

ECRHS APPENDIX B 1 Main Questionnaire

Area number					1-3
Personal number					4-8
Sample					9
Date					10-15
	DAY	MONTH	YEAR		

I AM GOING TO ASK YOU SOME QUESTIONS. AT FIRST THESE WILL BE MOSTLY ABOUT YOUR BREATHING. WHEREVER POSSIBLE, I WOULD LIKE YOU TO ANSWER 'YES' OR 'NO'.

Wheeze and tightness in the chest

CARD 2

1. Have you had wheezing or whistling in your chest at any time in the last **12 months**? NO YES
 16

IF 'NO' GO TO QUESTION 2, IF 'YES':

1.1 Have you been at all breathless when the wheezing noise was present? NO YES
 17

1.2. Have you had this wheezing or whistling when you did **not** have a cold? NO YES
 18

2. Have you woken up with a feeling of tightness in your chest at any time in the last **12 months**? NO YES
 19

Shortness of breath

3. Have you had an attack of shortness of breath that came on during the day when you were at rest at any time in the last **12 months**? NO YES
 20

4. Have you had an attack of shortness of breath that came on **following** strenuous activity at any time in the last **12 months**? NO YES
 21

5. Have you been woken by an attack of shortness of breath at any time in the last **12 months**? NO YES
 22

Cough and phlegm from the chest

6. Have you been woken by an attack of coughing at any time in the last **12 months**? NO YES
 23

7. Do you **usually** cough first thing in the morning in the winter?
[IF DOUBTFUL, USE QUESTION 8.1 TO CONFIRM] NO YES
 24

8. Do you **usually** cough during the day, or at night, in the winter? NO YES
 25

IF 'NO' GO TO QUESTION 9, IF 'YES':

8.1 Do you cough like this on most days for as much as three months each year? NO YES
 26

ECRHS APPENDIX B 1 Main Questionnaire

9. Do you *usually* bring up any phlegm from your chest first thing in the morning in the winter? **[IF DOUBTFUL, USE QUESTION 10.1 TO CONFIRM]** NO YES
 27

10. Do you *usually* bring up any phlegm from your chest during the day, or at night, in the winter? NO YES
 28

IF 'NO' GO TO QUESTION 11, IF 'YES':

10.1 Do you bring up phlegm like this on most days for as much as three months each year? NO YES
 29

Breathing

11. Do you ever have trouble with your breathing? NO YES
 30

IF 'NO' GO TO QUESTION 12, IF 'YES':

11.1 Do you have this trouble TICK ONE BOX ONLY
a) continuously so that your breathing is never quite right? 1
b) repeatedly, but it always gets completely better? 2
c) only rarely? 3 31

12. Are you disabled from walking by a condition *other than* heart or lung disease? NO YES
 32

IF 'YES' STATE CONDITION _____ AND GO TO QUESTION 13, IF 'NO':

12.1 Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? NO YES
 33

IF 'NO' GO TO QUESTION 13, IF 'YES':

12.1.1 Do you get short of breath walking with other people of NOYES your own age on level ground? 34

IF 'NO' GO TO QUESTION 13, IF 'YES':

12.1.1.1 Do you have to stop for breath when walking at your own pace on level ground? NO YES
 35

Asthma

13. Have you ever had asthma? NO YES
 36

IF 'NO' GO TO QUESTION 14, IF 'YES':

13.1 Was this confirmed by a doctor? NO YES
 37

ECRHS APPENDIX B 1 Main Questionnaire

13.2 How old were you when you had your first attack of asthma? YEARS
 38-39

13.3 How old were you when you had your most recent attack of asthma? YEARS
 40-41

13.4.1-6 Which months of the year do you usually have attacks of asthma?

