

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)

e.g. Yes No

OR putting numbers in the appropriate box(es)

e.g.

We would like you to answer every question. If you are uncertain please do the best you can.

If you have any queries you can telephone us (01865) 289611

or email us queries@epic-oxford.org

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

Surname: Forename(s):

Address:

Postcode:

If you have an email address, would you be prepared for the study organisers to contact you about this study in the future? If yes, please write down your email address:

PLEASE COMPLETE USING A BLACK PEN IF POSSIBLE

1. What is your date of birth? / /

2. What is today's date? / /

3. 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
(remember bacon for breakfast and meat in sandwiches)

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

4. Do you eat any fish? Yes No

If yes, how many times a month do you eat the following?
put '0' if eaten less than once a month

Fatty fish times a month (e.g. sardines, salmon, mackerel, herring) Other fish times a month (e.g. cod, tuna, haddock)

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

5. Do you eat any dairy products? Yes No
(including milk, cheese, butter, yoghurt)

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

6. Do you eat any eggs? Yes No
(including eggs in cakes and other baked foods)

If yes, how many eggs do you eat each week? eggs each week
put '0' if eaten less than once a week

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

7. What type of milk do you use most often?

Full cream Soya milk fortified with calcium
Semi-skimmed Soya milk not fortified with calcium
Skimmed/fat-free Other
Goat's or sheep's milk 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 or more (>600 ml)
Half a pint (300 ml) None

8. What type of spread do you normally use on bread, crispbreads, etc. ?

Butter	<input type="checkbox"/>	Soya margarine or other dairy free margarine	<input type="checkbox"/>
Dairy spread e.g. Clover	<input type="checkbox"/>	Cholesterol lowering spread e.g. Benecol, Flora pro-activ	<input type="checkbox"/>
Low or reduced fat spread	<input type="checkbox"/>	Other margarine	<input type="checkbox"/>
Olive oil based spread	<input type="checkbox"/>	None	<input type="checkbox"/>
Polyunsaturated margarine	<input type="checkbox"/>		

9. Which type of bread do you normally eat?

White bread	<input type="checkbox"/>	Brown bread	<input type="checkbox"/>
Wholemeal bread	<input type="checkbox"/>	Other	<input type="checkbox"/>

10. What type of breakfast cereal do you normally eat?

Bran cereal e.g. Branflakes	<input type="checkbox"/>	Muesli, oat clusters, etc.	<input type="checkbox"/>
Wholewheat cereal e.g. Weetabix	<input type="checkbox"/>	Other e.g. cornflakes, Rice Krispies	<input type="checkbox"/>
Porridge, hot oat cereal	<input type="checkbox"/>	None	<input type="checkbox"/>

11. How often do you eat the following foods?

	Never	Seldom	Once a week	2-4 times a week	5-6 times a week	Once or more a day
Fresh fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dried fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salad/raw vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooked vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peanut butter, salted nuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other nuts and seeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. How often do you eat the following soya foods?

	Never	Seldom	Once a week	2-4 times a week	5-6 times a week	Once or more a day
Tofu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soya meat, burgers, TVP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soya cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soya yoghurt, soya desserts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. How much alcohol do you drink each week?

Beer, lager or cider <i>pints each week</i>	<input type="text"/>	Red wine <i>glasses each week</i>	<input type="text"/>
Sherry or fortified wine <i>glasses each week</i>	<input type="text"/>	White wine <i>glasses each week</i>	<input type="text"/>
Spirits - whisky, gin, brandy <i>glasses each week</i>	<input type="text"/>		

QUESTIONS ABOUT YOUR LIFESTYLE

14. 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

15. Do you smoke cigars? Yes No

16. Do you smoke a pipe? Yes No

17. Do you currently have a paid job?

Yes, full-time Yes, part-time No

If yes, we would like to know the type and amount of physical activity involved in your work. Please put a cross in the appropriate box

Sedentary occupation
you spend most of your time sitting (such as in an office)

Standing or walking occupation
you spend most of your time standing or walking, but your work does not require intense physical effort (e.g. shop assistant, hairdresser, guard)

Manual work
this involves some physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter)

Heavy manual work
this involves very vigorous physical activity including handling very heavy objects (e.g. bricklayer, construction worker)

18. How do you normally travel to work?

Car or motorbike	<input type="checkbox"/>	Walking	<input type="checkbox"/>
Public transport	<input type="checkbox"/>	Bicycle	<input type="checkbox"/>
Do not have to travel to work	<input type="checkbox"/>		

19. How would you describe your normal walking pace?

Slow Steady average Brisk

20. In a typical week during the past year, how many hours did you spend per week on each of the following activities? put '0' if none

	In Summer	In Winter
Walking, including to work, shopping and during leisure time	<input type="text"/> hours per week	<input type="text"/> hours per week
Cycling, including cycling to work and during leisure time	<input type="text"/> hours per week	<input type="text"/> hours per week
Gardening	<input type="text"/> hours per week	<input type="text"/> hours per week
Physical exercise such as keep-fit/aerobics, swimming, jogging, tennis, etc.	<input type="text"/> hours per week	<input type="text"/> hours per week

21. In a typical week during the past 12 months, did you practise any activity vigorously enough to cause sweating or a faster heart beat? Yes No

If yes, for how many hours per week in total did you practise such vigorous activity? hours per week

22. What is your weight now?

stones pounds or kilograms

23. Compared with two years ago, has your weight changed?

No Yes, lost weight through dieting/exercise
Yes, gained weight Yes, lost weight for other reason

