Ontario Health Study
Étude sur la santé Ontario

Baseline 2 Questionnaire

Table of Contents

DIRECTIONS FOR COMPLETING THIS QUESTIONNAIRE

Thank you for participating in the Ontario Health Study! Please complete the following questionnaire over the next six weeks. **You do not need to finish this questionnaire all at once.** You may stop working on the questionnaire, save your progress and return to it at any time over the next six weeks. None of your information will be lost.

To answer all of the questions, including optional questions, it would be helpful if you had:

- The Drug Identification Number (DIN) of any prescription medications you are taking at this time. The DIN may be located on the bottle your medication is stored in;
- Your current height and weight;
- The circumference of your waist and hips. Instructions to measure your waist and hips will be provided later in the questionnaire.

Please enter a response to each question on the screen. If there are questions you do not feel comfortable answering, please select the "Prefer not to answer" option.

If you are not sure how to answer a question, please feel free to contact us:

Call our toll-free number in Canada: 1-866-606-0686

Email us at: info@ontariohealthstudy.ca

For answers to commonly asked questions, check our website at OntarioHealthStudy.ca/en/faq

DEMOGRAPHIC INFORMATION

Tell us about you! Please share some general information about yourself. This will help us understand the health of different parts of our community across Ontario.

DE01. How old are you? _____ years

ETHNIC BACKGROUND - PARTICIPANT

People living in Ontario come from many different cultural and educational backgrounds. This can have an impact on health and access to health services. Please tell us a little bit about where you are from, the languages you speak and your educational background.

EB01. In what country were you born?

|_| Canada
|_| China
|_| France
|_| Germany
|_| Greece
|_| India
|_| Islamic Republic of Iran
|_| Ireland
|_| Italy
|_| Jamaica
|_| Republic of Korea
|_| Philippines
|_| Poland
|_| Portugal
|_| Russian Federation
|_| Ukraine
|_| United Kingdom
|_| United States
|_| Vietnam
|_| Other country ---------->Country Name: _____
|_| Don't know
|_| Prefer not to answer

IF YOU WERE BORN IN CANADA SKIP TO EB03

EB02. How old were you when you first came to Canada to live?
|_| Age when you first came to Canada to live: _____
|_| Don't know
I_I Prefer not to answer

EB03. What is your ethnic background? Please select all that apply.
|_| Aboriginal (e.g.,First Nations, Métis, Inuit)
|_| Arab (e.g.,Egypt, Iraq, Jordan, Lebanon)
|_| Black (African or Caribbean descent)
|_| Chinese
|_| Filipino
|_| Japanese
|_|

|_| Korean
|_| Latin American/Hispanic
|_| South Asian (e.g.,India, Sri Lanka, Pakistan, Bangladesh)
|_| Southeast Asian (e.g.,Malaysia, Indonesia, Vietnam, Cambodia, Laos)
|_| West Asian (e.g.,Turkey, Iran, Afghanistan)
|_| White (European descent)
|_| Other ethnic group (not listed above)
|_| Don't know
|_| Prefer not to answer

LANGUAGES

LS01. What is the language that you first learned at home, in childhood, and can still understand? Please select all that apply if more than one language was learned at the same time.

|_| English
|_| French
|_| Arabic
|_| Aboriginal Language(s)
|_| Bengali
|_| Cantonese
|_| Danish
|_| Dutch
|_| Farsi/Persian
|_| Finnish
|_| Gaelic
|_| German
|_| Greek
|_| Hindi
|_| Hungarian
|_| Icelandic
|_| Italian
|_| Korean
|_| Mandarin
|_| Norwegian
|_| Polish
|_| Portuguese
|_| Punjabi
|_| Russian
|_| Spanish
|_| Swedish
|_| Tagalog/Filipino
|_| Tamil
|_| Ukrainian
|_| Urdu
|_| Vietnamese
|_| Welsh
|_| Other - please specify: _____
|_| Prefer not to answer

LS02. What is the language spoken most often at home?

|_| English
|_| French
|_| Arabic
|_| Aboriginal Language(s)
|_| Bengali
|_| Cantonese
|_| Danish
|_| Dutch
|_| Farsi/Persian
|_| Finnish
|_| Gaelic
|_| German
|_| Greek
|_| Hindi
|_| Hungarian
|_| Icelandic
|_| Italian
|_| Korean
|_| Mandarin
|_| Norwegian
|_| Polish
|_| Portuguese
|_| Punjabi
|_| Russian
|_| Spanish
|_| Swedish
|_| Tagalog/Filipino
|_| Tamil
|_| Ukrainian
|_| Urdu
|_| Vietnamese
|_| Welsh
|_| Other - please specify: _____
|_| Prefer not to answer

LS03. How well can you speak and understand English?
|_| Very well
|_| Well
|_| Not well
|_| Not at all
|_| Prefer not to answer

LS04. How well can you speak and understand French?
|_| Very well
|_| Well
|_| Not well
|_| Not at all
|_| Prefer not to answer

LS05. If available, in what official language do you prefer receiving health services?
|_| English
|_| French
|_| Prefer not to answer

EDUCATION

EL01. What is the highest level of education you have completed?
|_| Elementary School
|_| High School
|_| Trade, technical or vocation school, apprenticeship training or technical CEGEP
|_| Diploma from a community college, pre-university CEGEP or non-university certificate
|_| University certificate below Bachelor's level
|_| Bachelor's degree
|_| Graduate degree (MSc, MBA, MD, PhD, etc.)
|_| None → Skip to RE01
I_I Prefer not to answer → Skip to RE01

EL02. What was your age when you completed this level of education?
|_| Age when you completed this level of education: _____
|_| Don't know
I_I Prefer not to answer

RESIDENCE

Where people live affects their exposure to environmental and noise pollution. Since this is a very important topic, we will ask you for more detailed information about this in a follow-up questionnaire. We will only ask you a few basic questions today.

RE01. How old were you when you started living in the dwelling where you live now?
|_| Age when started living at current location: _____
|_| Don't know
I_I Prefer not to answer

RE02. Throughout your life to date, is the dwelling that you live in now the one where you have lived for the longest period of time?
|_| Yes
|_| No
|_| Don't know
I_I Prefer not to answer

WORKING STATUS

Different occupations involve different lifestyles and exposures associated with health and disease. These questions ask about your current employment status. Given the importance of this topic, we will ask more detailed questions about your past work history in future questionnaires.

WS01. Which of the following best describes your current employment status?
Full time means 30 hours or more per week. Part time means less than 30 hours per week.
|_| Full-time employed/self-employed
|_| Part-time employed/self-employed

|_| Retired
|_| Looking after home and/or family
|_| Unable to work because of sickness or disability
|_| Unemployed
|_| Doing unpaid or voluntary work
|_| Student
I_I Prefer not to answer

SKIP TO WS07

WS02. What is currently your main job title, meaning the job at which you work the most hours? Give as full a description as you can (e.g. office clerk, factory worker, forestry technician).
|_| _____
|_| Don't know
I_I Prefer not to answer

WS03. What kind of business, industry or service do you work in?
|_| _____
|_| Don't know
I_I Prefer not to answer

WS04. How old were you when you started working at your current job?
|_| Age when you started working at current job: _____
|_| Don't know
I_I Prefer not to answer

WS05. Which one of the following best describes your working schedule in your current job? Choose ONE only. A night shift is work during the early hours of the morning, after midnight. An evening shift is work during the evening ending at or before midnight.
|_| Regular daytime schedule or shift
|_| Regular evening shift
|_| Regular night shift
|_| Rotating shift, changing periodically from days to evenings or to nights
|_| Split shift, consisting of two or more distinct periods each day
|_| Irregular schedule, or on call
|_| Other, please specify: _____
I_I Prefer not to answer

WS06. Is your current job the one you have worked in for the longest time (most number of years)?
|_| Yes → Skip to HI01
|_| No

I_I Prefer not to answer

WS07. What was the title of the main job that you held for the longest time, meaning the one at which you worked the most hours? Refer to the jobs that you did when you were employed by someone else, or when you were self-employed. Give as full a description as you can (e.g. office clerk, factory worker, forestry technician.)
|_| _____
|_| Don't know
I_I Prefer not to answer

WS08. What kind of business, industry or service did you work in for the longest time (most number of years)?
|_| _____
|_| Don't know
I_I Prefer not to answer

WS09. Which one of the following best describes your working schedule for the job that you held for the longest time? A night shift is work during the early hours of the morning, after midnight. An evening shift is work during the evening ending at or before midnight.

Choose ONE only
|_| Regular daytime schedule or shift
|_| Regular evening shift
|_| Regular night shift
|_| Rotating shift, changing periodically from days to evenings or to nights
|_| Split shift, consisting of two or more distinct periods each day
|_| Irregular schedule, or on call
|_| Other- please specify: _____
I_I Prefer not to answer

HOUSEHOLD INCOME

The next questions ask about your household income. We understand that your household income is very personal – the confidentiality of your data will be protected with every possible measure by the OHS. The following questions are important because they will help us to determine whether the Study includes a wide range of participants from Ontario. Income is also an important determinant of health and well-being itself.

HI01. What was your total approximate household income (from all sources) before taxes last year? Please include the total income including salaries, pensions and allowances.
|_| Less than $10, 000
|_| $10, 000 - $24, 999
|_| $25, 000 - $49, 999
|_| $50, 000 - $74, 999
|_| $75, 000 - $99, 999
|_| $100, 000 - $149, 999
|_| $150, 000 - $199, 999
|_| $200, 000 or more
|_| Don't know
I_I Prefer not to answer

HI02. How many individuals does that income support, including children, parents and other persons living in your home and outside your home?
|_| Number of individuals: _____
|_| Don't know
I_I Prefer not to answer

HI03. How many adults (age 18 or older) including yourself are currently living in your household?
|_| Number of adults: _____
I_I Prefer not to answer

HI04. How many children (under 18 years of age) are currently living in your household?
|_| Number of children: _____
I_I Prefer not to answer

SEXUAL ORIENTATION AND GENDER IDENTITY

Research evidence has shown that sexual orientation and gender identity are relevant to many areas of health, including access to health services and medical screening tests. These questions have not been included in many health surveys, giving you and the Ontario Health Study the opportunity to contribute to a greater understanding of the role of sexual orientation on health.

SO01. What is your sex? |_| Male |_| Female

The following question will be asked only of women:

SO02. Are you currently pregnant?
|_| Yes ----------> In what week are you? _____
|_| No
|_| Don't know
I_I Prefer not to answer

SO03. Research evidence has shown that sexual orientation is relevant to many areas of health. Do you consider yourself to be:
|_| Heterosexual or straight
|_| Gay or lesbian
|_| Bisexual
|_| Don't know
|_| Prefer not to answer

SO04. Do you consider yourself to be trans (transgender, transsexual, or a person with a history of transitioning sex)?
|_| Yes
|_| No → Skip to SO07
|_| Don't know → Skip to SO07
|_| Prefer not to answer → Skip to SO07

SO05. What was your assigned sex at birth?
|_| Male
|_| Female
|_| Undetermined
|_| Prefer not to answer

SO06. What is your felt gender?
|_| Male or primarily masculine
|_| Female or primarily feminine
|_| Masculine and feminine
|_| Neither male nor female
|_| Don't know
|_| Prefer not to answer

SO07. What gender do you currently live as in your day-to-day life?
|_| Male
|_| Female
|_| Sometimes male, sometimes female
|_| Third gender, or something other than male or female
|_| Prefer not to answer

SO08. Have you undertaken any of the following to medically transition sex? Please select all that apply.
|_| Hormone therapy
|_| Hair removal (electrolysis or laser)
|_| Mastectomy or chest reconstruction (an operation to remove breasts or construct a male chest)
|_| Breast augmentation (an operation to make breasts larger using implants)
|_| Hysterectomy (an operation to remove the uterus)
|_| Oophorectomy (an operation to remove the ovaries)
|_| Metoidioplasty (an operation to free the clitoris)
|_| Phalloplasty (an operation to construct a penis)
|_| Orchiectomy (an operation to remove the testicles)
|_| Vaginoplasty (an operation to construct a vagina)
|_| None of the above
|_| Prefer not to answer

YOUR HEALTH

What keeps us healthy or causes us to get sick can be complicated. To help researchers answer as many health-related questions as possible, we are interested in many different aspects of your health.

HS01. Do you regard yourself as being left or right-handed, or ambidextrous?
An ambidextrous person is able to use either hand with equal dexterity.
|_| Left
|_| Right
|_| Ambidextrous
I_I Prefer not to answer

HS02. How would you rate your general health?
I_I Excellent
I_I Very good
I_I Good
I_I Fair
I_I Poor
I_I Prefer not to answer

HS03. Compared to one year ago, how would you say your health is now? Is it:
|_| Much better now than one year ago
|_| Somewhat better now than one year ago
|_| About the same as one year ago
|_| Somewhat worse now than one year ago
|_| Much worse now than one year ago
I_I Don't know
I_I Prefer not to answer

HS04. When was the last time you had a routine medical check-up, undertaken by a doctor or a nurse? A medical check-up is a physical exam that usually includes at least a blood pressure measurement and height and weight measurement.
I_I Less than 6 months ago
I_I 6 months to less than 1 year ago
I_I 1 year to less than 2 years ago
I_I 2 years to less than 3 years ago
I_I 3 or more years ago
I_I Never
I_I Don't know
I_I Prefer not to answer

HS05. When was the last time you saw a dental professional, including a dentist or a hygienist?
I_I Less than 6 months ago
I_I 6 months to less than 1 year ago
I_I 1 year to less than 2 years ago
I_I 2 years to less than 3 years ago
I_I 3 or more years ago
I_I Never
I_I Don't know
I_I Prefer not to answer

The following questions will be asked of pregnant women in addition to the questions above:

HS04p. Before your pregnancy, when was the last time you had a routine medical check-up, undertaken by a doctor or a nurse? A medical check-up is a physical exam that usually includes at least a blood pressure measurement and height and weight measurement.
I_I Less than 6 months ago
I_I 6 months to less than 1 year ago
I_I 1 year to less than 2 years ago
I_I 2 years to less than 3 years ago
I_I 3 or more years ago
I_I Never
I_I Don't know
I_I Prefer not to answer

HS05p. Before your pregnancy, when was the last time you saw a dental professional, including a dentist or a hygienist?
I_I Less than 6 months ago
I_I 6 months to less than 1 year ago
I_I 1 year to less than 2 years ago
I_I 2 years to less than 3 years ago
I_I 3 or more years ago
I_I Never
I_I Don't know
I_I Prefer not to answer

HS06. Are you able to stand without assistance?
|_| Yes
|_| No
I_I Prefer not to answer

REPRODUCTIVE HEALTH - MEN ONLY

Note: Transgender women whose assigned sex at birth was male will complete these questions.

