



*Algemene Directie Statistiek en  
Economische Informatie*  
Leuvenseweg 44 – 1000 Brussel

*Wetenschappelijk Instituut Volksgezondheid*  
Juliette Wytsmanstraat 14-16 – 1050 Brussel

## Health Interview Survey, Belgium, 2004

### Autoquestionnaire

PARTICIPANT:

Nr. of the person:

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First name: \_\_\_\_\_

INTERVIEWER:

Nr. of the interviewer:

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Date of the interview

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**How to complete this questionnaire:**

The questions have to be answered personally.

Read the question as well as all response categories attentively, before giving an answer.

Mark the response you have chosen with a cross (see example).

**Mark one response choice per question, unless suggested otherwise (i.e. ‘multiple response possible’).**

**Example**

**EX.01.** How many times per week do you get up after 9 o'clock in the morning?

Never .....  1

1 – 2 times.....  2

3 – 4 times.....  3

5 times or more .....  4

I don't know .....  5

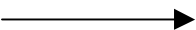
In some cases, next to your answer you'll find an arrow and the indication to “jump” a few questions in order to go directly to a question that is applicable for you. These “jumps” are indicated with an arrow, the mention “Go to ...” and the reference number of the question. If no jumps are mentioned, just pass to the following question.

**Example**

**EX.02** Did you ever take a plane?

Yes, several times .....  1

Yes, once .....  2

No, never .....  3  **Go to EX.06**

Those who select “Yes, several times” or “Yes, once” can continue with the next question (EX.03), while those who select “No, never” should go directly to question EX.06.

If you don't understand a question or you have problems to answer a question, please ask the interviewer for help or clarification.



## Perceived health

**SH.01. How is your health in general?**

- Very good .....  1
- Good .....  2
- Fair (reasonable) .....  3
- Bad .....  4
- Very bad .....  5

**SH.02. Compared to one year ago, how would you rate your health in general now?**

- Much better than last year .....  1
- Somewhat better .....  2
- About the same .....  3
- Somewhat worse .....  4
- Much worse .....  5

**SH.03. Do you suffer from (have) any chronic (long-standing) illness or condition (health problem)?**

- Yes .....  1
- No .....  2

**SH.04. For the past 6 months or more have you been limited in activities people usually do because of health problem?**

- Yes, strongly limited .....  1
- Yes limited .....  2
- No, not limited .....  3

## Complaints

**SL.01. Indicate how much the following problems have distressed you during the past week, including today.**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
01. Headaches .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
02. Faintness or dizziness.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
03. Pains in heart or chest .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
04. Pains in lower back .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
05. Nausea or upset stomach .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
06. Soreness of your muscles .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
07. Trouble getting your breath .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
08. Hot or cold spells .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
09. Numbness or tingling in parts of your body.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. Lump in your throat.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11. Feeling weak in parts of your body .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
12. Heavy feelings in your arms or legs.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
13. Nervousness or shakiness inside .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

### Complaints (continuation)

	Not at all	A little bit	Moderately	Quite a bit	Extremely
14. Repeated unpleasant thoughts that won't leave your mind .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
15. Loss of sexual interest or pleasure .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
16. Feeling low in energy or slowed down .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
17. Thoughts of ending your life	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
18. Trembling .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
19. Poor appetite .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
20. Crying easily .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
21. Feelings of being trapped or caught .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
22. Suddenly scared for no reason .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
23. Blaming yourself for things .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
24. Feeling lonely .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
25. Feeling blue .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
26. Worrying too much about things .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
27. Feeling no interest in things .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
28. Feeling fearful .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

### Complaints (continuation)

	Not at all	A little bit	Moderately	Quite a bit	Extremely
29. Heart pounding or racing .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
30. Trouble falling asleep .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
31. Your mind going blank.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
32. Feeling hopeless about the future.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
33. Feeling tense or keyed up .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
34. Thoughts of death or dying .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
35. Awakening in the early morning.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
36. Sleep that is restless or disturbed .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
37. Feeling everything is an effort.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
38. Spells of terror or panic .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
39. Feeling so restless you couldn't sit still.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
40. Feelings of worthlessness .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
41. The feeling that something bad is going to happen to you.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
42. Thoughts and images of a frightening nature .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**The next 3 questions are about suicide attempts.**

**Sometimes people consider suicide as an issue to their problems...**

**SL.02 Have you ever seriously thought of ending your life?**

Yes, several times .....  1

Yes, once .....  2

No, never .....  3

**SL.03 Have you ever attempted to commit suicide?**

Yes, several times .....  1

Yes, once .....  2

No, never .....  3

**—————▶ Go to HI.01 page 7**

**SL.04 Did you make a suicide attempt in the last 12 months?**

Yes .....  1

No .....  2

I don't know .....  9



## Attitude towards AIDS

**HI.01. Can one, according to your opinion, get contaminated with AIDS virus ...**

	Yes	No	One says no but I take care	Don't know
01. by sitting on a toilet seat .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
02. by drinking from some one's glass .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
03. by kissing some one on the mouth.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
04. from mosquito bites .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
05. by giving blood in Belgium nowadays .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9

**HI.02. Are the next methods safe to protect against HIV (the AIDS virus)?**

	Completely safe	Rather safe	Rather unsafe	Totally unsafe	Don't know
01. use the (contraceptive) pill .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9
02. choose partners who look healthy.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9
03. withdrawal before ejaculation.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9
04. wash oneself after sexual intercourse .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9

**HI.03. Have you ever been tested for HIV (the AIDS virus)?**

Yes, several times .....	<input type="checkbox"/> 1	}	→ <b>Go to HI.07 page 9</b>
Yes, once .....	<input type="checkbox"/> 2		
No .....	<input type="checkbox"/> 3		
Don't know.....	<input type="checkbox"/> 9		

