Vipuvoimaa EU:lta 2007–2013

Euroopan unioni
Euroopan aluekehitysrahasto
Euroopan sosiaalirahasto

POHJOIS-POHJANMAAN LIITTO
Council of Oulu Region

OULUN YLIOPISTO
UNIVERSITY of OULU

NORTHERN FINLAND BIRTH COHORT 1966 WELFARE AND HEALTH RESEARCH PROGRAMME

Background, lifestyle and health survey

INSTRUCTIONS ON HOW TO FILL IN THE SURVEY FORM

Give your answers by circling the number of the best-suited option and/or write your answer in the specified field. Some of the questions are in table format; give your answers by writing the information in the table. Remember to answer all the questions – if your answer is "no", mark it either by circling the corresponding number or by writing "0" in the specified field. Do not write your name on the survey form.

Certain response options are followed by: "Go to question...", in which case you can go straight to that question, skipping the ones that come before it. If necessary, a close relative or a practical nurse can assist you with completing the form.

Example 1.

What is your basic education?

1 less than 9 years of comprehensive school
(2) comprehensive school
3 matriculation examination

Example 2.

How many cups of coffee or tea do you normally drink in a day?

(mark 0 if none)

of coffee I__I_0I cups
of tea I__I_3I cups

Example 3.

How often do you currently use the following medications?

	never	some-times	regularly or all the time
Medication for back, joint or muscle problems...	1	(2)	3
Medication for headache...	(1)	2	3
Asthma medication...	1	2	(3)

SITUATION IN LIFE AND BACKGROUND INFORMATION

1. Your current marital status

1 married
2 cohabiting
3 partner in a registered partnership
4 unmarried
5 divorced
6 divorced from a registered partnership
7 widowed
8 widowed after a registered partnership

2. Do other people live in your household besides you?

1 no, I live alone
2 yes; what are their ages?

	no	yes	how many
spouse or cohabiting partner	1	2	
children aged 0–6 years	1	2	I___I___I
children aged 7–18 years	1	2	I___I___I
adults aged 19–64 years	1	2	I___I___I
adults aged over 64 years	1	2	I___I___I

3. Do you provide assistance or care to those close to you outside your home, e.g. your own parents or your spouse's parents?

1 no
2 yes: I___I___I___I hours/month

4. What is your basic education?

1 less than 9 years of comprehensive school
2 comprehensive school
3 matriculation examination

5. What vocational qualifications do you have? (circle the highest level of qualifications you have attained so far, and option 8, if you are in the middle of training)

1 no vocational training
2 vocational course
3 vocational school
4 college-level training
5 degree from a university of applied sciences
6 university or other higher education degree
7 other; please specify? _____
8 training <u>not finished</u>;
please specify?_____

6. How satisfied are you with your current situation in life in general?

1 very satisfied
2 somewhat satisfied
3 somewhat dissatisfied
4 very dissatisfied
5 cannot say

7. Have you ever lived outside of Finland for a year or more?

1 no
2 yes; how many years? I___I___I

8. If you have lived outside of Finland for a year or more, what was the main reason for your stay?

1 work
2 studies
3 other

LIFESTYLE

SLEEP AND SLEEPING

9. At what time do you normally go to bed (when you go to sleep)?

On workdays/weekdays around I___I___I:I___I___I **(e.g. 21:30; 24h clock)**
On days off/weekends around I___I___I:I___I___I

10. At what time do you normally get out of bed (and not go back again)?

On workdays/weekdays around I___I___I:I___I___I **(e.g. 07:30; 24h clock)**
On days off/weekends around I___I___I:I___I___I

11. How many hours do you sleep on average? (e.g. 10 hours 45 minutes)

At night? I___I___I hours I___I___I minutes
Per day? (including naps) I___I___I hours I___I___I minutes

12. People tend to be categorised into "morning persons" (early birds) and "evening persons" (night owls). Which one are you?

1 definitely a morning person
2 more of a morning than an evening person
3 more of an evening than a morning person
4 definitely an evening person

13. Assuming the conditions are suitable, how easy is it for you to get up in the morning?

1 not easy at all
2 not very easy
3 somewhat easy
4 very easy

14. How tired do you feel for the first half hour in the morning?

1 very tired
2 somewhat tired
3 somewhat rested
4 well-rested

The following questions are meant to identify whether you have experienced difficulty in sleeping in <u>the last month</u>. Circle the option you think describes the degree of difficulty of the problem with sleeping you have experienced (if any), if you have experienced the problem <u>at least three times a week during the last month.</u>

15. Falling asleep? (the time it takes for you to fall asleep after the lights have been turned off in order to go to sleep)

1 No problem
2 Somewhat delayed
3 Significantly delayed
4 Very long delay

16. Waking up at night?

1 No problem
2 Slight problem
3 Moderate problem
4 Serious problem

17. Night sleep ends too early in the morning?

1 Not at all
2 Slightly earlier
3 Significantly earlier
4 Very much earlier

18. Total amount of sleep?

1 Sufficient
2 Somewhat sufficient
3 Significantly insufficient
4 Totally insufficient

19. Quality of sleep? (regardless of how long you slept)

1 Satisfactory
2 Somewhat unsatisfactory
3 Significantly unsatisfactory
4 Totally unsatisfactory

20. Let's assume you have decided to take up a sports activity. Your friend recommends that your training programme should be twice a week for one hour at a time. The best time for your friend is in the morning from 7:00 to 8:00. Bearing in mind the daily rhythm that is best suited to you, how do you think you would manage?

1 I am in great shape
2 I am in reasonable shape
3 It would feel somewhat challenging
4 It would feel very challenging

21. Let's assume that you have to do two hours of hard manual labour. You can freely decide your own schedule. Bearing in mind the daily rhythm that is best suited to you, which option would you choose?

1 8:00–10:00
2 11:00–13:00
3 15:00–17:00
4 19:00–21:00

22. Let's assume you are free to decide your working hours. Let's assume that the working day is five hours long, that the work is interesting and that the pay is performance-based. Which FIVE CONSECUTIVE hours would you choose? (circle five options)

01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12	12-13
13-14	14-15	15-16	16-17	17-18	18-19	19-20	20-21	21-22	22-23	23-24	24-01

EXERCISE AND SITTING

23. How often do you exercise in your leisure time?

		Once a month or less	2–3 times a month	Once a week	2–3 times a week	4–6 times a week	Daily
1	Light exercise (no sweating or getting out of breath)	1	2	3	4	5	6
2	Brisk exercise (you get out of breath and sweat at least mildly)	1	2	3	4	5	6

24. How long do you exercise for at any one time?

		none	less than 20 minutes	20–39 minutes	40–59 minutes	1–1.5 hours	more than 1.5 hours
1	Light exercise (no sweating or getting out of breath)	1	2	3	4	5	6
2	Brisk exercise (you get out of breath and sweat at least mildly)	1	2	3	4	5	6

25. How much do you exercise and strain yourself physically in your leisure time? (If this differs much between seasons, circle the option that best describes an average situation)

1 In my leisure time, I read, watch television and do chores that do not involve much movement or straining myself physically.

2 In my leisure time, I walk, ride a bike or do other types of exercise at least for four hours a week. This includes walking, fishing and hunting, light gardening, etc. but not commuting.

