



 Ontario Health Study Étude sur la santé Ontario	OHS QUESTIONNAIRE SUMMARY TABLE				For access inquiries, please contact <a href="mailto:access@ontariohealthstudy.ca">access@ontariohealthstudy.ca</a>
	Baseline 1 Questionnaire	Baseline 2 Questionnaire	Follow-up Questionnaire	COVID-19 Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	NOTES
<b>DEMOGRAPHICS</b>	✓	✓	✓	✓	
Age/DOB	✓	✓	✓	✓	
The first three digits of your current residential Postal Code				✓	
<b>Ethnic Background</b>	✓	✓			
Country of birth	✓	✓			
How old were you when you first came to Canada to live?	✓	✓			
What is your ethnic background?	✓	✓			
<b>Language</b>	✓	✓			
First learned language at home	✓	✓			
Language spoken		✓			
How well speak/understand English		✓			
How well speak/understand French		✓			
Preferred language		✓			
<b>Education level</b>	✓	✓			
Highest level of education	✓	✓			
Age when you completed highest level of education	✓	✓			
<b>Residence</b>	✓	✓			
Age when you started living in the dwelling	✓	✓			
Dwelling type	✓	✓			
<b>Occupational history</b>	✓	✓	✓		
Current employment status	✓	✓	✓		
currently main job title	✓	✓			
kind of business, industry or service do you work in	✓	✓			
Age of start working in current job	✓	✓			
working schedule in current job	✓	✓			
The main job title that you held for the longest time	✓	✓			
Kind of business, industry or service do you work in for the longest time	✓	✓			
Working schedule for the job that you held for the longest time	✓	✓			
<b>Household Income</b>	✓	✓	✓		
Household income (from all sources) before taxes last year	✓	✓	✓		
How many individuals does that income support	✓	✓		✓	
Household composition, adults and children	✓	✓			
Type of dwelling do you currently live in				✓	
<b>Sexual orientation and gender identity</b>	✓	✓		✓	
Sex	✓	✓		✓	*Sex at birth **Sex at birth <i>and</i> current sex
<b>Women Only</b>	✓	✓		✓	
Are you currently pregnant	✓	✓			
Sexual orientation	✓	✓			
Do you consider yourself to be trans	✓	✓			
Assigned sex at birth	✓	✓		✓	
Your felt gender	✓	✓			

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Gender you currently live as in your day-to-day life	✓	✓		✓	
History of medically transition sex	✓	✓			
<b>YOUR HEALTH</b>	✓	✓			
Hand Preference	✓	✓			
General Health	✓	✓	✓		
Your Health NOW		✓			
Medical & Dental Check-up	✓	✓	✓		
Fecal occult blood test (FOBT) or a fecal immunochemical test (FIT)			✓		
History of removing polyp from colon			✓		
<b>Pregnant Women Only</b>		✓			
Last medical & dental check-up before pregnancy		✓			
<b>Pregnant Women Only</b>		✓			
Able to stand without assistance				✓	
Blood type				✓	
<b>REPRODUCTIVE HEALTH - Men Only</b>	✓	✓			
# of biological child	✓	✓			
# of adopted child	✓	✓			
History of Vasectomy		✓			
Sexual activity in the past 12 months	✓	✓			
<b>REPRODUCTIVE HEALTH - Women Only - NOT Pregnant</b>	✓	✓			
Age of first menstrual period	✓	✓			
Contraceptive Use (age at first use; total time taken)	✓	✓	✓		
Pregnancy history (# of pregnancies)	✓	✓			
<b>For each pregnancy</b>	✓	✓			
Age at the time of this pregnancy		✓			
<b>For each pregnancy</b>		✓			
Number of weeks this pregnancy last		✓			
<b>For each pregnancy</b>		✓			
Pregnant with twins or multiples		✓			
<b>For each baby</b>		✓			
Outcome of this pregnancy		✓			
<b>For each baby</b>		✓			
Birth weight		✓			
<b>For each baby</b>		✓			
Sex of this baby		✓			
<b>For each baby</b>		✓			
Breastfeed this baby		✓			
Breast feeding history	✓	✓			
<b>REPRODUCTIVE HEALTH - Women Only - Current Pregnant</b>	✓	✓			
First day of last menstrual period (LMP)		✓			
How many weeks pregnant were you when you first learned of it		✓			
Did you have plan to be pregnant		✓			
How long trying to get pregnant		✓			
Plan to raise this child as your own, IF not, why		✓			
Receive medical consultation for getting pregnant		✓			
Have surgery to become pregnant (IVF, Antagon, Cetrotide)		✓			