13.4.1 January / February NO YES
 42

13.4.2 March / April 43

13.4.3 May / June 44

13.4.4 July / August 45

13.4.5 September / October 46

13.4.6 November / December 47

13.5 Have you had an attack of asthma in the last **12 months**? NO YES
 48

IF 'NO' GO TO QUESTION 13.6, IF 'YES':

13.5.1 How many attacks of asthma have you had in the last **12 months**? NUMBER
 49-50

13.6 Are you currently taking any medicines, including inhalers, aerosols or tablets, for asthma? NO YES
 51

Other conditions

14. Do you have any nasal allergies, including hay fever? NO YES
 52

15. Have you ever had eczema or any kind of skin allergy? NO YES
 53

16. Are you allergic to any insect stings or bites? NO YES
 54

IF 'NO' GO TO QUESTION 17, IF 'YES':

16.1 Which insect? _____ 55-56

16.2.1-3 What kind of reaction do you have?

16.2.1 breathing difficulty, feeling faint, nausea or fever NO YES
 57

16.2.2 redness, itching or swelling at the site of the sting 58

16.2.3 other: _____ 59

17. Have you ever had any difficulty with your breathing after taking medicines? NO YES
 60

IF 'NO' GO TO QUESTION 18, IF 'YES':

ECRHS APPENDIX B 1 Main Questionnaire

17.1 Which medicines? _____ 1 61
 2 62

Your parents' smoking

18. Did your father ever smoke regularly during your childhood? NO YES DONT KNOW 63

19. Did your mother ever smoke regularly during your childhood, or before you were born? NO YES DONT KNOW 64

IF 'NO' OR 'DONT KNOW' GO TO QUESTION 20, IF 'YES':

19.1 When your mother was pregnant, in particular with you, did she
 a) stop smoking before pregnancy? TICK ONE BOX ONLY 1
 b) cut down or stop during pregnancy? 2
 c) smoke as usual during pregnancy? 3
 d) don't know 4 65

More about yourself

20. When were you born? DAY MONTH YEAR 66-71

21. What country were you born in? _____ 72-74

22. Are you male or female? MALE FEMALE 75

23. How many brothers do or did you have? NUMBER 76-77

INTERVIEW TYPE?

At centre face to face TICK ONE BOX ONLY 1
 At home face to face 2
 By telephone 3 78

23. continued... CARD NUMBER 79-80
 CARD 3

IF 'NONE' GO TO QUESTION 24, IF 'YES':

23.1 How many *older* brothers? DUPLICATE 1-9 NUMBER 10-11
 23.2 How many *younger* brothers? 12-13
 23.3 How many of your brothers ever had asthma? 14-15
 23.4 How many of your *other* brothers ever had eczema, skin or nasal allergy or hay fever? NUMBER 16-17
 NUMBER

ECRHS APPENDIX B 1 Main Questionnaire

- a) a manager working for an employer? 1
- b) a foreman or supervisor working for an employer? 2
- c) working for an employer, but neither a manager, supervisor or foreman? 3
- d) self-employed? 4 43

32.5 Does being at work ever make your chest tight or wheezy? NO YES 44

32.6 Have you ever had to change or leave your job because it affected your breathing? NO YES 45

IF 'NO' GO TO QUESTION 32.7 IF 'YES':

32.6.1 What was this job? [Be as precise as possible]

_____ 46-48

32.7 Have you ever worked in a job which exposed you to vapours, gas, dust or fumes? NO YES 49

IF 'NO' GO TO QUESTION 33, IF 'YES':

32.7.1 What was or is this job? [Be as precise as possible]
If current job write 'current job'

_____ 50-52

Your home

33. How many years have you lived in your present home? YEARS 53-54

34. How many years have you lived in _____? [Insert area name] YEARS 55-56

35. When was your present home built? TICK ONE BOX ONLY

- a) before 1960? 1
- b) 1961-1970? 2
- c) 1971-1980? 3
- d) 1981 or later? 4
- e) don't know 5 57

36. Which best describes the building in which you live? TICK ONE BOX ONLY

- a) a mobile home or trailer? 1
- b) a one family house detached from any other house? 2
- c) a one family house attached to one or more houses? 3
- d) a building for two families? 4

ECRHS APPENDIX B 1 Main Questionnaire

- e) a building for three or four families? 5
- f) a building for five or more families? 6
- g) a boat, tent or van 7
- e) other: _____ 8 58

37.1-3 Does your home have any of the following?

