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SCOTTISH FAMILY HEALTH STUDY

PRE-CLINIC QUESTIONNAIRE

FOR OFFICE USE ONLY

Researcher Name _____

_____

Researcher Code ☐☐☐

Date ☐☐ ☐☐ ☐☐☐☐
d d m m y y y y

Place barcode sticker here

SF ☐ Geographical Site

Funded by Scottish Executive Health Department, Chief Scientist Office

SCOTTISH FAMILY HEALTH STUDY

Generation Scotland

Instructions to help with completion of questionnaire

- Complete using a black ballpoint pen if possible.
- Please complete as much of the form as possible.
- Enter numbers clearly inside the boxes.
- Enter a cross (X) inside appropriate boxes.
- Write all entries clearly using block capital letters when writing text.
- If you make a mistake and want to change an entry, please cross through the original and write the correct entry above or to the side.
- Please write only in designated areas.
- Please ignore the little review box on each page. This is for office-use only.

Pre-Clinic Questionnaire

We would be grateful if you would answer the questions on this form before you attend the GENERATION SCOTLAND clinic. Don't worry if you cannot answer all the questions, any information you can provide will be helpful. You should bring your completed form when you attend your clinic appointment.

A. Personal Details

1. Where were your parents living at the time of your birth?

If not known cross here

Mother

_____ (town or council area) *OR* ☐

_____ (country) *OR* ☐

Father

_____ (town or council area) *OR* ☐

_____ (country) *OR* ☐

2. Where were **you** born?

_____ (town or council area) *OR* ☐

_____ (country) *OR* ☐

3. Were you born outside the UK? ☐ Yes ☐ No *OR* ☐

If born outside the UK, when did you come to live here? ☐☐ / ☐☐ / ☐☐☐☐ *OR* ☐

d d m m y y y y

4. What is your cultural background?
(Mark an **X** in one box from each of A and B)

A	B
☐ White	☐ Scottish
☐ Black	☐ English
☐ Asian	☐ Welsh
☐ Mixed, specify _____	☐ N. Irish
☐ Other, specify _____	☐ Irish
	☐ Pakistani
☐ Not disclosed	☐ Indian
	☐ Bangladeshi
	☐ Chinese
	☐ African
	☐ Carribean
	☐ Other, specify _____
	☐ Not disclosed

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Place barcode sticker here

Review ☐

If not known cross here

B. Family History

1. What is/was your **father's** date of birth? d d / m m / y y y y *OR* ☐

2. Where was your father born?

_____ (town or council area) *OR* ☐

_____ (country) *OR* ☐

3. Is your father still alive? ☐ Yes ☐ No *OR* ☐

If No, what was the date of his death? d d / m m / y y y y *OR* ☐

4. If he has died, what was the cause of his death?

_____ *OR* ☐

5. Where was your **father's father** born?

_____ (town or council area) *OR* ☐

_____ (country) *OR* ☐

6. Where was your **father's mother** born?

_____ (town or council area) *OR* ☐

_____ (country) *OR* ☐

7. What is/was your **mother's** date of birth? d d / m m / y y y y *OR* ☐

8. Where was your mother born?

_____ (town or council area) *OR* ☐

_____ (country) *OR* ☐

9. Is your mother still alive? ☐ Yes ☐ No *OR* ☐

If No, what was the date of her death? d d / m m / y y y y *OR* ☐

10. If she has died, what was the cause of her death?

_____ *OR* ☐

11. Where was your **mother's father** born?

_____ (town or council area) *OR* ☐

_____ (country) *OR* ☐

12. Where was your **mother's mother** born?

_____ (town or council area) *OR* ☐

_____ (country) *OR* ☐

FOR OFFICE USE ONLY

MCD _____

FCD _____

Review ☐

C. Medications

At the clinic you will be asked about the medications or supplements you REGULARLY take. These include:

- prescribed medicines from your GP or hospital,
- over the counter medicines bought from a chemist or shop
- supplements, vitamins, complementary or alternative medicines (eg evening primrose oil)

Don't forget to include contraceptive pills or injections; hormone replacement therapy; and inhalers (eg Ventolin)

