Assessment Centre Questionnaire

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Directions for Completing This Questionnaire

Thank you for participating in the assessment centre visit! Before coming to the assessment centre, please complete the following questionnaire. The information we ask in this questionnaire will enhance the usefulness of the measurements and samples we collect at the assessment centre. Once you have completed this questionnaire you will be able to book an appointment to visit the OHS Assessment Centre.

The questionnaire takes approximately 10 minutes to complete. You do not need to complete this questionnaire all at once. You may stop working on the questionnaire and return to it at any time over the next two weeks. None of your information will be lost.

Please enter a response to each question on the screen. If there are questions you do not feel comfortable answering, please select the “Don’t know” 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

DEMOGRAPHIC INFORMATION

DE01. How old are you? _____ years

DE02. What is your sex? |_| Male |_| Female

CARDIOVASCULAR HEALTH

At the assessment centre, a number of measurements will be recorded that measure factors related to your heart function and cardiovascular system. Your responses to the following questions will help researchers interpret those measurements.

Cardiovascular History

CH1. Has a health professional ever told you that you have a heart murmur or damage to your heart valves?
|_| Yes
|_| No
|_| Don't know

CH2. Has a health professional ever said that your heart is weak, or does not pump as strongly as it should, or that you had fluid on the lungs?
|_| Yes
|_| No
|_| Don’t Know

CH3. Have you ever experienced heart palpitations or an irregular heart beat?
|_| Yes
|_| No
|_| Don’t Know

CH4. Has a health professional ever told you that your heart sometimes beats faster or slower than it normally should?
|_| Yes
|_| No
|_| Don't know

CH5. Did your biological mother have a heart attack (myocardial infarction) before age 60?
|_| Yes - Age at first diagnosis of mother: ___
|_| No
|_| Don't know

CH6. Did your biological father have a heart attack (myocardial infarction) before age 60?
|_| Yes - Age at first diagnosis of father: ___
|_| No
|_| Don't know

CH7. Did your biological mother have a stroke before age 60?
|_| Yes - Age at first diagnosis of mother: ___
|_| No
|_| Don't know

CH8. Did your biological father have a stroke before age 60?

|_| Yes - Age at first diagnosis of father: ___
|_| No
|_| Don't know

Heart Procedures

HP1. Have you ever had any of the following cardiovascular (heart) procedures? Please select all that apply.

|_| Angioplasty/Stents (PCI)
|_| Cardiac bypass surgery
|_| Heart valve surgery
|_| Heart pacemaker insertion
|_| Implantable cardioverter defibrillator (ICD) insertion
|_| Carotid artery (endarterectomy) surgery or stent – respond to HP2
|_| Abdominal aorta surgery
|_| Femoral or lower leg artery surgery
|_| None of the above
|_| Don't know
|_| Prefer not to answer

HP2. Which side(s) underwent carotid artery surgery/stent?

|_| Right
|_| Left
|_| Both
|_| Don't know

Blood Pressure

BP1. When was the last time you had your blood pressure measured by a health professional?

|_| Less than 6 months ago
|_| 6 months to less than 1 year ago
|_| 1 year to less than 2 years ago
|_| 2 or more years ago
|_| Never had blood pressure measured by a health professional → Skip to BP3
|_| Don't know → Skip to BP3

BP2. The last time your blood pressure was measured by a health professional (excluding during pregnancy), were you told that your blood pressure was high?

|_| Yes
|_| No
|_| Don't know

BP3. In the past month, have you taken any medication for high blood pressure?

|_| Yes
|_| No
|_| Don't know

BP4. In the past month, did you do anything else, recommended by a health care professional, to reduce or control your blood pressure?

|_| Yes
|_| No → Skip to CL1
|_| Don't know → Skip to CL1

BP5. What did you do? Please select all that apply.

|_| Reduce your salt intake
|_| Change the types of foods you eat (e.g., choosing more fruits and vegetables)

|_| Exercise more
|_| Lost weight
|_| Drink less alcohol
|_| Other → Specify _____
|_| Don't know

