

den norske *Mor & barn undersøkelsen*

Questionnaire 3C

This questionnaire applies mainly to the period after week 12 of your pregnancy. We will ask you some questions which you may recognise from the first questionnaire. We do this because we want to continue following your and your child's progress. It would be useful for you to consult your pregnancy health card before you start answering the questions so that you can use the information contained in it when completing this questionnaire. If you feel uncomfortable with a question or it is difficult to answer, you can skip this question and go on to the next one.

This questionnaire will be processed by a computer. It is therefore important that you follow these instructions:

- Use a blue or black ballpoint pen.
- Put a cross in the box that is most relevant like this:
- If you put a cross in the wrong box, correct it by filling in the correct box.
- Write a number or capital letter in the large green boxes.

It is important that you only write in the white area.

Please do not use this questionnaire. Contact us at morbarn@fhi.no or phone + 47 53 20 40 40 if you need a questionnaire.

Number:

1	2	3	4	5	6	7	8	9	0
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- When entering a single-digit number in boxes containing two or more squares, use the square on the right. **For example:** 5 is written like this:

	5
--	---
- A number of questions in this questionnaire concern the week of pregnancy. For example: If you want to indicate something that happened 14 weeks after your last period, enter a cross in the box for week 13-16.
- Specific information concerning, for example, medication or profession should be written in the boxes or on the lines provided. Please write clearly in CAPITAL LETTERS.
- Remember to enter the date when you completed the questionnaire.

Please return the completed questionnaire in the stamped addressed envelope provided.

Date when the questionnaire was completed

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Day

--	--

Month

--	--	--	--

Year

(write the year in full, e.g. 2001)

Antenatal care and health

1. Where have you been to antenatal check-ups?

(Fill in one or more boxes.) Specify how many times.

- Public health centre

--	--

 times
- Doctor's surgery

--	--

 times
- Hospital (outpatients) clinic

--	--

 times

2. Who has examined you each time? (Fill in one or more boxes.) Specify how many times.

- Midwife

--	--

 times
- General practitioner

--	--

 times
- Gynaecologist

--	--

 times
- Public health nurse

--	--

 times

3. Is your doctor male or female?

How many times have you gone to him/her?

- General practitioner female

--	--

 times
- male

--	--

 times
- Gynaecologist female

--	--

 times
- male

--	--

 times

4. If you visit or have visited a gynaecologist or hospital clinic for your antenatal check-ups, what is or was the reason?

- Referred due to complications during this pregnancy
- Referred due to previous illness or complications in previous pregnancies
- On your own initiative without a referral
- Referred for another reason

5. Do you agree with the following statements concerning your antenatal check-ups?

	Agree completely	Agree somewhat	Disagree somewhat	Disagree completely
I have been given sufficient advice and information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been well taken care of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There was not enough time during the consultations . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt secure during these check-ups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been able to discuss everything I needed to during the check-ups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On the whole, I am satisfied with the way I have been followed up by the health service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Have you contacted a midwife or doctor in addition to your normal check-ups?

	No	Yes
Midwife	<input type="checkbox"/>	<input type="checkbox"/>
Doctor	<input type="checkbox"/>	<input type="checkbox"/>

7. If yes, was it difficult to get an appointment?

	Midwife	Doctor
Not difficult	<input type="checkbox"/>	<input type="checkbox"/>
Somewhat difficult	<input type="checkbox"/>	<input type="checkbox"/>
Very difficult	<input type="checkbox"/>	<input type="checkbox"/>

8. Have you had a gynaecological examination during your pregnancy (internal examination)? If so, how many times?

No

Yes Times

9. How many ultrasound examinations have you had during your pregnancy?

External ultrasound examination Times

Internal ultrasound examination Times

10. How many children are you expecting?

11. Have you been offered an amniocentesis or placenta biopsy?

No (go to question 16)

Yes

12. If yes, were any tests performed and what were the results?

	Was the test performed?		Were the results normal?	
	Yes	No	Yes	No
Amniocentesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Placenta biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the tests were abnormal, describe the findings:

13. If an amniocentesis or placenta biopsy was performed, what was the reason?

- Due to my age (normally 38 or older at the time of delivery)
- Previous child with a chromosome disorder
- Previous child with neural tube defect (spina bifida)
- Epilepsy (medication for epilepsy)
- Ultrasound findings
- Other

14. Were there complications during the first 2 weeks following the amniocentesis?

- No
- Yes

15. If yes, what kind of complications?

- Vaginal bleeding
- Leakage of amniotic fluid
- Abdominal pain (similar to or stronger than menstrual pains)
- Other _____

16. Have you had an X-ray during pregnancy?

- No
- Yes

17. If yes, what part of your body was X-rayed? How many X-rays were taken and in which week of pregnancy? (Fill in one or more boxes.)