- | | | | |
|-------------------------|-----------------------------|------------------------------|----|
| 37.1 central heating | NO <input type="checkbox"/> | YES <input type="checkbox"/> | 59 |
| 37.2 ducted air heating | <input type="checkbox"/> | <input type="checkbox"/> | 60 |
| 37.3 air conditioning | <input type="checkbox"/> | <input type="checkbox"/> | 61 |

38.1-7 Which of the following fuels do you use for heating or for hot water?

- | | | | |
|-----------------------------------|-----------------------------|------------------------------|----|
| 38.1 open coal, coke or wood fire | NO <input type="checkbox"/> | YES <input type="checkbox"/> | 62 |
| 38.2 open gas fire | <input type="checkbox"/> | <input type="checkbox"/> | 63 |
| 38.3 electric heater | <input type="checkbox"/> | <input type="checkbox"/> | 64 |
| 38.4 paraffin heater | <input type="checkbox"/> | <input type="checkbox"/> | 65 |
| 38.5 gas-fired boiler | <input type="checkbox"/> | <input type="checkbox"/> | 66 |
| 38.6 oil-fired boiler | <input type="checkbox"/> | <input type="checkbox"/> | 67 |
| 38.7 other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | 68 |

39. What kind of stove do you *mostly* use for cooking?

- | | | | |
|-------------------------------------|-------------------|--------------------------|----|
| a) coal, coke or wood (solid fuel)? | TICK ONE BOX ONLY | | |
| b) gas? | 1 | <input type="checkbox"/> | |
| c) electric? | 2 | <input type="checkbox"/> | |
| d) paraffin? | 3 | <input type="checkbox"/> | |
| e) other: _____ | 4 | <input type="checkbox"/> | |
| | 5 | <input type="checkbox"/> | 69 |

40. Do you have an extractor fan over the cooker?

	NO	YES	DON'T KNOW	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70

IF 'NO' OR 'DON'T KNOW' GO TO QUESTION 41, IF 'YES':

40.1 When cooking, do you use the fan

- | | | | |
|----------------------|-------------------|--------------------------|----|
| a) all of the time? | TICK ONE BOX ONLY | | |
| b) some of the time? | 1 | <input type="checkbox"/> | |
| c) none of the time? | 2 | <input type="checkbox"/> | |
| | 3 | <input type="checkbox"/> | 71 |

40.2 Does the fan take the fumes outside the house?

	NO	YES	DON'T KNOW	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	72

41.1-5 Does the room which you use most at home during the day

- | | | | |
|--|-----------------------------|------------------------------|----|
| 41.1 have fitted carpets covering the whole floor? | NO <input type="checkbox"/> | YES <input type="checkbox"/> | 73 |
|--|-----------------------------|------------------------------|----|