Cholesterol

CL1. Have you ever had your blood cholesterol measured?
|_| Yes
|_| No
|_| Don't know

CL2. Have you ever been told by a health professional that your blood cholesterol was high?
|_| Yes
|_| No → Skip to SY1
|_| Don't know → Skip to SY1

CL3. In the past month, did you take any prescription medications (for example Lipitor or Crestor) to control your blood cholesterol levels?
|_| Yes
|_| No
|_| Don't know

CL4. In the past month, did you do anything else, recommended by a health care professional, to reduce or control your blood cholesterol level?
|_| Yes
|_| No → Skip to SY1
|_| Don't know → Skip to SY1

CL5. What did you do? Select all that apply.
|_| Change the types of foods you eat (e.g., reducing your intake of foods high in saturated fat)
|_| Exercise more
|_| Lost weight
|_| Take non-prescription medications or dietary supplements
|_| Other → Specify _____
|_| Don't know

Syncope-Fainting

SY1. Have you ever lost consciousness (fainted)?
|_| Yes
|_| No – Skip to CP01
|_| Don't know – Skip to CP01

SY2. Under what condition(s) does this happen? Please select all that apply.
|_| Standing up quickly
|_| After standing for a long time
|_| Getting up from lying down
|_| After an injury/accident (e.g., concussion, head injury)
|_|
|_| During or after exercise
|_| After fasting for a long period of time
|_| On hot days
|_| At random
|_| Other

|_| Don’t know

SY3. Have you fainted or lost consciousness in the past year?
|_| Yes
|_| No
|_| Don’t know

Chest Pain on Effort
CP01. Have you ever had any pain or discomfort in your chest in the past year?
|_| Yes
|_| No → Skip to HF1
|_| Don’t know → Skip to HF1

CP02. Do you get it when you walk uphill or hurry?
|_| Yes
|_| No
|_| Never hurry or walk uphill
|_| Don’t know

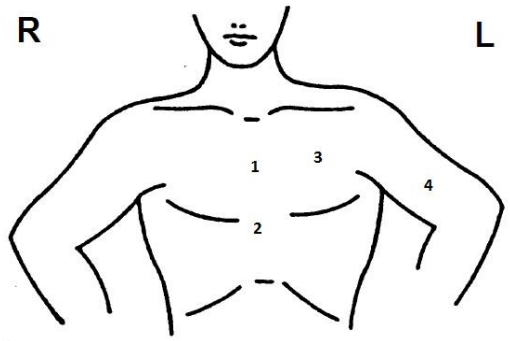
CP03. Do you get it when you walk at an ordinary pace on a level surface?
|_| Yes
|_| No
|_| Don’t know

CP04. What do you do if you get it while you are walking?
|_| Stop or slow down
|_| Carry on
|_| Don’t know

CP05. If you stand still, what happens to it?
|_| Relieved
|_| Not Relieved → Skip to CP07
|_| Don’t know → Skip to CP07

CP06. How soon do you feel relief upon standing still?
|_| 10 minutes or less
|_| More than 10 minutes
|_| Don’t know

CP07. Indicate where the chest pain occurred.
|_| 1: Sternum (upper or middle)
|_| 2: Sternum (lower)
|_| 3: Left anterior chest
|_| 4: Left arm
|_| Other
|_| Don’t know



CP08. Did you see a doctor because of this chest pain?
|_| Yes
|_| No → Skip to CP10
|_| Don't know → Skip to CP10

CP09. What was the doctor's diagnosis of this chest pain?
|_| Angina
|_| Other heart disease
|_| Heart attack
|_| Other
|_| Don't know

CP10. Were you hospitalized for this chest pain?
|_| Yes
|_| No
|_| Don't know

CP11. How long ago did you start getting this pain?
|_| Less than one month ago
|_| One month but less than 6 months ago
|_| 6 months but less than one year ago
|_| One year but less than two years ago
|_| Two years ago or more
|_| Don't know

CP12. Have you used nitroglycerin to relieve this pain in the past six months?
|_| Yes
|_| No → Skip to end of section
|_| Don't know → Skip to end of section

