the tomorrow PROJECT

Albertans Studying the Connection Between Lifestyle and Cancer

Health and Lifestyle Questionnaire

The label above contains your unique study number and your gender.

Alberta Cancer Board

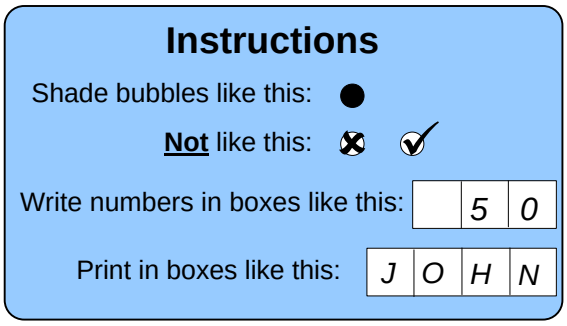
A research initiative of the Alberta Cancer Board

The Health and Lifestyle Questionnaire is one of three surveys that will describe your past and current health as you begin to participate in *The Tomorrow Project* cancer research study.

- This questionnaire may take about 30 to 40 minutes to answer.
- Please follow the directions carefully. You will be asked to skip certain questions or whole sections that do not apply to you.
- Section N asks for some body measurements. We have provided a tape measure for this purpose.
- There is an important section at the end of the questionnaire that asks for information to help us keep in touch with you. Please complete this information section before you return your survey.
- If you are not sure how to answer a question, please feel free to contact us:
  - ✓ Call our toll-free number in Canada: 1.877.919.9292
  - ✓ Email us at: tomorrow@cancerboard.ab.ca
  - ✓ OR, for answers to questions we are frequently asked about the questionnaire, check our website: www.thetomorrowproject.org

We are interested in your feedback about the questionnaire. Jot down your thoughts and suggestions in the space provided at the back. We look forward to your input because it will help us to improve the questionnaire for other participants.

DIRECTIONS FOR COMPLETING THIS QUESTIONNAIRE



Use a pencil or black pen.

Shade in the bubbles completely, as in the example.

PLEASE PRINT IN CAPITAL LETTERS.

Section A

Please start here by answering these first questions about your personal health.

PHI 1 How would you rate your general health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

Has a doctor ever told you that you had any of the following conditions?

(Shade Yes or No for each condition)

		Yes	No
PHI 2	Cancer (does not include skin cancer unless it is melanoma)	○	○
PHI 3	High blood pressure	○	○
PHI 4	Angina (chest pains from a heart problem)	○	○
PHI 5	High cholesterol in your blood	○	○
PHI 6	Heart attack	○	○
PHI 7	Stroke	○	○
PHI 8	Emphysema	○	○
PHI 9	Chronic bronchitis	○	○
PHI 10	Diabetes	○	○
PHI 11	Polyps in your colon or rectum	○	○
PHI 12	Ulcerative colitis	○	○
PHI 13	Crohn's Disease	○	○
PHI 14	Hepatitis	○	○
PHI 15	Cirrhosis of your liver	○	○

PHI 16 List any other long-term conditions that have lasted or are expected to last at least six months

1. _____ 2. _____

3. _____ 4. _____

Section B

This section is about **FEMALE** reproductive health. If you are **MALE**, go to Section C, page7.

FRH 1 How old were you when you had your first menstrual period? (Your best guess)

○ 9 or less ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16 ○ 17 ○ 18 or more ○ Never had a period → (Go to FRH 3)

FRH 2 How old were you when your periods first became regular? (Your best guess)

○ 9 or less ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16 ○ 17 ○ 18 or more ○ Never regular

FRH 3 Have you ever been pregnant?

○ Yes
○ No → (Go to FRH 13)
○ Don't Know → (Go to FRH 13)

FRH 4 Are you currently pregnant?

○ Yes → If yes, about how many weeks pregnant are you ? ☐☐ Weeks
○ No
○ Don't Know

FRH 5 How many times have you been pregnant?

☐☐ Pregnancies

FRH 6 Of your pregnancies, how many ended <u>before</u> 20 weeks?

☐☐ Pregnancies

FRH 7 Of your pregnancies, how many lasted 20 weeks or more? (Include all pregnancies that ended in live births and still births)

☐☐ Pregnancies → (If you answered 0 pregnancies, go to FRH 13)

FRH 8 How old were you when you completed your first pregnancy that lasted 20 weeks or more?

☐☐ Years

FRH 9 Did you breast feed or nurse any children for at least one month?

○ Yes
○ No → (Go to FRH 13)

FRH 10 How many children did you breast feed for at least one month?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 or more

FRH 11 How old were you when you first breast fed a child for at least one month?

○ Less than 20
○ 20 - 24
○ 25 - 29
○ 30 - 34
○ 35 - 39
○ 40 - 44
○ 45 or older

FRH 12 Thinking about all the children you breast fed, how many months in total did you breast feed?

○ 1 - 3 months
○ 4 - 6 months
○ 7 - 12 months
○ 13 - 23 months
○ 2 - 4 years
○ More than 4 years

FRH 13 Have you ever tried to become pregnant for more than one year without becoming pregnant?

○ Yes
○ No

FRH 14 Between the time you had your first period, and your last period, did you ever go without having a period for at least one year? (Do not count times when you were pregnant or breast feeding.)

○ Yes
○ No
○ Don't Know
○ Never had a period

FRH 15 Have you ever taken birth control pills for any reason? (Do not include birth control pills prescribed for menopause)

○ Yes
○ No → (Go to FRH 18)
○ Don't Know → (Go to FRH 18)

FRH 16 How old were you when you first started taking birth control pills?