I. Name of Prescribed or Bought Pills or other Oral Medication *OR* **Cross here if none** ☐

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

II. Name of Prescribed or Bought Cream/Ointment or Other Topical Preparation (such as patches) *OR* **Cross here if none** ☐

1. _____
2. _____
3. _____
4. _____
5. _____

III. Name of Prescribed or Bought Inhaler or Nasal Spray *OR* **Cross here if none** ☐

1. _____
2. _____
3. _____
4. _____
5. _____

IV. Name of Prescribed or Bought Injection or Suppository *OR* **Cross here if none** ☐

1. _____
2. _____
3. _____
4. _____
5. _____

Review ☐

D. Operations

Please give details below of any operations you have had and what age you were when you had them.

If age not known, cross here

OR If you have had no operations cross here ☐

1. _____ ☐☐ age *OR* ☐
2. _____ ☐☐ age *OR* ☐
3. _____ ☐☐ age *OR* ☐
4. _____ ☐☐ age *OR* ☐
5. _____ ☐☐ age *OR* ☐
6. _____ ☐☐ age *OR* ☐

E. Family Health

1. Please mark an **X** in the box if you, your father, mother or any brother, sister or grandparent has been affected by any of these conditions:

	You	Father	Mother	Brother(s)/ Sister(s)	Grand parent
a. Heart Disease	☐	☐	☐	☐	☐
b. Stroke	☐	☐	☐	☐	☐
c. High Blood Pressure	☐	☐	☐	☐	☐
d. Diabetes	☐	☐	☐	☐	☐
e. Alzheimer's disease	☐	☐	☐	☐	☐
f. Parkinson's disease	☐	☐	☐	☐	☐
g. Depression	☐	☐	☐	☐	☐
h. Breast Cancer	☐	☐	☐	☐	☐
i. Bowel Cancer	☐	☐	☐	☐	☐
j. Lung Cancer	☐	☐	☐	☐	☐
k. Prostate Cancer	☐	☐	☐	☐	☐
l. Hip Fracture	☐	☐	☐	☐	☐
m. Osteoarthritis	☐	☐	☐	☐	☐
n. Rheumatoid arthritis	☐	☐	☐	☐	☐
o. Asthma	☐	☐	☐	☐	☐

p. Any Other Serious Illness which runs in your family..... (i) _____

(ii) _____

Review ☐

F. Chest Pain

1. Do you ever get pain or discomfort in your chest? ☐ Yes ☐ No

   IF NO, GO TO SECTION G

2. Do you get this pain or discomfort when you walk uphill or hurry? ☐ Yes ☐ No

   IF NO, GO TO SECTION G

3. Do you get it when you walk at an ordinary pace on the level? ☐ Yes ☐ No

4. When you get pain or discomfort in your chest what do you do?

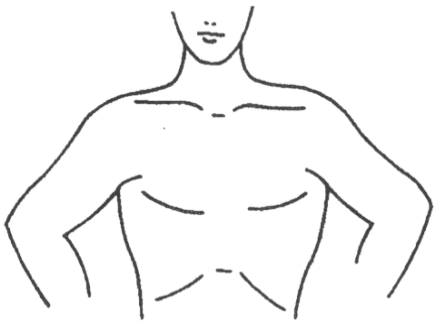
   ☐ Stop ☐ Slow Down ☐ Continue at same pace

5. Does it go away when you stand still or sit down? ☐ Yes ☐ No

   If so, how soon? ☐ 10 minutes or less ☐ More than 10 minutes

6. Where do you get this pain or discomfort?
   *(Mark the place(s) with an **X** on the picture)*

Right



Left

7. Have you ever had a severe pain across the front of your chest lasting for half an hour? ☐ Yes ☐ No

   If Yes, what was the cause? _____

G. Musculoskeletal History

1. Have you ever suffered a fracture? (broken bone) ☐ Yes ☐ No ☐ Don't Know

   If Yes, please complete below:

Site of broken bone (e.g. leg, hip, arm)	**What age you were**
a. _____	☐☐ yrs
b. _____	☐☐ yrs
c. _____	☐☐ yrs
d. _____	☐☐ yrs
e. _____	☐☐ yrs
f. _____	☐☐ yrs

2. Have you been diagnosed as suffering from Osteoarthritis (wear and tear arthritis)? ☐ Yes ☐ No ☐ Don't Know

   If Yes, please tell us which joints are affected:

	Age first affected		**Age first affected**		**Age first affected**
a. Neck	☐☐ yrs	e. Hands	☐☐ yrs	i. Ankles	☐☐ yrs
b. Shoulder	☐☐ yrs	f. Back	☐☐ yrs	j. Feet	☐☐ yrs
c. Elbows	☐☐ yrs	g. Hips	☐☐ yrs	k. Other	☐☐ yrs
d. Wrist	☐☐ yrs	h. Knees	☐☐ yrs		

If Other, specify _____

3. Have you been diagnosed as suffering from Rheumatoid Arthritis? ☐ Yes ☐ No ☐ Don't Know

Review ☐

H. Chronic Pain

1. Are you currently troubled by pain or discomfort, either all the time or on and off? ☐ Yes ☐ No

IF NO, GO TO SECTION I

2. Have you had this pain or discomfort for more than 3 months? ☐ Yes ☐ No

IF NO, GO TO SECTION I

3. Where is this pain or discomfort?
(mark **X** in the box for each question)

	Yes	No
a. Back pain	☐	☐
b. Neck or shoulder pain	☐	☐
c. Headache, facial or dental pain	☐	☐
d. Stomach ache or abdominal pain	☐	☐
e. Pain in your arms, hands, hips, legs or feet	☐	☐
f. Chest pain	☐	☐
g. Other pain	☐	☐

If Other pain, please specify _____

4. Which **one** of these pains or discomforts has bothered you the most in the past three months?
(mark **X** in <u>one box only</u> to indicate your response)

- a. Back Pain ☐
- b. Neck or shoulder pain ☐
- c. Headache, facial or dental pain ☐
- d. Stomach ache or abdominal pain ☐
- e. Pain in your arms, hands, hips, legs or feet ☐
- f. Chest pain ☐
- g. Other pain ☐

(Please circle the number on the scale below, where 0=No Pain and 10=Pain as bad as could be)

In the <u>past 3 months</u>,	***No Pain***										***Pain as bad as could be***
5. How intense was your worst pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
6. How intense was your usual pain?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

In the <u>past 3 months</u>,

7. How many days have you been kept from your usual activities (work/housework) because of this pain?
(mark **X** in the box to indicate your response) ☐ 0-6 days ☐ 7-14 days ☐ 15-30 days ☐ 31 or more days

(Please circle the number on the scale below, where 0=No Interference and 10=Unable to carry on activities)

In the <u>past 3 months</u>,	***No Interference***										***Unable to carry out activities***
8. Has the pain interfered with your daily activities?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

(Please circle the number on the scale below, where 0=No Change and 10=Extreme Change)

In the <u>past 3 months</u>,	***No Change***										***Extreme Change***
9. How much has this pain changed your ability to take part in recreational, social and family activities?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
10. How much has this pain changed your ability to work (including housework)?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Review ☐

I. Physical Activity

Please record number of hours and minutes in the space provided. If you DO NOT SPEND ANY TIME on the activity record 0

For how long do **you usually**....

1. Work in paid employment each week? ☐☐ hours ☐☐ mins

2. Do housework each week? ☐☐ hours ☐☐ mins

3. When **working** (including housework) for how long are you **usuall**y....

   a. Very active each week? ☐☐ hours ☐☐ mins
   (such as heavy lifting or carrying, hurried walking, going up stairs and ladders, digging, heavy housework)

   b. Moderately active each week? ☐☐ hours ☐☐ mins
   (such as light lifting or carrying, walking at slightly increased pace, light housework, shopping, painting, decorating)

   c. Inactive each week? ☐☐ hours ☐☐ mins
   (such as sitting, standing, light arm movements, unhurried walking, driving))

