

IN CONFIDENCE



POPULATION SURVEY

NATIONAL HEALTH SURVEY 2001

ADULT FORM

PSU, BLOCK, DWELLING, HH, PERSON grid with checkboxes for digits 0-9 and X.

Interviewer: Commence interview at Q.18

Main survey questions: 1. OFFICE USE ONLY, 2. SEX, 3. AGE, 4. SAMPLE NUMBER, 5. INDIGENOUS STATUS, 6. COUNTRY OF BIRTH, 7. YEAR OF ARRIVAL, 8. Answering own schedule, 9. WOMEN'S HEALTH FORM.

<p>10. HOUSEHOLD TYPE</p> <p>1 (Nothing further) ... <input type="checkbox"/> 1</p> <p>2 ... <input type="checkbox"/> 2</p> <p>3 ... <input type="checkbox"/> 3</p> <p>4 ... <input type="checkbox"/> 4</p> <p>5 ... <input type="checkbox"/> 5</p> <p>6 (Complete Q.12) ... <input type="checkbox"/> 6</p> <p>7 (Complete Q.12) ... <input type="checkbox"/> 7</p> <p>8 (Complete Q.12) ... <input type="checkbox"/> 8</p> <p>9 (Complete Q.13) ... <input type="checkbox"/> 9</p>	16. OFFICE USE ONLY				
<p>11. Husband (Nothing further) ... <input type="checkbox"/> 1</p> <p>Wife (Nothing further) ... <input type="checkbox"/> 2</p> <p>Son/daughter (Nothing further) ... <input type="checkbox"/> 3</p>	<p>A Relationship</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9</p>	<p>B Family Number</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9</p>	<p>C UR Scope Exclusion</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p>	<p>D Initial Schedule Response</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6</p>	<p>E Incomplete Schedule Response</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6</p>
<p>12. Father/mother (Nothing further) ... <input type="checkbox"/> 1</p> <p>Son/daughter (Nothing further) ... <input type="checkbox"/> 2</p>	<p>F Income</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p>	<p>G Compulsion Queried</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2</p>	<p>H Number of people aged 0-6 in household</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9</p>	<p>I Number of people aged 7-14 in household</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9</p>	<p>J Number of people aged 15-17 in household</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9</p>
<p>13. Parent (Nothing further) ... <input type="checkbox"/> 1</p> <p>Partner/spouse (Nothing further) ... <input type="checkbox"/> 2</p> <p>Son/daughter in couple family (Nothing further) ... <input type="checkbox"/> 3</p> <p>Son/daughter in lone parent family (Nothing further) ... <input type="checkbox"/> 4</p> <p>Other relative (Nothing further) ... <input type="checkbox"/> 5</p> <p>Not related (Nothing further) ... <input type="checkbox"/> 6</p>	<p>K Number of people aged 18 or over in household</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9</p>	<p>L Selected adult attending educational institution (full-time 18-24)</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p>	<p>M Social Marital Status</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9</p>	<p>N Selected adult has child(ren) 0-14 in household</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p>	<p>O Selected adult has child(ren) 15-24 in household</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p>
	<p>P Selected adult has child(ren) in household 15-24 who are full-time students</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p>	<p>S Registered Marital Status</p> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p>			

18. Interviewer: Code best description of structure of dwelling

- Separate house 01
- Semi-detached, row or terrace house, town house etc. with:
 - 1 storey 02
 - 2 or more storeys 03
- Flat attached to house 04
- Other flat/unit/apartment
 - in a 1 or 2 storey block 05
 - in a 3 storey block 06
 - in a 4 or more storey block 07
- Caravan/tent/cabin in a caravan park, houseboat in a marina, etc. 08
- Caravan not in a caravan park/ houseboat not in a marina, etc. 09
- Improvised home/campers out 10
- House or flat attached to a shop, office, etc. 11

20. THE FIRST QUESTIONS ARE ABOUT LANGUAGE, EDUCATION AND WHETHER YOU ARE CURRENTLY WORKING.

THESE HELP US TO UNDERSTAND THE RELATIONSHIP BETWEEN HEALTH AND OTHER ISSUES IN PEOPLE'S LIVES.

DO YOU SPEAK A LANGUAGE OTHER THAN ENGLISH AT HOME?

Interviewer: If more than one language, prompt for language used most often

- No, English only 01
- Yes, Italian 02
- Yes, Greek 03
- Yes, Cantonese 04
- Yes, Mandarin 05
- Yes, Arabic 06
- Yes, Vietnamese 07
- Yes, German 08
- Yes, Spanish 09
- Yes, Tagalog (Filipino) 10
- Yes, Other (Specify) 11

21.
-
-
-
-
-
-
-
-

22. Sequence Guide:

- . If English only (code '01') in Q.20 → Q.24 1
- . Otherwise → Q.23 2

23. DO YOU CONSIDER YOU SPEAK ENGLISH VERY WELL, WELL OR NOT WELL?

- Very well 1
- Well 2
- Not well 3
- Not at all 4

24. Sequence Guide:

- . If aged 25 or more → Q.26 1
- . If currently attending school, TAFE, university, or other educational institution full-time (column G on HF) → Q.28 2
- . Otherwise → Q.25 3

25. ARE YOU CURRENTLY ATTENDING A TAFE, UNIVERSITY, OR OTHER EDUCATIONAL INSTITUTION ON A PART-TIME BASIS?

- Yes 1
- No 2

25A. → Q.28

26. ARE YOU CURRENTLY ATTENDING A TAFE, UNIVERSITY, OR OTHER EDUCATIONAL INSTITUTION?

- Yes 1
- No → Q.28 2

27. IS THIS ON A FULL-TIME OR PART-TIME BASIS?

- Full-time 1
- Part-time 2

28. AT WHAT AGE DID YOU MOST RECENTLY LEAVE PRIMARY OR SECONDARY SCHOOL?

- Never went to school → Q.30 01
- 13 years and under 02
- 14 years 03
- 15 years 04
- 16 years 05
- 17 years 06
- 18 years 07
- 19 years 08
- 20 years 09
- 21 years and over 10
- Still at school 11

29. WHAT IS THE HIGHEST YEAR OF PRIMARY OR SECONDARY SCHOOL YOU HAVE COMPLETED?

- Year 12 or equivalent 1
- Year 11 2
- Year 10 3
- Year 9 4
- Year 8 or lower 5

30. (SINCE LEAVING SECONDARY SCHOOL,) HAVE YOU COMPLETED A TRADE CERTIFICATE, DIPLOMA, DEGREE OR ANY OTHER EDUCATIONAL QUALIFICATION?

- Yes 1
 No → Q.35 2

31. WHAT IS THE NAME OF THE HIGHEST QUALIFICATION YOU HAVE COMPLETED?

Interviewer: If 'certificate', 'diploma' or 'degree', prompt for the type

- Secondary school qualification → Q.35 01
 Nursing qualification ... → Q.32 02
 Teaching qualification → Q.33 03
 Trade Certificate/Apprenticeship → Q.35 04
 Technician's Certificate/Advanced Certificate ... → Q.35 05
 Certificate other than above → Q.34 06
 Associate Diploma ... → Q.34 07
 Undergraduate Diploma → Q.34 08
 Bachelor Degree → Q.35 09
 Postgraduate Diploma/Graduate Certificate ... → Q.35 10
 Masters Degree/Doctorate → Q.35 11
 Other → Q.34 12

32. WHAT IS THE NAME OF THE HIGHEST NURSING QUALIFICATION YOU HAVE COMPLETED?

- Mothercraft Nurse → Q.35 1
 Enrolled Nurse → Q.35 2
 Nursing Aide/Auxiliary Nurse/Psychiatric Aide → Q.35 3
 Registered Nurse/Sister → Q.35 4
 Triple/Double Certificate Nurse/Theatre Nurse/Registered Midwife ... → Q.35 5
 Other → Q.34 6

33. WHAT IS THE NAME OF THE HIGHEST TEACHING QUALIFICATION YOU HAVE COMPLETED?

- Teaching certificate/TPTC/TSTC/TITC → Q.35 1
 Diploma of Teaching (Dip T) → Q.35 2
 Graduate Certificate/Diploma of Education (Dip Ed) → Q.35 3
 Other 4

34. HOW LONG DOES THAT (CERTIFICATE/DIPLOMA/QUALIFICATION) TAKE TO COMPLETE, STUDYING FULL-TIME?

- Less than 1 semester 1
 1 semester to less than 1 year 2
 1 year to less than 3 years 3
 3 years or more 4

35. THE NEXT FEW QUESTIONS ARE ABOUT WHETHER YOU ARE WORKING OR LOOKING FOR WORK.

I WOULD LIKE TO ASK YOU ABOUT LAST WEEK, THAT IS, THE WEEK STARTING MONDAY THE AND ENDING (LAST SUNDAY THE/YESTERDAY).

LAST WEEK, DID YOU DO ANY WORK AT ALL IN A JOB, BUSINESS OR FARM?

- Yes → Q.38 1
 No 2
 Permanently unable to work → Q.57 3
 Permanently not intending to work (if aged 65+ only) → Q.57 4

36. LAST WEEK, DID YOU DO ANY WORK WITHOUT PAY IN A FAMILY BUSINESS?

- Yes → Q.38 1
 No 2
 Permanently not intending to work (if aged 65+ only) → Q.57 3

37. DID YOU HAVE A JOB, BUSINESS OR FARM THAT YOU WERE AWAY FROM BECAUSE OF HOLIDAYS, SICKNESS OR ANY OTHER REASON?

- Yes 1
 No → Q.51 2
 Permanently not intending to work (if aged 65+ only) → Q.57 3

38. DID YOU HAVE MORE THAN 1 JOB OR BUSINESS (LAST WEEK)?

- Yes 1
 No → Q.40 2

39. I WOULD NOW LIKE TO ASK YOU ABOUT THE JOB OR BUSINESS IN WHICH YOU USUALLY WORK THE MOST HOURS.

40. DID YOU WORK FOR AN EMPLOYER, OR IN YOUR OWN BUSINESS?

- Employer 1
 Own business → Q.43 2
 Other/Uncertain → Q.42 3

41. ARE YOU PAID A WAGE OR SALARY, OR SOME OTHER FORM OF PAYMENT?

- Wage/Salary → Q.45 1
 Other/Uncertain 2

<p>42. WHAT ARE YOUR (WORKING/PAYMENT) ARRANGEMENTS?</p> <p>Unpaid voluntary work → Q.51 <input type="checkbox"/> 01</p> <p>Contractor/Subcontractor <input type="checkbox"/> 02</p> <p>Own business/Partnership <input type="checkbox"/> 03</p> <p>Commission only <input type="checkbox"/> 04</p> <p>Commission with retainer → Q.45 <input type="checkbox"/> 05</p> <p>In a family business without pay → Q.45 <input type="checkbox"/> 06</p> <p>Payment in kind → Q.45 <input type="checkbox"/> 07</p> <p>Paid by the piece/item produced → Q.45 <input type="checkbox"/> 08</p> <p>Wage/salary earner ... → Q.45 <input type="checkbox"/> 09</p> <p>Other → Q.45 <input type="checkbox"/> 10</p>	<p>47. WHAT IS THE NAME OF YOUR (EMPLOYER/BUSINESS)?</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>43. DO YOU HAVE EMPLOYEES (IN THAT BUSINESS)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p>	<p>48. (IN YOUR JOB WITH (Specify employer/business in Q.47),) DID YOU DO ANY SHIFT WORK AT ANY TIME DURING THE LAST 4 WEEKS?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.50 <input type="checkbox"/> 2</p>
<p>44. IS THAT BUSINESS INCORPORATED?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p>	<p>49. IS YOUR SHIFT -</p> <p>A ROTATING SHIFT WHICH CHANGES PERIODICALLY? <input type="checkbox"/> 1</p> <p>A REGULAR EVENING, NIGHT OR GRAVEYARD SHIFT? <input type="checkbox"/> 2</p> <p>A REGULAR MORNING SHIFT? <input type="checkbox"/> 3</p> <p>A REGULAR AFTERNOON SHIFT? <input type="checkbox"/> 4</p> <p>WHAT KIND OF SHIFT IS IT?</p> <p>Irregular shift <input type="checkbox"/> 5</p> <p>Split shift (consisting of two distinct periods each day) <input type="checkbox"/> 6</p> <p>On call <input type="checkbox"/> 7</p> <p>Other <input type="checkbox"/> 8</p>
<p>45. WHAT IS YOUR OCCUPATION IN (THAT/YOUR MAIN) (JOB/BUSINESS)?</p> <p>(Title)</p> <p>.....</p> <p>WHAT ARE YOUR MAIN TASKS AND DUTIES?</p> <p>(Main tasks/duties)</p> <p>.....</p> <p>.....</p>	<p>50. HOW MANY HOURS DO YOU USUALLY WORK EACH WEEK IN (THAT JOB/THAT BUSINESS/ ALL YOUR JOBS)?</p> <p>Number of hours <input style="width: 50px; height: 20px;" type="text"/> → Q.57</p> <p>Less than 1 hour/ No hours <input type="checkbox"/> 96</p>
<p>46. WHAT KIND OF BUSINESS OR SERVICE IS CARRIED OUT BY YOUR (EMPLOYER AT THE PLACE WHERE YOU WORK/BUSINESS)?</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>a</p> <p>b</p>	<p>51. AT ANY TIME DURING THE LAST 4 WEEKS, HAVE YOU BEEN LOOKING FOR FULL-TIME WORK?</p> <p>Yes → Q.53 <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>52. HAVE YOU BEEN LOOKING FOR PART-TIME WORK AT ANY TIME DURING THE LAST 4 WEEKS?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.57 <input type="checkbox"/> 2</p>

53. AT ANY TIME IN THE LAST 4 WEEKS HAVE YOU -

WRITTEN, PHONED OR APPLIED IN PERSON TO AN EMPLOYER FOR WORK? 01

ANSWERED AN ADVERTISEMENT FOR A JOB? 02

LOOKED IN NEWSPAPERS?

Yes

No

CHECKED FACTORY NOTICE BOARDS, OR USED THE TOUCHSCREENS AT CENTRELINK OFFICES? 03

AT ANY TIME IN THE LAST 4 WEEKS HAVE YOU -

BEEN REGISTERED WITH CENTRELINK AS A JOBSEEKER? 04

CHECKED OR REGISTERED WITH AN EMPLOYMENT AGENCY? 05

DONE ANYTHING ELSE TO FIND A JOB?

Advertised or tendered for work 06

Contacted friends/relatives 07

Other 08 → Q.57

Only looked in newspapers 09 → Q.57

None of these 10 → Q.57

54. IF YOU HAD FOUND A (PART-TIME) JOB COULD YOU HAVE STARTED WORK LAST WEEK?

Yes 1

No 2 → Q.57

Don't know 3

55. WHEN DID YOU BEGIN LOOKING FOR WORK?

a Enter date

Less than 2 years ago / /

2 years or more ago / /

5 years or more ago / /

Day Month Year

0	0	19	0	0
1	1	20	1	1
2	2		2	2
3	3		3	3
4	4		4	4
5	5		5	5
6	6		6	6
7	7		7	7
8	8		8	8
9	9		9	9

b Did not look for work 1

56. WHEN DID YOU LAST WORK FOR AT LEAST 2 WEEKS IN A JOB OF 35 HOURS OR MORE A WEEK?

a Enter date

Less than 2 years ago / /

2 years or more ago / /

5 years or more ago / /

Day Month Year

0	0	19	0	0
1	1	20	1	1
2	2		2	2
3	3		3	3
4	4		4	4
5	5		5	5
6	6		6	6
7	7		7	7
8	8		8	8
9	9		9	9

b Has never worked in a job of 35+hrs/week (for 2 weeks or more) 1

57. THE NEXT QUESTION IS ABOUT THIS (Specify dwelling type in Q.18).

HOW MANY BEDROOMS ARE THERE IN THIS (Specify dwelling type in Q.18)?