	Week of pregnancy						No. of times
	0-12	13-16	17-20	21-24	25-28	29+	
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
Lungs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
Arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
Pelvis/abdomen/back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>

18. Have you received treatment to prevent a premature birth during this pregnancy? (Fill in one or more boxes.)

- No
- Yes, relax or bed-rest
- Yes, medication

Which medicines? _____

19. Have you been vaccinated during this pregnancy?

- No
- Yes

Which vaccine? _____

20. Has the midwife or doctor told you that you have or have had high blood pressure during this pregnancy?

- No
- Yes

21. If yes, what was the highest reading during this pregnancy? (High blood pressure is over 140/90) (Refer to your health card.)

/ E.g. /

- Don't know

22. Have you had high blood pressure without being pregnant?

- No
- Yes
- Don't know

23. If yes, what was the highest reading before this pregnancy?

/ E.g. /

- Don't know

30. Do you wake up at night due to pelvic pain?

- Yes, frequently
 Yes, sometimes
 No, never

31. Do you have to use a stick or crutches in order to walk due to pelvic pain?

- No, never
 Yes, but not every day, the pain varies from day to day
 Yes, I have to use a stick or crutches every day

32. Have you received an anaesthetic in connection with surgery or dental treatment during this pregnancy?

- No
 Yes

33. If yes, what type of anaesthetic have you had? (Fill in one or more boxes.)

- General (full) anaesthetic
 Spinal anaesthetic (epidural)
 Local anaesthetic
 Don't know

34. Have you been to the dentist during this pregnancy?

- No
 Yes

35. If yes, did the dentist perform any of the following treatments? (Fill in one or more boxes.)

	Yes	No
Put in new amalgam fillings (silver fillings)	<input type="checkbox"/>	<input type="checkbox"/>
Removed or replaced amalgam fillings	<input type="checkbox"/>	<input type="checkbox"/>
Put in new white fillings	<input type="checkbox"/>	<input type="checkbox"/>

36. How many teeth do you have and how many have fillings? (Look in the mirror and count.)

Total number of teeth	<input type="text"/>	<input type="text"/>
Number of teeth with amalgam fillings	<input type="text"/>	<input type="text"/>
Number of teeth with other types of fillings	<input type="text"/>	<input type="text"/>

37. At present, do your gums bleed when you brush your teeth?

- No, seldom or never
 Yes, sometimes
 Yes, frequently
 Yes, nearly always

38. Have you had a tattoo or body piercing, including extra holes in the ears? (Do not include pierced ears if you have one hole in each ear.)

- No
 Yes

39. If yes, where and when was it done? (Fill in one or more boxes.)

	Tattoo	Body piercing
Before this pregnancy:		
In Norway	<input type="checkbox"/>	<input type="checkbox"/>
Abroad	<input type="checkbox"/>	<input type="checkbox"/>
During this pregnancy:		
In Norway	<input type="checkbox"/>	<input type="checkbox"/>
Abroad	<input type="checkbox"/>	<input type="checkbox"/>

40. Have you ever had a blood transfusion? If yes, give the number of transfusions.

- No
 Yes, during this pregnancy Times
 Yes, before this pregnancy Times

41. If yes, in which country and which year? (Give the last 2 transfusions.)

Country: _____
 Country: _____

42. Have you ever had breast surgery?

- No
 Yes

43. If yes, was it:

- Breast enlargement
 Breast reduction
 Cancer/biopsy
 Other, describe: _____

44. Have you ever had cervical dysplasia?

- No
 Yes
 Year the dysplasia was detected the first time

45. Have you had an operation on your cervix?

- No
 Yes
 Year of operation

46. Have you ever had a gamma globulin injection? (used to prevent infection of hepatitis A, primarily when travelling abroad.)

