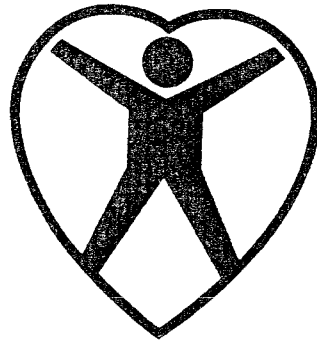


CONFIDENTIAL

HEALTH SURVEY



**Stress and Health Study
Department of Epidemiology and Public Health
University College London**

Civil Service Occupational Health Service

S3/August 1991

We are interested in identifying the characteristics of work and personal environment which may affect people's health. We should, therefore, be grateful if you would complete this questionnaire which asks for some general background information as well as questions about your activities.

The answers to these questions will, of course, be kept strictly confidential. All information on individuals will go into statistics for all men and women in the study, and it will not be possible to identify your responses from any reports or publications.

Under no circumstances will any information from an individual record be made available to anyone, either connected with the Civil Service, or outside it.

PLEASE USE BLOCK LETTERS THROUGHOUT

Once returned, the personal identification section will be removed. This will ensure the preservation of confidentiality in subsequent handling of the questionnaires.

| |
|---------|
| SURNAME |
|---------|

| |
|---------------------|
| FORENAMES (in full) |
|---------------------|

| |
|--------------|
| HOME ADDRESS |
|--------------|

| | |
|---------------------|----------------|
| MINISTRY/DEPARTMENT | XMINDEP |
|---------------------|----------------|

| |
|-------------|
| ROOM NUMBER |
|-------------|

| | |
|----------|---------------|
| BUILDING | XBUILD |
|----------|---------------|

| |
|------------------------|
| WORK ADDRESS (in full) |
|------------------------|

| |
|-----------------------|
| WORK TELEPHONE NUMBER |
|-----------------------|

This questionnaire asks about features of your way of life which may affect your health.

To study this we need to continue to monitor your health over the next few years.

In the last questionnaire we asked you to give us permission to monitor your health via your departmental sickness records. We would like to continue collecting this information and in cases of serious illness to obtain details from your general practitioner. We shall continue to treat all information with the strictest confidence.

If you agree, please complete the following.

Consent given: Yes No
(Please circle one)

If Yes, please sign your name here [] Date [][][]

If you have given your consent, please could you provide your General Practitioner's name and address.

NAME []

ADDRESS []

General instructions

Please read these notes before filling in the rest of the Questionnaire

- Please answer all the questions.
- The answers to most questions can be indicated by blocking in the appropriate rectangle - you don't need to be too precise; a single bold stroke over the length of the rectangle will do
- Please use only an HB pencil
- Please DO NOT mark your answers like this:
- Where a question requires you to indicate a number, simply block in the rectangle next to the appropriate number. The example here shows "48":
- In some cases where a number is required, an opportunity is given for you also to WRITE in the number. This is provided to assist you but please note that the appropriate rectangles MUST be blocked in.
- Where the answer is likely to be a phrase or sentence please write in the space indicated

Example What is your sex? Male [] Female []



Example What is her age? [10][20][30][40][50][60][70][80][90][100] her age? [1][2][3][4][5][6][7][8][9]

Example What is your date of birth? DAY MONTH YEAR [2][1][1][2]19[3][1] [10][1][10][1][10][1] [20][2][20][2][20][2] [30][3][30][3][30][3]

Example: PLEASE SPECIFY What was the main reason for being in hospital? Acute Bronchitis

THANK YOU

The Questionnaire

I. a) Please give your present or most recent grade title - IN FULL

| | |
|-------------|---------------|
| GRADE TITLE | XGRADE |
| | XLEVEL |

b) Is your grade title on the following list? If it is please indicate ONE.

NAME OF GRADE TITLE

- Senior Executive Officer
- Higher Executive Officer
- Executive Officer

- Senior Scientific Officer
- Higher Scientific Officer
- Scientific Officer
- Assistant Scientific Officer
- Principal Professional Technology Officer
- Higher Professional Technology Officer
- Professional Technology Officer

- Administrative Officer (formerly Clerical Officer)
- Administrative Assistant (formerly Clerical Assistant)
- Senior Personal Secretary
- Personal Secretary
- Typing Manager
- Typist (including specialist, audio shorthand typists)
- Support Manager 1 (includes Reprographics/Photoprinter Manager)
- Support Manager 2 (includes Chief Reprographics/Photoprinter Officer)
- Support Manager 3 (includes Chief Paperkeeper and Assistant Chief Reprographics Officer)
- Support Grade Band 1 (includes Senior Messenger, Senior Paperkeeper and Reprographics Operator 1)
- Support Grade Band 2 (includes Messenger, Paperkeeper and Reprographics Operator 2)

- Senior Information Officer
- Information Officer
- Assistant Information Officer

- Unified Grade 1
- Unified Grade 2
- Unified Grade 3 (including Undersecretary)
- Unified Grade 4
- Unified Grade 5 (including Assistant Secretary)
- Unified Grade 6 (formerly Senior Principal)
- Unified Grade 7 (formerly Principal level)

- Superintendent of Specialist Teleprinter Operators
- Specialist Teleprinter Operator
- Superintendent of Teleprinter Operators
- Teleprinter Operator

- Director of Audit (National Audit Office)
- Deputy Director of Audit (NAO)
- Chief Auditor (NAO)

- Senior Auditor (NAO)
- Auditor (NAO)
- Assistant Auditor (NAO)

- Superintendent Examiner (Patents Office)
- Principal Examiner (Patents Office)
- Senior Examiner (Patents Office)
- Examiner (Patents Office)

- Museum Warder Grade 1
- Museum Warder Grade 2
- Museum Warder Grade 3
- Museum Warder Grade 4
- Museum Warder Grade 5
- Museum Warder Grade 6
- Museum Warder Grade 7

- Curatorial Officer Grade D
- Curatorial Officer Grade E
- Curatorial Officer Grade F
- Curatorial Officer Grade G