Number

Bedsitter 96

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

201. THE NEXT QUESTION IS ABOUT HOW YOU FEEL OVERALL.

HOW DO YOU FEEL ABOUT YOUR LIFE AS A WHOLE, TAKING INTO ACCOUNT WHAT HAS HAPPENED IN THE LAST YEAR, AND WHAT YOU EXPECT TO HAPPEN IN THE FUTURE?

Interviewer: Show Prompt Card 4

PLEASE TELL ME THE NUMBER THAT MOST CORRESPONDS TO HOW YOU FEEL.

1 - Delighted	<input type="checkbox"/>	1
2 - Pleased	<input type="checkbox"/>	2
3 - Mostly satisfied	<input type="checkbox"/>	3
4 - Mixed	<input type="checkbox"/>	4
5 - Mostly dissatisfied	<input type="checkbox"/>	5
6 - Unhappy	<input type="checkbox"/>	6
7 - Terrible	<input type="checkbox"/>	7

202. I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR OWN HEALTH.

IN GENERAL, WOULD YOU SAY THAT YOUR HEALTH IS EXCELLENT, VERY GOOD, GOOD, FAIR OR POOR?

Excellent	<input type="checkbox"/>	1
Very good	<input type="checkbox"/>	2
Good	<input type="checkbox"/>	3
Fair	<input type="checkbox"/>	4
Poor	<input type="checkbox"/>	5

203. COMPARED TO 1 YEAR AGO, HOW WOULD YOU RATE YOUR HEALTH IN GENERAL NOW?

WOULD YOU SAY IT WAS MUCH BETTER, SOMEWHAT BETTER, ABOUT THE SAME, SOMEWHAT WORSE OR MUCH WORSE (THAN 1 YEAR AGO)?

Much better now than 1 year ago	<input type="checkbox"/>	1
Somewhat better now than 1 year ago	<input type="checkbox"/>	2
About the same as 1 year ago	<input type="checkbox"/>	3
Somewhat worse now than 1 year ago	<input type="checkbox"/>	4
Much worse now than 1 year ago	<input type="checkbox"/>	5

204. DO YOU CONSIDER YOURSELF TO BE ACCEPTABLE WEIGHT, UNDERWEIGHT OR OVERWEIGHT?

Acceptable weight	<input type="checkbox"/>	1
Underweight	<input type="checkbox"/>	2
Overweight	<input type="checkbox"/>	3

205. HOW MUCH DO YOU WEIGH?

Interviewer: Record reported weight in appropriate category

Kilograms 0 1 2 3

Stone/pounds 1 2 3 4 5 6 7 8 9

Pounds 0 1 2 3 4 5 6 7 8 9

Don't know 9998

206. HOW TALL ARE YOU WITHOUT SHOES?

Interviewer: Record reported height in appropriate category

Centimetres 0 1 2 3 4 5 6 7 8 9

Feet/inches 0 1 2 3 4 5 6 7 8 9

Don't know 9998

207. IN THE LAST 2 WEEKS, HAVE YOU WALKED FOR SPORT, RECREATION OR FITNESS?

Yes 1

No → Q.210 2

208. HOW MANY TIMES DID YOU WALK IN THE LAST 2 WEEKS?

Interviewer: Record number

Number

0 0
1 1
2 2
3 3
4 4
5 5
6 6
7 7
8 8
9 9

209. WHAT WAS THE TOTAL AMOUNT OF TIME YOU SPENT WALKING IN THE LAST 2 WEEKS?

Interviewer: Record appropriate time

Hours/minutes |

100 hours or more 9999

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4 4 4
5 5 5 5
6 6 6 6
7 7 7 7
8 8 8 8
9 9 9 9

210. I WILL NOW ASK YOU ABOUT MODERATE AND VIGOROUS EXERCISE APART FROM WALKING.

Interviewer: Show Prompt Card 5

IN THE LAST 2 WEEKS, DID YOU DO ANY EXERCISE WHICH CAUSED A MODERATE INCREASE IN YOUR HEART RATE OR BREATHING, THAT IS, MODERATE EXERCISE?

Yes 1

No → Q.213 2

211. HOW MANY TIMES DID YOU DO ANY MODERATE EXERCISE IN THE LAST 2 WEEKS?

Interviewer: Record number

Number

0 0
1 1
2 2
3 3
4 4
5 5
6 6
7 7
8 8
9 9

212. WHAT WAS THE TOTAL AMOUNT OF TIME YOU SPENT DOING MODERATE EXERCISE IN THE LAST 2 WEEKS?

Interviewer: Record appropriate time

Hours/minutes |

100 hours or more 9999

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4 4 4
5 5 5 5
6 6 6 6
7 7 7 7
8 8 8 8
9 9 9 9

213. IN THE LAST 2 WEEKS, DID YOU DO ANY (OTHER) EXERCISE WHICH CAUSED A LARGE INCREASE IN YOUR HEART RATE OR BREATHING, THAT IS, VIGOROUS EXERCISE?

Interviewer: Show Prompt Card 5

Yes 1

No → Q.220 2

214. HOW MANY TIMES DID YOU DO ANY VIGOROUS EXERCISE IN THE LAST 2 WEEKS?

Interviewer: Record number

Number

0 0
1 1
2 2
3 3
4 4
5 5
6 6
7 7
8 8
9 9

215. WHAT WAS THE TOTAL AMOUNT OF TIME YOU SPENT DOING VIGOROUS EXERCISE IN THE LAST 2 WEEKS?

Interviewer: Record appropriate time

Hours/minutes |

100 hours or more 9999

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4 4 4
5 5 5 5
6 6 6 6
7 7 7 7
8 8 8 8
9 9 9 9

220. I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT SMOKING.

DO YOU CURRENTLY SMOKE?

Yes 1

No → Q.222 2

221. DO YOU SMOKE REGULARLY, THAT IS, AT LEAST ONCE A DAY?

Yes → Q.223 1

No 2

222. HAVE YOU EVER SMOKED REGULARLY (THAT IS, AT LEAST ONCE A DAY)?

Yes 1

No 2

223. *Sequence Guide:*

. If single person household ... → Q.228 1

. Otherwise ... → Q.224 2

224. DOES ANYONE ELSE IN THIS HOUSEHOLD SMOKE REGULARLY, THAT IS, AT LEAST ONCE A DAY?

Yes 1

No → Q.228 2

225. HOW MANY OTHER PEOPLE IN THIS HOUSEHOLD SMOKE REGULARLY?

Interviewer: Record number

Number 0 0

Don't know 98 1 1

2 2

3 3

4 4

5 5

6 6

7 7

8 8

9 9

228. THE NEXT QUESTION IS ABOUT CHANGES IN FRECKLES AND MOLES.

DO YOU, OR ANYONE ELSE, REGULARLY CHECK YOUR SKIN FOR CHANGES IN FRECKLES AND MOLES?

Yes 1

No 2

Sample only

230. *Sequence Guide:*

. If aged 50 years or more ... → Q.231 1

. Otherwise ... → Q.250 2

231. THE FOLLOWING QUESTIONS ARE ABOUT INFLUENZA AND PNEUMOCOCCAL VACCINATIONS.

HAVE YOU EVER HAD AN INFLUENZA VACCINATION (FLU INJECTION OR FLU SHOT)?

Yes ... 1

No ... → Q.235 2

Don't know ... → Q.235 3

232. DID YOU HAVE THIS (VACCINATION/INJECTION/SHOT) IN THE LAST 12 MONTHS?

Yes ... 1

No ... → Q.235 2

Don't know ... → Q.235 3

233. DID YOU HAVE TO GET A PRESCRIPTION FOR THIS (VACCINATION/INJECTION/SHOT)?

Yes ... 1

No ... 2

Don't know ... 3

234. WAS THIS (INFLUENZA/FLU) VACCINE FREE OF CHARGE?

Yes ... 1

No ... 2

Don't know ... 3

235. HAVE YOU EVER HAD A PNEUMOCOCCUS OR PNEUMOVAX (VACCINATION/INJECTION/SHOT)?

Yes ... 1

No ... → Q.250 2

Don't know ... → Q.250 3

236. DID YOU HAVE THIS (VACCINATION/INJECTION/SHOT) IN THE LAST 5 YEARS?

Yes ... 1

No ... 2

Don't know ... 3

Sample only

250. THE FOLLOWING QUESTIONS ARE ABOUT YOUR FEELINGS IN THE PAST 4 WEEKS.

Interviewer: Show Prompt Card 7

IN THE PAST 4 WEEKS, ABOUT HOW OFTEN DID YOU FEEL TIRED OUT FOR NO GOOD REASON?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

251. (IN THE PAST 4 WEEKS,) ABOUT HOW OFTEN DID YOU FEEL NERVOUS?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5 → Q.253

252. (IN THE PAST 4 WEEKS,) ABOUT HOW OFTEN DID YOU FEEL SO NERVOUS THAT NOTHING COULD CALM YOU DOWN?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

253. (IN THE PAST 4 WEEKS,) ABOUT HOW OFTEN DID YOU FEEL HOPELESS?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

254. (IN THE PAST 4 WEEKS,) ABOUT HOW OFTEN DID YOU FEEL RESTLESS OR FIDGETY?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5 → Q.256

255. (IN THE PAST 4 WEEKS,) ABOUT HOW OFTEN DID YOU FEEL SO RESTLESS YOU COULD NOT SIT STILL?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

256. (IN THE PAST 4 WEEKS,) ABOUT HOW OFTEN DID YOU FEEL DEPRESSED?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

257. (IN THE PAST 4 WEEKS,) ABOUT HOW OFTEN DID YOU FEEL THAT EVERYTHING WAS AN EFFORT?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

258. (IN THE PAST 4 WEEKS,) ABOUT HOW OFTEN DID YOU FEEL SO SAD THAT NOTHING COULD CHEER YOU UP?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

259. (IN THE PAST 4 WEEKS,) ABOUT HOW OFTEN DID YOU FEEL WORTHLESS?

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

260. DURING THE PAST 4 WEEKS, HAVE YOU ACCOMPLISHED LESS THAN YOU WOULD LIKE AS A RESULT OF ANY EMOTIONAL PROBLEMS, SUCH AS FEELING DEPRESSED OR ANXIOUS?

- Yes 1
- No 2

261. DURING THE PAST 4 WEEKS, DID YOU NOT DO WORK OR OTHER REGULAR DAILY ACTIVITIES AS CAREFULLY AS USUAL AS A RESULT OF ANY EMOTIONAL PROBLEMS, SUCH AS FEELING DEPRESSED OR ANXIOUS?

- Yes 1
- No 2

262. SOME PEOPLE TAKE SUPPLEMENTS OR REMEDIES FOR ASPECTS OF THEIR MENTAL WELL-BEING. FOR EXAMPLE, TO IMPROVE THEIR CONCENTRATION OR REDUCE STRESS.

IN THE LAST 2 WEEKS, FOR YOUR MENTAL WELL-BEING, HAVE YOU TAKEN ANY -

- VITAMIN OR MINERAL SUPPLEMENTS? a 1
- HERBAL OR NATURAL TREATMENTS OR REMEDIES? b 2
- Neither of these c 3

263. *Interviewer: Show Prompt Card 8*

(OTHER THAN THE VITAMINS AND HERBAL REMEDIES YOU JUST TOLD ME ABOUT.)

HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS IN THE LAST 2 WEEKS?

- Yes 1
- No → *Q.301* 2

264. WHICH ONES?

- Sleeping tablets or capsules a 1
- Tablets or capsules for anxiety or nerves b 2
- Tranquillisers c 3
- Antidepressants d 4
- Mood stabilisers e 5
- Other medications for your mental health f 6

Sample only

<p>265A. <i>Interviewer:</i> Mark type of medication in next column</p>	<p>266. Type of Medication '1'</p>	<p>267. Type of Medication '2'</p>	<p>268. Type of Medication '3'</p>
<p>Sleeping tablets or capsules</p> <p>Tablets or capsules for anxiety or nerves</p> <p>Tranquillisers</p> <p>Antidepressants</p> <p>Mood stabilisers</p> <p>Other medications for your mental health</p>	<p>a)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p>	<p>a)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p>	<p>a)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6</p>
<p>265B. HOW LONG HAVE YOU BEEN TAKING (Specify type of medication 1/2/3)?</p> <p>IS IT, LESS THAN 1 MONTH, 1 TO 3 MONTHS, 3 TO 6 MONTHS, OR 6 MONTHS OR MORE?</p> <p>Less than 1 month</p> <p>1 month to less than 3 months</p> <p>3 months to less than 6 months</p> <p>6 months or more</p> <p>Don't know</p>	<p>b)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p>	<p>b)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p>	<p>b)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p>
<p>265C. HOW OFTEN DID YOU TAKE (Specify type of medication 1/2/3) IN THE LAST 2 WEEKS?</p> <p>Every day and/or night</p> <p>More than 3 days and/or nights a week</p> <p>1-3 days and/or nights a week</p> <p>Less than once a week</p> <p>Varies/as required</p>	<p>c)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p>	<p>c)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p>	<p>c)</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4</p> <p><input type="checkbox"/> 5</p>
<p>269. <i>Interviewer:</i> Please mark appropriate box.</p> <p>. If 3 or less types of medications taken ... <input type="checkbox"/> 1</p> <p>. If <u>more</u> than 3 types of medications taken ... <input type="checkbox"/> 2</p>	<p><i>(This section is currently blank in the sample form)</i></p>		

301. THE NEXT FEW QUESTIONS ARE ABOUT NUTRITION.

WHAT TYPE OF MILK DO YOU USUALLY CONSUME?

Whole 1

Low/reduced fat 2

Skim 3

Evaporated or sweetened condensed 4

Soy milk 5

None of the above 6

Don't know 7

302. THIS QUESTION IS ABOUT YOUR USUAL CONSUMPTION OF VEGETABLES, INCLUDING FRESH, FROZEN AND TINNED VEGETABLES.

Interviewer: Show Prompt Card 9

HOW MANY SERVES OF VEGETABLES DO YOU USUALLY EAT EACH DAY?

1 serve or less 1

2-3 serves 2

4-5 serves 3

6 serves or more 4

Don't eat vegetables 5

303. THIS QUESTION IS ABOUT YOUR USUAL CONSUMPTION OF FRUIT, INCLUDING FRESH, DRIED, FROZEN AND TINNED FRUIT.

Interviewer: Show Prompt Card 10

HOW MANY SERVES OF FRUIT DO YOU USUALLY EAT EACH DAY?

1 serve or less 1

2-3 serves 2

4-5 serves 3

6 serves or more 4

Don't eat fruit 5

304. HOW OFTEN DO YOU ADD SALT TO YOUR FOOD AFTER IT IS COOKED?

IS IT, NEVER, RARELY, SOMETIMES OR USUALLY?