○ Less than 20
○ 20 - 29
○ 30 - 39
○ 40 or older

FRH 17 In total, how long have you taken birth control pills, other than for menopause? (Please round to the nearest year.)

○ Less than one month
○ One month to 1 year
○ 2 - 3 years
○ 4 - 5 years
○ 6 - 9 years
○ 10 years or more

FRH 18 Did you ever have an operation to have both of your ovaries removed?

○ Yes
○ No → (Go to FRH 20)
○ Don't Know → (Go to FRH 20)

FRH 19 At what age did you have both of your ovaries removed? (If you had 2 separate operations to remove your ovaries, please indicate your age at the time of your last surgery.)

☐☐ Years

FRH 20 Did you ever have a hysterectomy? (An operation to have your uterus or womb removed)

○ Yes
○ No → (Go to FRH 22)
○ Don't Know → (Go to FRH 22)

FRH 21 At what age did you have your uterus (womb) removed?

☐☐ Years

FRH 22 Have you had a natural menstrual period during the past 12 months? (Answer "No" if your bleeding was induced by hormone replacement therapy.)

○ Yes → (Go to FRH 24)
○ No
○ Don't Know

FRH 23 Did your menstrual periods stop occurring naturally? (Answer "No" if your periods stopped because of surgery or because you started hormone replacement therapy.)

○ Yes → At what age did your periods stop occurring naturally? ☐☐ Years
○ No
○ Don't Know

FRH 24 Sometimes women take female hormones around the time of menopause. Have you ever used female hormones for menopause, e.g. tablets, pills, a patch or creams?

○ Yes
○ No → (Go to Section D, page 8)
○ Don't Know → (Go to Section D, page 8)

FRH 25 Are you currently using female hormones?

○ Yes
○ No → (Go to Section D, page 8)

FRH 26 In total, how long have you taken female hormones? (Round to the nearest year)

○ Less than one month
○ One month to 1 year
○ 2 - 3 years
○ 4 - 5 years
○ 6 - 9 years
○ 10 years or more

The FEMALE Reproductive Health Section is now complete.
Skip to Section D, page 8.

Section C

This section is about **MALE** reproductive health. If you are **FEMALE**, go to Section D, page 8.

MRH 1 Has a doctor ever told you that you have an enlarged prostate gland?

- ○ Yes
- ○ No
- ○ Don't know

MRH 2 Have you ever had surgery on your prostate gland?

- ○ Yes
- ○ No
- ○ Don't know

MRH 3 Have you ever had a vasectomy? (A sterilization procedure for men)

- ○ Yes
- ○ No
- ○ Don't know

This section is about your full blooded relatives' medical histories. Do not include family members who are related to you by marriage or adoption. (Full-blooded sisters and brothers are those who had the same two biological parents as you.)

Section D

Note: If you are adopted, please include any family history that you know about, or choose "Don't Know" where appropriate.

FMH 1 Have you ever had any full-blooded sisters who reached adulthood (age 21)?

- ○ Yes → How many? [ ][ ] Sisters
- ○ No
- ○ Don't know

FMH 2 Have you ever had any full-blooded brothers who reached adulthood (age 21)?

- ○ Yes → How many? [ ][ ] Brothers
- ○ No
- ○ Don't know

FMH 3 Have you ever had any daughters who reached adulthood (age 21)?

- ○ Yes → How many? [ ][ ] Daughters
- ○ No
- ○ Don't know

FMH 4 Have you ever had any sons who reached adulthood (age 21)?

- ○ Yes → How many? [ ][ ] Sons
- ○ No
- ○ Don't know

The next questions are about your natural (non-adoptive) mother and father.

FMH 5 Is your natural mother still alive?

- ○ Yes
- ○ No → (Go to FMH 7)
- ○ Don't know → (Go to FMH 8)

FMH 6 How old is your mother now?

[ ][ ][ ] Years → (Go to FMH 8)

FMH 7 How old was your mother when she died?

- ○ Less than 40
- ○ 40 - 49
- ○ 50 - 59
- ○ 60 - 69
- ○ 70 - 79
- ○ 80 - 89
- ○ 90 - 99
- ○ 100 years or older

FMH 8 Is your natural father still alive?

- ○ Yes
- ○ No → (Go to FMH 10)
- ○ Don't know → (Go to FMH 11)

FMH 9 How old is your father now?

☐☐☐ Years → (Go to FMH 11)

FMH 10 How old was your father when he died?

- ○ Less than 40
- ○ 40 - 49
- ○ 50 - 59
- ○ 60 - 69
- ○ 70 - 79
- ○ 80 - 89
- ○ 90 - 99
- ○ 100 years or older

We would like to know if your **mother, father, full-blooded sisters, full-blooded brothers, daughters or sons** ever had any of the conditions listed on the next three pages.

If you are adopted, please include any information that you know about your biological family.

In future questionnaires we may ask for more detailed family histories.