- No
 Yes
 If yes, which year?

How have you been recently?

Some questions about the time that has elapsed since the 13th week of pregnancy.

47. Have you had one or more episodes of vaginal bleeding after the 13th week of pregnancy?

- No
 Yes

48. If yes, how much did you bleed, in which week(s) of pregnancy and how many days did the bleeding last? (If you have had more than 2 episodes of bleeding, describe the last 2 only.)

The amount of blood (spotting means a few drops)	In which week of pregnancy did the bleeding occur?					No. of days bleeding lasted
	13-16	17-20	21-24	25-28	29+	
1. <input type="checkbox"/> Spotting <input type="checkbox"/> More than spotting <input type="checkbox"/> Large amounts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
2. <input type="checkbox"/> Spotting <input type="checkbox"/> More than spotting <input type="checkbox"/> Large amounts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Number of episodes of bleeding if more than 2						<input type="text"/>

49. Do you know why you bled?

- No
 Yes

50. If yes, what was the reason? (Fill in one or more boxes.)

- The placenta is too low/is in a difficult position/placenta previa
 Premature separation of the placenta/abruptio/ablatio placenta
 Threatening miscarriage/premature birth
 Cervical ulcer, bleeding of the mucous membrane in the vagina
 Following intercourse
 Other reason

51. Have you been bothered by uterine contractions?

- No
 Yes, a little
 Yes, a lot

52. Do you have or have you had any of the following illnesses or problems after the 13th week of pregnancy? If you have used tablets, mixtures, suppositories, inhalers, creams, etc. in connection with the illness or problem, give the name(s) of the medication(s), when and how long you took them. (Fill in one or more boxes.) (This applies to all types of medicines including alternative and herbal remedies, both regular and occasional use. Do not include vitamins and nutritional supplements as these are asked about elsewhere.)

	In which week of pregnancy did you have problems?					The name of the medication taken	In which week of pregnancy did you take medication					No. of days taken
	13-16	17-20	21-24	25-28	29+		13-16	17-20	21-24	25-28	29+	
1 Pelvic girdle pain . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
2 Back pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
3 Other pains in muscles/joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
4 Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
5 Long-term nausea and vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
6 Vaginal thrush	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
7 Vaginal catarrh, unusual discharge . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
8 Pregnancy itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
9 Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
10 Diarrhoea/gastric flu . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Continued...

	In which week of pregnancy did you have problems?					The name of the medication taken	In which week of pregnancy did you take medication					No. of days taken		
	13-16	17-20	21-24	25-28	29+		13-16	17-20	21-24	25-28	29+			
11 Unusual fatigue /drowsiness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
12 Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
13 Swelling of the body (oedema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
14 Common cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
15 Throat infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
16 Sinusitis/ear infection....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
17 Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
18 Pneumonia /bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
19 Other cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
20 Sugar in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
21 Protein in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
22 Bladder infection/ cystitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
23 Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
24 High blood pressure ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
25 Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
26 Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
27 Hay fever/other allergy ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
28 Headache/migraine...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
29 Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
30 Other psychological problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
31 Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

53. If you have had a fever once or more since the 13th week of pregnancy, indicate in which week of pregnancy, name of any medication taken to reduce the fever and the highest temperature measured. (If more than 3 times, indicate the last 3.)

	Which week of pregnancy did you have a fever?					Name any medication taken to lower the fever	Highest recorded temperature (e.g. 38.9° C)	Temperature not taken
	13-16	17-20	21-24	25-28	29+			
1st time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="text"/> , <input type="text"/> °C	<input type="checkbox"/>
2nd time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="text"/> , <input type="text"/> °C	<input type="checkbox"/>
3rd time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="text"/> , <input type="text"/> °C	<input type="checkbox"/>

Fever more than 3 times

59. Give the complete name(s) of all the vitamins and nutritional supplements you take. Include also herbal remedies and diet products. (Write clearly using CAPITAL LETTERS since this will be read by a computer.)

1	e.g.	V	I	T	A	P	L	E	X	M	E	D	J	E	R	N								
2																								
3																								
4																								
5																								
6																								

60. If you take multivitamins (with or without minerals), do these contain folate/folic acid?

- No
 Yes
 Don't know

WORK

61. Have you been in paid employment during this pregnancy?

- No (go to question 76)
 Yes

62. Do you have the same job conditions now after the 13th week of pregnancy that you described in the first questionnaire?