Never/rarely 1

Sometimes 2

Usually 3

305. *Sequence Guide:*

. If respondent is female AND aged less than 50 → **Q.306** 1

. Otherwise → **Q.309** 2

306. THE NEXT FEW QUESTIONS ARE ABOUT FOLATE OR FOLIC ACID WHICH CAN BE ADDED TO SOME FOODS, BEVERAGES, AND VITAMIN OR MINERAL SUPPLEMENTS.

IN THE LAST 2 WEEKS, HAVE YOU EATEN ANY FOOD PRODUCTS BECAUSE THEY HAD FOLATE ADDED TO THEM?

Yes 1

No 2

Don't know 3

307. IN THE LAST 2 WEEKS, DID YOU DRINK ANY BEVERAGES BECAUSE THEY HAD FOLATE ADDED TO THEM?

Yes 1

No 2

Don't know 3

308. IN THE LAST 2 WEEKS, HAVE YOU TAKEN ANY VITAMIN OR MINERAL SUPPLEMENTS BECAUSE THEY CONTAINED FOLATE OR FOLIC ACID?

Yes 1

No 2

Don't know 3

309. IN THE LAST 12 MONTHS, WERE THERE ANY TIMES THAT YOU RAN OUT OF FOOD AND COULDN'T AFFORD TO BUY MORE?

Yes 1

No 2

310. *Interviewer: Mark day on which interview conducted*

Monday 1

Tuesday 2

Wednesday 3

Thursday 4

Friday 5

Saturday 6

Sunday 7

311. THE NEXT FEW QUESTIONS ARE ABOUT ALCOHOLIC DRINKS.

SOME PEOPLE MAY DRINK MORE OR LESS THAN OTHERS, DEPENDING ON THEIR LIFESTYLE AND INDIVIDUAL CHOICES.

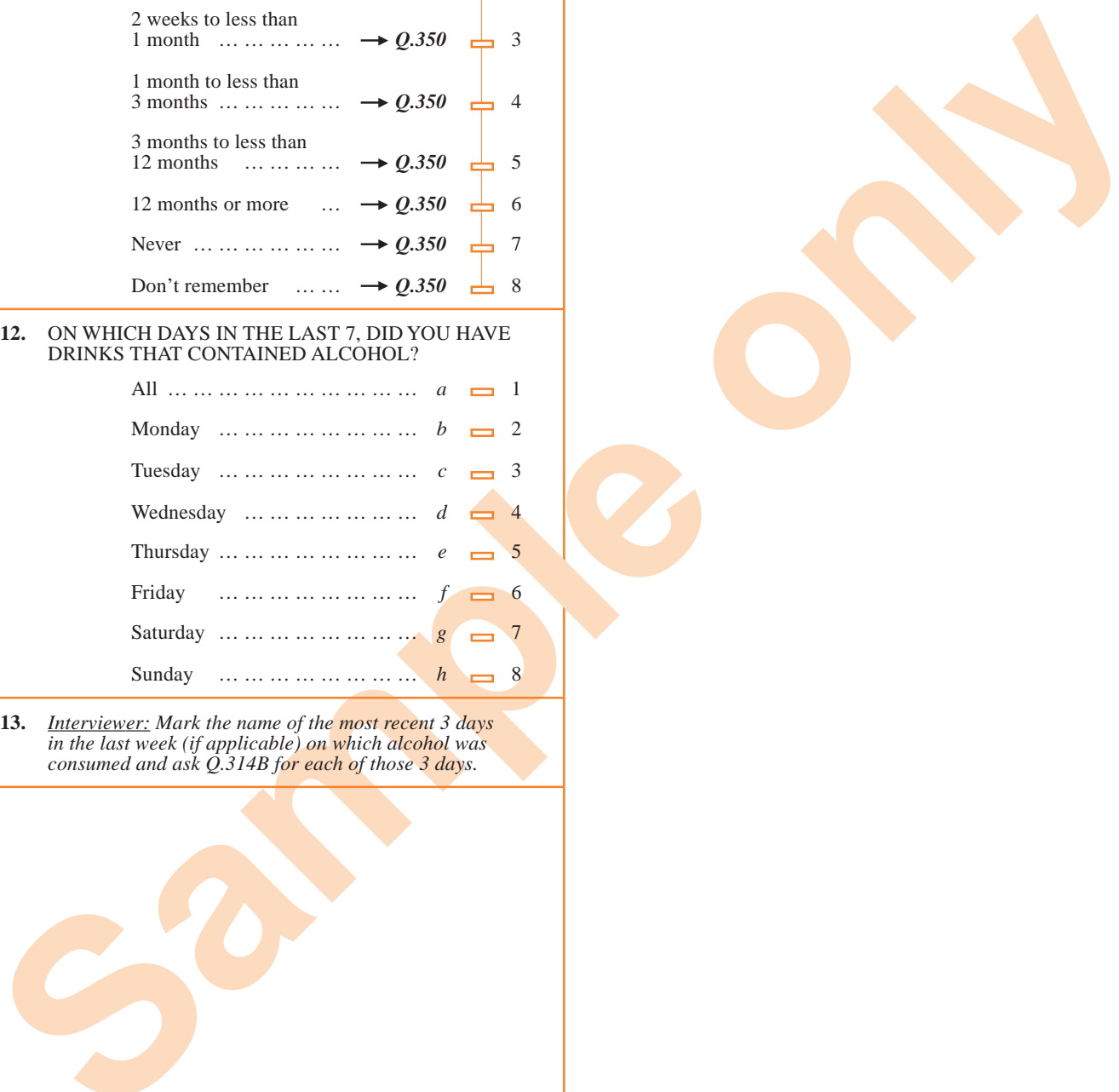
HOW LONG AGO DID YOU LAST HAVE AN ALCOHOLIC DRINK?

- 1 week or less 1
- More than 1 week to less than 2 weeks → Q.350 2
- 2 weeks to less than 1 month → Q.350 3
- 1 month to less than 3 months → Q.350 4
- 3 months to less than 12 months → Q.350 5
- 12 months or more ... → Q.350 6
- Never ... → Q.350 7
- Don't remember ... → Q.350 8

312. ON WHICH DAYS IN THE LAST 7, DID YOU HAVE DRINKS THAT CONTAINED ALCOHOL?

- All ... a 1
- Monday ... b 2
- Tuesday ... c 3
- Wednesday ... d 4
- Thursday ... e 5
- Friday ... f 6
- Saturday ... g 7
- Sunday ... h 8

313. *Interviewer:* Mark the name of the most recent 3 days in the last week (if applicable) on which alcohol was consumed and ask Q.314B for each of those 3 days.



	315. Most recent a) Monday ... <input type="checkbox"/> 1 Tuesday ... <input type="checkbox"/> 2 Wednesday ... <input type="checkbox"/> 3 Thursday ... <input type="checkbox"/> 4 Friday ... <input type="checkbox"/> 5 Saturday ... <input type="checkbox"/> 6 Sunday ... <input type="checkbox"/> 7	316. 2nd most recent a) Monday ... <input type="checkbox"/> 1 Tuesday ... <input type="checkbox"/> 2 Wednesday ... <input type="checkbox"/> 3 Thursday ... <input type="checkbox"/> 4 Friday ... <input type="checkbox"/> 5 Saturday ... <input type="checkbox"/> 6 Sunday ... <input type="checkbox"/> 7	317. 3rd most recent a) Monday ... <input type="checkbox"/> 1 Tuesday ... <input type="checkbox"/> 2 Wednesday ... <input type="checkbox"/> 3 Thursday ... <input type="checkbox"/> 4 Friday ... <input type="checkbox"/> 5 Saturday ... <input type="checkbox"/> 6 Sunday ... <input type="checkbox"/> 7	
314B. WHAT DID YOU HAVE TO DRINK ON (Specify day)? <i>Interviewer:</i> Prompt for quantity and brand type if not given (b) Beer: light	b)	b)	b)	Beer Glasses Best 5oz - 140ml 7oz - 200ml 10oz - 285ml 15oz - 425ml 20oz - 575ml Second best 7oz/glass/butcher middy pot schooner pint
OFFICE USE ONLY	c) <input type="text"/>	c) <input type="text"/>	c) <input type="text"/>	Third best Small sg 200ml
(d) Beer: mid strength	d)	d)	d)	Medium mg 285ml Large lg 425ml
OFFICE USE ONLY	e) <input type="text"/>	e) <input type="text"/>	e) <input type="text"/>	Bottles/cans by size Small sb/sc 10oz/250ml twist tops
(f) Beer: full strength <i>Interviewer:</i> Specify if stout	f)	f)	f)	Medium mb/mc 13oz/375ml stubbie, normal can
OFFICE USE ONLY	g) <input type="text"/>	g) <input type="text"/>	g) <input type="text"/>	Large lb 26oz/750ml bottle, longneck

<i>Interviewer:</i> Transfer day from Q.315a, Q.316a, Q.317a respectively.	315. Most recent	316. 2nd most recent	317. 3rd most recent	
(h) Wine/champagne <i>Interviewer:</i> Specify if red, white, low alcohol or sparkling wine	h) 1	h) 2	h) 3	Glasses Small <i>sg</i> 120ml Medium <i>mg</i> 140ml Large <i>lg</i> 200ml
OFFICE USE ONLY	i) [][][][][]	i) [][][][][]	i) [][][][][]	Bottles <i>lb</i> 26oz/750ml bottle of wine or champagne
(j) Spirits/liqueurs <i>Interviewer:</i> Specify whether spirit, liqueur or UDL	j) 1	j) 2	j) 3	Flagon <i>f</i> Cask <i>k</i> 2 litres <i>2k</i> 4 litres <i>4k</i> 5 litres <i>5k</i>
OFFICE USE ONLY	k) [][][][][]	k) [][][][][]	k) [][][][][]	Spirits half nip = <i>hn</i> nip = <i>n</i> double nip = <i>dn</i>
(l) Fortified wine	l) 1	l) 2	l) 3	
OFFICE USE ONLY	m) [][][][][]	m) [][][][][]	m) [][][][][]	
(n) Other (<i>Specify</i>)	n) 1	n) 2	n) 3	
OFFICE USE ONLY	o) [][][][][]	o) [][][][][]	o) [][][][][]	

318. IS THE AMOUNT YOU DRANK LAST WEEK MORE, ABOUT THE SAME, OR LESS, COMPARED TO MOST WEEKS?

- More 1
- About the same 2
- Less 3

350. *Sequence Guide:*

- . If respondent aged less than 45 → **Q.351** 1
- . Otherwise → **Q.359** 2

351. THE NEXT FEW QUESTIONS DO NOT REFER TO TIMES WHEN YOU HAVE HAD COUGHS, COLDS OR OTHER INFECTIONS.

HAS YOUR CHEST EVER SOUNDED WHEEZY OR WHISTLY?

- Yes 1
- No → **Q.353** 2
- Don't know → **Q.353** 3

352. WHEN WAS THE LAST TIME IT SOUNDED THAT WAY?

- Less than 1 year ago 1
- 1 year to less than 3 years ago 2
- 3 years ago or more 3
- Don't know 4

353. (REMEMBERING NOT TO INCLUDE TIMES WHEN YOU HAVE HAD COUGHS, COLDS OR OTHER INFECTIONS,)

HAVE YOU EVER WOKEN AT NIGHT COUGHING BECAUSE OF SHORTNESS OF BREATH?

- Yes 1
- No → **Q.355** 2
- Don't know → **Q.355** 3

354. WHEN WAS THE LAST TIME THAT HAPPENED?

- Less than 1 year ago 1
- 1 year to less than 3 years ago 2
- 3 years ago or more 3
- Don't know 4

355. (REMEMBERING NOT TO INCLUDE TIMES WHEN YOU HAVE HAD COUGHS, COLDS OR OTHER INFECTIONS,)

IN THE LAST 12 MONTHS, DURING PHYSICAL EXERTION, HAVE YOU HAD A WHEEZY CHEST?

- Yes 1
- No → **Q.357** 2
- Don't know → **Q.357** 3

356. *Interviewer: Show Prompt Card 11*

DURING PHYSICAL EXERTION, HOW OFTEN DOES THIS HAPPEN?

- Always 1
- Usually 2
- Sometimes 3
- Seldom 4
- Don't know 5

357. (REMEMBERING NOT TO INCLUDE TIMES WHEN YOU HAVE HAD COUGHS, COLDS OR OTHER INFECTIONS.)

IN THE LAST 12 MONTHS, DURING PHYSICAL EXERTION, HAVE YOU HAD A BOUT OF COUGHING?

Yes 1

No → *Q.359* 2

Don't know → *Q.359* 3

358. *Interviewer: Show Prompt Card 11*

DURING PHYSICAL EXERTION, HOW OFTEN DOES THIS HAPPEN?

Always 1

Usually 2

Sometimes 3

Seldom 4

Don't know 5

359. THE NEXT QUESTIONS ARE ABOUT LONG TERM HEALTH CONDITIONS. PLEASE INCLUDE ONLY THOSE CONDITIONS THAT HAVE LASTED, OR ARE EXPECTED TO LAST, FOR 6 MONTHS OR MORE.

THE NEXT FEW QUESTIONS ARE ABOUT ASTHMA.

HAVE YOU EVER BEEN TOLD BY A DOCTOR OR NURSE THAT YOU HAVE ASTHMA?

Yes 1

No → *Q.400* 2

Don't know → *Q.400* 3

360. DO YOU STILL GET ASTHMA?

Yes 1

No → *Q.400* 2

361. DO YOU HAVE A WRITTEN ASTHMA ACTION PLAN?

Yes 1

No → *Q.364* 2

Never heard of one → *Q.364* 3

Don't know → *Q.364* 4

362. DID YOU GET THIS ACTION PLAN FROM A -

DOCTOR? 1

NURSE? 2

CHEMIST? 3

Other 4

363. IS YOUR ACTION PLAN SIMILAR TO THIS?

Interviewer: Show Prompt Card 12

Yes 1

No 2

364. THE NEXT FEW QUESTIONS ARE ABOUT MEDICATION THAT YOU MAY HAVE USED OR TAKEN FOR YOUR ASTHMA IN THE LAST 2 WEEKS.

PLEASE EXCLUDE VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, FROM YOUR ANSWER. THESE WILL BE RECORDED LATER.

HAVE YOU TAKEN ANY MEDICATION FOR ASTHMA IN THE LAST 2 WEEKS?

Yes 1

No → *Q.375* 2

Don't know → *Q.375* 3

Sample only



365. (IT MIGHT BE EASIER TO ANSWER THESE QUESTIONS IF YOU HAVE THE MEDICATION IN FRONT OF YOU.)

WHAT ARE THE NAMES OR BRANDS OF ALL THE ASTHMA MEDICATION YOU HAVE USED IN THE LAST 2 WEEKS?

