

**TRANSPORT PERSONNEL HEALTH COHORT STUDY (TRAPHEAC)
SHORT BASELINE SURVEY V2**

IDENTIFYING AND GEOGRAPHICAL DATA

[IT Service]

A FEW QUESTIONS ABOUT YOU

In order to carry out the study, we would be grateful if you could provide some identification data. This information is essential to ensure the reliability of the analysis and to simplify your participation in the study.

The identification data, including your surname, first name, date of birth, address and ideally your AVS number, will be used by the Federal Statistical Office (FSO) to associate the data accurately and error-free. This approach aims to facilitate your participation by limiting the number and complexity of the questions asked.

Identification data will be stored and secured by Unisanté's IT department. More specifically, they will be stored and maintained with rigorous protection on a dedicated, secure server located in Switzerland and managed by authorized professionals for technical operations only. Only these people will have access to your data for IT management purposes (e.g. maintenance operations, portal management). The entire process is approved by the relevant ethics committee (CER-VD), guaranteeing compliance with ethical standards and the confidentiality of your information.

You will be assigned two personal, unique and de-identifying participant numbers. The first is for technical reasons and will be managed by Unisanté's IT department. The second will be the identifier used during the study. Only the SFO will have the correspondence between this study identifier and your identifying information.

We remind you that your answers will be treated as strictly confidential. The scientists carrying out the analyses will not have access to your identifying data. None of the individual results will be made public or communicated.

The questionnaire takes about 45-60 minutes to complete. We ask you to complete each section as completely as possible. You are free not to answer all the questions, but the value of the results of this survey depends above all on the information collected being as complete as possible.

1. What is/are your name(s)?

2. What is/are your first name(s)?

3. What is your date of birth?

. .

Day

Month

Year

4. What is your current address?¹ (drop-down list)

Path	N°
Additional address	
Postal code	Location
Canton	

Floor to ground :

-6+	-5	-4	-3	-2	-1	0	1	2	3	4	5	6	7	8	9	10+
<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. What is your AVS number? (optional)

. .

¹ We need this question to find out how much radon is present in your home's soil. Radon is a naturally occurring element in the earth, but its concentration can vary according to geographical region.

DEMOGRAPHICS: PERSONAL INFORMATION

A FEW QUESTIONS ABOUT YOU

This information is essential for understanding the survey results. The results **will not be individually examined**, but will be grouped together with the responses of all participants. This will enable us to make group analyses based on the criteria listed below.

1. What is your biological sex?

- Male Female Other

2. If Other: If you identify with another gender, please specify:

3. What is your current marital status?

- Single Married Divorced Widowed
 Unmarried - in a registered partnership
 Dissolved partnership (Judicially, by death or after declaration of absence)

4. What is your highest level of education? *(one answer only)*

- Primary/secondary school degree/diploma
 High school diploma
 CFC / Apprenticeship / Higher education professional maturity
 Higher education: Bachelor's
 Higher education: Master's degree/licence
 Higher education: Doctorate/PhD

5. Have you completed an apprenticeship?

- Yes No

5.1 If yes, in which field/sector of activity?

6. Did you have a professional activity before becoming a bus driver?

- Yes No

6.1 If yes, which one?

Profession / Occupation: _____

6.2 In which economic sector?

Business sector: _____

7. Are you still working as a bus driver?

Yes No => **remove following section: Working conditions**

7.1 What is your current situation (only one answer possible) :

- Retired
- Professional retraining
- On disability pension or permanent total work incapacity
- Looking for work
- Homemaker
- Another profession

8. If not, are you currently professionally active?

Yes No → skip Part C, Q3

8.1 If yes. What is your current activity?

Professional activity: _____

8.2 In which business sector?

Sector of activity : _____

8.3 When did you stop working as a bus driver?

_____ (DD:MM:YY)

Working conditions

We're now going to ask you a few questions about your working conditions. First, we'll ask you about your usual working hours, breaks and working environment. Secondly, we'll ask you how you currently experience these working conditions.

Clarification of the term "week": In this questionnaire, when we mention the term "week", we are referring to a block of work between two non-working days (your official rest days).

1. During the last 12 months, have you had irregular working hours? (Hours that change a lot during the month, such as working days and nights, or with very different shifts from one week to the next).