- No
 Yes (go to question 66)

63. If no, in which week of your pregnancy did your work situation change?

Week of pregnancy

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64. How has your work situation changed?

- I have stopped working
 I have gone over to a part-time position
 Other

65. If you have stopped working, why did you stop?

- I handed in my notice
 The work was temporary (seasonal, short-term contract)
 I was fired
 Other

66. Have your working arrangements been changed during this pregnancy making your job more suitable for you now that you are pregnant?

- No
 Yes

67. If no, why have your working conditions not been changed to make them more suitable for you?

- Not necessary
 Impossible or nearly impossible
 I have asked for changes but no changes have been made
 It is difficult to ask
 None of the above (explain why)

68. What are your working hours? (Fill in one or more boxes.)

- Permanent day work
 Permanent afternoon or evening work
 Permanent night work
 Shift work or shift rotas
 No set times (extra work, extra shifts, temporary employment, etc.)
 Other

69. Answer each of the following questions for your present work. (Fill in each item.)

	Yes daily, more than half of working hours	Yes daily, less than half of working hours	Yes periodically, but not daily	Seldom or never
Do you ever have so much to do that your work situation becomes stressful and annoying? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have to bend or turn many times a day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you work with your hands at shoulder level or higher?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you work standing or walking about?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In some jobs it is possible to decide yourself how much and how quickly you work. You can, for example, work a little faster one day and take it a little easier the next. Do you have this opportunity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there so much noise at your workplace that it is uncomfortable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there so much noise that you have to raise your voice to speak with others even at a distance of one metre?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

70. How often have you worked with a radio transmitter or radar after the 13th week of pregnancy?

- Seldom/never
- A few times a week
- Daily
- On average, more than 1 hour a day

71. How often have you worked with X-ray equipment (at a distance of less than 2 metres) after the 13th week of pregnancy? (Do not include treatment as a patient.)

- Seldom/never
- A few times a week
- Daily
- On average, more than 1 hour a day

72. Have you been absent from your normal job for more than two weeks after the 13th week of pregnancy?

- No
- Yes, part time
- Yes

73. Are you absent from regular work at the present time?

- No
- Yes, part time
- Yes

74. If yes, why are you currently absent from work?

(Fill in for only one item.)

- Sick leave (with sick compensation pay)
- Absent due to sick child
- Made redundant with compensation
- Absent with maternity allowance due to the working environment
- Started maternity leave (with allowance)
- Service leave
- Other (describe)

75. Complete the table below if you were on sick leave (full or part time) after the 13th week of pregnancy. Fill in the reason (e.g. pelvic girdle pain, pneumonia), which weeks you were on sick leave, the number of days and the percentage of time each period of sick leave represents. (Give one reason for sick leave per line.)

Reason for sick leave	Sick leave during week of pregnancy:					Number of days	% sick leave
	13-16	17-20	21-24	25-28	29+		
<i>Example: Pelvic girdle pain</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14	50
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

76. Do you currently lift anything over 10 kilos while you are pregnant? (10 kilos is equivalent to a full bucket of water)

	Home	Work
Seldom or never	<input type="checkbox"/>	<input type="checkbox"/>
Yes, less than 20 times a week	<input type="checkbox"/>	<input type="checkbox"/>
Yes, more than 20 times a week	<input type="checkbox"/>	<input type="checkbox"/>
Yes, 10-20 times a day	<input type="checkbox"/>	<input type="checkbox"/>
Yes, more than 20 times a day	<input type="checkbox"/>	<input type="checkbox"/>

77. Have others helped you with housework or childcare more than they usually do to relieve you during this pregnancy?

- Yes, considerably
- Yes, to a fair extent
- No, no one has offered
- No, it has not been necessary

78. If you are on maternity leave for this pregnancy, when did it start?

Date:

day month year

Habits

79. How often do you talk on a mobile phone?

- Seldom/never
- A few times a week
- Daily
- On average, more than 1 hour a day

80. Do you talk on your mobile phone for longer than 15 minutes at a time?

- Never
- Seldom
- Frequently

81. How frequently have you worked with a computer monitor, laser printer or photocopier machine (at a distance of less than 2 metres) after the 13th week of pregnancy?

