

The Intergenerational Health Effects of Service in the Military

Appendix 8

Questionnaire – mothers

Revised
June 2007



CENTRE FOR MILITARY & VETERANS' HEALTH

Section 1: Your health
DIAGNOSED OR TREATED MEDICAL CONDITIONS

We would like to know whether a medical doctor has ever diagnosed you with, or treated you for, any of the following medical problems or conditions. **If YES**, please indicate the year you were first diagnosed, and whether you have been treated by a medical doctor for this condition in the **past year**.

1. Has a medical doctor ever diagnosed you with, or treated you for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Heart disease or condition	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Motor neurone disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other lung disease e.g. emphysema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stomach or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Colitis / Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hepatitis or yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Cirrhosis of the liver	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bowel disorder e.g. diarrhoea, constipation, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Kidney disease e.g. stones, infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bladder disease e.g. infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Incontinence or difficulty passing urine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
A thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malaria	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Dengue	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

1. Has a medical doctor ever diagnosed you with, or treated you for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Any significant infections	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Leishmaniasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Filariasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fibrositis or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Back or neck problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Joint problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eye or vision problems e.g. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malignant melanoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other skin cancer e.g. squamous cell or basal cell skin cancers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other kind of cancer, tumour or malignancy (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
More than 25 moles on your body	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other skin problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the hair or scalp, including hair loss.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Alcohol abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Drug abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Anxiety, stress or depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Post Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other psychiatric or psychological condition needing treatment or counselling (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sleep apnoea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

1. Has a medical doctor ever diagnosed you with, or treated you for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fungal disease or candidiasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple chemical sensitivity or environmental illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sick building syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Food allergy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the genital organs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

2. Apart from those listed in the table above, are there any other medical problems or conditions which a medical doctor has diagnosed you with, or treated you for?

NO YES

If YES, please complete the following table indicating which condition/s, what year were you first diagnosed, and have you been treated for that condition by a medical doctor in the past year?

Which condition?	Year first diagnosed	Has this condition been treated by a doctor in the past year?
		<input type="checkbox"/> NO <input type="checkbox"/> YES
		<input type="checkbox"/> NO <input type="checkbox"/> YES
		<input type="checkbox"/> NO <input type="checkbox"/> YES
		<input type="checkbox"/> NO <input type="checkbox"/> YES

DRUGS AND ALCOHOL

1. Over your lifetime, would you have smoked as much as 100 cigarettes or a similar amount of tobacco?

- YES NO

2. Do you currently smoke as much as one cigarette per day (or 1 cigar per week or 1 gram of tobacco per month)?

- YES NO

If YES:

a. How old were you when you started smoking as much as one cigarette per day (or 1 cigar per week or 1 gram of tobacco per month)?

_____ Age in years

b. What is the average number of cigarettes per day, grams of tobacco per day and/or number of cigars per week that you currently smoke?

_____ Cigarettes per day
_____ Grams of tobacco per day (do not include tobacco
from Cigarettes or cigars)
_____ Cigars per week

3. Have you ever smoked as much as one cigarette per day (or 1 cigar per week or 1 gram of tobacco per month)?

- YES NO

If YES:

a. How old were you when you started smoking as much as one cigarette per day (or 1 cigar per week or 1 gram of tobacco per month)?

_____ Age in years

b. How old were you when you stopped smoking as much as one cigarette per day (or 1 cigar per week or 1 gram of tobacco per month)?

_____ Age in years

c. What was the average number of cigarettes per day, grams of tobacco per day and/or number of cigars per week that you smoked?

_____ Cigarettes per day
_____ Grams of tobacco per day (don't include
tobacco from cigarettes or cigars)
_____ Cigars per week

4. About how tall are you, without shoes?

5. About how much do you weigh?

(Note: If pregnant at the moment, write in your usual weight when not pregnant)

6. How often do you have a drink containing alcohol?

- Never Less than once a month Monthly Weekly Daily or almost daily

If **NEVER**, go to question the next section.

In answering the following questions, please remember that a standard drink contains 10g of pure alcohol



7. How many 'standard' drinks (see above) containing alcohol do you have on a typical day when you are drinking?

- 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

8. How often do you have six or more drinks on one occasion?

<input type="checkbox"/> Never	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
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9. How often during the last year have you found that you were not able to stop drinking once you had started?