ECRHS APPENDIX B 1 Main Questionnaire

41.2 contain rugs?	<input type="checkbox"/>	<input type="checkbox"/>	74
41.3 have double glazing?	<input type="checkbox"/>	<input type="checkbox"/>	75
41.4 have curtains?	<input type="checkbox"/>	<input type="checkbox"/>	76
41.5 have upholstered or soft furnishings?	<input type="checkbox"/>	<input type="checkbox"/>	77
	BLANK		78
	CARD NUMBER <input type="checkbox"/>		79-80
	CARD 4		
42.1-5 Does your bedroom	DUPLICATE 1-9		
	NO	YES	
42.1 have fitted carpets covering the whole floor?	<input type="checkbox"/>	<input type="checkbox"/>	10
42.2 contain rugs?	<input type="checkbox"/>	<input type="checkbox"/>	11
42.3 have double glazing?	<input type="checkbox"/>	<input type="checkbox"/>	12
42. continued...			
	NO	YES	
42.4 have curtains?	<input type="checkbox"/>	<input type="checkbox"/>	13
42.5 have upholstered or soft furnishings?	<input type="checkbox"/>	<input type="checkbox"/>	14
If 'NO' ask: Do you have a conventional mattress?			
If 'YES': code 'YES'			
	NO	YES	
43. Do you sleep with the windows open at night during winter?	<input type="checkbox"/>	<input type="checkbox"/>	15
IF 'NO' GO TO QUESTION 44, IF 'YES':			
43.1 Do you sleep with the windows open		TICK ONE BOX ONLY	
a) all of the time?		1 <input type="checkbox"/>	
b) sometimes?		2 <input type="checkbox"/>	
c) only occasionally?		3 <input type="checkbox"/>	16
		DONT	
44. Has there ever been any water damage to the building or its contents, for example, from broken pipes, leaks or floods?	NO	YES	KNOW
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			17
IF 'NO' OR 'DON'T KNOW' GO TO QUESTION 45, IF 'YES':			
44.1 Has there been any water damage in the last <i>12 months</i> ?	NO	YES	DONT KNOW
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			18
45. Do you have a basement or cellar?		NO	YES
		<input type="checkbox"/>	<input type="checkbox"/>
			19
IF 'NO' GO TO QUESTION 46, IF 'YES':			
45.1 Does water ever collect on the basement floor?	NO	YES	DONT KNOW
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			20
IF 'NO' OR 'DON'T KNOW' GO TO QUESTION 46, IF 'YES':			
45.1.1 Has this happened in the last <i>12 months</i> ?	NO	YES	
	<input type="checkbox"/>	<input type="checkbox"/>	21
		DONT	
46. Has there ever been any mould or mildew on any surface, other than	NO	YES	KNOW

ECRHS APPENDIX B 1 Main Questionnaire

food, inside the home?

22

IF 'NO' OR 'DON'T KNOW' GO TO QUESTION 47, IF 'YES':

46.1.1-6 Which rooms have been affected?

46.1.1 bathroom(s)

NO YES 23

46.1.2 bedroom(s)

24

46.1.3 living area(s)

25

46.1.4 kitchen

26

46.1.5 basement or attic

27

46.1.6 other: _____

28

46.2 Has there been mould or mildew on any surfaces inside the home in the last **12 months**?

NO YES 29

47. Do you use a humidifier, including any humidifier built into your heating system?

NO YES DON'T KNOW 30

IF 'NO' OR 'DON'T KNOW' GO TO QUESTION 48, IF 'YES':

47.1 What kind of humidifier do you use?

a) humidifier built into heating system

TICK ONE BOX ONLY

1

b) portable cold mist (ultrasonic or spinning disc)

2

c) portable hot mist vaporiser

3

d) other: _____

4 31

47.2 Under what circumstances do you use your humidifier?
 ONE

a) only when someone is ill - in their room

BOX ONLY

1

b) to humidify the house

2

d) other: _____

3 32

Animals, dust and feathers

48. Do you keep a cat?

NO YES 33

IF 'NO' GO TO QUESTION 49, IF 'YES':

48.1 Is your cat ever allowed into your bedroom?

NO YES 34

48.2 Do all your cats stay outside the house?

35

49. Do you keep a dog?

NO YES 36

IF 'NO' GO TO QUESTION 50, IF 'YES':

NO YES

ECRHS APPENDIX B 1 Main Questionnaire

49.1 Is your dog ever allowed into your bedroom?

<input type="checkbox"/>	<input type="checkbox"/>	37
--------------------------	--------------------------	----

49.2 Do all your dogs stay outside the house?

<input type="checkbox"/>	<input type="checkbox"/>	38
--------------------------	--------------------------	----

NO YES

50. Do you keep any birds?

<input type="checkbox"/>	<input type="checkbox"/>	39
--------------------------	--------------------------	----

IF 'NO' GO TO QUESTION 51, IF 'YES':

50.1 Are any of these birds kept inside the house?

<input type="checkbox"/>	<input type="checkbox"/>	40
--------------------------	--------------------------	----

51.1-12 When you were a child did anyone in your household keep any of the following pets?

