkts pipe tobacco/week

How old were you when you started smoking?(age)

Smoked foryears (*applies to both smokers and ex-smokers*)

Stopped smoking in.....(year)

Upper and lower airways

20. Do you have or have you ever had asthma? No Yes

If NO go to question 24, if YES:

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

22. How old were you when you first experienced asthma symptoms? years

23. In which year did you last experience asthma symptoms? 19...../ 20.....

24. Has a doctor ever told that you have COPD (BOLD) No Yes

25. Have you ever had wheezing or whistling in your chest? No Yes

25.1 If "Yes", how old were you when you first noticed wheezing or whistling in your chest? years

25.2. If "Yes", when was the last year you noticed wheezing and whistling in your chest? 19...../ 20.....

26. 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 25, if YES:

26.1 How old were you when you experienced them for the first time? years

26.2 Have you had these kind of nasal symptoms in the last 12 months? No Yes

26.3 At which time of the year are your nasal symptoms worst?

Spring Summer Autumn Winter Always Don't know

27. Has your nose been blocked for more than 12 weeks during the last 12 months? No Yes
28. Have you had pain or pressure around the forehead, nose or eyes for more than 12 weeks during the last 12 months? No Yes
29. Have you had discoloured nasal discharge (snot) or discoloured mucus in the throat for more than 12 weeks during the last 12 months? No Yes
30. Has your sense of smell been reduced or absent for more than 12 weeks during the last 12 months? No Yes

In-door and out-door environment

31. In which type of accommodation do you live?
 Detached house Semidetached or terraced house Apartment Other
32. When did you move to your current home? 19
33. How many hours per day do you spend in your home most days? Approx. hours/day
34. Does tobacco smoking take place in your present home?
 Yes every day Yes, frequently 1-4 times/week Yes, sometimes 1-3 times/month No never
35. Have any of the following been identified in your home during the past 12 months:
- 35.1 *Water leakage or water damage indoors in walls, floor or ceilings No Yes
- 35.2 *Bubbles or yellow discoloration on plastic floor covering, or black discoloration of parquet floor No Yes
- 35.3 *Visible mould growth indoors on walls, floor or ceilings. No Yes
36. Have you seen any signs of damp, water leakage or mould in your home at any time during the past X years? No Yes
37. Have you seen any signs of damp, water leakage or mould in your workplace at any time during the past X years? No Yes
38. Is your bedroom window towards a nearby street (<20 m)?
 No
 Yes a street with little traffic
 Yes a street with moderate traffic
 Yes a street with much traffic

39. Can you in your bedroom hear traffic noise?

- Not at all
- A little
- Much
- Very much

40. How much time do you usually spend walking or travelling along streets with busy traffic a typical weekday?

Approx minutes/day

Marital status

41. What is your marital status? (*more than one alternative may be true*)

- 1. Single
- 2. Currently married
- 3. Cohabiting
- 4. Separated or divorced
- 5. Widowed
- 6. Do not wish to answer

Marital status

42. Please mark the educational level which best describes your level:

- 1) Primary school
- 2) Lower or upper secondary school, or technical school
- 3) College or university

Occupation and work

43. Are you currently working?

No Yes

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

.....

How many years have you worked or did you work in this occupation?

.....years

45. We assume that your work ability, when it was as best, was 100 percent.

How would you rate your current work ability, expressed in percent?

..... %

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

46.1 If "Yes", in which years?

46.2 If "Yes", from which occupation/job did you change? (could be several)

47. Have you ever changed job because of hayfever or nasal symptom No Yes

47.1 If Yes, in which years?

47.2 If "Yes", from which occupation/job did you change? (could be several)

48. Have you ever changed job because of other health problems/diseases? No Yes

48.1 If Yes, in which years?

48.2 If "Yes", which occupation/job did you change from? (could be several)

49. Have you ever worked as a painter? No Yes

If "Yes", between which years?

50. Have you ever worked as a cleaner? No Yes

If "Yes", between which years?

