

The Norwegian Influenza Cohort Study

Questionnaire about influenza and vaccines

About influenza

The form will be read by a machine. Therefore it is important to use blue or black ballpoint pen and write clearly.

- In the small check boxes, set a cross for the most appropriate answer, as follows:
- If you have set the cross in the wrong box, you can correct it by filling in the box completely, as follows:
- Number boxes have two or more panes. When you write a one-digit number, use the right pane. Example: 5 is written as

Enter day, month and year of completion of the form (write the year with 4 digits, e.g. 2010)
day month year

When is your ultrasound due date:

Which week of pregnancy are you in now?

1. During the past 12 months have you had swine influenza or other influenza-like illness?

No Yes Don't know

If 'no' go to Q14

2. When were you ill? (Specify which month and year each time)

Month Year

3. Did you visit the doctor?

No Yes

4. If yes, No Yes Don't know

Was a nasal or throat sample taken from you?

Was a blood sample taken from you?

5. Did the test(s) confirm that you had:

No Yes Don't know

Swine influenza?

Seasonal influenza?

6. How ill did you feel?

Not very ill

Quite ill, in bed for several days

Very ill

7. Were you hospitalised in connection with influenza?

No Yes

If yes, in which hospital?

8. When were you hospitalised? (Enter date in month and year.)

Month Year

9. How long were you ill?

0-2 days

3-5 days

More than 5 (number of days):

Don't know

10. If you had influenza, mark which symptoms you had and how many days they lasted.

(You can select multiple symptoms)

	No Yes		Number of days with symptoms		
			0-2	3-5	More than 5
1. Headache					
2. Stuffy nose / runny nose					
3. Sore throat					
4. Cough					
5. Shortness of breath					
6. Chest pain					
7. Fever below 39.0					
8. Fever of 39.0 or higher					
9. Fever (not measured)					
10. Convulsions					
11. Other convulsions					
12. Joint pain					
13. Muscle pain					
14. Vomiting, diarrhoea					
15. Ear infection					
16. Pneumonia					
17. Other					
Describe					

11. If you had swine influenza / influenza, were you pregnant when you were ill?

No Yes, week of pregnancy

12. If you were pregnant when you had swine influenza / influenza, did you experience any of the following while you were ill?

	Number of days (duration)			Did you visit doctor/midwife?			
	No	Yes	0-2	3-5	More than 5	No	Yes
Braxton-Hicks (false) contractions							
- More than before							
- Less than before							
Foetal activity / kicking							
- More than before							
- Less than before							
Other, describe below							

13. Did you experience fatigue following swine influenza / influenza?

No

Yes, number of weeks duration

Yes, still experiencing fatigue

Don't know

14. Do you have one or more of the following diseases / conditions?

No Yes

1. Asthma
2. Diabetes type 1
3. Diabetes type 2
4. Other lung disease
5. Severe overweight
6. Cardiovascular disease
7. Kidney disease
8. Impaired immune system
9. Other condition

Describe:

15. Has anyone in your household had swine influenza / influenza in the last 12 months?

No

Yes

If yes, who?

Spouse / Partner No

Children

Other

If yes, were you pregnant then?

Yes, in week XX of pregnancy

Don't know

16. How worried are you that swine influenza / influenza can be dangerous for you or your child?

Very little worried Very worried

0 1 2 3 4 5 6 7 8 9 10

About the use of medicines

17. Have you used / do you use medicine during pregnancy?

No Yes

18. If yes, state the name of the medicine and whether it is used regularly or occasionally.

Use regularly Use as required

Medicine 1

Medicine 2

Medicine 3

Medicine 4

19. Have you used medicines for influenza during the last 12 months?

No Yes

20. If yes, what type of medicine did you use and were you pregnant when you used it?

Number of days (duration)

1-5 5-10 more than 10

Were you pregnant when you used the medicine?