- Yes No → go to Q3

1.1 If yes, how many times a month do you have to work irregular hours (on average, over the last 12 months)?

- All the time
 Three-quarters of the time
 Half the time
 A quarter of the time
 Occasionally

2. Do you have a schedule rotation?

- Yes, regular Yes, irregular No → go to Q4

2.1 If yes to 2, How often are schedules rotated?

- Daily change Weekly change
 Monthly change Quarterly change
 Change every six months Other

2.2 If yes to 3, Do you have a change of tour of duty / rotation :

- Cyclic** (e.g. morning, afternoon, evening, night, then repeat in the same order)
 Alternate (e.g. morning, afternoon, evening, night, then change order, e.g. evening, afternoon, morning)
 Variable (randomly changing schedules)

2.3 What is your work pattern in terms of consecutive days worked before one or more days off?

My rhythm is regular:

I usually work ___ consecutive days before one or more days off.

- 1 day 2 days 3 days 4 days 5 days 6 days
 7 days 8 days 9 days 10 days 11 days 12 days 13 days

My rhythm is irregular/variable:

I sometimes work up to ___ consecutive days before one or more days off.

- 1 day 2 days 3 days 4 days 5 days 6 days
 7 days 8 days 9 days 10 days 11 days 12 days 13 days

There's no pattern

2.4 How many days off do you have between consecutive working days?

days

We now ask you to take a week as a block of work, which lies between two non-working days.

3. On average, how often do you work between 04h and 06h per week (work block)? *(one answer possible)*

- | | |
|---|---|
| <input type="checkbox"/> 1 time a week | <input type="checkbox"/> 2 times a week |
| <input type="checkbox"/> 3 times a week | <input type="checkbox"/> 4 times a week |
| <input type="checkbox"/> 5 times a week | <input type="checkbox"/> 6 times a week |
| <input type="checkbox"/> 7 times a week | |

4. If yes to In the evening Q1. On average, how often do you work between 8 p.m. and midnight per week (work block)? *(one answer possible)*

- | | |
|---|---|
| <input type="checkbox"/> 1 time a week | <input type="checkbox"/> 2 times a week |
| <input type="checkbox"/> 3 times a week | <input type="checkbox"/> 4 times a week |
| <input type="checkbox"/> 5 times a week | <input type="checkbox"/> 6 times a week |
| <input type="checkbox"/> 7 times a week | |

5. If yes to At night Q1. On average, how often do you work between 00:00 and 04:00 per week (work block)? *(one answer possible)*

- | | |
|---|---|
| <input type="checkbox"/> 1 time a week | <input type="checkbox"/> 2 times a week |
| <input type="checkbox"/> 3 times a week | <input type="checkbox"/> 4 times a week |
| <input type="checkbox"/> 5 times a week | <input type="checkbox"/> 6 times a week |
| <input type="checkbox"/> 7 times a week | |

6. During the last 12 months, have you also worked nights (between 11pm and 6am)

- No
- Yes, occasionally (less than 3 times a week on average over the year)
- Yes, regularly (more than 3 times a week on average over the year)

7. How many hours a DAY do you usually work?

hours AND min /day

8. How many hours per WEEK (work block) do you usually work?

hours/week

9. How many times a week have you worked over 10 hours?

Amplitude refers to the time between the start and end of the working day, including breaks.

- Never 1 time a week 2 times a week
 3 times a week 4 times a week
 5 times a week 6 or more times a week
 7 or more times a week

10. What days of the week do you usually work? (Multiple answers possible)

- Weekdays (Monday - Friday) Saturday
 Sunday

10.1 If yes for Saturday. Have you worked on any of the last 4 Saturdays?

- Yes No

10.2 If yes for Sunday. Have you worked on any of the last 4 Sundays?

- Yes No

11. During your working day, do you drive in pleasant environments?

- Yes No

11.1 If yes, why do you find them pleasant? (one answer per line)

- 11.1.1 Green spaces Yes No
- 11.1.2 Blue spaces (rivers, lakes) Yes No
- 11.1.3 Monuments, architecture Yes No
- 11.1.4 Bright, open spaces Yes No
- 11.1.5 Ease of driving Yes No

12. During your driving day, do you find yourself in traffic jams? (one answer possible)

- Never Rarely (1-2h a day)
 Frequently (2-5h a day) All the time

Your paid breaks and terminal stop

13. In general, how many paid breaks do you take a day?

breaks/day

14. In general, how long does each break last?

minutes

15. During these breaks, do you have access to:

	Never	Rarely	Sometimes	Often	Very often
Toilets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A break area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A coffee or beverage dispenser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15.1 If rarely, sometimes, often or very often for the break area. Describe this break area (several answers possible)

Outdoors

- A beautiful natural landscape
- Attractive cityscape
- A pretty rural landscape
- The presence of plants or flowers
- Is airy
- Nothing remarkable

Inside

- Green plants
- Is calm
- Includes games for relaxing (e.g. table soccer)
- Sports equipment
- Armchair, sofa, relaxation area
- Nothing remarkable

16. On a normal working day, how much time can you spend in a break area?

breaks/day

17. In general, how many times a day do you stop at the terminus?

minutes

18. In general, how long does a stop at the terminus last?

minute(s)

