**Please see our newsletter inside**

We guarantee that all information will be treated with absolute confidentiality and will be used only for medical research. To help us read your answers, please write as clearly as possible with a black pen and complete the questionnaire by putting a cross in the appropriate box(es)

**If your name and/or your address has changed or is incorrect, please give the correct details below:**

Surname: ______________________  Forename(s): ______________________

Address: ______________________

Postcode: ______________________

**PLEASE COMPLETE USING A BLACK PEN**

<table>
<thead>
<tr>
<th>Date of birth:</th>
<th>Date today:</th>
</tr>
</thead>
</table>

**QUESTIONS ABOUT YOUR DIET**

1. **Do you eat any meat?**
   - Yes [ ]
   - No [ ]
   - (including bacon, poultry, game, meat pies, sausages)

   **If yes,** how many times a week do you eat meat?
   - times a week

   **If no,** how old were you when you last ate meat?
   - years old

2. **Do you eat any fish?**
   - Yes [ ]
   - No [ ]
   - (e.g. sardines, cod, tuna, salmon, mackerel, herring)

   **If yes,** how many times a month do you eat the following?
   - times
   - times

   **If no,** how old were you when you last ate fish?
   - years old

3. **Do you eat any dairy products?**
   - Yes [ ]
   - No [ ]

   **If no,** how old were you when you last ate dairy products?
   - years old

4. **Do you eat any eggs?**
   - Yes [ ]
   - No [ ]

   **If yes,** how many eggs do you eat each week?
   - eggs each week

   **If no,** how old were you when you last ate eggs?
   - years old

5. **What type of milk do you use most often?**
   - Full cream [ ]
   - Semi-skimmed [ ]
   - Skimmed/fat free [ ]
   - Soya milk not fortified with calcium [ ]
   - Soya milk fortified with calcium [ ]
   - Other [ ]
   - None [ ]

   **How much milk do you drink each day, including milk with tea, coffee, cereals, etc.?**
   - Less than quarter of a pint (<150 ml) [ ]
   - Three quarters of a pint (450 ml) [ ]
   - Quarter of a pint (150 ml) [ ]
   - One pint (600 ml) [ ]
   - Half a pint (300 ml) [ ]
   - More than one pint (>600 ml) [ ]

6. **What type of spread do you use most often on bread, crispbreads, vegetables, etc.?**
   - Butter [ ]
   - Hard margarine (in wrapper not tub) [ ]
   - Dairy spread e.g. Clover [ ]
   - Soya margarine or other milk free margarine [ ]
   - Low or reduced fat spread e.g. Benecol, Flora pro-activ [ ]
   - Cholesterol lowering spread e.g. Benecol, Flora pro-activ [ ]
   - Olive based spread e.g. Flora [ ]
   - Other margarine [ ]
   - None [ ]

   **How thickly do you spread it?**
   - thick [ ]
   - medium [ ]
   - thin [ ]

   **Do you add it to potatoes?**
   - Yes [ ]
   - No [ ]

   **Do you add it to other vegetables?**
   - Yes [ ]
   - No [ ]
7. What type of fat do you use most often for cooking?

<table>
<thead>
<tr>
<th>+ Butter</th>
<th>Lard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft margarine</td>
<td>Olive oil</td>
</tr>
<tr>
<td>Hard margarine</td>
<td>Other vegetable oil</td>
</tr>
<tr>
<td>Solid vegetable fat</td>
<td>None</td>
</tr>
</tbody>
</table>

8. Do you eat organic food?

<table>
<thead>
<tr>
<th>Never</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
</table>

9. How much bread, crispbread etc. do you normally eat each day?

<table>
<thead>
<tr>
<th>White bread slices a day</th>
<th>Crispbread biscuits a day</th>
<th>Wholemeal bread slices a day</th>
</tr>
</thead>
</table>

10. What type of breakfast cereal do you eat most often?

<table>
<thead>
<tr>
<th>Bran cereal e.g. Branflakes</th>
<th>Muesli, oat clusters, etc.</th>
<th>Wholemeal cereal e.g. Weetabix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Porridge, hot oat cereal</td>
<td>Other e.g. cornflakes, Rice Krispies</td>
<td>None</td>
</tr>
</tbody>
</table>