No Yes weeks of pregnancy

Tamiflu

Relenza

Name of medicine

Antipyretic drugs:

Antibiotics:

Other prescribed medicine:

Other non-prescription medicine:

21. Was the medicine used because you were ill or to prevent disease?

Because I had influenza / swine influenza

Preventive

22. Did you experience side effects from the medicine?

No Yes Don't know

If yes, please describe

About swineinfluenza vaccine and other vaccines

23. Are you vaccinated against swine influenza?

No Yes Don't know

If not, why not? (you may mark multiple boxes)

I am pregnant

I was afraid of adverse events

I want a natural immune system

The experts disagreed about the vaccine

Healthcare professionals advised against vaccination

I did not trust the vaccine

I am principally opposed to vaccines

I have had swine influenza

Swine influenza is not dangerous

Other, describe _____

If yes, why? (you may mark multiple boxes)

Swine influenza can be a serious illness

I wanted to protect my unborn child

Healthcare professionals advised vaccination

I am in a risk group for swine influenza

Because of my work

To avoid infecting family or friends

A vaccination day was arranged

Other, describe

24. On a scale of 0 to 10, to which degree do you agree that you have received good information about the vaccine against swine influenza?

Totally disagree Totally agree

0 1 2 3 4 5 6 7 8 9 10

25. On a scale of 0 to 10, how concerned are you that the swine influenza vaccine may be dangerous for you or your child?

Very little worried Very worried

0 1 2 3 4 5 6 7 8 9 10

If you have NOT had the vaccine against swine influenza, go to question 35.

26. Were you pregnant when you received the vaccine against swine influenza?

No

Yes, in pregnancy week

Do not know

27. If you were pregnant when you received the vaccine against swine influenza, did you experience any of the following after you were vaccinated?

If yes, number of days with symptoms (duration) If yes, visited doctor or midwife

No Yes 0-2 3-5 More than 5 No Yes

Braxton-Hicks(false) contractions

- More than before

- Less than before

Foetal activity / kicking

- More than before

- Less than before

Other, describe below

28. If you have received the swine influenza vaccine, did you experience any adverse events?

No Yes Don't know

29. If yes, how long after vaccination did the adverse event(s) start?

Within 30 minutes

30 minutes -12 hours

13 to 23 hours

1 - 3 days

After 3 days

Don't know

30. If you experienced adverse events from the swine influenza vaccine, which events and how long did they last?

(you may mark multiple adverse events)

Number of days with adverse events

0-2 days 3-5 days more than 5 days

1. Pain, swelling in the arm

2. Fever

3. Headache

4. Rash elsewhere on the body than around the injection site

5. Nausea, vomiting

6. Influenza-like symptoms

7. Allergic reaction

8. Anaphylactic reaction (shock)

9. Other adverse events

Describe

31. Did you experience fatigue after the vaccine?

No

Yes, number of weeks

Yes, I am still experiencing fatigue

32. Did you contact a doctor because of adverse events?

No
Yes

33. Were you hospitalised because of the adverse events?

No
Yes

34. If yes, which hospital

35. Have you received vaccine against seasonal influenza during the last 12 months?

No Yes Don't know

36. Have you received other vaccines during the last 12 months?

No Yes

37. If yes, which vaccine(s)

38. Are you allergic to eggs?

No
Yes, slight allergy
Yes, severe allergy
Yes, have had an anaphylactic shock
Don't know

39. Do you have any other allergies?

No Yes

40. If yes, what kind of allergy do you have?

Pollen allergy / hay fever
Animal hair Allergy
Food allergy
Other, describe

41. Have you ever had an allergic shock (anaphylactic reaction)?

No Yes

42. Have you in 3 months duration before pregnancy / during this pregnancy which were marked by some of the following problems:

If yes

Last three months of pregnancy before pregnancy	In this pregnancy, week of pregnancy
No Yes	0-12 13-24 25 +

Mental and / or physical fatigue

Sleeping problems

Depressed mood

Concentration problems

Difficulty performing daily activities, work, school, etc.

Comments

Have you remembered to fill in the date for completing the form on page 1?
Thank you for your help.