3 In my leisure time, I do actual fitness training, such as running, jogging, skiing, gymnastics, swimming and ball games, or strenuous gardening or other similar tasks on average at least for two hours a week.

4 In my leisure time, I regularly do competitive training several times a week; running, orienteering, skiing, swimming, ball games, or other strenuous sports activities.

26. How many hours do you sit on average during weekdays? (Mark 0 if none)

During the workday at the office or other such place |____|____| h |____|____| min
At home watching TV or videos |____|____| h |____|____| min
At home at the computer |____|____| h |____|____| min
In a vehicle |____|____| h |____|____| min
Other |____|____| h |____|____| min

NUTRITION

27. Do you normally eat the following meals?

	On weekdays		On weekends	
	no	yes	no	yes
Breakfast	1	2	1	2
Lunch (daytime meal around 11-13)	1	2	1	2
Dinner (evening meal)	1	2	1	2
Light snack in the evening	1	2	1	2
Snacks between meals (06–22)	1	2	1	2
Night-time meal (warm dish between 22–06)	1	2	1	2
Snacks during the night (22–06)	1	2	1	2

28. How many snacks do you eat ing a day?

on weekdays |____|____|
on weekends |____|____|
on the night shift |____|____|

29. Where do you most often eat your lunch (daytime meal)?

1 I do not eat lunch
2 at home
3 I bring my own food to eat at the workplace
4 in the workplace canteen/staff restaurant
5 in a restaurant, in a bar
6 other; please specify: _____

30. Do you have a special diet?

		no	yes
1	lactose-free diet	1	2
2	gluten-free diet (I avoid domestic cereals)	1	2
3	food allergy	1	2
4	diabetic diet	1	2
5	cholesterol-lowering diet	1	2
6	weight loss diet	1	2
7	vegetarian diet	1	2
8	low-sodium diet	1	2
9	other; please specify: _____	1	2

31. How often do you normally consume the following foodstuffs? (Think of the last six months.

Circle one option from each line, based on whichever is the closest to your frequency of use.)

	less than once a month or not at all	once or twice a month	once a week	a couple of times a week	nearly every day	once a day or more
CEREAL PRODUCTS:						
Rye bread or crispbread	1	2	3	4	5	6
Yeast bread, graham bread or mixed grain bread, whole wheat baguette	1	2	3	4	5	6
French bread, white flour baguette/toast	1	2	3	4	5	6
Sweet pastry	1	2	3	4	5	6
Rye porridge, oatmeal, barley porridge or four grain porridge	1	2	3	4	5	6
Sugar-free muesli	1	2	3	4	5	6
Whole-grain (dark) macaroni/pasta or (brown) rice	1	2	3	4	5	6
DAIRY PRODUCTS:						
Low-fat (1% or less fat) yoghurt or soured whole milk	1	2	3	4	5	6
Full-fat yoghurt or soured whole milk	1	2	3	4	5	6
Organic yoghurt or soured whole milk	1	2	3	4	5	6
Low-fat cheeses, 17% or less fat	1	2	3	4	5	6
Full-fat cheeses, more than 17% fat	1	2	3	4	5	6
Ice cream	1	2	3	4	5	6
VEGETABLES:						
Potatoes, boiled or mashed	1	2	3	4	5	6
Fried potatoes or french fries	1	2	3	4	5	6
Fresh vegetables, root vegetables, fresh salad	1	2	3	4	5	6
Boiled vegetable side dish	1	2	3	4	5	6
Vegetarian food (soups, casseroles, stews)	1	2	3	4	5	6

	less than once a month or not at all	once or twice a month	once a week	a couple of times a week	nearly every day	once a day or more
FRUIT, BERRIES:						
Fruit	1	2	3	4	5	6
Fresh or frozen berries	1	2	3	4	5	6
FISH, MEAT, EGGS:						
Oily fish (salmon, rainbow trout, herring, eel, anchovy, mackerel)	1	2	3	4	5	6
Medium-fat fish (whitefish, bream, vendace, flatfish, Baltic herring, common roach, tuna)	1	2	3	4	5	6
Low-fat fish (pike, pike perch, perch, burbot, cod, coalfish)	1	2	3	4	5	6
Broiler chicken, turkey, chicken dishes	1	2	3	4	5	6
Sausage dishes, frankfurters, sausages	1	2	3	4	5	6
Cold cuts – sausage (e.g. 'lauantaimakkara', salami)	1	2	3	4	5	6
Cold cuts – meat (e.g. cooked ham)	1	2	3	4	5	6
Reindeer, elk, game birds	1	2	3	4	5	6
Eggs	1	2	3	4	5	6
OTHER:						
Oil-based salad dressing	1	2	3	4	5	6
Hamburgers, pizza	1	2	3	4	5	6
Sugar-sweetened soft drinks	1	2	3	4	5	6
Sweets	1	2	3	4	5	6
Chocolate	1	2	3	4	5	6
Potato crisps	1	2	3	4	5	6
Sports drinks	1	2	3	4	5	6
Energy drinks	1	2	3	4	5	6
Xylitol chewing gum or pastilles	1	2	3	4	5	6

STIMULANTS

32. Are you currently using any alcoholic beverages, even occasionally? (e.g. beer, cider, mild wines, wine or spirits)

1 no, I never have; *go to question 39*
2 no, because I stopped using alcohol
|____|____| years ago, *go to question 39*
3 yes, less than once a month
4 yes, at least once a month

33. How often do you normally drink beer (IVA or III), **cider or Finnish long drink?**

1 never
2 once a year or less
3 a couple of times a year
4 3–4 times a year
5 once every couple of months
6 once a month
7 a couple of times a month
8 once a week
9 a few times a year
10 daily

34. How much beer (IVA or III), **cider or Finnish long drink do you normally drink at a time?** (1 bottle = 1/3 l)

1 less than one bottle
2 1 bottle
3 2 bottles
4 3 bottles
5 4–5 bottles
6 6–9 bottles
7 10–14 bottles
8 15 bottles or more
9 I do not drink these beverages

35. How often do you normally drink wine? (Mild or fortified, including homemade)

1 never
2 once a year or less
3 a couple of times a year
4 3–4 times a year
5 once every couple of months
6 once a month
7 a couple of times a month
8 once a week
9 a few times a year
10 daily

36. How much do you normally drink mild, fortified or homemade wine at a time?

1 half a glass
2 one glass (= 16cl)
3 a couple of glasses
4 about half a bottle (bottle = 3/4l)
5 slightly more than a bottle
6 approximately one bottle
7 1–2 bottles
8 more than two bottles
9 I do not drink wine

37. How often do you normally drink spirits?

1 never
2 once a year or less
3 a couple of times a year
4 3–4 times a year
5 once every couple of months
6 once a month
7 a couple of times a month
8 once a week
9 a few times a year
10 daily

38. How much do you normally drink spirits at a time?

1 less than one restaurant measure at a time (less than 4 cl)
2 one restaurant measure (approximately 4 cl)
3 a couple of restaurant measures
4 3–4 restaurant measures
5 5–6 restaurant measures
6 7–10 restaurant measures
7 approximately one half-litre bottle
8 more than one half-litre bottle
9 I do not drink spirits

