For me. For all.
Swiss health study

Pilot phase

Questionnaires

The English version of this booklet was only developed for the codebooks and was not available during data collection.

DID

CID

For me. For all.
Swiss health study

Pilot phase

Attitude towards medical research

About yourself

1 **You are:**

- ☐ Female
- ☐ Male

2 **What is your year of birth?**

Year: _____

3 **What is your nationality?**

- ☐ Swiss
- ☐ Dual nationality (namely): _____ and _____
- ☐ Foreign nationality (namely): _____

4 **Which language(s) do you speak at home?**

Multiple answers possible.

- ☐ French
- ☐ Swiss German
- ☐ German
- ☐ Italian
- ☐ Other (please specify): _____

5 **How long have you lived in Switzerland?**

- ☐ From birth
- ☐ Since _____ (year(s))

6 **What is your current housing situation?**

- ☐ I live by myself
- ☐ I live with a partner/family (even if only temporarily, e.g., in case of shared custody)
- ☐ I live in a shared apartment/community accommodation
- ☐ Other living situation

(please specify): _____

7 **What is your highest level of education?**

Please check only one box.

- ☐ Primary school
- ☐ Secondary school
- ☐ High school
- ☐ Apprenticeship / professional baccalaureate
- ☐ University degree: Bachelors
- ☐ University degree: Masters/License
- ☐ University degree: Doctorate/ PhD
- ☐ Other (please specify): _____
- ☐ I do not wish to answer

8 **Approximately, what is your household's total net monthly income?**

One answer only.

- ☐ < CHF 3‘000
- ☐ between CHF 3‘000.- and CHF 4‘500.-
- ☐ between CHF 4‘500.- and CHF 6‘000.-
- ☐ between CHF 6‘000.- and CHF 9‘000.-
- ☐ between CHF 9‘000.- and CHF 11‘000.-
- ☐ > CHF 11‘000
- ☐ I do not wish to answer

9 **Information concerning your profession:**

1 What profession are you currently practicing? _____

2 What profession have you been trained for? _____

10 **Do you belong to a religious denomination?**

- ☐ Yes

  Which one?

  - ☐ Christian Catholic
  - ☐ Christian Protestant
  - ☐ Islam
  - ☐ Judaism
  - ☐ Other (please specify): _____

- ☐ No
- ☐ I do not wish to answer

11 **How would you describe your general health status?**

One answer only.

- ☐ Very good
- ☐ Good
- ☐ Average
- ☐ Poor
- ☐ Very poor

Your opinion on health research

Your opinion on health research and the questions it raises is very important to us. We are in the process of preparing a nationwide health study and would like to know the public's opinion on this subject.

To do this, we'd like you to put yourself in the shoes of Mrs. Martin, a fictional person. This will give you a more concrete idea of what things might be like if you were asked to take part in such a study. **There are no right or wrong answers, it is YOUR opinion that counts**!

Mrs. Martin receives a letter from health researchers. The researchers ask her if she'd be interested in taking part in a major health study that should lead to better prevention or treatment of certain diseases.

12 **In this situation, what is your first impression when you are told about this health study? Generally speaking…**

- ☐ I would be very much in favour
- ☐ I would be somewhat in favour
- ☐ I would be somewhat against it
- ☐ I would be very much against it
- ☐ I am not concerned, or I don't care

13 **Have you ever taken part in a health study?**

- ☐ Yes

  If so, please give us details about this study (e.g., study name, its objectives, your contribution)?

  _____

  _____

- ☐ No
- ☐ I don’t know

The invitation letter inviting her to take part in the study lists the name and phone number of a contact person. Mrs. Martin calls and asks this person exactly how the study was conducted. She is told that the study involved filling in questionnaires and having blood and urine samples collected in a study centre.

14 **In this situation, would you agree to take part in a study involving the following actions:**

		Yes	No
1	Completing a detailed questionnaire on certain risk factors and about your health	☐	☐
2	Going to a study centre for a health examination (e.g., cantonal hospital or research centre)	☐	☐
3	Provide a blood, urine, or saliva sample	☐	☐

Mrs. Martin wonders whether this study is really useful and of good quality. Above all, she would like to know whether she is risking anything by taking part. To address this question, the contact person informs her that the study has been approved by her canton's ethics committee.

15 **Have you ever heard the term "ethics committee"?**

☐ Yes, and I could explain the term

☐ Yes, but I don't know exactly what it means

☐ No

An ethics committee is a group of independent experts who assess the scientific, moral, social, and legal aspects of research projects. Any research project involving human beings must be approved by an ethics committee beforehand.

16 **To what extent do the following aspects contribute to your confidence and trust in health research, or in a specific study?**

		Very	Somewhat	Barely/not at all
1	Being informed in a transparent and comprehensible manner about the progress of the research and its results	☐	☐	☐
2	Having the possibility of determining who may obtain my data	☐	☐	☐
3	Having the opportunity to meet the research team	☐	☐	☐
4	Approval of the study by an ethics committee	☐	☐	☐
5	To be able to express my opinion on the conduct of the study and to know that it will be taken into account, whenever possible.	☐	☐	☐

Mrs. Martin agrees to take part in the study and signs an informed consent form. By signing, she agrees to share with the researchers:

- *Her **health data**: this data is collected using questions about her health status, medical records and living situation. This information should make it easier to prevent and treat certain diseases.*
- *A **sample** of her blood and other biological fluids (urine, saliva) for research into the biological mechanisms of certain diseases.*

Mrs. Martin would like to know whether her name will be disclosed to the researchers and who will have access to her health data and biological samples.

There are three options for handling Mrs Martin's name and identity during a study:

a) **Unencrypted data**: The researchers know the name and date of birth of the participants and, like the doctors, are subject to medical confidentiality.

b) **Encrypted data**: The researchers don't know whose data or blood they are analysing. However, in the interests of Mrs Martin (e.g., when the results are important for her health), the encryption of the data can be reversed. This can only be done with Mrs Martin's prior consent.

c) **Anonymised data**: The researchers do not know who the data or samples belong to and they have no way of determining which data and samples originate from Mrs. Martin. They can no longer provide Mrs Martin with information about her personal data, or only with exceptional effort.

17 **Would you make your health data available to research, should they be in the following form?**

		Yes	Possibly	No
1	Unencrypted data	☐	☐	☐
2	Encrypted data	☐	☐	☐
3	Anonymised data	☐	☐	☐

18 **Would you share your biological samples (blood, urine, saliva), should they be in the following form?**

		Yes	Possibly	No
1	Unencrypted data	☐	☐	☐
2	Encrypted data	☐	☐	☐
3	Anonymised data	☐	☐	☐

On the phone, the contact person explains to Mrs. Martin that the health study she was being invited to includes a section on genetics (the study of genes). Mrs. Martin was informed that genetic tests are only relevant to her health in very rare cases and that only a small number of illnesses have a purely genetic explanation. Other factors, such as the environment and lifestyle, can also influence their development. The contact person explains that genetic analysis is useful in gaining a better understanding of the emergence of these diseases.

19 **In this situation, what is your first impression of genetic research?**

☐ I'm very much in favour

☐ I'm somewhat in favour

☐ I'm somewhat against it

☐ I'm very much against it

☐ I'm not concerned by genetic research, or I don't care

20 **If you were asked: in principle, would you be willing to participate in a study involving genetic issues?**

☐ Yes

☐ No (Please state the reason here): _____

☐ I don't know

Mrs. Martin agreed to provide the researchers with a tube of blood. For the study in question, only part of the sample is analysed immediately, while the rest is kept in a 'biobank' for future research.

21 **Have you ever heard the term "biobank"?**

- ☐ Yes, and I could explain the term
- ☐ Yes, but I don't know exactly what it means
- ☐ No

A biobank is a facility for storing and managing biological samples (e.g., blood, urine, saliva) and their associated data. Participants' samples are stored (anonymously) for several years and made available for scientific research. Analysing such a large number of samples provides a better understanding of the factors involved in the development of individual health. The greater the number of samples, the greater the potential for understanding the links between risk factors and disease.

22 **Would you welcome the establishment of a national biobank in Switzerland for research purposes?**

- ☐ Yes, definitely
- ☐ Rather yes
- ☐ Rather no
- ☐ No, not at all
- ☐ I don't know

Mrs. Martin agrees to her blood being stored in a biobank along with the health data collected at the study centre. The contact person explains to Mrs. Martin that it is she who gives her agreement (consent) to the various ways in which the samples and associated data will be used. To do this, she signs a declaration of consent, which can take various forms. Mrs. Martin is also told that she can change her mind and withdraw her agreement to the use of her blood and associated data at any time.

There are several forms of consent:

General consent: Mrs. Martin can give her consent just once, which allows the research teams to use the blood samples for any research project that has been validated by an ethics committee.

Specific consent: Mrs. Martin may be contacted again for each new research project, so that she can decide whether or not she agrees to her blood samples being used.

Dynamic consent: Mrs. Martin can decide at the time of the blood draw for which type of research project(s) her blood samples may be used. This option also allows her to change her preferences over time.

23 **In the occurrence of a large national health study, what form of consent would you give?**

Bearing in mind that you could withdraw or change your consent at any time and request that your samples be destroyed.

- ☐ General consent
- ☐ Specific consent
- ☐ Dynamic consent
- ☐ I would not donate biological material for research
- ☐ I don’t know

Over the phone, the contact person also informs Mrs. Martin that an "electronic patient record" had recently been introduced in Switzerland. This allows patients to collect and centralise their medical data and manage it themselves.

24 **Are you familiar with the term "electronic patient record"?**

- ☐ Yes, and I could explain the term
- ☐ Yes, but I don't know exactly what it means
- ☐ No

The electronic patient record is the collection of personal information, data and documents relating to a person's health on a secure Internet platform. This information can be consulted at any time by medical staff, with the consent of the individual concerned. The electronic patient record could help researchers in a health study to understand the link between a current or future illness and certain substances detected in samples.