- Conservation Officer D
- Conservation Officer E
- Conservation Officer F
- Conservation Officer G

c) If you DO NOT know your official grade title, give a brief description of your job, including level of seniority

| |
|-----------------|
| JOB DESCRIPTION |
|-----------------|

d) If you have left the civil service; please give your last civil service grade title and your leaving date. Please also state if you are working elsewhere, your current occupation and industry.

| | | |
|--------------------|-----------------|----------------|
| LAST GRADE | XGRDTIT | XLSTGRD |
| CURRENT OCCUPATION | XCURROCC | |
| INDUSTRY | XIND | |

LEAVING DATE

| Day | Month | Year |
|---------------|----------|-----------|
| XDTLET | | |
| <u>10</u> | <u>1</u> | <u>10</u> |
| <u>20</u> | <u>2</u> | <u>2</u> |
| <u>30</u> | <u>3</u> | <u>3</u> |
| <u>4</u> | <u>4</u> | <u>4</u> |
| <u>5</u> | <u>5</u> | <u>50</u> |
| <u>6</u> | <u>6</u> | <u>60</u> |
| <u>7</u> | <u>7</u> | <u>70</u> |
| <u>8</u> | <u>8</u> | <u>80</u> |
| <u>9</u> | <u>9</u> | <u>90</u> |

e) If retired, please give your last civil service grade title and your leaving date. Please also state your retirement date and reasons for stopping work.

| | |
|--------------------------|-----------------|
| LAST GRADE TITLE | XLGRDTIT |
| REASON FOR STOPPING WORK | XRESSTOP |

RETIREMENT DATE

| Day | Month | Year |
|---------------|----------|-----------|
| XDTRET | | |
| <u>10</u> | <u>1</u> | <u>10</u> |
| <u>20</u> | <u>2</u> | <u>2</u> |
| <u>30</u> | <u>3</u> | <u>3</u> |
| <u>4</u> | <u>4</u> | <u>4</u> |
| <u>5</u> | <u>5</u> | <u>50</u> |
| <u>6</u> | <u>6</u> | <u>60</u> |
| <u>7</u> | <u>7</u> | <u>70</u> |
| <u>8</u> | <u>8</u> | <u>80</u> |
| <u>9</u> | <u>9</u> | <u>90</u> |

2. a) What is your date of birth?

XDATB
DATE OF BIRTH

| Day | | | Month | | | Year | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

b) Sex Male Female **XSEX**

3. a) Are you married/cohabiting? **XMARCOH**
Yes No

If No, go to part (c)
If Yes,

b) Is this your first marriage/cohabitation?
Yes No **XFSTMAR**

Now go to Question 4

c) If **not** now married/cohabiting, which are you?
XNOTMAR
Single Widowed Divorced or separated

4. a) How many brothers do you have? **XBROTH**

b) How many sisters do you have? **XSISS**

XOWNCHD
c) How many of your own children do you have?

5. Is the accommodation in which you live owned or rented?

XACCOM
Own outright or have mortgage
Rent from local authority
Rent privately: unfurnished
Rent privately: furnished

6. Is there a car or van normally available for use by you or other members of your household?

Yes No **XCAR**

7. Is your natural father still alive?

Yes No

XLIVEF

If Yes, how old is he?

| | | | | | | | | | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

XAOF

If No, how old was your father when he died? **XAODF**

| | | | | | | | | | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

8. Is your natural mother still alive?

Yes No

XLIVEM

If Yes, how old is she? **XAOM**

| | | | | | | | | | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

If No, how old was your mother when she died? **XAODM**

| | | | | | | | | | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

9. How many **near relatives** (i.e. brothers, sisters, parents or your own children) have ever received treatment for any of the following disorders?
Please answer each part.

- | | | | | |
|---------------------|----------------------|----------------------|----------------------|----------------------|
| a) Senile Dementia | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| b) Schizophrenia | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| c) Manic-depression | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| d) Depression | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| e) Alcoholism | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

XPSFAM1

XFAMHST1

XPSFAM2

XFAMHST2

XPSFAM3

XFAMHST3

XPSFAM4

XFAMHST4

XPSFAM5

XFAMHST5

THIS SECTION CONCERNS YOUR OWN HEALTH

10. Over the last 12 months would you say your health has been

XHLTHYR

Very good Good Average
 Poor Very Poor

11. a) Do you have any longstanding illness, disability or infirmity? (*longstanding means anything that has troubled you over a period of time or that is likely to affect you over a period of time*)

Yes No **XLONGILL**

If No, go to Question 12

If Yes,

b) What is the matter with you?

XLONGIL1 **XLONGIL2** **XLONGIL3**

12. a) Have you ever had any pain or discomfort in your chest?

Yes No **XCHPAIN**

If No, go to Question 13

If Yes,

b) Do you get this pain or discomfort when you walk uphill or hurry?

XCHPUPH

Yes No

c) Do you get it when you walk at an ordinary pace on the level?

XCHPLEV

Yes No

d) When you get any pain or discomfort in your chest, what do you do?

XCHPACT

Stop Slow down Continue at the same pace

e) Does it go away when you stand still?

Yes No **XCHPSTOP**

f) How soon?

In 10 mins or less More than 10 mins

XCHPTIME

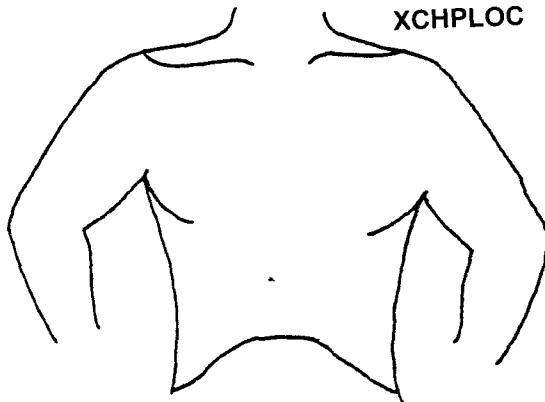
g) Where do you get this pain or discomfort?