51.1 cats

<input type="checkbox"/>	<input type="checkbox"/>	41
--------------------------	--------------------------	----

51.2 dogs

<input type="checkbox"/>	<input type="checkbox"/>	42
--------------------------	--------------------------	----

51.3 horses

<input type="checkbox"/>	<input type="checkbox"/>	43
--------------------------	--------------------------	----

51.4 birds

<input type="checkbox"/>	<input type="checkbox"/>	44
--------------------------	--------------------------	----

51.5 guinea pigs

<input type="checkbox"/>	<input type="checkbox"/>	45
--------------------------	--------------------------	----

51.6 hamsters

<input type="checkbox"/>	<input type="checkbox"/>	46
--------------------------	--------------------------	----

51. continued...

51.7 mice

<input type="checkbox"/>	<input type="checkbox"/>	47
--------------------------	--------------------------	----

51.8 rats

<input type="checkbox"/>	<input type="checkbox"/>	48
--------------------------	--------------------------	----

51.9 rabbits

<input type="checkbox"/>	<input type="checkbox"/>	49
--------------------------	--------------------------	----

51.10 gerbils

<input type="checkbox"/>	<input type="checkbox"/>	50
--------------------------	--------------------------	----

51.11 ferrets

<input type="checkbox"/>	<input type="checkbox"/>	51
--------------------------	--------------------------	----

51.12 other: _____

<input type="checkbox"/>	<input type="checkbox"/>	52
--------------------------	--------------------------	----

52.1-6 When you are near animals, such as cats, dogs or horses, near feathers, including pillows, quilts or duvets, or in a dusty part of the house, do you *ever*

52.1 start to cough?

<input type="checkbox"/>	<input type="checkbox"/>	53
--------------------------	--------------------------	----

52.2 start to wheeze?

<input type="checkbox"/>	<input type="checkbox"/>	54
--------------------------	--------------------------	----

52.3 get a feeling of tightness in your chest?

<input type="checkbox"/>	<input type="checkbox"/>	55
--------------------------	--------------------------	----

52.4 start to feel short of breath?

<input type="checkbox"/>	<input type="checkbox"/>	56
--------------------------	--------------------------	----

52.5 get a runny or stuffy nose or start to sneeze?

<input type="checkbox"/>	<input type="checkbox"/>	57
--------------------------	--------------------------	----

52.6 get itchy or watering eyes?

<input type="checkbox"/>	<input type="checkbox"/>	58
--------------------------	--------------------------	----

Trees, grass, plants, flowers and pollen

53.1-6 When you are near trees, grass or flowers, or when there is a lot of pollen about, do you *ever*

53.1 start to cough?

<input type="checkbox"/>	<input type="checkbox"/>	59
--------------------------	--------------------------	----

53.2 start to wheeze?

<input type="checkbox"/>	<input type="checkbox"/>	60
--------------------------	--------------------------	----

53.3 get a feeling of tightness in your chest?

<input type="checkbox"/>	<input type="checkbox"/>	61
--------------------------	--------------------------	----

ECRHS APPENDIX B 1 Main Questionnaire

- | | | | |
|---|--------------------------|--------------------------|----|
| 53.4 start to feel short of breath? | <input type="checkbox"/> | <input type="checkbox"/> | 62 |
| 53.5 get a runny or stuffy nose or start to sneeze? | <input type="checkbox"/> | <input type="checkbox"/> | 63 |
| 53.6 get itchy or watering eyes? | <input type="checkbox"/> | <input type="checkbox"/> | 64 |

IF 'YES' TO ANY OF THE ABOVE:

- | | | | |
|---|--------------------------|--------------------------|----|
| 53.1.1-4 Which time of year does this happen? | | | |
| 53.1.1 winter | <input type="checkbox"/> | <input type="checkbox"/> | 65 |
| 53.1.2 spring | <input type="checkbox"/> | <input type="checkbox"/> | 66 |
| 53.1.3 summer | <input type="checkbox"/> | <input type="checkbox"/> | 67 |
| 53.1.4 autumn | <input type="checkbox"/> | <input type="checkbox"/> | 68 |