25 **Can you envisage opening an electronic patient file?**

- ☐ I already have an electronic patient record
- ☐ Yes
- ☐ No
- ☐ I don’t know

26 **At present, there are no intent to use electronic patient records for research purposes. However, if you had an electronic patient record, would you be willing to give researchers access to information in this record?**

(As a patient, you decide which information could be accessed)

- ☐ Yes
- ☐ No
- ☐ I don’t know

Willingness to participate in a long-term health study

There are different forms of health research, and we'd like to hear your views on long-term health studies (also known as "longitudinal cohort studies"), in which participants are monitored over a long period of time (questionnaires, medical visits) to observe changes in their health status. Why does one person fall ill while another remains in good health? What promotes the onset of disease? What role do the environment, social context, diet, or genetic predisposition play?

These are the questions that long-term studies aim to answer, in order to improve disease prevention, diagnosis and treatment. Here again, your opinion is invaluable, as it will help us to set up a new long-term study in Switzerland, the Swiss Health Study.

27 **In principle, would you be willing to participate in a longitudinal study?**

- ☐ Yes, definitely
- ☐ Rather yes
- ☐ Rather no
- ☐ No, not at all
- ☐ I don't know

Why not? _____

28 **How would you like to be contacted as a first instance about participating in a longitudinal study?**

Please tick all that apply.

- ☐ By postal letter
- ☐ By phone
- ☐ Via Internet (e-mail, social media, etc.)
- ☐ By a home visit from the research team
- ☐ At my GP/family doctor's office
- ☐ At the pharmacy
- ☐ At the hospital
- ☐ Other option(s): _____

29 **Should you agreed to take part in a longitudinal study, how would you like to answer the study questions?**

Please tick all that apply.

- ☐ In writing (via questionnaires)
- ☐ By telephone (as an interview)
- ☐ Online via the Internet
- ☐ By a personal interview at your home
- ☐ By a personal interview at a study centre
- ☐ On your Smartphone (mobile phone) via an app
- ☐ Other option(s): _____

30 **What is/would be your motivation to participate in a longitudinal study and donate time, information and, if necessary, biological material?**

Please tick all that apply.

- ☐ I would like to contribute to medical progress
- ☐ I would like to contribute to improving the health of other people
- ☐ I am interested in research and health
- ☐ I would like to benefit from a free medical check-up
- ☐ I am interested in knowing the results of the study
- ☐ I am proud to be taking part in an important study in Switzerland
- ☐ I am motivated by financial remuneration
- ☐ I am motivated by small gifts (e.g., REKA cheque, travel vouchers)
- ☐ Other possibility(s): _____
- ☐ No reason would motivate me

31 **For which reasons would you refuse to participate in a longitudinal study?**

Please tick all that apply.

- ☐ I'm not interested at all
- ☐ I don't have the time
- ☐ I'll only have time to take part in the evenings or during weekends
- ☐ I'll never benefit personally from the results
- ☐ I'm not in favour of health research
- ☐ I don't think such study could help improve the health of the population
- ☐ I don't want to travel to the study centre
- ☐ I don't want to share my health data
- ☐ I don't want to donate blood (or other biological samples)
- ☐ I'm afraid my data won't be properly protected
- ☐ I'm afraid my data might be misused (e.g., by health insurance companies, employers, etc.)
- ☐ I fear that my contribution will serve the private interests of the pharmaceutical industry
- ☐ Other possibility(s):_____
- ☐ I would not refuse

32 **Which biological samples would you donate to research as part of a longitudinal study (all are equally important and valuable for research)?**

Please tick all that apply.

- ☐ Saliva
- ☐ Hair
- ☐ Urine
- ☐ Blood
- ☐ Stool
- ☐ Genetic material (DNA) (e.g., from a blood or saliva sample)
- ☐ None of the above

33 **What types of examination would you be willing to take as part of a longitudinal study?**

Please tick all that apply.

- ☐ Simple anthropometric measurements (e.g., height, weight, waist circumference, arm circumference)
- ☐ Measurement of body functions (e.g., blood pressure, bone density measurement, ECG)
- ☐ Wearing of small measuring devices for a defined period of time (e.g., 24-hour blood pressure, measurement of physical activity over 1 week, etc.)
- ☐ Physical capacity tests (e.g., handgrip test, lung capacity, mobility tests)
- ☐ Medical imaging (e.g., ultrasound, MRI)
- ☐ Questionnaires on specific topics (e.g., diet, use of chemicals)
- ☐ Blood count
- ☐ Sensory analysis (sight, smell, hearing, taste)
- ☐ Cognitive tests (e.g., memory)
- ☐ Collection of urine over 24 hours at home with organized transport to the study centre
- ☐ Collection of a drop of blood from the finger on blotting paper (equipment provided) and sent by post via pre-stamped postal envelope
- ☐ Collection of stool at home (simple and hygienic collection system) with organised transport to the study centre
- ☐ Collection of samples at the research centre in your region
- ☐ Diagnostic tests (e.g., allergy tests, diabetes)

34 **All these examinations can provide important information about your health, with some illnesses having treatment or prevention possibilities, others not directly. What type of results would you be interested in knowing, if possible?**

		Yes	No
1	The results of a simple medical check-up carried out during your visit to the study centre (high blood pressure, suspected diabetes, and simple laboratory tests, e.g., high cholesterol)	☐	☐
2	Results of your environmental exposure (e.g., pesticides, plastic compounds, heavy metals)	☐	☐
3	Genetic findings, should they indicate the risk of preventable diseases	☐	☐
4	Genetic findings, should they indicate the risk of treatable diseases	☐	☐
5	Genetic findings, should their be a chance they could have an impact on my (future) children	☐	☐

35 **How would you like these results to be communicated to you?**

Please tick all that apply.

☐ I don't want to know the study results

☐ I want to know the study results

Please specify :

		General results from examinations and tests (except genetic tests)	Genetic Findings
1	Per letter/mail	☐	☐
2	Per e-mail	☐	☐
3	Per phone	☐	☐
4	During a medical consultation with my GP or family doctor	☐	☐
5	During a visit by the research team	☐	☐

The aim of the planned longitudinal study is to understand the influence of the environment on health, e.g., pollution by pesticides, plastics or noise, as well as our lifestyle habits (e.g., diet, physical activity).

36 **How important do you think it is to study the possible effects of the environment on health?**

☐ Very important

☐ Quite important

☐ Not so important

☐ Not important at all

☐ I don't feel concerned by this issue / I don't care

For some research studies, collaborations are desirable, as they can improve the results obtained through the contribution of other researchers, the pooling of several datasets, or the provision of additional funding to carry out additional analyses. Participant health data and/or biological samples from a biobank can then potentially be shared with researchers from institutions other than the one that carried out the research in the first place, in Switzerland or abroad. Data is only exchanged with the consent of the participant and in compliance with Swiss legal provisions, particularly in terms of data protection.

37 **Which researchers or institutions would you authorise to use your data and biological samples for research?**

Multiple answers possible.

- ☐ Researchers from Swiss universities or clinics
- ☐ Researchers from foreign universities and clinics
- ☐ Researchers from federal offices (researchers subsidised by the government)
- ☐ Researchers from non-profit organisations (e.g. Ligue contre le cancer)
- ☐ Researchers from the pharmaceutical industry
- ☐ Researchers from the agri-food industry
- ☐ Researchers from the fitness industry
- ☐ I would not like to share my biological samples with researchers

33 **In the context a longitudinal study, would you allow the researchers in charge of the study to request access to your health information from the following sources?**

Please note that this will not be done for the pilot phase of the Swiss Health Study.

		Yes	Possibly	No
1	General practitioner/Family doctor	☐	☐	☐
2	Specialists (gynecologist, dermatologist, ophthalmologist....)	☐	☐	☐
3	Other medical partners (pharmacy, Spitex/Ambulatory care, nursing home)	☐	☐	☐
4	Hospital	☐	☐	☐
5	Databases of institutions and medical organizations	☐	☐	☐
6	Health and diagnostic registers (e.g. tumour registers)	☐	☐	☐

The origin of an illness is often complex, and several factors may come into play. In order to study the origins of an illness, all the factors that influence health must be identified. For this reason, the questionnaires for a long-term study can be relatively long, but they can be completed in several stages.

39 **What is a reasonable time commitment for you to complete a questionnaire (paper or online) about your health and life circumstances?**

- ☐ 4 hours or more
- ☐ 2 - 4 hours
- ☐ 1 - 2 hours
- ☐ Less than 1 hour
- ☐ I don't know / it would depend on the questions

A visit to the study centre is used to carry out a detailed assessment of a person's state of health. Numerous parameters and symptoms of potential illnesses must be recorded. The visit to the study centre may therefore take some time, depending on the examinations performed.