Mark the place(s) with an X on the diagram.

RIGHT

LEFT

XCHPLOC



FRONT VIEW

13. a) Have you ever had a severe pain across the front of your chest lasting half an hour or more?

Yes No

If No, go to Question 14

If Yes,

XCHPEXT

b) Did you talk to a doctor about it?

Yes No

If No, go to Question 14

If Yes,

XCHPDOC

c) What did he say it was?

XCHPDIAG

d) How many of these attacks have you had?

XCHPNUM

NUMBER

14. a) Have you ever had heart trouble suspected or confirmed by your GP or a hospital doctor?

Yes No

If No, go to Question 15

If Yes,

XHTR

b) When was the first time? *Give year.* **XHTRFST**

19

| | | | | | | | | |
|----|----|----|----|----|----|----|----|----|
| 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

c) What was the diagnosis? **XHTRDIAG**

Heart attack Valve disease

Angina Hole in heart

High blood pressure Other (please specify)

OTHER

XOTHDIAG

d) Did you attend a hospital? Yes No

e) Are you still attending a doctor for heart trouble? **XHTRHOSP**

Yes No

XHTRDOC

15. Have you had any of the following symptoms in the last 14 days? *Please answer all questions*

XSYPMP01 a) A cough, catarrh or phlegm Yes No

XSYPMP02 b) Diarrhoea Yes No

XSYPMP03 c) Heartburn, wind or indigestion Yes No

XSYPMP04 d) Shortness of breath Yes No

XSYPMP05 e) Dizziness or giddiness Yes No

XSYPMP06 f) Earache or discomfort in the ears Yes No

XSYPMP07 g) Swollen ankles Yes No

XSYPMP08 h) Nervy, tense or depressed Yes No

XSYPMP09 i) A cold or 'flu' Yes No

XSYPMP10 j) A sore throat Yes No

XSYPMP11 k) Difficulty in sleeping Yes No

XSYPMP12 l) Pains in the chest Yes No

XSYPMP13 m) A backache or pains in the back Yes No

XSYPMP14 n) Nausea or vomiting Yes No

- XSYMP15**) Feeling tired for no apparent reason Yes No
- XSYMP16**) Rash, itches or other skin trouble Yes No
- XSYMP17**) Blocked or runny nose Yes No
- XSYMP18**) Dry throat Yes No
- XSYMP19**) Headache Yes No
- XSYMP20**) Dry, itchy or tired eyes Yes No
- XSYMP21**) Wheeziness Yes No
- XSYMP22**) Toothache or trouble with the gums Yes No
- w) Any other complaints in the last 14 days? **XSYMP23** Yes No

OTHER COMPLAINTS

16. In the last 12 months how many days were you off work for health reasons? **XOFFWK**

| | | | | | | | | | |
|---|----|----|----|----|----|----|----|----|----|
| 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

17. Do you suffer from diabetes? **XDIABETE** Yes No

18. a) Do you usually bring up any phlegm from your chest first thing in the morning in winter? **XPHLEGM** Yes No

If No, go to Question 19

If Yes,
b) Do you usually bring up phlegm in the morning on most days for as much as 3 months in the winter? **XPHLREG** Yes No

19. In the past three years have you had a period of increased cough and phlegm lasting for three weeks or more? **XPHLINC**

None One period Two or more periods

FOR WOMEN ONLY

If MALE go to Question 30

22. a) Are you taking any contraceptive pills? **XORALCON** Yes No

If No, go to Question 23

If Yes, b) At what age did you first start? **XOCAGE**

| | | | | | | | | |
|----|----|----|----|----|----|----|----|----|
| 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

c) For how many years altogether have you taken the pill? **XOCYRST**

| | | | | | | | | |
|----|----|----|----|----|----|----|----|----|
| 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

d) Which pill are you currently taking? *Please specify brand*

BRAND **XOCTYPE**

Now go to Question 24

23. IF NOT NOW TAKING CONTRACEPTIVE PILLS:-
a) Did you ever take contraceptive pills? **XOCPAST** Yes No

If No, go to Question 24

20. a) This question concerns any medicines that you may have taken during the last fourteen days. Have you been taking any medicines, tablets, tonics or pills **prescribed by a doctor** (excluding contraceptive pills) within the last fourteen days? **XPRESDOC** Yes No

If Yes,

b) Please list any medicines below:

i) **XPRSMED1**

ii) **XPRSMED2**

iii) **XPRSMED3**

iv) **XPRSMED4**

21. a) During the last 12 months, were you in hospital as an in-patient, overnight, or longer? **XINPATNT** Yes No

If No, go to Question 22

If Yes,

b) How many times did you go into hospital overnight or longer during the last 12 months? **XINPATNO**

NUMBER

c) How many days altogether were you in hospital during the last 12 months? **XINPATNO**

NUMBER

d) What were the main reasons for you being in hospital? *Please specify*

XINPT1

XINPT2

XINPT3

If Yes, **XOCPSTAG**

| | | | | | | | | |
|----|----|----|----|----|----|----|----|----|
| 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

b) At what age did your first start? **XOCYRSPS**

| | | | | | | | | |
|----|----|----|----|----|----|----|----|----|
| 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

c) For how many years altogether did you take contraceptive pills? **XOCYRSPS**

| | | | | | | | | |
|----|----|----|----|----|----|----|----|----|
| 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

24. a) Have you ceased having your periods? **XPERSTOP** Yes No

If No, go to part d

If Yes, b) At what age did you stop? **XPERSTOP**

| | | | | | | | | |
|----|----|----|----|----|----|----|----|----|
| 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

c) What was the cause of menopause? **XPERWHY**

Natural menopause

Hysterectomy (removal of womb only)

Hysterectomy plus removal of ovaries

Other *Please specify*

OTHER

d) Have you ever had hormone replacement therapy? **XHORMEV** Yes No

If No, go to Question 25

If Yes,

| | | | | | | | | | |
|-------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 |
| Years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