19. During your terminal stops, do you have access to : (one answer per line)

	Never	Rarely	Sometimes	Often	Very often
Toilets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A break area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A coffee or beverage dispenser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19.1 If rarely, sometimes, often or very often for the break area. Describe this break area (several answers possible)

Outdoors

- A beautiful natural landscape
- Attractive cityscape
- Beautiful rural scenery
- Presence of plants or flowers
- Is airy
- Nothing remarkable

Inside

- Green plants
- Is calm, unhurried
- Games for relaxing (e.g. table soccer)
- Sports equipment
- Armchair, sofa, relaxation area
- Nothing remarkable

Scale: BORG → Perception of effort

20. How would you rate the intensity of the physical effort involved in your work during a typical working day? Tick the number corresponding to your choice on the scale from 0 to 10 below, ranging from "No effort" to "Maximal effort": *(one answer possible)*

No effort	Very light	Light	Moderate	Somewhat hard	Hard	Very hard	Extremely hard	Near maximum effort	Maximal effort
0	0.5	1	2	3	4	5	6	7-9	10
<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"/>

Scale: Work-Family Conflict

21. We are now going to ask you some questions about your feelings at work. Please choose to what extent you agree or disagree with the sentences below. *(one answer per line)*

	Strongly disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree
The demands of my work interfere with my home and family life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The amount of time my job takes up makes it difficult to fulfill family responsibilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Things I want to do at home do not get done because of the demands my job puts on me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My job produces strain that makes it difficult to fulfill family duties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Due to work-related duties, I have to make changes to my plans for family activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scale: Effort-Reward Imbalance Questionnaire - Short (ERI-S)

22. The following items relate to your current profession. Indicate whether you agree or disagree with each sentence by ticking the corresponding box (*one answer per line*).

	Strongly disagree	Disagree	Agree	Strongly Agree
I have constant time pressure due to a heavy workload.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many interruptions and disturbances while performing my job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over the past few years, my job has become more and more demanding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I receive the respect I deserve from my superior or a respective relevant person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My job promotion perspectives are poor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have experienced or I expect to experience an undesirable change in my work situation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My job security is poor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Considering all my efforts and achievements, I receive the respect and prestige I deserve at work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Considering all my efforts and achievements, my job promotion prospects are adequate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Considering all my efforts and achievements, my salary / income is adequate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get easily overwhelmed by time pressures at work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As soon as I get up in the morning I start thinking about work problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When I get home, I can easily relax and 'switch off' work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People close to me say I sacrifice too much for my job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work rarely lets me go, it is still on my mind when I go to bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I postpone something that I was supposed to do today I'll have trouble sleeping at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scale: 1-item measure of job stressfulness

23. In general, how do you find your job? (one answer possible).

Not at all stressful	Mildly stressful	Moderately stressful	Very stressful	Extremely stressful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Scale: Perceived Occupational Stress Scale

24. Rate the extent to which you agree or disagree with the following propositions: (one answer per line)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
My work is stressful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking about my work makes me feel tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At work I feel under pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My work has negative effects on my health

Scale: Burnout Assessment Tool - Short (BAT-S)

25. The following statements relate to how you feel about your work and how you experience it. Please indicate how often each statement applies to you. (One answer per line)

	Never	Rarely	Sometimes	Often	Always
1. At work, I feel mentally exhausted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. After a day at work, I find it hard to recover my energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At work, I feel physically exhausted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I struggle to find any enthusiasm for my work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I feel a strong aversion towards my job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I'm cynical about what my work means to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. At work, I have trouble staying focused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I'm forgetful and distracted at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I make mistakes in my work because I have my mind on other things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. At work, I feel unable to control my emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I do not recognize myself in the way I react emotionally at work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. At work I may overreact unintentionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. Please indicate how often you encounter the following situations in your current job. (one answer per line)

	Less than once a month or never	1 time per month	2-3 times a month	About once a week	2-3 times a week approx.	Approx. once a day	Several times a day
Outside the bus...							
I suffer from the aggression of other road users (cars, bikes).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm afraid of having an accident with another vehicle (car, truck).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm afraid of having an accident with a bicycle, scooter or motorcycle.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm afraid of having an accident with my vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm afraid of causing an accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inside the bus...							
I'm subjected to verbal aggression from bus passengers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm afraid of having an accident on my bus, causing injuries.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. In the last 12 months, at your work, have you been subject to... (several answers possible)

- Age discrimination
- Discrimination based on your sex or gender
- Discrimination based on your nationality, ethnic origin or skin color
- Verbal abuse
- Threats and humiliating behaviour
- Physical violence