39. Have you ever smoked tobacco?

1 no *(→ go to question 45)*
2 yes, I started when I was I____I____I years old

40. Have you ever smoked regularly? (= one cigarette, cigar, cigarillo or a pipe of tobacco nearly every day for at least a year)

1 no
2 yes, I have smoked regularly in total for I____I____I years

41. If you have stopped smoking, at what age was this?

I____I____I

42. Do you currently smoke?

1 7 days a week
2 5-6 days a week
3 2-4 days a week
4 one day a week
5 occasionally
6 no

43. When did you last smoke?
(If you smoke constantly, circle option 1)

1 yesterday or today
2 2 days – 1 month ago
3 1 month – 6 months ago
4 7 months –11 months ago
5 1 – 5 years ago; *go to question 45*
6 6 – 10 years ago; *go to question 45*
7 more than 10 years ago; *go to question 45*

44. How much do you smoke now, or used to smoke before you stopped, on average per day? (answer each section; if you do not smoke the product, mark '0')

1 filtered cigarettes I____I____I a day
2 other cigarettes I____I____I a day
3 pipes of tobacco I____I____I a day
4 cigars I____I____I a day

45. Do you currently use snuff or chewing tobacco?

1 no
2 occasionally
3 yes, regularly

46. How many hours a day do you spend on premises where you have to inhale tobacco smoke produced by other people? (if none, mark '0')

I___I___I hours

LIVING ENVIRONMENT

47. What type of accommodation do you live in?

1 owner-occupied flat
2 rental accommodation
3 right of occupancy flat
4 company-owned flat
5 student accommodation
6 subsidised housing

48. How many rooms, including the kitchen, does your flat have?

|____|____|____| rooms

49. Do you live on a working, agricultural or animal production, farm?

1 No *(go to question 52)*
2 Yes

50. What production animals are kept on your farm?

	Number of production animals				
	0	**1-10**	**11-50**	**51-100**	**>100**
Cows	1	2	3	4	5
Horses	1	2	3	4	5
Pigs	1	2	3	4	5
Sheep	1	2	3	4	5
Other (e.g. domestic fowls, rabbits)	1	2	3	4	5

51. How many hours a day on average have you worked/spent time in a cowshed or an animal shelter during the last twelve months?

|____|____| hours a day

52. How often have you visited a farm where animals are kept or horse stables during the last twelve months?

1 none
2 no more than a couple times a year
3 1–2 times a month
4 once a week or more

53. Circle the number for 'yes' or 'no' based on whether or not you currently have any of the following pets at home?

	no	**yes**	**how many**
Cat	1	2	I___I___I
Dog	1	2	I___I___I
Other furry or feathered animals	1	2	I___I___I

54. Has there ever been any major water damage to your current flat (e.g. leaky pipes, storm damage, flooding, etc.), in which large areas/parts of the building have been soaked by large quantities of water?

1 no
2 yes, in the last twelve months
3 yes, more than twelve months ago
4 I do not know

55. Does any of the living space of your flat currently have water damage?

1 no
2 yes

56. In your current flat:

	no	yes	I do not know
has there ever been			
visible mould	1	2	3
smell of mould or an underground basement smell	1	2	3
is there currently			
visible mould	1	2	3
smell of mould or an underground basement smell	1	2	3

57. Symptoms/illnesses indoors

	no	yes, in the last year	yes, but more than a year ago
1 Have you had any symptoms/illnesses related to spending time in your flat?	1	2	3
2 Have you had any symptoms/illnesses related to spending time in your work space?	1	2	3

58. Do you heat your flat by burning wood in a fireplace, an oven or a stove?

1 no *(go to question 60)*
2 yes

59. How often do you burn wood in such an apparatus during the cold season (October–April)?

1 less than once a month
2 1–2 days a month
3 1–2 days a week
4 3–4 days a week
5 5–7 days a week

STATE OF HEALTH

60. How would you estimate your current state of health?

1 very good
2 good
3 moderate
4 poor
5 very poor

61. Your weight l___l___l___l kg

62. Your height l___l___l___l cm

63. Do you currently have, or have you ever had, any of the following symptoms, diseases or injuries diagnosed or treated by a doctor?

	No	Yes
Cardiovascular diseases		
High blood pressure, hypertension	1	2
Congenital heart disease; please specify: _____	1	2
Congestive heart failure	1	2
Coronary artery disease (angina pectoris)		2
....	1	
Diabetes		
Juvenile diabetes (Type 1)	1	2
Adult-onset diabetes (Type 2)	1	2
Thyroid dysfunction		
Hypothyroidism	1	2
Hyperthyroidism	1	2
Gastric and intestinal diseases		
Gastric or duodenal ulcer	1	2
Celiac disease	1	2
Inflammatory bowel disease (Chrohn's disease or ulcerative colitis)	1	2
Skin diseases		
Psoriasis	1	2
Hand dermatitis (allergic or other)	1	2
Other skin disease	1	2

Do you currently have, or have you ever had, any of the following symptoms, diseases or injuries diagnosed or treated by a doctor? Continued...	**No**	**Yes**
Infections		
Gallstone, gallbladder infection	1	2
Long-term urinary tract infection, nephritis	1	2
Ovarian inflammation (women)	1	2
Prostatitis (men)	1	2
Chlamydia inflammation	1	2
Condyloma	1	2
Genital herpes	1	2
Other genital infection	1	2
Ear disease or trauma to the ear	1	2
Eye diseases and symptoms		
Eye disease or injury to the eye	1	2
Increased intraocular pressure	1	2
Glaucoma	1	2
Cataract	1	2
Macular degeneration	1	2
Impaired vision due to amblyopia (lazy eye)	1	2
Strabismus (squint)	1	2
Diabetic retinopathy	1	2
Colour retinopathy	1	2
Other intraocular inflammation	1	2
Brain and nervous system diseases		
Epilepsy	1	2
Migraine headaches	1	2
Cerebrovascular disorder (cerebral infarction, apoplexy)	1	2
Other disease of the nervous system	1	2
Cancers		
Skin cancer or precancerous conditions	1	2
Other type of cancer	1	2
Hernia	1	2
Anaemia (low haemoglobin)	1	2
Oral diseases and disorders		
Malocclusion that required orthodontic treatment	1	2
Cleft lip and palate	1	2

Do you currently have, or have you ever had, any of the following symptoms, diseases or injuries diagnosed or treated by a doctor?
Continued...