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If IVF (# of implemented embryos, # frozen embryos)		✓			
Using donor egg (who donated the egg)		✓			
Sperm (from your husband/partner only, donor only, or both)		✓			
Have you previously undergone this treatment, IF YES, the result		✓			
Used drug to improve fertility in current pregnancy, IF YES, type of drug, Who used, Number of months used		✓			
History of using drug to improve fertility and the result		✓			
Used drug to improve fertility by the biological father in current pregnancy, IF YES, type of drug, Number of months used		✓			
Infertility treatment cost		✓			
Last Medical & Dental Check-up before pregnancy	✓	✓			
Your age at current Pregnancy	✓	✓			
Current Pregnancy (# of pregnancies, # of live births, weight, sex)	✓	✓			
<b>REPRODUCTIVE HEALTH - Women Only - Fertility</b>	✓	✓			
Fertility treatment history	✓	✓			
# livebirth after treatment	✓	✓			
# of adopted child	✓	✓			
Sexual Activity in the past 12 months	✓	✓			
Have you gone through menopause	✓	✓	✓		
Age of menstural stopped	✓	✓	✓		
Hormone Replacement Therapy (HRT) history (Age of starting treatment, How long did you use HRT, Type of HRT)	✓	✓	✓		
History of Hysterectomy (Age)	✓	✓			
History of removing ovaries (Age, have one or both ovaries removed, Were both of your ovaries removed at the same time)	✓	✓			
History of tubal legitation	✓	✓			
Cost of infertility treatment	✓	✓			
<b>MOTHER HEALTH DURING PREGNANCY - Women Only</b>		✓			
Vaginal Bleeding since becoming pregnant (how often)		✓			
Nausea since becoming pregnant (how often)		✓			
Swollen feet or hand since becoming pregnant (how often)		✓			
<b>SLEEP PATTERN</b>	✓	✓	✓		
Average of hours slept in a 24 hour period	✓	✓	✓		
Average of hours slept in a 24 hour period - 3 month before pregnancy		✓			
Trouble going to sleep or staying asleep	✓	✓	✓		
Trouble going to sleep or staying asleep - 3 month before pregnancy		✓			
Light enters your room while you are sleeping	✓	✓			


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Experience of snoring		✓			
Experience of snoring - 3 month before pregnancy		✓			
Experience of quit or stop breathing during sleep		✓			
Experience of quit or stop breathing during sleep - 3 month before pregnancy		✓			
<b>SUN EXPOSURE</b>	✓	✓			
Artificial sunlight use, tanning	✓	✓			
Sunburn risk	✓	✓			
Natural hair colour	✓	✓			
Natural eye colour					
<b>FOOD CONSUMED IN A TYPICAL DAY</b>	✓				
In a typical day, Total servings of vegetables	✓	✓			
In a typical day, Total servings of 100% fruit or vegetable juice	✓	✓			
In a typical day, Total servings of fruit (not including fruit juice)	✓	✓			
Take any of the following types of fibre or fibre supplements on a regular basis (more than once a week)? -psyllium products (such as Metamucil, Prodiem, Correctol) -bran products (such as bran cereals)		✓			
<b>ALCOHOL USE</b>	✓	✓	✓		
Ever consumed alcohol	✓	✓	✓		
Since March 2020 alcohol consumption <u>changed</u>				✓	
Over the last year, how often drink alcohol	✓	✓	✓		
Over the last year, have you changed how much alcohol you drink		✓	✓		
How many drinks do you have during a typical week -Red Wine -White Wine -Beer -Liquor/Spirits -Other Alcohol	✓	✓	✓		
Drink alcohol mostly on weekend (or non-working) days	✓	✓			
<b>MEN ONLY:</b> How often did you have five or more drinks at the same sitting or occasion	✓	✓	✓		
<b>WOMEN ONLY:</b> How often did you have four or more drinks at the same sitting or occasion	✓	✓	✓		
<b>ALCOHOL USE – PREGNANT WOMEN</b>		✓			
Ever consumed alcohol		✓			
<u>Over the 12 months just before your pregnancy</u> , how often drink alcohol		✓			

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Years in Use	2010-2013	2011-2018	2016-2018	2020	NOTES
<u>Over the 12 months just before your pregnancy.</u> How many drinks do you have during a typical week -Red Wine -White Wine -Beer -Liquor/Spirits -Other Alcohol		✓			
<u>Over the 12 months just before your pregnancy.</u> Drink alcohol mostly on weekend (or non-working) days		✓			
<u>Over the 12 months just before your pregnancy.</u> How often did you have four or more drinks at the same sitting or occasion		✓			
<u>Currently, during your pregnancy,</u> how often drink alcohol		✓			
<u>Currently, during your pregnancy.</u> How many drinks do you have during a typical week -Red Wine -White Wine -Beer -Liquor/Spirits -Other Alcohol		✓			
<u>Currently, during your pregnancy.</u> Drink alcohol mostly on weekend (or non-working) days		✓			
<u>Currently, during your pregnancy.</u> How often did you have four or more drinks at the same sitting or occasion		✓			
<b>FOOD SECURITY</b>		✓			
The best description of the food eaten in your household in the past 12 months		✓			
How often you and other household members worried that food would run out before you got money to buy more.		✓			
How often the food that you and other household members bought just didn't last, and there wasn't any money to get more		✓			
How often you and other household members couldn't afford to eat balanced meals		✓			
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—Bran products (such as bran cereals), How often?		✓			
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?		✓			
In the past 12 months, did you personally lose weight because you didn't have enough money for food?		✓			
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?		✓			