- Never Less than once a month Monthly Weekly Daily or almost daily

10. How often during the last year have you failed to do what was normally expected from you because of drinking?

<input type="checkbox"/> Never	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
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11. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?

<input type="checkbox"/> Never	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
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12. How often during the last year have you had a feeling of guilt or remorse after drinking?

<input type="checkbox"/> Never	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
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13. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

<input type="checkbox"/> Never	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily
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14. Have you or someone else been injured as a result of your drinking?

<input type="checkbox"/> No	<input type="checkbox"/> Yes, but not in the last year	<input type="checkbox"/> Yes, during the last year
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15. Has a relative, a friend, a doctor or other health professional been concerned about your drinking or suggested you cut down?

<input type="checkbox"/> No	<input type="checkbox"/> Yes, but not in the last year	<input type="checkbox"/> Yes, during the last year
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YOUR MENTAL HEALTH

	Better than usual	Same as Usual	Less than usual	Much less than usual
	▼	▼	▼	▼
1. Have you recently been able to concentrate on whatever you're doing?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	Not at all	No more than usual	Rather more than usual	Much more than usual
	▼	▼	▼	▼
2. Have you recently lost much sleep over worry?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	More so than usual	Same as usual	Less so than usual	Much less capable
	▼	▼	▼	▼
3. Have you recently felt that you are playing a useful part in things?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Have you recently felt capable of making decisions about things?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	Not at all	No more than usual	Rather more than usual	Much more than usual
	▼	▼	▼	▼
5. Have you recently felt constantly under strain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Have you recently felt you couldn't overcome your difficulties?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	More so than usual	Same as usual	Less so than usual	Much less capable
	▼	▼	▼	▼
7. Have you recently been able to enjoy your normal day-to-day activities?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

8. Have you recently been able to face up to your problems?

1234

Not at all

No more than usual

Rather more than usual

Much more than usual



9. Have you recently been feeling unhappy and depressed?

1234

10. Have you recently been losing confidence in yourself?

1234

11. Have you recently been thinking of yourself as a worthless person?

1234

More so than usual

Same as usual

Less so than usual

Much less capable



12. Have you recently been feeling reasonably happy, all things considered?

1234

13. In the past month, about how often did you feel tired for no good reason?

All of the Time

Most of the time

Some of the time

A little of the time

None of the time

14. In the past month, about how often did you feel nervous?

All of the Time

Most of the time

Some of the time

A little of the time

None of the time

15. In the past month, about how often did you feel so nervous that nothing could calm you down?

All of the Time

Most of the time

Some of the time

A little of the time

None of the time

16. In the past month, about how often did you feel hopeless?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| All of the Time | Most of the time | Some of the time | A little of the time | None of the time |

17. In the past month, about how often did you feel restless or fidgety?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| All of the Time | Most of the time | Some of the time | A little of the time | None of the time |

18. In the past month, about how often did you feel so restless that you could not sit still?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| All of the Time | Most of the time | Some of the time | A little of the time | None of the time |

19. In the past month, about how often did you feel depressed?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| All of the Time | Most of the time | Some of the time | A little of the time | None of the time |

20. In the past month, about how often did you feel that everything was an effort?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| All of the Time | Most of the time | Some of the time | A little of the time | None of the time |

21. In the past month, about how often did you feel so sad that nothing could cheer you up?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| All of the Time | Most of the time | Some of the time | A little of the time | None of the time |

22. In the past month, about how often did you feel worthless?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| All of the Time | Most of the time | Some of the time | A little of the time | None of the time |

YOUR CHILDREN'S HEALTH AND YOUR PREGNANCY HISTORY

We would now like to ask you some questions about your pregnancy history. You may need to refer to your spouse/partner/s, or to your Child Health Record, to assist you in answering these questions. Your answers to these questions will help us compare your experience with information held in Australian National Registries, as well as the experiences of military personnel and their families as a whole.

1. How many times have you EVER been pregnant?

_____ times (please specify)

If your answer to question 1 is zero (0) please GO TO the next section.

If one or more, proceed with question 2.

2. If you answered YES in question 1 please provide additional information, if known, about those particular pregnancies in the following table. Please complete a separate column for each pregnancy – pregnancies involving twins/triplets will require multiple columns.