Diet

- | | | | |
|---|--|--|--|
| 54. How often do you eat pre-packaged food, such as tinned food or pre-prepared frozen meals? | | | |
| a) every day or most days | | | |
| b) at least once a week | | | |
| c) less than once a week | | | |
- TICK ONE BOX ONLY
- | | | |
|---|--------------------------|----|
| 1 | <input type="checkbox"/> | |
| 2 | <input type="checkbox"/> | |
| 3 | <input type="checkbox"/> | 69 |

- | | | | |
|--|--|--|--|
| 55. How often do you drink sweet fizzy drinks? | | | |
| a) every day or most days | | | |
| b) at least once a week | | | |
| c) less than once a week | | | |
- TICK ONE BOX ONLY
- | | | |
|---|--------------------------|----|
| 1 | <input type="checkbox"/> | |
| 2 | <input type="checkbox"/> | |
| 3 | <input type="checkbox"/> | 70 |

- | | | | |
|---------------------------------------|--------------------------|--------------------------|----|
| 56. Do you take snacks between meals? | <input type="checkbox"/> | <input type="checkbox"/> | 71 |
|---------------------------------------|--------------------------|--------------------------|----|

IF 'NO' GO TO QUESTION 57, IF 'YES':

- | | | | |
|---|--------------------------|--------------------------|----|
| 56.1-3 Which of the following would you have as a snack at least <i>once a week</i> ? | | | |
| 56.1 savoury biscuits or crisps | <input type="checkbox"/> | <input type="checkbox"/> | 72 |
| 56.2 sweets, chocolates or sweet biscuits | <input type="checkbox"/> | <input type="checkbox"/> | 73 |
| 56.3 fruit or vegetables | <input type="checkbox"/> | <input type="checkbox"/> | 74 |

- | | | | |
|---|--------------------------|--------------------------|----|
| 57. Have you ever had an illness or trouble caused by eating a <i>particular</i> food or foods? | <input type="checkbox"/> | <input type="checkbox"/> | 75 |
|---|--------------------------|--------------------------|----|

IF 'NO' GO TO QUESTION 58, IF 'YES':

- | | | | |
|---|--------------------------|--------------------------|----|
| 57.1 Have you nearly always had the same illness or trouble after eating this type of food? | <input type="checkbox"/> | <input type="checkbox"/> | 76 |
|---|--------------------------|--------------------------|----|

BLANK 77-78

ECRHS APPENDIX B 1 Main Questionnaire

CARD NUMBER

--	--

79-80

IF 'NO' GO TO QUESTION 58, IF 'YES':

CARD 5

DUPLICATE 1-9

57.1.1 What type of food was this? [List up to 3]

--	--

10-11

--	--

12-13

--	--

14-15

57.1.2.1-6 Did this illness or trouble include

57.1.2.1 a rash or itchy skin?

57.1.2.2 diarrhoea or vomiting?

57.1.2.3 runny or stuffy nose?

57.1.2.4 severe headaches?

57.1.2.5 breathlessness?

57.1.2.6 other: _____

NO YES

--	--

--	--

16

--	--

--	--

17

--	--

--	--

18

--	--

--	--

19

--	--

--	--

20

--	--

--	--

21

Smoking

58. Have you ever smoked for as long as a year?

NO YES

--	--

--	--

22

['YES' means at least 20 packs of cigarettes or 12 oz (360 grams) of tobacco in a lifetime, or at least one cigarette per day or one cigar a week for one year]

ECRHS APPENDIX B 1 Main Questionnaire

IF 'NO' GO TO QUESTION 59, IF 'YES':

58.1 How old were you when you started smoking? YEARS
 23-24

58.2 Do you **now** smoke, as of *one month ago*? NO YES
 25

IF 'NO' GO TO QUESTION 58.3.1, IF 'YES':

58.2.1-4 How much do you **now** smoke on average

58.2.1 number of cigarettes per day NUMBER
 26-27

58.2.2 number of cigarillos per day 28-29

58.2.3 number of cigars a week 30-31

58.2.4 pipe tobacco in a) ounces / week 32-33

b) grams / week 34-36

58.3 Have you stopped or cut down smoking? NO YES
 37

IF 'NO' GO TO QUESTION 58.4, IF 'YES':

58.3.1 How old were you when you stopped or cut down smoking? YEARS
 38-39

58.3.2.1-4 *On average* of the entire time you smoked, before you stopped or cut down, how much did you smoke?