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	Baseline 1	Baseline 2	Follow-up	COVID-19	NOTES
	Questionnaire	Questionnaire	Questionnaire	Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	
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? How often?		✓			
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?		✓			
In the past 12 months, did you personally lose weight because you didn't have enough money for food		✓			
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? How often?		✓			
<b>TOBACCO USE</b>	✓	✓	✓		
Current and past smoke a whole cigarette	✓	✓		✓	
Since March 2020 your smoking changed				✓	
<u>In the past 12 months</u> : used cannabis				✓	
<u>In the past 12 months</u> : reason of using cannabis				✓	
Since March 2020 your use of cannabis				✓	
Age of smoke first whole cigarette	✓	✓			
Smoked at least 100 cigarettes in your life	✓	✓	✓		
How often do you smoke cigarettes	✓	✓	✓		
Age of smoking cigarettes daily	✓	✓	✓		
# of cigarettes smoked daily	✓	✓	✓		
How easy or difficult would you find it to go without smoking for a whole day			✓		
<u>In the three months before becoming pregnant</u> , how often do you smoke cigarettes		✓			
<u>In the three months before becoming pregnant</u> , # of cigarettes smoked daily		✓			
# of years and smoking cigarettes daily	✓	✓			
<u>During the total years that you have smoked daily</u> # of years and smoking cigarettes daily	✓	✓	✓		
<u>On the last 30 days</u> # of days that smoking at least one cigarette	✓	✓	✓		
<u>On the last 30 days</u> # of cigarettes smoked daily	✓	✓			
<u>On the last 30 days</u> did you use an e-cigarette				✓	
Since March 2020 e-cigarette use change				✓	
Age begin smoking cigarettes daily	✓	✓			
Stop smoking cigarettes daily	✓	✓			
Stop smoking cigarettes		✓			
Current and past use of:	✓	✓			
Cigars	✓	✓			
Small cigars (cigarillos)	✓	✓			
Tobacco pipe	✓	✓			
Chewing tobacco	✓	✓			

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Nicotine patches	✓	✓			
Nicotine gum	✓	✓			
Betel Nut	✓	✓			
Paan	✓	✓			
Sheesha	✓	✓			
Other (i.e. electronic cigarettes)	✓	✓			
Second hand smoke exposure	✓	✓	✓		
<u>At Home</u> , How often to be second hand smoke exposure	✓	✓			
<u>Outside</u> , How often to be second hand smoke exposure	✓	✓			
<u>At Work</u> , How often to be second hand smoke exposure	✓	✓			
# of years to be second hand smoke exposure	✓	✓			
<b>MARIJUANA USE</b>			✓		
Currently have a prescription for medical marijuana			✓		
Have you ever used marijuana or hashish			✓		
Age begin using marijuana or hashish			✓		
Smoked marijuana or hashish at least once a month for more than one year			✓		
Age begin using marijuana or hashish at least once a month for more than one year			✓		
How long has it been since you last smoked marijuana or hashish at least once a month for one year			✓		
How often usually use marijuana or hashish			✓		
How many joints or pipes usually smoke in a day			✓		
How long has it been since you last used marijuana or hashish			✓		
<u>During the past 30 days</u> , on how many days did you use marijuana or hashish			✓		
<b>E-CIGARETTE USE</b>			✓		
Ever tried an electronic cigarette			✓		
<u>In the past 30 days</u> , used an electronic cigarette			✓		
The last time you used an e-cigarette, did it contain nicotine			✓		
In the past two years, did you ever use the e-cigarette as an aid while attempting to quit smoking			✓		
<b>PHYSICAL ACTIVITY</b>	✓	✓			
# days of doing vigorous physical activity	✓	✓			
# Hrs & Min of doing vigorous physical activity	✓	✓			
# days of doing moderate physical activity	✓	✓			
# Hrs & Min of doing moderate physical activity	✓	✓			
# days of walking for at least 10 minutes	✓	✓			
# Hrs & Min of walking for at least 10 minutes	✓	✓			

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	Questionnaire	Questionnaire	Questionnaire	Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	
# Hrs & Min of spend sitting on a week day	✓	✓			
# Hrs & Min of spend sitting on a weekend day	✓	✓			
# Hrs & Min of spend SITTING EACH DAY while traveling to and from places on a WEEK day.		✓			
# Hrs & Min of spend SITTING EACH DAY while at work on a WEEK day		✓			
# Hrs & Min of spend SITTING EACH DAY while watching television on a WEEK day.		✓			
# Hrs & Min of spend SITTING EACH DAY while using a computer at home on a WEEK day.		✓			
# Hrs & Min of spend SITTING EACH DAY in your leisure time (e.g., visiting friends, movies, dining out, etc.), NOT including watching television on a WEEK day.		✓			
# Hrs & Min of spend SITTING EACH DAY while traveling to and from places on a WEEKEND day.		✓			
# Hrs & Min of spend SITTING EACH DAY while watching television on a WEEKEND day.		✓			
# Hrs & Min of you spend SITTING EACH DAY while using a computer at home on a WEEKEND day.		✓			
# Hrs & Min of spend SITTING EACH DAY in your leisure time (e.g., visiting friends, movies, dining out, etc.), NOT including watching television on a WEEKEND day.		✓			
Height	✓	✓			
Weight	✓	✓	✓		
Before this pregnancy, Weight		✓			
In 6 months before this pregnancy, Lose any weight		✓			
In 6 months before this pregnancy, to control your weight how often use:		✓			
Vomiting		✓			
Laxatives		✓			
Fasting		✓			
Hard physical exercise		✓			
Weight at each of the following ages		✓			
<b>CANCER SCREENING</b>	✓	✓			
Last time you had a fecal occult blood test or an FOBT & Why	✓	✓			
Last time you had a colonoscopy & Why	✓	✓	✓		
Last time you had a sigmoidoscopy & Why	✓	✓	✓		
Had a polyp removed from your colon	✓	✓			
Last time you had a PSA blood test & Why	✓	✓			
Last time you had a mammogram & Why	✓	✓			
Before this pregnancy, Last time you had a mammogram & Why		✓			





