IV The Oslo Health Study

Date of completion
Day Month Year
☐☐ ☐☐ ☐☐☐☐

WORK AND INCOME

Is your position in any way a supervisory position - in such a way that other people work under your direction or guidance? ..... Yes ☐ No ☐
(If you are pensioned, - describe the situation in the last job you had. This also applies to the next question)

How many people are employed in the company/enterprise where you are working?
(e.g. hospital, branch of a bank, workshop, school etc.)

Less than 5 persons	5-19 persons	20-50 persons	More than 50 persons
☐1	☐2	☐3	☐4

What was your total income last year? *(Total gross annual income, including benefits/pension, before income tax and other deductions)*

No income	Less than 50,000	50 - 100,000	100 - 150,000
☐1	☐2	☐3	☐4

150 - 200,000	200 - 300,000	300 - 400,000	More than 400,000
☐5	☐6	☐7	☐8

If you are more than one person in your household, how much did you earn altogether last year? *(Total gross annual income, including benefits/pension, before income tax and other deductions)*

No income	Less than 50,000	50 - 100,000	100 - 150,000	150 - 200,000
☐1	☐2	☐3	☐4	☐5

200 - 300,000	300 - 400,000	400 - 500,000	More than 500,000
☐6	☐7	☐8	☐9

SKIN PROBLEMS

<u>The last week</u>, have you had any of the following complaints:

	No	Yes, a little	Yes, quite a lot	Yes, very much
Itchy skin	☐	☐	☐	☐
Dry itchy/sore rash	☐	☐	☐	☐
Scaly skin	☐	☐	☐	☐
Itchy rash on your hands	☐	☐	☐	☐
Pimples	☐	☐	☐	☐
Other rashes on the face	☐	☐	☐	☐
Warts	☐	☐	☐	☐
Troublesome sweating	☐	☐	☐	☐
Loss of hair	☐	☐	☐	☐
Other skin problems	☐	☐	☐	☐
	1	2	3	4

Do not write here!
Dog
☐☐☐ ☐☐☐
Grief *Help*
☐☐ ☐☐ ☐☐ ☐☐

SKIN PROBLEMS (cont.)

If «Yes»:

When did the skin problems start? *(One cross)*

The last week	The last month	1-6 months ago	More than 6 months ago
☐1	☐2	☐3	☐4

Did the doctor tell you that you have had:

(One cross for each line)	Yes	No
Acne	☐	☐
Psoriasis	☐	☐
Atopic dermatitis	☐	☐
Handeczema	☐	☐
Skin cancer	☐	☐
An other skin disease	☐	☐

<u>The last week</u>, have you been embarrassed in the company of other people because of your skin? *(One cross)*

No	Now and then	Often	Very often
☐1	☐2	☐3	☐4

<u>The last week</u>, has your capacity of work been reduced because of your skin? *(One cross)*

No	Little	Quite a lot	Very much
☐1	☐2	☐3	☐4

<u>The last week</u>, have your leisure activities been reduced because of your skin? *(One cross)*

No	Little	Quite a lot	Very much
☐1	☐2	☐3	☐4

METABOLISM

Have you ever been given the diagnosis:
(One cross for each diagnosis)

Goitre		Hyper-thyroidism		Hypo-thyroidism		Thyroid cancer	
Yes	No	Yes	No	Yes	No	Yes	No
☐	☐	☐	☐	☐	☐	☐	☐

KEEPING DOGS

	Yes	No	Number of dogs
Is there one or more dogs in your houshold?	☐	☐	☐☐

If Yes, which breed? *(Use capital letters)*
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If you don't have a dog, would you have liked to have one if you could? *(One cross)*

No	Yes, but I can not	Yes, but not allowed in household
☐1	☐2	☐3

Is there other pets in your household?

No	Yes, cat	Yes, other pet
☐	☐	☐

KEEPING DOGS (cont.)

The next questions is for dog-owners only.
If you do not have a dog, please go to SOCIAL CONTACT

How many years have you had a dog? *(One cross)*

Less than 1 year	1-2 years	2-4 years	More than 4 years
☐ 1	☐ 2	☐ 3	☐ 4

Who has the daily responsibilty for the dog?

Myself	A child	A partner	Other
☐ 1	☐ 2	☐ 3	☐ 4

Your own daily company with the dog, including week-ends?