	Computer monitor	Laser printer	Photocopier machine
Seldom/never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A few times a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On average, more than 1 hour a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

82. Do you live close to high-voltage power lines?

- No
- Yes, closer than 50 metres
- Yes, between 50 - 100 metres
- Yes, more than 100 metres

83. How often have you been to a discotheque since you answered the previous questionnaire?

- Never
- At least 1-2 times a week
- Less often

84. How often do you exercise at present? (Fill in for each item.)

	Never	1-3 times a month	Once a week	Twice a week	3 times or more a week
1. Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Brisk walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Running/jogging/orienteering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cycling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Training studio/weight training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Special gymnastics/aerobics for pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Aerobics/gymnastics/dance without running and jumping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Aerobics/gymnastics/dance with running and jumping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Dancing (swing/rock/folk)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Skiing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Ball sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Swimming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Riding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

85. How often do you do exercises at home or at a gym for the following groups of muscles? (Fill in for each item.)

	Never	1-3 times a month	Once a week	Twice a week	3 times a week or more
Abdominal muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic floor muscles (Muscles around the vagina, urethra, anus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

86. How often at the moment are you so physically active in your spare time and/or at work that you get out of breath or sweat? (Fill in for both spare time and work.)

	Spare time	At work
Never	<input type="checkbox"/>	<input type="checkbox"/>
Less than once a week	<input type="checkbox"/>	<input type="checkbox"/>
Once a week	<input type="checkbox"/>	<input type="checkbox"/>
Twice a week	<input type="checkbox"/>	<input type="checkbox"/>
3-4 times a week	<input type="checkbox"/>	<input type="checkbox"/>
5 or more times a week	<input type="checkbox"/>	<input type="checkbox"/>

87. How often on average have you had sexual intercourse during the last month?

- Daily
- 5-6 times a week
- 3-4 times a week
- 1-2 times a week
- Less frequently
- Never

88. Have you been abroad during the last year?

- No
- Yes

89. If yes, which countries did you visit and when?

Country	Month	Year
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>

90. Have you come into contact with animals either at work or in your free time?

- No
- Yes

91. If yes, which animals have you come into contact with and how often?

	Daily	3-6 times a week	1-2 times a week	Less often
Dog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guinea pig/hamster/rabbit/rat, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canary or other caged birds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hens and other poultry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cow/sheep/goat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Horse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pig	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

92. How many hours a day do you usually sleep now when you are pregnant?

- Over 10 hours
- 8-9 hours
- 6-7 hours
- 4-5 hours
- Less than 4 hours

93. Do you currently sleep on a waterbed or use an electric blanket?

	Yes	No
Waterbed	<input type="checkbox"/>	<input type="checkbox"/>
Electric blanket.	<input type="checkbox"/>	<input type="checkbox"/>

94. Can you rest during the day (both at home and at work)?

- No
- Yes

95. Have you been in a sauna while you have been pregnant?

- No
- 1-5 times
- 6-10 times
- More than 10 times

96. Have you been in a solarium while you have been pregnant?

- No
- 1-5 times
- 6-10 times
- More than 10 times

97. Are you exposed to passive smoking either at home or at work? If yes, how many hours a day?

	No	Yes	No. of hrs
Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>

98. Do you smoke at present? If yes, how many cigarettes?

- No
- Sometimes Cigarettes per week
- Daily Cigarettes per day

99. Does the baby's father smoke at present? If yes, how many cigarettes?

- No
- Sometimes Cigarettes per week
- Daily Cigarettes per day

100. If one or both of you have stopped smoking during the pregnancy, in which week of pregnancy did you stop?

- You Week of pregnancy
- Baby's father Week of pregnancy

101. If you or the baby's father have smoked during the pregnancy, were there periods during which you or the baby's father did not smoke? (Fill in the weeks during pregnancy when you did not smoke.)