Now we would like to ask you some general questions about your reproductive history.

MN01. How many children are you a biological parent to, including live births only?
I_I Number of children: _____
I_I None
I_I Don't know
I_I Prefer not to answer

MN02. Have you adopted any children?
|_| Yes
|_| No
|_| Don’t know
I_I Prefer not to answer

MN03. Have you ever had a vasectomy?
|_| Yes
|_| No
|_| Don’t know
|_| Prefer not to answer

MN04. Have you had sex with a female in the past 12 months?
|_| Yes
|_| No
|_| Prefer not to answer

MN05. Have you had sex with a male in the past 12 months?
|_| Yes
|_| No
|_| Prefer not to answer

REPRODUCTIVE HEALTH – WOMEN ONLY (NOT PREGNANT)

Note: Transgender men whose assigned sex at birth was female will complete these questions.

Now we would like to ask you some general questions about women's health and your reproductive history.

WH01. How old were you when you had your first menstrual period?
I_I Age at first menstrual period: _____
I_I Never had a menstrual period
I_I Don't know
I_I Prefer not to answer

WH02. Have you ever used any hormonal contraceptives for any reason? Hormonal contraceptives include birth control pills, implants, patches, injections, and rings or intra-uterine devices that release female hormones.
|_| Yes, I am currently using hormonal contraceptives
|_| Yes, I have used hormonal contraceptives in the past
|_| No → Skip to WH05
|_| Don't know → Skip to WH05
I_I Prefer not to answer → Skip to WH05

WH03. How old were you when you started using hormonal contraceptives?
|_| Age when started using hormonal contraceptives: _____
|_| Don't know
I_I Prefer not to answer

WH04. In total, how many years or months did you use or have you been using hormonal contraceptives? Add up all the time that you used contraceptives even if you started and stopped several times.
|_| Years **OR** |_| Months: _____
|_| Don't know
I_I Prefer not to answer

WH05. How many times have you been pregnant, including live births, stillbirths, spontaneous miscarriages or therapeutic abortions?
Do not count your current pregnancy and count twins or other multiples as one pregnancy.
|_| Number of pregnancies: _____
|_| Never been pregnant →Skip to WH13
|_| Don't know →Skip to WH13
I_I Prefer not to answer →Skip to WH13

The online questionnaire will prompt the following questions for <u>each pregnancy</u> depending on the number of reported pregnancies.

	Prompt for each pregnancy reported in WH05
WH06. How old were you at the time of this pregnancy?	___Age in years |_| Don't know |_| Prefer not to answer
WH07. How many weeks did the pregnancy last?	_____ Number of weeks |_| Don't know

	|_| Prefer not to answer
WH08. Were you pregnant with twins or multiples?	|_| Yes |_| No |_| Don't know |_| Prefer not to answer
The following questions will be asked for each baby	
WH09. What was the outcome of this pregnancy?	|_| Live birth |_| Spontaneous miscarriage →Skip to *WH13* |_| Termination of pregnancy or therapeutic abortion →Skip to *WH13* |_| Stillborn →Skip to *WH13* |_| Other Please specify: →Skip to *WH13* |_| Prefer not to answer →Skip to *WH13*
WH10. What was the birth weight? Please answer the question using grams or pounds and ounces.	_____ grams OR _____ lbs and oz |_| Don't know |_| Prefer not to answer
WH11. What was the sex of this baby?	|_| Male |_| Female |_| Don't Know |_| Prefer not to answer
WH12. Did you breastfeed this baby?	|_| Yes, I breastfed this baby If yes, _____ number of months or ___ weeks |_| Yes, I am still breastfeeding this baby If yes, _____ number of months or ___ weeks |_| No →Skip to *WH13* |_| Don't know →Skip to *WH13* |_| Prefer not to answer →Skip to *WH13*

WH13. Have you ever received hormone fertility treatment to help you get pregnant?
|_| Yes
|_| No
|_| Don't know
I_I Prefer not to answer

WH14. Have you adopted any children?
|_| Yes
|_| No
|_| Don't know
I_I Prefer not to answer

WH15. Have you had sex with a male in the past 12 months?
|_| Yes
|_| No
|_| Prefer not to answer

WH16. Have you had sex with a female in the past 12 months?
|_| Yes
|_| No

|_| Prefer not to answer

WH17. Have you gone through menopause, meaning that your menstrual periods stopped for at least one year and did not restart?
|_| Yes, natural menopause
|_| Yes, other reasons (surgery, chemotherapy, medication)
|_| No → Skip to WH19
|_| Don't know → Skip to WH19
I_I Prefer not to answer → Skip to WH19

WH18. How old were you when your menstrual periods stopped for at least one year and did not restart?
|_| Age when menstrual periods stopped: _____
|_| Don't know
I_I Prefer not to answer

WH19. Have you ever used hormone replacement therapy (HRT) for any reason?
Hormone replacement therapy includes progesterone and/or estrogen. It includes all forms such as patches, rings, creams and other topical forms prescribed by a doctor.
It does not include thyroid hormone treatment or hormonal contraceptives and it does not include other 'natural' treatments that can be bought over the counter.
|_| Yes, I am currently using HRT
|_| Yes, I have used HRT in the past
|_| No → Skip to WH22
|_| Don't know → Skip to WH22
I_I Prefer not to answer → Skip to WH22

WH20. How old were you when you started using hormone replacement therapy?
|_| Age when started using hormone replacement therapy: _____
|_| Don't know
I_I Prefer not to answer

WH21. In total, for how many years or months did you use, or have you been using, hormone replacement therapy? Add up all the time that you used hormone replacement therapy even if you started and stopped several times.
|_| Years **OR** |_| Months: _____
|_| Don't know
I_I Prefer not to answer

WH22. Have you ever had a hysterectomy (an operation to have your uterus or womb removed)?
|_| Yes
|_| No → Skip to WH24
|_| Don't know → Skip to WH24
I_I Prefer not to answer→ Skip to WH24

WH23. How old were you when you had your hysterectomy?
|_| Age at hysterectomy: _____
|_| Don't know
I_I Prefer not to answer

WH24. Have you ever had an operation to have your ovaries removed?
|_| Yes
|_| No → Skip to WH28
|_| Don't know → Skip to WH28
I_I Prefer not to answer → Skip to WH28

WH25. Did you have one or both ovaries removed?
|_| Both
|_| One → Skip to WH28
|_| Don't know → Skip to WH28
I_I Prefer not to answer → Skip to WH28

WH26. Were both of your ovaries removed at the same time?
|_| Yes
|_| No
|_| Don't know
I_I Prefer not to answer

WH27. How old were you when you had the last surgery?
|_| Age at last surgery: _____
|_| Don't know
I_I Prefer not to answer

WH28. Have you ever had a tubal ligation (had “your tubes tied”)?
|_| Yes
|_| No
|_| Don’t know
I_I Prefer not to answer

REPRODUCTIVE HEALTH – PREGNANT WOMEN

Now we would like to ask you some general questions about women's health and your reproductive history.

WH01. How old were you when you had your first menstrual period?
I_I Age at first menstrual period: _____
I_I Never had a menstrual period
I_I Don't know
I_I Prefer not to answer

WH02. Have you ever used any hormonal contraceptives for any reason? Hormonal contraceptives include birth control pills, implants, patches, injections, and rings or intra-uterine devices that release female hormones.
|_| Yes, I currently using hormonal contraceptives
|_| Yes, I have used hormonal contraceptives in the past
|_| No → Skip to WH05
|_| Don't know → Skip to WH05
I_I Prefer not to answer → Skip to WH05

WH03. How old were you when you started using hormonal contraceptives?
|_| Age when started using hormonal contraceptives: _____
|_| Don't know
I_I Prefer not to answer

WH04. In total, how many years or months did you use or have you been using hormonal contraceptives? Add up all the time that you used contraceptives even if you started and stopped several times.
*|_| Years **OR** |_| Months: _____*
|_| Don't know
I_I Prefer not to answer

*WH05. How many times have you been pregnant, including live births, stillbirths, spontaneous miscarriages or therapeutic abortions? **Do not count your current pregnancy and count twins or other multiples as one pregnancy.***
|_| Number of pregnancies: _____
|_| Never been pregnant →Skip to WH13
|_| Don't know →Skip to WH13
I_I Prefer not to answer →Skip to WH13

The online questionnaire will prompt the following questions for <u>each pregnancy</u> depending on the number of reported pregnancies.

	Prompt for each pregnancy reported in WH06
WH06. How old were you at the time of this pregnancy?	*___Age in years* *|_| Don't know* *|_| Prefer not to answer*
WH07. How many weeks did the pregnancy last?	*_____ Number of weeks* *|_| I don't know* *|_| Prefer not to answer*

WH08. Were you pregnant with twins or multiples?	|_| *Yes* |_| *No* |_| *Don't know* |_| *Prefer not to answer*
The following questions will be asked for each baby	
WH09. What was the outcome of this pregnancy?	|_| *Live birth* |_| *Spontaneous miscarriage →Skip to WH13* |_| *Termination of pregnancy or therapeutic abortion →Skip to WH13* |_| *Stillborn →Skip to WH13* |_| *Other (SPECIFY :_____ _) →Skip to WH13* |_| *Prefer not to answer →Skip to WH13*
WH10. What was the birth weight? Please answer the question using grams or pounds and ounces.	*_____ grams OR _____ lbs and oz* |_| *I don't know* |_| *Prefer not to answer*
WH11. What was the sex of this baby?	|_| *Male* |_| *Female* |_| *Don't Know* |_| *Prefer not to answer*
WH12. Did you breastfeed this baby?	|_| *Yes, I breastfed this baby* *If yes, _____ number of months or ___ weeks* |_| *Yes, I am still breastfeeding this baby* *If yes, _____ number of months or ___ weeks* |_| *No →Skip to WH13* |_| *Don't know →Skip to WH13* |_| *Prefer not to answer →Skip to WH13*

WH13. Have you ever received hormone fertility treatment to help you get pregnant?
|_| *Yes*
|_| *No*
|_| *Don't know*
I_I Prefer not to answer

WH14. Have you adopted any children?
|_| *Yes*
|_| *No*
|_| *Don't know*
|_|*I Prefer not to answer*

WH15. Have you had sex with a male in the past 12 months?
|_| Yes
|_| No
|_| Prefer not to answer

WH16. Have you had sex with a female in the past 12 months?
|_| Yes
|_| No
|_| Prefer not to answer

WH17. Have you ever had an operation to have your ovaries removed?

|_| Yes
|_| No → Skip to WH28
|_| Don't know → Skip to WH28
I_I Prefer not to answer → Skip to WH28

WH18. Did you have one or both ovaries removed?
|_| Both
|_| One → Skip to WH28
|_| Don't know → Skip to WH28
I_I Prefer not to answer → Skip to WH28

WH19. Were both of your ovaries removed at the same time?
|_| Yes
|_| No
|_| Don't know
I_I Prefer not to answer

WH20. How old were you when you had the last surgery?
|_| Age at last surgery: _____
|_| Don't know
I_I Prefer not to answer

WH21. Have you ever had a tubal ligation (had "your tubes tied")?
|_| Yes
|_| No
|_| Don't know
I_I Prefer not to answer

CONCEPTION OF CURRENT PREGNANCY

The following questions ask about the conception of your current pregnancy.

CP01. What was the first day of your last menstrual period?

_____ _____ _____
MONTH *DAY* *YEAR*

CP02. About how many weeks pregnant were you when you first learned of it? For example, at the time of missing your period, you were about 4 weeks pregnant.
_____ *NUMBER OF WEEKS*
|_| *Don't know*
|_| *Prefer not to answer*

CP03. At the time that you became pregnant with this baby, did you:
|_| *Want to be pregnant*
|_| *Want to wait until later → Skip to CP05*
|_| *Not want to become pregnant at all → Skip to CP05*
|_| *Not care → Skip to CP05*
|_| *Don't know → Skip to CP05*
|_| *Prefer not to answer → Skip to CP05*

CP04. How long were you trying to get pregnant?