4. When **working** (including housework), how often are you physically active for at least 20 minutes during which time you become short of breath or perspire?
   (mark **X** in the box to indicate your response)

   ☐ never ☐ less than once a week ☐ once a week ☐ 2-3 times a week ☐ 4 or more times a week

5. During your **non-working time** (including going to and from work) for how long are you **usually**....

   a. Very active each week? ☐☐ hours ☐☐ mins
   (such as competitive sports, football, hockey, squash, badminton, hill walking, cycling, swimming, running, aerobics, heavy gardening, windsurfing)

   b. Moderately active each week? ☐☐ hours ☐☐ mins
   (such as moderate walking, golf, light gardening, cricket, dancing, bowls, playing pool, sailing, taking a shower or bath, getting dressed and undressed)

   c. Inactive each week? ☐☐ hours ☐☐ mins
   (such as sitting, standing, watching TV or films, listening to music, cooking, drinking, eating, piano playing, card playing, driving)

6. During **non-working time** how often are you physically active for at least 20 minutes during which time you becomeshort of breath or perspire?
   (mark **X** in the box to indicate your response)

   ☐ never ☐ less than once a week ☐ once a week ☐ 2-3 times a week ☐ 4 or more times a week

Review ☐

I. Physical Activity cont'd

7. **During the past 12 months**, has the level of your physical activity.....?
(mark **X** in the box to indicate your response)

☐ increased ☐ stayed the same ☐ decreased

If it has changed, for how long has your physical activity been at its current level? ☐☐ months ☐☐ weeks

8. How many hours a day do you **usually** spend in bed ....? on work days ☐☐ hours *OR* Not applicable ☐

on non-work days ☐☐ hours *OR* Not applicable ☐

J. Dietary Intake

1. **In <u>general</u>, how often do you eat.....?**

	Number of times eaten	(please mark **X** in one box only) day	week	month	year	If '0 times', what age were you when you last ate this
a. Fresh fruit	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
b. Green leafy vegetables	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
c. Other types of vegetables	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
d. Oily fish (eg sardines, mackeral, salmon, herring)	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
e. Other types of fish (cod, tinned tuna, haddock)	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
f. Chicken, turkey or other poultry	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
g. Liver (including liver pate and liver sausage)	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
h. Other types of meat (including bacon, sausages, ham)	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
i. Eggs (including eggs in quiche, cakes and omelettes)	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
j. Dairy products (milk, yoghurt, cheese, butter)	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years
k. Brown bread	☐☐☐	per ☐ **or**	☐ **or**	☐ **or**	☐	☐☐ years

K. Alcohol consumption

1. Have you ever had an alcoholic drink?
(mark **X** in the box to indicate your response)

☐ Yes, currently drink	**GO TO QUESTION 2**
☐ Yes, but stopped within past 12 months	**GO TO QUESTION 4**
☐ Yes, but stopped more than 12 months ago	**GO TO QUESTION 4**
☐ No, never drank	**GO TO SECTION L**

2. **During the past week**, please record how many units of alcohol you have had: ☐☐☐ units
(If you have had no units, please enter 0)

To help you calculate the number of units of alcohol you have had, the following is given as a guideline.

A unit of alcohol is:	**Approximate Units**
1 pint of ordinary beer, cider or lager	2
1 bottle/can of ordinary strenght beer/lager	2
1 bottle/can of extra strength beer /lager	4
1 can of cider	2
1 litre of cider	9
1 small glass of wine (125ml)	1
1 bottle of wine (75cl)	9
1 bottle of fortified wine	10
1 litre of fortified wine	14
1 small glass of sherry	1
1 bottle of sherry	12
1 pub measure of spirits (25ml)	1
1 bottle of spirits (75cl)	30
1 bottle of alcopops	2

