

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) +

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 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

What is your date of birth? / /

What is today's date? / /

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
(remember bacon for breakfast and meat in sandwiches)

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

2. 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

3. 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

4. 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

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

Full cream Soya milk not fortified with calcium
Semi-skimmed Other
Skimmed/fat free None
Soya milk fortified with calcium

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 Cholesterol lowering spread e.g. Benecol, Flora pro-activ
Olive based spread e.g. Olivio Other margarine
Polyunsaturated margarine e.g. Flora 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?

+	Butter	<input type="checkbox"/>	Lard	<input type="checkbox"/>
	Soft margarine	<input type="checkbox"/>	Olive oil	<input type="checkbox"/>
	Hard margarine	<input type="checkbox"/>	Other vegetable oil	<input type="checkbox"/>
	Solid vegetable fat <i>e.g. White Flora</i>	<input type="checkbox"/>	None	<input type="checkbox"/>

8. Do you eat organic food?

Never	<input type="checkbox"/>	Usually	<input type="checkbox"/>
Sometimes	<input type="checkbox"/>	Always	<input type="checkbox"/>

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

White bread <i>slices a day</i>	<input type="checkbox"/>	Crispbread <i>biscuits a day</i>	<input type="checkbox"/>
Brown bread <i>slices a day</i>	<input type="checkbox"/>	Sweet biscuits <i>biscuits a day</i>	<input type="checkbox"/>
Wholemeal bread <i>slices a day</i>	<input type="checkbox"/>		

put '0' if none

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

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

How many bowls of breakfast cereal do you eat each week? *put '0' if none*

bowls a week

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

Tea <i>cups daily</i>	<input type="checkbox"/>	Pure fruit juice <i>glasses daily</i>	<input type="checkbox"/>
Herb tea <i>cups daily</i>	<input type="checkbox"/>	Fruit drinks, squash <i>glasses daily</i>	<input type="checkbox"/>
Coffee <i>cups daily</i>	<input type="checkbox"/>	"Diet" fizzy soft drinks <i>glasses/cans daily</i>	<input type="checkbox"/>
Water <i>glasses daily</i>	<input type="checkbox"/>	Fizzy soft drinks <i>glasses/cans daily</i>	<input type="checkbox"/>

put '0' if none

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

put '0' if none teaspoons each day

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

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

put '0' if none

14. How often do you eat the following?

Please cross one box for each item

	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 (raw)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stewed fruit, tinned fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pasta, e.g. spaghetti	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pizza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baked beans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lentils, dried beans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tomatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Green vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other cooked vegetables	<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"/>
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"/>
Other veggie burgers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cottage cheese	<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"/>
Yogurt, dairy desserts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soya yogurt, soya desserts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cream, ice cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soya cream, ice cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cakes, puddings, pies, buns, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate, any type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other sweets, e.g. boiled sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crisps, Hula Hoops, etc.	<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 not in muesli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jam, marmalade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yeast extract, e.g. Marmite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

QUESTIONS ABOUT YOUR LIFESTYLE

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

16. Do you smoke cigars? Yes No

17. Do you smoke a pipe? Yes No

18. Do you have a paid job at present?
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 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. docker, miner, bricklayer, construction worker)

19. 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"/> <input type="text"/> hours per week	<input type="text"/> <input type="text"/> hours per week
Cycling, including cycling to work and during leisure time	<input type="text"/> <input type="text"/> hours per week	<input type="text"/> <input type="text"/> hours per week
Gardening	<input type="text"/> <input type="text"/> hours per week	<input type="text"/> <input type="text"/> hours per week
Do-it-yourself	<input type="text"/> <input type="text"/> hours per week	<input type="text"/> <input type="text"/> hours per week
Physical exercise such as keep-fit/aerobics, swimming, jogging, tennis, etc.	<input type="text"/> <input type="text"/> hours per week	<input type="text"/> <input type="text"/> hours per week
Housework, such as cleaning, washing, cooking and childcare	<input type="text"/> <input type="text"/> hours per week	

20. In a typical week during the past 12 months, did you practise any of these activities vigorously enough to cause sweating or a faster heartbeat?