	No	Yes
Mental health		
Mental disorder, psychosis	1	2
Depression	1	2
Other mental health problem	1	2
Substance abuse		
Alcohol problem	1	2
Other substance abuse	1	2
Sleep apnoea	1	2
Musculoskeletal disorders and rheumatic diseases		
Fibromyalgia	1	2
Rheumatoid arthritis	1	2
Psoriatic arthritis	1	2
Reactive arthritis	1	2
Juvenile rheumatoid arthritis	1	2
Ankylosing spondylitis	1	2
Gout	1	2
Other types of arthritis	1	2
Other rheumatic or autoimmune disease; please specify: _____	1	2
Bone loss (osteoporosis)	1	2
Bone fractures; how many?_____	1	2
Tendon injuries; please specify: _____	1	2
Tendonitis; please specify: _____	1	2
Back pain due to wear and tear, other back disease	1	2
Osteoarthritis:	1	2
1 Knee	1	2
2 Hip	1	2
3 Spine	1	2
4 Finger	1	2
5 Temporomandibular joint	1	2
6 Ankle joint	1	2
7 Foot	1	2
8 Shoulder	1	2
9 Other; please specify: _____	1	2
10 Other joint disease; please specify: _____	1	2
Other disease or injury; please specify:_____	1	2

64. Questions about infections:

	No	Yes
Have you had pneumonia at least two times in your life?	1	2
Have you been hospitalised due to an infectious disease?	1	2
Have your sinuses been operated on due to recurrent infections?	1	2
Have you had recurrent inflammation of the ear in adulthood?	1	2
Do you have other recurrent infections endangering your health?	1	2
In your perception, do you have more bouts of flu than what is normal?	1	2
In your perception, are you more susceptible to infections than other people?	1	2
Does any of your close relatives have innately reduced defence capability against infections?	1	2

65. Have you experienced any of the following symptoms:

	No	Yes
Dry eyes?	1	2
Dry mouth?	1	2
White finger syndrome (Raynaud's phenomenon)?	1	2
Solar dermatitis?	1	2
Skin burns easily in the sun?	1	2
Mild fever, over 37 degrees?	1	2
Low white cell count?	1	2
Low platelet count (thrombocyte count)?	1	2
Joint pain?	1	2
Joint swelling?	1	2
Pain under or at the back of the heel?	1	2
Sausage-shaped swelling of the fingers and toes?	1	2

66. In this section, write down the names, strengths and dosages of the medicines you are using. Do you use these medicines regularly or on a needs basis, and for which purpose? (on-the-shelf drugs, prescription drugs, ointments, vitamins and food supplements)

Medicine	Strength	Dosage	On a needs basis	Regularly	Purpose of use
e.g. Burana	*800 mg*	*1 tablet*	*X*		*For back pain*
e.g. vitamin D	*15 µg*	*1 tablet/day*		*X*	*Vitamin supplement*

Continued...

… list of medications continues

Medicine	Strength	Dosage	On a needs basis	Regularly	Purpose of use

67. How many of the following types of accidents <u>requiring treatment by a doctor</u> have you had? (mark '0' if none)

1 Accidents at work |___|___|
2 Traffic accidents |___|___|
3 Accidents at home |___|___|
4 Exercise-related accidents |___|___|
5 Other leisure-time accidents |___|___|
6 Violence, assault |___|___|

SENSES

68. Do you have symptoms of presbyopia? (problems with near-sightedness without reading glasses or bifocals, or when using distance glasses only)

1 no
2 yes; the symptoms started |____|____|
years ago

69. Do you wear contact lenses?

1 no
2 sometimes
3 yes

70. Have you had your vision checked within the least five years?

1 no
2 yes

71. Do you use terminal glasses for reading from the computer screen?

1 No, I use my normal eyeglasses during computer work
2 I do not use eyeglasses during computer work
3 Yes, I have an intermediate prescription for computer work (terminal glasses)

72. Do you have difficulties with the following functions (even if you are wearing your eyeglasses):

		none	slight	moderate	major
1	Recognising traffic signs and signals?	1	2	3	4
2	Reading TV subtitles from a distance of 2–3 metres?	1	2	3	4
3	Reading a regular newspaper?	1	2	3	4
4	Reading the labels on medicine bottles, the product descriptions of foodstuffs and the text in the phone book	1	2	3	4
5	Reading text from a computer screen?	1	2	3	4

73. Within the last two weeks, have you had:

		no	yes
1	A foreign body sensation/a feeling that you have something in your eye?	1	2
2	Watery eyes?	1	2
3	Sensitivity to light (photophobia)?	1	2
4	Eye pain/sore eyes?	1	2
5	Visual disturbances (e.g. distorted/blurred vision)	1	2
6	Night-blindness (nyctalopia)?	1	2

74. Have you had occlusion therapy for impaired vision due to amblyopia (lazy eye) in your childhood?

1 no
2 yes
3 cannot say

75. Have you had any eye injuries that required treatment (e.g. a blow to the eye)?

1 no
2 yes, to my right eye
   a. In |___|___|___|___|
   b. Where were you treated?
      _____
3 yes, to my left eye
   a. In |___|___|___|___|
   b. Where were you treated?
      _____

76. Have you had refractive surgery (e.g. LASIK/PRK)?

1 no
2 yes, to my right eye
When (year)? |___|___|___|___|
Where were you treated? _____
3 yes, to my left eye
When (year)? |___|___|___|___|
Where were you treated? _____

77. Have you had other types of eye surgery?

1 no
2 yes, to my right eye
When (year)? |___|___|___|___|
Where were you treated? _____
3 yes, to my left eye
When (year)? |___|___|___|___|
Where were you treated? _____

78. Is it difficult for you to follow a conversation in noisy conditions,

such as when the TV or radio is on, or the kids are playing?

1 no
2 yes

that usually last for more than five minutes?

1 no
2 yes

79. Do you currently hear sounds inside your head or in your ears (tinnitus)

ORAL HEALTH

80. How often do you brush your teeth?

1 Never or hardly ever
2 Once a day
3 Twice a day
4 More than twice a day
5 Now and then during the week

81. Do you use the following products?

		never or hardly ever	daily or almost every day	now and then during the week
1	An electric toothbrush	1	2	3
2	Dental floss	1	2	3
3	Toothpicks	1	2	3
4	Interdental brush	1	2	3
5	Fluoride toothpaste	1	2	3

82. How many teeth do you have in your mouth in total? |____|____|

83. In your opinion, do you currently have:

		no	yes
1	Holes in your teeth?	1	2
2	Bleeding from your gums when you brush your teeth?	1	2
3	A tooth or teeth that should be removed?	1	2
4	Aching or other symptoms in your mouth?	1	2
5	A healthy mouth that does not need dental care?	1	2

HEART

84. Have you experienced any pain in your chest that occurs under strain within the last 12 months?

1 no

2 yes

STOMACH

85. Have you ever had problems with heartburn or acid reflux?

1 no *(go to question 91)*

2 yes

86. Have you had problems with heartburn or acid reflux within the last year?

1 no

2 yes

☐ Heartburn (you can tick both boxes)

☐ Acid reflux

87. What age were you when you had these symptoms for the first time?

Age |____|____|

88. How often do you have problems with heartburn/acid reflux?

1 Less than once a month

2 At least once a month

3 Weekly

4 Daily

89. Do you wake up at night on account of heartburn/acid reflux?

1 no

2 yes

90. Have you used any medication for heartburn/acid reflux within the last year?

1 no

2 yes,

☐ daily; what medication?

_____

☐ on a needs basis; what medication?

_____

91. Have you ever had recurring gastric/intestinal problems (excluding heartburn/acid reflux)?

1 no *(go to question 98)*

2 yes

92. Have you had <u>recurring</u> gastric/intestinal problems (excluding heartburn/acid reflux) that started more than six months ago?