40 **How much time would you agree to dedicate to examinations at a study centre (incl. travel, examination, sample collection)?**

- ☐ A whole day
- ☐ Half a day
- ☐ 1-2 hours
- ☐ I don't know

41 **In some studies, study participants are involved in the decision making regarding the study. What is your opinion on this?**

- ☐ I don't want to be involved
- ☐ I would like to be informed regularly, for example by means of a newsletter
- ☐ I would like to express my opinion about decisions concerning the study
- ☐ I would like to take an active part in shaping the research framework in a discussion group
- ☐ I don't know
- ☐ I would like to contribute in some other way

  (please specify): _____

42 **Would you be interested in being involved in decisions about this study, as part of a focus group organised by the research team?**

☐ Yes

☐ No

42.1 **If you would like to be part of such a group, please let us know how you would like to be contacted:**

_____

_____

We value your opinion

43 **If you have any further information for us, please use the space below to provide any suggestions, requests, comments or criticism.**

_____

_____

_____

_____

_____

_____

For me. For all.
Swiss health study

Pilot phase

Medical history

1. Medical history

History for each illness requested (current or past illness)

Example Group of illnesses	Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
Example of filling	Was this disease / condition diagnosed by a doctor?	What year was your illness/condition diagnosed?	Are you currently receiving treatment for this illness / condition?	Do you regularly see a doctor for this illness / condition?	How many times have you seen a doctor in the last 12 months?	Have you ever been hospitalised for this illness / condition?	How many nights have you spent in hospital for this illness / condition in the last 12 months?
A ***Example - illness 1***	☒ Yes → ☐ No ☐ I don't know	1 9 8 5	☐ Yes ☒ No ☐ I don't know	☐ Yes ☒ No ☐ I don't know	0	☒ Yes ☐ No ☐ I don't know	0
B ***Example - illness 2***	☒ Yes → ☐ No ☐ I don't know	2 0 0 9	☒ Yes ☐ No ☐ I don't know	☒ Yes ☐ No ☐ I don't know	5	☒ Yes ☐ No ☐ I don't know	3
C ***Example - illness 3***	☐ Yes → ☒ No ☐ I don't know		☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know		☐ Yes ☐ No ☐ I don't know	

If you ticked "no", please leave the rest of the row blank (area shaded in grey here)

- If you have been diagnosed with the indicated illness (« **Yes** »), **please answer the subsequent questions by scrolling right on the table**: your answers are essential, even an approximation.

- If you have not received a diagnosis (« **No** ») or if you do not know (« **I don't know** »), please **do not fill in the subsequent questions in the area shaded in grey** (see example above).

MUSCULOSKELETAL DISORDERS		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
1	***Daily back pain for at least the last 3 months***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
2	***Osteoporosis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
3	***Osteoarthritis/Arthrosis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

	LUNG DISEASES	Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
4	***Asthma***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
5	***Chronic bronchitis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
6	***Chronic obstructive pulmonary disease (COPD)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
7	***Pulmonary emphysema***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
8	***Sleep apnoea***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
9	***Pneumonia***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
10	***Other pulmonary disease:*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

If you have ever had asthma (even if not diagnosed by a doctor), please answer the following questions:

Z 4.1

Have you had one or more asthma attacks in the last 12 months?
Please tick only one answer.

☐ Yes

☐ No

☐ I don’t know

Z 4.2

If yes, how many attacks have you had in the last 12 months?
Please give a number, even an approximation.

☐☐☐ Asthma attack(s)

Z 4.3

Are you currently on any asthma medication (including inhalers, aerosol sprays, tablets)?
Please tick only one answer.

☐ Yes

☐ No

☐ I don’t know

If you have had pneumonia in the LAST 12 months, please answer the following questions:

Z 9.1

What was the origin of the pneumonia?
Please tick only one answer.

☐ Novel coronavirus

☐ Viral (other than coronavirus)

☐ Legionnaires' disease

☐ Bacterial (other than legionnaires' disease)

☐ I don’t know

Z 9.2

Have you been tested for legionellosis/legionnaires' disease in the last 12 months? ***If you have been tested, please provide the date of the test(s), the result of the test(s) and the type of test(s).***

☐ Yes →

☐ No

☐ I don’t know

Date of test	Result	Type of test
☐☐☐☐☐☐ d d m m y y	□ positive □ negative □ inconclusive	□ Urinary antigen test □ Culture testing from spit or oral swab □ Genetic test (PCR) from spit or oral swab □ Serological testing from blood □ I don't know
☐☐☐☐☐☐ d d m m y y	□ positive □ negative □ inconclusive	□ Urinary antigen test □ Culture testing from spit or oral swab □ Genetic test (PCR) from soit or oral swab □ Serological testing from blood □ I don't know

Z 9.3

If you have had Legionnaires' disease, has the source of contamination been investigated?
Please tick only one answer.

☐ Yes, successfully - please specify the source of contamination:

☐ Yes, but unsuccessfully

☐ No

☐ I don’t know

Z 9.4

Who investigated the source of contamination?
Please tick only one answer.

☐ The attending physician

☐ The cantonal physician

☐ Yourself

☐ Other - *please specify:*

☐ I don’t know

SKIN DISORDERS		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
11	***Atopic dermatitis (neurodermatitis) or eczema***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
12	***Psoriasis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
13	***Severe acne***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

ALLERGIC DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
14	***Hay fever***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
15	***Other allergic rhinitis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
16	***Allergy to insect stings (bee, wasp, bumblebee, hornet)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
17	***Allergy to dust mites***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

ALLERGIC DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
18	***Allergy to animal hair***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
19	***Contact allergies (latex, nickel, perfumes, etc.)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
20	***Chronic sinusitis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
21	***Food allergy (please specify):*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
22	***Food intolerance (please specify):*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
23	***Other allergy*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

	INFECTIOUS DISEASES	Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
24	***Human Immunodeficiency Virus (HIV) or AIDS***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
25	***Hepatitis B***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
26	***Hepatitis C***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
27	***Tuberculosis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
28	***Herpes zoster (shingles)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
29	***Epstein-Barr virus (EBV, mononucleosis)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
30	***Borreliosis (Lyme disease)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
31	***Other chronic infection:*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

HEART DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
32	***Myocardial infarction***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
33	***Angina pectoris, coronary heart disease***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
34	***Heart failure***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
35	***Heart rhythm disorders (pacemaker)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
36	***Peripheral obliterative arteriopathy, or peripheral arterial occlusive disease (PAOD)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
37	***Arterial hypertension***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

If you have had a myocardial infarction (heart attack), please answer the following questions:

Z 32.1 **How many heart attacks have you had?**

☐☐ heart attack(s)

Z 32.2 **At what age did you experience your first heart attack?**

☐☐ *years old*

Z 32.3 **At what age did you experience your last heart attack?**

☐☐ *years old*

CANCERS		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
38	***Lung cancer***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
39	***Colon cancer***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
40	***Breast cancer***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
41	***Women: Cervical cancer***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
42	***Men: Prostate cancer***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
43	***Leukaemia***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
44	***Skin cancer / Melanoma***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
45	***Other cancer 1:*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
46	***Other cancer 2:*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

METABOLISM DISORDERS		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
47a	***Type I diabetes mellitus***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
47 b	***Type II diabetes mellitus***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
47 c	***Gestational diabetes (during pregnancy)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
48	***Increase in blood lipids, cholesterol or triglycerides***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
49	***Gout***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
50 a	***Hyperthyroidism***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
50 b	***Hypothyroidism***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
50 c	***Other thyroid disorder*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

If you have diabetes, please answer the following questions:

Z 47.1

Which treatment are you currently undergoing (including insulin injections and insulin pumps)?
Please tick only one answer.

☐ Insulin only
☐ Tablets only
☐ Insulin and tablets
☐ Nutritional treatment only
☐ Other treatment
☐ I don't follow any treatment
☐ I don’t know

Z 47.2

If you are taking insulin, how old were you when you first started taking it?
Please provide an answer, even if it's an approximate age.

☐☐ years old

Z 47.3

Do you suffer from complications related to diabetes? *Several answers possible.*

☐ Retinopathy, damage to the cornea
☐ Blindness
☐ Proteinuria (protein in urine)
☐ Renal failure or renal insufficiency
☐ Dialysis treatment or kidney transplant
☐ Diabetic foot / poor wound healing
☐ Amputations (toe, foot, leg)
☐ I don’t know

☐ None of these diseases or complications

KIDNEY, LIVER, STOMACH AND INTESTINAL DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
51	***Gastric or duodenal ulcer***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
52	***Heartburn or gastric reflux***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
53	***Intestinal inflammation (e.g. ulcerative colitis or Crohn's disease)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
54	***Gallstones***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
55	***Liver cirrhosis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
56	***Kidney stones, including in the ureter or in the bladder***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
57	***Impaired renal function (e.g. chronic renal failure)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

If you have ever had kidney failure, please answer the following question:

Z 57.1

Have you ever been dialysed?

Please tick only one answer.

☐ Yes

☐ No

☐ I don't know

NEUROLOGICAL AND PSYCHOLOGICAL DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
58	***Stroke***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
59	***Epilepsy***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
60	***Migraines***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
61	***Parkinson's syndrome***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
62	***Depression***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

NEUROLOGICAL AND PSYCHOLOGICAL DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
63	***Anxiety disorder or panic attacks***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
64	***Eating disorders***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
65	***Attention-deficit with or without hyperactivity disorder (ADHD)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
66	***Dementia or Alzheimer's***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

If you have or have had an eating disorder, please answer the following question:

Z 64.1 **What type of eating disorder is it or was it?**

☐ Anorexia

☐ Boulimia nervosa

☐ Binge-Eating

☐ Other _____

WOMEN'S DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
67	***Polycystic ovary syndrome (Stein-Leventhal syndrome)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
68	***Endometriosis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
69	***Uterine myoma (benign tumour)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
70	***Uterine prolapse (descent of the uterus)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
71	***Papillomavirus / HPV infection (of the cervix)***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

EYE DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
72	*Cataract*	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
73	*Glaucoma*	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
74	*Age-related macular degeneration (AMD)*	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
75	*Other eye disease:* _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

HEARING DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
76	*Tinnitus*	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
77	*Hearing loss*	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
78	*Hearing problems*	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
79	*Balance problems / Vertigo*	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

OTHER DISEASES AND RARE DISEASES		Diagnosis of the disease / condition	Year of diagnosis	Current treatment	Medical follow-up	Medical consultations over the last 12 months	Hospitalisation	Hospital stay over the last 12 months
80	***Rheumatoid arthritis / Polyarthritis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
81	***Multiple sclerosis***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
82	***Fibromyalgia***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
83	***Congenital malformation***	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
84	***Other disease 1:*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐
85	***Other disease 2:*** _____	☐ Yes→ ☐ No ☐ I don't know	☐☐☐☐	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐☐☐	☐ Yes ☐ No ☐ I don't know	☐☐☐

If you have a congenital malformation, please answer the following question:

Z 83.1

What type of congenital malformation is it?