CP13. If yes, is nitroglycerin usually effective in relieving the pain?
|_| Yes
|_| No
|_| Don't know

Heart Failure Symptoms
HF1. In the last six months, did you have trouble breathing or shortness of breath?
|_| Yes
|_| No → Skip to HF3
|_| Don't know → Skip to HF3

HF2. In the last six months, …

	Yes	No	Don't know
… did you have trouble breathing or shortness of breath when hurrying on a level surface?	|_|	|_|	|_|
… did you have trouble breathing or shortness of breath when walking at ordinary pace on a level surface?	|_|	|_|	|_|
… did you stop for breath after walking 100 meters on a level surface?	|_|	|_|	|_|
… did you have difficulty breathing when you are not walking or active? (i.e. when at rest)	|_|	|_|	|_|

HF3. Have you ever had to sleep on 2 or more pillows in order to help you breathe?
|_| Yes
|_| No
|_| Don't know

HF4. Are there times when you wake up at night because you have difficulty breathing?
|_| Yes
|_| No
|_| Don't know

HF5. Have you ever had swelling of feet, or ankles (excluding during pregnancy)?
|_| Yes
|_| No → Skip to HF7
|_| Don't know →Skip to HF7

HF6. Does this swelling tend to come on during the day or go down overnight?
|_| Yes
|_| No
|_| Don't know

HF7. Are you currently taking medications for heart failure?
|_| Yes
|_| No
|_| Don't know

NEUROLOGY & MEMORY

Your visit to the assessment centre will include a series of short tests that measure your alertness, attention span and memory. Your answers to the following questions will help researchers interpret your responses.

Traumatic Brain Injury
The following questions are about head and neck injuries in your past. Please indicate whether or not you have experienced each scenario.

	Yes	No	Don't know
TBI01. Have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.	|_|	|_|	|_|
TBI02. Have you ever injured you head or neck in a car accident or from some other moving vehicle accident?	|_|	|_|	|_|
TBI03. Have you ever injured your head or neck in a fall or from being hit by something?	|_|	|_|	|_|
TBI04. Have you ever injured your head or neck in a fight, from being hit by someone or being shaken violently? This may have occurred in sports such as hockey, boxing or martial arts.	|_|	|_|	|_|
TBI05. Have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat-related incidents.	|_|	|_|	|_|

If TBI1 to TBI5 are "no" then go to RH01.

TBI06. Were you knocked out following any of the injuries you mentioned above? Do not include losing consciousness due to drug overdose or from being choked.
|_| Yes
|_| No → Skip to RH01
|_| Don't know → Skip to RH01

TBI07. How many times in total have you been knocked out?
_____ →If 5 or less skip TBI09 to TBI12
|_| Don't know → Skip TBI09 to TBI12

TBI08 How long were you knocked out? ***For each incident, please answer in hours or minutes***
1: ___ Hour(s) ___Minutes Age_____
2: ___ Hour(s) ___Minutes Age_____
3: ___ Hour(s) ___Minutes Age_____
4: ___ Hour(s) ___Minutes Age_____
5: ___ Hour(s) ___Minutes Age_____

TBI10. What was the longest period of time you were knocked out? : ___ Hour(s) ___Minutes

TBI11. Thinking about all of the times you were knocked out, how many lasted longer than 30 minutes? _____

TBI12. How old were you the first time you were knocked out? _____ years

TBI13. Were you dazed or do you have a gap in your memory from the injury(ies) you mentioned above? (Exclude alcohol blackouts)
|_| Yes
|_| No
|_| Don't know

RESPIRATORY HEALTH

Your assessment centre visit will include a measurement that evaluates how well you are able to move air into and out of your lungs. The following questions will provide researchers with additional information about your lungs and how well you breathe.