**HI.04. When were you last tested for HIV?**

Less than 3 months ago.....	<input type="checkbox"/> 1
More than 3 months but less than 1 year ago.....	<input type="checkbox"/> 2
More than one year ago.....	<input type="checkbox"/> 3
Don't know.....	<input type="checkbox"/> 9

**HI.05. Who took the initiative for the HIV-test?**

- Own initiative.....  1
- My physician.....  2
- Someone else.....  3
- Who ? \_\_\_\_\_ ←

**HI.06. Why were you tested for HIV?**

***Multiple responses possible***

- 01. Because of physical complaints.....  1
- 02. Because I wanted to get pregnant .....  1
- 03. In the context of a prenatal follow-up .....  1
- 04. In the context of a global physical check-up.....  1
- 05. Because I wanted to undergo surgery .....  1
- 06. Because I was worried I could have been infected  
With the AIDS-virus:
  - a) after sexual intercourse .....  1
  - b) for another reasons .....  1
- 07. For administrative reasons (insurance, employment,  
visa, ...) .....  1
- 08. Because I wanted to start a new relation or I was  
Planning to get married .....  1
- 09. In the context of a blood donation.....  1
- 10. Other reason .....  1
- Which? \_\_\_\_\_ ←

**HI.07. Would you accept ...**

	Yes	Yes, but I would be scared	No, I would be too scared	Don't know
01. to share a meal with a sero-positive person .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9
02. to let your children in the company of a HIV-infected person (nanny, other HIV-infected children)? .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 9

**HI.08. Do you agree that...**

	I agree completely	I rather agree	I rather disagree	I disagree completely	Don't know
01. an employer must be able to fire a AIDS- infected person .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9
02. I must be informed in case one of my colleagues is HIV-positive, even without his permission.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9
03. people who knows they are HIV-positive and have sex without telling their partner should Be brought before court.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9

**HI.09. Do you agree that...?**

	I agree completely	I rather agree	I rather disagree	I disagree completely	Don't know
01. HIV/AIDS is not a serious disease any more...	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9
02. new therapies can cure HIV/AIDS.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9
03. thanks to new therapies, HIV/AIDS is not a fatal disease any more.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9
04. there is an effective vaccine against HIV/AIDS.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9
05. HIV/AIDS is no longer a problem in Belgium and in the other European countries..	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 9

## Social contacts

**SO.01. How would you estimate your social contacts?**

- Very satisfying .....  1
- Rather satisfying .....  2
- Rather unsatisfying .....  3
- Really unsatisfying .....  4

**SO.02. In general, how many times do you have contact with relatives, children, friends, ...?**

- More than once a week .....  1
- Once a week .....  2
- At least once a month .....  3
- More or less once a year .....  4
- Never .....  5

**SO.03. How often did you take part in meetings or activities sponsored by organizations or associations such as a youth movement, sports club, recreational group (to play cards for instance) parents' association, self-help groups, ... in the past 12 months?**

- At least once a week .....  1
- At least once a month .....  2
- At least 3 or 4 times a year .....  3
- At least once a year .....  4
- Never .....  5

**SO.04. About how many close friends and close relatives do you have (people you feel at ease with and can talk to about what is on your mind)?**

Write down the number of close friends and close relatives: ..... 

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I don't know .....  999

**SO.05. People sometimes look for others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you needed it?**

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
01. Someone to help you if you were confined to bed .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
02. Someone you can count on to listen to you When you need to talk.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
03. Someone to give you good advice about a crisis.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
04. Someone to take you to the doctor if you needed it.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
05. Someone who shows you love and affection.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
06. Someone to have a good time with .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
07. Someone to give you information to help you understand a situation.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
08. Someone to confide in or talk to about yourself or your problems .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
09. Someone who hugs you .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
10. Someone to get together with for relaxation .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
11. Someone to prepare your meals if you were unable to do it yourself .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
12. Someone whose advice you really want.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
13. Someone to do things with to help you get your mind off things .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
14. Someone to help with daily chores if you were sick .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
15. Someone to share your most private worries and fears with.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
16. Someone to turn to for suggestions about how to deal with a personal problem.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
17. Someone to do something enjoyable with.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
18. Someone who understands your problems .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
19. Someone to love and make you feel wanted .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

## Tobacco consumption

**TA.01. Have you ever smoked at least 100 cigarettes, or the equivalent amount of tobacco, in your lifetime?**

Yes.....  1

No.....  2

*If you have never smoked this amount, go to ID.01, page 14*

**TA.02. Do you now smoke?**

Yes, daily.....	<input type="checkbox"/> 1
Yes, occasionally.....	<input type="checkbox"/> 2

No.....  3

FOR SMOKERS

**TA.03. What tobacco items do you smoke and how frequently?**

*For each item, indicate whether you smoke:*

1) **Daily**  
2) **Occasionally**  
3) **Not at all**

	Daily	Occasion-ally	Not at all
01. Cigarettes in packs (manufactured).....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
02. Hand-rolled cigarettes, <u>without</u> filter.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
03. Hand-rolled cigarettes, <u>with</u> filter.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
04. Cigars /cigarillos.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
05. Pipes.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
06. Other : .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(Specify) : \_\_\_\_\_

