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ID No.

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CONFIDENTIAL

The Canterbury Health Questionnaire

How to complete this questionnaire

INSTRUCTIONS

Please use a black/blue pen

To answer each question you just need to tick [✓] the appropriate response box.

Example: In general, would you say your health is: (Tick one only)

- | | |
|-----------|---|
| Excellent | [] |
| Very good | [] |
| Good | [✓] <i>You would tick this one if you think your health is good</i> |
| Fair | [] |
| Poor | [] |

If you have any questions or need help filling in this questionnaire please contact **Canterbury Chronic Diseases Study**

c/- Clinical Pharmacology

Private Bag 4710

Christchurch Hospital

CHRISTCHURCH 8140

Tel: 03 364 1858 **Email:** chronicdiseases.study@otago.ac.nz

<http://www.uoc.otago.ac.nz/research/chronic/index.htm>

If you do NOT want to participate in this study
PLEASE return the blank questionnaire to us in the pre-paid envelope provided.

Thank-you for your help with this important research

Section A

First we would like to ask you about some particular medical conditions. You may not know what these are, but they will be familiar to you if you or someone in your family has been diagnosed with them.

As some of these conditions tend to run in families, we are interested in whether YOU or anyone in your FAMILY has EVER had these conditions. By FAMILY we mean your immediate biological mother, father, brothers, sisters, sons and daughters.

This list does not contain all medical conditions. There is room on page 5 to write down any other medical conditions that you or your family have.

1	Have you or anyone in your FAMILY EVER been diagnosed with or treated for any of these specific conditions (please tick TWO boxes on each line)	YOURSELF		FAMILY MEMBER		Affected family member(s) (please list)
		Yes	No	Yes	No	
a	Diabetes <i>(a condition where the body is unable to automatically regulate blood sugar levels)</i>	[]	[]	[]	[]	
b	Heart disease <i>(includes heart attack, angina and heart failure)</i>	[]	[]	[]	[]	
c	High Blood Pressure <i>(hypertension; persistently high blood pressure)</i>	[]	[]	[]	[]	
d	Thyroid disease <i>(abnormally high or low levels of thyroid hormones)</i>	[]	[]	[]	[]	
e	Osteoporosis <i>(a disease that thins the bone in the skeleton resulting in an increased chance of fractures especially in older people)</i>	[]	[]	[]	[]	
f	Asthma <i>(a disease that affects the airways in the lungs causing difficulties in breathing)</i>	[]	[]	[]	[]	
g	Eczema <i>(a rash of the skin which may be itchy)</i>	[]	[]	[]	[]	
h	Multiple sclerosis <i>(a disease affecting the nervous system, primarily the brain and spinal cord)</i>	[]	[]	[]	[]	
i	Gout <i>(a disease caused by build up of uric acid crystals on cartilage of joints, tendons & surrounding tissue)</i>	[]	[]	[]	[]	

j	Appendicitis <i>(inflammation of the appendix, usually requiring surgery)</i>	[]	[]	[]	[]	
k	Psychological Disorders <i>(includes anxiety, depression, panic attacks, schizophrenia etc)</i>	[]	[]	[]	[]	

2	Have you or anyone in your FAMILY EVER been diagnosed with or treated for any of these specific conditions that may reflect an altered immune system (please tick TWO boxes on each line)	YOURSELF		FAMILY MEMBER		Affected family member(s) <i>(please list)</i>
		No	Yes	No	Yes	
a	Rheumatoid arthritis <i>(painful, swollen joints with inflammation and deformity)</i>	[]	[]	[]	[]	
b	Lupus <i>(red scaly rash on the face, arthritis, damage to kidneys and other internal organs)</i>	[]	[]	[]	[]	
c	Coeliac disease <i>(intolerance to gluten, affects the digestion and absorption of nutrients)</i>	[]	[]	[]	[]	
d	Psoriasis <i>(scaly patches on the body and scalp that may itch, sting and occasionally bleed)</i>	[]	[]	[]	[]	
e	Liver disease <i>(For example cirrhosis of the liver. Causes include fatty liver disease, viruses causing hepatitis, primary biliary cirrhosis)</i>	[]	[]	[]	[]	
f	Ankylosing spondylitis <i>(a form of arthritis affecting the spine)</i>	[]	[]	[]	[]	
g	Sjogren's Syndrome <i>(a disease where the body's own immune system especially attacks its own moisture-producing glands)</i>	[]	[]	[]	[]	

