

Baseline 2 Questionnaire

(v.07 2013 10 24)

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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
- 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.

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

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

- | | |
|---|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Korean |
| <input type="checkbox"/> French | <input type="checkbox"/> Mandarin |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Norwegian |
| <input type="checkbox"/> Aboriginal Language(s) | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Punjabi |
| <input type="checkbox"/> Danish | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Dutch | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Farsi/Persian | <input type="checkbox"/> Swedish |
| <input type="checkbox"/> Finnish | <input type="checkbox"/> Tagalog/Filipino |
| <input type="checkbox"/> Gaelic | <input type="checkbox"/> Tamil |
| <input type="checkbox"/> German | <input type="checkbox"/> Ukrainian |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Hungarian | <input type="checkbox"/> Welsh |
| <input type="checkbox"/> Icelandic | <input type="checkbox"/> Other - please specify: _____ |

Italian

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

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

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

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

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
- 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
- Prefer not to answer

WS03. What kind of business, industry or service do you work in?

- _____
- Don't know
- 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
- 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: _____
- 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
- 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
- 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
- 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: _____
- 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
- 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
- Prefer not to answer

HI03. How many adults (age 18 or older) including yourself are currently living in your household?

- Number of adults: _____
- Prefer not to answer

HI04. How many children (under 18 years of age) are currently living in your household?

- Number of children: _____
- 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

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
- Prefer not to answer

HS02. How would you rate your general health?

- Excellent
- Very good
- Good
- Fair
- Poor
- 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
- Don't know
- 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.

- 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

HS05. When was the last time you saw a dental professional, including a dentist or a hygienist?

- 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 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.

- 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*

HS05p. Before your pregnancy, when was the last time you saw a dental professional, including a dentist or a hygienist?

- 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*

HS06. Are you able to stand without assistance?

- Yes
- No
- 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?

Number of children: _____

None

Don't know

Prefer not to answer

MN02. Have you adopted any children?

Yes

No

Don't know

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?

- Age at first menstrual period: _____
- Never had a menstrual period
- Don't know
- 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
- 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
- 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
- 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
- Prefer not to answer →Skip to WH13

The online questionnaire will prompt the following questions for each pregnancy 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 <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer
WH07. How many weeks did the	_____ Number of weeks

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

WH13. Have you ever received hormone fertility treatment to help you get pregnant?

- Yes
 No
 Don't know
 Prefer not to answer

WH14. Have you adopted any children?

- Yes
 No
 Don't know
 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
- 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
- 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
- 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
- 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
- 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
- Prefer not to answer → Skip to WH24

WH23. How old were you when you had your hysterectomy?

- Age at hysterectomy: _____

- Don't know
- 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
- 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
- Prefer not to answer → Skip to WH28

WH26. Were both of your ovaries removed at the same time?

- Yes
- No
- Don't know
- Prefer not to answer

WH27. How old were you when you had the last surgery?

- Age at last surgery: _____
- Don't know
- Prefer not to answer

WH28. Have you ever had a tubal ligation (had "your tubes tied")?

- Yes
- No
- Don't know
- 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?

Age at first menstrual period: _____

Never had a menstrual period

Don't know

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

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

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

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

Prefer not to answer →Skip to WH13

The online questionnaire will prompt the following questions for each pregnancy 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 <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer
WH07. How many weeks did the pregnancy last?	_____ Number of weeks <input type="checkbox"/> I don't know

	<input type="checkbox"/> Prefer not to answer
WH08. Were you pregnant with twins or multiples?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer
<i>The following questions will be asked for each baby</i>	
WH09. What was the outcome of this pregnancy?	<input type="checkbox"/> Live birth <input type="checkbox"/> Spontaneous miscarriage →Skip to WH13 <input type="checkbox"/> Termination of pregnancy or therapeutic abortion →Skip to WH13 <input type="checkbox"/> Stillborn →Skip to WH13 <input type="checkbox"/> Other (SPECIFY : _____) →Skip to WH13 <input type="checkbox"/> 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 <input type="checkbox"/> I don't know <input type="checkbox"/> Prefer not to answer
WH11. What was the sex of this baby?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Don't Know <input type="checkbox"/> Prefer not to answer
WH12. Did you breastfeed this baby?	<input type="checkbox"/> Yes, I breastfed this baby If yes, _____ number of months or _____ weeks <input type="checkbox"/> Yes, I am still breastfeeding this baby If yes, _____ number of months or _____ weeks <input type="checkbox"/> No →Skip to WH13 <input type="checkbox"/> Don't know →Skip to WH13 <input type="checkbox"/> 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
 Prefer not to answer

WH14. Have you adopted any children?

- Yes
 No
 Don't know
 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
- 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
- Prefer not to answer → Skip to WH28

WH19. Were both of your ovaries removed at the same time?