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<u>Before this pregnancy</u> , Last time you had a mammogram & Why		✓			
<u>Since becoming pregnant</u> , had a mammogram		✓			
Last time you had a Pap test or a smear test	✓	✓			
<u>Before this pregnancy</u> , Last time you had a Pap test or a smear test & Result		✓			
<b>PERSONAL MEDICAL HISTORY</b>	✓	✓			
High blood pressure (Age at first diagnosis)	✓	✓	✓		
High cholesterol (Age at first diagnosis)	✓	✓	✓		
High blood sugar (Age at first diagnosis)	✓	✓			
Cancer or a malignancy of any kind:	✓	✓			
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)	✓	✓		✓	
Skin (Melanoma)				✓	
Skin (Non-Melanoma)				✓	
Age at first diagnosis of cancer	✓	✓			
Cancer treatment	✓	✓		✓	
<b>Heart and Circulatory System Conditions</b>	✓	✓			
Diagnosed for:	✓	✓			


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Atrial fibrillation (Age)		✓	✓		
Angina (Age)		✓	✓		
Heart failure (Age)		✓	✓		
Heart disease (Age)		✓			
Heart attack (myocardial infarction)	✓	✓	✓		
Valvular heart disease (Age/Type)		✓	✓		
Atherosclerosis/Coronary Heart Disease (Age)		✓	✓		
Other heart condition (please specify) (Age)		✓	✓		
History of prescribed a medication for a cardiovascular condition		✓			
Last time had an Angina attack		✓			
Have been advised by health professional to take blood thinners after Atrial Fibrillation		✓			
<b>Neurological Conditions</b>	✓	✓	✓	✓	
Diagnosed for:	✓	✓			
Stroke (Age)	✓	✓			
Transient ischemic attack (TIA) (Age)		✓			
Migraine (Age)	✓	✓	✓		
Brain tumour (Age)		✓			
Brain Injury (Age)		✓			
Autism or autism spectrum disorder (Age)		✓			
Epilepsy or seizure (Age)		✓	✓		
Multiple sclerosis (Age)	✓	✓	✓	✓	
Parkinson's disease (Age)		✓	✓		
Dementia (Age)	✓	✓			
Alzheimer's disease (Age)			✓		
Chronic fatigue syndrome (Age)			✓		
Spinal cord injury (Age)		✓			
Other neurological condition (please specify) (Age)		✓	✓		
History of prescribed a medication for a neurological condition		✓			
Thrombotic stroke (Age)			✓	✓	
Hemorrhagic stroke (Age)			✓	✓	
<b>Lung/Respiratory System</b>	✓	✓	✓		
Diagnosed for:	✓	✓	✓		
Asthma (Age)	✓	✓	✓		
Chronic obstructive pulmonary disorder (COPD) (Age)	✓	✓	✓		
Chronic bronchitis (Age)		✓	✓		
Emphysema (Age)		✓	✓		
Sleep apnea (Age)	✓	✓	✓		
Other Breathing Condition (please specify) (Age)		✓	✓		
History of prescribed a medication for a lung or respiratory condition		✓			
<b>Endocrine or Metabolic Conditions</b>	✓	✓			
Diagnosed for:	✓	✓			
Diabetes	✓	✓		✓	