XHORMYR
XHORMMT Months

| | | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

f) Please specify the names of the medicine(s)

| |
|-----------------|
| MEDICINE |
| XHORMTAB |

g) Are you still taking hormone replacement therapy? **XHORMNOW** Yes No

If you have ceased having your periods go to Question 29

25. Which of the following descriptions apply to your periods during the last 12 months?

- XPERNORM** a) Normal for you in terms of regularity flow and duration? Yes No
- XPERREG** b) Less regular than usual? Yes No
- XPERSHT** c) Shorter in duration over the year? Yes No
- XPERSKPP** d) One or more skipped periods? Yes No

26. a) What was the date of the start of your last period?

| | |
|----------------|------|
| XPERLST | DATE |
|----------------|------|

b) What is the usual length of your cycle?

| | | |
|--|------|----------------|
| | DAYS | XCYCLNG |
|--|------|----------------|

27. Are your periods regular? **XPERREGU** Always Usually Sometimes Never

SMOKING HABITS

30. a) Do you smoke cigarettes now? **XSMOKE** (i.e., not cigars/pipe) Yes No

If No, go to Question 31

b) How many manufactured cigarettes do you smoke per day? **XCIGNUM** NUMBER

and/or

c) About how many ounces of tobacco do you use per week for hand-rolled cigarettes? **XTOBOZ** OUNCES

31. a) Do you smoke cigars? Yes No

If Yes, b) How many cigars per week? **XCIGARNO** NUMBER

28. If you are still having periods, do you experience any premenstrual symptoms?

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes, a lot | Yes, somewhat | Yes, a little | No, not at all |
| XSYMIRR | | | | |
| a) Irritability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Swelling or weight gain (bloated feeling) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XSYMIBL | | | | |
| c) Breast tenderness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XSYMBRST | | | | |
| d) Lower back pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XSYMBACK | | | | |
| e) Headache | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XSYMHEAD | | | | |
| f) Other Please specify | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XPMSYOT | | | | |

| |
|--|
| |
|--|

29. a) Do you experience menopausal symptoms?

XSYM MEN Yes No

If No, go to Question 30

If Yes, to what extent do you experience the following symptoms?

- | | | | | |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes, a lot | Yes, somewhat | Yes, a little | No, not at all |
| XSYMHOTF | | | | |
| b) Hot flushes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XSYMDEP | | | | |
| d) Sleep disturbance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XSYM SLP | | | | |
| e) Bone pains | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XSYM BON | | | | |
| f) Night sweats | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XSYM NIG | | | | |
| g) Other Please specify | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XMP SYMOT | | | | |

| |
|--|
| |
|--|

XPIPE c) Do you smoke a pipe? Yes No

If Yes, **XTOBOP**

d) How many ounces of tobacco do you smoke per week? OUNCES

32. a) If currently a non-smoker, to what extent are you exposed to cigarette smoke at work?

XEXSMWK Not at all Quite a lot A little Very much

b) If currently a non-smoker, to what extent are you exposed to cigarette smoke at home?

XEXSMHM Not at all Quite a lot A little Very much

DRINKING HABITS

33. a) In the past 12 months have you taken an alcoholic drink?

Indicate one only **XALCYR**

- Twice a day or more
- Daily or almost daily
- Once or twice a week
- Once or twice a month
- Special occasions only
- No

b) If No, have you always been a non-drinker?
XNONDRNK Yes No

If always a non-drinker go to Question 36

c) Compared with 5 years ago do you now drink:

- A lot more A bit more The same
- A bit less A lot less

XALCH5YR

d) If you have **given up or reduced** drinking, what was the main reason?

Indicate one only **XALCRED**

- Illness/doctors orders Health precautions
- Finance Other Please specify

OTHER

XALRDOTH

34. a) Have you had an alcoholic drink in the last seven days? **XALCWK**

Yes No

If No, go to Question 35

If Yes,

In the last seven days, how many drinks have you had of each of the following?

Please remember that a drink poured at home could be equivalent to 2 or 3 pub measures.

If none, indicate 0.

b) Spirits (Whisky, gin, rum, brandy, vodka etc.) or liqueurs

XSPRTWK

MEASURES

c) Wine (including sherry, port, vermouth)

XWINEWK

GLASSES

d) Beer (including lager and cider)

XBEERWK

PINTS

35. a) Have you ever felt that you ought to cut down on your drinking? Yes No

XDRNKCUT

b) Have people annoyed you by criticising your drinking? Yes No

XDRNKANN

c) Have you ever felt bad or guilty about your drinking? Yes No

XDRNKGLT

d) Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No

XDRNKHNG

COFFEE AND TEA CONSUMPTION

36. The following questions about your regular beverage apply to work as well as home.

If you do not drink tea or coffee go to Question 37

How many cups of tea or coffee on average do you drink every day?

a) Tea If none indicate 0

XTEAAV

CUPS

b) Coffee If none indicate 0

XCOFFAV

CUPS

c) If you drink coffee, how is it usually prepared?

(Please mark one box only) **XCOFFPRP**

Instant

Ground, freshly prepared

Boiled ground coffee, e.g. on filter machine with heated jug

d) Which type of coffee do you usually drink? (Please mark one box only)

XCOFFTP

Caffeinated

Decaffeinated

Please answer the following questions about your food habits.