☐ Malformations of the musculoskeletal system (e.g. clubfoot, hip dysplasia)

☐ Malformations of the internal urogenital system (e.g. kidney malformation)

☐ Cardiovascular malformations

☐ Malformations of the digestive system

☐ Malformations of the central nervous system (e.g. neural tube defect / spina bifida)

☐ Malformations of the external urogenital system (e.g. hypospadia)

☐ Facial clefts (e.g. cleft lip and/or palate)

☐ Chromosomal aberrations

☐ Ear malformations

☐ Eye malformations

☐ Minor morphogenesis malformations (e.g. single palmar crease, non-closure of rectus abdominis muscles, excess or fusion of the fingers or toes, haemangiomas, nevi...)

☐ Other

GENERAL HEALTH

86 **Are you currently suffering from an illness or health problem that has not been diagnosed by a doctor?**

☐ No

☐ Yes, please specify:

_____

_____

_____

87 **To what extent do each of the following statements apply to you?** *Please tick only one answer for each statement (1-9).*

In the last 12 months, have you …		No	Yes	I don't know
1.	… at any time, had wheezing in the chest?	☐	☐	☐
2.	… felt breathless when the wheezing was audible?	☐	☐	☐
3.	… had wheezing although you didn't have a cold?	☐	☐	☐
4.	… woken up with a feeling of tightness in the chest?	☐	☐	☐
5.	… ever been woken up by a coughing fit?	☐	☐	☐
6.	… experienced abnormal shortness of breath after strenuous physical activity?	☐	☐	☐
7.	… been woken up at night by abnormal shortness of breath?	☐	☐	☐
8.	… experienced abnormal breathlessness at rest during the day?	☐	☐	☐
9.	If you have ever had an attack of breathlessness during the day: How old were you when you first experienced abnormal breathlessness at rest during the day?	☐☐ years old		

88 Dry cough

Please tick only one answer for each statement (1-4).

		No	Yes	I don't know
1.	In winter, do you usually cough when you get up in the morning?	☐	☐	☐
2.	In winter, do you usually cough during the day or at night?	☐	☐	☐
3.	Did you have a cough like this most days, during at least 3 months a year? (if no, please move on tot he next question)	☐	☐	☐
4.	For how many years?	☐ less than 2 years		
		☐ 2 years or more	☐☐ number of years	

89 Expectoration (coughing up phlegm or sputum)

Please tick only one answer for each statement (1-4).

		No	Yes	I don't know
1.	In winter, do you usually spit in the morning just after waking up?	☐	☐	☐
2.	In winter, do you usually spit during the day or at night?	☐	☐	☐
3.	Do you usually spit most days for at least 3 months a year? *(If no, please go to the next question)*	☐	☐	☐
4.	For how many years?	☐ less than 2 years		
		☐ 2 years or more	☐☐ number of years	

90 **Please indicate the number of times you have experienced the following symptoms in the last 12 months.**

Please count as follows:

- *If, in the last 12 months, you have caught a cold 3 times and an ear infection once, this counts as 4 infections in total, so answer "3-4 times".*
- *An infectious episode lasting several consecutive days counts as 1 event.*

Please tick only one answer per row (1-5).

Over the last 12 months, how often have you suffered from...	Never	1 time	2 times	3-4 times	5-6 times	> 6 times
1. **… Fever** above 38°C?	☐	☐	☐	☐	☐	☐
2. … an **upper respiratory tract** infection *(e.g. cold, sinusitis, otitis, tonsil infection, angina, laryngitis)*	☐	☐	☐	☐	☐	☐
3. … a **lower** respiratory tract infection *(e.g. bronchitis or pneumonia)?*	☐	☐	☐	☐	☐	☐
4. … a **gastrointestinal infection** with diarrhoea *(diarrhoea is characterised by the occurrence of unformed (liquid) stools at least 3 times in 24 hours)?*	☐	☐	☐	☐	☐	☐
5. … a **urinary tract infection** (cystitis)?	☐	☐	☐	☐	☐	☐

91 **Are you prone to experiencing pain or periods of discomfort?**

Please tick only one answer.

☐ Yes

☐ No

☐ I don't know

92 **Do you regularly take painkillers?**

Please tick only one answer.

☐ Never

☐ Very rarely (less than once a month)

☐ Rarely (1-2 times per month)

☐ Sometimes (less than once a week)

☐ Often (1 to 5 times per week)

☐ Everyday

93 **Do you have a food allergy or food intolerance?**

☐ No, I don't have any

☐ Yes. If yes, which ones? *Several answers possible.*

☐ Lactose
☐ Gluten
☐ Other: _____

94 **Do you suffer, or have you suffered, any of the following complications related to tattoos or piercings?** *Please tick only one answer.*

☐ I don't have any tattoos or piercings

☐ I have tattoos or piercings, but I've never had any complications

☐ I have or have had an occasional inflammation

☐ I have a chronic inflammation

☐ I've had an allergic reaction to the tattoo or piercing

Sleep

95 **How well have you slept over the last four weeks?**
Please tick only one answer.

☐ Really well

☐ Well

☐ Fairly well

☐ Poorly

☐ Really poorly

☐ I don't know

96 **How many hours per night have you actually slept in the last four weeks? Do not consider time spent in bed without sleeping.**

Actual sleep time per night:

1. Hours of sleep during the week (Sun-Thu): ☐☐ per night

2. Hours of sleep during the weekend (Fr-Sa) ☐☐ per night

97 **How often do you usually take naps?**
Please tick only one answer.

- ☐ Never
- ☐ Less than once a week
- ☐ 1 to 4 times a week
- ☐ 5 or 6 times a week
- ☐ Everyday

98 **How long does your nap usually last (in minutes)?**
(If you do not take a nap, please enter 0)

☐☐☐ minutes

Stress

99 **Do you feel stressed at the time?**
(1 = no stress; 6 = extremely stressed)
Please tick only one answer.

No stress					Extremely stressed
1	2	3	4	5	6
☐	☐	☐	☐	☐	☐

100 **Over the past year, have you been stressed at home?**
Please tick only one answer.

No stress					Extremely stressed
1	2	3	4	5	6
☐	☐	☐	☐	☐	☐

101 **In the past year, have you been stressed at work?**
Please tick only one answer.

Kein Stress					Extremer Stress
1	2	3	4	5	6
☐	☐	☐	☐	☐	☐

102 **Do you manage to maintain a satisfactory balance between your professional activities and your personal life (family, partner, friends)?**
Please tick only one answer.

Not at all					Yes very well
1	2	3	4	5	6
☐	☐	☐	☐	☐	☐

103 **On a scale of 1 to 6, how would you rate your ability to manage stress?**
(1 = I manage stree really well, 6 = I can't cope with st**ress at all**)
Please tick only one answer.

I manage my stress very well					I can't cope with stress at all
1	2	3	4	5	6
☐	☐	☐	☐	☐	☐

Body image

104 Body image

For women

Which of these body types best describes you at the following age?
(If you seem to be hesitating between two body types, tick both).

Currently								
When you were 8 years old								
When you had your first period								
When you were 30 years old (please leave blank if you are not 30 yet)								
When you were 45 years old (please leave blank if you are not 45 yet)								
When your period stopped ("stopped" means you have not had your period for the last 12 months or more; please leave blank if you are still menstruating)								
When you were 60 years old (please leave blank if you are not 60 yet)								

For men

Which of these body types best describes you at the following age?
(If you seem to be hesitating between two body types, tick both).

Currently								
When you were 8 years old								
When you were 30 years old (please leave blank if you are not 30 yet)								
When you were 45 years old (please leave blank if you are not 45 yet)								
When you were 60 years old (please leave blank if you are not 60 yet)								

Operations

105 **Have you undergone any of the following operations?**
Please tick when the operation has taken place.
Multiple answers possible.

- ☐ I have never had an operation before
- ☐ Heart valve surgery
- ☐ Coronary angioplasty (PTCA) with or without stenting
- ☐ Coronary artery bypass grafting
- ☐ Placement of a pacemaker
- ☐ Balloon dilation of a leg vein with or without stenting
- ☐ Peripheral leg artery bypass surgery
- ☐ Carotid artery surgery
- ☐ Spinal surgery (e.g. herniated disc, sciatica)
- ☐ Knee surgery
- ☐ Knee prosthesis
- ☐ Hand or arm surgery (e.g. carpal tunnel operation)
- ☐ Shoulder surgery
- ☐ Ankle or foot surgery (Hallux valgus)
- ☐ Hip surgery
- ☐ Hip prosthesis implantation
- ☐ Appendix surgery
- ☐ Spleen surgery
- ☐ Throat or tonsil surgery
- ☐ Thymus
- ☐ Operation on polyps in the paranasal sinuses
- ☐ Gall bladder operation
- ☐ Thyroid operation
- ☐ Uterine operation (women)
- ☐ Ovarian operation (women)
- ☐ Operation on left breast
- ☐ Operation on right breast
- ☐ Prostate surgery (men)
- ☐ Other, please specify _____

Use of medical services

106 **Do you have a family doctor (GP)??**
Please tick only one answer.