PREGNANCY OUTCOME	1st pregnancy	2nd pregnancy	3rd pregnancy	4th pregnancy	5th pregnancy
Was this a twin / multiple pregnancy? (If this was a multiple pregnancy please use one column for each child)	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES
Live birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Termination or Stillbirth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of the event/birth (please be as specific as you can)	___/___/___ day mth yr	___/___/___ day mth yr	___/___/___ day mth yr	___/___/___ day mth yr	___/___/___ day mth yr
Number of weeks pregnant At time of event/birth (if known) Note: Full term is 40 weeks	___ weeks <input type="checkbox"/> Not known	___ weeks <input type="checkbox"/> Not known	___ weeks <input type="checkbox"/> Not known	___ weeks <input type="checkbox"/> Not known	___ weeks <input type="checkbox"/> Not known
If live preterm birth, miscarriage, or,	_____	_____	_____	_____	_____

PREGNANCY OUTCOME	1st pregnancy	2nd pregnancy	3rd pregnancy	4th pregnancy	5th pregnancy
stillbirth please specify the cause (if known)	<input type="checkbox"/> Not known	<input type="checkbox"/> Not known	<input type="checkbox"/> Not known	<input type="checkbox"/> Not known	<input type="checkbox"/> Not known
In which State or Territory did the event/birth occur?	<input type="checkbox"/> NSW <input type="checkbox"/> QLD <input type="checkbox"/> VIC <input type="checkbox"/> ACT <input type="checkbox"/> WA <input type="checkbox"/> SA <input type="checkbox"/> TAS <input type="checkbox"/> NT <input type="checkbox"/> Overseas	<input type="checkbox"/> NSW <input type="checkbox"/> QLD <input type="checkbox"/> VIC <input type="checkbox"/> ACT <input type="checkbox"/> WA <input type="checkbox"/> SA <input type="checkbox"/> TAS <input type="checkbox"/> NT <input type="checkbox"/> Overseas	<input type="checkbox"/> NSW <input type="checkbox"/> QLD <input type="checkbox"/> VIC <input type="checkbox"/> ACT <input type="checkbox"/> WA <input type="checkbox"/> SA <input type="checkbox"/> TAS <input type="checkbox"/> NT <input type="checkbox"/> Overseas	<input type="checkbox"/> NSW <input type="checkbox"/> QLD <input type="checkbox"/> VIC <input type="checkbox"/> ACT <input type="checkbox"/> WA <input type="checkbox"/> SA <input type="checkbox"/> TAS <input type="checkbox"/> NT <input type="checkbox"/> Overseas	<input type="checkbox"/> NSW <input type="checkbox"/> QLD <input type="checkbox"/> VIC <input type="checkbox"/> ACT <input type="checkbox"/> WA <input type="checkbox"/> SA <input type="checkbox"/> TAS <input type="checkbox"/> NT <input type="checkbox"/> Overseas
Baby's sex	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not known	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not known	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not known	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not known	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not known
Birth weight (if known)	____ lbs ____ oz ____ kgs <input type="checkbox"/> Not known	____ lbs ____ oz ____ kgs <input type="checkbox"/> Not known	____ lbs ____ oz ____ kgs <input type="checkbox"/> Not known	____ lbs ____ oz ____ kgs <input type="checkbox"/> Not known	____ lbs ____ oz ____ kgs <input type="checkbox"/> Not known
Presence of birth defect (eg, cleft lip/palate)	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known
Presence of chromosomal abnormality (eg, Down syndrome)	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____ <input type="checkbox"/> Not known

3. For all of your liveborn children, have any of the children died, had a cancer or other serious health problem?

- If NO go to question 10.
- If YES please complete the rest of the table below.

PREGNANCY OUTCOME	1st pregnancy	2nd pregnancy	3rd pregnancy	4th pregnancy	5th pregnancy
Cancers?	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____	<input type="checkbox"/> NO <input type="checkbox"/> YES specify type _____
Other serious health	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES

problems?	specify problem _____	specify problem _____	specify problem _____	specify problem _____	specify problem _____
Has any child died?	<input type="checkbox"/> NO <input type="checkbox"/> YES specify cause _____	<input type="checkbox"/> NO <input type="checkbox"/> YES specify cause _____	<input type="checkbox"/> NO <input type="checkbox"/> YES specify cause _____	<input type="checkbox"/> NO <input type="checkbox"/> YES specify cause _____	<input type="checkbox"/> NO <input type="checkbox"/> YES specify cause _____

4. Have you and your partner ever been unable to get pregnant after trying for 12 months?

NO YES

If YES

a. When did you start trying to get pregnant?