_____ *months*
|_| *Prefer not to answer*

CP05. Do you plan on raising this child as your own?
|_| *Yes → Skip to CP07*
|_| *No*
|_| *Don't know → Skip to CP07*
|_| *Prefer not to answer → Skip to CP07*

CP06. Could you please explain why?
|_| *I am a surrogate carrying someone else's baby*
|_| *I am choosing/considering adoption*
|_| *Other*
|_| *Prefer not to answer*

CP07. Did you or your partner go to a doctor or other medical care provider to talk about ways to help you become pregnant?
|_| *Yes*
|_| *No → Skip to next section of questionnaire*
|_| *Prefer not to answer*

CP08. Did you have surgery to help you become pregnant?
|_| *Yes, Surgery to correct blocked tubes*
|_| *Yes, Other type of surgery (please specify :_____)*
|_| *No*
|_| *Don't know*
|_| *Prefer not to answer*

CP09. Did you undergo In Vitro Fertilization (IVF) or artificial insemination to help you become pregnant?
|_| *Yes, I underwent In Vitro Fertilization (IVF) (implanted embryo)*
|_| *Yes, I underwent artificial insemination (implanted sperm only) → Skip to CP16*
|_| *No → Skip to CP19*
|_| *Don't know → Skip to CP19*
|_| *Prefer not to answer → Skip to CP19*

CP10. In combination with IVF, did you also take Lupron, Suprefact, Ganerelix (Antagon) or Cetrorelix (Cetrotide) (drugs that keeps you from releasing eggs too early)?
|_| *Yes*
|_| *No*
|_| *Don't know*
|_| *Prefer not to answer*

CP11. As the part of in vitro fertilization, sometimes a donor egg is used. Was a donor egg used as a part of your in vitro fertilization?
|_| *Yes*
|_| *No → Skip to CP13*
|_| *Don't know → Skip to CP13*
|_| *Prefer not to answer → Skip to CP13*

CP12. Who donated the egg?

|_| *A relative that you are biologically related to*
|_| *A relative that you are not biologically related to*
|_| *A friend*
|_| *An anonymous donor*
|_| *Some other person*
|_| *Don't know*
|_| *Prefer not to answer*

CP13. There are several procedures that are used to increase the success rate of in vitro fertilization. Of the following procedures, which were used as part of your in vitro fertilization? Please select all that apply.
|_| *No additional procedures used*
|_| *Intracytoplasmic sperm injection (ICSI)*
|_| *Assisted hatching*
|_| *Blastocyst culturing*
|_| *Embryo co-culturing*
|_| *Round spermatid nucleic injection (ROSNI)*
|_| *Cytoplasmic transfer*
|_| *Pre-Implantation genetic diagnosis (PGD)*
|_| *Other (Please specify_____)*
|_| *Don't know*
|_| *Prefer not to answer*

CP14. How many embryos were implanted during the in vitro fertilization procedure?
_____ number of embryos
|_| *Don't know*
|_| *Prefer not to answer*

CP15. Sometimes embryos created during in vitro fertilization are frozen so that they can be implanted later when the couple is ready to have another baby. Was a previously frozen embryo used to help you become pregnant with the current pregnancy?
|_| *Yes*
|_| *No*
|_| *Don't know*
|_| *Prefer not to answer*

CP16. Was sperm used from your husband/partner only, from some other donor only, or from both?
|_| *Husband/partner only*
|_| *Donor only*
|_| *Both husband/partner and donor*
|_| *Don't know*
|_| *Prefer not to answer*

CP17. Have you previously undergone this treatment?
|_| *Yes How many times: _____*
|_| *No → Skip to CP18*
|_| *Prefer not to answer*

CP18. Did this previously result in a live birth?
|_| *Yes*
|_| *No*

|_| *Prefer not to answer*

CP19. Did you take any drugs (injections or pills) to help you become pregnant?
|_| *Yes*
|_| *No → Skip to CP23*
|_| *Don't know → Skip to CP23*
|_| *Prefer not to answer → Skip to CP23*

(QUESTION BELOW IS SKIPPED IF NO DRUGS INDICATED IN QUESTION CP19)

CP20. Which of the drugs below did you use to improve your fertility? Please select all that apply.

	Used by you	***Number of months used***
Clomiphene (Brand names: Clomid, Serophene)	|_|	_____ *months*
Gonadotropins (Brand names:, Pergonal, Repronex , Pregnyl, Profasi, or Puregon, Menopur, Novarel, Ovidrel, Metrodin)	|_|	_____ *months*
Follicle Stimulating Hormone (FSH) (Brand names: Follistim, Fertinex, Metrodin, Bravelle, and Gonal-F)	|_|	_____ *months*
Bromocriptine *(Brand name: Parlodel)*	|_|	_____ *months*
HCG injections (human chorionic gonadotropin)	|_|	_____ *months*
HMG (human menopausal gonadotropin)	|_|	_____ *months*
Other drug (Please specify _____)	|_|	_____ *months*
None	|_|	_____ *months*
Don't know	|_|	
Prefer not to answer	|_|	

CP21. Before your current pregnancy, had you previously used any of these drugs?
|_| *Yes*
|_| *No → Skip to CP23*
|_| *Prefer not to answer → Skip to CP23*

CP22. Did this result in a live birth?
|_| *Yes*
|_| *No*
|_| *Prefer not to answer*

CP23. Did the biological father use any medications to help improve his fertility for this pregnancy?
|_| *Yes*
|_| *No → Skip*
|_| *Don't know → Skip to CP27*
|_| *Prefer not to answer → Skip to CP27*

CP24. What drugs did he use?

Drug name:_____
|_| *Don't know*
|_| *Prefer not to answer*

CP25. How long did he take these drugs?
_____ months
|_| *Don't know*
|_| *Prefer not to answer*

CP26. Did you receive any other services or treatments to help you become pregnant?
|_| *Yes, advice only*
|_| *Yes, other types of medical help (Please specify_____)*
|_| *No*
|_| *Prefer not to answer*

CP27. After seeking treatment how long did it take you to get pregnant?
_____weeks or _____ months
|_| *Prefer not to answer*

CP28. How much money have you spent on fertility treatments related to this pregnancy?
_____ Canadian dollars
|_| *Don't know*
|_| *Prefer not to answer*

CP29. Thinking back to all your pregnancies, how much money have you spent in total on fertility treatments?
_____ Canadian dollars
|_| *Don't know*
|_| *Prefer not to answer*

MOTHER'S HEALTH DURING PREGNANCY

The next questions ask about your health during your current pregnancy

MH01. Since becoming pregnant, have you experienced any vaginal bleeding?
|_| *Yes*
|_| *No → Skip to MH03*
|_| *Don't know → Skip to MH03*
|_| *Prefer not to answer → Skip to MH03*

MH02. How often have you experienced bleeding during this pregnancy?
|_| *5 or more times a week*
|_| *2-4 times a week*
|_| *Once a week*
|_| *1-3 times a month*
|_| *Less than once a month*
|_| *Don't know*
|_| *Prefer not to answer*

MH03. Since becoming pregnant, have you experienced any nausea?
|_| *Yes*
|_| *No → Skip to MH05*
|_| *Don't know → Skip to MH05*

|_| *Prefer not to answer → Skip to MH05*

MH04. How often have you experienced nausea?
|_| *5 or more times a week*
|_| *2-4 times a week*
|_| *Once a week*
|_| *1-3 times a month*
|_| *Less than once a month*
|_| *Don't know*
|_| *Prefer not to answer*

MH05. Since becoming pregnant, have you experienced swollen feet or hands?
|_| *Yes*
|_| *No → Skip to CS01*
|_| *Don't know → Skip to SP01*
|_| *Prefer not to answer → Skip to SP01*

MH06. How often have you experienced swollen feet or hands?
|_| *5 or more times a week*
|_| *2-4 times a week*
|_| *Once a week*
|_| *1-3 times a month*
|_| *Less than once a month*
|_| *Don't know*
|_| *Prefer not to answer*

SLEEP PATTERN

Good quality sleep is a critical component of staying healthy. Sleep disorders are becoming more common in the Canadian population. They are also closely associated with many chronic diseases. These next questions ask about your sleep behaviour.

SP01. On average how many hours per day do you usually sleep, including naps? A day refers to a 24 hour period. Please think of the total amount of sleep (including any naps) that you get in a 24 hour period.
|_| Hours per day: _____ |_| Don't know
I_I Prefer not to answer

SP01p. In the three months before your pregnancy, on average how many hours per day did you usually sleep, including naps? A day refers to a 24 hour period. Please think of the total amount of sleep (including any naps) that you get in a 24 hour period.
|_| *Hours per day: _____*
|_| *Don't know*
|_| *Prefer not to answer*

SP02. How often do you have trouble going to sleep or staying asleep?
|_| Never
|_| Part of the time
|_| Some of the time
|_| Most of the time
|_| All the time
|_| Don't know

|_| Prefer not to answer

SP02p. In the three months before your pregnancy, how often did you have trouble going to sleep or staying asleep?
|_| *Never*
|_| *Part of the time*
|_| *Some of the time*
|_| *Most of the time*
|_| *All the time*
|_| *Don't know*
|_| *Prefer not to answer*

SP03. On average how much light enters your room while you are sleeping?
|_| Virtually no light
|_| Some light
|_| A lot of light
|_| Don't know
|_| Prefer not to answer

SP04. Have you been told that you snore?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

SP04p. In the three months before your pregnancy, did anyone tell you that you snore?
|_| *Yes*
|_| *No*
|_| *Don't know*
|_| *Prefer not to answer*

SP05.Has anyone noticed that you quit or stop breathing during your sleep?
|_| Yes
|_| No
|_| *Don't know*
|_| *Prefer not to answer*

SP05p. In the three months before your pregnancy, did anyone notice that you quit or stopped breathing during your sleep?
|_| *Yes*
|_| *No*
|_| *Don't know*
|_| *Prefer not to answer*

SUNLIGHT

Exposure to sunlight and the use of artificial tanning equipment have been associated with the development of skin cancer and other conditions. These questions ask about your exposure to ultraviolet light.

SU01. In the past 12 months, how many times have you used artificial tanning equipment such as a tanning bed, sunlamp or tanning light for any reason, including medical reasons?
|_| Never
|_| 1 to 4 times
|_| 5 to 9 times
|_| 10 to 14 times
|_| 15 to 19 times
|_| 20 to 24 times
|_| 25 or more times
|_| Don't know
|_| Prefer not to answer

SU02. After several months of not being in the sun, if you then went out in the sun during the summer in the middle of the day without sunscreen or protective clothing for one hour, which one of these would happen to your skin? If you do not go out in the sun, make your best guess of what would happen if you did.
|_| A severe sunburn with blistering
|_| A painful sunburn for a few days followed by peeling
|_| Mildly burnt followed by tanning
|_| Darker/brown without any sunburn
|_| There would be no change
|_| Other
|_| Prefer not to answer

SU03. What is your natural hair colour? If your hair is now grey, please select the colour of your hair before it turned grey. Choose ONE only.
|_| Blonde
|_| Red
|_| Light brown
|_| Dark brown
|_| Black
|_| Prefer not to answer

SU04. What is your natural eye colour? Choose ONE only.
|_| Amber
|_| Blue
|_| Brown
|_| Grey
|_| Green
|_| Hazel
|_| Prefer not to answer

FOOD CONSUMED IN A TYPICAL DAY

The next few questions ask about the food and alcohol you consume in a typical day. Since diet and alcohol consumption are very important factors that affect many areas of health and disease, we will ask more about these areas in future questionnaires. Today, we will ask only a few basic questions.

FC01. In a typical day, how many total servings of vegetables do you eat? A serving of fresh, frozen, canned or cooked leafy vegetables is about 1/2 cup or 125 ml.
|_| Number of servings per day: _____
|_| None
|_| Don't know
I_I Prefer not to answer

FC02. In a typical day, how many total servings of fruit (not including fruit juice) do you eat? A serving is about 1/2 cup or 125 ml of fresh, frozen or canned fruit.
|_| Number of servings per day: _____
|_| None
|_| Don't know
I_I Prefer not to answer

FC03. In a typical day, how many total servings of 100% fruit or vegetable juice do you drink? This includes mixtures of fruit and vegetable juice, but not fruit drinks or fruit cocktails. A serving of fruit or vegetable juice is about 1/2 cup or 125 ml.
|_| Number of servings per day: _____
|_| None
|_| Don't know
I_I Prefer not to answer

FC04. Do you take any of the following types of fibre or fibre supplements on a regular basis (more than once a week)? Please select all that apply.
|_| No
|_| Yes, psyllium products (such as Metamucil, Prodiem, Correctol)
|_| Yes, bran products (such as bran cereals)
|_| Don’t know
|_| Prefer not to answer

ALCOHOL USE

AU01. Have you ever consumed alcohol?
|_| Yes
|_| No → Skip to FS01
|_| Don't know → Skip to FS01
I_I Prefer not to answer → Skip to FS01

AU02. On average, over the last year, how often did you drink alcohol?
|_| 6 to 7 times a week
|_| 4 to 5 times a week
|_| 2 to 3 times a week
|_| Once a week
|_| 2 to 3 times a month → Men: skip to AU06; Women: skip to AU07
|_| About once a month → Men: skip to AU06; Women: skip to AU07
|_| Less than monthly → Men: skip to AU06; Women: skip to AU07
|_| Never → Skip to FS01
|_| Don't know → Skip to FS01
I_I Prefer not to answer → Skip to FS01

AU03. Over the last year, have you changed how much alcohol you drink?
|_| Yes, I have decreased the amount of alcohol I drink
|_| Yes, I have increased the amount of alcohol I drink
|_| No, I drink about the same amount now as I did a year ago
|_| Don't know
I_I Prefer not to answer

AU04. On average, how many drinks do you have during a typical week?
A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43mL) of liquor. If you do not drink a type of alcohol please select **none**.

Red Wine
I_I Drinks per week: _____
I_I None
I_I Don't know
I_I Prefer not to answer

White Wine
I_I Drinks per week: _____
I_I None
I_I Don't know
I_I Prefer not to answer

Beer
I_I Drinks per week: _____
I_I None
I_I Don't know
I_I Prefer not to answer

Liquor/Spirits
I_I Drinks per week: _____

I_I None
I_I Don't know
I_I Prefer not to answer

Other Alcohol
I_I Drinks per week: _____
I_I None
I_I Don't know
I_I Prefer not to answer

AU05. During a typical week, do you drink alcohol mostly on weekend (or non-working) days?
|_| Yes
|_| No
I_I Prefer not to answer

MEN ONLY, WOMEN SKIP TO AU07

AU06. During the past 12 months, how often did you have five or more drinks at the same sitting or occasion?
|_| 6 to 7 times a week
|_| 4 to 5 times a week
|_| 2 to 3 times a week
|_| Once a week
|_| 2 to 3 times a month
|_| About once a month
|_| 6 to 11 times a year
|_| 1 to 5 times a year
|_| Never
|_| Don't know
I_I Prefer not to answer

WOMEN ONLY, MEN SKIP TO FS01

AU07. During the past 12 months, how often did you have four or more drinks at the same sitting or occasion?
|_| 6 to 7 times a week
|_| 4 to 5 times a week
|_| 2 to 3 times a week
|_| Once a week
|_| 2 to 3 times a month
|_| About once a month
|_| 6 to 11 times a year
|_| 1 to 5 times a year
|_| Never
|_| Don't know
I_I Prefer not to answer

ALCOHOL USE – PREGNANT WOMEN

Note: Pregnant women will answer the following questions instead of the questions above.