Interviewer: Write a maximum of 3 names or brands

- (a)
- (b)
- (c)

Interviewer: Mark number of medications reported in a-c 1
 2
 3

or

Mark if 4 or more medications reported 4

OFFICE USE ONLY

366.	367.	368.
<input type="text"/>	<input type="text"/>	<input type="text"/>

369. WAS (Specify brand 'a' in Q.365) USED FOR PREVENTION, RELIEF OR BOTH?

Prevention 1
 Relief 2
 Both 3
 Neither 4
 Don't know 5

370. *Sequence Guide:*
 . If more than 1 medication reported in Q.365 → **Q.371** 1
 . Otherwise → **Q.374** 2

371. WAS (Specify brand 'b' in Q.365) USED FOR PREVENTION, RELIEF OR BOTH?

Prevention 1
 Relief 2
 Both 3
 Neither 4
 Don't know 5

372. *Sequence Guide:*
 . If more than 2 medications reported in Q.365 → **Q.373** 1
 . Otherwise → **Q.374** 2

373. WAS (Specify brand 'c' in Q.365) USED FOR PREVENTION, RELIEF OR BOTH?

Prevention 1
 Relief 2
 Both 3
 Neither 4
 Don't know 5

374. DURING THE LAST 2 WEEKS, HAVE YOU USED A NEBULISER TO ADMINISTER (THIS/ANY OF THESE) MEDICATION(S) FOR YOUR ASTHMA?

Yes 1
 No 2
 Don't know 3

375. *Interviewer:* Show Prompt Card 14

HAVE YOU TAKEN ANY OF THESE ACTIONS FOR YOUR ASTHMA IN THE LAST 2 WEEKS?

Yes 1
 No → **Q.400** 2

376. WHICH ONES?

Admitted to hospital as an inpatient a 01
 Visited outpatient clinic b 02
 Visited casualty/emergency c 03
 Visited day clinic d 04
 Consulted doctor (General Practitioner or specialist) e 05
 Consulted other health practitioner f 06
 Had day(s) away from work/school g 07
 Had other days of reduced activity h 08
 Taken vitamin/mineral supplements i 09
 Used natural/herbal medicines ... j 10

400. THE NEXT FEW QUESTIONS ARE ABOUT CANCER.
 HAVE YOU EVER BEEN TOLD BY A DOCTOR OR NURSE THAT YOU HAVE CANCER?

Yes 1
 No → **Q.450** 2

401. WHAT TYPE OF CANCER WERE YOU TOLD YOU HAD?

Skin cancer (include melanoma, basal cell carcinoma, squamous cell carcinoma) *a* 01
 Colon/rectum/bowel cancer (colorectal) *b* 02
 Breast *c* 03
 Prostate *d* 04
 Lung (include trachea, pleura and bronchus) *e* 05
 Female reproductive organs (include cervix, uterus, ovary) ... *f* 06
 Bladder/kidney *g* 07
 Stomach *h* 08
 Leukaemia *i* 09
 Lymphoma (include Non-Hodgkin's Lymphoma) *j* 10
 Cancer of unknown primary site *k* 11
 Other (*Specify*)
 *l* 12

OFFICE USE ONLY

402.

403. *Sequence Guide:*
 . If skin cancer (code '01') in Q.401 → **Q.404** 1
 . Otherwise → **Q.405** 2

404. WHAT TYPE OF SKIN CANCER WAS THIS?

Melanoma *a* 1
 Basal cell carcinoma (BCC) ... *b* 2
 Squamous cell carcinoma (SCC) *c* 3
 Other form of skin cancer *d* 4
 Don't know *e* 5

405. *Sequence Guide:*
 . If breast cancer (code '03') in Q.401 → **Q.406** 1
 . Otherwise → **Q.407** 2

406. AT WHAT AGE WERE YOU FIRST DIAGNOSED WITH BREAST CANCER?

Interviewer: Record age in years

Age

0
 1
 2
 3
 4
 5
 6
 7
 8
 9

407. INCLUDING CANCER WHICH IS IN REMISSION, DO YOU CURRENTLY HAVE CANCER?

Yes 1
 No → **Q.450** 2

408. WHAT TYPE OF CANCER DO YOU HAVE?

Skin cancer (include melanoma, basal cell carcinoma, squamous cell carcinoma) *a* 01
 Colon/rectum/bowel cancer (colorectal) *b* 02
 Breast *c* 03
 Prostate *d* 04
 Lung (include trachea, pleura and bronchus) *e* 05
 Female reproductive organs (include cervix, uterus, ovary) ... *f* 06
 Bladder/kidney *g* 07
 Stomach *h* 08
 Leukaemia *i* 09
 Lymphoma (include Non-Hodgkin's Lymphoma) *j* 10
 Cancer of unknown primary site *k* 11
 Other (*Specify*)
 *l* 12

OFFICE USE ONLY

409.

410. *Sequence Guide:*
 . If skin cancer (code '01') in Q.408 → **Q.411** 1
 . Otherwise → **Q.412** 2

411. WHAT TYPE OF SKIN CANCER IS THIS?

Melanoma *a* 1

Basal cell carcinoma (BCC) ... *b* 2

Squamous cell carcinoma (SCC) *c* 3

Other form of skin cancer ... *d* 4

Don't know *e* 5

412. THE NEXT FEW QUESTIONS ARE ABOUT MEDICATION THAT YOU MAY HAVE USED OR TAKEN FOR CANCER IN THE LAST 2 WEEKS.

WE ARE ONLY INTERESTED IN MEDICATION YOU ARE USING OR TAKING WHICH IS DIRECTLY RELATED TO THE CONDITION(S) YOU HAVE TOLD ME ABOUT.

INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAVE YOU USED ANY MEDICATION FOR CANCER IN THE LAST 2 WEEKS?

Yes 1

No → *Q.450* 2

413. (IT MIGHT BE EASIER TO ANSWER THESE QUESTIONS IF YOU HAVE THE MEDICATION IN FRONT OF YOU.)

IN THE LAST 2 WEEKS, FOR CANCER, HAVE YOU TAKEN ANY -

VITAMIN OR MINERAL SUPPLEMENTS? *a* 1

HERBAL OR NATURAL TREATMENTS OR REMEDIES? *b* 2

Neither of these → *Q.415* *c* 3

414. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT,

HAVE YOU USED OR TAKEN ANY MEDICATION FOR CANCER IN THE LAST 2 WEEKS?

Yes 1

No → *Q.450* 2

415. WHAT ARE THE NAMES OR BRANDS OF ALL THE MEDICATION YOU HAVE USED FOR CANCER IN THE LAST 2 WEEKS?

Interviewer: Write a maximum of 3 names or brands

(a)

(b)

(c)

Interviewer: Mark number of medications reported in a-c

1

2

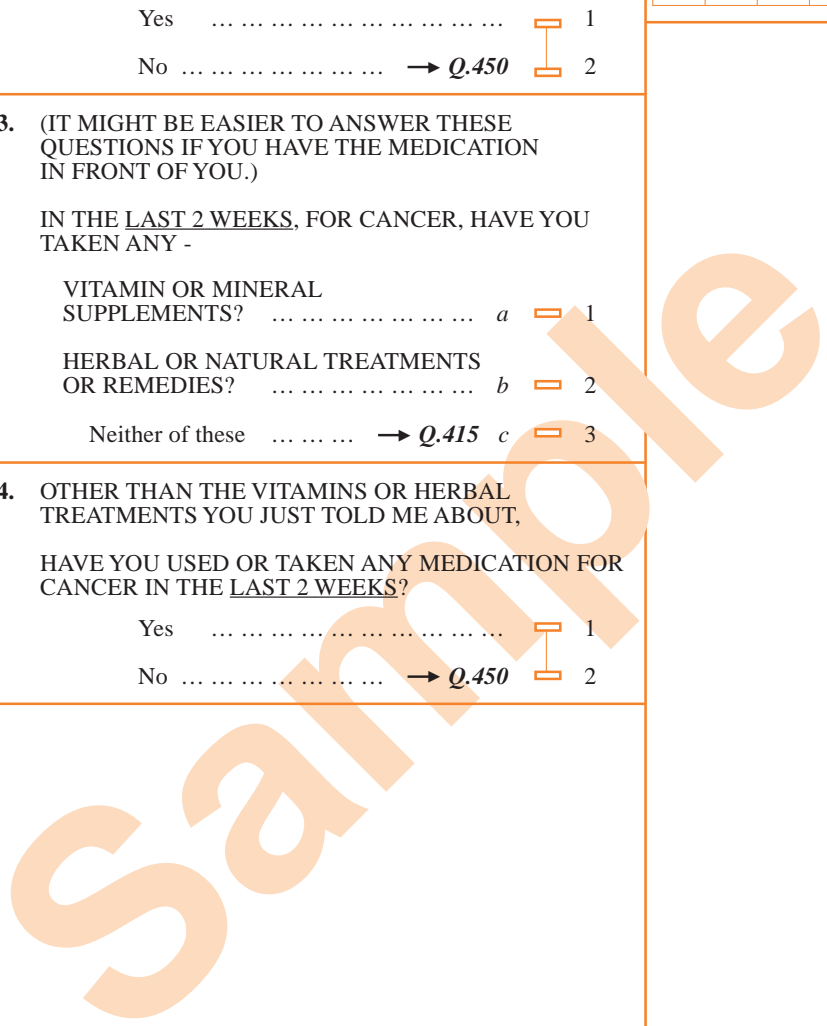
3

or

Mark if 4 or more medications reported 4

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416.	417.	418.												
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450. THE NEXT FEW QUESTIONS ARE ABOUT CONDITIONS OF THE HEART AND CIRCULATORY SYSTEMS.

Interviewer: Show Prompt Card 15

THIS CARD SHOWS SOME EXAMPLES OF THESE CONDITIONS.

INCLUDING ANY CONDITIONS WHICH CAN BE CONTROLLED WITH MEDICATION, HAVE YOU EVER BEEN TOLD BY A DOCTOR OR NURSE THAT YOU HAVE ANY HEART OR CIRCULATORY CONDITIONS?

- Yes 1
- No → **Q.500** 2

451. WHAT ARE THE NAMES OF THESE CONDITIONS?

- Rheumatic heart disease a 01
- Heart attack b 02
- Stroke (including after effects of stroke) c 03
- Angina d 04
- High blood pressure/hypertension e 05
- Hardening of the arteries/ atherosclerosis/arteriosclerosis ... f 06
- Fluid problems/fluid retention/ oedema g 07
- High cholesterol h 08
- Rapid or irregular heartbeats/ tachycardia/palpitations i 09
- Heart murmur/heart valve disorder j 10
- Haemorrhoids k 11
- Varicose veins l 12
- Other
(Interviewer: Write in the names of up to 3 conditions below)
- (a)..... m 13
- (b)..... n 14
- (c)..... o 15

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452(a). <input style="width: 100%; height: 20px;" type="text"/>	452(b). <input style="width: 100%; height: 20px;" type="text"/>	452(c). <input style="width: 100%; height: 20px;" type="text"/>
---	---	---

453. INCLUDING ANY CONDITIONS WHICH YOU ARE CONTROLLING WITH MEDICATION, DO YOU CURRENTLY HAVE ANY HEART OR CIRCULATORY CONDITIONS?

- Yes 1
- No → **Q.500** 2

454. WHAT ARE THE NAMES OF THESE HEART OR CIRCULATORY CONDITIONS?

- Rheumatic heart disease a 01
- Heart attack b 02
- Stroke (including after effects of stroke) c 03
- Angina d 04
- High blood pressure/hypertension e 05
- Hardening of the arteries/ atherosclerosis/arteriosclerosis ... f 06
- Fluid problems/fluid retention/ oedema g 07
- High cholesterol h 08
- Rapid or irregular heartbeats/ tachycardia/palpitations i 09
- Heart murmur/heart valve disorder j 10
- Haemorrhoids k 11
- Varicose veins l 12
- Other
(Interviewer: Write in the names of up to 3 conditions below)
- (a)..... m 13
- (b)..... n 14
- (c)..... o 15

OFFICE USE ONLY

455(a). <input style="width: 100%; height: 20px;" type="text"/>	455(b). <input style="width: 100%; height: 20px;" type="text"/>	455(c). <input style="width: 100%; height: 20px;" type="text"/>
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456. *Sequence Guide:*

- . If shaded box marked in Q.454 → **Q.457** 1
- . Otherwise → **Q.459** 2

457. (AGAIN REMEMBERING TO INCLUDE ANY CONDITIONS WHICH CAN BE CONTROLLED WITH MEDICATION,)

(HAS THIS/HAVE ANY OF THESE) CONDITION(S) LASTED, OR (IS IT/ARE THEY) EXPECTED TO LAST, FOR 6 MONTHS OR MORE?

- Yes 1
- No → **Q.500** 2

- 458. WHICH CONDITIONS ARE THEY?**
- Angina *a* 01
 - High blood pressure/hypertension *b* 02
 - Hardening of the arteries/
atherosclerosis/arteriosclerosis ... *c* 03
 - Fluid problems/fluid retention/
oedema *d* 04
 - High cholesterol *e* 05
 - Rapid or irregular heartbeats/
tachycardia/palpitations *f* 06
 - Heart murmur/heart valve disorder *g* 07
 - Haemorrhoids *h* 08
 - Varicose veins *i* 09
 - Condition '(a)' from Q.454 *j* 10
 - Condition '(b)' from Q.454 *k* 11
 - Condition '(c)' from Q.454 *l* 12

- 459. Sequence Guide:**
- . If 1 box only marked in Q.454 → **Q.464** 1
 - . Otherwise → **Q.460** 2

- 460. THE NEXT FEW QUESTIONS ARE ABOUT MEDICATION THAT YOU MAY HAVE USED OR TAKEN, IN THE LAST 2 WEEKS, WHICH ARE DIRECTLY RELATED TO YOUR HEART OR CIRCULATORY CONDITIONS.**
- INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAVE YOU USED ANY MEDICATION FOR ANY OF YOUR HEART OR CIRCULATORY CONDITIONS IN THE LAST 2 WEEKS?
- Yes 1
 - No → **Q.500** 2

- 461. DO YOU KNOW WHICH CONDITIONS YOU ARE TAKING EACH MEDICATION FOR?**
- Yes → **Q.464** 1
 - No 2
 - Some → **Q.464** 3

- 462. (IT MIGHT BE EASIER TO ANSWER THESE QUESTIONS IF YOU HAVE THE MEDICATION IN FRONT OF YOU.)**
- IN THE LAST 2 WEEKS, FOR YOUR HEART OR CIRCULATORY CONDITIONS, HAVE YOU TAKEN ANY -
- VITAMIN OR MINERAL SUPPLEMENTS? *a* 1
 - HERBAL OR NATURAL TREATMENTS OR REMEDIES? *b* 2
 - Neither of these → **Q.489** *c* 3

- 463. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT, HAVE YOU USED OR TAKEN ANY OTHER MEDICATION FOR YOUR HEART OR CIRCULATORY CONDITIONS IN THE LAST 2 WEEKS?**
- Yes → **Q.489** 1
 - No → **Q.500** 2
 - Don't know → **Q.500** 3

- 464. (THE NEXT FEW QUESTIONS ARE ABOUT MEDICATION THAT YOU MAY HAVE USED OR TAKEN, IN THE LAST 2 WEEKS, WHICH ARE DIRECTLY RELATED TO YOUR HEART OR CIRCULATORY CONDITION(S).)**
- INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAVE YOU USED ANY MEDICATION FOR (*Specify name of condition 1 recorded in Q.454*) IN THE LAST 2 WEEKS?
- Yes 1
 - No → **Q.471** 2
 - Don't know → **Q.471** 3

- 465. (IT MIGHT BE EASIER TO ANSWER THESE QUESTIONS IF YOU HAVE THE MEDICATION IN FRONT OF YOU.)**
- IN THE LAST 2 WEEKS, FOR (*Specify name of condition 1 recorded in Q.454*), HAVE YOU TAKEN ANY -
- VITAMIN OR MINERAL SUPPLEMENTS? *a* 1
 - HERBAL OR NATURAL TREATMENTS OR REMEDIES? *b* 2
 - Neither of these → **Q.467** *c* 3