58.3.2.1 number of cigarettes per day NUMBER
 40-41

58.3.2.2 number of cigarillos per day 42-43

58.3.2.3 number of cigars a week 44-45

58.3.2.4 pipe tobacco in a) ounces / week 46-47

b) grams / week 48-50

58.4 Do you or did you inhale the smoke? NO YES
 51

59. Have you been **regularly** exposed to tobacco smoke in the last **12 months**? ['Regularly' means on most days or nights] NO YES
 52

IF 'NO' GO TO QUESTION 60, IF 'YES':

59.1 Not counting yourself, how many people in your household smoke regularly? NUMBER
 53-54

59.2 Do people smoke regularly in the room where you work? NO YES
 55

59.3 How many hours per day are you exposed to *other people's* tobacco smoke? HOURS
 56-57

Medicines and inhalers

ECRHS APPENDIX B 1 Main Questionnaire

60. Have you used any **inhaled** medicines to help your breathing at any time in the last **12 months**? NO YES
 58

IF 'NO' GO TO QUESTION 61, IF 'YES':

60.1-6 Which of the following have you used in the last **12 months**?

60.1 **beta-2-agonist inhalers** NO YES
 59

60.1.1 If used, which one? _____ 60-61

60.2 **non-specific adrenoreceptor agonist inhalers** NO YES
 62

60.2.1 If used, which one? _____ 63

60.3 **anti-muscarinic inhalers** NO YES
 64

60.3.1 If used, which one? _____ 65

60.4 **inhaled steroids** NO YES
 66

60.4.1 If used, which one? _____ 67

60.5 **other inhalers (non-steroid, single drug)** NO YES
 68

60.5.1 If used, which one? _____ 69

60.6 **inhaled compound inhalers** NO YES
 70

60.6.1 If used, which one? _____ 71

61. Have you used any **pills, capsules, tablets** or **medicines**, other than inhaled medicines, to help your breathing at any time in the last **12 months**? NO YES
 72

IF 'NO' GO TO QUESTION 62, IF 'YES':

61.1-6 Which of the following have you used in the last **12 months**?

61.1 **oral specific beta-2-agonists** NO YES
 73

61.1.1 If used, which one? _____ 74

61.2 **oral non-specific adrenoreceptor agonists** NO YES
 75

61.2.1 If used, which one? _____ 76

61.3 **oral anti-muscarinic drugs** NO YES
 77

61.3.1 If used, which one? _____ 78

ECRHS APPENDIX B 1 Main Questionnaire

CARD NUMBER 79-80
 CARD 6
 DUPLICATE 1-9

- 61.4 **oral methylxanthines** NO YES 10
 60.4.1 If used, which one? _____ 11
- 61.5 **oral steroids** NO YES 12
 61.5.1 If used, which one? _____ 13-14
- 61.6 **oral antihistamines** NO YES 15
 61.6.1 If used, which one? _____ 16
- 61.7 **oral compound bronchodilators (no sedatives)** NO YES 17
 61.7.1 If used, which one? _____ 18
- 61.8 **oral compound bronchodilators with sedatives** NO YES 19
 61.8.1 If used, which one? _____ 20
- 61.9 **other oral medications** NO YES 21
 61.9.1 If used, which one? _____ 22
62. Have you ever been vaccinated for allergy at any time in your life? NO YES DON'T KNOW 23
IF 'NO' OR 'DON'T KNOW' GO TO QUESTION 63, IF 'YES':
- 62.1 Have you been vaccinated for allergy in the last *12 months*? NO YES 24
63. Have you had any other **injections** to help your breathing at any time in the last *12 months*? NO YES 25
IF 'NO' GO TO QUESTION 64, IF 'YES':
- 63.1 What injections? _____ 26
 _____ 27
64. Have you had any suppositories to help your breathing at any time in the last *12 months*? NO YES 28

IF 'NO' GO TO QUESTION 65, IF 'YES':