FOR EX-SMOKERS

**TA.09. What tobacco items did you smoke and how frequently?**

*For each item, indicate whether you smoked:*

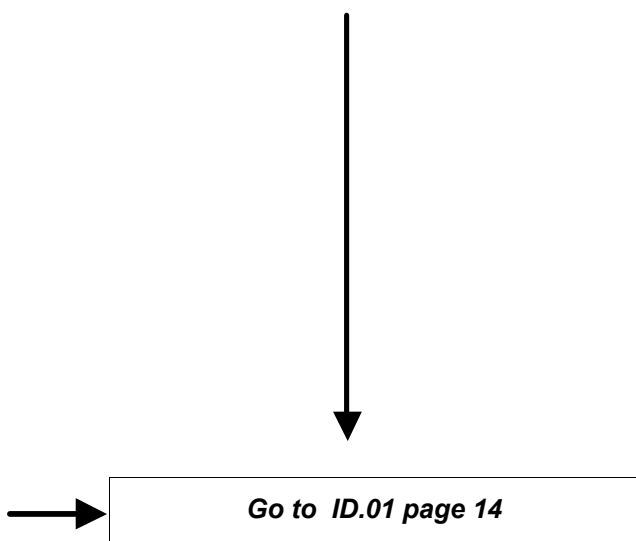
1) **Daily**  
2) **Occasionally**  
3) **Not at all**

	Daily	Occasion-ally	Not at all
01. Cigarettes in packs (manufactured).....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
02. Hand-rolled cigarettes, <u>without</u> filter.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
03. Hand-rolled cigarettes, <u>with</u> filter.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
04. Cigars /cigarillos.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
05. Pipes.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
06. Other : .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(Specify) : \_\_\_\_\_

<b><u>FOR SMOKERS</u></b>	
<b>TA.04. How old were you when you started smoking regularly?</b>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> years old
<b>TA.05. How many cigarettes do you usually smoke on average per day?</b>	- I usually smoke <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> cigarettes/ day  - I don't smoke cigarettes ..... <input style="width: 30px; height: 20px;" type="text"/> 88 - I don't smoke daily ..... <input style="width: 30px; height: 20px;" type="text"/> 99
<b>TA.06. When do you smoke your first cigarette after waking?</b>	- Within 5 minutes ..... <input style="width: 30px; height: 20px;" type="text"/> 1 - Within 6 to 30 minutes ..... <input style="width: 30px; height: 20px;" type="text"/> 2 - Within 31 to 60 minutes ..... <input style="width: 30px; height: 20px;" type="text"/> 3 - After 60 minutes ..... <input style="width: 30px; height: 20px;" type="text"/> 4
<b>TA.07. Compared with 2 years ago, would you say your tobacco consumption has now changed?</b>	- I smoke more than 2 years ago ..... <input style="width: 30px; height: 20px;" type="text"/> 1 - I smoke less than 2 years ago ..... <input style="width: 30px; height: 20px;" type="text"/> 2 - No changes since 2 years ..... <input style="width: 30px; height: 20px;" type="text"/> 3
<b>TA.08. Have you ever tried to stop smoking?</b>	- Yes ..... <input style="width: 30px; height: 20px;" type="text"/> 1 - No ..... <input style="width: 30px; height: 20px;" type="text"/> 2

<b><u>FOR EX-SMOKERS</u></b>	
<b>TA.10. How old were you when you started smoking regularly?</b>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> years old
<b>TA.11. How many cigarettes did you usually smoke on average per day?</b>	- I usually smoked <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> cigarettes/day  - I didn't smoke cigarettes ..... <input style="width: 30px; height: 20px;" type="text"/> 88 - I didn't smoke daily ..... <input style="width: 30px; height: 20px;" type="text"/> 99
<b>TA.12. How long is it since you've stopped smoking?</b>	- Less than 1 month ago ..... <input style="width: 30px; height: 20px;" type="text"/> 1 - 1 month ago or longer, but less than 6 months ago ..... <input style="width: 30px; height: 20px;" type="text"/> 2 - 6 months ago or longer, but less than 1 year ago ..... <input style="width: 30px; height: 20px;" type="text"/> 3 - 1 year ago or longer, but less than 2 years ago ..... <input style="width: 30px; height: 20px;" type="text"/> 4 - 2 years ago or longer ..... <input style="width: 30px; height: 20px;" type="text"/> 5



## Consumption of other products

**ID.01. Have you ever taken cannabis (hashish or marijuana)?**

Yes .....  1

No .....  2 → **Go to AL.01 page 15**

**ID.02. At what age did you take cannabis (hashish or marijuana) for the first time?**

Years old

**ID.03. During the last 12 months, have you taken cannabis (hashish or marijuana)?**

Yes .....  1

No .....  2 → **Go to AL.01 page 15**

**ID.04. During the last 30 days, have you taken cannabis (hashish or marijuana)?**

Yes .....  1

No .....  2 → **Go to AL.01 page 15**

**ID.05. During the last 30 days, on how many days did you take cannabis (hashish or marijuana)?**

20 days or more .....  1

10-19 days .....  2

4-9 days .....  3

1-3 days .....  4

**ID.06. Do you use more often marijuana or hashish?**

(Almost) always marijuana .....  1

More often marijuana than hashish .....  2

Both equally often .....  3

More often hashish than marijuana .....  4

(Almost) always hashish .....  5

I don't know .....  9



## Consumption of alcoholic beverages

**AL.01.** Please indicate on the following list which alcoholic beverages you drank in the past 12 months (even if only once)?

- 01. Beer (excluding low-alcoholic beer)..... 1
- 02. Wine, sherry, porto, vermouth, pineau... .. 1
- 03. Liquor, advocaat, kir... .. 1
- 04. Gin, brandy, cognac, whisky, vodka... .. 1
- 05. Long-drinks, cocktails, breezer ... .. 1
- 06. Drinks with a low percentage of alcohol  
(e.g. low-alcohol beer)..... 1
- 07. Other alcoholic beverages..... 1

Which? \_\_\_\_\_

*If you haven't had any alcohol in the past 12 months, go directly to question NS.01 on page 19*

**AL.02.** In the past 6 months, did you ever drink 6 glasses or more of alcoholic beverages (possibly different) in one day?