- 466. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT, HAVE YOU USED OR TAKEN ANY MEDICATION FOR (*Specify name of condition 1 recorded in Q.454*) IN THE LAST 2 WEEKS?**
- Yes 1
 - No → **Q.471** 2
 - Don't know → **Q.471** 3

<p>467. WHAT ARE THE NAMES OR BRANDS OF ALL THE MEDICATION YOU HAVE USED FOR (Specify name of condition 1 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p><i>Interviewer: Write a maximum of 3 names or brands</i></p> <p>(a)</p> <p>(b)</p> <p>(c)</p> <p><i>Interviewer: Mark number of medications reported in a-c</i></p> <p style="text-align: right;"><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p>or</p> <p>Mark if 4 or more medications reported <input type="checkbox"/> 4</p> <p>or</p> <p>Mark if no names or brands known <input type="checkbox"/> 8</p>	<p>475. WHAT ARE THE NAMES OR BRANDS OF ALL THE MEDICATION YOU HAVE USED FOR (Specify name of condition 2 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p><i>Interviewer: Write a maximum of 3 names or brands</i></p> <p>(a)</p> <p>(b)</p> <p>(c)</p> <p><i>Interviewer: Mark number of medications reported in a-c</i></p> <p style="text-align: right;"><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p>or</p> <p>Mark if 4 or more medications reported <input type="checkbox"/> 4</p> <p>or</p> <p>Mark if no names or brands known <input type="checkbox"/> 8</p>																		
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<p>471. Sequence Guide:</p> <ul style="list-style-type: none"> . If only 1 condition recorded in Q.454 → Q.500 <input type="checkbox"/> 1 . If more than 1 condition recorded in Q.454 → Q.472 <input type="checkbox"/> 2 	<p>479. Sequence Guide:</p> <ul style="list-style-type: none"> . If only 2 conditions recorded in Q.454 → Q.487 <input type="checkbox"/> 1 . If more than 2 conditions recorded in Q.454 → Q.480 <input type="checkbox"/> 2 																		
<p>472. INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAVE YOU USED ANY MEDICATION FOR (Specify name of condition 2 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes</p> <p>No → Q.479 <input type="checkbox"/> 2</p> <p>Don't know → Q.479 <input type="checkbox"/> 3</p>	<p>480. INCLUDING ANY VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, HAVE YOU USED ANY MEDICATION FOR (Specify name of condition 3 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes</p> <p>No → Q.487 <input type="checkbox"/> 2</p> <p>Don't know → Q.487 <input type="checkbox"/> 3</p>																		
<p>473. IN THE <u>LAST 2 WEEKS</u>, FOR (Specify name of condition 2 recorded in Q.454), HAVE YOU TAKEN ANY -</p> <p>VITAMIN OR MINERAL SUPPLEMENTS? a <input type="checkbox"/> 1</p> <p>HERBAL OR NATURAL TREATMENTS OR REMEDIES? b <input type="checkbox"/> 2</p> <p>Neither of these → Q.475 c <input type="checkbox"/> 3</p>	<p>481. IN THE <u>LAST 2 WEEKS</u>, FOR (Specify name of condition 3 recorded in Q.454), HAVE YOU TAKEN ANY -</p> <p>VITAMIN OR MINERAL SUPPLEMENTS? a <input type="checkbox"/> 1</p> <p>HERBAL OR NATURAL TREATMENTS OR REMEDIES? b <input type="checkbox"/> 2</p> <p>Neither of these → Q.483 c <input type="checkbox"/> 3</p>																		
<p>474. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT,</p> <p>HAVE YOU USED OR TAKEN ANY MEDICATION FOR (Specify name of condition 2 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes</p> <p>No → Q.479 <input type="checkbox"/> 2</p> <p>Don't know → Q.479 <input type="checkbox"/> 3</p>	<p>482. OTHER THAN THE VITAMINS OR HERBAL TREATMENTS YOU JUST TOLD ME ABOUT,</p> <p>HAVE YOU USED OR TAKEN ANY MEDICATION FOR (Specify name of condition 3 recorded in Q.454) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes</p> <p>No → Q.487 <input type="checkbox"/> 2</p> <p>Don't know → Q.487 <input type="checkbox"/> 3</p>																		

483. WHAT ARE THE NAMES OR BRANDS OF ALL THE MEDICATION YOU HAVE USED FOR (Specify name of condition 3 recorded in Q.454) IN THE LAST 2 WEEKS?

Interviewer: Write a maximum of 3 names or brands

(a)

(b)

(c)

Interviewer: Mark number of medications reported in a-c

or

Mark if 4 or more medications reported

or

Mark if no names or brands known

1
 2
 3
 4
 8

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484.	485.	486.
<input type="text"/>	<input type="text"/>	<input type="text"/>

487. Sequence Guide:

. If yes (code '1') in Q.461 ... → **Q.500** 1

. If some (code '3') in Q.461 ... → **Q.488** 2

488. HAVE YOU USED OR TAKEN ANY OTHER MEDICATION FOR YOUR HEART OR CIRCULATORY CONDITIONS IN THE LAST 2 WEEKS?

Yes 1

No → **Q.500** 2

489. WHAT ARE THE NAMES OR BRANDS OF ALL THE (OTHER) MEDICATION YOU HAVE USED FOR YOUR HEART OR CIRCULATORY CONDITION(S) IN THE LAST 2 WEEKS?

Interviewer: Write a maximum of 3 names or brands

(a)

(b)

(c)

Interviewer: Mark number of medications reported in a-c

or

Mark if 4 or more medications reported

1
 2
 3
 4

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490.	491.	492.
<input type="text"/>	<input type="text"/>	<input type="text"/>

500. THE NEXT FEW QUESTIONS ARE ABOUT DIABETES AND HIGH SUGAR LEVELS.

HAVE YOU EVER BEEN TOLD BY A DOCTOR OR NURSE THAT YOU HAVE -

DIABETES? a 1

HIGH SUGAR LEVELS IN YOUR BLOOD OR URINE? b 2

Neither → **Q.522** c 3

501. AT WHAT AGE WERE YOU FIRST TOLD THAT YOU HAD (DIABETES/HIGH SUGAR LEVELS)?

Interviewer: If diabetes and high sugar levels marked in Q.500, record age first told had diabetes

Years 1 1
 2 2
 3 3
 4 4
 Less than 1 year ... 97 5 5
 6 6
 7 7
 Don't know 98 8 8
 9 9

502. Sequence Guide:

. If diabetes (code '1') in Q.500 → **Q.503** 1

. Otherwise → **Q.506** 2

503. WHAT TYPE OF DIABETES WERE YOU TOLD YOU HAVE?

Type 1 (Insulin Dependent Diabetes Mellitus/Juvenile Onset Diabetes) a 1

Type 2 (Non-Insulin Dependent Diabetes Mellitus/Adult Onset Diabetes) b 2

Gestational (pregnancy) c 3

Diabetes insipidus d 4

Other (Specify)
 e 5

Don't know f 6

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504.

505. Sequence Guide:

. If diabetes insipidus only (code '4') in Q.503 ... → **Q.522** 1

. Otherwise → **Q.506** 2

<p>506. DO YOU CURRENTLY HAVE (DIABETES/HIGH SUGAR LEVELS)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.522 <input type="checkbox"/> 2</p> <p>Don't know → Q.522 <input type="checkbox"/> 3</p>	<p>512. (IT MIGHT BE EASIER TO ANSWER THE NEXT QUESTION IF YOU HAVE THE MEDICATION IN FRONT OF YOU.)</p> <p>(APART FROM INSULIN INJECTIONS,) WHAT ARE THE NAMES OR BRANDS OF ALL THE MEDICATION YOU HAVE USED FOR (DIABETES/HIGH SUGAR LEVELS) IN THE <u>LAST 2 WEEKS</u>?</p> <p><i>Interviewer: Write a maximum of 3 names or brands</i></p> <p>(a)</p> <p>(b)</p> <p>(c)</p> <p><i>Interviewer: Mark number of medications reported in a-c</i></p> <p style="text-align: right;"><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p>or</p> <p><i>Mark if 4 or more medications reported</i> <input type="checkbox"/> 4</p>																		
<p>507. Sequence Guide:</p> <p>. If Type 1 or Type 2 diabetes (code '1' or '2') in Q.503 → Q.509 <input type="checkbox"/> 1</p> <p>. If Gestational only (code '3') in Q.503 → Q.509 <input type="checkbox"/> 2</p> <p>. Otherwise → Q.508 <input type="checkbox"/> 3</p>	<p>OFFICE USE ONLY</p>																		
<p>508. (HAS/HAVE) YOUR (Specify other type in Q.503/HIGH SUGAR LEVELS) LASTED, OR (IS IT/ARE THEY) EXPECTED TO LAST, FOR 6 MONTHS OR MORE?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.522 <input type="checkbox"/> 2</p> <p>Don't know → Q.522 <input type="checkbox"/> 3</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center; padding: 2px;">513.</td> <td style="width: 33%; text-align: center; padding: 2px;">514.</td> <td style="width: 33%; text-align: center; padding: 2px;">515.</td> </tr> <tr> <td style="text-align: center; height: 20px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> </td> <td style="text-align: center; height: 20px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> </td> <td style="text-align: center; height: 20px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table> </td> </tr> </table>	513.	514.	515.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table>					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table>					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td><td style="width: 25px; height: 20px;"></td></tr> </table>				
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<p>509. ARE YOU CURRENTLY HAVING INSULIN INJECTIONS EVERY DAY?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.511 <input type="checkbox"/> 2</p> <p>Don't know → Q.511 <input type="checkbox"/> 3</p>	<p>516. DID YOU CHANGE YOUR EATING PATTERNS OR DIET BECAUSE OF YOUR (DIABETES/HIGH SUGAR LEVELS)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.518 <input type="checkbox"/> 2</p>																		
<p>510. AT WHAT AGE DID YOU START HAVING THESE INSULIN INJECTIONS EVERY DAY?</p> <p>Years <input style="width: 40px; height: 20px;" type="text"/> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9</p> <p>Less than 1 year <input type="checkbox"/> 97 <input type="checkbox"/> 98</p> <p>Don't know <input type="checkbox"/> 98 <input type="checkbox"/> 99</p>	<p>517. ARE YOU CURRENTLY FOLLOWING A CHANGED EATING PATTERN OR DIET BECAUSE OF YOUR (DIABETES/HIGH SUGAR LEVELS)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p>																		
<p>511. THE NEXT FEW QUESTIONS ARE ABOUT OTHER MEDICATION THAT YOU MAY HAVE USED OR TAKEN FOR YOUR (DIABETES/HIGH SUGAR LEVELS) IN THE <u>LAST 2 WEEKS</u>.</p> <p>PLEASE EXCLUDE VITAMIN AND MINERAL SUPPLEMENTS, AS WELL AS ANY NATURAL OR HERBAL MEDICINES, FROM YOUR ANSWER. THESE WILL BE RECORDED LATER.</p> <p>(APART FROM INSULIN INJECTIONS,) HAVE YOU USED ANY (OTHER) MEDICATION(S) FOR (DIABETES/HIGH SUGAR LEVELS) IN THE <u>LAST 2 WEEKS</u>?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.516 <input type="checkbox"/> 2</p> <p>Don't know → Q.516 <input type="checkbox"/> 3</p>	<p>518. Interviewer: Show Prompt Card 16</p> <p>(APART FROM INSULIN INJECTIONS, MEDICATION OR BEING ON A SPECIAL DIET,)</p> <p>IN THE <u>LAST 2 WEEKS</u>, HAVE YOU TAKEN ANY (OTHER) ACTION TO MANAGE YOUR (DIABETES/HIGH SUGAR LEVELS)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.520 <input type="checkbox"/> 2</p>																		
<p>519. WHICH OTHER ACTIONS HAVE YOU TAKEN TO MANAGE YOUR (DIABETES/HIGH SUGAR LEVELS)?</p> <p>Losing weight a <input type="checkbox"/> 1</p> <p>Exercised most days b <input type="checkbox"/> 2</p> <p>Taken vitamin/mineral supplements c <input type="checkbox"/> 3</p> <p>Taken natural/herbal medicines d <input type="checkbox"/> 4</p> <p>Other e <input type="checkbox"/> 5</p>																			

520. *Interviewer: Show Prompt Card 17*

IN THE LAST 12 MONTHS, (HAS/HAVE) YOUR (DIABETES/HIGH SUGAR LEVELS) INTERFERED WITH ANYTHING YOU USUALLY DO?

- Yes 1
 No → *Q.522* 2

521. WHICH ACTIVITIES?

- Work *a* 1
 Study *b* 2
 Other day to day activities *c* 3

522. I WOULD NOW LIKE TO ASK YOU ABOUT YOUR EYESIGHT.

ARE YOU COLOUR BLIND?

- Yes 1
 No 2

523. DO YOU CURRENTLY WEAR GLASSES OR CONTACT LENSES TO CORRECT, OR PARTIALLY CORRECT, YOUR EYESIGHT?

- Yes 1
 No → *Q.526* 2

524. *Interviewer: Show Prompt Card 18*

WHAT SIGHT PROBLEMS DO YOUR GLASSES OR CONTACT LENSES CORRECT, OR PARTIALLY CORRECT?

- Astigmatism *a* 1
 Short-sightedness/Myopia *b* 2
 Age-related sight problems/
 Presbyopia *c* 3
 Long-sightedness/Hyperopia ... *d* 4
 Other (*Specify*)
 *e* 5
 Don't know *f* 6

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525.

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526. DO YOU HAVE ANY (OTHER) PROBLEMS WITH YOUR SIGHT?

- Yes 1
 No → *Q.533* 2
 Don't know → *Q.533* 3

527. CAN ANY OF THESE (OTHER) PROBLEMS BE CORRECTED, OR PARTIALLY CORRECTED, BY GLASSES OR CONTACT LENSES?

- Yes 1
 No → *Q.531* 2
 Don't know → *Q.531* 3

528. Interviewer: Show Prompt Card 18

WHAT (OTHER) SIGHT PROBLEMS DO YOU HAVE THAT CAN BE CORRECTED, OR PARTIALLY CORRECTED, BY GLASSES OR CONTACT LENSES?

- Astigmatism a 1
- Short-sightedness/Myopia b 2
- Age-related sight problems/Presbyopia c 3
- Long-sightedness/Hyperopia ... d 4
- Other (Specify)
- e 5
- Don't know f 6

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529.

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530. DO YOU HAVE ANY (OTHER) SIGHT PROBLEMS?

- Yes 1
- No → Q.533 2
- Don't know → Q.533 3

531. WHAT (OTHER) SIGHT PROBLEMS DO YOU HAVE?

- Totally blind in both eyes a 01
- Totally blind in 1 eye only b 02
- Partially blind in both eyes c 03
- Partially blind in 1 eye only d 04
- Glaucoma e 05
- Cataracts f 06
- Trachoma g 07
- Lazy eye/Strabismus h 08
- Other (Specify)
- i 09
- Don't know j 10

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532.