	Weeks of pregnancy <u>without</u> smoking							
	0-4	5-8	9-12	13-16	17-20	21-24	25-28	29+
You ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baby's father...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

102. Have you used other forms of nicotine after the 13th week of pregnancy?

	No	Yes
Nicotine chewing gum	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine patches	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine inhaler	<input type="checkbox"/>	<input type="checkbox"/>
Chewing tobacco/snuff	<input type="checkbox"/>	<input type="checkbox"/>

103. Have you used any of the following substances after the 13th week of pregnancy?

	No	Yes
Hash	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>

104. Have you ever used any of the following substances? (Fill in for each item.)

	No	Previously	Last 6 months before pregnancy	During this pregnancy
Anabolic steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testosterone products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Growth hormones (e.g. genotropin/somatropin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Food and drink

105. How often do you eat the following foods? (Fill in for each item.)

	Before the pregnancy				During the pregnancy		
	Never	A few times a year	1-3 times a Month	Once a week or more	Never	1-3 times a month	Once a week or more
1 Crab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Shrimps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Shellfish (e.g. mussels, oysters)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Fish liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Tuna fish or halibut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Flounder/other flat fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Pike or perch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Other fresh water fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Reindeer meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Mutton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Liver or kidney from game	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Wild mushrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

106. How often do you eat the following types of food? (Fill in for each item.)

	Never	A few times a year	1-3 times a month	Once a week or more
Food from restaurant/street vendors/canteen or the like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat (not including tinned) bought in other countries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat (including poultry) that is raw or undercooked (pink near the bone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Raw minced meat/meat mixtures (even to taste)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoked or cured salmon or trout (uncooked)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft cheeses (e.g. cream cheese, camembert, blue cheese, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unwashed raw vegetables, unwashed fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

107. Do you avoid eating the following foods during this pregnancy?

	No	Yes
Fish	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>
Nuts	<input type="checkbox"/>	<input type="checkbox"/>
Oranges, lemons	<input type="checkbox"/>	<input type="checkbox"/>
Strawberries	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify		

108. What type of drinking water do you have where you live?

- Own water source (e.g. well)
 - Water company (public or private)
 - Other source
- Name of water company _____
- Don't know the name of the water company

109. Is your water treated (chlorinated or UV-radiated)?

- No
- Yes, UV radiation
- Yes, chlorinated
- Don't know

110. What was your fluid consumption (number of cups/glasses) per day after the 13th week of pregnancy? (1 mug = 2 cups, 1 small plastic bottle (0.5 litre) = 4 cups, 1 large plastic bottle (1.5 litres) = 12 cups)

	Number of cups / glasses	Decaffeinated (fill in)
1. Filter coffee	<input type="text"/>	<input type="checkbox"/>
2. Instant coffee	<input type="text"/>	<input type="checkbox"/>
3. Boiled coffee	<input type="text"/>	<input type="checkbox"/>
4. Other coffee	<input type="text"/>	<input type="checkbox"/>
5. Tea	<input type="text"/>	<input type="checkbox"/>
6. Coca Cola/Pepsi, etc.	<input type="text"/>	<input type="checkbox"/>
7. Other fizzy drinks	<input type="text"/>	<input type="checkbox"/>
8. Diet Coca Cola, diet Pepsi	<input type="text"/>	<input type="checkbox"/>
9. Other diet fizzy drinks	<input type="text"/>	<input type="checkbox"/>
10. Tap water	<input type="text"/>	
11. Bottled water	<input type="text"/>	

	Number of cups/glass	Organic (fill in)
12. Juice/squash	<input type="text"/>	<input type="checkbox"/>
13. Diet juice/squash	<input type="text"/>	<input type="checkbox"/>
14. Milk (skimmed, low fat, whole)	<input type="text"/>	<input type="checkbox"/>
15. Yogurt, all types.	<input type="text"/>	<input type="checkbox"/>
16. Yogurt with active Lactobacillus all types	<input type="text"/>	<input type="checkbox"/>
17. Other type of cultured milk (kefir)	<input type="text"/>	<input type="checkbox"/>
18. Other.	<input type="text"/>	<input type="checkbox"/>

111. How often did you consume alcohol before and how often do you consume it now?

	Last 3 months before last period	In this pregnancy week of pregnancy		
		0-12	13-24	25+
Roughly 6-7 times a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roughly 4-5 times a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roughly 2-3 times a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roughly 1 time a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roughly 1-3 times a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than once a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Never.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol units

Alcohol units are used to compare the different types of alcoholic beverages. 1 alcohol unit = 1.5 cl. pure alcohol.