1 no

2 within the last three months

3 earlier during the last year

93. Have you had these problems at least three days per month?

1 no

2 yes

94. How long ago did the gastric/intestinal problems start?

1 6 months to 5 years ago
2 5 to 10 years ago
3 10 to 20 years ago
4 more than 20 years ago

95. What type of symptoms did you have? (you can circle more than one)

1 Pain or ache in the upper part of the abdomen
2 A burning sensation in the upper part of the abdomen
3 An unpleasant feeling of fullness after a meal
4 An early feeling of becoming full after a meal

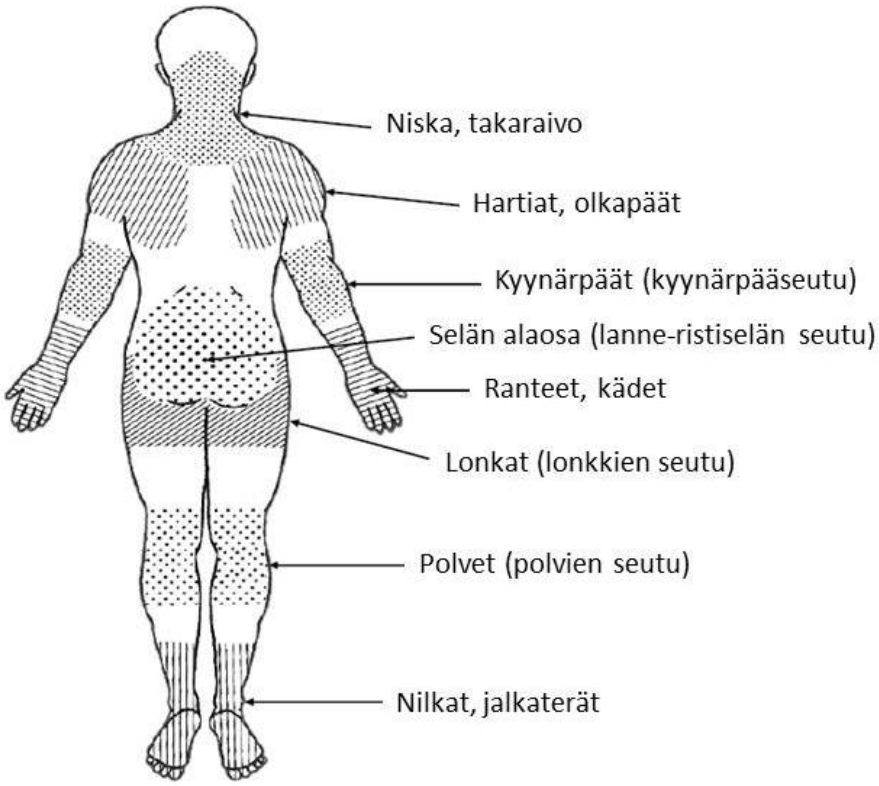
96. Have you experienced pain, aches or problems anywhere in the abdominal area? (circle only one of the options)

1 In the upper part of the abdomen
2 In the lower part of the abdomen
3 In both the upper and lower part of the abdomen

97. Gastric and intestinal problems

		no	**yes**
1	Do the problems go away during bowel movements/passing of faeces?	1	2
2	Do the problems start when your bowel movements become more/less frequent than normal?	1	2
3	Do the problems start when your faeces are harder/softer than usual?	1	2
4	Do you often have diarrhoea (completely watery or fluffy, pasta-like faeces in 25% or more of the times of passing of faeces)?	1	2
	a. On such occasions, do you have blood in your faeces?	1	2
5	Do you often have constipation?	1	2
	a. On such occasions, do you see blood when you wipe yourself?	1	2
6	Do you have gastric problems or diarrhoea when you use milk (lactose-intolerance)?	1	2
7	Have you had any gastroscopic or intestinal endoscopic examinations?	1	2
	a. What?_____		
	b. Where?_____		

PAINS AND ACHES



98. Have you <u>ever</u> had any pain or aches in the following parts of your body? (the relevant parts of the body have been named in the adjacent picture; please refer to it when answering the following questions)			**Please answer these questions only if you have had pain or aches in the area in question.**			
			Have you <u>ever</u> been examined or treated for such pain by a doctor, physiotherapist, chiropractor, or other such profes-sional?		Have you had pain or aches in this area <u>within the last 12 months</u>?	
	no	yes	no	yes	no	yes
Neck, back of the head	1	2	1	2	1	1. 1–7 days 2. 8-30 days 3. More than 30 days, but not daily 4. Daily
Neck pain that radiates to the forearm or hand	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily
Shoulder(s)	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily
Arms or elbows	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily

Have you <u>ever</u> had any pain or aches in the following parts of your body? (the relevant parts of the body have been named in the adjacent picture; please refer to it when answering the following questions)			**Please answer these questions only if you have had pain or aches in the area in question.**			
			Have you <u>ever</u> been examined or treated for such pain by a doctor, physiotherapist, chiropractor, or other such profes-sional?		Have you had pain or aches in this area <u>within the last 12 months</u>?	
	no	yes	no	yes	no	yes
Wrists, hands or fingers	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily
Lower back (= pelvic/lumbar area)	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily
Lower back pain associated with a pain that radiates to a lower limb below the knee or numbness (sciatica)	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily
Long-term lower back pain of more than three months, associated with a pain that radiates to a lower limb below the knee or numbness (sciatica)	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily
Hips	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily
Knees	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily
Ankles, feet	1	2	1	2	1	1. 1–7 days 2. 8–30 days 3. More than 30 days, but not daily 4. Daily

99. If you have had the listed musculoskeletal pain <u>within the last 2 months</u>, how intense and interfering was the pain in your experience?

	0 = “not at all interfering”/“no pain” 10 = “totally interfering”/“worst possible pain”										
Every type of musculoskeletal pain in total											
Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference											
at work	0	1	2	3	4	5	6	7	8	9	10
during leisure time	0	1	2	3	4	5	6	7	8	9	10
while asleep	0	1	2	3	4	5	6	7	8	9	10
Neck, back of the head											
Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10
Neck pain that radiates to the forearm or hand											
Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10
Shoulder(s)											
Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10
Arms or elbows											
Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10
Wrists, hands or fingers											
Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10

Lower back (= pelvic/lumbar area)

Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10

Lower back pain associated with a pain that radiates to a lower limb below the knee or numbness (sciatica)

Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10

Long-term lower back pain of more than three months, associated with a pain that radiates to a lower limb below the knee or numbness (sciatica)

Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10

Hips

Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10

Knees

Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10

Ankles, feet

Intensity	0	1	2	3	4	5	6	7	8	9	10
Interference (= in total, work, leisure time and sleep)	0	1	2	3	4	5	6	7	8	9	10

100. Have you experienced the following sensations in your lower back (pelvic/lumbar) area for periods of more than three months:

	no	**yes**
Morning stiffness that lasts for more than 30 minutes from when you wake up?	1	2
Pain that eases when you move but not when you rest?	1	2
Pain that wakes you up in the early hours of the morning?	1	2
Pain in the buttocks that varies from side to side?	1	2

101. Have you had the following symptoms?

		no	once a week	more frequently
1	Pain in your temples, temporomandibular joints, face or jaws	1	2	3
2	Pain when you open your mouth wide or when you chew	1	2	3
3	A locked jaw	1	2	3

102. Have you had a recurring headache with the following characteristics?

		no	yes
1	Exercise/strain makes the headache worse, or I have to lie down when my head hurts	1	2
2	The intensity of my headache prevents me from performing my normal daily activities	1	2
3	My headache is often one-sided	1	2
4	My headache is often throbbing or pulsating	1	2
5	My periods often include a headache	1	2
6	My headache includes nausea and vomiting	1	2
7	Bright lights and/or loud sounds irritate me when I have a headache	1	2