37. a) What type of bread do you eat most frequently? *Indicate one only* **XBREAD**

White Wholemeal Granary or wheatmeal Other brown Both brown and white

b) What type of milk do you usually use? *Indicate one only* **XMILK**

Do not use milk Channel Islands Whole milk (gold top) Whole Milk (silver/red top or sterilised)

Skimmed milk Semi-skimmed milk Other *Please specify*

OTHER

38. How often do you eat fresh fruit or vegetables?

XFRUITVG

Seldom or never Less than once a month 1-3 times a month 1-2 times a week
 3-4 times a week 5-6 times a week Daily 2 or more times daily

HEALTH AND DAILY ACTIVITIES

39. In general, would you say your health is:-

XGENHLTH

Please indicate one

Excellent Very good Good Fair Poor

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

Please indicate one

XHLTHNOW

Much better now than one year ago Somewhat worse now than one year ago
 Somewhat better now than one year ago Much worse now than one year ago
 About the same as one year ago

41. The following items are about activities you might do during a typical day.

Does **your health now limit you** in these activities? If so, how much?

| | Yes, limited a lot | Yes, limited a little | No, Not limited at all |
|--|--------------------------|-----------------------------|------------------------------|
| a) Vigorous activities , such as running, lifting heavy objects, XACTIV01 participating in strenuous sports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling XACTIV02 or playing golf | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XACTIV03 Lifting or carrying groceries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XACTIV04 Climbing several flights of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XACTIV05 Climbing one flight of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XACTIV06 Bending, kneeling or stooping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XACTIV07 Walking more than one mile | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XACTIV08 Walking half a mile | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XACTIV09 Walking one hundred yards | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| XACTIV10 Bathing and dressing yourself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

42. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? Please indicate one answer for each question.

- a) Cut down the **amount of time** you spent on work or other activities **XNKHL01** Yes No
- b) **Accomplished less** than you would like **XNKHL02** Yes No
- c) Were limited in the **kind** of work or other activities **XNKHL03** Yes No
- d) Had **difficulty** performing the work or other activities (for example, it took extra effort) **XNKHL04** Yes No

43. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? Please indicate one answer for each question

- XNKEM01**
- a) Cut down the **amount of time** you spent on work or other activities Yes No
 - b) **Accomplished less** than you would like **XNKEM02** Yes No
 - c) Didn't do work or other activities as **carefully** as usual. **XNKEM03** Yes No

44. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups? Please indicate one

- Not at all Slightly Moderately Quite a bit Extremely
- XHLSOC**

45. How much **bodily** pain have you had during the **past 4 weeks**? **XBODPAIN**

- Please indicate one
- None Very mild Mild Moderate Severe Very severe

46. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)? Please indicate one

- XPAININT**
- Not at all A little bit Moderately Quite a bit Extremely

47. How much of the time during the **past 4 weeks**,

Please indicate one answer for each question

- | | | All of the time | Most of the time | A good bit of the time | Some of the time | A little of the time | None of the time |
|--|----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) Did you feel full of life? | XTIME01 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Have you been a very nervous person? | XTIME02 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Have you felt so down in the dumps that nothing could cheer you up? | XTIME03 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Have you felt calm and peaceful? | XTIME04 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Did you have a lot of energy? | XTIME05 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Have you felt downhearted and blue? | XTIME06 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Did you feel worn out? | XTIME07 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Have you been a happy person? | XTIME08 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Did you feel tired? | XTIME09 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

48. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)? Please indicate one

- XHLEMSOC**
- All of the time Most of the time Some of the time A little of the time None of the time

49. Please choose the answer that best describes how **true** or **false** each of the following statements is for you:

Please indicate one answer for each question

- | | | Definitely true | Mostly true | Don't know | Mostly false | Definitely false |
|---|-----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) I seem to get sick a little easier than other people | XSICKEAS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) I am as healthy as anybody I know | XHLTHAN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) I expect my health to get worse | XHLTHWRS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) My health is excellent | XHLTHEXC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

50. Please indicate the degree to which each of the following statements is TRUE OF YOU in general:

Please indicate one answer for each question

| | | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|--|-----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) Sudden loud noises really bother me | XLOWTOL1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) I hate to be too hot or too cold | XLOWTOL2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) I am quick to sense the hunger contractions in my stomach | XLOWTOL3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) I have a low tolerance for pain | XLOWTOL4 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

51. How often do you take part in sports or activities that are mildly energetic, moderately energetic or vigorous?
See details below

| | | 3 times a week or more | Once or twice a week | About once to 3 times a month | Never/hardly ever |
|---|--------------|--------------------------|--------------------------|-------------------------------|--------------------------|
| a) Mildly energetic (e.g. walking, woodwork, weeding, hoeing, bicycle repair, playing darts, general housework) | XMILD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Moderately energetic (e.g. scrubbing, polishing car, dancing, golf, cycling, decorating, lawn mowing, leisurely swimming) | XMOD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Vigorous (e.g. running, hard swimming, tennis, squash, digging, cycle racing) | XVIG | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please give the average number of hours per week you spend in such sports or activities.

XVIGHRS

d) Mildly energetic HOURS e) Moderately energetic HOURS f) Vigorous HOURS

52. Compared to someone of the same age and sex do you usually walk:

Slower Faster About the same pace **XWALKSPD**

53. How many times a week do you engage in vigorous physical activity long enough to work up a sweat?
If none, indicate 0

XSWEATTM Times each week TIMES **XSWEATHR** Hours each week HOURS

WORK CHARACTERISTICS

If you are no longer working please go to Question 69

54. How long do you spend daily travelling to and from work? (i.e. there and back). If none, indicate 0

Hours **XTRAVWKH** 0 1 2 3 4 5 6 7 8 9 10

Mins **XTRAVWKM** 10 20 30 40 50 0 1 2 3 4 5 6 7 8 9

55. Do you find commuting stressful (emotionally or physically)? **XCOMMSTR**

Yes, very much Yes, quite a lot Yes, a little No, not at all

56. a) Do you work with visual display units (VDU's) or desk top television screens? Yes No

If No, go to Question 57

XVDU

If Yes,

c) On average, how many hours per week do you use a VDU?

b) When did you first start using VDU's regularly (Year)?