ECRHS APPENDIX B 1 Main Questionnaire

64.1 What suppositories? _____ 29
 _____ 30

65. Have you used any other **remedies** to help your breathing at any time in the last **12 months**? NO YES 31

IF 'NO' GO TO QUESTION 66, IF 'YES':

65.1 What remedies? _____ 32
 _____ 33
 _____ 34

66. Do you take drugs every day to help your breathing even if you don't feel short of breath? NO YES 35

IF 'NO' GO TO QUESTION 67, IF 'YES':

66.1 Which drugs? _____ 36-37
 _____ 38-39
 _____ 40-41
 _____ 42-43
 _____ 44-45
 _____ 46-47
 _____ 48-49
 _____ 50-51

67. Do you take any drugs **only** for attacks of breathlessness? NO YES 52

IF 'NO' GO TO QUESTION 68, IF 'YES':

67.1 Which drugs? _____ 53-54
 _____ 55-56
 _____ 57-58
 _____ 59-60
 _____ 61-62
 _____ 63-64

67.2 Do you take these drugs 65
 a) at the onset of the attack? 1
 b) only when the attack becomes more severe? 2

68. Has your doctor ever prescribed medicines, including inhalers, for your breathing? NO YES 66

IF 'NO' GO TO QUESTION 69, IF 'YES':

ECRHS APPENDIX B 1 Main Questionnaire

68.1 If you are prescribed medicines for your breathing, do you *normally* take

- a) all of the medicine?
- b) most of the medicine?
- c) some of the medicine?
- d) none of the medicine?

TICK ONE BOX ONLY

1	<input type="checkbox"/>
2	<input type="checkbox"/>
3	<input type="checkbox"/>
4	<input type="checkbox"/>

67

68.2 *When your breathing gets worse*, and you are prescribed medicines for your breathing, do you normally take

- a) all of the medicine?
- b) most of the medicine?
- c) some of the medicine?
- d) none of the medicine?

TICK ONE BOX ONLY

1	<input type="checkbox"/>
2	<input type="checkbox"/>
3	<input type="checkbox"/>
4	<input type="checkbox"/>

68

68.3 Do you think it is bad for you to take medicines all the time to help your breathing?

NO	YES
<input type="checkbox"/>	<input type="checkbox"/>

69

68.4 Do you think you should take as much medicine as you need to get rid of *all* your breathing problems?

NO	YES
<input type="checkbox"/>	<input type="checkbox"/>

70

69. Have you ever visited a hospital casualty department or emergency room because of breathing problems?

NO	YES
<input type="checkbox"/>	<input type="checkbox"/>

71

70. Have you ever spent a night in hospital because of breathing problems?

NO	YES
<input type="checkbox"/>	<input type="checkbox"/>

72

IF 'NO' GO TO QUESTION 71, IF 'YES':

70.1 How many times in the last *12 months*?

NUMBER	
<input type="text"/>	<input type="text"/>

73-74

71. Have you ever been seen by a doctor because of breathing problems or because of shortness of breath?

NO	YES
<input type="checkbox"/>	<input type="checkbox"/>

75

IF 'NO' GO TO END, IF 'YES':

71.1 When was the last time you were seen by a doctor because of breathing problems or because of shortness of breath?

- a) within the last seven days
- b) more than seven days ago but within the last four weeks
- c) more than four weeks ago but within the last 12 months
- d) more than a year ago

TICK ONE BOX ONLY

1	<input type="checkbox"/>
2	<input type="checkbox"/>
3	<input type="checkbox"/>
4	<input type="checkbox"/>

76

71.2 *Where* were you seen?

TICK ONE BOX ONLY

ECRHS APPENDIX B 1 Main Questionnaire

- a) by a GP at home
- b) by a GP in his office or surgery
- c) by a specialist at home
- d) by a specialist in his office or hospital outpatients department
- e) in a casualty department or emergency room
- f) admitted to a hospital ward

1		
2		
3		
4		
5		
6		77

END

FIELDWORKER NUMBER		78
CARD NUMBER		79-80