☐ No (please go to question 108)

☐ Yes

☐ I don’t know

107 **How many times have you consulted your family doctor in the last 12 months?**
Please give an number, even if it's an approximation.

times

108 **In the last 12 months, how many times have you consulted the specialists shown on the following list?** *Please take into account consultations at a medical practice or prevention centre (even if the doctor himself was not met) and home visits. Do not include telephone consultations. If applicable, please tick the box and specify the number of visits. Multiple answers possible.*

☐ None of the following specialties	
Specialist in	**Number of visits (in the past 12 months)**
☐ General medicine	☐☐☐
☐ Internal medicine	☐☐☐
☐ Otorhinolaryngology, ENT	☐☐☐
☐ Ophthalmology	☐☐☐
☐ Radiology	☐☐☐
☐ Neurology	☐☐☐
☐ Psychiatry	☐☐☐
☐ Psychology	☐☐☐
☐ Urology	☐☐☐
☐ Orthopaedics	☐☐☐
☐ Metabolic disorders / Diabetology	☐☐☐
☐ Pneumology	☐☐☐
☐ Dermatology / Allergology	☐☐☐
☐ Gynaecology	☐☐☐
☐ Alternative medicine / Complementary medicine	☐☐☐
☐ Other: _____	☐☐☐

109 **What year did you last visit a dental practice?**

1. ☐ Dental examination year of visit: ☐☐☐☐ ☐ never visited

2. ☐ Dental hygiene year of visit: ☐☐☐☐ ☐ never visited

110 **What was the main reason for your last visit to the dentist?**
Please tick only one answer.

☐ I went for a check-up on my own initiative

☐ My dentist suggested a check-up

☐ Placement of a dental composite (alternative to a filling)

☐ Placement of a filling

☐ Replacement of a filling

☐ Tooth extraction

☐ Placement of a crown, bridge, prosthesis or implant (including denture repair)

☐ Gum problems (periodontal disease)

☐ Correction of tooth position (braces)

☐ Dental pain

☐ Other

111 **How many amalgams ("dark" fillings) or fillings with dental composite (resin) do you currently have, or have you had?**

		None	1	2	3	4	≥5	Exact number unknown
1.	Amalgam, **current**	☐	☐	☐	☐	☐	☐	☐
2.	Amalgam, **former**	☐	☐	☐	☐	☐	☐	☐
3.	**Current** dental composite (resin)	☐	☐	☐	☐	☐	☐	☐

112 **In the last 12 months, how many times have you been hospitalised in a standard hospital or a specialised clinic?** *Please give a number (even an approximate one), taking into account all stays with the exception of spa treatments and childbirth (transfer from one hospital to another counts as one stay). If you haven't been hospitalised in the last 12 months, please enter 0.*

1. Number of stays in the last 12 months ☐☐☐

2. Total number of nights at the hospital in the last 12 months ☐☐☐

113 **In the last 12 months, did you visit the emergency room (hospital, outpatient clinic, policlinic or private clinic)?**
***Please tick only one answer**.*

☐ No

☐ Yes

☐ I don't know

114 **In the last 12 months, have you undergone outpatient rehabilitation or rehabilitation in a specialised department? *Multiple answers possible.***

☐Yes, on an outpatient basis - What was the reason?

☐Yes, in a specialised department - What was the reason?

☐ No (please continue to question 117)

115 **How many days did your outpatient rehabilitation last?**

☐☐☐ outpatient days

116 **How long did your rehabilitation in a specialised department last?**

☐☐☐ inpatient days

117 **In the last 12 months, have you consulted any of the following therapists?**

1.	Naturopath	☐ Yes	☐ No
2.	Kinesiologist/Physiotherapist	☐ Yes	☐ No
3.	Psychologist	☐ Yes	☐ No
4.	Other, please specify	_____	

Medication and therapy

118 **At present, how many drugs do you regularly use (an approximation is fine) (i.e. at least once a week for at least one month), including painkillers, tranquillisers, sleeping pills and natural treatments (tablets, syrups, nasal sprays, eye drops, suppositories, injections, ointments, etc.)?**
If you do NOT take medication regularly, please enter 0.

☐☐☐ Number of medications used regularly

119 **Please give the name and intake frequency for all the drugs you are using (including painkillers, tranquillisers, sleeping pills and natural treatments).**
Please tick only one answer per row.

Drug name (dose):	Several times a day	Once a day	Several times a week	Once a week
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

120 **Have you ever undergone chemotherapy or radiotherapy?**
Multiple answers possible.

☐ No

☐ Chemotherapy _____*(please indicate year(s) of treatment)*

☐ Radiotherapy _____*(please indicate year(s) of treatment)*

Reproductive health

121 **Do you have any biological children?**

☐ No (continue to question 123)

☐ Yes, total number of biological children? _____

122 **For each of your biological children, please indicate their sex, year of birth, birth weight, whether they were breastfed (even partially) and, if so, for how many months:**

Child	Sex		Year of birth	Birth weight	Breastfeeding			Malformation (e.g. heart malformation, cleft lip...)
	♂	♀			Yes	No	Number of brestfeeding months*	
1	☐	☐	_ _ _ _	_____g	☐	☐	_ _	
2	☐	☐	_ _ _ _	_____g	☐	☐	_ _	
3	☐	☐	_ _ _ _	_____g	☐	☐	_ _	
4	☐	☐	_ _ _ _	_____g	☐	☐	_ _	

* if you breastfed for less than a month, indicate "0"; between 1 and 2 months, indicate "1", etc.

123 **Have you or your partner ever suffered a miscarriage or stillbirth?**

☐ No

☐ Yes

If yes: how many times? _____

on what week(s) of pregnancy? _____

☐ I do not wish to answer

124 **Have you ever tried to conceive a child for at least 1 year, but without success?**

☐ No

☐ Yes

if yes: has a medical diagnosis been made?
☐ No
☐ Yes, diagnosis: ☐ Male infertility, please specify: _____
☐ Female infertility, please specify: _____
☐ Other, please specify: _____
☐ Reason unknown

☐ I do not wish to answer

Women's health

125 **At what age did you have your first period?**

☐☐ years old

☐ I do not wish to answer

126 **When did you last have your period?**

☐ 3 months ago or less

date (day-month-year): ☐☐ / ☐☐ / ☐☐☐☐

☐ Between 3 and 12 months ago

date (day-month-year): ☐☐ / ☐☐ / ☐☐☐☐

☐ More than 12 months ago

years ☐☐☐☐

☐ I don't know

☐ I do not wish to answer

127 **According to your last 3 cycles, are your periods...?**

☐ Naturally regular

☐ Regular when on hormone treatment (e.g. pill)

☐ Irregular

☐ I don't know

☐ I do not wish to answer

128 **How long do your menstrual cycles last on average?**

☐☐ Number of days

☐ My cycles are too irregular

☐ I do not wish to answer

129 **What is the reason behind the absence of menstruation for the past 3 months or more?**
Please tick only one answer.

☐ I'm menopausal or post-menopausal

☐ I am pregnant

☐ I am breast-feeding

☐ I am an elite sportswoman

☐ I am taking a continuous hormonal treatment (pill, IUD or other)

please specify: _____

☐ I have had my uterus removed

☐ I have had both ovaries removed

☐ Other situation

please specify: _____

☐ I don't know

☐ I do not wish to answer

130 **Are you under or have you ever been under hormone replacement therapy such as the intake of oestrogens, progestins or a combination of the 2 (e.g. to treat menopausal symptoms or an absence of menstrual periods)?** *Please considerall forms of treatment: tablets, creams or gels, patches, injections, suppositories or drops. Please tick only one answer.*

☐ No

☐ Yes, I have been in the past

☐ Yes

☐ I don't know

☐ I do not wish to answer

131 **Are you currently using a hormonal contraceptive method?**

☐No
☐Yes

If yes, please specify:

☐ Pill

☐ Hormonal implant

☐ Hormonal IUD

☐ Copper IUD

☐ Vaginal ring

☐ Other hormonal treatment

Product name: _____

Since when? _____

☐ I do not wish to answer

We value your opinion

132 **If you have any further information for us, please use the space below to provide any suggestions, requests, comments or criticism.**

_____

_____

_____

_____

_____

_____

For me. For all.
Swiss health study

Pilot phase

Living environment and exposures

Thank you for filling in the questionnaire below.
We are truly grateful for your time!

The following questions concern your environment and lifestyle. Unless stated otherwise, they concern the address where you spend most of your time, including night time.

1 How many people live in your main household (including yourself)?

Number of people : _____of which :

0-5 years old Number : _____

6-10 years old Number : _____

11-18 years old Number : _____

Over 18 years old Number : _____

2 How many pets do you have in your main household?

☐ I do not have any pets

I have the following pets :

☐ Dog(s) Number : _____

☐ Cat(s) Number : _____

☐ Rabbit(s) Number : _____

☐ Rodent(s) Number : _____

Other pet(s) (species and number):

Specie : _____ Number : _____

Specie : _____ Number : _____

Specie : _____ Number : _____

Specie : _____ Number : _____

3 **Where is your main home?**
Multiple answers possible.

☐ In the city centre

☐ Near the city/suburb

☐ In an industrial area

☐ In the countryside/in a village

☐ Adjacent to cultivated agricultural land,
distance to the nearest field/agricultural land in metres: | | | |

☐ Other _____

4 **How far away (as the crow flies) from your main home is the nearest transit road (heavy traffic)?**

☐ 0 - 10m

☐ 10m – 50m

☐ 50m – 100m

☐ 100m – 500m

☐ more than 500m

5 **What type of accommodation do you live in?** *Only one answer (row) possible. Please indicate the number of rooms excluding the kitchen and bathroom(s).*

☐ Rented apartment Size (m^2) _____ number of room(s)_____

☐ Owned apartment Size (m^2) _____ number of room(s)_____

☐ Rented house Size (m^2) _____ number of room(s)_____

☐ Owned house Size (m^2) _____ number of room(s)_____

☐ Other : _____ Size (m^2) _____ number of room(s)_____

6 **On which floor of your main residence are the kitchen, living room and bedroom?**
Please tick what applies for each row.

	Basement	Ground floor/ (raised) ground floor	1st floor	2nd floor	3rd floor	Higher	Which floor ?
1 Kitchen	☐	☐	☐	☐	☐	☐	_____
2 Living room	☐	☐	☐	☐	☐	☐	_____
3 Bedroom	☐	☐	☐	☐	☐	☐	_____

7 **When was your main residence built?**
If you do not know exactly, please give an estimate.