3. How does this compare to what you usually drink in a week? ☐ More ☐ Same ☐ Less

CURRENT ALCOHOL DRINKERS GO TO SECTION L

4. Why did you stop drinking alcohol? ☐ On doctor's advice ☐ Other reason

If Other, specify _____

_____

Review ☐

L. Smoking History

1. Have you ever smoked tobacco?
(mark **X** in the box to indicate your response)

☐ Yes, currently smoke	**GO TO QUESTION 2**
☐ Yes, but stopped within past 12 months	**GO TO QUESTION 2**
☐ Yes, but stopped more than 12 months ago	**GO TO QUESTION 2**
☐ No, never smoked	**GO TO SECTION M**

2. What age were you when you started smoking? ☐☐ years old

3. What is the maximum number you have smoked per week for as long as a year?
☐☐☐ cigarettes per week ☐☐ packets of tobacco per week
☐☐ cigars per week

CURRENT SMOKERS GO TO SECTION M

4. How long is it since you gave up smoking? ☐☐ years ☐☐ months ☐☐ days

5. Why did you give up smoking?
(mark **X** in the box to indicate your response)

☐ On doctor's advice
☐ Personal decision
☐ Other reason If Other, specify

_____

_____

M. Exposure to Tobacco Smoke

1. Are you **regularly** exposed to **other people's** tobacco smoke.....? (mark **X** in the box to indicate your response)

	Yes, a lot	Yes, some	Yes, a little	No, None at all	Not Applicable
a. at work.....	☐	☐	☐	☐	☐
b. in your home.....	☐	☐	☐	☐	☐
c. in other places (eg social groups).....	☐	☐	☐	☐	☐

2. **On average**, for how many hours per week are you exposed to other people's tobacco smoke? ☐☐ hours per week
(If exposed for no hours per week, please enter 0)

3. Do you live with anyone who smokes? ☐ Yes ☐ No

Review ☐

N. Educational and Occupational History

1. How many years altogether did you attend school or study full-time? ☐☐ years

2. What is the highest educational qualification you have obtained?
(mark **X** in the box indicating your response)

☐ University degree
☐ Other professional or technical qualification or diploma after leaving school
☐ Higher Grade
☐ Standard Grade or 'O' Level
☐ No Qualification
☐ Other qualification

3. What is your employment? (if currently unemployed, give details of your last job)

OR **Cross here, if never worked** ☐

4. If you live with a spouse or partner please give details of his/her job

OR **Cross here, if spouse/partner never worked** ☐

If you do not live with a spouse or partner, cross here ☐

5. What is your and your spouse's/partner's current employment status?
(mark **X** in the box indicating your response)

	YOU	**SPOUSE/PARTNER**
a. Self-employed employing others	☐	☐
b. Self-employed not employing others	☐	☐
c. Paid employee supervising others	☐	☐
d. Paid employee not supervising	☐	☐
e. In unpaid employment	☐	☐
f. Housewife/homemaker	☐	☐
g. Retired	☐	☐
h. Full-time student	☐	☐
i. Unemployed, sick or disabled	☐	☐
j. Unemployed, seeking work	☐	☐

OR **Cross here if no spouse/partner** ☐

i. If you are unemployed, please state for how long ☐☐ years ☐☐ months

ii. If you are employed, what best describes the type of work your job mainly involves?
(mark **X** in the box indicating your response)

☐ Sedentary, spend most of time sitting down (eg office worker)
☐ Standing, spend most of time standing or walking (eg hairdresser)
☐ Manual, involves physical effort (eg plumber)
☐ Heavy manual, involves vigour effort (eg miner)

iii. If you are employed, how many hours in a typical week would you work in the evening/overnight between 7pm-7am? ☐☐ hours

6. What is the average total income before tax of your entire household?
(mark **X** in the box indicating your response)

☐ less than £10,000
☐ between £10,000 and £30,000
☐ between £30,000 and £50,000
☐ between £50,000 and £70,000
☐ more than £70,000
☐ prefer not to answer

Review ☐

O. Household History

1. Including yourself, how many people live in your household? (record number) ☐☐

2. Are you living with anyone in your household as a couple? ☐ Yes ☐ No

3. What type of accommodation do you live in?
(mark **X** in the box indicating your response)

- ☐ House or bungalow
- ☐ Flat or apartment
- ☐ Hostel
- ☐ Mobile or caravan
- ☐ Sheltered house
- ☐ Homeless
- ☐ Other (please specify) _____