AU01. Have you ever consumed alcohol?
|_| *Yes*
|_| *No → Skip to* FS01
|_| *Don't know → Skip to* FS01
I_I Prefer not to answer → *Skip to* FS01

	Over the 12 months just before your pregnancy	*Currently, during your pregnancy*
AU02. How often did/do you drink alcohol?	|_| *6 to 7 times a week* |_| *4 to 5 times a week* |_| *2 to 3 times a week* |_| *Once a week* |_| *2 to 3 times a month → skip to AU05* |_| *About once a month → skip to AU05* |_| *Less than monthly → skip to AU05* |_| *Never → Skip to TU01* |_| *Don't know → Skip to TU01* *I_I Prefer not to answer → Skip to TU01*	|_| *6 to 7 times a week* |_| *4 to 5 times a week* |_| *2 to 3 times a week* |_| *Once a week* |_| *2 to 3 times a month → skip to AU05* |_| *About once a month → skip to AU05* |_| *Less than monthly → skip to AU05* |_| *Never → Skip to TU01* |_| *Don't know → Skip to TU01* *I_I Prefer not to answer → Skip to TU01*
AU03. On average, how many drinks did you have during a typical week? *A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43mL) of liquor.* *If you do not drink a type of alcohol please select **none**.*	*Red Wine* *I_I Drinks per week: _____* *I_I None* *I_I Don't know* *I_I Prefer not to answer* *White Wine* *I_I Drinks per week: _____* *I_I None* *I_I Don't know* *I_I Prefer not to answer* *Beer* *I_I Drinks per week: _____* *I_I None* *I_I Don't know* *I_I Prefer not to answer* *Liquor/Spirits* *I_I Drinks per week: _____* *I_I None* *I_I Don't know* *I_I Prefer not to answer* *Other Alcohol* *I_I Drinks per week: _____*	*Red Wine* *I_I Drinks per week: _____* *I_I None* *I_I Don't know* *I_I Prefer not to answer* *White Wine* *I_I Drinks per week: _____* *I_I None* *I_I Don't know* *I_I Prefer not to answer* *Beer* *I_I Drinks per week: _____* *I_I None* *I_I Don't know* *I_I Prefer not to answer* *Liquor/Spirits* *I_I Drinks per week: _____* *I_I None* *I_I Don't know* *I_I Prefer not to answer* *Other Alcohol* *I_I Drinks per week: _____*

	I_I None *I_I Don't know* *I_I Prefer not to answer*	*I_I None* *I_I Don't know* *I_I Prefer not to answer*
AU04. During a typical week, did you drink alcohol mostly on weekend (or Non working) days?	*|_| Yes* *|_| No* *I_I Prefer not to answer*	*|_| Yes* *|_| No* *I_I Prefer not to answer*
AU05. How often did you have four or more drinks at the same sitting or occasion?	*|_|6 to 7 times a week* *|_|4 to 5 times a week* *|_|2 to 3 times a week* *|_|Once a week* *|_|2 to 3 times a month* *|_|About once a month* *|_|6 to 11 times a year* *|_|1 to 5 times a year* *|_|Never* *|_|Don't know* *I_I Prefer not to answer*	*|_|6 to 7 times a week* *|_|4 to 5 times a week* *|_|2 to 3 times a week* *|_|Once a week* *|_|2 to 3 times a month* *|_|About once a month* *|_|6 to 11 times a year* *|_|1 to 5 times a year* *|_|Never* *|_|Don't know* *I_I Prefer not to answer*

FOOD SECURITY

Inadequate access to nutritious food because of financial constraints has been associated with a number of chronic health conditions, including diabetes and heart disease. The following questions ask about your access to food over the past 12 months.

FS01. Which of the following statements best describes the food eaten in your household in the past 12 months?
|_| You and other household members always had enough of the kinds of food you wanted to eat.
|_| You and other household members had enough to eat, but not always the kinds of food you wanted.
|_| Sometimes you and other household members did not have enough to eat.
|_| Often you and other household members didn't have enough to eat.
|_| Don't know
|_| Prefer not to answer

FS02. You and other household members worried that food would run out before you got money to buy more. Was that often true, sometimes true, or never true in the past 12 months?
|_| Often true
|_| Sometimes true
|_| Never true
|_| Don't know
|_| Prefer not to answer

FS03. The food that you and other household members bought just didn't last, and there wasn't any money to get more. Was that often true, sometimes true, or never true in the past 12 months?
|_| Often true
|_| Sometimes true
|_| Never true
|_| Don't know
|_| Prefer not to answer

FS04. You and other household members couldn't afford to eat balanced meals. In the past 12 months was that often true, sometimes true, or never true?
|_| Often true
|_| Sometimes true
|_| Never true
|_| Don't know
|_| Prefer not to answer

If the participant responds "often true" or "sometimes true" to ANY ONE of FS02–FS04 OR "Sometimes" or "Often" to FS01, then continue to FS05; otherwise, skip to the next section.

FS05. In the past 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?
|_| Yes
|_| No → Skip to FS09

|_| Don’t know
|_| Prefer not to answer

FS06. How often did this happen?
|_| Almost every month
|_| Some months but not every month
|_| Only 1 or 2 months
|_| Don’t know
|_| Prefer not to answer

FS07. In the past 12 months, did you personally ever eat less than you felt you should have because there wasn’t enough money to buy food?
|_| Yes
|_| No
|_| Don’t know
|_| Prefer not to answer

FS08. In the past 12 months, did you personally lose weight because you didn’t have enough money for food?
|_| Yes
|_| No
|_| Don’t know
|_| Prefer not to answer

If the participant responded “yes” to FS05, FS07 or FS08, continue to FS09; otherwise, skip to the next section

FS09. In the past 12 months, did you or other adults in your household ever not eat for a whole day because there wasn’t enough money for food?
|_| Yes
|_| No → Skip to TU01
|_| Don’t know → Skip to TU01
|_| Prefer not to answer → Skip to TU01

FS10. How often did this happen?
|_| Almost every month
|_| Some months but not every month
|_| Only 1 or 2 months
|_| Don’t know
|_| Prefer not to answer

TOBACCO USE

This section is about tobacco use. The first questions are about CIGARETTE SMOKING. The term "cigarette" refers to cigarettes that are bought ready-made as well as those you roll yourself. Do not include cigars, cigarillos or pipes when you answer these first questions about cigarettes.

TU01. Have you ever smoked a whole cigarette?
|_| Yes
|_| No → Skip to TU16
|_| Don't know → Skip to TU16
I_I Prefer not to answer → Skip to TU16

TU02. At what age did you smoke your first whole cigarette?
|_| Age: _____
I_I Prefer not to answer

TU03. Have you smoked at least 100 cigarettes in your life? (About 4 - 5 packs)
|_| Yes
|_| No
|_| Don't know
I_I Prefer not to answer

TU04. At the present time, do you smoke cigarettes daily, occasionally, or not at all?
|_| Daily (At least one cigarette every day for the past 30 days)
|_| Occasionally (At least one cigarette in the past 30 days, but not every day) → Skip to TU09
|_| Not at all (You did not smoke at all in the past 30 days) → Skip to TU11
I_I Prefer not to answer → Skip to TU11

TU05. At what age did you begin smoking cigarettes daily?
|_| Age: _____
I_I Prefer not to answer

TU06. How many cigarettes do you smoke each day now?
|_| 1 - 5 cigarettes
|_| 6 - 10 cigarettes
|_| 11 - 15 cigarettes
|_| 16 - 20 cigarettes
|_| 21 - 25 cigarettes
|_| 26+ cigarettes ---------->How many? _____
I_I Prefer not to answer

The following two questions will be asked of pregnant women only:
TU04p. In the three months before becoming pregnant, did you smoke cigarettes daily, occasionally, or not at all?
|_| *Daily (At least one cigarette every day for the past 30 days)*
|_| *Occasionally (At least one cigarette in the past 30 days, but not every day) → Skip to TU09*
|_| *Not at all (You did not smoke at all in the past 30 days) → Skip to TU11*
I_I Prefer not to answer → Skip to TU11

TU06p. In the three months before your pregnancy, how many cigarettes did you smoke each day?
|_| *1 - 5 cigarettes*
|_| *6 - 10 cigarettes*
|_| *11 - 15 cigarettes*
|_| *16 - 20 cigarettes*
|_| *21 - 25 cigarettes*
|_| *26+ cigarettes ----------->How many? _____*
|_| *Prefer not to answer*

TU07. For how many total years have you smoked daily?
|_| Years: _____
|_| Prefer not to answer

TU08. During the total years that you have smoked daily, about how many cigarettes per day have you usually smoked? (If your smoking pattern has changed over the years, make your best guess of the average number of cigarettes you have smoked per day.)
|_| 1 - 5 cigarettes
|_| 6 - 10 cigarettes
|_| 11 - 15 cigarettes
|_| 16 - 20 cigarettes
|_| 21 - 25 cigarettes
|_| 26+ cigarettes ----------->How many? _____
|_| Prefer not to answer

----------> **If you currently smoke <u>daily</u>** SKIP TO TU16

TU09. On how many of the last 30 days did you smoke at least one cigarette?
|_| 1 - 5 days
|_| 6 - 10 days
|_| 11 - 20 days
|_| 21 - 29 days
|_| Prefer not to answer

TU10. On the days that you smoked, how many cigarettes did you usually smoke?
|_| 1 - 5 cigarettes
|_| 6 - 10 cigarettes
|_| 11 - 15 cigarettes
|_| 16 - 20 cigarettes
|_| 21 - 25 cigarettes
|_| 26+ cigarettes
|_| Prefer not to answer

TU11. Have you ever smoked cigarettes daily? (At least one cigarette a day for 30 days in a row)
|_| Yes
|_| No → Skip to TU16
|_| Don't know → Skip to TU16
|_| Prefer not to answer → Skip to TU16

TU12. At what age did you begin to smoke daily?
|_| Age: _____
|_| Prefer not to answer

TU13. When you smoked daily, how many cigarettes did you usually smoke each day?
|_| 1 - 5 cigarettes
|_| 6 - 10 cigarettes
|_| 11 - 15 cigarettes
|_| 16 - 20 cigarettes
|_| 21 - 25 cigarettes
|_| 26+ cigarettes ---------->How many? _____
|_| Prefer not to answer

TU14. For how many total years did you smoke daily?
|_| Years: _____
|_| Prefer not to answer

TU15. When did you stop smoking cigarettes daily?
|_| Less than 1 year ago
|_| 1 to 2 years ago
|_| 3 to 5 years ago
|_| More than 5 years ago
|_| Don't know
|_| Prefer not to answer

The following question will be asked of pregnant women who reported smoking before pregnancy but are not smoking currently:

TU15p. When did you stop smoking cigarettes?
|_| *More than 2 weeks before you knew you were pregnant*
|_| *Less than 2 weeks before you knew you were pregnant*
|_| *When you found out you were pregnant*
|_| *After you found out you were pregnant*
|_| *I never smoked*
|_| *Don't know*
|_| *Prefer not to answer*

OTHER TYPES OF TOBACCO

These next questions are about tobacco use other than cigarettes, such as cigars, pipes and chewing tobacco.

TU16. In your lifetime, have you ever used other types of tobacco on a regular basis and for a period of at least six months?
|_| Yes
|_| No → Skip to ET01
|_| Don't know → Skip to ET01
I_I Prefer not to answer → Skip to ET01

TU17. What other types of products listed below have you ever used on a regular basis and for a period of at least six months?

Cigars
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Small cigars (cigarillos)
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Tobacco pipes
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Chewing tobacco or snuff
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Nicotine patches
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Nicotine gum
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Betel nut
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Paan
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Sheesha
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Other
|_| Yes Please specify: _____
|_| No
|_| Don't know
|_| Prefer not to answer

TU19. Do you **currently** use any other types of products listed below?

Cigars
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Small cigars (cigarillos)
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Tobacco pipes
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Chewing tobacco or snuff
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Nicotine patches
|_| Yes

|_| No
|_| Don't know
|_| Prefer not to answer

Nicotine gum
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Betel nut
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Paan
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Sheesha
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Other;
|_| Yes Please specify:_____
|_| No
|_| Don't know
|_| Prefer not to answer

ENVIRONMENTAL TOBACCO SMOKE

Many studies have suggested that 'second-hand smoke' exposure can impact our health. These questions ask about your exposure to other people's tobacco smoke.

ET01. From birth until the age of 18, how many years did you live with a person who smoked cigarettes, cigars or pipes inside your home?
|_| Years: _____
|_| None
|_| Don't know
|_| Prefer not to answer

ET02. As an adult, from age 18 years to now, how many years did you live with a person who smoked cigarettes, cigars or pipes inside your home?
|_| Years: _____
|_| None
|_| Don't know
|_| Prefer not to answer

ET03. At home how often are you usually exposed to other people's tobacco smoke inside your home?
|_| Every day
|_| Almost every day
|_| At least once a week
|_| At least once a month
|_| Less than once a month
|_| Never
|_| Don't know
|_| Prefer not to answer

ET04. During leisure time outside of your home, how often are you usually exposed to other people's tobacco smoke?
|_| Every day
|_| Almost every day
|_| At least once a week
|_| At least once a month
|_| Less than once a month
|_| Never
|_| Don't know
|_| Prefer not to answer

ET05. As an adult, from age 18 years to now, how many years did you regularly work in an environment where other people smoked cigarettes, cigars or pipes in your presence?
|_| Years: _____
|_| None
|_| Don't know
|_| Prefer not to answer

ET06. At work how often are you usually exposed to other people's tobacco smoke?
|_| Every day
|_| Almost every day

|_| At least once a week
|_| At least once a month
|_| Less than once a month
|_| Never
|_| Don't know
|_| Prefer not to answer

PHYSICAL ACTIVITY

We are interested in finding out about the physical activities that people do as part of their everyday lives. These questions will ask about the time you spent being physically active in the last 7 days. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think *only* about those physical activities that you did for at least 10 minutes at a time.

