

QUESTIONNAIRE REPLIES

YES = 1
NO = 0

Blank if not applicable.
Or Coded 0 - 9.

Name.....Address.....

1. Serial Number:

Sex: M = 1 F = 2

3. Marital State:

4. Occupation:

5. Residence: BSN Town = 0

Country = 1

6. Country of Birth:

7. Family Doctor:

8. Husband/Wife in Survey?

No = 0

Yes = 1

Name.....

9. Blood Relatives in Survey?

No = 0

Yes = 1

Names and Relationship:

.....

.....

.....

10. Date of Birth:

11. Time Glucose Drink Taken?

12. Time Last Eaten Anything?

13. In Good Health To-day?

14A. Any Disease or Incapacity?

14B. (i.e.).....

15. On Prescribed Drugs?

i.e.).....

.....

16. Thirst

Polyuria

18. Eyesight Failing?

19. Skin Infection?

20. Number of Children Born?

21. Babies Over 10-lb.

22. Defective Infants?

(i.e.).....

WOMEN ONLY:

23. Pruritis Vulvae?

24A. Menopause?

24B. Year of Menopause

25. Miscarriages, Etc.

ALL SUBJECTS:

26. Angina Pectoris?

27. Myocardial Infarction?

28. Intermittent Claudication?

29. Family History Diabetes?

30. Specific Heart Trouble?

31. Specific Kidney Trouble?

32. Specific Liver Dis./Jaundice?

33. Indigestion?

34. Known Ulcer?

MEN ONLY:

35. Winter Cough?

36. Winter Sputum?

37. Attacks Increased Sputum Past Three Years?

38. Dyspnoea?

39. Chest Wheezes or Whistles?

40. Chest Illnesses Past 3 Years?

41. Specific Chest Illnesses?

42. Dusty Job?

ALL SUBJECTS:

43. Non-Smoker/Ex-Smoker/Smoker?

44. Inhaler?

45. Smoking Details?

46. Age Starting Smoking?

47. Age Ceased Smoking?

48. Urti Past 7 Days?

49. Hay Fever?

50. Non-Drinker/Ex-Drinker/Drinker?

51. Mild/Moderate/Heavy Drinker?