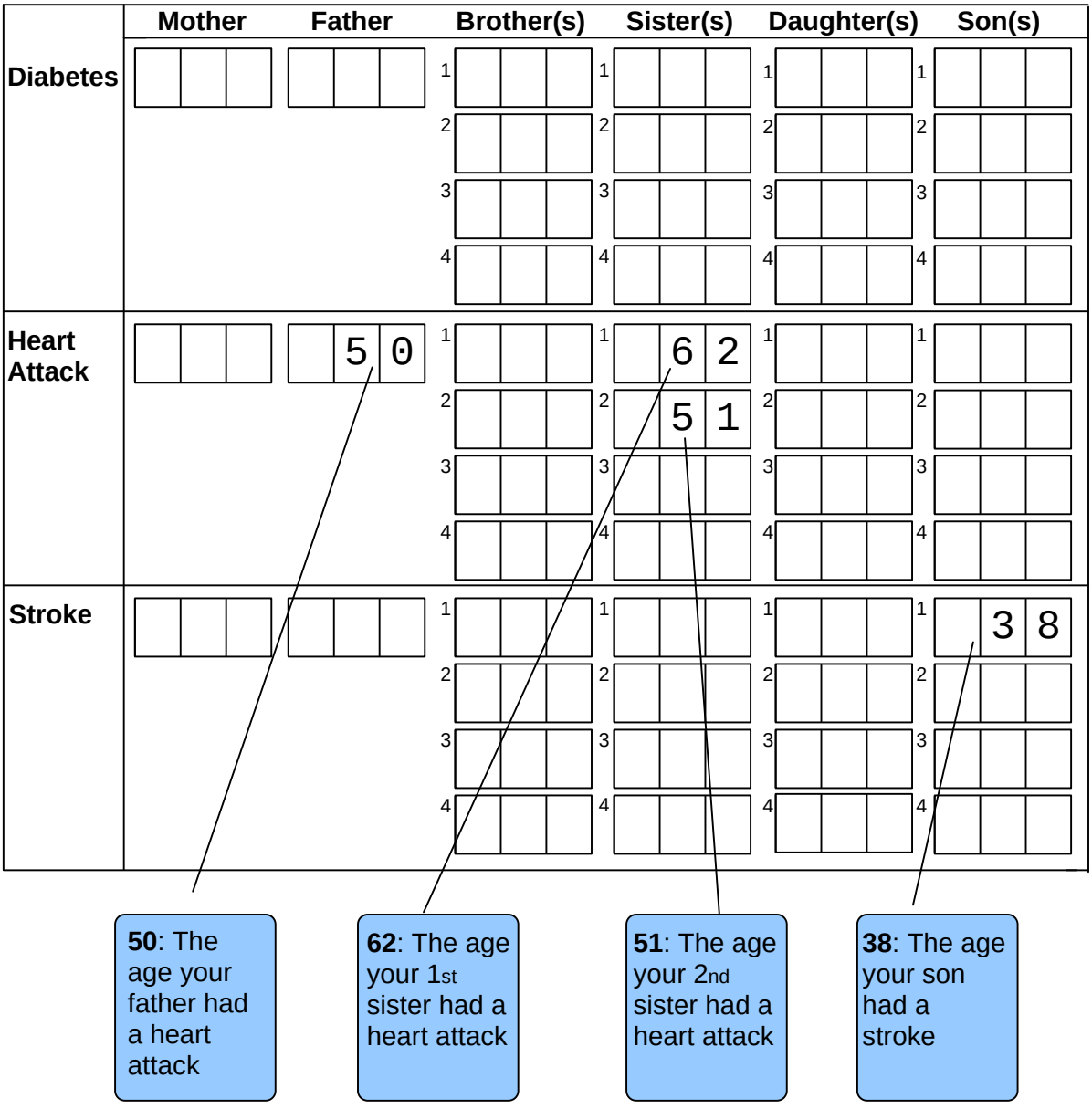
- Enter the **age** each person was **first diagnosed**. (Your best guess)

OR

- **Shade the bubble** at the bottom of the page if, as far as you know, no one in your biological family has had the conditions listed.

Look over the sample question below then complete the charts on the next three pages.

Sample Question



START HERE

FMH 11 ↓ Has anyone been diagnosed with **diabetes, heart attack or stroke**?

- If YES, write the **age** the condition was **first diagnosed**.

OR

- If NO, **shade the bubble** at the bottom of the page.

	Mother	Father	Brother(s)	Sister(s)	Daughter(s)	Son(s)
Diabetes			1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Heart Attack			1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Stroke			1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

OR

○ To my knowledge, no one in my family has had diabetes, a heart attack or a stroke.

FMH 12 This chart is about cancer your full-blooded relatives may have had. Often cancer will start in one part of the body and then spread. We are interested in where the cancer started.

Has anyone been diagnosed with any of the following kinds of cancer?

- If YES, write the **age** the cancer was **first diagnosed**.

OR

- If NO, **shade the bubble** at the bottom of the page.

	Mother	Father	Brother(s)	Sister(s)	Daughter(s)	Son(s)
Breast Cancer			1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Cancer of the Rectum			1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Colon Cancer			1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Ovarian Cancer			1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

OR

○ To my knowledge, no one in my family has had any of the cancers listed above.

Has anyone been diagnosed with any of the following kinds of cancer?

- If YES, write the **age** the cancer was **first diagnosed**.

OR

- If NO, **shade the bubble** at the bottom of the page.

	Mother	Father	Brother(s)	Sister(s)	Daughter(s)	Son(s)
***Other Cancer (specify)**			1	1	1	1
			2	2	2	2
			3	3	3	3
			4	4	4	4
***Other Cancer (specify)**			1	1	1	1
			2	2	2	2
			3	3	3	3
			4	4	4	4
***Other Cancer (specify)**			1	1	1	1
			2	2	2	2
			3	3	3	3
			4	4	4	4
***Other Cancer (specify)**			1	1	1	1
			2	2	2	2
			3	3	3	3
			4	4	4	4

OR

○ To my knowledge, no one in my family has had any other type of cancer.

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This section is about cancer screening tests for **FEMALES**. If you are **MALE**, go to Section F, page 16.

Section E

SBW 1 Have you ever had a Pap smear test?

- ○ Yes
- ○ No → (Go to SBW 4)
- ○ Don't know → (Go to SBW 4)

SBW 2 When was the last time you had a Pap smear?