Yes..... 1

No..... 2

**Go to AL.04 page 16**

**AL.03.** In the past 6 months, how often did you drink 6 or more alcoholic beverages (possibly different) in one day?

- Every day..... 1
- 5 to 6 times a week..... 2
- 3 to 4 times a week..... 3
- 1 to 2 times a week..... 4
- 1 to 3 times a month..... 5
- 3 to 5 times in six months..... 6
- 1 to 2 times in six months..... 7

**AL.04.** Do you usually drink alcoholic beverages during the days of the week (Monday till Thursday)?

Yes.....  1

No.....  2

**Go to AL.07 page 17**

**AL.05.** On how many weekdays (Monday to Thursday) do you usually drink alcoholic beverages?

- 4 days.....	<input type="checkbox"/>	1
- 3 days .....	<input type="checkbox"/>	2
- 2 days.....	<input type="checkbox"/>	3
- 1 day.....	<input type="checkbox"/>	4

**AL.06.** How many glasses of alcoholic beverage do you drink on average per day during weekdays (Monday to Thursday)?

- 11 or more glasses.....	<input type="checkbox"/>	1
- 7 to 10 glasses .....	<input type="checkbox"/>	2
- 6 glasses.....	<input type="checkbox"/>	3
- 4 of 5 glasses .....	<input type="checkbox"/>	4
- 3 glasses.....	<input type="checkbox"/>	5
- 2 glasses.....	<input type="checkbox"/>	6
- 1 glas.....	<input type="checkbox"/>	7

**AL.07. Do you usually drink alcoholic beverages during the weekend (Friday to Sunday)?**

Yes.....  1

No.....  2

**Go to AL.10 page 18**

**AL.08. On how many days of the weekend (Friday to Sunday) do you usually drink alcoholic beverages?**

- 3 days.....	<input type="checkbox"/>	1
- 2 days.....	<input type="checkbox"/>	2
- 1 day.....	<input type="checkbox"/>	3

**AL.09. How many glasses of alcoholic beverage do you drink on average per day during the weekend (Friday to Sunday)?**

- 11 or more glasses .....	<input type="checkbox"/>	1
- 7 to 10 glasses.....	<input type="checkbox"/>	2
- 6 glasses .....	<input type="checkbox"/>	3
- 4 to 5 glasses.....	<input type="checkbox"/>	4
- 3 glasses .....	<input type="checkbox"/>	5
- 2 glasses .....	<input type="checkbox"/>	6
- 1 glas.....	<input type="checkbox"/>	7

**AL.10. Have you ever felt the need to cut down on your drinking?**

Yes .....  1

No.....  2

**AL.11. Have you ever felt annoyed by criticism of your drinking?**

Yes .....  1

No.....  2

**AL.12. Have you ever felt guilty about drinking?**

Yes .....  1

No.....  2

**AL.13. Did you ever take a morning eye opener?**

Yes .....  1

No.....  2

## Nutrition

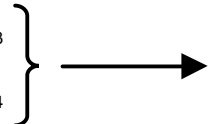
**NS.01. At this time, are you trying to slim, to gain weight or to keep your weight stable? Or doesn't your weight bother you?**

I am trying to slim.....  1

I am trying to keep my weight stable.....  2

I am trying to gain weight .....  3

I don't bother about my weight .....  4



**Go to TR.09  
page 20**

**NS.02. At this time, what are you doing to slim or to keep your weight stable?**

***Multiple responses possible***

01. I watch the type of food I eat.....  1

02. I eat less calories .....  1

03. I take more exercise .....  1

04. I skip meals.....  1

05. I change the relative importance of meals:  
I eat more at breakfast and less in the evening .....  1

06. I fast 24 hours or longer .....  1

07. I use diet products.....  1

08. I use products to slim .....  1

09. I smoke.....  1

10. I use laxatives .....  1

11. I take part in group sessions (for example Weight Watchers).....  1

12. Something else, (specify): \_\_\_\_\_  1

**NS.03. Who advised you to do something about your weight?**

***Multiple responses possible***

01. General practitioner.....  1

02. Specialist .....  1

03. Dietician.....  1

04. Media, press, magazines.....  1

05. Members of the family, friends or relatives.....  1

06. Own initiative .....  1

07. On advice of someone else (Who?): \_\_\_\_\_  1

## Trauma

TR.09. In the past 12 months, have you been a victim of verbal/ psychological violence (insult, threats, harassment) or physical violence (hit, sexual assault) or burglary, robbery, hold-up?

Yes..... <input type="checkbox"/> 1	No..... <input type="checkbox"/> 2
-------------------------------------	------------------------------------

**Go to WB.01  
page 23**

TR.10. What type of violence did you personally experience in the past 12 months, and where did it take place?

*More than one answer possible. Tick the appropriate boxes in function of the type of violence experienced and where it took place*

	At home	at work/ school	in a public place	on the street	else- where
01. Burglary, hold-up, racketeering.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

### Verbal/ psychological violence

	At home	at work/ school	in a public place	on the street	else- where
02. Insults, offense, blame, mockery, humiliations, sarcasm.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
03. Threats, intimidation, blackmail, denigration, sexual or racist comments/harassment.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
04. Isolation, deprivation of freedom.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

### Physical violence

	At home	at work/ school	in a public place	on the street	else- where
05. Knocked down, given a shaking, pinched, boxed on the ear, scratched.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
06. Kicked, punched, hit/cut with an object.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
07. Sexual assault, forced intercourse.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
08. Other: Specify: _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**Verbal or psychological violence (without physical violence)**

If you experienced verbal or psychological violence (without physical violence) in the past 12 months, please refer to **the worst incident** when answering the next questions.