- Yes
- No
- Don't know
- Prefer not to answer

WH20. How old were you when you had the last surgery?

- Age at last surgery: _____
- Don't know
- Prefer not to answer

WH21. Have you ever had a tubal ligation (had "your tubes tied")?

- Yes
- No
- Don't know
- 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 Cetorelix (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)	<input type="checkbox"/>	_____ months
Gonadotropins (Brand names: Pergonal, Repronex, Pregnyl, Profasi, or Puregon, Menopur, Novarel, Ovidrel, Metrodin)	<input type="checkbox"/>	_____ months
Follicle Stimulating Hormone (FSH) (Brand names: Follistim, Fertinex, Metrodin, Bravelle, and Gonal-F)	<input type="checkbox"/>	_____ months
Bromocriptine (Brand name: Parlodel)	<input type="checkbox"/>	_____ months
HCG injections (human chorionic gonadotropin)	<input type="checkbox"/>	_____ months
HMG (human menopausal gonadotropin)	<input type="checkbox"/>	_____ months
Other drug (Please specify _____)	<input type="checkbox"/>	_____ months
None	<input type="checkbox"/>	_____ months
Don't know	<input type="checkbox"/>	
Prefer not to answer	<input type="checkbox"/>	

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

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
- 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
- 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
- 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
- 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
- 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
- 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

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

White Wine

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

Beer

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

Liquor/Spirits

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

Other Alcohol

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

AU05. During a typical week, do you drink alcohol mostly on weekend (or non-working) days?

- Yes
 No
 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
 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
 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

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?	<input type="checkbox"/> 6 to 7 times a week <input type="checkbox"/> 4 to 5 times a week <input type="checkbox"/> 2 to 3 times a week <input type="checkbox"/> Once a week <input type="checkbox"/> 2 to 3 times a month → skip to AU05 <input type="checkbox"/> About once a month → skip to AU05 <input type="checkbox"/> Less than monthly → skip to AU05 <input type="checkbox"/> Never → Skip to TU01 <input type="checkbox"/> Don't know → Skip to TU01 <input type="checkbox"/> Prefer not to answer → Skip to TU01	<input type="checkbox"/> 6 to 7 times a week <input type="checkbox"/> 4 to 5 times a week <input type="checkbox"/> 2 to 3 times a week <input type="checkbox"/> Once a week <input type="checkbox"/> 2 to 3 times a month → skip to AU05 <input type="checkbox"/> About once a month → skip to AU05 <input type="checkbox"/> Less than monthly → skip to AU05 <input type="checkbox"/> Never → Skip to TU01 <input type="checkbox"/> Don't know → Skip to TU01 <input type="checkbox"/> 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 <u>none</u> .	<p><u>Red Wine</u></p> <input type="checkbox"/> Drinks per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer	<p><u>Red Wine</u></p> <input type="checkbox"/> Drinks per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer
	<p><u>White Wine</u></p> <input type="checkbox"/> Drinks per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer	<p><u>White Wine</u></p> <input type="checkbox"/> Drinks per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer
	<p><u>Beer</u></p> <input type="checkbox"/> Drinks per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer	<p><u>Beer</u></p> <input type="checkbox"/> Drinks per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer
	<p><u>Liquor/Spirits</u></p> <input type="checkbox"/> Drinks per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer	<p><u>Liquor/Spirits</u></p> <input type="checkbox"/> Drinks per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer
	<p><u>Other Alcohol</u></p>	<p><u>Other Alcohol</u></p>

	<input type="checkbox"/> I Drink per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> I Drink per week: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer
AU04. During a typical week, did you drink alcohol mostly on weekend (or Non working) days?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer
AU05. How often did you have four or more drinks at the same sitting or occasion?	<input type="checkbox"/> 6 to 7 times a week <input type="checkbox"/> 4 to 5 times a week <input type="checkbox"/> 2 to 3 times a week <input type="checkbox"/> Once a week <input type="checkbox"/> 2 to 3 times a month <input type="checkbox"/> About once a month <input type="checkbox"/> 6 to 11 times a year <input type="checkbox"/> 1 to 5 times a year <input type="checkbox"/> Never <input type="checkbox"/> Don't know <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> 6 to 7 times a week <input type="checkbox"/> 4 to 5 times a week <input type="checkbox"/> 2 to 3 times a week <input type="checkbox"/> Once a week <input type="checkbox"/> 2 to 3 times a month <input type="checkbox"/> About once a month <input type="checkbox"/> 6 to 11 times a year <input type="checkbox"/> 1 to 5 times a year <input type="checkbox"/> Never <input type="checkbox"/> Don't know <input type="checkbox"/> 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
- Prefer not to answer → Skip to TU16

TU02. At what age did you smoke your first whole cigarette?