☐ My main residence was built in:_____

Approximate year of construction :

☐ before 1918

☐ 1918-1933

☐ 1934-1949

☐ 1950-1965

☐ 1966-1974

☐ 1975-1988

☐ 1989-1997

☐ 1998-2008

☐ after 2008

☐ I don’t know exactly

8 **Is your main residence labelled Minergie?**

☐ Yes

☐ No

☐ I don't know

9 **Is the basement/part of the basement in your main residence made of clay (not concrete)?**

☐ Yes

☐ No

☐ I don't know

10 **What material are the floors in your living room, bedroom and the rest of your home made of?**
One answer per column.

		Living room	Bedroom	Other rooms
1	Wood (parquet flooring, planks)	☐	☐	☐
2	Cork	☐	☐	☐
3	Laminated	☐	☐	☐
4	PVC	☐	☐	☐
5	Linoleum	☐	☐	☐
6	Tiles (e.g. stone, marble, terrazzo)	☐	☐	☐
7	Carpet: Synthetic fibres	☐	☐	☐
8	Carpet: Natural fibres	☐	☐	☐
9	Other material (please specify) ?	_____	_____	_____
10	I do not know	☐	☐	☐

Have you laid out movable carpets (i.e. play rugs, bath mats, runners, NOT carpeting)?

11	Presence of movable carpets	☐	☐	☐

11 **Do you have any of the following problems in your main residence ?**
Only one answer per row.

		Yes	No	I don't know
1	Mould or mildew stains on walls or other surfaces	☐	☐	☐
2	Water damage (e.g. broken pipes, leaking roof, water in the cellar...)	☐	☐	☐
3	Musty or mouldy smell	☐	☐	☐
4	Humidity issues (e.g. peeling paint on walls or window sills)	☐	☐	☐
5	Radon (concentration above 300 Bq/m3)	☐	☐	☐

12 **How many hours a day on average do you spend outdoors?**
- **During warm months (May-September) and cold months (October-April)**
- **During the week and during the weekends**

Please tick only one answer per row.

Hours per day		Rarely / never	0-1h	1-2h	2-3h	3-4h	More than 4h
1	During warm months – on week days (Mon-Fri)?	☐	☐	☐	☐	☐	☐
2	During warm months - on weekends (Sat-Sun)?	☐	☐	☐	☐	☐	☐
3	During cold months - on week days (Mon-Fri)?	☐	☐	☐	☐	☐	☐
4	During cold months - on weekends (Sat-Sun)?	☐	☐	☐	☐	☐	☐

13 **Are you or have you been regularly exposed to dust or smoke in your immediate living environment (outside the home)?**
If yes, please specify number of years.
Please take into account all the dwellings you occupy. One answer only.

	No	Yes, currently or within the last 3 years	Yes, more than 3 years ago	Number of years of exposure
Dust or smoke (other than tobacco smoke, e.g. dust from unpaved roads, wood fire smoke)	☐	☐	☐	☐☐

14 **How often do you usually cook for yourself?**

☐ Rarely/never (1 time per month or less) → **go to question 18**

☐ 2 to 4 times per month

☐ 2 to 4 times per week

☐ At least 5 times per week

15 **What kind of cooker do you normally use for cooking?**
Multiple answers possible.

☐ Electric, Ceramic hob

☐ Induction

☐ Gas

☐ Pyrolysis oven

☐ Wood, coal

☐ Other (please specify) : _____

16 **If you have an extractor fan above the cooker: how often is it switched on during cooking?**

☐ I don't have an extractor above my cooker

☐ Always on

☐ Mostly on (50-100% of the time)

☐ Sometimes on (20-50% of the time)

☐ Rarely on (0-20% of the time)

☐ Never on

17 **How often is a door or window to the outside open while cooking?**

☐ Always

☐ Mostly (50-100% of the time)

☐ Sometimes (20-50% of the time)

☐ Rarely (0-20% of the time)

☐ Never

18 **How often do you use an open fireplace (Sweden stove excluded)? Please distinguish between warm and cold seasons.**
Please tick only one answer per row.

		Never / I do not have an open fireplace	On less than 1 day per week	On 1-3 days per week	On 4-7 days per week
1	Warm season (May - September)	☐	☐	☐	☐
2	Cold Season (October - April)	☐	☐	☐	☐

19 **How often do candles (excluding scented candles) burn in your home? Distinguish between warm and cold seasons.**
Please tick only one answer per row.

		Never	Less than once a month	1-3 times a month	1-3 days a week	4-7 days a week
1	Warm season (May - September)	☐	☐	☐	☐	☐
2	Cold Season (October - April)	☐	☐	☐	☐	☐

20 **How often do you use scented candles or incense in your home? Think of the times of more intensive use.**
Please tick only one answer per statement.

		Never	Less than once a month	1-3 times a month	1-3 days a week	4-7 days a week
1	Scented candles	☐	☐	☐	☐	☐
2	Incense sticks	☐	☐	☐	☐	☐

21 **Do you usually sleep with the window open? Please distinguish between warm and cold seasons.**
Please tick only one answer per row.

		Never	Less than once a week	1-2 times a week	2-5 times a week	Always
1	Warm season (May - September)	☐	☐	☐	☐	☐
2	Cold Season (October - April)	☐	☐	☐	☐	☐

22 **To what extent does traffic noise bother you with your window open?**
Only one answer possible.

There is no noise						The noise does not bother me at all					The noise bothers me extremely / is unbearable
	1	2	3	4	5	6					
☐	☐	☐	☐	☐	☐	☐					

23 **How sensitive are you to noise?**
Please tick only one answer.

I am not at all sensitive to noise					I am very sensitive to noise
1	2	3	4	5	6
☐	☐	☐	☐	☐	☐

24 **How often do you use the following products?**
One possible answer per row.

		Never	Less than once per month	1-3 times per month	1-3 times per week	4-7 times per week	More than once per day
1	Cleaning sprays (e.g. for bathrooms or glass cleaning)	☐	☐	☐	☐	☐	☐
2	Air freshener, room perfumer (Spray, Vaporiser)	☐	☐	☐	☐	☐	☐
3	Insecticides (sprays, diffusers)	☐	☐	☐	☐	☐	☐
4	Mould remedies (sprays, diffusers)	☐	☐	☐	☐	☐	☐
5	WC cleaner (liquid, powder, excluding all-purpose cleaner)	☐	☐	☐	☐	☐	☐
6	Liquid glue (excluding stick glue)	☐	☐	☐	☐	☐	☐

25 **How often do you use the following products?**
One possible answer per row.

		Never	Less than once per month	1-3 times per month	1-3 times per week	4-7 times per week	More than once per day
1	Deodorant Spray	☐	☐	☐	☐	☐	☐
2	Deodorant roll-on, cream, etc. (NO spray)	☐	☐	☐	☐	☐	☐
3	Body lotion	☐	☐	☐	☐	☐	☐
4	Hand cream	☐	☐	☐	☐	☐	☐
5	Perfume	☐	☐	☐	☐	☐	☐
6	Hairspray (NO other hair care products)	☐	☐	☐	☐	☐	☐
7	Toothpaste	☐	☐	☐	☐	☐	☐

26 **For the above personal care products, could you please tell us which product you use most often?** *Please state the name and brand as completely as possible, e.g. deodorant roll-on: Nivea Roll-on dry comfort.*

		Product's name and brand
1	Deodorant Spray	_____
2	Deodorant roll-on, cream, etc.	_____
3	Body lotion	_____
4	Hand cream	_____
5	Perfume	_____
6	Hairspray	_____
7	Toothpaste	_____

27 **How often do you use a deodorant that contains aluminium salts?**

☐ Often (more than 5 times per week)

☐ Now and then (1-5 times per week)

☐ Never or rarely (less than 1 time per week)

☐ I don't know

28 **Have you ever smoked for more than a year? ("Yes" means at least 1 cigarette/e-cigarette/ per day or 1 cigar/cigarillos/pipe/shisha per week for 1 year).**
Only one answer possible per product. If you are or have been a smoker, please specify the age at which you started or stopped smoking.

		No, never smoked	Yes, I am currently a smoker	Yes, I used to smoke	I currently smoke, I started at the age of :	I used to smoke, I stopped at the age of :
1	Cigarettes	☐	☐	☐	___ ___	___ ___
2	Cigars/cigarillos	☐	☐	☐	___ ___	___ ___
3	Pipe	☐	☐	☐	___ ___	___ ___
4	E-cigarette (liquid-based)	☐	☐	☐	___ ___	___ ___
5	Heated tobacco products (heat-not-burn, e.g. IQOS, Ploom, glo)	☐	☐	☐	___ ___	___ ___
6	Shisha	☐	☐	☐	___ ___	___ ___
7	Other tobacco products (e.g. snuff, chewing tobacco) Please specify					
	_____	☐	☐	☐	___ ___	___ ___
	_____	☐	☐	☐	___ ___	___ ___

29 **How often do or did you smoke the following tobacco products, on average?** *Please indicate **either** the number per day **or** per week?*

		Number per day		Number per week
1	Cigarettes	☐☐☐	**or**	☐☐☐
2	Cigars/cigarillos	☐☐☐	**or**	☐☐☐
3	Pipe	☐☐☐	**or**	☐☐☐
4	E-cigarette (liquid-based)	☐☐☐	**or**	☐☐☐
5	Heated tobacco products (heat-not-burn, e.g. IQOS, Ploom, glo)	☐☐☐	**or**	☐☐☐
6	Shisha	☐☐☐	**or**	☐☐☐
7	Other tobacco products (e.g. snuff, chewing tobacco) *Please specify*. _____	☐☐☐	**or**	☐☐☐
	_____	☐☐☐	**or**	☐☐☐

30 **Have you been regularly exposed to tobacco smoke in the last 12 months? Regularly means most days or nights.**
Please tick only one answer.

☐ No

☐ Yes
If yes, where have you been exposed to tobacco smoke (home, work)?