- 1 glass of beer = 1 alcohol unit
- 1 wine glass of red or white wine = 1 alcohol unit
- 1 sherry glass of sherry or other fortified wine = 1 alcohol unit
- 1 spirit glass of spirits or liqueur = 1 alcohol unit
- 1 bottle/can breezer or cider = 1 alcohol unit

112. In the period just before you became pregnant and during this pregnancy, how many times have you consumed 5 units or more of alcohol? (See the explanation for units.)

	Last 3 mths before last period	In this pregnancy week of pregnancy		
		0-12	13-24	25+
Several times a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Once a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-3 times a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than once a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Never	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

113. How many units do you usually drink when you consume alcohol? (See the above explanation.)

	Last 3 mths before last period	In this pregnancy week of pregnancy		
		0-12	13-24	25+
10 or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5-6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

114. If you have changed your drinking habits before this pregnancy, when did the change occur? (Fill in one or more boxes.)

	Reduced intake	Increased intake
Last 3 months before last period	<input type="checkbox"/>	<input type="checkbox"/>
During pregnancy weeks 0-6	<input type="checkbox"/>	<input type="checkbox"/>
During pregnancy weeks 7-12	<input type="checkbox"/>	<input type="checkbox"/>
During pregnancy weeks 13-24	<input type="checkbox"/>	<input type="checkbox"/>
After pregnancy week 25	<input type="checkbox"/>	<input type="checkbox"/>

115. If you have modified your consumption of alcohol, how important were the following factors? (Fill in one or more boxes.)

	Not relevant	Not very important	Quite important	Important	Very important
Nausea, discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Altered taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For the baby's sake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other reasons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

You and your life now

116. What is your current civil status?

- Married
- Cohabiting
- Single
- Divorced/separated
- Widowed
- Other

117. Do you have anyone other than your husband/partner you can ask for advice in a difficult situation?

- No.
- Yes, 1 or 2 people
- Yes, more than 2 people

118. How frequently do you meet or talk on the telephone with your family (other than your husband/partner and children) or close friends?

- Once a month or less
- 2-8 times a month
- More than twice a week

119. Do you often feel lonely?

- Almost never
- Seldom
- Sometimes
- Usually
- Almost always

120. If you have given birth before, in general, how was the experience of giving birth?

- Very good
- Good
- Alright
- Bad
- Very bad

121. Do you agree or disagree with the following statements relating to the forthcoming birth of your baby?

(Fill in for each statement.)

	Agree completely	Agree	Agree somewhat	Disagree somewhat	Disagree	Disagree completely
I want to give birth as naturally as possible without painkillers or intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am really dreading giving birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I want to have enough medication so that the birth will be painless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I want to have an epidural regardless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I want to have an epidural if the midwife agrees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I could choose I would have a caesarean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think the woman herself should decide whether or not to have a caesarean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry all the time that the baby will not be healthy or normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am really looking forward to the baby coming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

122. How do these statements describe your relationship? (Only answer if you have a partner.)

(Fill in for each statement.)

	Agree completely	Agree	Agree somewhat	Disagree somewhat	Disagree	Completely disagree
My husband/partner and I have a close relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My partner and I have problems in our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am very happy in my relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My partner is usually understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often think about ending our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with my relationship with my partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We often disagree about important decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been lucky in my choice of a partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We agree on how children should be raised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think my partner is satisfied with our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

123. Have you been bothered during the last 2 weeks by any of the following? *(Enter a cross in a box for each item.)*

	Not bothered	Slightly bothered	Fairly much bothered	Very much bothered
1. Feeling fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nervousness or shakiness inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Feeling hopeless about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Worrying too much about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling everything is an effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling tense or keyed up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Suddenly scared for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

124. How often do you experience the following in your everyday life? *(Fill in for each statement.)*

	Seldom/never	Fairly seldom	Sometimes	Often	Very often
Feel pleased about something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel joyful, as though everything is going your way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel that you will scream at someone or hit something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel angry, irritated or annoyed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel mad at someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