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 3 years ago
- ○ 3 years to less than 5 years ago
- ○ 5 or more years ago

SBW 3 About how many Pap smears have you had in your lifetime? (Your best guess)

☐☐ Pap smears

SBW 4 Have you ever had a mammogram (a breast x-ray)?

- ○ Yes
- ○ No → (Go to SBW 8)
- ○ Don't know → (Go to SBW 8)

SBW 5 When was the last time you had a mammogram?

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 3 years ago
- ○ 3 years to less than 5 years ago
- ○ 5 or more years ago

SBW 6 How many mammograms in total have you had in your lifetime?

☐☐ Mammograms

SBW 7 Why did you have your last mammogram? (Choose **ALL** that apply.)

- ○ Family history of breast cancer
- ○ Part of regular checkup/routine screening
- ○ Age
- ○ Previously detected lump
- ○ Breast problem
- ○ On hormone replacement therapy
- ○ Other (Please specify):

_____

_____

_____

SBW 8 Other than a mammogram, have you ever had your breasts examined for lumps (tumors,cysts) by a doctor or health professional?

- ○ Yes
- ○ No → (Go to SBW 11)
- ○ Don't know → (Go to SBW 11)

SBW 9 When was the last time you had your breasts examined by a doctor or health professional?

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 5 years ago
- ○ 5 or more years ago

SBW 10 How many times in your lifetime have you had your breasts examined for lumps by a doctor or health professional? (Your best guess)

☐☐ Examinations

SBW 11 Have you ever examined your own breasts for lumps (tumors, cysts)?

- ○ Yes
- ○ No → (Go to Section G, page 17)
- ○ Don't know → (Go to Section G, page 17)

SBW 12 How often do you examine your breasts?

- ○ At least once a month
- ○ Once every 2 - 3 months
- ○ Less often than every 2 - 3 months

The FEMALE cancer screening section is now complete.
Skip to Section G, page 17.

This section is about a **MALE** cancer screening test. If you are **FEMALE**, go to Section G, page 17.

Section F

SBM 1 Have you ever had a "Prostate Specific Antigen test" for prostate cancer? That is, a PSA blood test?

- ○ Yes
- ○ No → (Go to Section G, page 17)
- ○ Don't know → (Go to Section G, page 17)

SBM 2 When was the last time you had a PSA test?

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 5 years ago
- ○ 5 or more years ago

SBM 3 Why did you have the last PSA test? (Choose **ALL** that apply)

- ○ Family history of prostate cancer
- ○ Part of regular checkup/routine screening
- ○ Age
- ○ Signs or symptoms of a possible problem
- ○ Follow-up of previous problem
- ○ Other (Please specify): _____

SBM 4 About how many times in total have you had a PSA test in your lifetime? (Your best guess)

☐☐ PSA tests

The MALE cancer screening section is now complete.
Go to Section G, page 17.

Section G

This section is about cancer screening tests for **BOTH MALES and FEMALES.**

SBB 1 Have you ever had a "digital rectal exam"? (A digital rectal exam is when a doctor inserts a finger into your rectum to check for cancer or other possible health problems.)

- ○ Yes
- ○ No → (Go to SBB 4)
- ○ Don't know → (Go to SBB 4)

SBB 2 When was the last time you had a digital rectal exam?

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 5 years ago
- ○ 5 or more years ago

SBB 3 About how many times in total have you had a digital rectal exam done? (Your best guess)

☐☐ Digital rectal exams

SBB 4 Have you ever had a "Blood Stool Test"? (A Blood Stool Test is when your stool is examined to determine if it contains blood.)

- ○ Yes
- ○ No → (Go to SBB 8)
- ○ Don't know → (Go to SBB 8)

SBB 5 When was the last time you had a Blood Stool Test done?

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 5 years ago
- ○ 5 or more years ago

SBB 6 Why did you have the last Blood Stool Test done? (Choose **ALL** that apply)

- ○ Family history of colon or rectal cancer
- ○ Part of regular checkup/routine screening
- ○ Age
- ○ Signs or symptoms of a possible problem
- ○ Follow-up of previous problem
- ○ Other (Please specify): _____

SBB 7 About how many times have you had a Blood Stool Test done in your lifetime? (Your best guess)

☐☐ Blood Stool Tests

SBB 8 Have you ever had a sigmoidoscopy or colonoscopy done?
(A **sigmoidoscopy** is an exam in which a doctor inserts a flexible tube into the rectum and the lower part of the colon, or lower bowel, to look for signs of cancer or other problems.
A **colonoscopy** is a similar exam but uses a longer tube to examine the entire colon. Before a colonoscopy is done, you are usually given medication through a needle in your arm to make you sleepy.)

- ○ Yes
- ○ No → (Go to Section H, page 19)
- ○ Don't know → (Go to Section H, page 19)

SBB 9 When was the last time that you had a sigmoidoscopy or colonoscopy exam?

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 5 years ago
- ○ 5 or more years ago

SBB 10 Why did you have the last sigmoidoscopy or colonoscopy test done?
(Choose **ALL** that apply)

- ○ Family history of colon or rectal cancer
- ○ Part of regular checkup/routine screening
- ○ Age
- ○ Signs or symptoms of a possible problem
- ○ Follow-up of previous problem
- ○ Other (Please specify): _____

SBB 11 About how many times in total have you had either of these tests done in your lifetime?

☐☐ Sigmoidoscopies

☐☐ Colonoscopies

The MALE and FEMALE cancer screening section is now complete.
Go to Section H, page 19.