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533. Sequence Guide:

- . If currently has diabetes/high sugar levels (code '1') in Q.506 → Q.534 1
- . Otherwise → Q.542 2

534. Sequence Guide:

- . If sight problem reported (code '1') in Q.523 or Q.526 → Q.535 1
- . Otherwise → Q.541 2

535. ARE ANY OF YOUR SIGHT PROBLEMS DUE TO YOUR (DIABETES/HIGH SUGAR LEVELS)?

- Yes 1
- No → Q.541 2
- Don't know → Q.541 3

536. Interviewer:

- . If only 1 sight problem reported in Q.524, Q.528 or Q.531, mark problem in Q.537 and ask Q.539 1
- . Otherwise → Q.537 2

537. OF THE SIGHT PROBLEMS YOU HAVE TOLD ME ABOUT, WHICH ONES ARE DUE TO YOUR (DIABETES/HIGH SUGAR LEVELS)?

- Astigmatism a 01
- Short-sightedness/Myopia b 02
- Long-sightedness/Hyperopia c 03
- Totally blind in both eyes d 04
- Totally blind in 1 eye only e 05
- Partially blind in both eyes f 06
- Partially blind in 1 eye only g 07
- Glaucoma h 08
- Cataracts i 09
- Trachoma j 10
- Lazy eye/Strabismus k 11
- Other (Specify)
- l 12
- Don't know m 13

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538.

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539. HOW LONG AGO SINCE YOU LAST CONSULTED AN EYE SPECIALIST OR OPTOMETRIST ABOUT ANY OF THESE CONDITIONS?

Interviewer: If has visited both an optometrist and an eye specialist, record the most recent visit

- Less than 1 year ... 1
1 to less than 2 years ... 2
2 to less than 5 years ... 3
5 years or more ... 4
Never ... 5
Don't know ... 6

540. -> Q.542

541. HOW LONG AGO SINCE YOU LAST CONSULTED AN EYE SPECIALIST OR OPTOMETRIST?

Interviewer: If has visited both an optometrist and an eye specialist, record the most recent visit

- Less than 1 year ... 1
1 to less than 2 years ... 2
2 to less than 5 years ... 3
5 years or more ... 4
Never ... 5
Don't know ... 6

542. DO YOU HAVE ANY HEARING PROBLEMS OR PROBLEMS WITH YOUR EARS THAT HAVE LASTED, OR ARE EXPECTED TO LAST, FOR 6 MONTHS OR MORE?

- Yes ... 1
No -> Q.545 ... 2

543. WHAT HEARING OR EAR PROBLEMS DO YOU HAVE?

- Total deafness ... a ... 1
Deaf in 1 ear ... b ... 2
Hearing loss/partially deaf ... c ... 3
Tinnitus ... d ... 4
Meniere's Disease/Syndrome ... e ... 5
Otitis media ... f ... 6
Other (Specify) ... g ... 7
Don't know ... h ... 8

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544.

Three empty boxes for recording data.

545. DO YOU CURRENTLY HAVE -

- OSTEOARTHRITIS? ... a ... 1
RHEUMATOID ARTHRITIS? ... b ... 2
GOUT? ... c ... 3
RHEUMATISM? ... d ... 4
OTHER TYPE OF ARTHRITIS? (Specify) ... e ... 5
Arthritis - type unknown ... f ... 6
None of these ... -> Q.550 g ... 7

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546.

Three empty boxes for recording data.

547. Sequence Guide:

- If osteoarthritis only (code 'I') in Q.545 ... -> Q.550 ... 1
Otherwise ... -> Q.548 ... 2

548. (HAS THIS/HAVE ANY OF THESE) CONDITION(S) LASTED, OR (IS IT/ARE THEY) EXPECTED TO LAST, FOR 6 MONTHS OR MORE?

- Yes ... 1
No -> Q.550 ... 2
Don't know -> Q.550 ... 3

549. Interviewer: If more than 1 condition marked in Q.545, ask WHICH ONES?

- Rheumatoid arthritis ... a ... 1
Gout ... b ... 2
Rheumatism ... c ... 3
Other type of arthritis ... d ... 4
Arthritis - type unknown ... e ... 5

550. THE NEXT FEW QUESTIONS ARE ABOUT OTHER LONG TERM CONDITIONS, THAT IS, CONDITIONS WHICH HAVE LASTED, OR ARE EXPECTED TO LAST, FOR 6 MONTHS OR MORE.

DO YOU HAVE ANY OF THESE CONDITIONS?

Interviewer: Show Prompt Card 20

- Yes 1
- No → **Q.552** 2

551. WHICH OF THESE DO YOU HAVE?

- Hayfever a 01
- Sinusitis or sinus allergy b 02
- Other allergy c 03
- Anaemia d 04
- Bronchitis e 05
- Cystic fibrosis f 06
- Emphysema g 07
- Epilepsy h 08
- Fluid problems/fluid retention/
oedema (not due to heart or
circulatory problems) i 09
- Hernias j 10
- Kidney stones k 11
- Migraine l 12
- Osteoporosis m 13
- Psoriasis n 14
- Stomach ulcers or other
gastrointestinal ulcers o 15
- Thyroid trouble/goitre p 16
- Tuberculosis q 17

552. (APART FROM THE CONDITION(S) YOU HAVE ALREADY TOLD ME ABOUT,)

DO YOU HAVE ANY OTHER CONDITIONS THAT HAVE LASTED, OR ARE EXPECTED TO LAST, FOR 6 MONTHS OR MORE. FOR EXAMPLE:

Interviewer: Show Prompt Card 21

- Yes 1
- No → **Q.558** 2

553. WHICH CONDITIONS DO YOU HAVE?

- (a)
 - (b)
 - (c)
 - (d) 1
 2
 3
 4
- Interviewer: Mark number of conditions reported in a-d*

OFFICE USE ONLY

554. <input type="text"/>	555. <input type="text"/>
556. <input type="text"/>	557. <input type="text"/>

558. (APART FROM THE CONDITION(S) YOU HAVE ALREADY TOLD ME ABOUT,)

DO YOU HAVE ANY (OTHER) LONG TERM CONDITIONS SUCH AS THESE:

Interviewer: Show Prompt Card 22

- Yes 1
- No → **Q.564** 2

559. WHICH CONDITIONS DO YOU HAVE?

- (a)
 - (b)
 - (c)
 - (d) 1
 2
 3
 4
- Interviewer: Mark number of conditions reported in a-d*

OFFICE USE ONLY

560. <input type="text"/>	561. <input type="text"/>
562. <input type="text"/>	563. <input type="text"/>

564. *Sequence Guide:*
 . If any condition reported anywhere
 (including sight and hearing conditions)
 → *Q.566* 1
 . Otherwise → *Q.600* 2

566. THE NEXT FEW QUESTIONS ARE ABOUT (ALL OF) THE CONDITION(S) YOU HAVE TOLD ME ABOUT.
 (IS THIS/ARE ANY OF THESE) CONDITION(S) WORK RELATED?
 Yes 1
 No → *Q.573* 2
 Don't know → *Q.573* 3

567. WHICH CONDITIONS ARE THEY?
 (a)
 (b)
 (c)
 (d)
 (e) 1
 2
 3
 4
 5
Interviewer: Mark number of conditions reported in a-e

OFFICE USE ONLY

568. <input type="text"/> <input type="text"/> <input type="text"/>	569. <input type="text"/> <input type="text"/> <input type="text"/>	570. <input type="text"/> <input type="text"/> <input type="text"/>
571. <input type="text"/> <input type="text"/> <input type="text"/>	572. <input type="text"/> <input type="text"/> <input type="text"/>	

573. (IS THIS/ARE ANY OF THE) CONDITION(S) YOU HAVE TOLD ME ABOUT, THE RESULT OF AN INJURY?
 Yes 1
 No → *Q.600* 2
 Don't know → *Q.600* 3

574. WHICH CONDITIONS ARE THEY?
 (a)
 (b)
 (c)
 (d)
 (e) 1
 2
 3
 4
 5
Interviewer: Mark number of conditions reported in a-e

OFFICE USE ONLY

575. <input type="text"/> <input type="text"/> <input type="text"/>	576. <input type="text"/> <input type="text"/> <input type="text"/>	577. <input type="text"/> <input type="text"/> <input type="text"/>
578. <input type="text"/> <input type="text"/> <input type="text"/>	579. <input type="text"/> <input type="text"/> <input type="text"/>	

580. *Interviewer: Ask Q.581, Q.582 and Q.583 for each condition reported in Q.574 (a-e). Mark the box in Q.581, Q.582 and Q.583 which corresponds to the code (a-e) in Q.574.*

581. DID YOU RECEIVE THIS INJURY -
 WHILE AT (WORK/SCHOOL)?
 Yes *a* *b* *c* *d* *e* 1

 No *a* *b* *c* *d* *e* 2

582. (DID YOU RECEIVE THIS INJURY -)
 IN A MOTOR VEHICLE ACCIDENT?
 Yes *a* *b* *c* *d* *e* 1

 No *a* *b* *c* *d* *e* 2

583. (DID YOU RECEIVE THIS INJURY -)
 DURING EXERCISE OR SPORT?
 Yes *a* *b* *c* *d* *e* 1

 No *a* *b* *c* *d* *e* 2

600. INJURIES ARE A MAJOR HEALTH PROBLEM. IN ORDER TO DEVELOP NEW WAYS TO HELP PREVENT BOTH ACCIDENTAL AND INTENTIONAL INJURIES, WE NEED TO KNOW MORE ABOUT THEM.

(SOME PEOPLE REMEMBER THEIR INJURIES BY THINKING ABOUT THE TYPES OF INJURY RECEIVED, WHILE OTHERS FIND IT EASIER TO RECALL INJURIES BY REMEMBERING HOW THE INJURY HAPPENED.)

Interviewer: Show Prompt Card 23

IN THE LAST 4 WEEKS, HAVE ANY OF THESE HAPPENED TO YOU?

Yes 1

No → Q.700 2

601. *Interviewer: Show Prompt Card 24*

DID ANY OF THESE EVENTS RESULT IN ANY OF THE FOLLOWING ACTIONS?

Yes 1

No → Q.700 2

602. WHICH EVENTS WERE THESE ACTIONS TAKEN FOR?

Interviewer: Show Prompt Card 25
Record the number of each type of event
Do not collect details about food poisoning

Type of event	No of events					
	1	2	3	4	5+	
Vehicle accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a
Low fall (1 metre or less)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b
High fall (more than 1 metre)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c
Hitting something or being hit by something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d
Attack by another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e
Near drowning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f
Exposure to fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g
Exposure to chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h
Bite or sting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i
Other event requiring some action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j

603. *Interviewer:*

. If only food poisoning reported → Q.700 1

. If only 1 event reported in Q.602, mark the appropriate box in Q.604 and ask Q.605 2

. Otherwise → Q.604 3

604. (NOT INCLUDING FOOD POISONING,) (OF THOSE), WHICH EVENT(S) HAPPENED (MOST RECENTLY/ SECOND MOST RECENTLY/THIRD MOST RECENTLY)?

Type of event	Most recent	2nd most recent	3rd most recent	
	a	b	c	
Vehicle accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	01
Low fall (1 metre or less)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	02
High fall (more than 1 metre)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	03
Hitting something or being hit by something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	04
Attack by another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	05
Near drowning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	06
Exposure to fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	07
Exposure to chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	08
Bite or sting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	09
Other event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10

605. I WOULD NOW LIKE TO ASK YOU ABOUT THE MOST RECENT EVENT, THAT IS, THE (Specify most recent event marked in Q.604).

Interviewer: Show Prompt Card 26

WHICH OF THESE BEST DESCRIBES THE INJURY(IES) YOU RECEIVED AS A RESULT OF (Specify most recent event recorded in Q.604)? (WHICH PART OR PARTS OF YOUR BODY WERE INJURED?)

Interviewer:

1. Mark the injury type, e.g. fractures, (down the left hand side)

2. Mark the body part that was injured as a result of EACH of the types of injuries, e.g. arms, (along the top)

		a	b	c	d	e	f	g	h	i	j	k	l
		Eyes	Head (ex. eyes)	Neck (ex. spine)	Shoulder (incl. collar bone)	Arms (incl. wrists)	Hands/ fingers	Back/ spine	Trunk (incl. chest, internal organs, groin & buttocks (bottom))	Hip	Legs/ feet	Whole body	
606	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
607	Dislocations, sprains, strains, torn muscles/ ligaments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
608	Internal injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
609	Open wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
610	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
611	Burns and scalds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
612	Concussion	<input type="checkbox"/>											
613	Choking	<input type="checkbox"/>											
614	Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
615	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
616	No injury sustained	<input type="checkbox"/> → Q.628											

COMMENTS

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<p>618. DID YOU RECEIVE THE INJURY(IES) WHILE -</p> <p>WORKING FOR INCOME? <input type="checkbox"/> 1</p> <p>WORKING AS A VOLUNTEER? → <i>Q.621</i> <input type="checkbox"/> 2</p> <p>Neither → <i>Q.620</i> <input type="checkbox"/> 3</p>	<p>622. DID YOU ATTEND HOSPITAL FOR THE INJURY(IES) RECEIVED IN (<i>Specify most recent event recorded in Q.604</i>)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → <i>Q.624</i> <input type="checkbox"/> 2</p> <p>Don't know → <i>Q.624</i> <input type="checkbox"/> 3</p>
<p>619. WAS THIS THE SAME OCCUPATION YOU TOLD ME ABOUT EARLIER?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>	<p>623. <i>Interviewer: Show Prompt Card 31</i></p> <p>WHICH OF THESE DID YOU ATTEND AT THE HOSPITAL?</p> <p>Inpatient stay in hospital <i>a</i> <input type="checkbox"/> 1</p> <p>Emergency/casualty department <i>b</i> <input type="checkbox"/> 2</p> <p>Outpatient clinic at hospital <i>c</i> <input type="checkbox"/> 3</p>
<p>619A. → <i>Q.621</i></p>	<p>624. <i>Interviewer: Show Prompt Card 32</i></p> <p>DID YOU VISIT ANY OF THESE FOR THE INJURY(IES) YOU RECEIVED IN (<i>Specify most recent event recorded in Q.604</i>)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → <i>Q.626</i> <input type="checkbox"/> 2</p> <p>Don't know → <i>Q.626</i> <input type="checkbox"/> 3</p>
<p>620. <i>Interviewer: Show Prompt Card 27</i></p> <p>WHICH OF THESE BEST DESCRIBES THE ACTIVITY YOU WERE DOING WHEN YOU RECEIVED THE INJURY(IES) SUSTAINED IN (<i>Specify most recent event recorded in Q.604</i>)?</p> <p>Sports activities <input type="checkbox"/> 1</p> <p>Leisure activities <input type="checkbox"/> 2</p> <p>Resting, sleeping, eating or other personal activities <input type="checkbox"/> 3</p> <p>Being nursed or cared for <input type="checkbox"/> 4</p> <p>Attending school/college/university <input type="checkbox"/> 5</p> <p>Domestic activities <input type="checkbox"/> 6</p> <p>Other <input type="checkbox"/> 7</p>	<p>625. WHICH ONES?</p> <p>Doctor, General Practitioner ... <i>a</i> <input type="checkbox"/> 1</p> <p>Other health professional <i>b</i> <input type="checkbox"/> 2</p>
<p>621. <i>Interviewer: Show Prompt Card 29</i></p> <p>IN WHICH OF THESE LOCATIONS WERE YOU WHEN YOU RECEIVED THE INJURY(IES) FROM THE (<i>Specify most recent event recorded in Q.604</i>)?</p> <p>Inside own/someone else's home ... <input type="checkbox"/> 01</p> <p>Outside own/someone else's home ... <input type="checkbox"/> 02</p> <p>At school/college/university <input type="checkbox"/> 03</p> <p>Residential institution <input type="checkbox"/> 04</p> <p>Health care facility <input type="checkbox"/> 05</p> <p>Sports facility/athletics field/park ... <input type="checkbox"/> 06</p> <p>Street/highway <input type="checkbox"/> 07</p> <p>Commercial place <input type="checkbox"/> 08</p> <p>Industrial place <input type="checkbox"/> 09</p> <p>Farm <input type="checkbox"/> 10</p> <p>Other <input type="checkbox"/> 11</p>	<p>626. DID YOU HAVE ANY TIME OFF (WORK/SCHOOL/ YOUR PLACE OF STUDY) DUE TO THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No/not applicable <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>
	<p>627. ON ANY OTHER DAYS, DID YOU CUT DOWN ON ANYTHING YOU USUALLY DO BECAUSE OF THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>
	<p>628. <i>Sequence Guide:</i></p> <p>. If <i>only 1</i> event recorded in <i>Q.604</i> → <i>Q.700</i> <input type="checkbox"/> 1</p> <p>. If <i>more than 1</i> event recorded in <i>Q.604</i> → <i>Q.629</i> <input type="checkbox"/> 2</p>

629. I WOULD NOW LIKE TO ASK YOU ABOUT THE SECOND MOST RECENT EVENT, THAT IS, THE (Specify 2nd most recent event recorded in Q.604).