PA01. During the last 7 days, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?
|_| Days per week: _____
|_| No vigorous physical activities → Skip to PA03
I_I Prefer not to answer → Skip to PA03

PA02. How much time did you usually spend doing vigorous physical activities on one of those days?
|_| Hours per day: _____ AND Minutes per day: _____
|_| Don't know/Not sure
I_I Prefer not to answer

Think about all the **moderate** activities that you did in the **last 7 days**. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

PA03. During the last 7 days, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.
|_| Days per week: _____
|_| No moderate physical activities → Skip to PA05
I_I Prefer not to answer → Skip to PA05

PA04. How much time did you usually spend doing moderate physical activities on one of those days?
|_| Hours per day: _____ AND Minutes per day: _____
|_| Don't know/Not sure
I_I Prefer not to answer

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

PA05. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?
|_| Days per week: _____

|_| No walking → Skip to PA07
I_I Prefer not to answer → Skip to PA07

PA06. How much time did you usually spend walking on one of those days?
|_| Hours per day: _____ AND Minutes per day: _____
|_| Don't know/Not sure
I_I Prefer not to answer

The next two questions are about the time you spent **sitting** on weekdays and weekend days during the **last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

PA07. During the last 7 days, how much time did you spend sitting on a week day?
|_| Hours per day: _____ AND Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA08. During the last 7 days, how much time did you spend sitting on a weekend day?
|_| Hours per day: _____ AND Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA9A. Please estimate how many hours you spend SITTING EACH DAY while traveling to and from places on a WEEK day.
|_| Hours per day: _____ AND Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA9B. Please estimate how many hours you spend SITTING EACH DAY while at work on a WEEK day.
|_| Hours per day: _____ AND Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA9C. Please estimate how many hours you spend SITTING EACH DAY while watching television on a WEEK day.
|_| Hours per day: _____ AND Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA9D. Please estimate how many hours you spend SITTING EACH DAY while using a computer at home on a WEEK day.
|_| Hours per day: _____ AND Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA9E. Please estimate how many hours you spend SITTING EACH DAY in your leisure time (e.g., visiting friends, movies, dining out, etc.), NOT including watching television on a WEEK day.
|_| Hours per day: _____ AND Minutes per day: _____

|_| Don't know
I_I Prefer not to answer

PA9F. Please estimate how many hours you spend SITTING EACH DAY while traveling to and from places on a WEEKEND day.
|_| Hours per day: _____ **AND** Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA9G. Please estimate how many hours you spend SITTING EACH DAY while watching television on a WEEKEND day.
|_| Hours per day: _____ **AND** Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA9H. Please estimate how many hours you spend SITTING EACH DAY while using a computer at home on a WEEKEND day.
|_| Hours per day: _____ **AND** Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA9I. Please estimate how many hours you spend SITTING EACH DAY in your leisure time (e.g., visiting friends, movies, dining out, etc.), NOT including watching television on a WEEKEND day.
|_| Hours per day: _____ **AND** Minutes per day: _____
|_| Don't know
I_I Prefer not to answer

PA10. How tall are you?
Please answer the question using feet and inches or centimeters.
|_| Feet & Inches ---------->_____ Feet _____ Inches
|_| Centimetres ---------->_____
|_| Don't know
|_| Prefer not to answer

PA11. How much do you weigh?
Please answer the question using pounds or kilograms.
|_| Pounds ---------->_____
|_| Kilograms ---------->_____
|_| Don't know
|_| Prefer not to answer

The following questions will be asked of pregnant women in addition to the questions above:

PA12. How much did you weigh just before this pregnancy? Please answer the question using pounds or kilograms.

_____ *Pounds OR* _____ *Kilograms*
|_| *Don't know*
|_|*Prefer not to answer*

PA13. In the 6 months before this pregnancy, did you lose any weight? Please answer the question using pounds or kilograms.

|_| *Yes*
|_| *No → Skip to PA15*
|_| *Don't know → Skip to PA15*
|_|*Prefer not to answer → Skip to PA15*

PA14. How much weight did you lose? Please answer the question using pounds or kilograms.
Pounds _____ or Kilograms_____
|_| *Don't know*
|_|*Prefer not to answer*

In the 6 months before this pregnancy, did you ever use any of the following methods to control your weight?

		At least once a week	*Seldom/Never*	*Prefer not to answer*
PA15.	*Vomiting*	*I_I*	*I_I*	*I_I*
PA16.	*Laxatives*	*I_I*	*I_I*	*I_I*
PA17.	*Fasting*	*I_I*	*I_I*	*I_I*
PA18.	*Hard physical exercise*	*I_I*	*I_I*	*I_I*

PA19. About how much did you weigh at each of the following ages?
(NOTE: only relevant ages will be shown)

20 years old: _____ Pounds or Kilograms
|_| Don't know
|_| Prefer not to answer

30 years old: _____ Pounds or Kilograms
|_| Don't know
|_| Prefer not to answer

40 years old: _____ Pounds or Kilograms
|_| Don't know
|_| Prefer not to answer

50 years old: _____ Pounds or Kilograms
|_| Don't know
|_| Prefer not to answer

60 years old: _____ Pounds or Kilograms
|_| Don't know
|_| Prefer not to answer

70 years old: _____ Pounds or Kilograms
|_| Don't know
|_| Prefer not to answer

80 years old: _____ Pounds or Kilograms
|_| Don't know
|_| Prefer not to answer

CANCER SCREENING

The following questions ask about cancer screening tests. Often these cancer screening tests are not routinely given until after a certain age. The following questions ask whether you have taken part in any of these screening tests.

CS01. When was the last time you had a fecal occult blood test or an FOBT?
A Fecal Occult Blood Test or FOBT is a test to check for blood in your stool. It is most commonly given to people aged 50 and older. After you have had a bowel movement, a stick or brush is used to smear a small sample on a special card. It is usually collected at home for two or three days in a row.
|_| Less than 6 months ago
|_| 6 months to less than 1 year ago
|_| 1 year to less than 2 years ago
|_| 2 years to less than 3 years ago
|_| 3 or more years ago
|_| Never → Skip to CS03
|_| Don't know → Skip to CS03
I_I Prefer not to answer→ Skip to CS03

CS02. If you have had an FOBT, why did you have it? Please select all that apply.
|_| Family history of colorectal cancer
|_| Part of regular check-up / routine screening
|_| Experiencing signs or symptoms of concern
|_| Follow-up of colorectal cancer treatment
|_| Other
|_| Don’t know
I_I Prefer not to answer

CS03. When was the last time you had a colonoscopy?
A colonoscopy is an exam where a long tube is used to examine the entire colon. Before the procedure is done, you are usually given a sedative.
|_| Less than 6 months ago
|_| 6 months to less than 1 year ago
|_| 1 year to less than 2 years ago
|_| 2 years to less than 3 years ago
|_| 3 or more years ago
|_| Never
|_| Don't know
I_I Prefer not to answer

CS04. When was the last time you had a sigmoidoscopy?
A sigmoidoscopy is an exam where a flexible tube is inserted into the rectum and lower part of the large bowel to look for signs of cancer or other problems. The procedure does not usually require sedation.
|_| Less than 6 months ago
|_| 6 months to less than 1 year ago
|_| 1 year to less than 2 years ago
|_| 2 years to less than 3 years ago
|_| 3 or more years ago
|_| Never
|_| Don't know

I_I Prefer not to answer

Items CS05 and CS06 are embedded in a skip pattern. They are not asked if participants check either "Never", "Don't know" or "Prefer not to answer" for <u>both</u> CS03 and CS04.

CS05. If you have had a colonoscopy or sigmoidoscopy, why did you have it? Select all that apply.
|_| Family history of colorectal cancer
|_| Part of regular check-up / routine screening
|_| Experiencing signs or symptoms of concern
|_| Follow-up of colorectal cancer treatment
|_| Follow-up of FOBT
|_| Other
|_| Don't know
I_I Prefer not to answer

CS06. Have you ever had a polyp removed from your colon?
A polyp is an abnormal growth of tissue.
|_| Yes
|_| No
|_| Don't know
I_I Prefer not to answer

CS07 & CS08 for Men only (including transgender women whose assigned sex at birth was male):

CS07. When was the last time you had a PSA blood test?
A PSA test is a specific blood test ordered by a doctor to test for prostate cancer.
|_| Less than 6 months ago
|_| 6 months to less than 1 year ago
|_| 1 year to less than 2 years ago
|_| 2 years to less than 3 years ago
|_| 3 or more years ago
|_| Never → Skip to PM01
|_| Don't know → Skip to PM01
I_I Prefer not to answer

CS08. If you have had a PSA blood test, why have you had it? Select all that apply.
|_| Family history of prostate cancer
|_| Part of regular check-up / routine screening
|_| Experiencing signs or symptoms of concern
|_| Follow-up of prostate cancer treatment
|_| Other
|_| Don't know
I_I Prefer not to answer

CS09 - CS11 for Women only (including transgender men whose assigned sex at birth was female):

CS09. When was the last time you had a mammogram?

A mammogram is a low dose x-ray of the breast in a device that compresses and flattens the breast and is used as a screening test for breast cancer.
|_| Less than 6 months ago
|_| 6 months to less than 1 year ago
|_| 1 year to less than 2 years ago
|_| 2 years to less than 3 years ago
|_| 3 or more years ago
|_| Never → Skip to CS12
|_| Don't know → Skip to CS12
I_I Prefer not to answer

CS10. Why did you have it? Please select all that apply.
|_| Family history of breast cancer
|_| Part of regular check-up / routine screening
|_| Experiencing signs or symptoms of concern
|_| Follow-up of breast cancer treatment
|_| Other
|_| Don't know
I_I Prefer not to answer

The following questions are asked only of pregnant women:
CS09p. Before this pregnancy, when was the last time you had a mammogram?
A mammogram is a low dose x-ray of the breast in a device that compresses and flattens the breast and is used as a screening test for breast cancer.
|_| *Less than 6 months ago*
|_| *6 months to less than 1 year ago*
|_| *1 year to less than 2 years ago*
|_| *2 years to less than 3 years ago*
|_| *3 or more years ago*
|_| *Never → Skip to WH30*
|_| *Don't know → Skip to WH30*
I_I Prefer not to answer

CS10p. Why did you have it? Please select all that apply.
|_| *Family history of breast cancer*
|_| *Part of regular check-up / routine screening*
|_| *Experiencing signs or symptoms of concern*
|_| *Follow-up of breast cancer treatment*
|_| *Other*
|_| *Don't know*
|_| *Prefer not to answer*

CS11p. Since becoming pregnant, have you had a mammogram?
|_| *Yes*
|_| *No*
|_| *Don't know*
|_| *Prefer not to answer*

CS12. When was the last time you had a Pap test or a smear test?

A Pap test (sometimes called a cervical smear) is a test performed by a doctor or a nurse where a sample of cells is taken from the cervix.
|_| Less than 6 months ago
|_| 6 months to less than 1 year ago
|_| 1 year to less than 2 years ago
|_| 2 years to less than 3 years ago
|_| 3 or more years ago
|_| Never
|_| Don't know
|_| Prefer not to answer

The following question will be asked only of pregnant women:
CS12p. Before this pregnancy, when was the last time you had a Pap test or a smear test? A Pap test (sometimes called a cervical smear) is a test performed by a doctor or a nurse where a sample of cells is taken from the cervix.
|_| *Less than 6 months ago*
|_| *6 months to less than 1 year ago*
|_| *1 year to less than 2 years ago*
|_| *2 years to less than 3 years ago*
|_| *3 or more years ago*
|_| *Never*
|_| *Don't know*
|_| *Prefer not to answer*

CS13. Have you ever had an abnormal pap smear?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

PERSONAL MEDICAL HISTORY

Now we would like to ask you about past and current chronic or ongoing health conditions. We are mostly interested in "long term" conditions that are expected to last, or have already lasted, six months or more and that have been diagnosed by a doctor.

Has a doctor ever diagnosed you with:

		Yes	No	Don't know	Prefer not to answer
PM01.	High blood pressure (hypertension, not including during pregnancy)		Skip to PM03	Skip to PM03	Skip to PM03
PM02.	Age at first diagnosis of high blood pressure (hypertension, not including during pregnancy)?				
PM03	High cholesterol		Skip to PM05	Skip to PM05	Skip to PM05
PM04.	Age at first diagnosis of high cholesterol?				
PM05.	High blood sugar or blood glucose		Skip to PM07	Skip to PM07	Skip to PM07
PM06.	Age at first diagnosis of high blood sugar or blood glucose?				