19 **XVDUFST** 10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

Hours **XVDUHR** 10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

57. Please answer the following questions (if applicable) **XSCKBLD1 XSCKBLD2 XSCKBLD3 XSCKBLD4 XSCKBLD5**

a) How close is your desk to a window? Very close Close Far Very far

b) How many people work in your room/area? 1 2-4 5-9 10-29 more than 30

c) Is there a carpet on the floor of your room/area? Yes No

d) In your room/area, can you switch lights on and off? Yes No

e) In your room/area, can you adjust the heating? Yes No

f) In your room/area, can you open the windows? Yes No **XSCKBLD6**

XLONGBLD

58. How long do you work in your building in a typical week? (to the nearest hour) HOURS

59. The following questions are about your work. For each please indicate the one answer that best describes your job or the way you deal with problems occurring at work. *Please answer all questions*

| | | Often | Sometimes | Seldom | Never/ Almost Never |
|---|----------------|-----------------------|-----------------------|-----------------------|---------------------------|
| Concerning your particular work: | | | | | |
| a) Do you have to work very fast? | XWORK01 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) Do you have to work very intensively? | XWORK02 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c) Do you have enough time to do everything? | XWORK03 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d) Are your tasks such that others can help you if you do not have enough time? | XWORK04 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e) Do you have the possibility of learning new things through your work? | XWORK05 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f) Does your work demand a high level of skill or expertise? | XWORK06 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g) Does your job require you to take the initiative? | XWORK07 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h) Do you have to do the same thing over and over again? | XWORK08 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i) Do you have a choice in deciding HOW you do your work? | XWORK09 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j) Do you have a choice in deciding WHAT you do at work? | XWORK10 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

60. About your position at work - how often do the following statements apply? *Please answer all questions*

| | | Often | Sometimes | Seldom | Never/ Almost Never |
|---|-----------------|-----------------------|-----------------------|-----------------------|---------------------------|
| a) Others take decisions concerning my work | XWKPOSN1 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) I have a good deal of say in decisions about work | XWKPOSN2 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c) I have a say in my own work speed | XWKPOSN3 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d) My working time can be flexible | XWKPOSN4 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e) I can decide when to take a break | XWKPOSN5 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f) I can take my holidays more or less when I wish | XWKPOSN6 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g) I have a say in choosing with whom I work | XWKPOSN7 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h) I have a great deal of say in planning my work environment | XWKPOSN8 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

61. About consistency and clarity regarding your job. *Please answer all questions*

| | | Often | Sometimes | Seldom | Never |
|---|-----------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a) Do different groups at work demand things from you that you think are hard to combine? | XJBCLAR1 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) Do you get sufficient information from line management (your superiors)? | XJBCLAR2 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c) Do you get consistent information from line management (your superiors)? | XJBCLAR3 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

62. Regarding job involvement. *Please answer all questions*

| | | Often | Sometimes | Seldom | Never |
|--|-----------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a) Does your job provide you with a variety of interesting things? | XJOBINV1 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b) Is your job too varied and split up? | XJOBINV2 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c) Is your job boring? | XJOBINV3 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d) Do you consider your job very important? | XJOBINV4 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e) Do you feel your immediate superior considers your job important? | XJOBINV5 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f) Do your colleagues consider your job very important? | XJOBINV6 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g) How often do you wish you were doing a different job? | XJOBINV7 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h) How often do you feel that you are doing your job only for the money? | XJOBINV8 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

63. How would you judge the contribution your job makes to the general welfare of society, compared with other jobs?

| | | | | | | | |
|----------------------------|-----------------------|---------------------|-----------------------|--------------------|-----------------------|-------------------------|-----------------------|
| Harmful or no contribution | <input type="radio"/> | Slight contribution | <input type="radio"/> | Great contribution | <input type="radio"/> | Very great contribution | <input type="radio"/> |
|----------------------------|-----------------------|---------------------|-----------------------|--------------------|-----------------------|-------------------------|-----------------------|

64. When you are having difficulties at work: *Please answer all questions*

| | Often | Sometimes | Seldom | Never |
|---|--------------------------|-------------------------------------|--------------------------|--------------------------|
| a) How often do you get help and support from your colleagues? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) How often are your colleagues willing to listen to your work related problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) How often do you get help and support from your immediate superior? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) How often is your immediate superior willing to listen to your problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

65. Compared to people in a similar job, do you have more or less control over your work? *(Please mark one box)*

| A lot more | Somewhat more | About the same | Somewhat less | A lot less |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

66. How much supervision do you have at work? *(Please mark one)*

| Far too much | Rather too much | About the right amount | Rather too little | Far too little |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

67. Major changes in the organisation and location of civil service departments have been made and/or are planned. Which of these changes affect you?

| | Has happened | Is planned | Not certain what will happen | Is not planned |
|---|--------------------------|--------------------------|------------------------------|--------------------------|
| a) Change of your department into an agency | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Major changes in the organisation or management of your department | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Your department is being relocated | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If your department has been, or will be relocated, please answer the following questions:

| | | |
|--|------------------------------|-----------------------------|
| i. I moved/will move with the department | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| ii. I transferred/will transfer to another department within the civil service | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| iii. I will leave the civil service | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

68. What is the effect of the actual or planned changes as far as your job is concerned?

| | Often | Sometimes | Seldom | Never |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a) I am uncertain about the future | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) I feel these changes are a good thing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Now go to Question 70

69. If you retired, was it because of the recent changes in the organisation or location of the civil service?

| | |
|------------------------------|-----------------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|------------------------------|-----------------------------|

70. The following questions are about how you usually are as a person. Please indicate the extent to which each description applies to you in the appropriate column.

| | Very much like me | Fairly like me | Not really like me | Very unlike me |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a) I am over-perfectionistic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) I am over-conscientious | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) I am always tense and apprehensive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) I am always very shy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) I need certainty and security | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) I let other people take over responsibility for major areas in my life | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

71. All things considered, rate how important each of the following areas are to your life at present.

| | Extremely important | Very important | Fairly important | Slightly important | Not important |
|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) Your health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Your marital or love relationship | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Your job | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Your sex life | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Your family life | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Your leisure time activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

72. All things considered, how satisfied or dissatisfied are you with the following areas of your life? *If applicable*

| | | Very dissatisfied | Moderately dissatisfied | A little dissatisfied | No feelings either way | A little satisfied | Moderately satisfied | Very satisfied |
|--|-----------------|--------------------------|----------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------|
| a) Your marital or love relationship | XHOWSAT1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Your leisure time activities | XHOWSAT2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Your standard of living | XHOWSAT3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Your job | XHOWSAT4 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Your health | XHOWSAT5 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Your family life | XHOWSAT6 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Your sex life | XHOWSAT7 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) The way you feel about yourself as a person | XHOWSAT8 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