If you didn't experience verbal or psychological violence, or if the incident(s) went along with physical violence, **go to question TR.15, page 22**

**TR.11. How many people were involved (as perpetrator) in this incident?**

- One single person.....  1
- A group of persons.....  2
- I don't know .....  3
- I prefer not to answer this question.....  -1

**TR.12. Do you personally know the author(s) of the incident?**

- Yes .....  1
- No .....  2
- I don't know .....  3
- I prefer not to answer this question.....  -1

**TR.13. Did these incidents of violence bring you to contact/consult one or more of the following services or institutions?**

*More than one answer admitted*

- 01. Police.....  1
- 02. Medical service (general practitioner, hospital,...).....  1
- 03. Law- or juridical agency.....  1
- 04. Victim assistance services, victim support organizations, help centers.....  1
- 05. Call-centers for assistance (télé-accueil, SOS children, SOS sexual abuse, center for battered women).....  1
- 06. Other (specify): \_\_\_\_\_  1
- 07. I prefer not to answer this question.....  -1

**TR.14. In the past 12 months, how many times did you experience verbal or psychological violence which affected you so much that you called upon one of these mentioned services?**

- Never.....  1
- Once.....  2
- Twice.....  3
- Three times or more.....  4

### Physical violence

If you experienced physical violence in the past 12 months, please refer to **the worst incident** when answering the following questions.

If you didn't experience physical violence, go to question **WB.01 page 23**.

**TR.15. How many people were involved (as perpetrator) in this incident?**

- One single person.....  1
- A group of persons.....  2
- I don't know .....  3
- I prefer not to answer this question.....  -1

**TR.16. Do you personally know the author(s) of the incident?**

- Yes.....  1
- No .....  2
- I don't know .....  3
- I prefer not to answer this question.....  -1

**TR.17. Did these incidents of violence bring you to contact/consult one or more of the following services or institutions?**

*More than one answer admitted*

- 01. Police.....  1
- 02. Medical service (general practitioner, hospital,...).....  1
- 03. Law- or juridical agency.....  1
- 04. Victim assistance services, victim support organizations, help centers.....  1
- 05. Call-centers for assistance (télé-accueil, SOS children, SOS sexual abuse, center for battered women).....  1
- 06. Other (specify): \_\_\_\_\_  1

**TR.18. How many times, during the past 12 months, were you a victim of physical violence for which you needed a medical intervention for subsequent injuries?**

- Never.....  1
- Once.....  2
- Twice.....  3
- Three times or more.....  4



## General Well-being

How have you felt over the past few weeks? Please indicate your recent complaints, not those you may have had in the past.

Have you recently ...

**WB.01.** ... been able to concentrate on whatever you're doing?

- Better than usual .....  1
- Same as usual .....  2
- Less than usual .....  3
- Much less than usual .....  4

**WB.02.** ... lost much sleep over worry?

- Not at all .....  1
- No more than usual .....  2
- Rather more than usual .....  3
- Rather more than usual .....  4

**WB.03.** ... felt that you are playing a useful part in things?

- More so than usual .....  1
- Same as usual .....  2
- Less useful than usual .....  3
- Much less useful .....  4

**WB.04.** ... felt capable of making decisions about things?

- More so than usual .....  1
- Same as usual .....  2
- Less so than usual .....  3
- Much less capable .....  4

**Have you recently ...**

**WB.05. ... felt constantly under strain?**

- Not at all.....  1
- No more than usual .....  2
- Rather more than usual .....  3
- Much more than usual .....  4

**WB.06. ... felt you couldn't overcome your difficulties?**

- Not at all.....  1
- No more than usual .....  2
- Rather more than usual .....  3
- Much more than usual .....  4

**WB.07. ... been able to enjoy your normal day-to-day activities?**

- More so than usual .....  1
- Same as usual .....  2
- Less so than usual.....  3
- Much less than usual .....  4

**WB.08. ... been able to face up to your problems?**

- More so than usual .....  1
- Same as usual .....  2
- Less able than usual.....  3
- Much less able .....  4

**Have you recently ...**

**WB.09. ... been feeling unhappy or depressed?**

- Not at all.....  1
- No more than usual .....  2
- Rather more than usual .....  3
- Much more than usual .....  4

**WB.10. ... been loosing confidence in yourself?**

- Not at all.....  1
- No more than usual .....  2
- Rather more than usual .....  3
- Much more than usual .....  4

**WB.11. ... been thinking of yourself as a worthless person?**

- Not at all.....  1
- No more than usual .....  2
- Rather more than usual .....  3
- Much more than usual .....  4

**WB.12. ... been feeling reasonably happy, all things considered?**

- More so than usual .....  1
- About same as usual .....  2
- Less so than usual.....  3
- Much less than usual .....  4

How much during the **past 4 weeks**...