Section H

This section is about tobacco. The first questions are about **CIGARETTE SMOKING**. The term "cigarette" refers to cigarettes that are bought ready-made as well as those you roll yourself. Do not include cigars, cigarillos or pipes when you answer these first questions about cigarettes.

SMK 1 Have you smoked at least 100 cigarettes in your life? (About 4 - 5 packs)

- ○ Yes → (Go to SMK 3)
- ○ No
- ○ Don't know

SMK 2 Have you ever smoked a whole cigarette?

- ○ Yes
- ○ No → (Go to SMK 16)
- ○ Don't know → (Go to SMK 16)

SMK 3 At what age did you smoke your first whole cigarette?

☐☐ Years

SMK 4 At the present time, do you smoke cigarettes daily, occasionally, or not at all?

- ○ Daily (At least one cigarette every day for the past 30 days)
  → **If you smoke daily, continue with SMK 5**
- ○ Occasionally (At least one cigarette in the past 30 days, but not every day)
  → **If you smoke occasionally, go to SMK 9**
- ○ Not at all (You did not smoke at all in the past 30 days)
  → **If you do not smoke at all, go to SMK 11**

SMK 5 At what age did you begin smoking cigarettes daily?

☐☐ Years

SMK 6 How many cigarettes do you smoke each day now?

- ○ 1 - 5 cigarettes
- ○ 6 - 10 cigarettes
- ○ 11 - 15 cigarettes
- ○ 16 - 20 cigarettes
- ○ 21 - 25 cigarettes
- ○ 26+ cigarettes

SMK 7 For how many total years have you smoked daily?

☐☐ Years

SMK 8 During the total years that you have smoked daily, about how many cigarettes per day have you usually smoked? (If your smoking pattern has changed over the years, make your best guess of the average number of cigarettes you have smoked per day.)

- ○ 1 - 5 cigarettes
- ○ 6 - 10 cigarettes
- ○ 11 - 15 cigarettes
- ○ 16 - 20 cigarettes
- ○ 21 - 25 cigarettes
- ○ 26+ cigarettes

→ **(If you currently smoke daily, go to SMK 16)**

SMK 9 On how many of the last 30 days did you smoke at least one cigarette?

- ○ 1 - 5 days
- ○ 6 - 10 days
- ○ 11 - 20 days
- ○ 21 - 29 days

SMK 10 On the days that you smoked, how many cigarettes did you usually smoke?

- ○ 1 - 5 cigarettes
- ○ 6 - 10 cigarettes
- ○ 11 - 15 cigarettes
- ○ 16 - 20 cigarettes
- ○ 21 - 25 cigarettes
- ○ 26+ cigarettes

SMK 11 Have you ever smoked cigarettes daily? (At least one cigarette a day for 30 days in a row)

- ○ Yes
- ○ No → (Go to SMK 16)
- ○ Don't know → (Go to SMK 16)

SMK 12 At what age did you begin to smoke daily?

☐☐ Years

SMK 13 When you smoked daily, how many cigarettes did you usually smoke each day?

- ○ 1 - 5 cigarettes
- ○ 6 - 10 cigarettes
- ○ 11 - 15 cigarettes
- ○ 16 - 20 cigarettes
- ○ 21 - 25 cigarettes
- ○ 26+ cigarettes

SMK 14 For how many <u>total years</u> did you smoke daily?

☐☐ Years

SMK 15 When did you stop smoking cigarettes daily?

- ○ Less than 1 year ago
- ○ 1 to 2 years ago
- ○ 3 to 5 years ago
- ○ More than 5 years ago
- ○ Don't know

SMK 16 Have you ever smoked cigars or cigarillos daily?

- ○ Yes
- ○ No
- ○ Don't know

SMK 17 Have you ever smoked a pipe daily?

- ○ Yes
- ○ No
- ○ Don't know

This section is complete.
If you are a NON SMOKER, continue with Section I, page 22.
If you CURRENTLY smoke cigarettes, cigars, cigarillos or a pipe DAILY or OCCASIONALLY, go to Section J, page 23.

This Section is about second hand smoke and should be answered by **NON SMOKERS ONLY**.

If you **CURRENTLY** smoke cigarettes, cigars, cigarillos or a pipe either **DAILY** or **OCCASIONALLY (at least once in the last 30 days)**, please proceed to Section J, page 23.

Section I

SHS 1 In the past year, were you exposed to second hand smoke on most days?

- ○ Yes
- ○ No

SHS 2 In the past year, were you exposed to second hand smoke at home?

- ○ Yes
- ○ No

SHS 3 In the past year, were you exposed to second hand smoke in a car or other private vehicle?

- ○ Yes
- ○ No

SHS 4 In the past year, were you exposed to second hand smoke in public places (bars, restaurants, shopping malls, arenas, bingo halls, bowling alleys)?

- ○ Yes
- ○ No

SHS 5 In the past year, were you exposed to second hand smoke when visiting friends or relatives?

- ○ Yes
- ○ No

SHS 6 In the past year, were you exposed to second hand smoke in the work place?

- ○ Yes
- ○ No

Section J

The next set of questions is about your exposure to the sun in the past twelve months.

SUN 1 In the past year, has any part of your body been sunburned? (A sunburn is any reddening or discomfort of your skin that lasts longer than 12 hours after exposure to the sun or other UV (ultraviolet) sources, such as tanning beds or sunlamps.)

- ○ Yes
- ○ No → (Go to SUN 4)

SUN 2 In the past year, did any of your sunburns involve blistering?

- ○ Yes
- ○ No

SUN 3 In the past year, did any of your sunburns involve pain or discomfort that lasted for more than 1 day?