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Gestational diabetes	✓	✓		✓	
Type 1 diabetes	✓	✓		✓	
Type 2 diabetes	✓	✓		✓	
Thyroid disease (Age)		✓			
Underactive thyroid (Hypothyroidism)		✓			
Overactive thyroid (Hyperthyroidism)		✓			
Thyroid nodule(s) (One or more lumps in the thyroid)		✓			
Thyroiditis (inflammation of the thyroid)		✓			
Goitre		✓			
History of prescribed a medication for diabetes or thyroid disease		✓			
<b>Gastrointestinal Conditions</b>	✓	✓	✓		
Diagnosed for:	✓	✓	✓		
Stomach (or duodenal) ulcer (Age)		✓	✓		
H. Pylori infection (Age)		✓			
Crohn's disease (Age)	✓	✓	✓		
Barrett's esophagus (Age)		✓			
Indigestion (Dyspepsia) (Age)		✓			
Diverticular disease (Age)		✓			
Ulcerative colitis (Age)	✓	✓	✓		
Irritable bowel syndrome (Age)	✓	✓	✓		
Reflux disease (GERD) (Age)		✓	✓		
Eosinophilic esophagitis (Age)		✓			
Celiac disease (Age)		✓			
Other gastrointestinal condition (please specify) (Age)		✓	✓		
History of prescribed a medication for a gastrointestinal condition		✓			
<b>Liver or Pancreas Conditions</b>	✓	✓	✓		
Diagnosed for:	✓	✓	✓		
Liver cirrhosis (Age)	✓	✓	✓		
Fatty liver (NAFLD / NASH) (Age)		✓	✓		
Pancreatitis (Age)		✓	✓		
Chronic hepatitis (Age)			✓		
Gallstones (Age)			✓		
Cholecystitis (Age)			✓		
Other liver condition (please specify) (Age)			✓		
History of prescribed a medication for a liver condition		✓			
<b>Renal Conditions</b>	✓	✓	✓		
Diagnosed for:	✓	✓	✓		
Glomerulonephritis		✓			
Diabetes		✓			
High blood pressure		✓			
Diseased kidney blood vessels		✓			
Polycystic kidney disease		✓			
Weak or failing kidney (Age)			✓		
Acute renal failure (Age)			✓		

 Ontario Health Study Étude sur la santé Ontario	OHS QUESTIONNAIRE SUMMARY TABLE				For access inquiries, please contact <a href="mailto:access@ontariohealthstudy.ca">access@ontariohealthstudy.ca</a>
	Baseline 1 Questionnaire	Baseline 2 Questionnaire	Follow-up Questionnaire	COVID-19 Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	NOTES
Chronic renal failure (Age)			✓		
Kidney stones (Age)			✓		
Pyelonephritis (kidney infection) (Age)			✓		
Other inherited condition		✓			
Other		✓	✓		
Have been told by your doctor(s) that you need dialysis in the next 5 years		✓			
History of prescribed a medication for for kidney disease		✓			
<b>Mental Health</b>	✓	✓	✓		
Diagnosed for:	✓	✓	✓		
Major Depression (Age)	✓	✓	✓		
Minor Depression (Age)			✓		
Bipolar Disorder (Age)		✓	✓		
Anxiety Disorder (Age)	✓	✓	✓		
Not being able to stop or control worrying			✓		
Worrying too much about different things			✓		
Trouble relaxing			✓		
Being so restless			✓		
Becoming easily annoyed or irritable			✓		
Feeling afraid as if something awful might happen			✓		
Over the <u>last 2 weeks</u> Little interest or pleasure in doing things			✓		
Over the <u>last 2 weeks</u> , Feeling down, depressed, or hopeless			✓		
Over the <u>last 2 weeks</u> , Trouble falling or staying asleep, or sleeping too much			✓		
Over the <u>last 2 weeks</u> , Feeling tired or having little energy			✓		
Over the <u>last 2 weeks</u> , Poor appetite or overeating			✓		
Over the <u>last 2 weeks</u> , Feeling bad about yourself — or that you are a failure or have let yourself or your family down			✓		
Over the <u>last 2 weeks</u> , Trouble concentrating on things, such as reading the newspaper or watching television			✓		
Over the <u>last 2 weeks</u> , Moving or speaking so slowly that other people could have noticed			✓		
Over the <u>last 2 weeks</u> , Thoughts that you would be better off dead or of hurting yourself in some way			✓		
Eating Disorder (Type, Age)		✓	✓		
Post-traumatic stress disorder (Age)		✓	✓		
Schizophrenia (Age)		✓	✓		
Obsessive compulsive disorder (Age)		✓	✓		
Addiction disorder (e.g., alcohol, drug or gambling dependence) (Age)	✓	✓			
Other mental health condition (Age)		✓	✓		
History of prescribed a medication for mental health condition		✓			