- Age: _____
- Prefer not to answer

TU03. Have you smoked at least 100 cigarettes in your life? (About 4 - 5 packs)

- Yes
- No
- Don't know
- 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
- Prefer not to answer → Skip to TU11

TU05. At what age did you begin smoking cigarettes daily?

- Age: _____
- 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? _____
- 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

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 daily 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
- 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
 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
 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
 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
 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
- 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
- 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
- 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
- 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
- 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
- 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
- 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
- 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

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

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

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

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

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PA16.	Laxatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PA17.	Fasting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PA18.	Hard physical exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

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
- 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 both 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
- 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
- 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
- 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
- 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
- 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
- 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*
- 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
 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 ----->
- No
- Don't know
- Prefer not to answer

What type of treatment was it?

Please select all that apply.

- Chemotherapy
- 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

- | | |
|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy or seizure |
| <input type="checkbox"/> Transient ischemic attack (TIA) | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Brain tumour | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Spinal cord injury |
| <input type="checkbox"/> Autism or autism spectrum disorder | <input type="checkbox"/> 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

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Chronic obstructive pulmonary disorder (COPD) | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> 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

- | | |
|--|---|
| <input type="checkbox"/> Stomach (or duodenal) ulcer | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> H. Pylori infection | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Reflux disease (GERD) |
| <input type="checkbox"/> Barrett's esophagus | <input type="checkbox"/> Eosinophilic esophagitis |
| <input type="checkbox"/> Indigestion (Dyspepsia) | <input type="checkbox"/> Celiac disease |
| <input type="checkbox"/> Diverticular disease | <input type="checkbox"/> 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
- Fatty liver (NAFLD / NASH)
- Pancreatitis
- Other liver condition (please specify): _____
- Chronic hepatitis
- Gallstones

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
- Prefer not to answer
- Don't know
- 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

- | | |
|--|--|
| <input type="checkbox"/> Major depression | <input type="checkbox"/> Post-traumatic stress disorder |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Schizophrenia or schizoaffective disorder |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Obsessive compulsive disorder |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Addiction disorder (e.g., alcohol, drug or gambling dependence) |
| <input type="checkbox"/> Other mental health 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 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

- | | |
|--|---|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Chronic neck pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Chronic back pain | <input type="checkbox"/> 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
- Ankylosing 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

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other skin condition (please specify) |
| <input type="checkbox"/> Psoriasis | _____ |

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

- | | |
|--|--|
| <input type="checkbox"/> Meningitis or encephalitis | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Human immunodeficiency virus (HIV) | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Mononucleosis ("Mono") | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Genital herpes |
| <input type="checkbox"/> Genital warts | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> 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

- | | |
|---|---|
| <input type="checkbox"/> Down's syndrome | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Cystic fibrosis |
| <input type="checkbox"/> Thalassemia | <input type="checkbox"/> Klinefelter syndrome (XXY chromosomes) |
| <input type="checkbox"/> Congenital adrenal hyperplasia | <input type="checkbox"/> Turner syndrome (XO chromosome) |
| <input type="checkbox"/> Complete androgen insensitivity syndrome | |
| <input type="checkbox"/> 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

- | | |
|---|--|
| <input type="checkbox"/> Polycystic Ovary Syndrome (PCOS) | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> 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

- | | |
|---|--|
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Colour vision problems |
| <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> Double vision (diplopia) |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Crossed eyes (strabismus) |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Other eye or vision condition |
| <input type="checkbox"/> Lazy eye (amblyopia) | (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: _____
 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
 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in the teeth with hot/cold foods/fluids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
- 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Heart Attack (myocardial infarction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full	<input type="checkbox"/> # Children__

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

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Brain Tumour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Lung/Respiratory Conditions				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Endocrine or Metabolic Conditions				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half	<input type="checkbox"/> # Children__

	Mother	Father	Siblings	Children
			Siblings_____	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Gastrointestinal Conditions				
Stomach (or duodenal) ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
H. pylori infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Reflux disease (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Barrett's esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Eosinophilic esophagitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Indigestion (Dyspepsia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____	<input type="checkbox"/> # Children__

	Mother	Father	Siblings	Children
			# Half Siblings____	
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Diverticular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Liver and Pancreas Conditions				
Liver Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Chronic Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Fatty liver (NAFLD / NASH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Mental Health Conditions				
Major Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Addiction Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Post-traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Schizophrenia or Schizoaffective Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Skin Conditions				
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Bone and Joint Conditions				
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__

	Mother	Father	Siblings	Children
			Siblings_____	
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Chronic Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Chronic Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Infectious Diseases				
Meningitis or encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Human Immunodeficiency virus (HIV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Mononucleosis ("Mono")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____ # Half Siblings_____	<input type="checkbox"/> # Children__
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings_____	<input type="checkbox"/> # Children__