73. On an average weekday, approximately how many hours do you spend on the following activities: *If applicable*

| a) Work (daytime and work brought home) | b) Time with family | c) Sleep |
|--|--|---|
| <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 XWKWORK | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 XWKTIME | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 XWKSLEEP |

74. How often do you feel **physically exhausted** at the end of the day?

Hardly ever/never Once in a while Often Very often/always

75. How often do you feel **emotionally or mentally exhausted** at the end of the day?

Hardly ever/never Once in a while Often Very often/always

76. In general, how much stress or pressure have you experienced in your daily living **in the past four weeks?**

(Please mark one box) None A little A fair amount Quite a lot A great deal

77. To what extent do you feel that the stress or pressure you have experienced in your life has affected your health?

(Please mark one box) Not at all Slightly Moderately A lot Extremely

78. a) Are you currently providing any personal care or help to an aged or disabled relative(s)?

Yes No **XAGEDREL**

If **Yes**,

b) How many hours in an average week do you spend looking after this person(s)?

0 1 2 3 4 5 6 7 8 9 **XHRREL**
 10 20 30 40 50 60 70 80 90
 100

79. a) Are there any relatives outside your household whom you regularly visit or who visit you? (Not necessarily the same person each time) **XVSTREL**

Almost daily About once a week About once a month
 Once every few months Never/almost never No relatives outside household

If you have no relatives outside household, go to Question 80.

b) How many relatives do you see once a month or more? **XVSTRLM**

None 1 - 2 3 - 5 6 - 10 More than 10

80. a) Do you have any friends or acquaintances you visit or who visit you? (Not necessarily the same person each time) **XVSTFRND**

Almost daily About once a week About once a month
 Once every few months Never/almost never

b) How many friends or acquaintances do you see once a month or more? **XVSTFRM**

None 1 - 2 3 - 5 6 - 10 More than 10

81. a) Are you an active member of: social or recreational groups, trade unions, commercial groups, professional organisations, political parties, sports clubs, cultural groups, pressure groups etc.?

Yes No **XCLUB**

If No, go to Question 82

If Yes,

b) Taking all the above organisations together, how many hours in an average month do you devote to activities of these organisations?

10 20 30 40 50 60 70 80 90 100 200
0 1 2 3 4 5 6 7 8 9 **XCLUBHRS**

82. a) At what age do you think most people enter middle age?

10 20 30 40 50 60 70 80 90 **XENTMID**
1 2 3 4 5 6 7 8 9

b) At what age do you think most people leave middle age?

10 20 30 40 50 60 70 80 90 **XLUMID**
1 2 3 4 5 6 7 8 9

83. How much do you agree or disagree with the following statements?

Please indicate one for each of the following questions

| | | Strongly DISAGREE | Moderately DISAGREE | Slightly DISAGREE | Slightly AGREE | Moderately AGREE | Strongly AGREE |
|--|-----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) At Home , I feel I have control over what happens in most situations | XCONTHM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) At work , I feel I have control over what happens in most situations | XCONTWK | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Keeping healthy depends on things that I can do | XKEEPHLT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) There are certain things I can do for myself to reduce the risk of a heart attack | XRISKHT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) There are certain things I can do for myself to reduce the risk of getting cancer | XRISKCA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) I feel that what happens in my life is often determined by factors beyond my control | XBEOCONT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) I have a sense of direction and purpose in my life | XDIRECT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Over the next 5 - 10 years I expect to have many more positive than negative experiences | XPOSEXP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) I often have the feeling that I am being treated unfairly | XUNFAIR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j) In the past ten years my life has been full of changes without my knowing what will happen next | XFULLCHG | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k) One can always find a solution to painful things in life | XFINDSOL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l) My life in the future will probably be full of changes without my knowing what will happen next | XLIFEFUT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m) I very often have the feeling that there's little meaning in the things I do in my daily life | XLITMEAN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| n) I am certain that there will always be people whom I will be able to count on in the future | XCERTAIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

84. Do your family life and family responsibilities **interfere with** your performance on your job in any of the following ways?

Would you say:-

| | Not at all | To some extent | A great deal | Not applicable |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a) Family matters reduce the time you can devote to your job | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Family worries or problems distract you from your work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Family activities stop you getting the amount of sleep you need to do your job well | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Family obligations reduce the time you need to relax or be by yourself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

85. To what extent do your job responsibilities **interfere with** your family life?

Would you say:-

| | Not at all | To some extent | A great deal | Not applicable |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| a) Your job reduces the amount of time you can spend with the family | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Problems at work make you irritable at home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Your job involves a lot of travel away from home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Your job takes so much energy you don't feel up to doing things that need attention at home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

XJOBINT1
XJOBINT2
XJOBINT3
XJOBINT4

86. a) How often do you have worries or problems with other relatives (e.g. parents or in-laws)?

Always Often Sometimes Seldom Never XFAMPRB1

b) How often does it happen that you do not have enough money to afford the kind of food or clothing you/ your family should have?

Always Often Sometimes Seldom Never XFAMPRB2

c) How much difficulty do you have in meeting the payment of bills?

Very great Great Some Slight Very little None XFAMPRB3

d) To what extent do you have problems with your housing (e.g. too small, repairs, damp etc.)?

Very great problems Great Some Slight Very little None XFAMPRB4

e) To what extent do you have problems with the neighbourhood in which you live (e.g. noise, unsafe street, few local facilities)?

Very great problems Great Some Slight Very little None XFAMPRB5

GENERAL HEALTH QUESTIONS

Please read this carefully

We should like to know if you have had any medical complaints, and how your health has been in general **over the past few weeks**. Please answer ALL questions on the following pages simply by indicating the answer which you think most nearly applies to you. Remember that we want to know about your present and recent complaints, **not** those you had in the past.