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	Baseline 1 Questionnaire	Baseline 2 Questionnaire	Follow-up Questionnaire	COVID-19 Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	NOTES
<b>Bone and Joint Conditions</b>	✓	✓	✓	✓	
Diagnosed for:	✓	✓	✓	✓	
Osteoporosis (Age)	✓	✓	✓	✓	
Arthritis (Age, Type)		✓	✓	✓	
Gout (Age)		✓			
Chronic back pain (Age)		✓			
Chronic neck pain (Age)		✓			
Lupus (Age)	✓	✓	✓	✓	
Fibromyalgia (Age)		✓	✓	✓	
Other bone or joint condition (please specify) (Age)		✓	✓		
History of prescribed a medication for a musculoskeletal condition		✓			
Rheumatoid arthritis	✓	✓	✓		
Osteoarthritis	✓	✓	✓		
Anklosing spondylitis		✓			
Psoriatic arthritis		✓			
Other arthritis (Please specify)	✓	✓	✓		
<b>Skin Conditions</b>	✓	✓	✓	✓	
Diagnosed for:	✓	✓	✓	✓	
Eczema (Age)	✓	✓	✓	✓	
Psoriasis (Age, Type)	✓	✓	✓	✓	
Other skin condition (please specify) (Age)		✓	✓		
History of prescribed a medication for a skin condition		✓			
Scleroderma				✓	
<b>Infectious Diseases</b>		✓	✓		
Diagnosed for:		✓	✓		
Meningitis or encephalitis (Age)		✓			
Human immunodeficiency virus (HIV) (Age)		✓	✓		
Mononucleosis ("Mono") (Age)		✓			
Gonorrhea (Age)		✓			
Genital warts (Age)		✓	✓		
Malaria (Age)		✓			
Tuberculosis (TB) (Age)		✓			
Chlamydia (Age)		✓			
Genital herpes (Age)		✓	✓		
Syphilis (Age)		✓			
Other skin condition (please specify) (Age)		✓	✓		
History of prescribed a medication for a infection disease		✓			
<b>Genetic Conditions</b>	✓	✓			
Diagnosed for:	✓	✓			
Down's syndrome		✓			
Sickle cell anemia		✓			
Thalassemia		✓			
Congenital adrenal hyperplasia	✓	✓			

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	Baseline 1 Questionnaire	Baseline 2 Questionnaire	Follow-up Questionnaire	COVID-19 Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	NOTES
Complete androgen insensitivity syndrome (Age)	✓	✓			
Hemophilia (Age)		✓			
Cystic fibrosis (Age)		✓			
Klinefelter syndrome (XXY chromosomes) (Age)	✓	✓			
Turner syndrome (XO chromosome) (Age)	✓	✓			
Other genetic condition (please specify) (Age)	✓	✓			
History of prescribed a medication for a genetic disease		✓			
<b>Gynaecologic Conditions (WOMEN ONLY)</b>		✓			
Diagnosed for:		✓			
Polycystic Ovary Syndrome (PCOS) (Age)		✓			
Uterine fibroids(Age)		✓			
Endometriosis (Age)		✓			
Other skin condition (please specify) (Age)		✓			
History of prescribed a medication for a gynecologic condition		✓			
<b>Eye and Vision Conditions</b>		✓	✓		
Diagnosed for:		✓	✓		
Macular degeneration (Age)		✓	✓		
Diabetic retinopathy (Age)		✓			
Glaucoma (Age)		✓	✓		
Cataracts (Age)		✓	✓		
Lazy eye (amblyopia) (Age)		✓			
Colour vision problems (Age)		✓			
Double vision (diplopia) (Age)		✓			
Crossed eyes (strabismus) (Age)		✓			
Other eye or vision condition (please specify) (Age)		✓	✓		
History of prescribed a medication for a eye or vision condition		✓			
<b>Auditory Conditions</b>		✓	✓		
Diagnosed for:		✓	✓		
Tinnitus (sound in your ears or head) (Age, Type, Frequency, nature, impact on daily activity)		✓	✓		
Hearing loss (Age)		✓	✓		
Chronic ear infections (otitis media) (Age)		✓			
Meniere's disease (Age)		✓			
Swimmer's ear (otitis externa) (Age)		✓			
Vertigo (Age)		✓			
Other auditory condition (please specify) (Age)		✓	✓		
History of prescribed an auditory condition		✓			
<b>Other Long-term Health Conditions</b>	✓	✓	✓		
History of long-term health conditions	✓	✓	✓		
History of prescribed for any of listed long-term health conditions		✓	✓		

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	Baseline 1 Questionnaire	Baseline 2 Questionnaire	Follow-up Questionnaire	COVID-19 Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	NOTES
History of Allergies (Cats, dogs or other animals, Foods, Insect bites or stings, Latex, Medications, Metal – Jewellery, Mold or dust, Plants, grasses or trees (e.g. pollen))		✓			
Urinary problems (Pain when you urinate, Urinating frequently, Inability to urinate (cannot empty bladder), Leakage of urine)		✓			
<b>EMOTIONAL HEALTH AND WELL-BEING</b>		✓			
How often - Little interest or pleasure in doing things		✓		✓*	✓*: Since March 2022
How often -Feeling down, depressed or hopeless		✓		✓*	✓*: Since March 2023
How often - Trouble falling or staying asleep, or sleeping too much				✓*	✓*: Since March 2022
How often -Feeling tired or having little energy				✓*	✓*: Since March 2023
How often - Poor appetite or overeating				✓*	✓*: Since March 2022
How often -Feeling bad about yourself – or that you are a failure or have let yourself or your family down				✓*	✓*: Since March 2023
How often - Trouble concentrating on things, such as reading the newspaper or watching television				✓*	✓*: Since March 2022
How often - Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				✓*	✓*: Since March 2023
Compare your mental and emotional health before March 2020 to now.				✓	
How your relationships have changed since March 2020.				✓*	✓*: Since March 2023
How often -Feeling nervous, anxious, or on edge		✓		✓	
How often -Not being able to stop or control worrying		✓		✓	
How often -Worrying too much about different things				✓	
How often -Trouble relaxing				✓	
How often -Being so restless that it's hard to sit still				✓	
How often -Becoming easily annoyed or irritable				✓	
How often -Becoming easily annoyed or irritable				✓	
<b>JOINTS AND PAIN</b>	✓	✓			
free of pain or discomfort (Y/N)	✓	✓			
Describe the usual intensity of your pain or discomfort	✓	✓			
# Activities to prevent your pain or discomfort	✓	✓			
Headaches or body pain on MOST DAYS of the PAST MONTH		✓			