**WB.13. ... did you feel full of life?**

- All of the time.....  1
- Most of the time .....  2
- A good bit of the time.....  3
- Some of the time.....  4
- A little of the time .....  5
- None of the time .....  6

**WB.14. ... did you have lots of energy?**

- All of the time.....  1
- Most of the time .....  2
- A good bit of the time.....  3
- Some of the time.....  4
- A little of the time .....  5
- None of the time .....  6

**WB.15. ... did you feel worn out?**

- All of the time.....  1
- Most of the time .....  2
- A good bit of the time.....  3
- Some of the time.....  4
- A little of the time .....  5
- None of the time .....  6

**WB.16. ... did you feel tired?**

- All of the time.....  1
- Most of the time .....  2
- A good bit of the time.....  3
- Some of the time.....  4
- A little of the time .....  5
- None of the time .....  6

### Prevention

#### Blood pressure

**PR.01. Have you ever had your blood pressure measured?**

- Yes .....  1
- No .....  2 —————> **Go to PR.06 page 28**
- I don't know .....  2 —————> **Go to PR.06 page 28**

**PR.02. Who measured your blood pressure last time?**

- A doctor, a nurse or an other health professional .....  1
- Myself .....  2
- Another layperson .....  3
- I don't know .....  9

**PR.03. When was the last time you had your blood pressure measured?**

- Less than 1 year ago .....  1
- 1 to less than 2 years ago .....  2
- 2 to less than 3 years ago .....  3
- 3 to less than 5 years ago .....  4
- More than 5 years ago .....  5
- I don't know .....  9

**PR.04. When measuring your blood pressure, were you ever told that you had a high blood pressure?**

- Yes .....  1
- No .....  2 —————> **Go to PR.06 page 28**
- I don't know .....  9 —————> **Go to PR.06 page 28**

**PR.05. Because of your high blood pressure, did a doctor advise you then, to ...**

***Multiple responses possible***

- 01. take medical drugs .....  1
- 02. lose weight .....  1
- 03. reduce salt intake .....  1
- 04. increase physical activity .....  1
- 05. decrease alcohol intake .....  1
- 99. I don't know .....  1

## Cholesterol

**PR.06** Have you ever had your blood cholesterol measured?

- Yes .....  1
- No .....  2 → **Go to PR.10 page 29**
- I don't know .....  9 → **Go to PR.10 page 29**

**PR.07.** When was the last time you had your blood cholesterol measured?

- Less than 1 year ago .....  1
- 1 to less than 2 years ago .....  2
- 2 to less than 3 years ago .....  3
- 3 to less than 5 years ago .....  4
- More than 5 years ago .....  5
- I don't know .....  9

**PR.08.** When measuring your blood cholesterol, were you ever told that you had high blood cholesterol?

- Yes .....  1
- No .....  2 → **Go to PR.10 page 29**
- I don't know .....  9 → **Go to PR.10 page 29**

**PR.09.** Because your cholesterol was too high, did a doctor advise you then to ...

***Multiple responses possible***

01. take drugs .....  1
02. lose weight .....  1
03. adapt your nutritional habits .....  1
04. increase your physical activity .....  1
99. I don't know .....  1

### Blood sugar

**PR.10. Have you ever had your blood sugar (glycemia) measured?**

- Yes .....  1
- No .....  2 → **Go to PA.01 page 30**
- I don't know .....  9 → **Go to PA.01 page 30**

**PR.11. When was the last time you had your blood sugar measured?**

- Less than 1 year ago .....  1
- 1 to less than 2 years ago .....  2
- 2 to less than 3 years ago .....  3
- 3 to less than 5 years ago .....  4
- More than 5 years ago .....  5
- I don't know .....  9

**PR.12. When measuring your blood sugar, were you ever told that you had a high blood sugar (glycemia)?**

- Yes .....  1
- No .....  2
- I don't know .....  9

## Physical activity

The two following questions are only dealing with your leisure time physical activities

**PA.01. What describes best your leisure time activities during the last year?**

- Hard training and competitive sport more than once a week .....  1
- Jogging and other recreational sports or gardening, at least 4 hours per week .....  2
- Jogging and other recreational sports or gardening, at the most 4 hours per week .....  3
- Walking, bicycling or other light activities at least 4 hours a week .....  4
- Walking, bicycling or other light activities at the most 4 hours a week .....  5
- Reading, watching TV or other sedentary activities .....  6
- I don't know .....  9

**PA.02. At least once a week do you engage in any regular activity such as jogging, cycling, etc. long enough to work up sweat?**

- Yes .....  1
- No .....  2
- I don't know .....  9

**If yes, specify:**

days per week

The questions will ask you about the time you spent being physically active in the **last 7 days**.

Please answer each question even if you do not consider yourself to be an active person.

Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.



### Vigorous physical efforts

**Vigorous** physical activities refer to activities that take hard physical effort and make you breathe **much** harder than normal.

Think about all the <b>vigorous</b> activities that you did in the <b>last 7 days</b>	Think <b>only</b> about those physical activities that you did for <b>at least 10 minutes</b> at a time.
---	--

**PA.03.** During the **last 7 days**, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?

day(-s) per week      In case your answer is «0 days», go to "Moderate physical efforts"

**PA.04.** How much time did you usually spend doing vigorous physical activities on one of those days?

hours       minutes / day  
 I don't know..... 99

### Moderate physical efforts

**Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal.

Think about all the <b>moderate</b> activities that you did in the <b>last 7 days</b> .	Think <b>only</b> about those physical activities that you did for <b>at least 10 minutes</b> at a time.
---	--

**PA.05.** During the **last 7 days**, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis?

**!!! Do not include walking!!!**

days(-s) per week      In case your answer is «0 days», go to "walking" page 32

**PA.06.** How much time did you usually spend doing moderate physical activities on one of those days?

hours       minutes / day  
 I don't know..... 99

### Walking

Think about the time you spent <b>walking</b> in the <b>last 7 days</b> .	This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.
---	---

**PA.07. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?**

day(-s) per week → ***In case your answer is «0 days», go to "Sitting"***

**PA.08. How much time did you usually spend walking on one of those days?**

hours       minutes / day

Don't know .....  99

**PA.09. At what pace did you usually walk? Did you walk at:**

- a vigorous pace, that makes you breathe much harder than normal .....  1
- a moderate pace that makes you breathe somewhat harder than normal .....  2
- a slower pace where there is no change in your breathing.....  3
- Don't know.....  9