RH01. What is the least amount of activity that would make you short of breath?
|_| Light household activities, getting dressed, or just sitting at rest
|_| Walking up to 100 m on level ground
|_| Walking more than 100 m on level ground at your own pace
|_| Walking up a slight hill or hurrying on level ground
|_| Only with strenuous exercise
|_| Don’t know

RH02. Do you have a cough on most days that has lasted for at least 8 weeks?
|_| Yes
|_| No
|_| Don't know

RH03. On most days do you cough up phlegm?
|_| Yes
|_| No
|_| Don't know

RH04. Do you get frequent colds that go to your chest and persist longer than those of other people you know?
|_| Yes
|_| No
|_| Don't know

EMOTIONAL HEALTH & WELL-BEING

Research has shown that our state of mind can impact many aspects of our physical health. Mental health problems like depression are a significant issue for many Canadians and play a role in the development of several chronic diseases. The following questions ask you about your emotional health and well-being. Your responses to these questions will help researchers examine the relationship between our mental health and our physical health.

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 & BODY PAIN

Pain can affect every aspect of our physical and mental health. 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. We would also like you to tell us if you have ever broken or fractured any of your bones. The assessment centre visit includes several measurements of how well you move and the health of your bones. Your responses to the following questions will help researchers interpret those measurements.

P01. Have any of your joints been troublesome (painful, aching, swollen or stiff) on MOST DAYS of the PAST MONTH?
|_| Yes
|_| No → Skip to P03
|_| Don't know → Skip to P03
|_| Prefer not to answer → Skip to P03

P02. 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

P03. Have you had any headaches or body pain on MOST DAYS of the PAST MONTH?
|_| Yes
|_| No
|_| Don't know
|_| Prefer not to answer

P04. Have you had any numbness or tingling or weakness during the PAST MONTH?
|_| Yes
|_| No → Skip to P03
|_| Don't know → Skip to P03

Please select whether or not this condition occurred on the left side and/or right side of your body.

	Yes, on left side	Yes, on right side	No, neither side	Don't know
P05. Numbness in arm	|_|	|_|	|_|	|_|
P06. Tingling in arm	|_|	|_|	|_|	|_|
P07. Weakness in arm	|_|	|_|	|_|	|_|
P08. Numbness in hand	|_|	|_|	|_|	|_|
P09. Tingling in hand	|_|	|_|	|_|	|_|
P10. Weakness in hand	|_|	|_|	|_|	|_|
P11. Numbness in leg	|_|	|_|	|_|	|_|
P12. Tingling in leg	|_|	|_|	|_|	|_|
P13. Weakness in leg	|_|	|_|	|_|	|_|
P14. Numbness in foot	|_|	|_|	|_|	|_|
P15. Tingling in foot	|_|	|_|	|_|	|_|
P16. Weakness in foot	|_|	|_|	|_|	|_|

Fracture History
P17. Have you had a fall over the last year?
□ Yes
□ No→ Skip to P19
□ Don't know→ Skip to P19

P18. How many falls have you had? _____

P19. Have you ever fractured a bone?
□ Yes
□ No→ Skip to EH01
□ Don't know→ Skip to EH01

P20. What bone(s) did you fracture (please select all that apply)?
|_| Hand ----------> Age at most recent fracture: _____
|_| Wrist ----------> Age at most recent fracture: _____
|_| Lower Arm ----------> Age at most recent fracture: _____
|_| Upper Arm ----------> Age at most recent fracture: _____
|_| Shoulder/Clavicle ----------> Age at most recent fracture: _____
|_| Ribs/Sternum ----------> Age at most recent fracture: _____

|_| Spine ----------> Age at most recent fracture: _____
|_| Pelvis ----------> Age at most recent fracture: _____
|_| Hip ----------> Age at most recent fracture: _____
|_| Femur (Thigh bone) ----------> Age at most recent fracture: _____
|_| Tibia (Shin bone) ----------> Age at most recent fracture: _____
|_| Ankle ----------> Age at most recent fracture: _____
|_| Foot ----------> Age at most recent fracture: _____
|_| Other (please specify) _____ Age at most recent fracture: _____

SLEEP

Sleep disorders are becoming more common in the Canadian population. The amount and quality of sleep we receive each night can influence many aspects of our health, including mental alertness and blood pressure. The following questions ask you about your sleep and your experience while you are trying to fall asleep.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in the past month. Even if you have not done some of these things recently, try to work out how they have affected you.