It is important that you try to answer **ALL** the questions

HAVE YOU RECENTLY:-

87. Been able to concentrate on whatever you're doing?

XGHQ01

Better than usual Same as usual Less than usual Much less than usual

88. Lost much sleep over worry?

XGHQ02

Not at all No more than usual Rather more than usual Much more than usual

89. Been having restless, disturbed nights?

XGHQ03

Not at all No more than usual Rather more than usual Much more than usual

HAVE YOU RECENTLY:-

90. Been managing to keep yourself busy and occupied?

XGHQ04

More so than usual Same as usual Rather less than usual Much less than usual

91. Been getting out of the house as much as usual?

XGHQ05

More so than usual About same as usual Less than usual Much less than usual

92. Been managing as well as most people would in your shoes?

XGHQ06

Better than most About the same Rather less well Much less well

93. Felt on the whole you were doing things well?

XGHQ07

Better than usual About the same Less well than usual Much less well

94. Been satisfied with the way you've carried out your task?

XGHQ08

More satisfied About same as usual Less satisfied than usual Much less satisfied

95. Been able to feel warmth and affection for those near to you?

XGHQ09

Better than usual About same as usual Less well than usual Much less well

96. Been finding it easy to get on with other people?

XGHQ10

Better than usual About same as usual Less well than usual Much less well

97. Spent much time chatting with people?

XGHQ11

More time than usual About same as usual Less time than usual Much less than usual

98. Felt that you are playing a useful part in things?

XGHQ12

More so than usual Same as usual Less useful than usual Much less useful

99. Felt capable of making decisions about things?

XGHQ13

More so than usual Same as usual Less so than usual Much less capable

100. Felt constantly under strain?

XGHQ14

Not at all No more than usual Rather more than usual Much more than usual

101. Felt you couldn't overcome your difficulties?

XGHQ15

Not at all No more than usual Rather more than usual Much more than usual

102. Been finding life a struggle all the time?

XGHQ16

Not at all No more than usual rather more than usual Much more than usual

HAVE YOU RECENTLY:-

XGHQ17

103. Been able to enjoy your normal day-to-day activities?

More so than usual Same as usual Less so than usual Much less than usual

104. Been taking things hard?

XGHQ18

Not at all No more than usual Rather more than usual Much more than usual

105. Been getting scared or panicky for no good reason?

XGHQ19

Not at all No more than usual Rather more than usual Much more than usual

106. Been able to face up to your problems?

XGHQ20

More so than usual Same as usual Less able than usual Much less able

107. Found everything getting on top of you?

XGHQ21

Not at all No more than usual Rather more than usual Much more than usual

108. Been feeling unhappy and depressed?

XGHQ22

Not at all No more than usual Rather more than usual Much more than usual

109. Been losing confidence in yourself?

XGHQ23

Not at all No more than usual Rather more than usual Much more than usual

110. Been thinking of yourself as a worthless person?

XGHQ24

Not at all No more than usual Rather more than usual Much more than usual

111. Felt that life is entirely hopeless?

XGHQ25

Not at all No more than usual Rather more than usual Much more than usual

112. Been feeling hopeful about your own future?

XGHQ26

More so than usual About same as usual Less so than usual Much less hopeful

113. Been feeling reasonably happy, all things considered?

XGHQ27

More so than usual About same as usual Less so than usual Much less than usual

114. Been feeling nervous and strung-up all the time?

XGHQ28

Not at all No more than usual Rather more than usual Much more than usual

115. Felt that life isn't worth living?

XGHQ29

Not at all No more than usual Rather more than usual Much more than usual

116. Found at times you couldn't do anything because your nerves were too bad?

XGHQ30

Not at all No more than usual Rather more than usual Much more than usual

PLEASE ADD ANY COMMENTS BELOW, IF YOU WISH

COMMENTS

XCMNT

XCMNTQ1 **XCMNTQ2** **XCMNTQ3** **XCMNTQ4**

XVERSION

THANK YOU VERY MUCH FOR YOUR CO-OPERATION

FOR OFFICE USE ONLY

STUDY NUMBER

| | | | | | | | |
|----------|----------|----------|----------|----------|----------|----------|----------|
| <u>0</u> | <u>0</u> | <u>0</u> | <u>0</u> | <u>0</u> | <u>0</u> | <u>A</u> | <u>N</u> |
| <u>1</u> | <u>1</u> | <u>1</u> | <u>1</u> | <u>1</u> | <u>1</u> | <u>B</u> | <u>O</u> |
| <u>2</u> | <u>2</u> | <u>2</u> | <u>2</u> | <u>2</u> | <u>2</u> | <u>C</u> | <u>P</u> |
| <u>3</u> | <u>3</u> | <u>3</u> | <u>3</u> | <u>3</u> | <u>3</u> | <u>D</u> | <u>Q</u> |
| <u>4</u> | <u>4</u> | <u>4</u> | <u>4</u> | <u>4</u> | <u>4</u> | <u>E</u> | <u>R</u> |
| <u>5</u> | <u>5</u> | <u>5</u> | <u>5</u> | <u>5</u> | <u>5</u> | <u>F</u> | <u>S</u> |
| <u>6</u> | <u>6</u> | <u>6</u> | <u>6</u> | <u>6</u> | <u>6</u> | <u>G</u> | <u>T</u> |
| <u>7</u> | <u>7</u> | <u>7</u> | <u>7</u> | <u>7</u> | <u>7</u> | <u>H</u> | <u>U</u> |
| <u>8</u> | <u>8</u> | <u>8</u> | <u>8</u> | <u>8</u> | <u>8</u> | <u>I</u> | <u>V</u> |
| <u>9</u> | <u>9</u> | <u>9</u> | <u>9</u> | <u>9</u> | <u>9</u> | <u>J</u> | <u>W</u> |
| | | | | | | <u>K</u> | <u>X</u> |
| | | | | | | <u>L</u> | <u>Y</u> |
| | | | | | | <u>M</u> | <u>Z</u> |