Interviewer: Show Prompt Card 26

WHICH OF THESE BEST DESCRIBES THE INJURY(IES) YOU RECEIVED AS A RESULT OF (Specify 2nd most recent event recorded in Q.604)? (WHICH PART OR PARTS OF YOUR BODY WERE INJURED?)

Interviewer:

1. Mark the injury type, e.g. fractures, (down the left hand side)

2. Mark the body part that was injured as a result of EACH of the types of injuries, e.g. arms, (along the top)

		a	b	c	d	e	f	g	h	i	j	k	l
		Eyes	Head (ex. eyes)	Neck (ex. spine)	Shoulder (incl. collar bone)	Arms (incl. wrists)	Hands/ fingers	Back/ spine	Trunk (incl. chest, internal organs, groin & buttocks (bottom))	Hip	Legs/ feet	Whole body	
630	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
631	Dislocations, sprains, strains, torn muscles/ ligaments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
632	Internal injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
633	Open wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
634	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
635	Burns and scalds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
636	Concussion	<input type="checkbox"/>											
637	Choking	<input type="checkbox"/>											
638	Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
639	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
640	No injury sustained	<input type="checkbox"/> → Q.652											

COMMENTS

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<p>642. DID YOU RECEIVE THE INJURY(IES) WHILE -</p> <p>WORKING FOR INCOME? <input type="checkbox"/> 1</p> <p>WORKING AS A VOLUNTEER? → <i>Q.645</i> <input type="checkbox"/> 2</p> <p>Neither → <i>Q.644</i> <input type="checkbox"/> 3</p>	<p>646. DID YOU ATTEND HOSPITAL FOR THE INJURY(IES) RECEIVED IN (<i>Specify 2nd most recent event recorded in Q.604</i>)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → <i>Q.648</i> <input type="checkbox"/> 2</p> <p>Don't know → <i>Q.648</i> <input type="checkbox"/> 3</p>
<p>643. WAS THIS THE SAME OCCUPATION YOU TOLD ME ABOUT EARLIER?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>	<p>647. <i>Interviewer: Show Prompt Card 31</i></p> <p>WHICH OF THESE DID YOU ATTEND AT THE HOSPITAL?</p> <p>Inpatient stay in hospital <i>a</i> <input type="checkbox"/> 1</p> <p>Emergency/casualty department <i>b</i> <input type="checkbox"/> 2</p> <p>Outpatient clinic at hospital <i>c</i> <input type="checkbox"/> 3</p>
<p>643A. → <i>Q.645</i></p>	<p>648. <i>Interviewer: Show Prompt Card 32</i></p> <p>DID YOU VISIT ANY OF THESE FOR THE INJURY(IES) YOU RECEIVED IN (<i>Specify 2nd most recent event recorded in Q.604</i>)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → <i>Q.650</i> <input type="checkbox"/> 2</p> <p>Don't know → <i>Q.650</i> <input type="checkbox"/> 3</p>
<p>644. <i>Interviewer: Show Prompt Card 27</i></p> <p>WHICH OF THESE BEST DESCRIBES THE ACTIVITY YOU WERE DOING WHEN YOU RECEIVED THE INJURY(IES) SUSTAINED IN (<i>Specify 2nd most recent event recorded in Q.604</i>)?</p> <p>Sports activities <input type="checkbox"/> 1</p> <p>Leisure activities <input type="checkbox"/> 2</p> <p>Resting, sleeping, eating or other personal activities <input type="checkbox"/> 3</p> <p>Being nursed or cared for <input type="checkbox"/> 4</p> <p>Attending school/college/university <input type="checkbox"/> 5</p> <p>Domestic activities <input type="checkbox"/> 6</p> <p>Other <input type="checkbox"/> 7</p>	<p>649. WHICH ONES?</p> <p>Doctor, General Practitioner ... <i>a</i> <input type="checkbox"/> 1</p> <p>Other health professional <i>b</i> <input type="checkbox"/> 2</p>
<p>645. <i>Interviewer: Show Prompt Card 29</i></p> <p>IN WHICH OF THESE LOCATIONS WERE YOU WHEN YOU RECEIVED THE INJURY(IES) FROM THE (<i>Specify 2nd most recent event recorded in Q.604</i>)?</p> <p>Inside own/someone else's home <input type="checkbox"/> 01</p> <p>Outside own/someone else's home <input type="checkbox"/> 02</p> <p>At school/college/university <input type="checkbox"/> 03</p> <p>Residential institution <input type="checkbox"/> 04</p> <p>Health care facility <input type="checkbox"/> 05</p> <p>Sports facility/athletics field/park <input type="checkbox"/> 06</p> <p>Street/highway <input type="checkbox"/> 07</p> <p>Commercial place <input type="checkbox"/> 08</p> <p>Industrial place <input type="checkbox"/> 09</p> <p>Farm <input type="checkbox"/> 10</p> <p>Other <input type="checkbox"/> 11</p>	<p>650. DID YOU HAVE ANY TIME OFF (WORK/SCHOOL/ YOUR PLACE OF STUDY) DUE TO THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No/not applicable <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>
	<p>651. ON ANY OTHER DAYS, DID YOU CUT DOWN ON ANYTHING YOU USUALLY DO BECAUSE OF THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>
	<p>652. <i>Sequence Guide:</i></p> <p>. If only 2 events recorded in <i>Q.604</i> → <i>Q.700</i> <input type="checkbox"/> 1</p> <p>. If more than 2 events recorded in <i>Q.604</i> → <i>Q.653</i> <input type="checkbox"/> 2</p>

653. I WOULD NOW LIKE TO ASK YOU ABOUT THE THIRD MOST RECENT EVENT, THAT IS, THE (Specify 3rd most recent event recorded in Q.604).

Interviewer: Show Prompt Card 26

WHICH OF THESE BEST DESCRIBES THE INJURY(IES) YOU RECEIVED AS A RESULT OF (Specify 3rd most recent event recorded in Q.604)? (WHICH PART OR PARTS OF YOUR BODY WERE INJURED?)

Interviewer:

1. Mark the injury type, e.g. fractures, (down the left hand side)

2. Mark the body part that was injured as a result of EACH of the types of injuries, e.g. arms, (along the top)

		a	b	c	d	e	f	g	h	i	j	k	l
		Eyes	Head (ex. eyes)	Neck (ex. spine)	Shoulder (incl. collar bone)	Arms (incl. wrists)	Hands/ fingers	Back/ spine	Trunk (incl. chest, internal organs, groin & buttocks (bottom))	Hip	Legs/ feet	Whole body	
654	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
655	Dislocations, sprains, strains, torn muscles/ ligaments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
656	Internal injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
657	Open wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
658	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
659	Burns and scalds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
660	Concussion	<input type="checkbox"/>											
661	Choking	<input type="checkbox"/>											
662	Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
663	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
664	No injury sustained	<input type="checkbox"/> → Q.700											

COMMENTS

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<p>666. DID YOU RECEIVE THE INJURY(IES) WHILE -</p> <p>WORKING FOR INCOME? <input type="checkbox"/> 1</p> <p>WORKING AS A VOLUNTEER? → Q.669 <input type="checkbox"/> 2</p> <p>Neither → Q.668 <input type="checkbox"/> 3</p>	<p>670. DID YOU ATTEND HOSPITAL FOR THE INJURY(IES) RECEIVED IN (Specify 3rd most recent event recorded in Q.604)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.672 <input type="checkbox"/> 2</p> <p>Don't know → Q.672 <input type="checkbox"/> 3</p>
<p>667. WAS THIS THE SAME OCCUPATION YOU TOLD ME ABOUT EARLIER?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>	<p>671. <i>Interviewer:</i> Show Prompt Card 31</p> <p>WHICH OF THESE DID YOU ATTEND AT THE HOSPITAL?</p> <p>Inpatient stay in hospital a <input type="checkbox"/> 1</p> <p>Emergency/casualty department b <input type="checkbox"/> 2</p> <p>Outpatient clinic at hospital c <input type="checkbox"/> 3</p>
<p>667A. → Q.669</p>	<p>672. <i>Interviewer:</i> Show Prompt Card 32</p> <p>DID YOU VISIT ANY OF THESE FOR THE INJURY(IES) YOU RECEIVED IN (Specify 3rd most recent event recorded in Q.604)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No → Q.674 <input type="checkbox"/> 2</p> <p>Don't know → Q.674 <input type="checkbox"/> 3</p>
<p>668. <i>Interviewer:</i> Show Prompt Card 27</p> <p>WHICH OF THESE BEST DESCRIBES THE ACTIVITY YOU WERE DOING WHEN YOU RECEIVED THE INJURY(IES) SUSTAINED IN (Specify 3rd most recent event recorded in Q.604)?</p> <p>Sports activities <input type="checkbox"/> 1</p> <p>Leisure activities <input type="checkbox"/> 2</p> <p>Resting, sleeping, eating or other personal activities <input type="checkbox"/> 3</p> <p>Being nursed or cared for <input type="checkbox"/> 4</p> <p>Attending school/college/university <input type="checkbox"/> 5</p> <p>Domestic activities <input type="checkbox"/> 6</p> <p>Other <input type="checkbox"/> 7</p>	<p>673. WHICH ONES?</p> <p>Doctor, General Practitioner ... a <input type="checkbox"/> 1</p> <p>Other health professional ... b <input type="checkbox"/> 2</p>
<p>669. <i>Interviewer:</i> Show Prompt Card 29</p> <p>IN WHICH OF THESE LOCATIONS WERE YOU WHEN YOU RECEIVED THE INJURY(IES) FROM THE (Specify 3rd most recent event recorded in Q.604)?</p> <p>Inside own/someone else's home <input type="checkbox"/> 01</p> <p>Outside own/someone else's home <input type="checkbox"/> 02</p> <p>At school/college/university <input type="checkbox"/> 03</p> <p>Residential institution <input type="checkbox"/> 04</p> <p>Health care facility <input type="checkbox"/> 05</p> <p>Sports facility/athletics field/park ... <input type="checkbox"/> 06</p> <p>Street/highway <input type="checkbox"/> 07</p> <p>Commercial place <input type="checkbox"/> 08</p> <p>Industrial place <input type="checkbox"/> 09</p> <p>Farm <input type="checkbox"/> 10</p> <p>Other <input type="checkbox"/> 11</p>	<p>674. DID YOU HAVE ANY TIME OFF (WORK/SCHOOL/YOUR PLACE OF STUDY) DUE TO THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No/not applicable <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>
	<p>675. ON ANY OTHER DAYS, DID YOU CUT DOWN ON ANYTHING YOU USUALLY DO BECAUSE OF THE INJURY(IES)?</p> <p>Yes <input type="checkbox"/> 1</p> <p>No <input type="checkbox"/> 2</p> <p>Don't know <input type="checkbox"/> 3</p>

700. Sequence Guide:

- . If aged 65 years or more ... → **Q.707** 1
- . If student (code '2') in Q.24 or (code '1') in Q.25 or Q.26 ... → **Q.701** 2
- . If had job last week (code '1' or '2') in Q.38 ... → **Q.701** 3
- . Otherwise ... → **Q.707** 4

708. (APART FROM WHEN YOU WERE AWAY FROM (WORK/SCHOOL/YOUR PLACE OF STUDY),)

ON ANY (OTHER) DAYS IN THE LAST 2 WEEKS, HAVE YOU HAD TO CUT DOWN ON ANYTHING YOU USUALLY DO BECAUSE OF THESE ILLNESSES OR INJURIES?

Yes 1

No → **Q.710** 2

701. I NOW WANT YOU TO THINK ABOUT ANY ILLNESS OR INJURY YOU HAD, AND THE EFFECTS THIS MAY HAVE HAD ON YOU IN THE LAST 2 WEEKS.

IN THE LAST 2 WEEKS, HAVE YOU STAYED AWAY FROM YOUR (WORK/SCHOOL/PLACE OF STUDY) FOR MORE THAN HALF THE DAY BECAUSE OF ANY ILLNESS OR INJURY YOU HAD?

Yes 1

No → **Q.704** 2

709. ON HOW MANY DAYS IN THE LAST 2 WEEKS, HAVE YOU CUT DOWN ON YOUR USUAL ACTIVITIES?

Interviewer: Record number

Number 1 2 3 4 5 6 7 8 9

14 days 14

702. ON HOW MANY DAYS IN THE LAST 2 WEEKS HAVE YOU STAYED AWAY FROM YOUR (WORK/SCHOOL/PLACE OF STUDY)?

Interviewer: Record number

Number 1 2 3 4 5 6 7 8 9

14 days → **Q.710** 14

704. IN THE LAST 2 WEEKS, DID YOU HAVE ANY DAYS OFF (WORK/SCHOOL/STUDY) TO LOOK AFTER OR CARE FOR SOMEONE ELSE BECAUSE THEY WERE SICK OR INJURED?

Yes 1

No → **Q.708** 2

705. ON HOW MANY DAYS IN THE LAST 2 WEEKS, HAVE YOU STAYED AWAY FROM YOUR (WORK/SCHOOL/PLACE OF STUDY) TO LOOK AFTER SOMEONE ELSE?

Interviewer: Record number

Number 1 2 3 4 5 6 7 8 9

14 days → **Q.710** 14

706. → **Q.708**

707. I NOW WANT YOU TO THINK ABOUT ANY ILLNESS OR INJURY YOU HAD, AND THE EFFECTS THIS MAY HAVE HAD ON YOU IN THE LAST 2 WEEKS.

710. THE FOLLOWING QUESTIONS ARE ABOUT YOUR USE OF HEALTH SERVICES IN THE LAST 2 WEEKS.

IN THE LAST 2 WEEKS, HAVE YOU VISITED THE OUTPATIENTS SECTION OF A HOSPITAL FOR YOUR OWN HEALTH?

Yes 1

No → **Q.713** 2

711. HOW MANY TIMES IN THE LAST 2 WEEKS, DID YOU ATTEND THE OUTPATIENTS SECTION?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

712. (I WANT TO ASK ABOUT THE MOST RECENT OF THESE VISITS.)