	Never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	Don't know
S01. Sitting and reading	|_|	|_|	|_|	|_|	|_|
S02. Watching TV	|_|	|_|	|_|	|_|	|_|
S03. Sitting quietly in a public place (e.g., in a theatre or meeting)	|_|	|_|	|_|	|_|	|_|
S04. As a passenger in a car for an hour without a break	|_|	|_|	|_|	|_|	|_|
S05. Lying down to rest in the afternoon when circumstances permit	|_|	|_|	|_|	|_|	|_|
S06. Sitting and talking to someone	|_|	|_|	|_|	|_|	|_|
S07. Sitting quietly after a lunch without alcohol	|_|	|_|	|_|	|_|	|_|
S08. In a car, while stopped for a few minutes in traffic	|_|	|_|	|_|	|_|	|_|

During the past month, have you experienced the following?

	Never	Rarely (has occurred less than once a week)	Sometimes (1-2 times per week)	Frequently (3-4 times per week)	Always or Almost Always (5-7 times per week)	Don't know
S09. No matter how much sleep you had, you didn't wake up feeling rested	|_|	|_|	|_|	|_|	|_|	|_|
S10. Needed to wake up from sleep to use the toilet two or more times	|_|	|_|	|_|	|_|	|_|	|_|

S11. Do you snore?
|_| Yes
|_| No → Skip to PM01
|_| Don't know → Skip to PM01

S12. Your snoring is:
|_| Slightly louder than breathing
|_| As loud as talking
|_| Louder than talking
|_| Very loud – can be heard in adjacent rooms
|_| Don't know

S14. How often do you snore?
|_| Nearly every day
|_| 3-4 times a week
|_| 1-2 times a week
|_| 1-2 times a month
|_| Never or nearly never
|_| Don't know

S15. Has your snoring ever bothered other people?
|_| Yes
|_| No
|_| Don't know

S16. Has anyone noticed that you quit breathing during your sleep?
|_| Nearly every day
|_| 3-4 times a week
|_| 1-2 times a week
|_| 1-2 times a month
|_| Never or nearly never
|_| Don't know

PERSONAL MEDICAL HISTORY

Your own personal medical history is one of the most important factors that will affect the interpretation of your physical measurements. Many participants coming to the assessment centre will have completed the baseline questionnaire over a year ago, and so we are repeating a small number of questions to make sure the interpretation of your physical measures is as accurate as possible. Please complete the following questions so that we have the most up-to-date information about your health.

PM01. Over the last 12 months, has a doctor told you that you have cancer?
|_| Yes
|_| No – Skip to PM02
|_| Don't know – Skip to PM02
|_| Prefer not to answer – Skip to PM02

Please select all that apply.

|_| Prostate
|_| Lung and/or 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
|_| Brian - Malignant tumour
|_| Ovary
|_| Multiple myeloma
|_| Liver
|_| Esophagus
|_| Cervix
|_| Larynx
|_| Testicular
|_| Trachea
|_| Anal
|_| Other (please specify):_____

(For each cancer selected, the following question will be asked:)
Did you receive treatment for this cancer?
|_| Yes ----------> What type of treatment was it? (Choose ALL that apply).
|_| No

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

|_| Chemotherapy
|_| Radiation
|_| Surgery
|_| Don't know
|_| Prefer not to answer
|_| Other (Please specify): _____

Heart and Circulatory System

PM02. Over the last 12 months, has a doctor told you that you have any of the following heart conditions? Please select all that apply.

|_| High blood pressure (hypertension)
|_| Heart attack (myocardial infarction)
|_| High cholesterol
|_| Angina
|_| Heart failure
|_| Atrial fibrillation
|_| Aortic stenosis
|_| Mitral stenosis
|_| Mitral valve prolapse
|_| Other heart condition (please specify) _____

|_| No – Skip to PM03
|_| Don't know – Skip to PM03
|_| Prefer not to answer – Skip to PM03