3	Have you or anyone in your FAMILY EVER been diagnosed with or treated for any of these stomach and/or bowel conditions Please remember to tick the YES box if you have ever been diagnosed with any of these conditions but have since been cured or are in remission (please tick TWO boxes on each line)	YOURSELF		FAMILY MEMBER		Affected family member(s) (please list)
		No	Yes	No	Yes	
a	Ulcerative colitis (inflammation of the large bowel, e.g. colon and rectum causing diarrhoea and the passage of blood)	[]	[]	[]	[]	
b	Crohn's disease (inflammation of the full thickness of the intestine involving any part of the digestive tract from the mouth to the anus)	[]	[]	[]	[]	
c	Indeterminate colitis (a diagnosis given to patients when it is impossible to distinguish between ulcerative colitis and Crohn's disease)	[]	[]	[]	[]	
d	Helicobacter pylori infection of the stomach (can result in stomach ulcers and is treated with antibiotics)	[]	[]	[]	[]	
e	Irritable bowel syndrome (chronic abdominal pain, bloating, constipation and/or diarrhoea of unknown cause)	[]	[]	[]	[]	

4	Have you or anyone in your FAMILY EVER been diagnosed with any of the following cancers Please remember to tick the YES box if you have ever been diagnosed with cancer but have since recovered or are in remission (please tick TWO boxes on each line)	YOURSELF		FAMILY MEMBER		Affected family member(s) (please list)
		No	Yes	No	Yes	
a	Bowel cancer	[]	[]	[]	[]	
b	Breast cancer	[]	[]	[]	[]	
c	Prostate cancer	[]	[]	[]	[]	

d	Other cancer <i>(Please write down)</i>	[]	[]	[]	[]	
		[]	[]	[]	[]	
		[]	[]	[]	[]	
		[]	[]	[]	[]	

5	Please write down any other medical conditions that you or other members of your family have EVER been diagnosed with: <i>(please tick TWO boxes on each line)</i>	YOURSELF		FAMILY MEMBER		Affected family member(s) <i>(please list)</i>
		No	Yes	No	Yes	
a		[]	[]	[]	[]	
b		[]	[]	[]	[]	
c		[]	[]	[]	[]	
d		[]	[]	[]	[]	
e		[]	[]	[]	[]	
f		[]	[]	[]	[]	
g		[]	[]	[]	[]	
h		[]	[]	[]	[]	
i		[]	[]	[]	[]	
j		[]	[]	[]	[]	
k		[]	[]	[]	[]	
l		[]	[]	[]	[]	
m		[]	[]	[]	[]	

Section B

Now we would like to ask you about medications you may have taken in the
PAST 12 MONTHS

6	How often have you taken ASPIRIN in the past 12 months <i>(Please tick one box only)</i> <i>(Examples are Aspec, Aspro, Aspro Clear, Disprin)</i>	Never	[]
		Occasionally	[]
		Less than once a month	[]
		2-3 times a month	[]
		Once a week	[]
		2-3 times a week	[]
		4-7 times a week	[]
		Twice or more per day	[]
7	How often have you taken ANTIBOTICS in the past 12 MONTHS? <i>(Please tick one box only)</i> <i>(amoxicillin, erythromycin, trimethoprin, Augmentin)</i>	Never	[]
		Less than 1 course	[]
		1-2 courses	[]
		3-5 courses	[]
		More than 5 courses	[]
8	How often have you taken ANTI-INFLAMMATORY DRUGS in the past 12 MONTHS? <i>(Please tick one box only)</i> <i>(Examples are ibuprofen, Nurofen, Voltaren, diclofenac, naproxen, I-Profen)</i>	Never	[]
		Occasionally	[]
		Less than once a month	[]
		2-3 times a month	[]
		Once a week	[]
		2-3 times a week	[]
		4-7 times a week	[]
Twice or more per day	[]		
9	How often have you taken STEROID tablets in the past 12 months? <i>(Please tick one box only)</i> <i>(Examples are prednisone, dexamethasone, hydrocortisone)</i>	Never	[]
		Occasionally	[]
		Less than once a month	[]
		2-3 times a month	[]
		Once a week	[]
		2-3 times a week	[]
		4-7 times a week	[]
Twice or more per day	[]		
10	How often have you taken either STEROID inhalers (e.g. puffers) or used STEROID ointments or creams in the past 12 MONTHS? <i>(Please tick one box only)</i> <i>(Examples are Beclazone, beclomethasone, Pulmicort, Flixotide, hydrocortisone, Locoid-C, Dermal, Eumovate, Betnovate)</i>	Never	[]
		Occasionally	[]
		Less than once a month	[]
		2-3 times a month	[]
		Once a week	[]
		2-3 times a week	[]
		4-7 times a week	[]
Twice or more per day	[]		

Section D

Now we would like to ask you some questions about your ALCOHOL INTAKE

15.	Which of these best describes YOU? <i>(Please tick one box only)</i>	I am a life-long NON-drinker <i>(Please go to Section E)</i>	[]
		I currently drink alcohol <i>(Please go to question 17)</i>	[]
		I used to drink alcohol <i>(Please go to question 16)</i>	[]