Please specify year _____

b. Was there any cause for infertility found?

NO YES, please specify _____

c. Have you sought or undertaken infertility treatment?

NO YES

d. Have you managed to get pregnant a pregnancy since then?

NO YES → Which year? __ __ __ __ year Health during pregnancy

5. During your pregnancy/pregnancies did you drink alcohol?

	Yes, occasionally	Yes, most days	No
Pregnancy 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. During your pregnancy/pregnancies did you have diabetes?

	Yes	No	Don't know
Pregnancy 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. During your pregnancy/pregnancies, did you have high blood pressure needing treatment (admission to hospital or medication)?

	Yes	No
Pregnancy 1	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 2	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 3	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 4	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 5	<input type="checkbox"/>	<input type="checkbox"/>

8. During your pregnancy/pregnancies did you smoke cigarettes?

	Yes	No
Pregnancy 1	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 2	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 3	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 4	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 5	<input type="checkbox"/>	<input type="checkbox"/>

9. After the birth of your child/children, did you suffer from Post-Natal Depression?

	Yes	No	Don't know
Pregnancy 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*We would like to know whether a medical doctor has ever diagnosed your son or daughter with, or treated your son or daughter for, any of the following medical problems or conditions. **If YES**, please indicate the year your son or daughter was first diagnosed, and whether your son or daughter has been treated by a medical doctor for this condition in the **past year**.*

Child number 1: Date of birth _____

10.Has a medical doctor ever diagnosed your son or daughter with, or treated you for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Heart disease or condition	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

10. Has a medical doctor ever diagnosed your son or daughter with, or treated you for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Motor neurone disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other lung disease e.g. emphysema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stomach or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Colitis / Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hepatitis or yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Cirrhosis of the liver	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bowel disorder e.g. diarrhoea, constipation, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Kidney disease e.g. stones, infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bladder disease e.g. infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Incontinence or difficulty passing urine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
A thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malaria	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Dengue	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any significant infections	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Leishmaniasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Filariasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fibrositis or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Back or neck problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Joint problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eye or vision problems e.g. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

10. Has a medical doctor ever diagnosed your son or daughter with, or treated you for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malignant melanoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other skin cancer e.g. squamous cell or basal cell skin cancers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other kind of cancer, tumour or malignancy (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
More than 25 moles on your body	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other skin problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the hair or scalp, including hair loss.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Alcohol abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Drug abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Anxiety, stress or depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Post Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other psychiatric or psychological condition needing treatment or counselling (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sleep apnoea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fungal disease or candidiasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple chemical sensitivity or environmental illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sick building syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Food allergy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the genital organs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

Child number 2: Date of Birth _____

We would like to know whether a medical doctor has ever diagnosed your son or daughter with, or treated your son or daughter for, any of the following medical problems or conditions. **If YES**, please indicate the year they were first diagnosed, and whether they have been treated by a medical doctor for this condition in the **past year**.

5. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Heart disease or condition	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Motor neurone disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other lung disease e.g. emphysema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stomach or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Colitis / Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hepatitis or yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Cirrhosis of the liver	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bowel disorder e.g. diarrhoea, constipation, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Kidney disease e.g. stones, infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bladder disease e.g. infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Incontinence or difficulty passing urine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
A thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malaria	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

5. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Dengue	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any significant infections	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Leishmaniasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Filariasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fibrositis or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Back or neck problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Joint problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eye or vision problems e.g. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malignant melanoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other skin cancer e.g. squamous cell or basal cell skin cancers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other kind of cancer, tumour or malignancy (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
More than 25 moles on your body	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other skin problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the hair or scalp, including hair loss.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Alcohol abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Drug abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Anxiety, stress or depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Post Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

5. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Other psychiatric or psychological condition needing treatment or counselling (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sleep apnoea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fungal disease or candidiasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple chemical sensitivity or environmental illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sick building syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Food allergy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the genital organs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

Child number 3: Date of Birth _____

*We would like to know whether a medical doctor has ever diagnosed your son or daughter with, or treated your son or daughter for, any of the following medical problems or conditions. **If YES**, please indicate the year they were first diagnosed, and whether they have been treated by a medical doctor for this condition in the **past year**.*

6. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Heart disease or condition	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Motor neurone disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

6. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Asthma	<input checked="" type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other lung disease e.g. emphysema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stomach or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Colitis / Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hepatitis or yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Cirrhosis of the liver	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bowel disorder e.g. diarrhoea, constipation, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Kidney disease e.g. stones, infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bladder disease e.g. infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Incontinence or difficulty passing urine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
A thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malaria	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Dengue	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any significant infections	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Leishmaniasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Filariasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fibrositis or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Back or neck problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Joint problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eye or vision problems e.g. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

6. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malignant melanoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other skin cancer e.g. squamous cell or basal cell skin cancers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other kind of cancer, tumour or malignancy (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
More than 25 moles on your body	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other skin problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the hair or scalp, including hair loss.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Alcohol abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Drug abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Anxiety, stress or depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Post Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other psychiatric or psychological condition needing treatment or counselling (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sleep apnoea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fungal disease or candidiasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple chemical sensitivity or environmental illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sick building syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Food allergy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the genital organs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

Child number 4: Date of Birth _____

We would like to know whether a medical doctor has ever diagnosed your son or daughter with, or treated your son or daughter for, any of the following medical problems or conditions. **If YES**, please indicate the year they were first diagnosed, and whether they have been treated by a medical doctor for this condition in the **past year**.

7. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Heart disease or condition	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Motor neurone disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other lung disease e.g. emphysema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stomach or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Colitis / Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hepatitis or yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Cirrhosis of the liver	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bowel disorder e.g. diarrhoea, constipation, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Kidney disease e.g. stones, infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bladder disease e.g. infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Incontinence or difficulty passing urine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
A thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malaria	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

7. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Dengue	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any significant infections	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Leishmaniasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Filariasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fibrositis or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Back or neck problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Joint problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eye or vision problems e.g. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malignant melanoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other skin cancer e.g. squamous cell or basal cell skin cancers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other kind of cancer, tumour or malignancy (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
More than 25 moles on your body	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other skin problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the hair or scalp, including hair loss.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Alcohol abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Drug abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Anxiety, stress or depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Post Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

7. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Other psychiatric or psychological condition needing treatment or counselling (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sleep apnoea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fungal disease or candidiasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple chemical sensitivity or environmental illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sick building syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Food allergy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the genital organs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

Child number 5: Date of Birth _____

We would like to know whether a medical doctor has ever diagnosed your son or daughter with, or treated your son or daughter for, any of the following medical problems or conditions. If YES, please indicate the year they were first diagnosed, and whether they have been treated by a medical doctor for this condition in the past year.

8. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Heart disease or condition	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Motor neurone disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

8. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other lung disease e.g. emphysema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Stomach or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Colitis / Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hepatitis or yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Cirrhosis of the liver	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bowel disorder e.g. diarrhoea, constipation, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Kidney disease e.g. stones, infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Bladder disease e.g. infection, bleeding	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Incontinence or difficulty passing urine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
A thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malaria	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Dengue	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any significant infections	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Leishmaniasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Filariasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Arthritis or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fibrositis or fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Back or neck problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Joint problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eye or vision problems e.g. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

8. Has a medical doctor ever diagnosed your son or daughter with, or treated your son or daughter for any of the following medical problems or conditions?	NO	YES	If YES	
			Year first diagnosed	Has this condition been treated by a doctor in the past year?
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Malignant melanoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other skin cancer e.g. squamous cell or basal cell skin cancers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other kind of cancer, tumour or malignancy (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
More than 25 moles on your body	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any other skin problem	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the hair or scalp, including hair loss.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Alcohol abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Drug abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Anxiety, stress or depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Post Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Other psychiatric or psychological condition needing treatment or counselling (please specify type)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sleep apnoea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Fungal disease or candidiasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Multiple chemical sensitivity or environmental illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sick building syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Food allergy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Any disease of the genital organs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> NO <input type="checkbox"/> YES