For each condition selected:

For each condition selected:

Are you taking prescribed medications or receiving treatment for the condition?
|_| Yes
|_| No
|_| Don't know

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

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

Neurological Conditions

PM03. Over the last 12 months, has a doctor told you that you have any of the following neurological conditions? Please select all that apply.

|_| Stroke
|_| Transient ischemic attack (TIA)
|_| Migraine
|_| Brain tumour
|_| Epilepsy or seizure
|_| Multiple sclerosis
|_| Parkinson's disease
|_| Dementia

|_| Brain Injury
|_| Autism or autism spectrum disorder
|_| Spinal cord injury
|_| Other neurological condition (please specify) _____

|_| No – Skip to PM04
|_| Don't know – Skip to PM04
|_| Prefer not to answer – Skip to PM04

For each condition selected:
Are you taking prescribed medications or receiving treatment for the condition?
|_| Yes
|_| No
|_| Don't know

Lung/Respiratory Conditions
PM04. Over the last 12 months, has a doctor told you that you have any of the following lung or respiratory conditions? Please select all that apply.
|_| Asthma
|_| Chronic obstructive pulmonary disorder (COPD)
|_| Chronic bronchitis
|_| Emphysema
|_| Sleep Apnea
|_| Other Breathing Condition (please specify)_____

|_| No – Skip to PM05
|_| Don't know – Skip to PM05
|_| Prefer not to answer – Skip to PM05

For each condition selected:
Are you taking prescribed medications or receiving treatment for the condition?
|_| Yes
|_| No
|_| Don't know

Endocrine or Metabolic Conditions
PM05. Over the last 12 months, has a doctor told you that you have diabetes?
|_| Yes
|_| No – Skip to PM06
|_| Don't know – Skip to PM06
|_| Prefer not to answer – Skip to PM06

If diabetes selected:
Which **type** of diabetes was it? Please select all that apply.
|_| Gestational (during pregnancy) diabetes
|_| Type 1 diabetes
|_| Type 2 diabetes
|_| Don't know

Are you taking prescribed medications or receiving treatment for diabetes?
|_| Yes
|_| No

|_| Don't know

PM06. Over the last 12 months, has a doctor told you that you have thyroid disease?
|_| Yes
|_| No – Skip to PM07
|_| Don't know – Skip to PM07
|_| Prefer not to answer – Skip to PM07

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

Are you taking prescribed medications or receiving treatment for thyroid disease?
|_| Yes
|_| No
|_| Don't know

Kidney
PM07. Over the last 12 months, has a doctor told you that you have kidney disease or failing or weak kidneys?
|_| Yes
|_| No – Skip to PM08
|_| Don't know – Skip to PM08
|_| Prefer not to answer – Skip to PM08

(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

Are you taking prescribed medications or receiving treatment for kidney disease?
|_| Yes
|_| No
|_| Don't know

Mental Health Conditions
PM08. Over the last 12 months, has a doctor told you that you have any of the following mental health conditions? Please select all that apply.
|_| Major depression |_| Post-traumatic stress disorder

|_| Bipolar disorder
|_| Schizophrenia or schizoaffective disorder
|_| Anxiety disorder
|_| Obsessive compulsive disorder
|_| Eating disorder
|_| Addiction disorder (e.g., alcohol, drug or gambling dependence)
|_| Other _____

|_| No – Skip to PM09
|_| Don't know – Skip to PM09
|_| Prefer not to answer – Skip to PM09

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

For each condition selected:
Are you taking prescribed medications or receiving treatment for the condition?
|_| Yes
|_| No
|_| Don't know

Bone and Joint Conditions
PM09. Over the last 12 months, has a doctor told you that you have any of the following musculoskeletal conditions?? Please select all that apply.
|_| Osteoporosis
|_| Arthritis
|_| Gout
|_| Lupus
|_| Other _____
|_| Chronic back pain
|_| Chronic neck pain
|_| Fibromyalgia

|_| No – Skip to EE01
|_| Don't know – Skip to EE01
|_| Prefer not to answer – Skip to EE01

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

For each condition selected:

For each condition selected:
Are you taking prescribed medications or receiving treatment for the condition?
|_| Yes
|_| No
|_| Don't know

WOMEN ONLY

Our risk for developing many different health problems can be influenced by our sex. The following questions ask about experiences and decisions that are relevant to the health of women.