### Sitting

The last question is about the time you spent <b>sitting</b> <b>on weekdays</b> during the <b>last 7 days</b>	Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.
---	---

**PA.10. During the last 7 days, how much time did you spend sitting on a week day?**

hour       minutes/ day

I don't know.....  99

## Health and sexuality

**RH.01. Did you have sexual intercourse during the last 12 months?**

Yes ..... <input type="checkbox"/> 1	No ..... <input type="checkbox"/> 2	
↓	↓      ↓	
↓	↓      ↓	
	<b>WOMEN</b> Go to SC.01 page 35	<b>MEN</b> Go to SU.01 page 40

**RH.02. During the last 12 months, did you use - yourself or your partner(s) - a protection method against sexually transmitted diseases?**

Yes .....  1

No.....  2

**RH.03. If you or your partner(s) used in the past 12 months one or more protection method(s) against sexually transmitted diseases, which method(s) did you use?**

*Multiple responses possible*

01. Male condom .....  1

02. Female condom .....  1

03. Avoiding oral contact.....  1

04. Avoiding vaginal contact.....  1

05. Avoiding anal contact.....  1

06. Other method .....  1

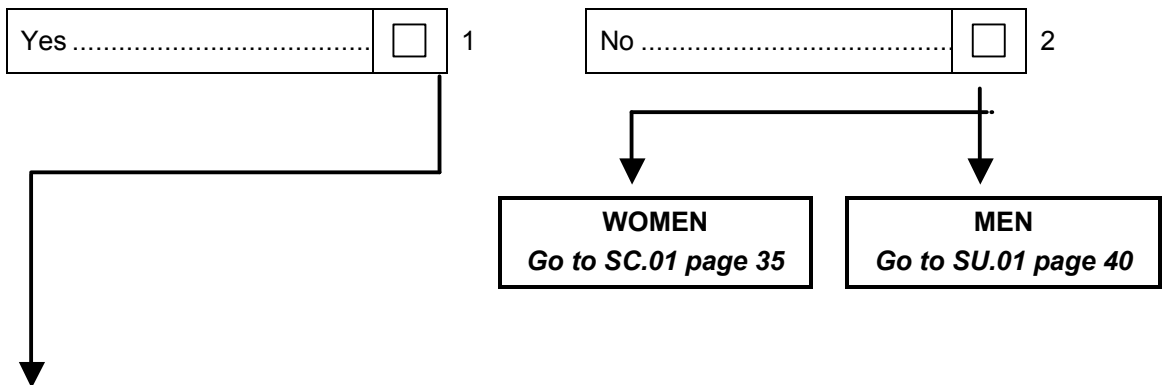
Specify : \_\_\_\_\_ ←

**RH.04. Did you have a stable relationship with one and the same partner during at least the last 12 months?**

Yes .....  1

No.....  2

**RH.05.** In the past 12 months, did you - yourself or your partner(s) - use a contraceptive method (to avoid a pregnancy)?



**RH.06.** Which contraceptive method(s) did you or your partner(s) use during the last 12 months?

*Multiple responses possible*

- 01. A contraceptive pill .....  1
- 02. A patch. ....  1
- 03. An implant.....  1
- 04. Injectable contraceptives (such as Depo-Provera®) .....  1
- 05. A vaginal ring (such as NuvaRing®).....  1
- 06. An IUD (intra-uterine device).....  1
- 07. A morning after pill .....  1
- 08. A diaphragm .....  1
- 09. A spermicide or a contraceptive sponge .....  1
- 10. A male condom .....  1
- 11. A female condom .....  1
- 12. Periodical abstention.....  1
- 13. Withdrawal .....  1
- 14. Sterilization of the woman .....  1
- 15. Sterilization of the man.....  1
- 16. Other method .....  1

Specify : \_\_\_\_\_

### Cancer screening

**Attention !**

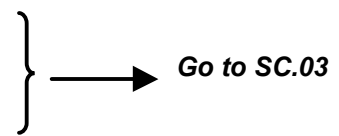
*Please note that this module is reserved to women.  
Men can directly go to the next module (SU.01 page 40).*

**SC.01. Have you ever done breast self-examination in order to detect an anomaly?**

Yes .....  1

No .....  2

I don't know .....  9



**SC.02. When did you last examine your breasts yourself?**

Less than 1 month ago .....  1

1 month ago or longer, but less than 1 year ago .....  2

1 year ago or longer .....  3

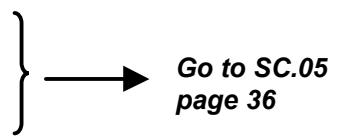
I don't know .....  9

**SC.03. Have you ever had your breasts examined by a physician (manual examination, not an echography nor a mammography)?**

Yes .....  1

No .....  2

I don't know .....  9



**SC.04. When did you last have your breasts examined by a physician?**

Less than 1 year ago .....  1

1 year ago or longer but less than 2 years ago .....  2

2 years ago or more .....  3

I don't know .....  9

**SC.05. Have you ever had a mammography (breasts X-ray)?**

- Yes .....  1
- No .....  2
- I don't know .....  9

} → **Go to SC.10  
page 37**

**SC.06. When did you have the last mammography?**

- Less than 1 year ago .....  1
- 1 year ago or longer but less than 2 years ago .....  2
- 2 years ago or more .....  3
- I don't know .....  9