_____

31 **During how many years in total were you regularly exposed to tobacco smoke from other people? Please also consider your childhood.**

☐☐ years

32 **To the best of your knowledge, did your parents smoke tobacco before you were conceived or during pregnancy?**
One answer per row.

		Yes	No	I don't know
1	My mother smoked tobacco regularly before I was conceived	☐	☐	☐
2	My mother was regularly exposed to tobacco smoke (passive smoking) before I was conceived	☐	☐	☐
3	My mother smoked tobacco regularly during pregnancy	☐	☐	☐
4	My mother was regularly exposed to tobacco smoke during pregnancy (passive smoking)	☐	☐	☐
5	My father smoked tobacco regularly before I was conceived	☐	☐	☐

33 **Have you ever used drugs (e.g. hashish, cocaine or others) in your life or do you use them regularly? Which ones and how often?**

		Never	Once	Rarely	Monthly	Weekly	Daily
1	Cannabis	☐	☐	☐	☐	☐	☐
2	Ecstasy	☐	☐	☐	☐	☐	☐
3	Cocaine	☐	☐	☐	☐	☐	☐
4	Heroin	☐	☐	☐	☐	☐	☐
5	Speed	☐	☐	☐	☐	☐	☐
6	LSD	☐	☐	☐	☐	☐	☐
7	Other (please specify)						
	_____	☐	☐	☐	☐	☐	☐
	_____	☐	☐	☐	☐	☐	☐

I do not wish to answer ☐

34a **How often do you eat the following foods?**
Two answers per row : frequency of consumption and percentage of organic products.

										How often do you consume these organic products?				
		Rarely / Never	Once a month	Every 2 weeks	1-2 times a week	3-6 times a week	Once a day	2-3 times a day	4 times a day and more	<10%	10-50%	50-90%	>90%	I do not know
1	Animal milk (including in coffee, tea, muesli, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	Animal milk products (yoghurt, quark, cream cheese, drinking yoghurt etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	Cheese (hard cheese, soft cheese)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	Eggs (breakfast egg, omelette etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	Poultry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	Meat (beef, pork, veal, game, etc., EXCLUDING poultry)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	Processed meat (sausages, cold cuts, dried meat, ready-made hamburgers, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	Tofu, quorn	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	Fish, seafood, fish products (fish fingers etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	Cereal products (pasta, rice, bread, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

34b **How often do you eat the following foods?**
Two answers per row : frequency of consumption and percentage of organic products.

										How often do you consume these organic products?				
		Rarely / Never	Once a month	Every 2 weeks	1-2 times a week	3-6 times a week	Once a day	2-3 times a day	4 times a day and more	<10%	10-50%	50-90%	>90%	I do not know
11	Breakfast cereals (muesli, oatmeal, corn flakes, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12	Wholegrain cereals (wholemeal bread, wholegrain rice, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13	Potatoes, potato dishes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14	Pulses (lentils, chickpeas, peas)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15	Fruits	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16	Cooked vegetables (excluding pulses)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17	Raw vegetables, salad	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18	Nuts and unsalted seeds (walnuts, hazelnuts, peanuts, sesame, linseed, sunflower seeds)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

34c **How often do you eat the following foods?**
Two answers per row : frequency of consumption and percentage of organic products.

										How often do you consume these organic products?				
		Rarely / Never	Once a month	Every 2 weeks	1-2 times a week	3-6 times a week	Once a day	2-3 times a day	4 times a day and more	<10%	10-50%	50-90%	>90%	I do not know
19	Sweets and desserts (e.g. chocolate, biscuits, ice cream, cakes)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20	Salty snacks (e.g. crisps, salty sticks, puff pastry, salted nuts)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

35 **What type of fish (including canned fish) or seafood do you eat most often?**

Please tick no more than two answers.

☐ Tuna

☐ Salmon

☐ Pangasius

☐ Tilapia

☐ Trout

☐ Shrimp

☐ Fish fingers

☐ Other (please specify) : _____

☐ I don't know

36 **In general, do you add salt to your food at the table when you eat?**
One answer per column only.

		When you eat at home	When you eat out
No, never	(0 out of 10 meals)	☐	☐
Yes, occasionally	(1-5 out of 10 meals)	☐	☐
Yes, most of the time	(6-9 out of 10 meals)	☐	☐
Yes, always	(10 out of 10 meals)	☐	☐

37 **What fats/oils do you mainly use at home for cooking?**
Please tick a maximum of 4 answers.

☐ Olive oil

☐ Sunflower oil

☐ Rapeseed oil

☐ Walnut oil

☐ Frying oil / Roasting fat

☐ Butter

☐ Margarine

☐ Whole cream

☐ Half cream

☐ Other, please specify _____

☐ I don't know _____

38 **How often do you usually eat outside the home? In a restaurant, canteen, cafeteria, kebab stand, etc.**

☐ More than 7 meals per week

☐ 5-7 meals per week

☐ 2-4 meals per week

☐ 1 meal per week

☐ 1 meal per month

☐ Less than one meal per month

☐ Never

39 **Of the meals you eat out, how many would you say are prepared using only organic products (to your knowledge)?**

☐ Less than 10% of meals

☐ 10-50% of meals

☐ 50-90% of meals

☐ More than 90% of meals

40 **How often do you eat hot meals from disposable packages / take-away? E.g. from McDonalds, Migros take-away, kebab stand, supermarket, etc.**
Please tick only one answer.

☐ More than 7 meals per week

☐ 5-7 meals per week

☐ 2-4 meals per week

☐ 1 meal per week

☐ 1-2 meals per month

☐ Less than one meal per month

☐ Never

41 **What diet do you follow?**
Only one answer possible per numbered sub-question.

		Since when? (in MONTHS; if you have been following this specific diet for more than 9 years please write down 99)
1	☐ Omnivorous (mixed diet, animal and plant products) ☐ Pesco-vegetarian (no meat/poultry) ☐ Ovo-lacto-vegetarian (no meat/poultry, no fish/seafood) ☐ Vegan (no animal products)	☐☐
2	☐ No particular diet ☐ Lactose-free ☐ Gluten-free ☐ Ketogenic (low carbohydrate) ☐ Other (please specify) : _____	☐☐

3 **Is there a specific reason for following this type of diet?**

☐ Weight loss
☐ Diabetes
☐ Reduction of cholesterol and fat intake
☐ Other (please specify) : _____
☐ No specific reason

42 **Do you take vitamins, trace elements or other supplementary micronutrients?**
Multiple answers possible. Please mark with a cross where applicable.

		Daily	Weekly	Prescribed by a doctor	No, I do not take any
1	Vitamins, please specify _____	☐	☐	☐	☐
2	Minerals, please specify _____ (magnesium, calcium, iron, zinc, etc…)	☐	☐	☐	☐
3	Combined preparations (minerals and vitamins), please specify _____	☐	☐	☐	☐
4	Other, please specify _____	☐	☐	☐	☐

43 **Do you take any other food supplements?**
Multiple answers possible. Please mark with a cross where applicable.

		Daily	Weekly	Prescribed by a doctor	No, I do not take any
1	Proteins	☐	☐	☐	☐
2	Carbohydrate preparations (e.g. isotonic drinks)	☐	☐	☐	☐
3	Dietary supplementation for athletes, please specify _____	☐	☐	☐	☐
4	Other, please specify _____	☐	☐	☐	☐

44 **How much of the following beverages do you usually drink in a day? 1 glass corresponds to 0.2 L (2dL).** *One answer per row.*

		More than 3 litres per day	2-3 litres per day	1-2 litres per day	0.5-1 litres per day	2-3 glasses per day (2-5 dL)	1 glass per day	1-6 glasses per week	Less than 1 glass per week
1	Tap water	☐	☐	☐	☐	☐	☐	☐	☐
2	Bottled mineral water	☐	☐	☐	☐	☐	☐	☐	☐
3	Fruit juices (100% juice)	☐	☐	☐	☐	☐	☐	☐	☐
4	Fruit nectar	☐	☐	☐	☐	☐	☐	☐	☐
5	Vegetable juices	☐	☐	☐	☐	☐	☐	☐	☐
6	Unsweetened beverages (e.g. coffee, black/green tea, herbal tea, fruit tea, flavoured water)	☐	☐	☐	☐	☐	☐	☐	☐
7	Sweet beverages (e.g. sweetened coffee or tea, cola, lemonade, iced tea, syrup, chocolate drinks, energy drinks (EXCEPT "light" or "zero" beverages)	☐	☐	☐	☐	☐	☐	☐	☐
8	Sugar-sweetened beverages (e.g. diet tea, Rivella blue, cola light, cola zero, diet energy drinks)	☐	☐	☐	☐	☐	☐	☐	☐
9	Alcoholic beverages (e.g. beer, wine, spirits, liqueurs, alcopops, etc.)	☐	☐	☐	☐	☐	☐	☐	☐
10	Drinks containing caffeine or tea (including those already mentioned above: e.g. coffee, black/green tea, energy drinks, cola)	☐	☐	☐	☐	☐	☐	☐	☐

45 **What brand of mineral water do you usually drink? Please specify whether it is still, medium or sparkling water.**

_____

☐ I do not drink bottled mineral water

46 **When you drink alcoholic beverages, how many drinks do you usually have per occasion?**
A standard drink corresponds to approximately 3 dL of beer (5 vol.%), 1 dL of wine (12.5 vol.%), 4 cL of liqueur (30 vol.%), 2 cL of strong alcohol (55 vol.%). One answer only.

☐ Never / less than 1 a day

☐ 1 or 2

☐ 3 or 4

☐ 5 or 6

☐ 7-9

☐ 10 or more

47 **If you have any further information for us, please use the space below to provide any suggestions, requests, comments or criticism.**

_____

_____

_____

_____

_____

_____


Thank
you!