DEMOGRAPHIC DATA

1. **Are you male or female?** Male Female
2. **What is your date birth?** ___ ___ / ___ ___ / 19 ___ ___ (day/ month/ year)
3. **In which country were you born?**
 - Australia
 - New Zealand
 - United Kingdom
 - Republic of Ireland
 - Italy
 - Germany, Federal Republic of
 - Greece
 - India
 - Canada
 - Lebanon
 - Malaysia
 - Malta
 - Philippines
 - Poland
 - South Africa
 - USA
 - Vietnam
 - China
 - Netherlands
 - Vietnam
 - Yugoslavia (Former) NFD
 - Other , please specify _____
4. **Do you regard yourself as being of Aboriginal or Torres Strait Islander origin?**
(If you are both Aboriginal and Torres Strait Islander origin, mark both “yes” boxes).
 - NO
 - YES - Aboriginal
 - YES – Torres Strait Islander
5. **Do you usually speak English in your household?**
 - YES
 - NO
6. **What is your current marital status? Choose one.**
 - Married
 - De facto relationship
 - Separated
 - Divorced
 - Widowed

- Single, never married
- Other, please specify _____

7. Which category best describes the highest educational qualification you have completed? Choose one.

- Primary school
- Secondary school up to grade 10
- Secondary school grades 11-12
- Certificate (trade, apprenticeship, technicians etc)
- Diploma (associate, undergraduate)
- Bachelor degree
- Post-graduate qualification
- Other

8. What is your current occupational status?

- Paid employment full-time
- Paid employed part-time/casual
- Volunteer/community work
- Student
- Home duties
- Retired
- Not working due to ill-health / TPI
- Unemployed
- Other, please specify _____

9. How many hours per week do you normally work? _____

10. What is your main source of income now? Choose one

- Wage or salary
- Own business or share in a partnership
- Age Service pension
- Invalidity Service Pension
- Compensation benefit
Under the VEA SRCA MRCA
- Other government pension / allowance / benefit
- Child allowance
- Superannuation / annuity
- Dividends / interest / income from investments
- Other _____ please

11. Are you in receipt of any type of pension?

- YES
- NO

12. Before income tax is taken out, what is your present yearly income (for you and your partner combined)?

INCLUDE PENSIONS AND ALLOWANCES BEFORE TAX, SUPERANNUATION OR HEALTH INSURANCE

You and partner combined

BEFORE TAX

- \$2400 or more per week (\$124,800 or more per year)
- \$2200-\$2399 per week (\$114,400-\$114,399 per year)
- \$2000-\$2199 per week (\$104,000-\$114,399 per year)
- \$1500-\$1999 per week (\$78,000 - \$103,999 per year)
- \$1000-\$1499 per week (\$52,000 - \$77,999 per year)
- \$800-\$999 per week (\$41,600-\$51,999 per year)
- \$700-\$799 per week (\$36,400-\$41,599 per year)
- \$600-\$699 per week (\$31,200 - \$36,399 per year)
- \$500-\$599 per week (\$26,000-\$31,199 per year)
- \$400-\$499 per week (\$20,800 - \$25,999 per year)
- \$300-\$399 per week (\$15,600-\$20,799 per year)
- \$200-\$299 per week (\$10,400-\$15,599 per year)
- \$100-\$199 per week (\$5,200 - \$10,399 per year)
- \$50-\$99 per week (\$2,600 - \$5,199 per year)
- \$1-\$49 per week (\$1-\$2,599 per year)
- Nil income
- Negative income
- Don't know
- Refused

13. Given your current needs and financial responsibilities, how would you say you and your family are getting on?

INCLUDES PARTNER AND CHILDREN LIVING AT HOME

- Prosperous
- Very comfortable
- Reasonably comfortable
- Just getting along
- Poor
- Very poor
- Don't know
- Refused

Over the last 12 months, due to shortage of money, have any of the following happened?

14. You have not been able to pay gas, electricity or telephone bills on time?

- Yes
- No
- Don't know
- Refuse

15. You could not pay the mortgage or rent on time?

- Yes
- No
- Don't know
- Refused

16. Adults or children have gone without meals?

- Yes
- No
- Don't know
- Refused

17. You have been unable to heat or cool your home?

- Yes
- No
- Don't know
- Refused

18. You have pawned or sold something?

- Yes
- No
- Don't know
- Refused

19. You have sought assistance from a welfare or community organisation?

- Yes
- No
- Don't know
- Refused

20. You had financial limits on the type of food you could buy?

- Yes
- No
- Don't know
- Refused

Thank you for completing this questionnaire. Your participation is appreciated.