**SC.07. In which year did you pass this last mammography?**

--	--	--	--

**SC.08. What was the reason for this mammography?**

***Multiple possible responses***

- 01. After advice of family practitioner, without there being a complaint or anomaly .....  1
- 02. After advice of your gynecologist without there being a complaint or anomaly .....  1
- 03. Breast cancer(s) among family members .....  1
- 04. You already had yourself breast cyst, tumour, cancer,  
or a surgical procedure on the breast .....  1
- 05. Follow-up of a previous examination .....  1
- 06. Pain in the breast .....  1
- 07. You noticed an anomaly in your breast yourself (e.g. a tubercle) .....  1
- 08. Your physician noticed an anomaly in your breast during an examination .....  1
- 09. Following an invitation letter .....  1
- 10. Other reason .....  1

Specify: \_\_\_\_\_ ←

**SC.09. Did you at the time this mammography, have also an echography of the breasts?**

- Yes .....  1
- No .....  2
- I don't know .....  9

**SC.10. Did you, in the last 2 years, receive an invitation letter inviting you to have a (mammographic) breast cancer screening examination?**

- Yes .....  1
  - No .....  2
  - I don't know .....  9
- } → **Go to SC.13  
page 38**

**SC.11. On the basis of this invitation letter, did you have a (mammographic) breast cancer screening examination?**

- Yes .....  1 → **Go to SC.13  
page 38**
- No .....  2

**SC.12. Why didn't you take a breast (mammographic) cancer screening examination following this invitation letter?**

*Multiple possible answers*

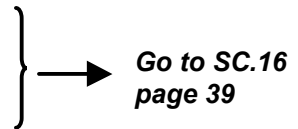
- 01. Because I already had a screening examination short before.....  1
  - 02. Because I didn't have the time.....  1
  - 03. Because such an examination costs too much.....  1
  - 04. Because I don't find it necessary .....  1
  - 05. Because I find the examination unpleasant.....  1
  - 06. Because I already had a surgical procedure with  
with ablation of a breast.....  1
  - 07. Other reason .....  1
- Specify: \_\_\_\_\_ ←

**SC.13. Have you ever had a cervix smear test?**

Yes .....  1

No .....  2

I don't know .....  9



**SC.14. When did you last have a cervix smear test?**

Less than 1 year ago .....  1

1 year ago or longer but less than 3 years ago .....  2

3 years ago or longer but less than 5 years ago .....  3

More than 5 years ago .....  4

I don't know .....  9

**SC.15. What was the reason for the cervix smear test?**

***Multiple possible answers***

01. After advice of family practitioner, without there being a complaint or anomaly...  1

02. After advice of your gynecologist without there being a complaint or anomaly...  1

03. Follow-up of a previous examination.....  1

04. Because of abnormal bleeding .....  1

05. You noticed another anomaly yourself .....  1

06. Your physician noticed an anomaly during an examination .....  1

07. You already had yourself a tumour of the cervix .....  1

08. Following an invitation letter .....  1

09. Other reason .....  1

Specify: \_\_\_\_\_



**ATTENTION, PLEASE GO DIRECTLY TO QUESTION SC.17 page 39**



**SC.16. Why didn't you get a pap smear test for cervix cancer screening during the last 3 years?**

**Multiple answers possible**

- 01. Because I did not have the time .....  1
  - 02. Because such an examination costs too much .....  1
  - 03. Because I don't find it necessary .....  1
  - 04. Because I find the examination unpleasant.....  1
  - 05. Because I already had a surgical procedure with ablation of the cervix .....  1
  - 06. Other reason.....  1
- Specify: \_\_\_\_\_ ←

**SC.17. Did you, in the last 3 years, receive a letter inviting you to have a pap smear test for cervix cancer screening?**

- Yes .....  1
  - No.....  2
  - I don't know.....  9
- } → **Go to SU.01 Page 40**

**SC.18. On basis of this letter, did you have a cervix cancer screening examination?**

- Yes .....  1 → **Go to SU.01 page 40**
- No.....  2

**SC.19. Why did you not get a cervix cancer screening examination following this invitation letter?**

**Multiple responses possible**

- 01. Because I already had a screening short before .....  1
  - 02. Because I did not have the time .....  1
  - 03. Because such an examination costs too much .....  1
  - 04. Because I don't find it necessary .....  1
  - 05. Because I find the examination unpleasant.....  1
  - Because I already had a surgical procedure with ablation of the uterus.....  1
  - 07. Other reason.....  1
- Specify: \_\_\_\_\_ ←

Finally, we'd like to ask you a few questions about this questionnaire

**SU.01. Did you find the questions difficult to answer?**

- Very difficult.....  1
- Rather difficult.....  2
- Not difficult, not easy.....  3
- Rather easy.....  4
- Very easy.....  5

**SU.02. Did you find the questions too personal or intimate?**

- Yes.....  1
- No.....  2

**SU.03. How did you complete this questionnaire?**

- Completely by myself.....  1
- With some help of the Interviewer.....  2
- With help of the Interviewer for most questions.....  3
- With help of the Interviewer for all questions.....  4
- Other, specify \_\_\_\_\_  5

**SU.04. How much time did it take to complete this questionnaire?**

		Minutes
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**SU.05. Did you find this part of the interview too long?**

- Yes.....  1
- No.....  2

**THANK YOU VERY MUCH FOR YOUR  
COLLABORATION**



SUPPLEMENTARY INFORMATION :

Mr. S. Demarest  
Mr. J. Van der Heyden

Department of Epidemiology  
Scientific Institute of Public Health  
Juliette Wytsmanstreet 14  
B - 1050 Brussels

Tel : 02/642.57.94  
02/642.57.26

e-mail [his@iph.fgov.be](mailto:his@iph.fgov.be)

<http://www.iph.fgov.be/epidemi/HIS>

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