51. Have you been reporting any days of sick leave during the last 12 months? No Yes

51.1 If yes, how many days have you been on sick leave?

1 – 7 days 8-30 days 31 days – 90 days More than three months

52. Have you been reporting any days of sick leave because of breathing problems during the last 12 months? No Yes

52.1 If yes, how many days have you been on sick leave for breathing problems?

1 – 7 days 8-30 days 31 days – 90 days More than three months

Childhood and family

53. What term best describes the place you lived most of the time when you were under the age of five years?

- | | |
|---|---|
| <input type="checkbox"/> Farm with livestock | <input type="checkbox"/> small town |
| <input type="checkbox"/> farm without livestock | <input type="checkbox"/> suburb of city |
| <input type="checkbox"/> village in rural area | <input type="checkbox"/> inner city |

54. When you were a child, which of the following were regularly used for heating?

Open wood	Coke or coal fire	Paraffin	Electricity	Gas or oil fired boiler
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

55. Did you have a serious respiratory infection before the age of five years?

Yes No Don't know

56.1. Did your father ever smoke regularly during your childhood?

Yes No Don't know

56.2 Did your mother ever smoke regularly during your childhood?

Yes No Don't know

56.3 Did other people (other than parents) smoke regularly at home during your childhood?

Yes No Don't know

57. When you were a child, how often did you eat fresh fruits?

Never	Rarely	Every week	Almost daily	Almost daily in the autumn season
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Mother (yes)	Father (yes)
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronich bronchitis, emphysema and/or COPD	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

59. Do you have children (including grown-up children)?

No Yes

If yes, how many?

..... children

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

Child	Birth year of child (year)	Asthma before 10 year (yes)	Asthma after 10 years (yes)	Hayfever/ rhinitis (yes)	Atopic eczema/Skin allergies (yes)
1					
2					
3					
4					
5					
6					
7					

Sleep and daytime symptoms

The numbers mean

- 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

How often has it occurred in the last months:

- | | | | | | |
|---|---|---|---|---|---|
| 60. that You snore loudly and disturbingly? | 1 | 2 | 3 | 4 | 5 |
| 61. that You have heartburn or belching when you have gone to bed? | 1 | 2 | 3 | 4 | 5 |
| 62. that You have difficulty in getting to sleep at night? | 1 | 2 | 3 | 4 | 5 |
| 63. that You wake up repeatedly during the night? | 1 | 2 | 3 | 4 | 5 |
| 64. that You perspire heavily during the night? | 1 | 2 | 3 | 4 | 5 |
| 65. that You feel drowsy in the daytime? | 1 | 2 | 3 | 4 | 5 |
| 66. that You wake up too early and have difficulty in getting to sleep again? | 1 | 2 | 3 | 4 | 5 |

67. Have you ever had sleep apnoea diagnosed by a doctor? No Yes

If "No" go to question 69, if "Yes":

67.1 What year did you get the diagnosis of sleep apnoea? Year

67.2 If you are currently treated for sleep apnoea, what treatment do you have?

- CPAP
- Oral appliance (bite splint)
- Previous surgery in the throat or nose
- Others

68 How long time do you usually sleep per night?

I usually sleephours andminutes.

Other diseases

69. Have ever had hypertension (high blood pressure) diagnosed by a doctor? No Yes

If yes:

69.1 When did you get the diagnosis hypertension (high blood pressure)? Year

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

70. Have you ever had stroke? No Yes

70.1 If you have had stroke, in which year was it? Year

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

If yes:

71.1 When were you treated (for the first time) at a hospital because of heart infarction or angina pectoris? Year

72. Have you ever had diabetes diagnosed by a doctor? No Yes

If yes:

72.1 What year did you get the diagnosis diabetes? Year:

72.2 What treatment are you currently using for diabetes?
 Insulin
 Tablets
 Both insulin and tablets
 Only diet

73. Do you have or have you ever had ulcerative colitis? No Yes

73.1 If yes: how old were you when the disease started? years

74. Do you have or have you ever had Crohn's disease? No Yes

74.1 If, yes, how old were you when the disease started?years

General health

75 Does your gum bleed when you brush your teeth?
 Always
 Often
 Sometimes
 Rarely
 Never

76 How often do you usually brush your teeth?
 2 times/day or more
 Once daily
 Less than daily

77. How frequently do you exercise? (Give an average)

Never	Less than once a week	Once a week	2-3 times a week	Almost every day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

77.1. If you do such exercise as frequently as once or more times a week: How hard do you push yourself? (Give an average)

- 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

77.2. How long does each session last? (Give an average)

Less than 15 minutes	6-30 minutes	30 minutes to 1 hour	More than 1 hour
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

78. Body silhouettes

Information and contact consent

In case we need to get in touch with you again please write your telephone number below

Telephone number: Daytime

 Evening

THANK YOU FOR YOUR HELP