PM07. Has a doctor ever told you that you had cancer or a malignancy of any kind?
|_| Yes
|_| No → Skip to PM06
|_| Don't know → Skip to PM06
I_I Prefer not to answer → Skip to PM06

PM08. Please select all that apply.

|_| Prostate
|_| Lung and Bronchus
|_| Breast
|_| Colon
|_| Rectum
|_| Non-Hodgkin Lymphoma
|_| Other Lymphoma
|_| Leukemia
|_| Bladder
|_| Melanoma
|_| Non-melanoma skin cancer
|_| Thyroid
|_| Kidney
|_| Uterus
|_| Pancreas
|_| Oral

|_| Stomach
|_| Brain - Benign tumour
|_| Brain - Malignant tumour
|_| Ovary
|_| Multiple myeloma
|_| Liver
|_| Esophagus
|_| Cervix
|_| Larynx
|_| Testicular
|_| Trachea
|_| Anal
|_| Other (please specify):_____

Age at first diagnosis of _____ cancer.
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Did you receive treatment for this cancer?
|_| Yes ----------> What type of treatment was it?
|_| No Please select all that apply.
|_| Don't know |_| Chemotherapy
|_| Prefer not to answer |_| Radiation
|_| Surgery
|_| Other –Please specify:____
|_| Don't know
|_| Prefer not to answer

Heart and Circulatory System Conditions
PM09. Has a doctor ever told you that you had any of the following heart conditions?
|_| Yes - Please select all that apply.
|_| No – Skip to PM10
|_| Don’t know – Skip to PM10
|_| Prefer not to answer – Skip to PM10

|_| Atrial fibrillation
|_| Angina
|_| Heart failure
|_| Heart disease
|_| Heart attack (myocardial infarction)
|_| Valvular heart disease (e.g., aortic stenosis, mitral valve prolapse)
|_| Atherosclerosis/Coronary Heart Disease (including angioplasty or stents)
|_| Other heart condition (please specify) _____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a cardiovascular condition?
|_| Yes

|_| No
|_| Don't know
|_| Prefer not to answer

If "Angina" is selected:
When was the last time you had an angina attack?
|_| Less than 1 month ago
|_| 1 month to 6 months ago
|_| 6 months to less than 1 year ago
|_| 1 year to less than 2 years ago
|_| 2 or more years ago
|_| Don't Know
|_| Prefer not to answer

If "Atrial Fibrillation" is selected:
Have you ever been advised by health professional to take blood thinners (e.g., Coumadin or Pradax) to reduce your risk of stroke?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

If "Valvular Heart Disease" is selected:
Please specify which type of valvular heart disease:
|_| Aortic stenosis
|_| Mitral stenosis
|_| Mitral valve prolapse
|_| Rheumatic heart disease
|_| Other (please specify): _____
|_| Don't know
|_| Prefer not to answer

Neurological Conditions
PM10. Has a doctor ever told you that you have any of the following neurological conditions?
|_| Yes - Please select all that apply.
|_| No – Skip to PM11
|_| Don't know – Skip to PM11
|_| Prefer not to answer – Skip to PM11

|_| Stroke
|_| Transient ischemic attack (TIA)
|_| Migraine
|_| Brain tumour
|_| Brain Injury
|_| Autism or autism spectrum disorder
|_| Epilepsy or seizure
|_| Multiple sclerosis
|_| Parkinson's disease
|_| Dementia
|_| Spinal cord injury
|_| Other neurological condition (please specify) _____

For each condition selected:

|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a neurological condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Lung/Respiratory System
PM11. Has a doctor ever told you that you have any of the following lung or respiratory conditions?
|_| Yes - Please select all that apply
|_| No – Skip to PM12
|_| Don’t know – Skip to PM12
|_| Prefer not to answer – Skip to PM12

|_| Asthma
|_| Chronic obstructive pulmonary disorder (COPD)
|_| Chronic bronchitis
|_| Emphysema
|_| Sleep apnea
|_| Other Breathing Condition (please specify) _____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a lung or respiratory condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Endocrine or Metabolic Conditions
PM12. Has a doctor ever told you that you have diabetes?
|_| Yes ----------→ Age at first diagnosis: _____
|_| No – Skip to PM13
|_| Don’t know – Skip to PM13
|_| Prefer not to answer – Skip to PM13

Which **type** of diabetes was it? Please select all that apply.
|_| Gestational (during pregnancy) diabetes (shown for females)
|_| Type 1 diabetes
|_| Type 2 diabetes
|_| Don't know
|_| Prefer not to answer

PM13. Has a doctor ever told you that you have thyroid disease?
|_| Yes ----------→ Age at first diagnosis: _____
|_| No – Skip to PM14

|_| Don’t know – Skip to PM14
|_| Prefer not to answer – Skip to PM14

Which **type** of thyroid disease was it?

|_| Underactive thyroid (Hypothyroidism)
|_| Overactive thyroid (Hyperthyroidism)
|_| Thyroid nodule(s) (One or more lumps in the thyroid)
|_| Thyroiditis (inflammation of the thyroid)
|_| Goitre
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for diabetes or thyroid disease?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Gastrointestinal Conditions
PM14. Has a doctor ever told you that you have any of the following gastrointestinal conditions?
|_| Yes - Please select all that apply
|_| No – Skip to PM15
|_| Don’t know – Skip to PM15
|_| Prefer not to answer – Skip to PM15

|_| Stomach (or duodenal) ulcer
|_| H. Pylori infection
|_| Crohn’s disease
|_| Barrett’s esophagus
|_| Indigestion (Dyspepsia)
|_| Diverticular disease
|_| Ulcerative colitis
|_| Irritable bowel syndrome
|_| Reflux disease (GERD)
|_| Eosinophilic esophagitis
|_| Celiac disease
|_| Other gastrointestinal condition (please specify) _____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a gastrointestinal condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Liver or Pancreas Conditions
PM15. Has a doctor ever told you that you have any of the following conditions affecting your liver?
|_| Yes - Please select all that apply

|_| No – Skip to PM16
|_| Don’t know – Skip to PM16
|_| Prefer not to answer – Skip to PM16

|_| Liver cirrhosis
|_| Chronic hepatitis
|_| Fatty liver (NAFLD / NASH)
|_| Gallstones
|_| Pancreatitis
|_| Other liver condition (please specify): _____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a liver condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Renal Conditions
PM16. Has a doctor ever told you that you have kidney disease or failing or weak kidneys?
|_| Yes ----------> |_| Age at first diagnosis of kidney disease or failing or weak kidneys: _____
|_| No
|_| Don't know
|_| Don't know
|_| Prefer not to answer
|_| Prefer not to answer

(If Yes)
Do you know the cause of your kidney disease? Please select all that apply.
|_| Glomerulonephritis
|_| Diabetes
|_| High blood pressure
|_| Diseased kidney blood vessels
|_| Polycystic kidney disease
|_| Other inherited condition
|_| Other
|_| Don’t know
|_| Prefer not to answer

Have you been told by your doctor(s) that you are likely to need dialysis in the next 5 years?
|_| Yes
|_| No
|_| Prefer not to answer

Have you ever been prescribed a medication for kidney disease?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Mental Health

PM17. Has a doctor ever told you that you have any of the following mental health conditions?
|_| Yes - Please select all that apply
|_| No – Skip to PM18
|_| Don't know – Skip to PM18
|_| Prefer not to answer – Skip to PM18

|_| Major depression
|_| Bipolar disorder
|_| Anxiety disorder
|_| Eating disorder
|_| Other mental health condition (please specify)
_____

|_| Post-traumatic stress disorder
|_| Schizophrenia or schizoaffective disorder
|_| Obsessive compulsive disorder
|_| Addiction disorder (e.g., alcohol, drug or gambling dependence)

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a mental health condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

If "Eating disorder" selected:
Which eating disorder were you diagnosed with?
|_| Anorexia
|_| Bulimia
|_| Binge eating
|_| Other (Please specify): _____
|_| Don't know
|_| Prefer not to answer

Bone and Joint Conditions

PM18. Has a doctor ever told you that you have any of the following conditions?
|_| Yes - Please select all that apply
|_| No – Skip to PM19
|_| Don't know – Skip to PM19
|_| Prefer not to answer – Skip to PM19

|_| Osteoporosis
|_| Arthritis
|_| Gout
|_| Chronic back pain
|_| Chronic neck pain
|_| Lupus
|_| Fibromyalgia
|_| Other bone or joint condition (please specify) _____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a musculoskeletal condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

If "Arthritis" is selected:
Which type of arthritis was it? Please select all that apply.
|_| Rheumatoid arthritis
|_| Osteoarthritis
|_| Ankolosing spondylitis
|_| Psoriatic arthritis
|_| Other arthritis (Please specify): _____
|_| Don't know
|_| Prefer not to answer

Skin Conditions
PM19. Has a doctor ever told you that you have any of the following skin conditions? |_| Yes - Please select all that apply|_| No – Skip to PM20
|_| Don't know – Skip to PM20
|_| Prefer not to answer – Skip to PM20

|_| Eczema
|_| Psoriasis
|_| Other skin condition (please specify)
_____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a skin condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Infectious Diseases
PM20. Has a doctor ever told you that you had any of the following infectious diseases?
|_| Yes - Please select all that apply
|_| No – Skip to PM21
|_| Don't know – Skip to PM21
|_| Prefer not to answer – Skip to PM21

|_| Meningitis or encephalitis
|_| Human immunodeficiency virus (HIV)
|_| Mononucleosis (“Mono”)
|_| Gonorrhea
|_| Genital warts
|_| Malaria
|_| Tuberculosis (TB)
|_| Chlamydia
|_| Genital herpes
|_| Syphilis
|_| Other infectious disease (please specify) _____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for an infectious disease?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Genetic Conditions
PM21. Has a doctor ever told you that you have any of the following genetic conditions?
|_| Yes - Please select all that apply
|_| No – Skip to PM22
|_| Don’t know – Skip to PM22
|_| Prefer not to answer – Skip to PM22

|_| Down’s syndrome
|_| Sickle cell anemia
|_| Thalassemia
|_| Congenital adrenal hyperplasia
|_| Hemophilia
|_| Cystic fibrosis
|_| Klinefelter syndrome (XXY chromosomes)
|_| Turner syndrome (XO chromosome)
|_| Complete androgen insensitivity syndrome
|_| Other genetic condition (please specify) _____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a genetic condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Gynaecologic Conditions (WOMEN ONLY)
PM22. Has a doctor ever told you that you have any of the following conditions?
|_| Yes - Please select all that apply
|_| No – Skip to PM23
|_| Don’t know – Skip to PM23
|_| Prefer not to answer – Skip to PM23

|_| Polycystic Ovary Syndrome (PCOS)
|_| Endometriosis

|_| Uterine fibroids

|_| Other gynaecologic condition (please specify) _____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a gynecologic condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Eye and Vision Conditions
PM23. Has a doctor ever told you that you have any of the following eye or vision conditions?
|_| Yes - Please select all that apply
|_| No – Skip to PM24
|_| Don’t know – Skip to PM24
|_| Prefer not to answer – Skip to PM24

|_| Macular degeneration
|_| Diabetic retinopathy
|_| Glaucoma
|_| Cataracts
|_| Lazy eye (amblyopia)
|_| Colour vision problems
|_| Double vision (diplopia)
|_| Crossed eyes (strabismus)
|_| Other eye or vision condition (please specify) _____

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for a vision condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

Auditory Conditions
PM24. Has a doctor or audiologist ever told you that you have any of the following hearing conditions?
|_| Yes – Please select all that apply
|_| No – Skip to PM25
|_| Don’t know – Skip to PM25
|_| Prefer not to answer – Skip to PM25

|_| Tinnitus (sound in your ears or head)
|_| Hearing loss
|_| Chronic ear infections (otitis media)
|_| Other hearing condition
|_| Meniere’s disease
|_| Swimmer’s ear (otitis externa)
|_| Vertigo

For each condition selected:
|_| Age at first diagnosis: _____
|_| Don't know
|_| Prefer not to answer

Have you ever been prescribed a medication for an auditory condition?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

If "Tinnitus" selected:
PM25. Do you experience tinnitus (sound in your ears and head that does not have an obvious cause) for longer than 5 minutes?
|_| Yes
|_| No → Skip to PM26
|_| Don't know →Skip to PM26
|_| Prefer not to answer → Skip to PM26

PM26. What is the frequency of your tinnitus?
|_| On and off
|_| Constant
|_| Don't know
|_| Prefer not to answer

PM27. What is the nature of your tinnitus?
|_| Ringing or hissing
|_| Roaring
|_| Pulsing
|_| Other
|_| Don't know
|_| Prefer not to answer

PM28. Does tinnitus affect your daily life and activities?
|_| Not at all
|_| Occasionally
|_| Frequently
|_| Constantly
|_| Don't know
|_| Prefer not to answer

PM29. Do you have or have you had any other long-term health conditions?
|_| Yes ----------> Please list these long-term conditions.
|_| No 1: _____
|_| Don't know 2: _____
I_I Prefer not to answer 3: _____
4: _____
5: _____

Have you ever been prescribed a medication for any of the conditions that you listed above?
|_| Yes
|_| No

|_| Don't know
|_| Prefer not to answer

PM30. Do you have any allergies?
|_| Yes
|_| No → Skip to PM32
|_| Don't know → Skip to PM32
I_I Prefer not to answer→ Skip to PM32

PM31. Do you currently have allergies to any of the following? Please select all that apply.
|_| Cats, dogs or other animals
|_| Foods
|_| Insect bites or stings
|_| Latex
|_| Medications
|_| Metal - Jewellery
|_| Mold or dust
|_| Plants, grasses or trees (e.g. pollen)
|_| Other – Please specify:_____
|_| Don't know
|_| Prefer not to answer

PM32. Do you have problems with urination, such as pain when you urinate, frequent urination or urine leakage (incontinence)?
|_| Yes
|_| No → Skip to Next Section
|_| Prefer not to answer → Skip to Next Section

PM33. What are your urinary problems? Please select all that apply.
|_| Pain when you urinate
|_| Urinating frequently
|_| Inability to urinate (cannot empty bladder)
|_| Leakage of urine
|_| Prefer not to answer

EMOTIONAL HEALTH AND WELL-BEING

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
EW01.	Little interest or pleasure in doing things				
EW02.	Feeling down, depressed or hopeless				
EW03.	Feeling nervous, anxious, or on edge				
EW04.	Not being able to stop or control worrying				

JOINTS AND PAIN

The next set of questions asks about the level of general bodily pain or discomfort you usually experience, and some more specific questions about joint pain. They are not about short-term illness or pain. Pain can affect people's level of activity, so we also ask about your ability to complete routine activities.

JP01. Are you usually free of pain or discomfort?
|_| Yes → Skip to JP04
|_| No
|_| Don't know → Skip to JP04
|_| Prefer not to answer → Skip to JP04

JP02. How would you describe the usual intensity of your pain or discomfort?
|_| Mild
|_| Moderate
|_| Severe
|_| Don't know
|_| Prefer not to answer

JP03. How many activities does your pain or discomfort prevent?
|_| None
|_| A few
|_| Some
|_| Most
|_| Don't know
|_| Prefer not to answer

JP04. Have you had headaches or body pain on MOST DAYS of the PAST MONTH?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

JP05. Have any of your joints been troublesome (painful, aching, swollen or stiff) on MOST DAYS of the PAST MONTH?
|_| Yes
|_| No → Skip to JP06
|_| Don't know → Skip to JP06
|_| Prefer not to answer

JP06. Which of the following joints have been troublesome? Please select all that apply.
|_| Back
|_| Neck
|_| Shoulder(s)
|_| Elbow(s)
|_| Wrist(s)
|_| Hand(s)/finger(s)

|_| Hip(s)
|_| Knee(s)
|_| Ankle(s)
|_| Foot/feet
|_| Other (please specify): _____
|_| Prefer not to answer

HEARING

Now, some questions about your hearing and how well you see. Hearing loss and vision impairment are important yet under-researched areas of health. Little is known about these conditions in the general Canadian population.