	Mother	Father	Siblings	Children
			# Half Siblings____	
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Genetic Conditions				
Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Eye and Vision Conditions				
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Lazy eye (Amblyopia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Colour Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Double vision (Diplopia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Crossed eyes (Strabismus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Other Conditions				
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Lung and Bronchus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Brain – Benign tumour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Brain – Malignant tumour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Ovary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Multiple myeloma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mother	Father	Siblings	Children
			# Full Siblings____ # Half Siblings____	# Children__
Cervix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Larynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Testicular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Trachea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Anal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # Children__
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> # Full Siblings____ # Half Siblings____	<input type="checkbox"/> # 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

Prefer not to answer → Skip to AM01

ME02. How many medications are you currently taking?

_____Number

Don't know

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 one medication name per line.

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

The following question will be asked only of pregnant women:

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
- 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.

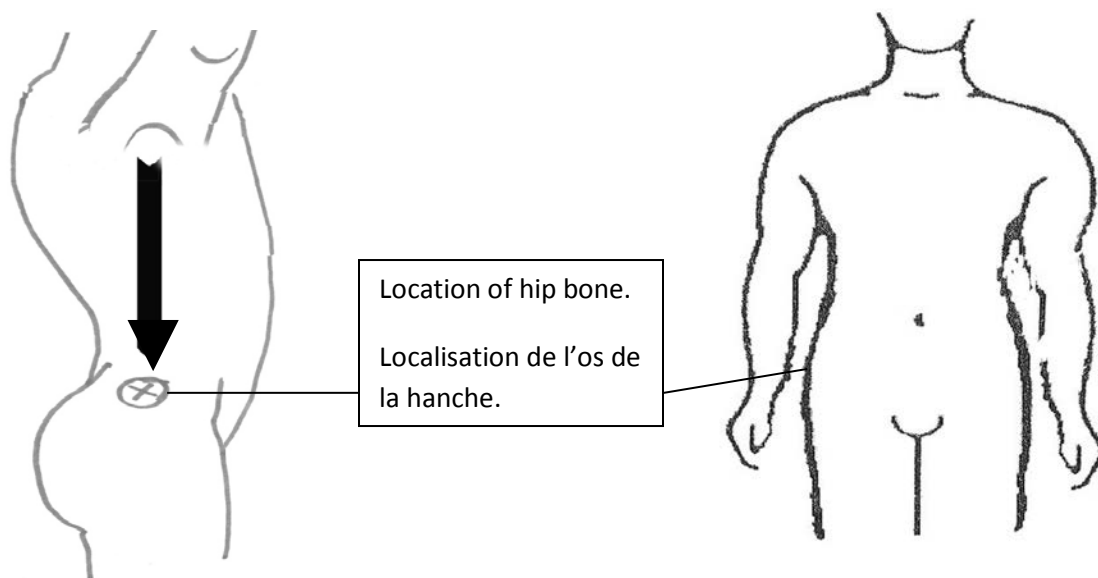
Please take me to the next section of the questionnaire.

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.

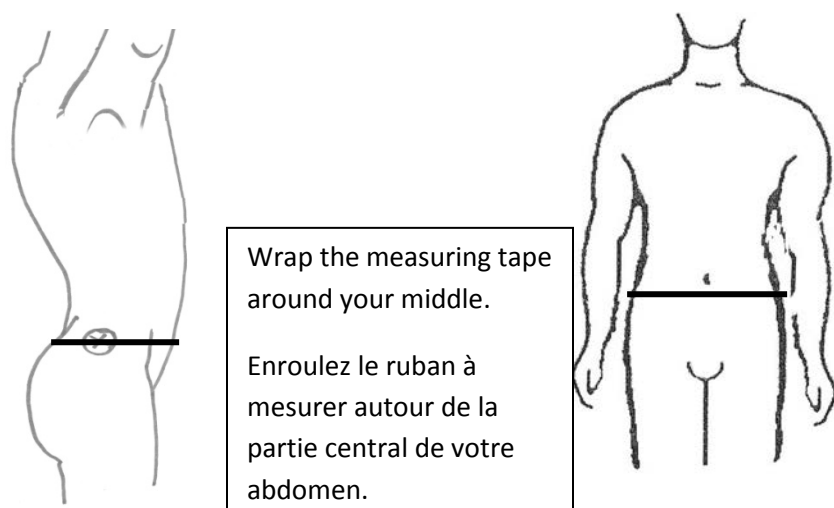
Waist Measurement

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.



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.

The largest point of the hip.
Le point le plus large de la hanche.



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>...I (or a member of my family) have a disease that I hope the OHS will study.</i>					
<i>...I hope to contribute to scientific knowledge that will help citizens in Ontario.</i>					
<i>...I hope my participation will help solve health problems globally.</i>					

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

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.