ALLERGIES AND RESPIRATION

103. Have you had the following respiratory and/or allergic symptoms or diseases?

		Personal opinion			Diagnosed or treated by a doctor	
		never	yes, within the last 12 months	yes, but more than a year ago	no	yes
1	Asthma	1	2	3	1	2
2	A cough that included wheezing	1	2	3	1	2
3	Recurring respiratory tract infections	1	2	3	1	2
4	Emphysema, long-term bronchitis, inflammation of the lungs	1	2	3	1	2
5	Allergic rhinitis (associated with animals and pollen, e.g. hay fever)	1	2	3	1	2
6	Eczema, also referred to as atopic dermatitis, dermatitis or atopic eczema	1	2	3	1	2
7	Symptoms of eye allergy (itching, watery eyes around animals and during the pollen season) . .	1	2	3	1	2

104. Have you had the following respiratory symptoms?
(circle the number for 'yes' or 'no' in each line)

		no	yes
1	Do you normally cough when you wake up on winter mornings?	1	2
2	Do you normally cough during the day or at night in winter?	1	2
3	Have you been coughing in the above-mentioned manner on most days for at least three months on an annual basis?	1	2
4	Do you normally cough up slimy mucous when you wake up on winter mornings? .	1	2
5	Do you normally cough up slimy mucous during the day or at night in winter?	1	2
6	Have you been coughing up slimy mucous on most days for at least three months on an annual basis?	1	2

SKIN

105. How easily does your skin burn in the sun in Finland?

1 Every time
2 Often
3 Occasionally
4 Never

106. How often have you burned your skin in the sun?

1 Several dozen times
2 10–20 times
3 Less than 10 times
4 5–10 times
5 Less than 5 times
6 Never

107. How often have you gone on a holiday in the sun abroad within the last ten years?

1 Several times a year
2 Annually
3 Every other year
4 3–4 times in 10 years
5 Not once

108. How often do you normally put on sunscreen in various situations?

	Not at all	Sometimes	Regularly	I do not spend time in the sun
While spending longer periods of time in the sun in Finland	1	2	3	4
While spending longer periods of time in the sun abroad	1	2	3	4

109. How often do you have itchy skin?

		Not at all	Very rarely	Monthly	Weekly	Daily
1	Itching in small areas of skin (e.g. scalp)	1	2	3	4	5
2	Extensive itching	1	2	3	4	5

QUESTIONS FOR WOMEN ONLY *(Men, go straight to question 122)*

Instructions: If you have never been pregnant, go straight to question 112.

110. If you have been pregnant, how many times have you (*mark '0' if none*)

Had a miscarriage? |____|____| times
Had an abortion? |____|____| times
Had an ectopic pregnancy? |____|____| times
Given birth? |____|____| times

111. If you have been pregnant, during the pregnancy, have you been diagnosed with

Gestational diabetes?

☐ No
☐ Yes; when (year): _____

How was it treated?

☐ Diet and meal plan; when (year): _____
☐ Insulin or other medical treatment; when (year): _____

High blood pressure during pregnancy, including protein in the urine (= pre-eclampsia)?

☐ No
☐ Yes; when (year): _____

How was it treated?

☐ Monitoring only; when (year): _____
☐ Medical treatment; when (year): _____

High blood pressure during pregnancy?

☐ No
☐ Yes; when (year):_____
During how many pregnancies: I__I__I

How was it treated?

☐ Monitoring only; when (year):_____
☐ Medical treatment; when (year):_____

112. Do you still have periods?

1 Yes, regularly; I had my last period in I___I___I.I___I___I.20 I___I___I

2 Yes, irregularly; I had my last period in I___I___I.I___I___I.20 I___I___I

3 No; I had my last period in _____ |___|___|___|___| (month/year).

4 No; I have had a hysterectomy

5 No, due to hormone therapy; which medication? _____

113. Have you had menopausal symptoms?

1 no

2 Yes *(If the answer is 'yes', mark in the table, which of the symptoms you have had)*

	Symptom occurrence rate:	**not at all**	**some what low**	**some**	**some what high**	**very high**
1	Hot flushes and/or night sweats	1	2	3	4	5
2	Mood symptoms (irritability, dejection, mood swings)	1	2	3	4	5
3	Insomnia or sleep disorders	1	2	3	4	5
4	Memory lapses or difficulty concentrating	1	2	3	4	5
5	Loss of libido	1	2	3	4	5
6	Vaginal dryness	1	2	3	4	5
7	Muscle and/or joint pain	1	2	3	4	5

	Symptom interference on a scale of 1 to 7:	**not at all interfering**						**very interfering**
1	Hot flushes and/or night sweats	1	2	3	4	5	6	7
2	Mood symptoms (irritability, dejection, mood swings)	1	2	3	4	5	6	7
3	Insomnia or sleep disorders	1	2	3	4	5	6	7
4	Memory lapses or difficulty concentrating	1	2	3	4	5	6	7
5	Loss of libido	1	2	3	4	5	6	7
6	Vaginal dryness	1	2	3	4	5	6	7
7	Muscle and/or joint pain	1	2	3	4	5	6	7

114. Have you been diagnosed with endometriosis?

1 no

2 Yes, at the age of |____|____|

If yes, how? *(you can select more than one option)*

- ☐ In a gynaecological examination
- ☐ In an ultrasound examination
- ☐ In an abdominal endoscopy/during abdominal surgery

115. Have you been diagnosed with myomia (uterine fibroids)?

1 no

2 Yes, at the age of |____|____|

If yes, how? *(you can select more than one option)*

- ☐ In a gynaecological examination
- ☐ In an ultrasound examination
- ☐ In an abdominal endoscopy/during abdominal surgery

116. Have you been diagnosed with polycystic ovaries and/or polycystic ovary syndrome (PCOS)?

1 no

2 yes

117. Have you used hormonal contraceptives <u>ever in your life</u>?

1 No

2 Yes

If you answered 'yes', circle in the table which products you have used and for how long (you can circle more than one option)

	Less than 5 years	**5 to 10 years**	**More than 10 years**
Combination hormonal contraception			
- pills	1	3	3
- patch or vaginal ring	1	3	3
Progestogen-only contraceptive pill (“mini-pill”)	1	3	3
Hormonal coil	1	3	3
Contraceptive implant	1	3	3
Other type of hormonal contraception; please specify:	1	3	3

_____

118. Are you <u>currently</u> using any of the following products for contraception or other reason (e.g. heavy menstrual bleeding, menopausal symptoms). How long have you used it for, continuously? *(you can select more than one option)*

1 no
2 yes

		Less than 5 years	5 to 10 years	More than 10 years
1	Pills, patch or vaginal ring	1	2	3
2	Progestogen-only contraceptive pill (“mini-pill”)	1	2	3
3	Hormonal coil	1	2	3
4	Contraceptive implant	1	2	3
5	Copper coil	1	2	3
6	Condoms	1	2	3
7	Sterilisation:			
	a. myself	1	2	3
	b. my spouse/partner	1	2	3
8	Hormone replacement therapy for menopausal symptoms	1	2	3
9	Other; please specify:_____	1	2	3