EH01. How much difficulty do you have hearing (without a hearing aid, if you use one) what is said in a conversation with one other person?
|_| No difficulty
|_| Some difficulty
|_| A lot of difficulty
|_| I cannot hear
|_| Don't know
|_| Prefer not to answer

EH02. How much difficulty do you have hearing (without a hearing aid, if you use one) what is said in a conversation with three other people?
|_| No difficulty
|_| Some difficulty
|_| A lot of difficulty
|_| I cannot hear
|_| Don't know
|_| Prefer not to answer

EH03. How much difficulty do you have hearing (without a hearing aid, if you use one) what is said in a telephone conversation?
|_| No difficulty
|_| Some difficulty
|_| A lot of difficulty
|_| I cannot hear
|_| Don't know
|_| Prefer not to answer

EH04. Do you use a hearing aid or hearing aids?
|_| Yes
|_| No → Skip to EH08
|_| Don’t know → Skip to EH08
|_| Prefer not to answer → Skip to EH08

EH05. With your hearing aid, how much difficulty do you have hearing what is said in a conversation with one other person?
|_| No difficulty

|_| Some difficulty
|_| A lot of difficulty
|_| I cannot hear
|_| Don't know
|_| Prefer not to answer

EH06. With your hearing aid, how much difficulty do you have hearing what is said in a conversation with three other people?
|_| No difficulty
|_| Some difficulty
|_| A lot of difficulty
|_| I cannot hear
|_| Don't know
|_| Prefer not to answer

EH07. With your hearing aid, how much difficulty do you have hearing what is said in a telephone conversation?
|_| No difficulty
|_| Some difficulty
|_| A lot of difficulty
|_| I cannot hear
|_| Don't know
|_| Prefer not to answer

EH08. Overall, how would you rate your hearing?
|_| I have no problem hearing
|_| I have difficulty hearing
|_| I cannot hear
|_| Don't know
|_| Prefer not to answer

VISUAL HEALTH

VH01. Are you able to see well enough to recognize a friend on the other side of the street without glasses or contact lenses?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

VH02. Are you usually able to see well enough to read ordinary newsprint without glasses or contact lenses?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

VH03. Do you wear glasses or contact lenses to see?
|_| Yes
|_| No → Skip to VH06
|_| Prefer not to answer → Skip to VH06

VH04. Are you able to see well enough to recognize a friend on the other side of the street with glasses or contact lens?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

VH05. Are you usually able to see well enough to read ordinary newsprint with glasses or contact lens?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

VH06. Overall, how would you describe your eyesight, using glasses or contact lenses if you use them?
|_| Excellent
|_| Very good
|_| Good
|_| Fair
|_| Poor
|_| Don't know
|_| Prefer not to answer

ORAL HEALTH

Next, some questions about the health of your mouth, including your teeth and gums.

OH01. How would you describe the condition of your teeth?
|_| Excellent
|_| Very good
|_| Good
|_| Fair
|_| Poor
|_| Don't know
|_| Prefer not to answer

OH02. Are any of your natural teeth missing for reasons other than injury or the removal of wisdom teeth?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

OH03. In the last month, how often have you had any other persistent or ongoing pain in your mouth, including your teeth or gums?
|_| Often
|_| Sometimes
|_| Rarely
|_| Never
|_| Don't know
|_| Prefer not to answer

OH04. In the last month have you experienced any of the following issues?

	Yes	No	Don't know	Prefer not to answer
Toothache	☐	☐	☐	☐
Pain in the teeth with hot/cold foods/fluids	☐	☐	☐	☐
Bleeding gums	☐	☐	☐	☐
Dry mouth	☐	☐	☐	☐
Bad breath	☐	☐	☐	☐

FAMILY CHARACTERISTICS

Please tell us about your family. Right now, we are asking about your biological parents, siblings, children and grandparents. While information about your family is important, if you do not know the answer to any of these questions, please select "Don't know" and move on to the next question.

FA01. What is your current marital status? Please choose the ONE status that best describes your current situation.
|_| Married and/or living with a partner → *Skip to FA05; Skip to FA03 if pregnant*
|_| Divorced
|_| Widowed
|_| Separated
|_| Single, never married
|_| Prefer not to answer

FA02. Are you currently in a relationship?
|_| Yes
|_| No → Skip FA04
|_| Other - please specify: _____
|_| Prefer not to answer

The following questions are asked only of pregnant women:

FA03. Is your current spouse or partner the biologic father of your unborn child?
|_| *Yes → Skip to FA05*
|_| *No*
|_| *Don't know*
|_| *Prefer not to answer*

FA04. Who is the biological father of your unborn child?
|_| *I am no longer in contact with him*
|_| *I am in contact with him but we are not partners*
|_| *Anonymous sperm donor.*
|_| *Don't know*
|_| *Prefer not to answer*

FA05. Were you adopted?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

FA06. Are you a twin or part of a multiple birth? Multiple births include twins, triplets, quadruplets, quintuplets, sextuplets, etc.
|_| Yes
|_| No →Skip to FA08
|_| Don't know → Skip to FA08
|_| Prefer not to answer → Skip to FA08

FA07. If you are a twin or part of a multiple birth, please select which type of birth you were part of:

|_| Identical twin
|_| Non-identical twin
|_| Triplet
|_| Four or more
|_| Don’t know
I_I Prefer not to answer

FA08. Do you have any biological siblings (brothers and sisters)? Please include those who have died and half siblings (one common parent), but do not include step siblings or adopted siblings.
|_| Yes
|_| No → Skip to FA10
|_| Don’t know → Skip to FA10
|_| Prefer not to answer → Skip to FA10

FA09. Please enter the number of brothers and sisters in the boxes below.
Full siblings
Brothers: _____
Sisters: _____

Half siblings
Brothers: _____
Sisters: _____

FA10. How many of your biological siblings are, or were, older than you?
If you are part of a multiple birth (e.g. twins, triplets etc), please treat all of the siblings that were born with you as being the same age as you, regardless of the order in which you were actually born.
|_| Number of siblings: _____
|_| Don't know
|_| Prefer not to answer

ETHNIC BACKGROUND - FAMILY

EB04. What is the ethnic background of your biological Mother? Please select all that apply.
|_| Aboriginal (e.g. First Nations, Métis, Inuit)
|_| Arab (e.g. Egypt, Iraq, Jordan, Lebanon)
|_| Black (African or Caribbean descent)
|_| Chinese
|_| Filipino
|_| Japanese
|_|
|_| Korean
|_| Latin American/Hispanic
|_| South Asian (e.g. India, Sri Lanka, Pakistan, Bangladesh)
|_| Southeast Asian (e.g. Malaysia, Indonesia, Vietnam, Cambodia, Laos)
|_| West Asian (e.g. Turkey, Iran, Afghanistan)
|_| White (European descent)
|_| Other ethnic group (not listed above)
|_| Don't know
|_| Prefer not to answer

EB05. What is the ethnic background of your biological Father? Please select all that apply.
|_| Aboriginal (e.g. First Nations, Métis, Inuit)
|_| Arab (e.g. Egypt, Iraq, Jordan, Lebanon)
|_| Black (African or Caribbean descent)
|_| Chinese
|_| Filipino
|_| Japanese
|_|
|_| Korean
|_| Latin American/Hispanic
|_| South Asian (e.g. India, Sri Lanka, Pakistan, Bangladesh)
|_| Southeast Asian (e.g. Malaysia, Indonesia, Vietnam)
|_| West Asian (e.g. Turkey, Iran, Afghanistan)
|_| White (European descent)
|_| Other ethnic group (not listed above)
|_| Don't know
|_| Prefer not to answer

EB06. In what country was your biological mother born?

|_| Canada
|_| China
|_| France
|_| Germany
|_| Greece
|_| India
|_| Islamic Republic of Iran
|_| Ireland
|_| Italy
|_| Jamaica
|_| Republic of Korea
|_| Philippines

|_| Poland
|_| Portugal
|_| Russian Federation
|_| Ukraine
|_| United Kingdom
|_| United States
|_| Vietnam
|_| Other country ---------->Country Name: _____
|_| Don't know
|_| Prefer not to answer

In what country was your biological father born?
|_| Canada
|_| China
|_| France
|_| Germany
|_| Greece
|_| India
|_| Islamic Republic of Iran
|_| Ireland
|_| Italy
|_| Jamaica
|_| Republic of Korea
|_| Philippines
|_| Poland
|_| Portugal
|_| Russian Federation
|_| Ukraine
|_| United Kingdom
|_| United States
|_| Vietnam
|_| Other country ---------->Country Name: _____
|_| Don't know
|_| Prefer not to answer

In what country was your mother’s mother born?
|_| Canada
|_| China
|_| France
|_| Germany
|_| Greece
|_| India
|_| Islamic Republic of Iran
|_| Ireland
|_| Italy
|_| Jamaica
|_| Republic of Korea
|_| Philippines
|_| Poland
|_| Portugal

|_| Russian Federation
|_| Ukraine
|_| United Kingdom
|_| United States
|_| Vietnam
|_| Other country ---------->Country Name: _____
|_| Don't know
|_| Prefer not to answer

In what country was your mother's father born?
|_| Canada
|_| China
|_| France
|_| Germany
|_| Greece
|_| India
|_| Islamic Republic of Iran
|_| Ireland
|_| Italy
|_| Jamaica
|_| Republic of Korea
|_| Philippines
|_| Poland
|_| Portugal
|_| Russian Federation
|_| Ukraine
|_| United Kingdom
|_| United States
|_| Vietnam
|_| Other country ---------->Country Name: _____
|_| Don't know
|_| Prefer not to answer

In what country was your father's mother born?
|_| Canada
|_| China
|_| France
|_| Germany
|_| Greece
|_| India
|_| Islamic Republic of Iran
|_| Ireland
|_| Italy
|_| Jamaica
|_| Republic of Korea
|_| Philippines
|_| Poland
|_| Portugal
|_| Russian Federation
|_| Ukraine

|_| United Kingdom
|_| United States
|_| Vietnam
|_| Other country ---------->Country Name: _____
|_| Don't know
|_| Prefer not to answer

In what country was your father’s father born?
|_| Canada
|_| China
|_| France
|_| Germany
|_| Greece
|_| India
|_| Islamic Republic of Iran
|_| Ireland
|_| Italy
|_| Jamaica
|_| Republic of Korea
|_| Philippines
|_| Poland
|_| Portugal
|_| Russian Federation
|_| Ukraine
|_| United Kingdom
|_| United States
|_| Vietnam
|_| Other country ---------->Country Name: _____
|_| Don't know
|_| Prefer not to answer

FAMILY HEALTH HISTORY

Please tell us about your family's health. For your family health history, please include ONLY include immediate blood relatives, including your mother, father, children and full- and half- brothers and sisters. In this questionnaire, we are only interested in genes you share with your family. Do not include relatives by marriage, stepbrothers and stepsisters, parents by adoption, stepchildren or adopted children. We will ask about these relatives in a future questionnaire.

Again, while the description of your family's health is important information, if you do not know the answer to these questions, please select "Don't know" and move on to the next question.

FM01. Have any of your immediate blood relatives ever been diagnosed by a medical doctor with any of the following (long-term health conditions)? **Note: long-term health condition populated with section headings in grey.**

|_| Yes
|_| No → Skip to FM02
|_| Don't know→ Skip to FM02
|_| Prefer not to answer → Skip to FM02

Please select all that apply.

	Mother	Father	Siblings	Children
Heart and Circulatory System Conditions				
High Blood Pressure (hypertension)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Heart Attack (myocardial infarction)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
High Cholesterol	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Angina	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Heart Failure	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Atrial Fibrillation	|_|	|_|	|_| # Full	|_| # Children__

	Mother	Father	Siblings	Children
			Siblings____ # Half Siblings____	
Heart Disease	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Valvular Heart Disease	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Atherosclerosis/Coronary Heart Disease (including angioplasty or stents)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Neurological Conditions				
Stroke	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Transient Ischemic Attack (TIA)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Migraine	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Brain injury caused by trauma or accident	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Spinal cord injury caused by trauma or accident	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Epilepsy or Seizure	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Multiple Sclerosis	|_|	|_|	|_|	|_|

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Parkinson's Disease	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Dementia	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Brain Tumour	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Lung/Respiratory Conditions				
Asthma	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Chronic Bronchitis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Emphysema	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Chronic Obstructive Pulmonary Disease (COPD)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Sleep Apnea	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Endocrine or Metabolic Conditions				
Diabetes	|_|	|_|	|_| # Full Siblings____ # Half	|_| # Children__

	Mother	Father	Siblings	Children
			Siblings____	
Thyroid Disease	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Gastrointestinal Conditions				
Stomach (or duodenal) ulcer	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
H. pylori infection	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Crohn's Disease	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Ulcerative Colitis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Irritable Bowel Syndrome	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Reflux disease (GERD)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Barrett's esophagus	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Eosinophilic esophagitis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Indigestion (Dyspepsia)	|_|	|_|	|_| # Full Siblings____	|_| # Children__

	Mother	Father	Siblings	Children
			# Half Siblings____	
Celiac disease	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Diverticular disease	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Liver and Pancreas Conditions				
Liver Cirrhosis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Chronic Hepatitis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Fatty liver (NAFLD / NASH)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Gallstones	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Pancreatitis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Mental Health Conditions				
Major Depression	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Anxiety Disorder	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Addiction Disorder	|_|	|_|	|_|	|_|

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Bipolar Disorder	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Post-traumatic Stress Disorder	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Schizophrenia or Schizoaffective Disorder	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Eating Disorder	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Obsessive Compulsive Disorder	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Skin Conditions				
Eczema	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Psoriasis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Bone and Joint Conditions				
Osteoporosis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Arthritis	|_|	|_|	|_| # Full Siblings____ # Half	|_| # Children__