WAS THIS VISIT RELATED TO -

A PREVIOUS ADMISSION TO HOSPITAL? 1

AN EXPECTED ADMISSION TO HOSPITAL? 2

Neither 3

Don't know 4

713. IN THE LAST 2 WEEKS, HAVE YOU VISITED A CASUALTY OR EMERGENCY WARD FOR YOUR OWN HEALTH?

Yes 1

No → **Q.715** 2

714. HOW MANY TIMES IN THE LAST 2 WEEKS, DID YOU ATTEND A CASUALTY OR EMERGENCY WARD?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

715. (APART FROM YOUR VISIT(S) TO (OUTPATIENTS/(OR) CASUALTY OR EMERGENCY),)

IN THE LAST 2 WEEKS, HAVE YOU BEEN TO A DAY CLINIC FOR MINOR SURGERY OR DIAGNOSTIC TESTS, OTHER THAN AN X-RAY, FOR YOUR OWN HEALTH?

Yes 1

No → **Q.717** 2

716. HOW MANY TIMES IN THE LAST 2 WEEKS, DID YOU VISIT A DAY CLINIC?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

717. I WOULD NOW LIKE TO ASK YOU ABOUT ALL OF THE TIMES YOU HAVE BEEN ADMITTED TO HOSPITAL IN THE LAST 12 MONTHS.

(APART FROM YOUR VISIT(S) TO (OUTPATIENTS/(OR) CASUALTY OR EMERGENCY/(OR) A DAY CLINIC),)

DURING THE LAST 12 MONTHS, HAVE YOU BEEN ADMITTED TO HOSPITAL?

Yes 1

No → **Q.722** 2

718. (APART FROM YOUR VISIT(S) TO (OUTPATIENTS/(OR) CASUALTY OR EMERGENCY/(OR) A DAY CLINIC),)

HOW MANY TIMES HAVE YOU BEEN ADMITTED TO HOSPITAL IN THE LAST 12 MONTHS?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

Don't know 98

719. I WOULD LIKE TO TALK ABOUT (THIS/YOUR MOST RECENT) ADMISSION TO HOSPITAL.

HOW MANY NIGHTS DID YOU STAY IN HOSPITAL?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

Don't know 98

720. WERE YOU DISCHARGED FROM HOSPITAL IN THE LAST 2 WEEKS?

Yes 1

No 2

721. DURING (THIS/YOUR MOST RECENT) ADMISSION TO HOSPITAL, WERE YOU ADMITTED AS A -

MEDICARE PATIENT? 1

PRIVATE PATIENT? 2

Don't know 3

722. IN THE LAST 2 WEEKS, HAVE YOU CONSULTED A DENTIST OR DENTAL PROFESSIONAL ABOUT YOUR TEETH, DENTURES OR GUMS?

Yes 1

No → **Q.724** 2

723. HOW MANY CONSULTATIONS HAVE YOU HAD IN THE LAST 2 WEEKS?

Interviewer: Record number

Number ... → **Q.725**

0
 1
 2
 3
 4
 5
 6
 7
 8
 9

724. WHEN WAS THE LAST TIME YOU CONSULTED A DENTIST OR DENTAL PROFESSIONAL?

Less than 3 months ago 1

3 months to less than 6 months ago 2

6 months to less than 12 months ago 3

12 months to less than 2 years ago 4

2 years ago or more 5

Never 6

Don't know 7

725. THE NEXT FEW QUESTIONS ARE ABOUT VISITS TO DOCTORS OR SPECIALISTS.

(APART FROM CONSULTATIONS DURING ANY HOSPITAL OR DAY CLINIC VISITS,)

IN THE LAST 2 WEEKS, HAVE YOU CONSULTED A GENERAL PRACTITIONER?

Yes 1

No → **Q.727** 2

726. HOW MANY TIMES IN THE LAST 2 WEEKS, DID YOU CONSULT A GENERAL PRACTITIONER?

Interviewer: Record number

Number ...

0
 1
 2
 3
 4
 5
 6
 7
 8
 9

727. (APART FROM CONSULTATIONS DURING ANY HOSPITAL OR DAY CLINIC VISITS,)

IN THE LAST 2 WEEKS, HAVE YOU CONSULTED A SPECIALIST?

Yes 1

No → **Q.729** 2

728. HOW MANY TIMES IN THE LAST 2 WEEKS, DID YOU CONSULT A SPECIALIST?

Interviewer: Record number

Number ... → **Q.731**

0
 1
 2
 3
 4
 5
 6
 7
 8
 9

729. *Sequence Guide:*

. If consulted a General Practitioner in last 2 weeks (code '1') in **Q.725** → **Q.731** 1

. Otherwise → **Q.730** 2

730. (APART FROM CONSULTATIONS DURING ANY HOSPITAL OR DAY CLINIC VISITS,)

WHEN WAS THE LAST TIME YOU CONSULTED A DOCTOR ABOUT YOUR OWN HEALTH?

Less than 3 months ago 1

3 months to less than 6 months ago 2

6 months to less than 12 months ago 3

12 months ago or more 4

Never 5

Don't know 6

731. *Interviewer: Show Prompt Card 33*

(APART FROM CONSULTATIONS DURING ANY HOSPITAL OR DAY CLINIC VISITS,)

IN THE LAST 2 WEEKS, HAVE YOU CONSULTED ANY OF THESE (FOR YOUR OWN HEALTH)?

Yes 1

No → **Q.751** 2

Don't know → **Q.751** 3

732. WHICH OF THESE HAVE YOU CONSULTED IN THE LAST 2 WEEKS ABOUT YOUR OWN HEALTH?

- Aboriginal health worker (nec) a 01
- Accredited counsellor b 02
- Acupuncturist c 03
- Alcohol and drug worker (nec) d 04
- Audiologist/Audiometrist e 05
- Chemist (for advice only) f 06
- Chiropracist/Podiatrist g 07
- Chiropractor h 08
- Dietitian/Nutritionist i 09
- Herbalist j 10
- Hypnotherapist k 11
- Naturopath l 12
- Nurse m 13
- Occupational Therapist n 14
- Optician/Optomtrist o 15
- Osteopath p 16
- Physiotherapist/Hydrotherapist q 17
- Psychologist r 18
- Social worker/Welfare Officer s 19
- Speech Therapist/Pathologist t 20

733. Sequence Guide:
 . If only 1 OHP marked in Q.732 ... → **Q.735** 1
 . Otherwise ... → **Q.734** 2

734. Interviewer: Show Prompt Card 33
 IN THE LAST 2 WEEKS, WHICH OF THESE DID YOU VISIT MOST RECENTLY?
Interviewer: Transcribe code from Q.732

0
 1
 2
 3
 4
 5
 6
 7
 8
 9

735. HOW MANY TIMES IN THE LAST 2 WEEKS, DID YOU CONSULT A (Specify only OHP in Q.732 OR most recent OHP in Q.734)?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

736. Sequence Guide:
 . If only 1 OHP in Q.732 ... → **Q.751** 1
 . If only 2 OHPs in Q.732 ... → **Q.738** 2
 . If more than 2 OHPs in Q.732 → **Q.737** 3

737. OTHER THAN THE (Specify OHP in Q.734) WHICH OF THESE DID YOU VISIT SECOND MOST RECENTLY?

Interviewer: Transcribe code from Q.732

0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

738. HOW MANY TIMES IN THE LAST 2 WEEKS, DID YOU CONSULT A (Specify second OHP in Q.732 or OHP in Q.737)?

Interviewer: Record number

Number 0 0
 1 1
 2 2
 3 3
 4 4
 5 5
 6 6
 7 7
 8 8
 9 9

751. THE NEXT FEW QUESTIONS ARE ABOUT PRIVATE HEALTH INSURANCE.

APART FROM MEDICARE, ARE YOU CURRENTLY COVERED BY PRIVATE HEALTH INSURANCE?

Yes 1

No → Q.756 2

Don't know → Q.757 3

752. ARE YOU COVERED BY FAMILY, COUPLE, SOLE PARENT OR SINGLE MEMBERSHIP?

Family membership 1

Couple membership 2

Sole parent membership 3

Single membership 4

753. Interviewer: Show Prompt Card 34

WHICH OF THESE BEST DESCRIBES WHAT YOUR PRIVATE HEALTH INSURANCE COVERS?

Hospital only 1

Ancillary only 2

Both hospital and ancillary 3

Don't know 4

754. WHAT ARE ALL THE REASONS YOU ARE COVERED BY PRIVATE HEALTH INSURANCE?

Security/protection/peace of mind *a* 01

Lifetime cover/avoid age surcharge *b* 02

Choice of doctor *c* 03

Allows treatment as private patient in hospital *d* 04

Provides benefits for ancillary services/"extras" *e* 05

Shorter wait for treatment/concern over public hospital waiting lists *f* 06

Always had it/parents pay it/condition of job *g* 07

To gain government benefits/avoid extra Medicare levy *h* 08

Other financial reasons *i* 09

Has illness/condition that requires treatment *j* 10

Elderly/getting older/likely to need treatment *k* 11

Other *l* 12

755. HOW LONG HAVE YOU BEEN COVERED BY PRIVATE HEALTH INSURANCE?

Less than 1 year 1

1 year to less than 2 years 2

2 years to less than 5 years 3

5 years or more 4

755A. → Q.757

756. WHAT ARE ALL THE REASONS YOU ARE NOT COVERED BY PRIVATE HEALTH INSURANCE?

Can't afford it/too expensive ... *a* 01

High risk category *b* 02

Lack of value for money/not worth it *c* 03

Medicare cover sufficient *d* 04

Don't need medical care/in good health/have no dependents *e* 05

Won't pay Medicare levy and private health insurance premium *f* 06

Disillusionment about having to pay "out of pocket" costs/Gap fees ... *g* 07

Prepared to pay cost of private treatment from own resources ... *h* 08

Pensioner/Veterans' Affairs/health concession card *i* 09

Not high priority/previously included in parents' cover *j* 10

Other *k* 11

757. DO YOU HAVE A DEPARTMENT OF VETERANS' AFFAIRS TREATMENT ENTITLEMENT CARD?

Yes 1

No → Q.759 2

Don't know → Q.759 3

758. WHAT COLOUR IS THAT CARD?

White 1

Gold 2

Other 3

759. Interviewer: Show Prompt Card 35

ARE YOU COVERED BY ANY OF THESE GOVERNMENT CONCESSION CARDS?

Health care card *a* 1

Pensioner concession card *b* 2

Commonwealth seniors health card *c* 3

None of the above *d* 4

801. I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT INCOME.

INCOME IS VERY IMPORTANT IN UNDERSTANDING HEALTH, AS IT INFLUENCES THE HEALTH SERVICES SOMEONE HAS ACCESS TO.

Interviewer: Show Prompt Card 36

IN THE LAST FINANCIAL YEAR, DID YOU RECEIVE INCOME FROM ANY OF THESE SOURCES?

Interviewer: If 'yes', prompt for which ones

Profit or loss from own unincorporated business or share in a partnership a 1

Profit or loss from rental property b 2

Dividends or interest c 3

No/none of the above → Q.803 d 4

805. BEFORE INCOME TAX IS TAKEN OUT, HOW MUCH DO YOU USUALLY RECEIVE FROM (THIS/THESE) SOURCE(S) IN TOTAL?

Interviewer: Record amount

\$

--	--	--	--	--	--	--	--

Don't know → Q.808 999998

802. BEFORE INCOME TAX IS TAKEN OUT (BUT AFTER BUSINESS EXPENSES HAVE BEEN DEDUCTED), HOW MUCH DID YOU RECEIVE FROM (THIS/THESE) SOURCE(S) LAST FINANCIAL YEAR?

Interviewer: If respondent unable to answer, prompt for their best estimate

(a) \$

--	--	--	--	--	--	--	--

Nil 999997

Don't know 999998

(b) Profit 1

Loss 2

806. WHAT PERIOD DOES THAT COVER?

Interviewer: Record period

Weeks

--	--	--	--

 1

Months

--	--	--	--

 2

808. *Sequence Guide:*

. If any government pension or allowance (code '2') in Q.803 → Q.809 1

. If more than one source of income in Q.801 & Q.803 → Q.812 2

. Otherwise → Q.813 3

803. *Interviewer:* Show Prompt Card 37

DO YOU CURRENTLY RECEIVE INCOME FROM ANY OF THESE SOURCES?

Interviewer: If 'yes', prompt for which ones

Wages or salary a 1

Government pension or allowance b 2

Child Support or maintenance c 3

Superannuation or annuity d 4

Any other regular source e 5

No/none of the above → Q.808 f 6

809. *Interviewer:* Show Prompt Card 38

DO YOU CURRENTLY RECEIVE ANY OF THESE PENSIONS, ALLOWANCES OR BENEFITS?

Interviewer: If yes, ask which one

Australian Age Pension 01

Newstart Allowance 02

Mature Age Allowance 03

Service Pension (DVA) 04

Disability Support Pension (Centrelink) 05

Wife Pension 06

Carer Payment 07

Sickness Allowance 08

Widow Allowance (Widow B pension) (Centrelink) 09

Special Benefit 10

Partner Allowance 11

Youth Allowance 12

No/none of these 13

810. Interviewer: Show Prompt Card 39
DO YOU CURRENTLY RECEIVE ANY OF THESE PENSIONS, ALLOWANCES OR OTHER FORMS OF ASSISTANCE?

Interviewer: If yes, ask which ones

- War Widow's Pension (DVA) ... a 1
- Disability Pension (DVA) ... b 2
- Carer Allowance (Child Disability Allowance) (Centrelink) ... c 3
- Overseas pensions/benefits ... d 4
- Parenting Payment ... e 5
- Other ... f 6
- No/none of these ... g 7

811. Sequence Guide:

- . If more than one source of income in Q.801 or Q.803 ... → Q.812 1
- . Otherwise ... → Q.813 2

812. WHAT IS YOUR MAIN SOURCE OF INCOME?

Interviewer: Show Prompt Card 40

- Wages or salary (including from own incorporated business) ... 1
- Profit or loss from own unincorporated business or share in a partnership ... 2
- Profit or loss from rental property ... 3
- Dividends or interest ... 4
- Any government pension or allowance ... 5
- Child support or maintenance ... 6
- Superannuation or annuity ... 7
- Workers' compensation ... 8
- Other ... 9

813. Sequence Guide:

- . If selected adult has spouse/partner ... → Q.815 1
- . Otherwise ... → Q.818 2

815. DOES YOUR (SPOUSE/PARTNER) CURRENTLY RECEIVE INCOME FROM ANY OF THESE SOURCES?

Interviewer: Show Prompt Card 41

- Wages or salary ... a 1
- Profit or loss from a business or rental property ... b 2
- Any government pension, benefit or allowance ... c 3
- Any other regular source ... d 4
- None of the above ... → Q.818 e 5

816. BEFORE INCOME TAX IS TAKEN OUT, HOW MUCH DOES YOUR (SPOUSE/PARTNER) USUALLY RECEIVE FROM (THIS/THESE) SOURCE(S) IN TOTAL?

Interviewer: If respondent unable to answer, prompt for best estimate

(a) \$

Don't know → Q.818 999998

-
-
-
-
-
-
-
-
-

(b)

- Profit ... 1
- Loss ... 2

817. WHAT PERIOD DOES THAT COVER?

Interviewer: Record period

Weeks 1

Months 2

-
-
-
-
-
-
-
-
-

818. Interviewer: Where selected adult is female, please administer WOMEN'S HEALTH FORM

819. No more questions ◀

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Sample only



Sample only