16.	When did you stop drinking alcohol? <i>(Please write down & go to Section E)</i> <div style="text-align: center;"> _____ weeks ago or _____ months ago or _____ years ago </div>
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17.	How old were you when you first started to drink alcohol at least once a month? <i>(Please write down)</i> <div style="text-align: right;">_____ years old</div>
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18.	On how many DAYS in a typical week do you drink ANY alcohol? <i>(Please tick one box only)</i>	None	[]
		Less than 1 day per week	[]
		1 day	[]
		2 days	[]
		3 days	[]
		4 days	[]
		5 days	[]
		6 days	[]
	7 days	[]	

The next question refers to a standard drink:

Beer: 1 stubby or can (373ml or 12oz)
 Wine: 1 medium glass (125ml or 4oz)
 Port or sherry: 1 small glass (60ml or 2oz)
 Spirits/liqueur: 1 nip (30ml or 1oz)

19.	How many alcoholic drinks do you usually have each week? <i>(Please tick one box only)</i>	None	[]
		Less than 1	[]
		1	[]
		2-4	[]
		5-6	[]
		7-13	[]
		14-20	[]
		21-27	[]
	28 or more	[]	

Section E

Finally we would like to ask you a few general questions about yourself.
These questions are about your nationality, ethnicity, education etc. We are interested in finding out whether these factors are linked to the development of medical conditions in any way. Most of these questions come directly from the census you may have filled in. Your answers will be kept strictly confidential.

20.	Are you male or female?	Male	[]
		Female	[]

21.	What is your date of birth? <i>(Please write down)</i> day /month /year
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22.	In which country were you born? <i>(Please tick one box only)</i>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">New Zealand</td><td style="text-align: center; width: 10%;">[]</td></tr> <tr><td style="padding: 2px;">Australia</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">England</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Scotland</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Wales</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Ireland</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">The Netherlands</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Germany</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">France</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">China</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Japan</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Korea</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Pacific Islands <i>(e.g. Fiji, Samoa)</i></td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Other <i>(Please specify below)</i></td><td></td></tr> </table>	New Zealand	[]	Australia	[]	England	[]	Scotland	[]	Wales	[]	Ireland	[]	The Netherlands	[]	Germany	[]	France	[]	China	[]	Japan	[]	Korea	[]	Pacific Islands <i>(e.g. Fiji, Samoa)</i>	[]	Other <i>(Please specify below)</i>		
New Zealand	[]																														
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Japan	[]																														
Korea	[]																														
Pacific Islands <i>(e.g. Fiji, Samoa)</i>	[]																														
Other <i>(Please specify below)</i>																															

23.	What is your ancestry? <i>(You may tick more than one ancestry if necessary)</i>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">European <i>(e.g. UK, French, German, Dutch)</i></td><td style="text-align: center; width: 10%;">[]</td></tr> <tr><td style="padding: 2px;">New Zealand Maori</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Pacific Islander <i>(e.g. Samoan, Tongan)</i></td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Chinese</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Japanese</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Korean</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Indian</td><td style="text-align: center;">[]</td></tr> <tr><td style="padding: 2px;">Other <i>(Please specify below)</i></td><td></td></tr> </table>	European <i>(e.g. UK, French, German, Dutch)</i>	[]	New Zealand Maori	[]	Pacific Islander <i>(e.g. Samoan, Tongan)</i>	[]	Chinese	[]	Japanese	[]	Korean	[]	Indian	[]	Other <i>(Please specify below)</i>		
European <i>(e.g. UK, French, German, Dutch)</i>	[]																		
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Chinese	[]																		
Japanese	[]																		
Korean	[]																		
Indian	[]																		
Other <i>(Please specify below)</i>																			

24.	Are you descended from a New Zealand Maori? (i.e. do you have a Maori birth parent, grandparent, great-grandparent)	Yes	[]
		No	[]
		Unsure	[]

25.	What is the level of the highest qualification you have completed? <i>(Please write below. For example trade certificate, bachelor degree, diploma)</i>

26.	What is your current occupation?

27.	Were you breastfed as a baby? <i>(Please only tick one box)</i>	Yes	[]
		No	[]
		Unsure	[]

28.	If you were breastfed as a baby, for how long were you breastfed? <i>(Please only tick one box)</i>	0-2 months	[]
		3-6 months	[]
		6-12 months	[]
		More than 12 months	[]
		Unsure	[]

29.	How tall are you without shoes <i>(Please write below)</i>
centimetres or feet inches	

30.	How much do you weigh? <i>(Please write below)</i>
kilograms or stone pounds	

31.	If we have any extra questions or need to check any of your responses to this questionnaire can we contact you?	No	[]
		Yes <i>(please write down your phone number &/or e-mail)</i>	[]
		Phone number: E-mail address:	

If you have any additional information that you would like to provide for this study, please note this on the back page.

Please post this questionnaire AND the blue copy of your **SIGNED consent** form back to us in the stamped self-addressed envelope provided.

THANK-YOU FOR FILLING IN THIS QUESTIONNAIRE