	Mother	Father	Siblings	Children
			Siblings____	
Lupus	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Chronic Back Pain	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Chronic Neck Pain	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Fibromyalgia	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Gout	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Infectious Diseases				
Meningitis or encephalitis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Human Immunodeficiency virus (HIV)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Mononucleosis (“Mono”)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Malaria	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Tuberculosis (TB)	|_|	|_|	|_| # Full Siblings____	|_| # Children__

	Mother	Father	Siblings	Children
			# Half Siblings____	
Syphilis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Genetic Conditions				
Down's Syndrome	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Sickle Cell Anemia	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Thalassemia	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Hemophilia	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Cystic Fibrosis	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Eye and Vision Conditions				
Macular Degeneration	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Diabetic Retinopathy	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Glaucoma	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Cataracts	|_|	|_|	|_|	|_|

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Lazy eye (Amblyopia)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Colour Vision Problems	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Double vision (Diplopia)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Crossed eyes (Strabismus)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Other Conditions				
Kidney Disease	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__

FM02. Have any of your immediate blood relatives ever been diagnosed with cancer?
|_| Yes - Please select all that apply|_| No → Skip to ME01
|_| Don't know → Skip to ME01
|_| Prefer not to answer → Skip to ME01

	Mother	Father	Siblings	Children
Prostate	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Lung and Bronchus	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Breast	|_|	|_|	|_|	|_|

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Colon	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Rectum	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Non-Hodgkin Lymphoma	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Other Lymphoma	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Leukemia	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Bladder	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Melanoma	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Non-melanoma skin cancer	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Thyroid	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Kidney	|_|	|_|	|_|	|_|

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Uterus	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Pancreas	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Oral	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Stomach	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Brain – Benign tumour	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Brain – Malignant tumour	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Ovary	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Multiple myeloma	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Liver	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Esophagus	|_|	|_|	|_|	|_|

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Cervix	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Larynx	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Testicular	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Trachea	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Anal	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__
Other (please specify)	|_|	|_|	|_| # Full Siblings____ # Half Siblings____	|_| # Children__

MEDICATIONS

You previously stated that you have been prescribed medication.
Please answer the following questions about prescribed medication that you are currently taking.

ME01. Are you currently taking any medications prescribed by a doctor and dispensed by a pharmacist? Prescription medication could include such things as pills, patches, injections, liquids, skin creams, eye drops, insulin, birth control and other hormonal therapies.
|_| Yes
|_| No → Skip to AM01
|_| Don't know → Skip to AM01
I_I Prefer not to answer → Skip to AM01

ME02. How many medications are you currently taking?
_____Number
|_| Don't know
I_I Prefer not to answer

For each prescribed medication that you are currently taking, please write down the name of the medication and (if known/available) the drug identification number (DIN).

The DIN is an 8 digit number that should be printed on the label that is attached to the container by the pharmacist. It is NOT the prescription number. The DIN is not required to complete this section of the questionnaire. If your prescription medication does not have a DIN please enter only the name of the medication.

Please enter <u>one</u> medication name per line.

Medication	Name of the medication	Drug identification Number(DIN)
1		
2		
3		
4		
5		
6		
7		
n		

<u>The following question will be asked only of pregnant women:</u>

ME01p. In the three months before your pregnancy, were you taking any medications prescribed by a doctor and dispensed by a pharmacist? Prescription medication could include such things as pills, patches, injections, liquids, skin creams, eye drops, insulin, birth control (and other hormonal therapies.
|_| *Yes*
|_| *No → Skip to AM01*

|_| *Don't know → Skip to AM01*
|_|*Prefer not to answer → Skip to AM01*

ME02p. How many medications are you currently taking?
_____Number
|_| *Don't know*
I_I Prefer not to answer

For each prescribed medication that you took during the three months before your pregnancy, please write down the name of the medication and (if known/available) the drug identification number (DIN).

The DIN is an 8 digit number that should be printed on the label that is attached to the container by the pharmacist. It is NOT the prescription number. The DIN is not required to complete this section of the questionnaire. If your prescription medication does not have a DIN please enter only the name of the medication.

Medication	***Name of the medication***	***Drug identification Number(DIN)***
1		
2		
3		
4		
5		
6		
7		
n		

ANTHROPOMETRIC MEASUREMENTS

These questions ask you to report some basic physical measurements. These questions are optional – if you are not comfortable providing this information or you do not know the answers, please select "Prefer not to answer" and move on to the next question.

Waist and Hips

If you do not have a tape measure available to you, consider using a piece of string or cord and a ruler to measure the circumference of your waist and hips. If you do not wish to report these measurements please click here to proceed to the next section of the questionnaire.

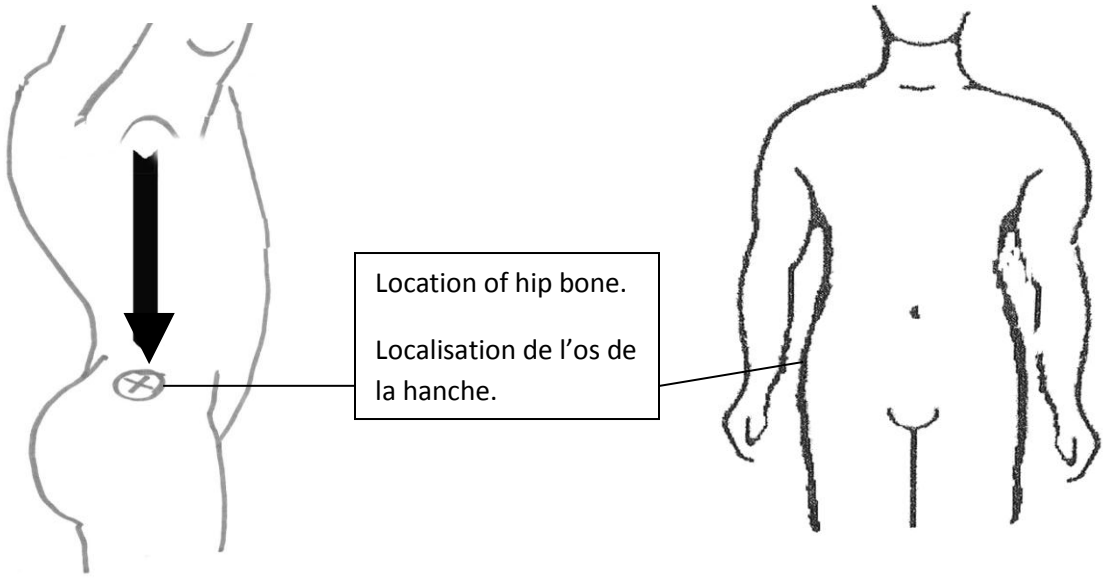
|_| I wish to continue with this section.
|_| Please take me to the next section of the questionnaire.

Ideally, these measurements should be taken without clothing or in loose fitting underwear.

1. Stand in front of a mirror to help position the measuring tape correctly.
2. Pull the measuring tool tight enough that it does not slide, but not too tight to indent the skin.
3. Record the measurement in inches or centimetres.

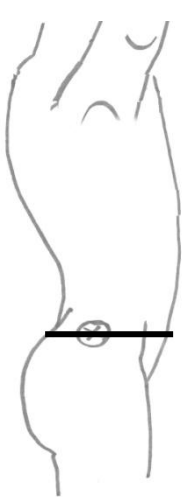
Waist Measurement

This measurement is taken at a specific spot found along your side. To find the spot simply place your thumb under your armpit, then slide your thumb straight down until you find the hip bone (see diagram)



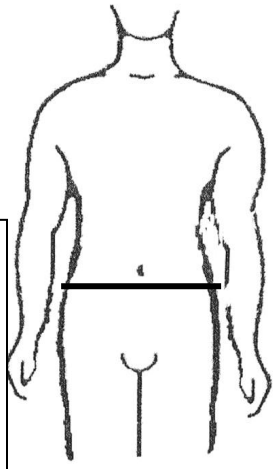
Using the mirror, line up the bottom edge of the measuring tape with the top of the hipbones on both sides of your body.

Tip: Once located, it may help to mark the top of your hipbones with a pen in order to aid you in correctly placing the tape.



Wrap the measuring tape around your middle.

Enroulez le ruban à mesurer autour de la partie central de votre abdomen.



Look in the mirror and turn in a circle to ensure the measuring tape is in a straight line and is not twisted at any point. Relax and take two normal breaths. After the second breath out, gently tighten the tape around your waist. Take the measurement, EVEN IF THIS IS NOT YOUR USUAL WAISTLINE.

Record your measurement to the nearest inch or centimetre.

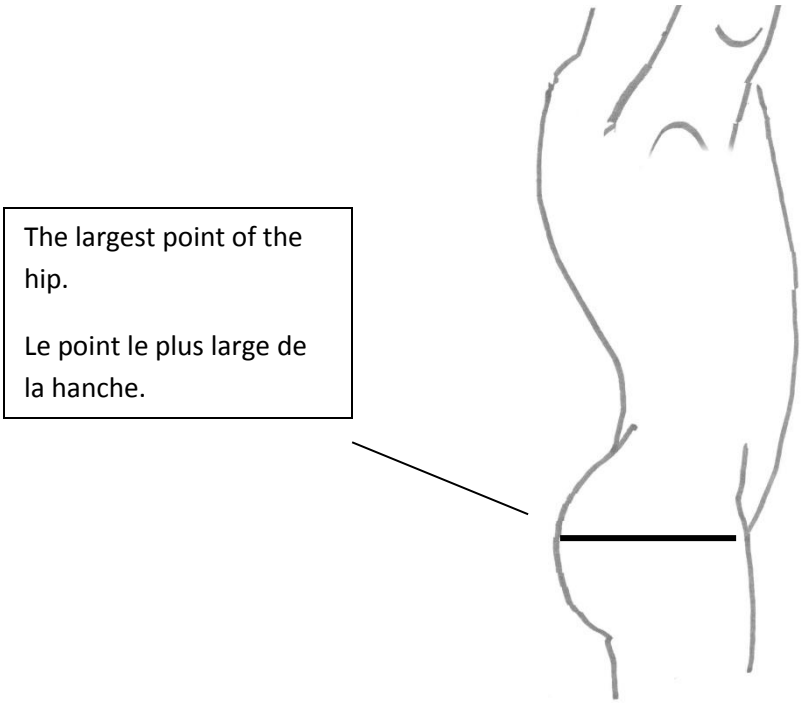
Measurement Units

|_| Inches ---------->_____ Inches
|_| Centimetres ---------->_____ Centimetres
|_| Prefer not to answer

Hips Measurement

Stand sideways in front of a mirror with your feet shoulder-width apart.

Look for the largest point of your buttocks and place the measuring tape at that position.



Now turn in a full circle in front of the mirror to be certain that the measuring tape is in a straight line and is not twisted at any point. Take the measurement.

Measurement Units

|_| Inches ---------->_____ Inches
|_| Centimetres ---------->_____ Centimetres
|_| Prefer not to answer

OPTIONAL EXIT SURVEY

Please help us make it easier for participants to take part in the Ontario Health Study by answering these eight short questions:

EQ01. Where did you complete the questionnaire? Please select all that apply.
|_| Home/home office
|_| Workplace
|_| School
|_| Friend's house
|_| Public Library
|_| Internet Café
|_| Other: (please specify) _____

EQ02. Please indicate below if you agree with the following statement: I found the questionnaire easy to use.
|_| Strongly agree
|_| Agree
|_| Neutral
|_| Disagree
|_| Strongly disagree

EQ03. How often would you be willing to complete a questionnaire of similar length to this questionnaire?
|_| Every 3 months
|_| Every 6 months
|_| Every 12 months
|_| Never

EQ04. Did you have help completing this questionnaire?
|_| No
|_| I needed help translating some of the questions
|_| I needed computer help to use the online questionnaire
|_| Someone else entered the responses because I have limited mobility
|_| I asked my spouse or contacted family members for responses to some of the questions
|_| Other (please specify): _____

EQ05. Think about why you decided to participate in the OHS. Please indicate how much you agree with each of the following statements.

I decided to join the OHS because…

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
…I (or a member of my family) have a disease that I hope the OHS will study.					
…I hope to contribute to scientific knowledge that will help citizens in Ontario.					
…I hope my participation will help solve health problems globally.					

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
…I have benefitted from scientific research; now it is my turn to contribute.					
…I didn't give my decision much thought					

EQ06. We will be contacting consenting participants in the future to complete questionnaires on topics including depression and mental health, diet, stress, occupational history, physical activity, and more. Are there other areas of your health that you think we should be asking about?

_____
_____
_____
_____

EQ07. Is there anything else you would like to tell us about your health?

_____
_____
_____
_____

At a future date, we would like to invite you to volunteer to provide physical measurements, or a blood or saliva sample. This information will help researchers even more as they investigate the causes and risk factors for diseases. It will be especially helpful when looking at how genes and family history affect health. Participation in these tests is entirely voluntary and optional.

There are a number of ways to collect this information. Please read the following options and tell us if you would participate in any or all of the following:

	Yes	Maybe	No	Prefer not to answer
Visit an Assessment Centre in downtown Toronto. Your visit would include tests of breathing, grip strength, and body fat percentage. You will also be asked to volunteer to provide small blood and urine samples. At the end of your visit, you will receive your test results, giving you a snapshot of your current health. Your visit would take about 2 hours.				

	Yes	Maybe	No	Prefer not to answer
Visit a Mini Assessment Centre in your neighbourhood. Your visit would include volunteering to providing a small blood or saliva sample and taking tests, such as blood pressure and body fat percentage. Your visit will take about 45 minutes.				
Visit a lab in your neighbourhood to provide a small blood or saliva sample.				
Provide a small saliva sample through a kit that you would mail back to the Study in a pre-paid envelope.				
Visit a hospital in your community to receive additional scans such as an MRI of the brain, heart, or liver.				

Please click "Finish" to submit your questionnaire.

Well done! Thank you for completing the questionnaire.