11. How much of the following do you drink each day?

<table>
<thead>
<tr>
<th>Tea cups daily</th>
<th>Pure fruit juice glasses daily</th>
<th>Herb tea cups daily</th>
<th>fruit drinks, squash glasses daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coffee cups daily</td>
<td>&quot;Diet&quot; fizzy soft drinks glasses/cans daily</td>
<td>Water glasses daily</td>
<td>Fizzy soft drinks glasses/cans daily</td>
</tr>
</tbody>
</table>

12. How many teaspoons of sugar, in total, do you add to tea, coffee, cereal, fruit etc. each day?

<table>
<thead>
<tr>
<th>Beer, lager or cider pints each week</th>
<th>Red wine glasses each week</th>
<th>White wine glasses each week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sherry or fortified wine glasses each week</td>
<td>Spirits - whisky, gin, brandy glasses each week</td>
<td></td>
</tr>
</tbody>
</table>

13. At present, about how many alcoholic drinks do you have each week?

<table>
<thead>
<tr>
<th>Beer, lager or cider pints each week</th>
<th>Red wine glasses each week</th>
<th>White wine glasses each week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sherry or fortified wine glasses each week</td>
<td>Spirits - whisky, gin, brandy glasses each week</td>
<td></td>
</tr>
</tbody>
</table>

14. How often do you eat the following?

<table>
<thead>
<tr>
<th>Fresh fruit</th>
<th>Never</th>
<th>Seldom</th>
<th>Once a week</th>
<th>2-4 times a week</th>
<th>5-6 times a week</th>
<th>Once or more a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dried fruit (raw)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stewed fruit, tinned fruit</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pasta, e.g. spaghetti</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Rice</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pizza</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Chips</td>
<td></td>
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<td></td>
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<tr>
<td>Other potatoes</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baked beans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lentils, dried beans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tomatoes</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Carrots</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Green vegetables</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other cooked vegetables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salad/raw vegetables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tofu</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Soya meat, burgers, TVP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other veggie burgers</td>
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<td></td>
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<tr>
<td>Cheese</td>
<td></td>
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<td></td>
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<tr>
<td>Cottage cheese</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Soya cheese</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yogurt, dairy desserts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soya yogurt, soya desserts</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Cream, ice cream</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Soya cream, ice cream</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cakes, puddings, pies, buns, etc.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Chocolate, any type</td>
<td></td>
<td></td>
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<tr>
<td>Other sweets, e.g. boiled sweets</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Crisps, Hula Hoops, etc.</td>
<td></td>
<td></td>
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<tr>
<td>Peanut butter, salted nuts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other nuts and seeds not in muesli</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jam, marmalade</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Yeast extract, e.g. Marmite</td>
<td></td>
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</tr>
</tbody>
</table>

15. Have you ever smoked cigarettes? Yes ☐ No ☐

If you have stopped smoking cigarettes, how old were you when you gave up? ☐ years old

If you smoke now, how many cigarettes, do you usually smoke each day? ☐ cigarettes a day
25. In the last six years, have you had any broken/fractured bones?  
Yes ☐  No ☐
If yes, please give details

Bone(s), e.g. hip, ankle, spine, wrist, finger
Cause, e.g. fall, found on X-ray, car accident

Month Year
Month Year

26. In the last six years, has your doctor told you that you had any of the following?

Cancer ☐
Polyps in large intestine ☐
Enlarged prostate (men only) ☐
High blood pressure ☐
High blood cholesterol ☐
Angina ☐
Stroke ☐
Heart attack ☐
Cardiac arrhythmias/palpitations/irregular heartbeat ☐
Blood clot in leg ☐
Blood clot in lung or elsewhere ☐
Diabetes ☐
Thyroid disease ☐
Cataract in eye ☐
Stomach ulcer ☐
Duodenal ulcer ☐
Gallstones ☐
Have you had your gall bladder removed? ☐
Diverticular disease ☐
Crohn's disease ☐
Ulcerative colitis ☐
Asthma ☐
Bronchitis/emphysema ☐
Rheumatoid arthritis ☐
Osteoarthritis ☐
Depression requiring treatment ☐

Please complete all appropriate boxes

type of cancer:

Other significant illnesses or operations, excluding hysterectomy - see Q.38. Please give details, including year first diagnosed.
27. Do you regularly take any vitamins, minerals or other supplements?  
   Yes  ☐  No  ☐  
   If yes, do you take: (you can cross more than one box)  
   + multivitamins (with minerals)  ☐  vitamin A  ☐  
   + multivitamins (without minerals)  ☐  vitamin B (thiamin, B6, folic acid)  ☐  
   + fish oil (including cod liver oil)  ☐  vitamin C  ☐  
   + evening primrose oil  ☐  vitamin D  ☐  
   + iron  ☐  zinc  ☐  calcium  ☐  vitamin E  ☐  
   Other (name and brand)  

28. Have you taken any medications for most of the last 4 weeks?  
   Yes  ☐  No  ☐  
   If yes, was it: (you can cross more than one box)  
   + amlodipine  (twin)  ☐  digoxin  ☐  prednisolone  ☐  
   + amitriptyline (Tryptizol, etc.)  ☐  propranolol  ☐  sleeping pills  ☐  
   + aspirin  ☐  ibuprofen  ☐  tamoxifen  ☐  
   + atenolol  ☐  insulin  ☐  thyroxine  ☐  
   + bendrofluazide  ☐  lithium  ☐  warfarin  ☐  
   + contraceptive pill  ☐  Losec/Zoton  ☐  paracetamol  ☐  
   + co-proxamol (Distalgesic)  ☐  Other (name and brand)  

29. About how many bowel movements do you have each week?  
   ☐ a week  ☐ once a month  ☐ put ‘0’ if none  

30. How often do you take laxatives?  
   ☐ a week  ☐ once a month  ☐ put ‘0’ if none  

31. Have you had a vasectomy?  
   Yes  ☐  No  ☐  
   If yes, at what age?  ☐ years old  

32. Have you had your menopause (stopped having periods)?  
   Yes  ☐  No  ☐  Not sure (because taking HRT, irregular periods, etc.)  ☐  
   If yes, how old were you when you stopped having periods?  ☐ years old  

33. How many periods have you had in the last 12 months?  
   ☐ put ‘0’ if none  ☐ periods  

34. Have you ever taken the contraceptive pill?  
   Yes  ☐  No  ☐  
   If yes, for how long altogether have you used the pill?  ☐ years  
   Are you currently taking the contraceptive pill?  Yes  ☐  No  ☐  
   If no, at what age did you stop?  ☐ years old  

35. Have you ever taken Hormone Replacement Therapy (HRT)?  
   Yes  ☐  No  ☐  
   If yes, for how long altogether have you used HRT?  ☐ years  
   Are you currently taking HRT?  Yes  ☐  No  ☐  
   If no, at what age did you stop?  ☐ years old  

36. During the last six years, have you had any children?  
   Yes  ☐  No  ☐  
   If yes, please enter the years of birth and sex below:  
   1.  ☐ Boy  ☐ Girl  ☐  
   2.  ☐ Boy  ☐ Girl  ☐  
   3.  ☐ Boy  ☐ Girl  ☐  

37. Have you ever had a son born with either of the following conditions?  
   Yes  ☐  No  ☐  
   Year of birth  ☐  
   Undescended testicles (Cryptorchidism)  ☐  
   Hypospadias (hole for urinating in the wrong place)  ☐  

38. Have you had a hysterectomy (womb removed)?  
   Yes  ☐  No  ☐  
   If yes, at what age?  ☐ years old  

39. Have you had an operation to remove one or both ovaries?  
   Yes  ☐  No  ☐  Don’t know  ☐  
   If yes, were one or both ovaries removed?  One  ☐  Both  ☐  Don’t know  ☐  
   At what age?  ☐ years old  

40. Have you ever had breast screening by mammography (x-ray)?  
   Yes  ☐  No  ☐  
   If yes, how many times in the last ten years?  ☐  
   When did you last have a breast screen?  ☐  

41. Have you ever had a cervical smear test?  
   Yes  ☐  No  ☐  
   If yes, how many times in the last ten years?  ☐  
   When did you last have a cervical smear?  ☐  

THANK YOU VERY MUCH FOR YOUR HELP  Please return this questionnaire in the pre-paid envelope