The following questions will be asked only of participants over the age of 35:

EE01. Over the last 12 months, 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 EE03
|_| Don't know → Skip to EE03
I_I Prefer not to answer → Skip to EE03

EE02. How old were you when your menstrual periods stopped for at least one year and did not restart?
|_| Age when menstrual periods stopped: _____ - Skip to AU01
|_| Don't know - Skip to AU01
|_| Prefer not to answer - Skip to AU01

EE03. In the past year, have you skipped any periods? (A skipped period is double your usual cycle length with no period).
|_| Yes
|_| No – Skip to AU01
|_| Don't know - Skip to AU01

EE04. How many periods did you skip?
|_|_| # Skipped periods
|_| Don't Know

EE5. In the past year, what is the longest length of time you have gone without getting your period?
|_| ≥ 90 days
|_| 60 – 89 days
|_| 35 – 59 days
|_| < 35 days
|_| Don't know

ALCOHOL USE

The next few questions ask you about the amount of alcohol you consume in a typical day. Alcohol consumption affects many other areas of health and disease, and can influence how researchers interpret some of the measurements we will record at the assessment centre.

AU01. 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 AU03; Women: skip to AU04
|_| About once a month → Men: skip to AU03; Women: skip to AU04
|_| Less than monthly → Men: skip to AU03; Women: skip to AU04
|_| I do not drink alcohol → Skip to TU01
|_| Don't know → Skip to TU01

AU02. On average, how many drinks do you have during a typical week?
|_| Drinks per week: _____
|_| None
|_| Don't know

MEN ONLY, WOMEN SKIP TO AU04

AU03. 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

WOMEN ONLY, MEN SKIP TO TU01

AU04. 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

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 questions about cigarettes.

TU01. 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 TU06
|_| Not at all (You did not smoke at all in the past 30 days) → Skip to TU08
I_I Prefer not to answer → Skip to TU08

TU02. At what age did you begin smoking cigarettes daily?
|_| Age: _____
I_I Prefer not to answer

TU03. How many cigarettes do you smoke each day now?
|_| 1 - 5 cigarettes
|_| 6 - 10 cigarettes
|_| 11 - 15 cigarettes
|_| 16 - 20 cigarettes
|_| 21 - 25 cigarettes
|_| 26+ cigarettes ---------->How many? _____
I_I Prefer not to answer

TU04. For how many total years have you smoked daily?
|_| Years: _____
|_| Prefer not to answer

TU05. 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 TU13

TU06. 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

TU07. 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

TU08. Have you ever smoked cigarettes daily? (At least one cigarette a day for 30 days in a row)
|_| Yes
|_| No → Skip to TU13
|_| Don't know → Skip to TU13
|_| Prefer not to answer → Skip to TU13

TU09. At what age did you begin to smoke daily?
|_| Age: _____
|_| Prefer not to answer

TU10. 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

TU11. For how many total years did you smoke daily?
|_| Years: _____
|_| Prefer not to answer

TU12. 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

TU13. 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

TU14. 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

TU15. In your lifetime, have you ever used **other types of tobacco** on a regular basis and for a period of at least six months? Other types of tobacco include cigars, pipes and chewing tobacco.
|_| Yes
|_| No
|_| Don't know

FINAL EVALUATION

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

1. I found the questionnaire easy to use.
   |_| Strongly agree
   |_| Agree
   |_| Neutral
   |_| Disagree
   |_| Strongly disagree

2. Is there anything else you would like to tell us about your experience completing this questionnaire?

_____
_____
_____
_____
_____
_____

Thank you for completing the questionnaire! Please click **"Finish"** and then make an appointment for your assessment centre visit using our convenient online booking program. We look forward to seeing you!