119. Urinary difficulty or incontinence

		never	rarely	often	all the time
1	Does urine leak out at times when your bladder is under pressure (e.g. when you cough, sneeze or lift something)?	1	2	3	4
2	Do you feel such a sudden, intense urge to pass urine that you cannot get to the toilet in time?	1	2	3	4

120. If you have urinary difficulty or incontinence, how much of a problem is it for you?

1 not at all
2 a slight problem
3 a moderate problem
4 a major problem

121. Do you have faecal difficulty or incontinence that interferes with your life?

1 no
2 yes

QUESTIONS FOR MEN ONLY *(Women, go straight to question 123)*

122. How often when you wake up in the morning do you currently have penile stiffening (an erection)?

1 two or more times a week
2 once a week
3 2–3 times a month
4 once a month
5 never

QUESTIONS FOR BOTH MEN AND WOMEN

123. Do you currently have difficulties with sexual intercourse?

1 no
2 yes
I am on medication
☐ no
☐ yes
3 I do not have a partner

124. How often do you think about sex? (including interest in sex, sexual fantasies, desire to have sex)?

1 Never
2 Once a month
3 Once a week
4 2–3 times a week
5 Daily

125. How often do you have sexual intercourse and/or masturbate?

1 Never
2 Once a month
3 Once a week
4 2–3 times a week
5 Daily

126. Has infertility ever been a problem for you?

1 no
2 yes
3 I have not tried to get pregnant
(→ go to question 130)

127. Have you or your current/former partner been examined for infertility?

1 no *(go to question 130)*
2 yes
☐ Myself
☐ My partner
☐ Both

128. Has the cause of infertility been identified?

1 In me
2 In my partner
3 In us both
4 The cause has not been identified

129. Have you or your partner been treated for infertility whilst you were trying to get pregnant together? (select more than one option, if necessary)

	Which treatments and in which year (mark as accurately as you remember)	A pregnancy that led to the birth of a child began as the result of/during the treatment	
		Yes	**No**
1 no *(go to question 130)*			
2 Ovarian stimulation using Clomifen	_____	in: _____	_____
3 insemination (injecting sperm into the uterus)	_____	in: _____	_____
4 surgical treatment; please specify _____	_____	in: _____	_____
5 in vitro fertilisation (IVF)	_____	in: _____	_____
6 intracytoplasmic sperm injection (ICSI)	_____	in: _____	_____
7 other; please specify: _____	_____	in:_____	_____

130. Listed below are problems and signs that most people have now and then. Circle the option that best describes how much the said problem has bothered you <u>within the last week</u>?

	not at all	**some**	**consider-ably**	**very much**
Headache	1	2	3	4
Difficulty in falling asleep	1	2	3	4
Feeling like there is no hope for the future	1	2	3	4
Tension or over-exhaustion	1	2	3	4
A feeling of loneliness	1	2	3	4
Feeling like your whole life has been a constant uphill battle	1	2	3	4
Bursts of panic or anxiety	1	2	3	4
Such a strong feeling of restlessness that it has been hard to sit still	1	2	3	4
A feeling of worthlessness	1	2	3	4
Nervousness and restlessness	1	2	3	4
Dizziness or a fainting feeling	1	2	3	4
Worry	1	2	3	4
Lack of sexual interest or pleasure	1	2	3	4
Lack of energy or impotency	1	2	3	4
Thoughts of ending your life	1	2	3	4
Tremor	1	2	3	4
Loss of appetite	1	2	3	4
Tearfulness	1	2	3	4
Feeling of being locked in or held captive	1	2	3	4
Sudden feeling of restlessness without an actual reason	1	2	3	4
Self-accusations	1	2	3	4
Dejection	1	2	3	4
Lack of interest	1	2	3	4
Distress	1	2	3	4
Heart palpitations	1	2	3	4

ADDITIONAL QUESTIONS

131. Your most recent visual acuity as you know it *(visual acuity, or Visus, abbreviation V, no +/- sign in front)*
Mark the box of the correct option with an (X)

Right eye (Right = OD = o.dx. = R)		Left eye (Left = OS = o.sin. = L)	
☐	2.0	☐	2.0
☐	1.6	☐	1.6
☐	1.4	☐	1.4
☐	1.2	☐	1.2
☐	1.0	☐	1.0
☐	0.8	☐	0.8
☐	0.63	☐	0.63
☐	0.6	☐	0.6
☐	0.5	☐	0.5
☐	0.4	☐	0.4
☐	0.3	☐	0.3
☐	0.2	☐	0.2
☐	0.1	☐	0.1
☐	CF = count fingers, correctly identify how many fingers	☐	CF = count fingers, correctly identify how many fingers
☐	HM= hand motion/movement, can see hand movement	☐	HM= hand motion/movement, can see hand movement
☐	PL= perceives light	☐	PL= perceives light
☐	0 = no light perception, totally blind	☐	0 = no light perception, totally blind
☐	I do not know	☐	I do not know

132. Do you wear eyeglasses?

1 No

2 Yes (fill in the details of your most used eyeglasses below)

1. Eyeglasses

Are your glasses: *1. distance glasses*
2. bifocals
3. reading glasses

How long have had your current glasses? |___|___| *years*

Fill in the following details from the eyeglass prescription (see example images on the following pages)

The strength of the glasses (from the eyeglass prescription/card; note: + or - signs, or at least the amount)

Right (OD/dx)	|___|___|	*(e.g. –1.25)*	*Left (OS/sin)*	|___|___|	*(e.g. +3.25)*
cyl	|___|___|	*(e.g. +0.75)*	*cyl*	|___|___|	*(e.g. –0.25)*
ax	|___|___|	*(e.g. 120)*	*ax*	|___|___|	*(e.g. 10)*
Add	|___|___|	*(e.g. 1.75)*				

2. Eyeglasses

Are your glasses: *1. distance glasses*
2. bifocals
3. reading glasses

How long have had your current glasses? |___|___| *years*

Fill in the following details from the eyeglass prescription (see example images on the following pages)

The strength of the glasses (from the eyeglass prescription/card; note: + or - signs, or at least the amount)

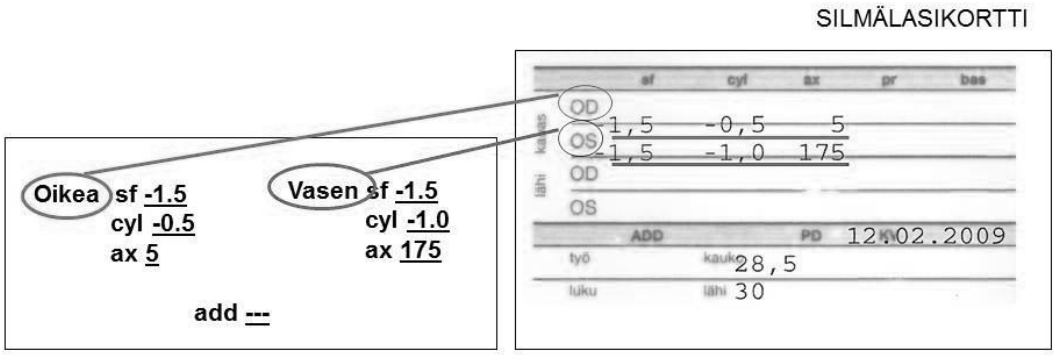
Right (OD/dx)	|___|___|	*(e.g. –1.25)*	*Left (OS/sin)*	|___|___|	*(e.g. +3.25)*
cyl	|___|___|	*(e.g. +0.75)*	*cyl*	|___|___|	*(e.g. –0.25)*
ax	|___|___|	*(e.g. 120)*	*ax*	|___|___|	*(e.g. 10)*
Add	|___|___|	*(e.g. 1.75)*				