- ○ Yes
- ○ No

SUN 4 Would you say that the untanned skin color of your inner upper arm is:

- ○ Light (white, fair, ruddy)
- ○ Medium (olive, light brown, medium brown)
- ○ Dark (dark brown, black)

SUN 5 During this past June through August, on a typical day outdoors, approximately how much time did you spend in the sun between 11am and 4pm?

- ○ Less than 30 minutes per day
- ○ 30 minutes to less than 1 hour per day
- ○ 1 to 2 hours per day
- ○ Greater than 2 hours per day

Section

K

Some studies have shown that stress can affect physical health. The following are stressful situations that sometimes come up in people's lives. As there are no right or wrong answers, the idea is to choose the answer **BEST** suited to your personal situation **AT THIS TIME**.

STR 1 You are trying to take on too many things at once.

- ○ True
- ○ False

STR 2 There is too much pressure on you to be like other people.

- ○ True
- ○ False

STR 3 Too much is expected of you by others.

- ○ True
- ○ False

STR 4 You don't have enough money to buy the things you need.

- ○ True
- ○ False

Please answer the next 3 questions if you are **married** or living **common-law** (living with a partner). If you are **single**, **widowed**, **separated** or **divorced**, go to STR 8.

Married or Common-law

STR 5 Your partner doesn't understand you.

- ○ True
- ○ False

STR 6 Your partner doesn't show you enough affection.

- ○ True
- ○ False

STR 7 Your partner is not committed enough to your relationship.

- ○ True → (Go to STR 9)
- ○ False → (Go to STR 9)

Single, Widowed, Separated or Divorced

STR 8 You find it difficult to find someone compatible with you.

- ○ True
- ○ False

The next 3 questions are about children, including grown children and step children

STR 9 Do you have any children?

- ○ Yes
- ○ No → (Go to STR 12)

STR 10 One of your children seems very unhappy.

- ○ True
- ○ False

STR 11 The behaviour of one of your children is a source of serious concern to you.

- ○ True
- ○ False

Continue with these questions about your current situation

STR 12 Your work around the home is not appreciated.

- ○ True
- ○ False

STR 13 Your friends are a bad influence.

- ○ True
- ○ False

STR 14 You would like to move but can't.

- ○ True
- ○ False

STR 15 Your neighborhood or community is too noisy or polluted.

- ○ True
- ○ False

STR 16 You have a parent, a child or a partner who is in very bad health and may die.

- ○ True
- ○ False

STR 17 Someone in your family has an alcohol, drug or gambling problem.

- ○ True
- ○ False

STR 18 People are too critical of you or what you do.

- ○ True
- ○ False

Section L

Some studies have shown that the level of support we get from our friends and relatives can affect our physical health. Next are some questions about the support that is available to you.

SPT 1 About how many close friends and close relatives do you have (people you feel at ease with and can talk to about what is on your mind)?

Write in number of close friends and close relatives: ☐☐

How often is each of the following kinds of support available to you?

		None Of The Time	A Little Of The Time	Some Of The Time	Most Of The Time	All Of The Time
SPT 2	Someone to help you if you were confined to bed	○	○	○	○	○
SPT 3	Someone you can count on to listen to you when you need to talk	○	○	○	○	○
SPT 4	Someone to give you advice about a crisis	○	○	○	○	○
SPT 5	Someone to take you to the doctor if you needed it	○	○	○	○	○
SPT 6	Someone who shows you love and affection	○	○	○	○	○
SPT 7	Someone to have a good time with	○	○	○	○	○
SPT 8	Someone to give you information in order to help you understand a situation	○	○	○	○	○
SPT 9	Someone to confide in and talk to about yourself or your problems	○	○	○	○	○
SPT 10	Someone to hug	○	○	○	○	○
SPT 11	Someone to get together with for relaxation	○	○	○	○	○
SPT 12	Someone to prepare your meals if you were unable to do it yourself	○	○	○	○	○
SPT 13	Someone whose advice you really want	○	○	○	○	○
SPT 14	Someone to do things with to help you get your mind off things	○	○	○	○	○
SPT 15	Someone to help you with daily chores if you were sick	○	○	○	○	○
SPT 16	Someone to share your most private worries and fears with	○	○	○	○	○
SPT 17	Someone to turn to for suggestions about how to deal with a personal problem	○	○	○	○	○
SPT 18	Someone to do something enjoyable with	○	○	○	○	○
SPT 19	Someone who understands your problems	○	○	○	○	○
SPT 20	Someone to love you and make you feel wanted	○	○	○	○	○

Section

M

Research suggests that people's feelings of spirituality may be related to their health.

For some people, being spiritual is similar to being religious; for other people, the ideas are different. Using a definition of spirituality that is most meaningful to you, please answer some questions about your spirituality.

SPI 1 Do spirituality values or faith play an important role in your life?

- ○ Yes
- ○ No

SPI 2 How religious or spiritual do you consider yourself to be?

- ○ Not at all
- ○ Not very
- ○ Moderate
- ○ Very

SPI 3 People may practice or express their spirituality in many different ways, for example through prayer or meditation, or by attending services or gatherings. On average, during the past 12 months how often have you practiced your spirituality in some way?

- ○ Daily or almost daily
- ○ At least once a week
- ○ At least once a month
- ○ At least 3 - 4 times a year
- ○ At least once a year
- ○ Not at all

Section

N

In this part of the survey, we need you to take accurate measurements of your height, weight, abdomen, and buttocks.

Measurements should be made in a single session at least two hours after a meal, and with the help of another adult.

Measure twice in either Imperial or Metric units. For example, in the weight question, record your weight twice in pounds **OR** twice in kilograms.