24. What are your present waist and hip measurements?

waist

or

inches

centimetres

hip

or

inches

centimetres

25. Has your height decreased since you were 20 years old? Yes No Don't know

26. What is your marital status?

Single

Widowed

Divorced

Married or living as married

Separated

QUESTIONS ABOUT YOUR HEALTH

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 vitamin A chromium

multivitamins with iron vitamin B6 magnesium

multivitamins with calcium vitamin B12 selenium

multivitamins with multiminerals vitamin C calcium

fish oil (including cod liver oil) vitamin D garlic

glucosamine/chondroitin vitamin E iron

soya isoflavones folic acid zinc

starflower/evening primrose oil flax/linseed

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)

alendronate (Fosamax) digoxin paracetamol

amlodipine enalapril paroxetine (Seroxat)

amitriptyline (Tryptizol) etidronate (Didronel) prednisolone

aspirin frusemide propranolol

atenolol HRT Prozac

atorvastatin (Lipitor) ibuprofen risedronate (Actonel)

beclomethasone (Becotide) insulin salbutamol (Ventolin)

bendrofluzide lisinopril simvastatin (Zocor)

co-codamol/co-dydramol lithium sleeping pills

contraceptive pill Losec/Zoton tamoxifen

co-proxamol metformin thyroxine

diclofenac (Voltarol) nifedipine warfarin

Other (name and brand)

29. Have you had a hip replacement? Yes No if yes, in what year?

30. Have you had a knee replacement? Yes No if yes, in what year?

31. Has your doctor ever told you that you had any of the following? Yes Year first diagnosed No

Cancer

Yes	Year first diagnosed	No
<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

type of cancer:

Blood clot in leg

Blood clot in lung or elsewhere

Stroke

TIA (transient ischaemic attack)

Angina

Heart attack

Palpitations/irregular heart beat (cardiac arrhythmia)

Diabetes

High blood cholesterol

High blood pressure

Asthma

Emphysema/chronic bronchitis

Thyroid problem

Cataract in eye

Stomach or duodenal ulcer

Bowel polyps

Diverticular disease

Crohn's disease/Ulcerative colitis

Coeliac disease

Osteoporosis

Rheumatoid arthritis

Osteoarthritis

Depression/anxiety

Gallstones

Gallbladder removed

Epilepsy

Multiple Sclerosis

Enlarged prostate (men only)

Other significant illnesses or operations, excluding hysterectomy - see Q.42
Please give details, including year first diagnosed.

32. **In the last ten years, have you had any broken/fractured bones?** Yes, once Yes, more than once No

If yes, please indicate which bones you have fractured/broken:

Please cross this box if the fracture was the result of a fall

	Year of fracture	
hip	<input type="checkbox"/>	<input type="checkbox"/>
wrist	<input type="checkbox"/>	<input type="checkbox"/>
arm	<input type="checkbox"/>	<input type="checkbox"/>
ankle	<input type="checkbox"/>	<input type="checkbox"/>
leg	<input type="checkbox"/>	<input type="checkbox"/>
finger/toe	<input type="checkbox"/>	<input type="checkbox"/>
rib	<input type="checkbox"/>	<input type="checkbox"/>
other	<input type="checkbox"/>	<input type="checkbox"/>

33. **How would you describe your health now?**

excellent good fair poor

QUESTIONS FOR MEN ONLY

34. **Have you had a vasectomy?** Yes No

If yes, at what age? years old

35. **Have you had a PSA (prostate specific antigen) test?** Yes No

If yes, at what age? years old

QUESTIONS FOR WOMEN ONLY

35. **Have you been through your menopause?**

- No
 Not sure because I had a hysterectomy
 Not sure because of irregular periods, taking HRT etc.
 Yes - If yes, how old were you when you had your menopause? years old

36. **How many natural periods have you had in the last 12 months?** (put '0' if none)
 Do not count bleeding while taking the pill or HRT periods

37. **Have you ever taken the contraceptive pill?** Yes No

If yes, at what age did you first use the pill? years old

For how long altogether have you used the pill? years

Are you currently taking the contraceptive pill? Yes No

If yes, is it the "mini pill"? Yes No
 e.g. Micronor, Noriday, Femulen, Microval, Norgeston, Cerazette

If no, at what age did you stop? years old

38. **Have you ever taken Hormone Replacement Therapy (HRT)?** Yes No

If yes, at what age did you first use HRT? years old

For how long altogether have you used HRT? years

Are you currently taking HRT? Yes No

If yes, what brand of HRT are you currently using?

- Prempak C 0.625mg Estraderm patch Estracombi
 Prempak C 1.25mg Trisequens Kliofem
 Evorel (25, 50, 75, 100 mcg) Premique Livial
 Evorel conti or sequi Nuvelle Implants
 Premarin 0.625mg Climesse Other
 Premarin 1.25mg Oestrogel Don't know

If you no longer take HRT, at what age did you stop? years old

39. **During the last six years, have you had any children?**

Yes No

If yes, please enter the year(s) of birth and sex below:

- Boy Girl
- Boy Girl
- Boy Girl

40. **Are you currently pregnant?** Yes No

41. **Have you ever had a son born with either of the following conditions?**

- Year of birth
- Hypospadias (hole for urinating in the wrong place) Yes No
- Undescended testicles (Cryptorchidism)

42. **Have you had a hysterectomy (womb removed)?** Yes No

If yes, at what age? years old

43. **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

44. **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? (please enter year)

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

We guarantee that all information will be treated with absolute confidentiality and will only be used for medical research
 PROF T KEY, EPIC STUDY, EPIDEMIOLOGY UNIT, UNIVERSITY OF OXFORD, RICHARD DOLL BUILDING, ROOSEVELT DRIVE, HEADINGTON, OXFORD OX3 7LF