(Cross once for each line)	Less than 1/2 hour	1/2-1 hour	1-2 hours	More than 2 hours
Walking	☐	☐	☐	☐
Active (play/training)..	☐	☐	☐	☐
Passive company	☐	☐	☐	☐
	1	2	3	4

Please consider the following statements: *(Cross once for each line)*

	Disagree	Partly disagree	Uncertain	Partly agree	Agree
The dog lightens contact with other people	☐	☐	☐	☐	☐
The dog has positive influence on my psychological health	☐	☐	☐	☐	☐
The dog makes me feel safer	☐	☐	☐	☐	☐
The dog makes me more physical active	☐	☐	☐	☐	☐
I am satisfied with the dogs behaviour	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

SOCIAL CONTACT

Please state how much the following problems bothered you the last week. *(One cross for each problem)*

Fear of embarrassment causes me to avoid doing things or speaking to people:

Not at all	A little bit	Somewhat	Very much	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

I avoid activities in which I am the centre of attention:

Not at all	A little bit	Somewhat	Very much	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Being embarrassed or looking stupid are among my worst fears:

Not at all	A little bit	Somewhat	Very much	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

THOUGHTS AND FEELINGS

Below you find some questions about thoughts and feelings. If you have been different from the usual the last weeks or months, you think back to the period when you were yourself, when you answer.

	Yes	No
Do you suspect that people will exploit you if they know too much about you?	☐	☐
Do you regularly feel anxious or tense with other people?	☐	☐
Are you unwilling to get involved with people because you are afraid that they will not like you?	☐	☐
If «Yes»: Has this influenced how many friends you have got?	☐	☐
Do you continually change the way you present yourself because you really do not know who you are?	☐	☐
Do you get angry or irritable because others do not recognize your special talent and achievements as much as they should?	☐	☐

INFLUENCE AND SELF-ESTEEM

How accurate are the following statements for you?

	Not at all true	Barely true	Moderately true	Exactly true
I feel powerless most of the time	☐	☐	☐	☐
Making waves never gets you anywhere	☐	☐	☐	☐
You can't fight city hall	☐	☐	☐	☐
When I am unsure about something, I usually go along with the group	☐	☐	☐	☐
Experts are in the best position to decide what people should do or learn	☐	☐	☐	☐
Most of the misfortunes in my life were due to bad luck	☐	☐	☐	☐
Usually, I feel alone	☐	☐	☐	☐
People have no right to be angry just because they dissent in something	☐	☐	☐	☐
People have right to make their own decisions, even if they are bad ones	☐	☐	☐	☐
People should try to live their lives the way they want to	☐	☐	☐	☐
People working together can have an effect on their community	☐	☐	☐	☐
People have more power if they join together as a group	☐	☐	☐	☐
Working with others in my community can help to change things for the better	☐ 1	☐ 2	☐ 3	☐ 4

INFLUENCE AND SELF-ESTEEM (cont.)

How accurate are the following statements for you?

	Not at all true	Barely true	Moderately true	Exactly true
Very often a problem can be solved by taking action	☐	☐	☐	☐
I always manage to solve difficult problems if I try hard enough	☐	☐	☐	☐
If someone opposes me, I can find means and ways to get what I want	☐	☐	☐	☐
It is easy for me to stick to my aims and accomplish my goals	☐	☐	☐	☐
I am confident that I could deal efficiently with unexpected events	☐	☐	☐	☐
Thanks to my resourcefulness, I know how to handle unforeseen situations	☐	☐	☐	☐
I can solve most problems if I invest the necessary effort	☐	☐	☐	☐
I remain calm when facing difficulties because I can rely on my coping abilities	☐	☐	☐	☐
When I am confronted with a problem, I usually find several solutions	☐	☐	☐	☐
If I am in a bind, I can usually think of something to do	☐	☐	☐	☐
No matter of what comes my way, I'm usually able to handle it	☐ 1	☐ 2	☐ 3	☐ 4

GRIEF

Have you experienced grief which has affected your health in the past or is affecting it now? *(One cross)*

Yes, once in the past	Yes, several times in the past	Yes, now	No
☐ 1	☐ 2	☐ 3	☐ 4

If you have <u>not</u> experienced grief that has affected/is affecting your health, go straight to INCONTINENCE (Bladder)

If you have experienced such grief, what kind of health disorders did you get as a result of the episode?
(the <u>last</u>, episode, if you have experienced several)

Mainly bodily	Mainly emotional	Both, to about the same extent
☐ 1	☐ 2	☐ 3

About how long did the health disorders last before, or have lasted now?
(the <u>last</u>, if you have experienced several episodes of grief)

☐☐ weeks or ☐☐ months or ☐☐ years

GRIEF (cont.)