If you have had refractive surgery (e.g. LASIK/PRK), how much was the refractive error before the surgery (at least the amount, note the example, + or – sign)

Right (OD/dx)	|___|___|	(e.g. –1.25)	Left (OS/sin)	|___|___|	(e.g. +3.25)
cyl	|___|___|	(e.g. +0.75)	cyl	|___|___|	(e.g. –0.25)
ax	|___|___|	(e.g. 120)	ax	|___|___|	(e.g. 10)

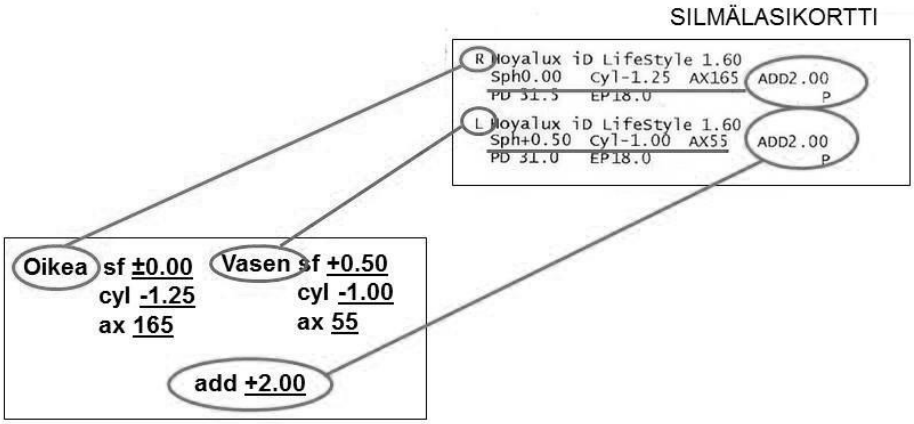
Example images

Esimerkki 1: Kaukolasit



Oikea = OD = o.dx. = R	Vasen = OS = o.sin. = L	add = lähilisä

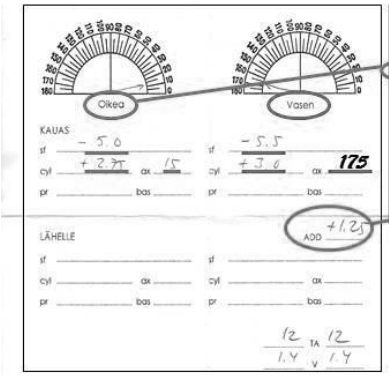
Esimerkki 2: Moniteholasit A



Oikea = OD = o.dx. = R	Vasen = OS = o.sin. = L	add = lähilisä

Esimerkki 3: Moniteholasit

SILMÄLASIRESEPTI



TAI

Oikea **sf -5.0** **Vasen** **sf -5.5**
cyl +2.75 **cyl +3.0**
ax 15 **ax 175**

add +1.25

SILMÄLASIKORTTI

Silmälasit	Peruspari	
Linssimääräys Nro.	694 378680	
Päivämäärä	15.05.2010	
Moniteho	Oikea	Vasen
Sf	-5.00	-5.50
Cyl	+2.75	+3.00
Ax	15	175
Prisma	0.00	0.00
Basis		
Add	1.25	1.25
Lukukorkeus	21.0	21.0
Kv	30.0	30.0
Des	0.0	0.0
Des.suun	0	180
Materiaali	RI7	RI7
Halkaisija	70.00	70.00
Tyyppi	IPR	IPR
Lukuosa	0	0
Lisäkäsittelyt		

Oikea = OD = o.dx. = R Vasen = OS = o.sin. = L add = lähilisä

Esimerkki 4: Lukulasit

Oikea **sf +2.75** **Vasen** **sf +3.00**
cyl -1.00 **cyl -1.50**
ax 155 **ax 55**

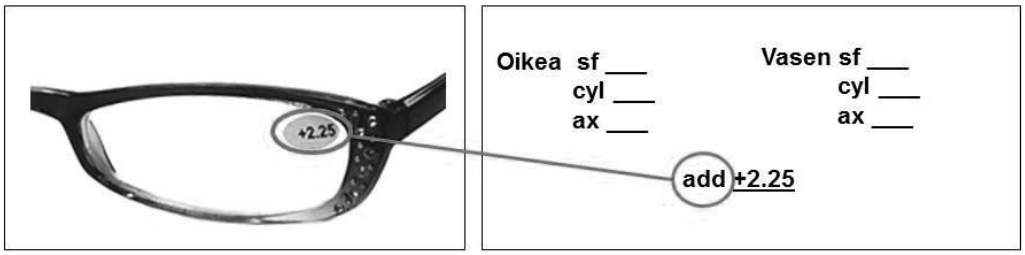
add ---

Silmälasit	Peruspari	
Linssimääräys Nro.	694 379641	
Päivämäärä	14.10.2010	
Lähi	Oikea	Vasen
Sf	+2.75	+3.00
Cyl	-1.00	-1.50
Ax	155	55
Prisma	0.00	0.00
Basis		
Add	0.00	0.00
Lukukorkeus	17.0	17.0
Kv	30.0	30.0
Des	0.0	0.0
Des.suun	0	180
Materiaali	BN6	BN6
Halkaisija	66.00	66.00
Tyyppi	200	200
Lukuosa	0	0
Lisäkäsittelyt	sar	

SILMÄLASIKORTTI

Oikea = OD = o.dx. = R Vasen = OS = o.sin. = L add = lähilisä

Esimerkki 5: Lukulasit A



VALMISLUKULASIT

Oikea = OD = o.dx. = R	Vasen = OS = o.sin. = L	add = lähilisä

THANK YOU FOR TAKING THE TIME TO RESPOND TO THIS SURVEY!

I completed the survey

1 myself
2 with the help of a carer, an assistant or other close relative
Date of completing the survey I___I___I.I___I___I 20 I___I___I

ID

Consent form

I have been given sufficient information about the “Northern Finland Birth Cohort 1966 Welfare and Health Research Programme”, and I wish to take part in it. I am aware that my participation is voluntary and that I can terminate my participation at any time without it affecting the way I am treated now or in the future.

I hereby give or do not give my consent as marked by an (X):

	Yes	No
1. The information collected about me under this research programme and the survey results may be used now or at a later time in anonymised format in scientific research.	☐	☐
2. National registration data about me may be combined with the information collected now under this research programme and earlier in anonymised format.	☐	☐
3. With respect to this research programme, the necessary patient record information about me can be requested from the relevant health care units.	☐	☐
4. The information collected about me earlier and under this research programme and the survey results may be disclosed without name and personal identity code, i.e. in anonymised format, for the purposes of cooperation with businesses.	☐	☐

Place_____ Date _____/_____/_____

Signature _____ Name in block letters _____

Personal ID code_____ Telephone number: _____

Address:_____