125. How well do these statements describe you? *(Fill in for each statement.)*

	Incorrect	Partly correct	Almost correct	Completely correct
I always manage to solve difficult problems if I try hard enough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If anyone opposes me, I find a way to get what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am sure that I can cope with unexpected events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am calm when I encounter difficulties because I trust my ability to cope ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I am in a difficult situation, I usually find a solution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

126. Do you agree or disagree with the following statements? (Fill in for each statement.)

	Disagree completely	Disagree somewhat	Don't agree or disagree	Agree somewhat	Agree	Agree completely
My life is largely what I wanted it to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My life is very good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have achieved so far what is important for me in my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I could start all over, there is very little I would do differently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

127. How do you feel about yourself? (Fill in for each statement.)

	Agree completely	Agree	Disagree	Disagree completely
I have a positive attitude toward myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel completely useless at times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I do not have much to be proud about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I am a valuable person, as good as anyone else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

128. Have you experienced any of the following during the last 12 months? If yes, how painful or difficult was it for you?

(Fill in for each statement.)

	No	Yes	IF YES		
			Not too bad	Painful/difficult	Very painful/difficult
Have you had problems at work or where you study?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had financial problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been divorced, separated or ended your relationship with your partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems or conflicts with your family, friends or neighbours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been seriously ill or injured?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone close to you been seriously ill or injured?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been involved in a serious accident, fire or robbery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you lost someone close to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

129. Have you ever experienced any of the following? (Fill in for each statement.)

	No, never	Yes, as a child (under 18)	Yes, as an adult (over 18)	Who was responsible for this?			Has this occurred during the last year?	
				A stranger	Family or relative	Another known person	No	Yes
Someone has over a long period of time systematically tried to subdue, degrade or humiliate you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Someone has threatened to hurt you or someone close to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You have been subjected to physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You have been forced to have sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Miscellaneous

130. Has anyone living with you had any of the following illnesses during this pregnancy? (Enter a cross and specify the period)

	In which week of pregnancy?			
	0-9	10-19	20-29	30+
<input type="checkbox"/> Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Childhood diseases (fever and rash)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prolonged cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other infectious disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

131. Have there been any instances of cot death in your family or your partner's family?

No
 Don't know
 Yes, in my family (see question 132)
 Yes, in the baby's father's family (see question 133)

132. The child that died of cot death in my family was:

My sister
 My brother
 My sister's child Boy Girl
 My brother's child Boy Girl
 My mother's sibling Boy Girl Sex unknown
 My father's sibling Boy Girl Sex unknown
 Other

133. The child that died of cot death in the baby's father's family was:

- Baby's father's sister
 Baby's father's brother
 Baby's father's sister's child Boy Girl
 Baby's father's brother's child Boy Girl
 Baby's paternal grandmother's sibling Boy Girl Sex unknown
 Baby's paternal grandfather's sibling Boy Girl Sex unknown
 Other

134. Have you ever lost a child?

- No (*if no, you are finished with the questionnaire*)
 Yes

135. If yes, what was the cause of death and when did the death occur?

- Stillbirth (Birth after the 16th week of pregnancy.)
 Cot death
 Accident
 Illness/birth defect
 Which illness/birth defect: _____
 Other

	Year	Child's age	
		Years	Months
Child 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
Child 2	<input type="text"/>	<input type="text"/>	<input type="text"/>

136. Did you receive counselling from healthcare staff or other persons after the death? How many sessions did you have with healthcare staff, and/or parent support group, family and friends? How many weeks did you receive support?

	Healthcare staff	Parent support group, family, friends
Number of meetings (approximately):	<input type="text"/>	<input type="text"/>
Number of sessions via telephone (approximately):	<input type="text"/>	<input type="text"/>
Weeks of support (approximately):	<input type="text"/>	<input type="text"/>

137. Do you feel that the follow-up you received after your child's death was adequate?

- No follow-up was provided
 Very good
 Good enough
 Should have been better
 Bad

138. Has the death made you more anxious during this pregnancy?

- No, not at all
 No, not very much
 Yes, to a fair extent
 Yes, very much

139. Do you feel that the health care staff at the antenatal clinics took into consideration this painful experience in their contact with you?

- Yes, very much
 Yes, to a fair extent
 No, not at all

Have you remembered to fill in the date on which you completed the questionnaire on page 1?

Thank you very much for your help!

Please return the completed questionnaire in the stamped addressed envelope provided.