**OHS QUESTIONNAIRE SUMMARY TABLE**

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	Baseline 1	Baseline 2	Follow-up	COVID-19	NOTES
	Questionnaire	Questionnaire	Questionnaire	Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	
<b>Joints been troublesome (painful, aching, swollen or stiff) on MOST DAYS of the PAST MONTH, Which of the following joint:</b> Back Neck Shoulder(s) Elbow(s) Wrist(s) Hand(s)/finger(s) Hip(s) Knee(s) Ankle(s) Foot/feet		✓			
<b>HEARING</b>		✓			
Hearing difficulties (How much) - in a conversation with one other person		✓			
Hearing difficulties (How much) - in a conversation with three other person		✓			
Hearing difficulties (How much) - in a telephone conversation		✓			
Using hearing aid or hearing aids		✓			
With your hearing aid, hearing difficulties (How much) - in a conversation with one other person		✓			
With your hearing aid, hearing difficulties (How much) - in a conversation with three other person		✓			
With your hearing aid, hearing difficulties (How much) - in a telephone conversation		✓			
Rate your hearing	✓	✓			
<b>VISUAL HEALTH</b>		✓			
Able to see well enough to recognize a friend on the other side of the street without glasses or contact lenses		✓			
Able to see well enough to read ordinary newsprint without glasses or contact lenses		✓			
Wearing glasses or contact lenses		✓			
Able to see well enough to recognize a friend on the other side of the street with glasses or contact lens		✓			
Able to see well enough to read ordinary newsprint with glasses or contact lens		✓			
Describe your eyesight	✓	✓			
<b>ORAL HEALTH</b>		✓			
Teeth condition		✓			
Missing teeth for reasons other than injury or the removal of wisdom teeth		✓			
Having pain in your mouth, including your teeth or gums		✓			
Toothache experience		✓			
Pain in the teeth with hot/cold foods/fluids experience		✓			
Bleeding gums experience		✓			
Dry mouth experience		✓			
Bad breath experience		✓			



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Years in Use	2010-2013	2011-2018	2016-2018	2020	NOTES
<b>FAMILY CHARACTERISTICS</b>	✓	✓			
Marital status	✓	✓	✓		
Currently in a relationship	✓	✓			
<u>Pregnant women</u>	✓	✓			
The biologic father of your unborn child	✓	✓			
Were you adopted	✓	✓			
Twin or part of a multiple birth (Type)	✓	✓			
# Biological siblings	✓	✓			
# Biological half siblings		✓			
# Older biological sibling	✓	✓			
<b>ETHNIC BACKGROUND - FAMILY</b>		✓			
Ethnic background of your biological Father	✓	✓			
Ethnic background of your biological Mother	✓	✓			
Country your biological mother was born	✓	✓			
Country your biological father was born	✓	✓			
Country your mother's mother born was born	✓	✓			
Country your mother's father born was born	✓	✓			
Country your father's mother born was born	✓	✓			
Country your father's father born was born	✓	✓			
<b>FAMILY HEALTH HISTORY</b>	✓	✓	✓	✓	Collecting Family History data for: Father, Mother, siblings child
<b>Heart and Circulatory System Conditions</b>	✓	✓	✓	✓	
High Blood Pressure (hypertension)	✓	✓	✓	✓	
Heart Attack (myocardial infarction)	✓	✓	✓	✓	
High Cholesterol	✓	✓			
Angina		✓		✓	
Heart Failure		✓		✓	
Atrial Fibrillation		✓		✓	
Heart Disease		✓			
Valvular Heart Disease		✓		✓	
Atherosclerosis/Coronary Heart Disease (including angioplasty or stents)		✓		✓	
<b>Neurological Conditions</b>	✓	✓			
Stroke	✓	✓	✓		
Transient Ischemic Attack (TIA)		✓			
Migraine	✓	✓			
Brain injury caused by trauma or accident		✓			
Spinal cord injury caused by trauma or accident		✓			
Epilepsy or Seizure		✓			
Multiple Sclerosis	✓	✓	✓		
Parkinson's Disease		✓			
Dementia	✓	✓			
Brain Tumour		✓			