4. What is the status of the accommodation in which you and your household live?
(mark **X** in the box indicating your response)

- ☐ Own outright
- ☐ Own with mortgage
- ☐ Rent from local authority
- ☐ Rent from private landlord or agency
- ☐ Pay part rent and part mortgage
- ☐ Live rent free
- ☐ Other (please specify) _____

5. How many cars/vans are available to you and your household? (record number) ☐☐
(if no cars/vans available, please enter 0)

P. WOMEN ONLY (This section should only be completed by women)

If not known, cross here

1. Have you ever had a period? ☐ Yes ☐ No

IF NO, GO TO QUESTION 3

2. a. What age were you when you had your first period? ☐☐ years old *OR* ☐

b. Are you still having periods? ☐ Yes ☐ No

c. If you no longer have periods, what age were you when they stopped? ☐☐ years old *OR* ☐

3. Have you had a hysterectomy? ☐ Yes ☐ No

If Yes, what age were you? ☐☐ years old *OR* ☐

4. Have you had your ovaries removed? ☐ Yes ☐ No

If Yes, what age were you? ☐☐ years old *OR* ☐

Review ☐

WOMEN ONLY (This section should only be completed by women) continued.....

If not known, cross here

5. Are you currently taking oral contraceptive pills? ☐ Yes ☐ No

If yes, age first started? ☐☐ years old *OR* ☐

From that age, for how long in total have you taken them? ☐☐ yrs ☐☐ mths *OR* ☐

If not currently taking oral contraceptive pills, did you previously take them? ☐ Yes ☐ No

If yes, age first started? ☐☐ years old *OR* ☐

age finally stopped? ☐☐ years old *OR* ☐

During this time, for how long in total did you take them? ☐☐ yrs ☐☐ mths *OR* ☐

6. Do you currently have regular contraceptive injections? (eg Depo-Provera) ☐ Yes ☐ No

If yes, age first started? ☐☐ years old *OR* ☐

From that age, for how long in total have you had them? ☐☐ yrs ☐☐ mths *OR* ☐

If not currently having regular contraceptive injections? (eg Depo-Provera), did you previously have them? ☐ Yes ☐ No

If yes, age first started? ☐☐ years old *OR* ☐

age finally stopped? ☐☐ years old *OR* ☐

During this time, for how long in total did you have them? ☐☐ yrs ☐☐ mths *OR* ☐

7. Are you currently taking hormone replacement therapy (HRT)? ☐ Yes ☐ No

If yes, age first started? ☐☐ years old *OR* ☐

From that age, for how long in total have you taken it? ☐☐ yrs ☐☐ mths *OR* ☐

If not currently taking hormone replacement therapy (HRT), did you previously take it? ☐ Yes ☐ No

If yes, age first started? ☐☐ years old *OR* ☐

age finally stopped? ☐☐ years old *OR* ☐

During this time, for how long in total did you take it? ☐☐ yrs ☐☐ mths *OR* ☐

8. Are you currently taking any other hormone therapy? ☐ Yes ☐ No

If yes, age first started? ☐☐ years old *OR* ☐

From that age, for how long in total have you taken it? ☐☐ yrs ☐☐ mths *OR* ☐

If not currently taking any other hormone therapy, did you previously take it? ☐ Yes ☐ No

If yes, age first started? ☐☐ years old *OR* ☐

age finally stopped? ☐☐ years old *OR* ☐

During this time, for how long in total did you take it? ☐☐ yrs ☐☐ mths *OR* ☐

Review ☐

MANY THANKS FOR TAKING THE TIME TO COMPLETE THESE QUESTIONS

PLEASE BRING YOUR COMPLETED QUESTIONNAIRE WITH YOU WHEN YOU ATTEND YOUR APPOINTMENT WITH THE GENERATION SCOTLAND, SCOTTISH FAMILY HEALTH STUDY

Q. Additional comments

Please use this space, to make additional comments on any of the questions you have been asked

Contact details

If you would like to find out more information about the study please find details below:

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