If you have experienced such grief, was it a result of?
(the <u>last</u>, if you have experienced several episodes of grief)
(One cross for each line)

Death of:	Yes	No
Spouse (husband or wife) or partner	☐	☐
Child	☐	☐
Parent(s)	☐	☐
Other close relation	☐	☐
Friend	☐	☐
Other	☐	☐

	Yes	No
Serious illness:	☐	☐
Separation/divorce:	☐	☐
Other:	☐	☐

If «Yes» to «Other», specify:

_____

Did you receive professional help after the episode? *(the <u>last</u>, if you have experienced several episodes)*	Yes	No
	☐	☐

If «Yes»; **Cross off for who gave the help:**
(One cross for each line)

	Yes	No
General practitioner	☐	☐
Psychiatrist	☐	☐
Psychologist	☐	☐
Other counsellor	☐	☐
Minister of religion (priest)	☐	☐
Grief counselling group	☐	☐
Other	☐	☐

If «Yes» to «Other», specify:

_____

Were you given on prescription medicine as part of the therapy? *(<u>last time</u>, if you have experienced several episodes of grief)*	Yes	No
	☐	☐

THE REMAINING SHOULD BE ANSWERED ONLY BY WOMEN:

LEAKAGE OF URINE

Yes No

Do you have leakage of urine (no matter how much) at least two times pr. month? ..... ☐ ☐

If «No» - move further to LEAKAGE OF GAS/STOOL.

If «Yes»:

How often do you have leakage of urine? *(One cross)*

Only few times pr. month	One or more times pr. week	Each day and/or night
☐ 1	☐ 2	☐ 3

How much urine do you leak each time? *(One cross)*

Drops or little ..... ☐ 1

Small dashes or more ..... ☐ 2

Do you have leakage of urine in conjunction to: Yes No

Coughing, sneezing or laughter? ..... ☐ ☐

Lifting? ..... ☐ ☐

Yes No

Does it happen that you leak urine in conjunction to strong impulse to urinate?..... ☐ ☐

How do you feel about your leakage of urine? *(One cross)*

No problem	Small problems	Problematic	Major problems	Very problematic
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Yes No

Have you ever asked for help concerning your urine leakage? ..... ☐ ☐

If «Yes»: **Who have you asked for help?**

Physiotherapist	General practitioner	Specialist/ hospital	Other
☐	☐	☐	☐

Yes No

Do you have received treatment for urine leakage? ☐ ☐

If «Yes»: **What treatment have you received?**

Pelvis floor exercise	Medicaments	Operation	Electrical stimulation	Other
☐	☐	☐	☐	☐

GAS/STOOL LEAKAGE

Yes No Not sure

Have you a chronic intestinal disease? ☐ ☐ ☐

No Yes, gas Yes, stool

Have you leakage of gas/stool? ..... ☐ ☐ ☐

How often do you have leakage of gas/stool?
(Cross once for gas and once for stool)

	Gas	Stool
Few times pr. year	☐ 1	☐ 1
Few times pr. month	☐ 2	☐ 2
One or more times pr. week	☐ 3	☐ 3
Each day and/or night	☐ 4	☐ 4

How do you feel about your leakage of gas/stool? *(One cross)*

No problem	Small problems	Problematic	Major problems	Very problematic
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Have you ever asked for help concerning your leakage of gas/stool?

No	Yes, for leakage of gas	Yes, for leakage of stool
☐	☐	☐

Who have you asked for help?

Physiotherapist	General practitioner	Specialist/ hospital	Other
☐	☐	☐	☐

Yes No

Have you received treatment for leakage of gas/stool? ☐ ☐

If «Yes»: **What treatment have you received?**

Pelvis floor exercise	Medicaments	Operation	Anal plug	Other
☐	☐	☐	☐	☐