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	Baseline 1 Questionnaire	Baseline 2 Questionnaire	Follow-up Questionnaire	COVID-19 Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	NOTES
<b>Gastrointestinal conditions</b>				✓	
Crohn's disease		✓		✓	
Ulcerative colitis		✓		✓	
Irritable bowel syndrome		✓		✓	
Celiac disease				✓	
<b>Renal disease / kidney failure conditions</b>				✓	
Acute renal failure				✓	
Chronic renal failure				✓	
<b>Lung/Respiratory Conditions</b>	✓	✓	✓	✓	
Asthma	✓	✓	✓	✓	
Chronic Bronchitis		✓		✓	
Emphysema		✓		✓	
Chronic Obstructive Pulmonary Disease (COPD)	✓	✓	✓	✓	
Sleep Apnea	✓	✓		✓	
Interstitial lung disease (lung tissue scarring resulting from other health conditions or exposures)				✓	
Cystic fibrosis				✓	
<b>Endocrine or Metabolic Conditions</b>	✓	✓			
Diabetes	✓	✓	✓		
Thyroid Disease		✓			
<b>Liver and Pancreas Conditions</b>	✓	✓		✓	
Liver Cirrhosis	✓	✓	✓	✓	
Chronic Hepatitis	✓	✓	✓	✓	
Fatty liver (NAFLD / NASH)		✓		✓	
Gallstones		✓			
Pancreatitis		✓			
<b>Mental Health Conditions</b>	✓	✓		✓	
Major Depression	✓	✓	✓	✓	
Minor Depression				✓	
Anxiety Disorder	✓	✓			
Addiction Disorder	✓	✓		✓	
Bipolar Disorder		✓		✓	
Post-traumatic Stress Disorder		✓		✓	
Schizophrenia or Schizoaffective Disorder		✓		✓	
Eating Disorder		✓		✓	
Obsessive Compulsive Disorder		✓		✓	
<b>Skin Conditions</b>	✓	✓			
Eczema	✓	✓	✓		
Psoriasis	✓	✓	✓		
<b>Bone and Joint Conditions</b>	✓	✓			
Osteoporosis	✓	✓	✓		
Arthritis	✓	✓	✓		
Lupus	✓	✓	✓		
Chronic Back Pain		✓			
Chronic Neck Pain		✓			
Fibromyalgia		✓			

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	Baseline 1 Questionnaire	Baseline 2 Questionnaire	Follow-up Questionnaire	COVID-19 Questionnaire	
Years in Use	2010-2013	2011-2018	2016-2018	2020	NOTES
Gout		✓			
<b>Immune system conditions</b>		✓			
A weakened or compromised immune system such as Severe Combined Immunodeficiency)				✓	
Hashimoto's thyroiditis, Sjögren's syndrome, or Ankylosing spondylitis				✓	
<b>Infectious Diseases</b>		✓			
Meningitis or encephalitis		✓			
Human Immunodeficiency virus (HIV)		✓		✓	
Mononucleosis ("Mono")		✓			
Malaria		✓			
Tuberculosis (TB)		✓			
Syphilis		✓			
<b>Genetic Conditions</b>		✓			
Down's Syndrome		✓			
Sickle Cell Anemia		✓			
Thalassemia		✓			
Hemophilia		✓			
Cystic Fibrosis		✓			
<b>Eye and Vision Conditions</b>		✓			
Macular Degeneration		✓			
Diabetic Retinopathy		✓			
Glaucoma		✓			
Cataracts		✓			
Lazy eye (Amblyopia)		✓			
Colour Vision Problems		✓			
Double vision (Diplopia)		✓			
Crossed eyes (Strabismus)		✓			
<b>Other Conditions</b>	✓	✓			
Kidney Disease		✓			
<b>Cancer</b>	✓	✓	✓		
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	✓	✓	✓		

### OHS QUESTIONNAIRE SUMMARY TABLE

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Years in Use	Baseline 1	Baseline 2	Follow-up	COVID-19	NOTES
	Questionnaire	Questionnaire	Questionnaire	Questionnaire	
	2010-2013	2011-2018	2016-2018	2020	
Brain – Benign tumour	✓	✓	✓		
Brain – Malignant tumour	✓	✓			
Ovary	✓	✓	✓		
Multiple myeloma	✓	✓	✓		
Liver	✓	✓	✓		
Esophagus	✓	✓	✓		
Cervix	✓	✓	✓		
Larynx	✓	✓	✓		
Testicular	✓	✓	✓		
Trachea	✓	✓			
Anal	✓	✓			
Small Intestine			✓		
Other (please specify)	✓	✓	✓		
<b>MEDICATIONS</b>	✓	✓	✓		
Currently taking any medications prescribed by a doctor	✓	✓	✓		
# Medications		✓	✓		
Regularly take aspirin or pain relievers 4 times a month or more: -Low-dose or “baby” aspirin (81 mg tablet) -Regular or extra-strength aspirin (Include Excedrin and powders with aspirin) -Ibuprofen (such as Motrin, Advil, Nuprin) -Acetaminophen (such as Tylenol) -Naproxen (such as Naprosyn, Aleve) -Other NSAID pain relievers (Such as Celebrex, meloxicam, diclofenac, nabumetone, indomethacin, sundac or piroxicam. Do not include narcotics or Lyrica)			✓		
<u>Pregnant women:</u> three months before pregnancy, taking any medications prescribed by a doctor		✓			
<u>Pregnant women:</u> # Medications		✓			
<b>ANTHROPOMETRIC MEASUREMENTS</b>	✓	✓			
Waist and Hips Measurement	✓	✓	✓		