Record as accurately as possible using the markings on the tape measure.

Height

If you use Imperial measurements, please change 'feet and inches' to inches. For example, record 5' 2.5" as 62.5 inches.

- Remove your shoes.
- Stand straight with your back and heels against a wall.
- Lay a book flat on top of your head and make a mark on the wall.
- Measure twice. The two measurements should be within a quarter-inch or half-centimetre of each other. If not, take a third measurement and record the closest two measurements.

BOD 1	First Measurement:		Inches	**OR**		Centimetres
BOD 2	Second Measurement:		Inches	**OR**		Centimetres

Weight

- Use a scale if possible to get your current weight. Adjust your scale to zero.
- Remove your shoes and wear light clothing.
- Weigh yourself twice. The two weights should be within one pound or kilogram of each other. If not, weigh yourself a third time and record the closest two weights.

BOD 3	First Measurement:		Pounds	**OR**		Kilograms
BOD 4	Second Measurement:		Pounds	**OR**		Kilograms

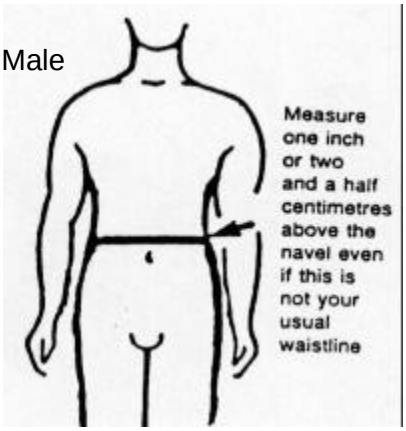
Abdomen and Buttocks

- Take the next measurements either unclothed or in close fitting underwear.
- Stand up straight in front of a mirror to position the measuring tape correctly.
- Pull the tape measure so that it is snug and does not slide, but do not indent the skin.
- Ensure that the tape is horizontal all the way around the body.
- Measure twice. The two measurements should agree to within a quarter-inch or half-centimetre of each other. If they do not, take a third measurement and record the closest two measurements.

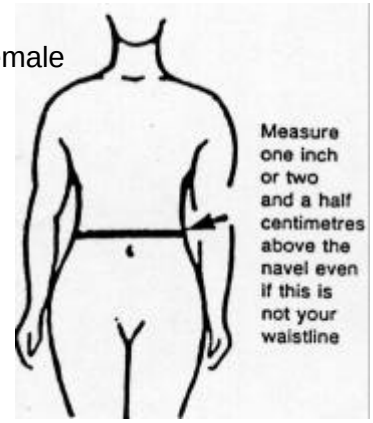
Abdomen

- Measure one inch (two and one half centimetres) above your navel or "belly button", EVEN IF THIS IS NOT YOUR USUAL WAISTLINE. See the diagrams below that show the correct measurement location.

Male



Female



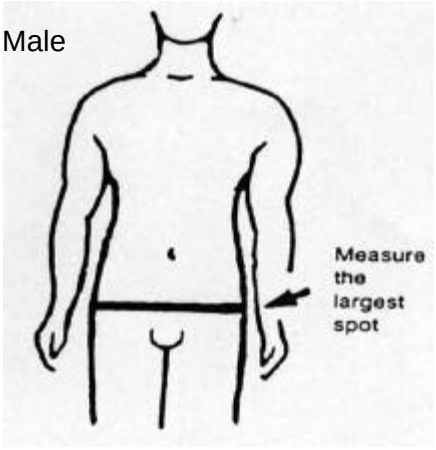
BOD 5 First Measurement: _____ Inches **OR** _____ Centimetres

BOD 6 Second Measurement: _____ Inches **OR** _____ Centimetres

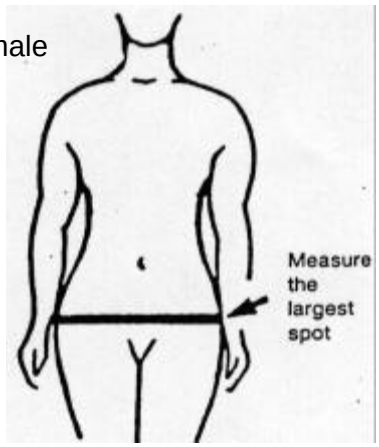
Buttocks

- Slide the tape measure up and down until you find the largest spot between your waist and thighs. See the diagrams below that show the correct measurement location.

Male



Female



BOD 7 First Measurement: _____ Inches **OR** _____ Centimetres

BOD 8 Second Measurement: _____ Inches **OR** _____ Centimetres

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We would like to ask you a few questions to describe yourself. Research has shown that there are connections between people's health and factors such as marital status, education, employment, income and ethnic background. **All information you provide will be kept completely confidential.**

Section O

DEM 1 What is your current marital status? (Please choose the **ONE** status that best describes your current situation.)

- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Not married, but living with someone
- ○ Single, never married

DEM 2 What is the highest level of education you have finished? (Please choose **ONE**)

- ○ Did not complete Grade 8
- ○ Completed Grade 8, but not high school
- ○ Completed high school
- ○ Some technical school/college training completed
- ○ Completed technical school/college training
- ○ Some part of university degree completed
- ○ Completed university degree
- ○ Some part of post-graduate university degree completed
- ○ Completed university post-graduate degree

DEM 3 What is your current employment status? (Please choose the **ONE** that best describes your current situation.)

- ○ Working full-time
- ○ Working part-time
- ○ Not employed, but looking for work → (Go to DEM 6)
- ○ Homemaker → (Go to DEM 6)
- ○ Student → (Go to DEM 6)
- ○ Retired → (Go to DEM 6)
- ○ Other _____ (Please Specify) → (Go to DEM 6)

DEM 4 If you currently work for pay, or are self employed, what type of work do you do in your job?