For me. For all.
Swiss health study

Pilot phase

Quality of life

Please read and answer each question. We ask that you think about your life and how you've been feeling in the last 2 weeks.

Please tick the number on the scale, that appears most appropriate for your situation.

		Very poor	Poor	Neither poor nor good	Good	Very good
1	How would you rate your quality of life?	☐	☐	☐	☐	☐

Please tick the number on the scale, that appears most appropriate for your situation.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2	How satisfied are you with your health?	☐	☐	☐	☐	☐

The following questions ask about how much you have experienced certain things in the last two weeks.

Please tick only one answer for each question.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	☐	☐	☐	☐	☐
4	How much do you need any medical treatment to function in your daily life?	☐	☐	☐	☐	☐
5	How much do you enjoy life?	☐	☐	☐	☐	☐
6	To what extent do you feel your life to be meaningful?	☐	☐	☐	☐	☐

Please tick only one answer for each question.

		Not at all	A little	A moderate amount	Very much	Extremely
7	How well are you able to concentrate?	☐	☐	☐	☐	☐
8	How safe do you feel in your daily life?	☐	☐	☐	☐	☐
9	How healthy is your physical environment (pollution, noise, cleanliness/hygiene, etc.)?	☐	☐	☐	☐	☐

The following questions ask about how completely you experience or were able to do certain things in the last two weeks.

Please tick only one answer for each question.

		Not at all	A little	Moderately	Mostly	Completely
10	Do you have enough energy for everyday life?	☐	☐	☐	☐	☐
11	Are you able to accept your bodily appearance?	☐	☐	☐	☐	☐
12	Do you have enough money to meet your needs?	☐	☐	☐	☐	☐
13	How available to you is the information you need in your day-to-day life?	☐	☐	☐	☐	☐
14	To what extent do you have the opportunity for leisure activities?	☐	☐	☐	☐	☐

Please tick only one answer for each question.

		Very poor	Poor	Neither poor nor good	Good	Very good
15	How well are you able to get around (physically)?	☐	☐	☐	☐	☐

The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks.

Please tick only one answer for each question.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16	How satisfied are you with your sleep?	☐	☐	☐	☐	☐
17	How satisfied are you with your ability to perform your daily living activities?	☐	☐	☐	☐	☐
18	How satisfied are you with your capacity for work?	☐	☐	☐	☐	☐

Please tick only one answer.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
19	How satisfied are you with yourself?	☐	☐	☐	☐	☐

Please tick only one answer for each question.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
20	How satisfied are you with your personal relationships?	☐	☐	☐	☐	☐
21	How satisfied are you with your sex life?	☐	☐	☐	☐	☐
22	How satisfied are you with the support you get from your friends?	☐	☐	☐	☐	☐
23	How satisfied are you with the conditions of your living place?	☐	☐	☐	☐	☐

Please tick only one answer.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
24	How satisfied are you with your access to health services?	☐	☐	☐	☐	☐

Please tick only one answer.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
25	How satisfied are you with your transport?	☐	☐	☐	☐	☐

The following question refers to how often you have felt or experienced certain things in the last two weeks.

Please tick only one answer.

		Never	Seldom	Quite often	Very often	Always
26	How often do you have negative feelings such as blue mood, despair, anxiety or depression?	☐	☐	☐	☐	☐

If you have any further information for us, please use the space provided for suggestions, requests, comments or criticism.

27

_____

_____

_____

_____

Thank you!

For me. For all.
Swiss health study

Pilot phase

Covid-19

Covid-19

1 **Are you or have you ever been ill with Covid-19? If so, when (start date)?**
One answer only.

☐ Yes, the disease has been confirmed by a doctor Date : _ _ / _ _ / _ _ _ _

☐ Yes, without doctor confirmation Date : _ _ / _ _ / _ _ _ _

☐ No

☐ I don’t know

2 **Have you been tested for SARS-CoV-2?**
One answer only.

☐ Yes

☐ No

3 **If you were tested, what were the results and circumstances of the test(s)?**
Please answer as precisely as possible.

Test date	**Reason(s) for testing** *multiple answers possible*	**Results**	**Type of test** *if known*
_ _ . _ _ . 2020	□ I had symptoms □ I had been in contact with an infected person □ I was part of a scientific study □ I am a medical/care worker □ Other	□ Positive □ Negative □ Inconclusive	□ Virus detection (PCR), after smear □ Serological analysis, after blood test
_ _ . _ _ . 2020	□ I had symptoms □ I had been in contact with an infected person □ I was part of a scientific study □ I am a medical/care worker □ Other	□ Positive □ Negative □ Inconclusive	□ Virus detection (PCR), after smear □ Serological analysis, after blood test
_ _ . _ _ . 2020	□ I had symptoms □ I had been in contact with an infected person □ I was part of a scientific study □ I am a medical/care worker □ Other	□ Positive □ Negative □ Inconclusive	□ Virus detection (PCR), after smear □ Serological analysis, after blood test
_ _ . _ _ . 2020	□ I had symptoms □ I had been in contact with an infected person □ I was part of a scientific study □ I am a medical/care worker □ Other	□ Positive □ Negative □ Inconclusive	□ Virus detection (PCR), after smear □ Serological analysis, after blood test

4 **If you have had Covid-19, what were the symptoms?** *Please indicate which ones and their degree of severity.*

☐ I had no symptoms (asymptomatic)

☐ I had symptoms *if ticked, please fill in the following table*

☐ I don't remember

Symptoms / Complications	**Yes**	**No**
Fever (= 38°C) or feverish feeling	☐	☐
Cough	☐	☐
Respiratory disorder, shortness of breath	☐	☐
Pneumonia (confirmed by imaging)	☐	☐
ARDS (Acute Respiratory Distress Syndrome)	☐	☐
Diarrhoea and/or nausea, vomiting, stomach ache	☐	☐
Loss of smell/loss of taste	☐	☐
Fatigue	☐	☐
Sore muscles	☐	☐
Chest/sternum pain	☐	☐
Sore throat	☐	☐
Headaches	☐	☐
Stuffy nose, runny nose	☐	☐
Other *Please specify:* _____	☐	☐

5 **If you have (had) Covid-19, what treatment(s) have you had?**
Multiple answers possible.

☐ No treatment

☐ I have self-medicated

☐ I have taken medication prescribed by a doctor

Please specify:

_____

_____

☐ I was hospitalized

If ticked, please reply to the following questions:

How many days were you hospitalized?	__ __	
I received a simple non-invasive respiratory aid (goggles, mask)	☐ Yes	☐ No
I was in intensive care	☐ Yes	☐ No
I've been intubated or I had a tracheotomy	☐ Yes	☐ No
Other *Please specify* _____	☐ Yes	☐ No

6 **In your opinion or that of medical staff - had your infection been traced back to an origin, how did you become infected?** *One answer only.*

☐ Contact with family in the same household

☐ Contact with family but not in the same household

☐ Contact with friends

☐ Contact with strangers (supermarket etc.)

☐ School/kindergarten/day nursery

☐ As a member of the medical or nursing staff

☐ At work, other than medical staff

☐ On public transport

☐ Travelling abroad

☐ Other contacts, *please specify*

_____

☐ Don't know

7 **Have you been vaccinated against the following diseases?** *Please complete the following table, attach photos of your vaccination record or bring it to the study visit if applicable.*

a. Flu	☐ Yes, every year (or almost) ☐ Yes, this winter only ☐ Yes, but not this winter ☐ No ☐ I don't know
b. Tuberculosis	☐ Yes ☐ No ☐ I don't know
c. Measles, mumps, rubella	☐ Yes ☐ No ☐ I don't know
d. Diphtheria, tetanus, whooping cough	☐ Yes ☐ No ☐ I don't know
e. Tick-borne encephalitis	☐ Yes ☐ No ☐ I don't know
f. Papillomavirus	☐ Yes ☐ No ☐ I don't know
g. Hepatitis A	☐ Yes ☐ No ☐ I don't know
h. Hepatitis B	☐ Yes ☐ No ☐ I don't know
i. Yellow fever	☐ Yes ☐ No ☐ I don't know
j. Typhoid fever	☐ Yes ☐ No ☐ I don't know
k. Rabies	☐ Yes ☐ No ☐ I don't know
l. Pneumococcus	☐ Yes ☐ No ☐ I don't know

m. Meningococcus	☐ Yes ☐ No ☐ I don't know
n. Poliomyelitis (Polio)	☐ Yes ☐ No ☐ I don't know
o. Varicella	☐ Yes ☐ No ☐ I don't know
p. Shingles	☐ Yes ☐ No ☐ I don't know
q. New Coronavirus (SARS-CoV-2), if available	☐ Yes ☐ No ☐ I don't know

8 **How have your habits changed as a result of lockdown?**
One answer per row.

Aspect	No change	Worse	Better
General state of health	☐	☐	☐
Quality of life	☐	☐	☐
General quality of diet	☐	☐	☐

Aspect	No change	Worse	Better
Appetite	☐	☐	☐
Sleep	☐	☐	☐
Stress	☐	☐	☐
Social contacts	☐	☐	☐
Use of medical services	☐	☐	☐
Physical activity	☐	☐	☐
Time spent outdoors	☐	☐	☐
Use of public transport	☐	☐	☐
Fish consumption	☐	☐	☐
Frequency of self-cooking	☐	☐	☐
Consumption of locally sourced food	☐	☐	☐
Consumption of organic food	☐	☐	☐
Alcohol consumption	☐	☐	☐
Drug use	☐	☐	☐
Smoking	☐	☐	☐
Weight	☐	☐	☐
Use of cosmetics	☐	☐	☐
Screen time	☐	☐	☐
Other *Please specify:* _____	☐	☐	☐
Other *Please specify:* _____	☐	☐	☐
Other *Please specify:* _____	☐	☐	☐


Thank
you!

For me. For all.
Swiss health study

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Département fédéral de l'intérieur DFI
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SWISS BIOBANKING PLATFORM

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