Yes No

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

21. What is your weight?

stones pounds or kilograms

22. Please indicate your marital status

Single Widowed Divorced
Married or living as married Separated

23. Please give your mother's place of birth (town, county, country)

24. Please give your father's place of birth (town, county, country)

QUESTIONS ABOUT YOUR HEALTH

25. In the last six years, have you had any broken/fractured bones? Yes No +

If yes, please give details (most recent first)

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? Please complete all appropriate boxes

Cancer Yes Year first diagnosed No

type of cancer:

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

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)

- | | | | | | |
|---|--------------------------|------------------------------------|--------------------------|--|--------------------------|
| | <input type="checkbox"/> | multivitamins (with minerals) | <input type="checkbox"/> | vitamin A | <input type="checkbox"/> |
| + | <input type="checkbox"/> | multivitamins (without minerals) | <input type="checkbox"/> | vitamin B
(including B ₆ & B ₁₂) | <input type="checkbox"/> |
| | <input type="checkbox"/> | fish oil (including cod liver oil) | <input type="checkbox"/> | vitamin C | <input type="checkbox"/> |
| | <input type="checkbox"/> | evening primrose oil | <input type="checkbox"/> | garlic | <input type="checkbox"/> |
| | <input type="checkbox"/> | iron | <input type="checkbox"/> | zinc | <input type="checkbox"/> |
| | <input type="checkbox"/> | calcium | <input type="checkbox"/> | vitamin D | <input type="checkbox"/> |
| | <input type="checkbox"/> | | <input type="checkbox"/> | vitamin E | <input type="checkbox"/> |

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)

- | | | | | | | |
|--------------------------|------------------------------------|--------------------------|-------------|--------------------------|----------------|--------------------------|
| <input type="checkbox"/> | amlodipine
(Istin) | <input type="checkbox"/> | digoxin | <input type="checkbox"/> | prednisolone | <input type="checkbox"/> |
| <input type="checkbox"/> | amitriptyline
(Tryptizol, etc.) | <input type="checkbox"/> | HRT | <input type="checkbox"/> | propranolol | <input type="checkbox"/> |
| <input type="checkbox"/> | aspirin | <input type="checkbox"/> | ibuprofen | <input type="checkbox"/> | sleeping pills | <input type="checkbox"/> |
| <input type="checkbox"/> | atenolol | <input type="checkbox"/> | insulin | <input type="checkbox"/> | tamoxifen | <input type="checkbox"/> |
| <input type="checkbox"/> | bendrofluzide | <input type="checkbox"/> | lithium | <input type="checkbox"/> | thyroxine | <input type="checkbox"/> |
| <input type="checkbox"/> | contraceptive pill | <input type="checkbox"/> | Losec/Zoton | <input type="checkbox"/> | warfarin | <input type="checkbox"/> |
| <input type="checkbox"/> | co-proxamol
(Distalgesic) | <input type="checkbox"/> | paracetamol | <input type="checkbox"/> | | |

Other (name and brand)

29. About how many bowel movements do you have each week? a week

How often do you take laxatives? times a month
put '0' if never

30. How would you describe your health now?
excellent good fair poor

QUESTION FOR MEN ONLY

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

QUESTIONS FOR WOMEN ONLY

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? periods
put '0' if none

34. Have you ever taken the contraceptive pill? Yes No

If yes, for how long altogether have you used the pill? years
put '0' if less than one year

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
put '0' if less than one year

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 year(s) of birth and sex below:

- | | | | |
|----|----------------------|------------------------------|-------------------------------|
| 1. | <input type="text"/> | Boy <input type="checkbox"/> | Girl <input type="checkbox"/> |
| 2. | <input type="text"/> | Boy <input type="checkbox"/> | Girl <input type="checkbox"/> |
| 3. | <input type="text"/> | Boy <input type="checkbox"/> | Girl <input type="checkbox"/> |

37. Have you ever had a son born with either of the following conditions? Yes Year of birth No

Hypospadias (hole for urinating in the wrong place)

Undescended testicles (Cryptorchidism)

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? please enter year

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? please enter year

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