_____

DEM 5 What is your job title?

_____

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DEM 6 The next question asks for your household income. We understand that this information is very private but the question is important for two reasons. Research has shown that there is a connection between income and health status. As well, the information helps to determine whether *The Tomorrow Project* includes a wide range of Albertans.

What was your approximate total **household** income before taxes last year? (Please choose **ONE**)

- ○ Less than $10,000
- ○ $10,000 - $19,999
- ○ $20,000 - $29,999
- ○ $30,000 - $39,999
- ○ $40,000 - $49,999
- ○ $50,000 - $59,999
- ○ $60,000 - $69,999
- ○ $70,000 - $79,999
- ○ $80,000 - $89,999
- ○ $90,000 - $99,999
- ○ $100,000 or more

DEM 7 This question asks about your ethnic background. There is evidence that some ethnic groups are more likely to develop certain health problems and in addition, the information will help to determine if a wide range of Albertans have joined *The Tomorrow Project.*

What are your ancestral ethnic groups as far back as your grandparents?
(Please choose **ALL** that apply)

- ○ British (e.g. English, Irish, Scottish, Welsh)
- ○ French (e.g. French, Acadian, French Canadian)
- ○ Western European (e.g. Austrian, Dutch, Belgian, German, Swiss)
- ○ Eastern European (e.g. Czech Republic, Hungarian, Polish, Romanian, Russian, Ukrainian)
- ○ Northern European (e.g. Danish, Finnish, Icelandic, Norwegian, Swedish)
- ○ Southern European (e.g. Albanian, Bulgarian, Croatian, Cypriot, Greek, Italian, Maltese, Portuguese, Serbian, Slovenian, Spanish, Yugoslav)
- ○ East/Central Asian (e.g. Burmese, Cambodian, Chinese, Indonesian, Japanese, Korean, Vietnamese, Filipino)
- ○ South Asian (e.g. Bangladeshi, Bengali, East Indian, Gujarati, Pakistani, Punjabi, Sinhalese, Sri Lankan, Tamil)
- ○ West Asian (e.g. Afghan, Armenian, Iranian, Israeli, Kurdish, Turkish)
- ○ Pacific Islands (e.g. Fijian, Polynesian, Hawaiian)
- ○ Australian/New Zealander
- ○ Arab/Middle Eastern (e.g. Egyptian, Iraqi, Lebanese, Moroccan, Maghrebi, Palestinian, Syrian)
- ○ Latin American (e.g. Nicaraguan, Costa Rican, Salvadorian, Mexican)
- ○ South American (e.g. Argentinean, Brazilian, Bolivian, Chilean, Peruvian)
- ○ North American (e.g. Canadian, American)
- ○ Caribbean (e.g. Barbadian, Cuban, Guyanese, Haitian, Jamaican, Trinidadian, Tobagonian)
- ○ African
- ○ South African
- ○ Aboriginal (e.g. North American Indian, Metis, Inuit)
- ○ Other (Please specify) _____
- ○ Don't Know

THANK YOU FOR ANSWERING THESE QUESTIONS...YOU ARE ALMOST DONE!
But before finishing...
Please provide us with important contact information on the following pages.
These pages will be removed at the study centre and stored separately from your health information.

Please Review The Following Information:

The label below contains the current information in our files about how to contact you. Please let us know if it is correct, or provide the correct information in the space provided.

1.

○ The information above is correct, OR
○ Please make the following corrections to my contact information:

_____
_____
_____
_____
_____
_____

2. If you have an email address that we may use to contact you, please print it clearly below.

Note: We will not release your e-mail address to anyone.

3. Please record the date this questionnaire was completed.

Year	**Month**	**Day**

WE WANT TO KEEP IN TOUCH WITH YOU!

The Tomorrow Project will be a long-term study, involving people for several decades of their lives. In order for the study to reach its goals, it is very important for us to stay in touch with you for as long as you choose to remain in the study, even if you move outside Alberta or Canada.

- In order to help us stay in touch, please provide us with the names and addresses of two people who do not live in your household but who are likely to know how to reach you if we are unable to.
- **NOTE: We would only use this information after trying all other ways to contact you.**
- Ask yourself: "Who would know how to find me if I disappeared off the face of the earth?"

First Person (Please PRINT in CAPITAL LETTERS only.)

○ **Mr.** ○ **Mrs.** ○ **Ms.** ○ **Miss** ○ **Dr.** ○ **Rev.** ○ **Pastor** ○ **None**

First Name

Last Name

Address

Address continued

City **Province** **Postal Code**

Country

Home Phone ( ) - **Other Phone** ( ) -

E-mail Address

Relationship to you

51891

Second Person (Please PRINT in CAPITAL LETTERS only.)

○ **Mr.** ○ **Mrs.** ○ **Ms.** ○ **Miss** ○ **Dr.** ○ **Rev.** ○ **Pastor** ○ **None**

First Name

Last Name

Address

Address continued

City **Province** **Postal Code**

Country

Home Phone **Other Phone**

( ) - ( ) -

E-mail Address

Relationship to you

Tell us what you think!

Your feedback is important to us and will be used as a tool to streamline and improve this survey. In the space below, please record your comments or concerns. If your comment is about a specific question, please refer to it by its code letters and number.

As a whole, how easy was this survey to complete?

○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Not easy at all						**Very easy**

Comments (Optional)

Thank you very much for answering the Health and Lifestyle Questionnaire!

Please return your questionnaire in the postage paid envelope at your earliest convenience.