Bullying, harassment, mobbing

Sexual harassment

None of this discrimination or violence

Your sleep → Scale: GSAQ

1. We're going to ask you a few questions about your sleep. Choose the answer that best suits you.

	Never	Sometimes	Usually	Always
Did you have difficulty falling asleep, staying asleep, or feeling poorly rested in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you fall asleep unintentionally or have to fight to stay awake during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did sleep difficulties or daytime sleepiness interfere with your daily activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did work or other activities prevent you from getting enough sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you snore loudly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you hold your breath, have breathing pauses, or stop breathing in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have restless or "crawling" feelings in your legs at night that went away if you moved your legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have repeated rhythmic leg jerks or leg twitches during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have nightmares, or did you scream, walk, punch, or kick in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the following things disturb your sleep:				
a. Pain Please specify : _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. Other physical problems Please specify : _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Worries Please specify : _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Medications Please specify : _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Other Please specify : _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel sad or anxious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YOUR HEALTH

We will now ask you a few questions about your current state of health and your past history. Please answer each question as accurately as possible. We remind you that your answers will remain anonymous and will be analyzed together with those of your colleagues, without individual identification.

A few questions about your health

1. What is your weight?

kg

2. What is your current height?

cm

3. Are you right- or left-handed?

Please tick only one answer.

Right-handed Left-handed Both

4. On a scale of 1 to 10, how would you rate your general state of health (both physical and mental)?

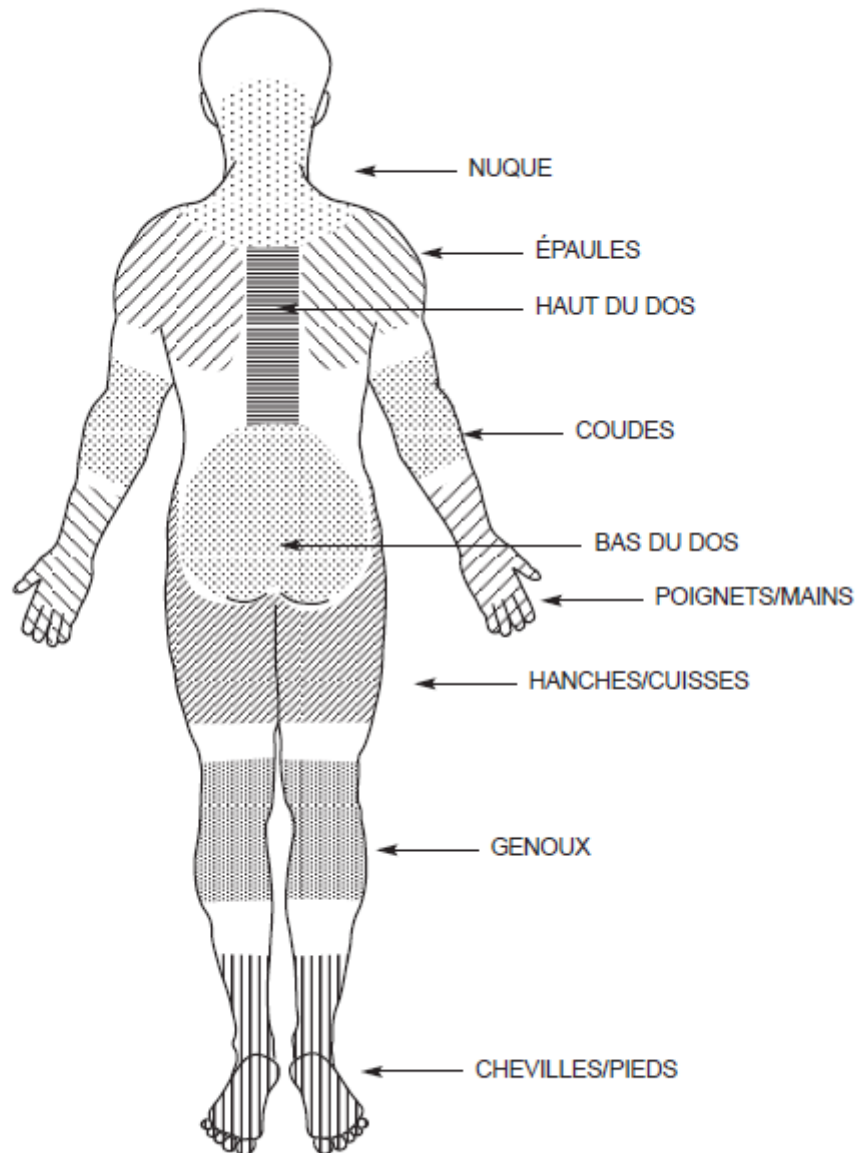
1- being very bad, 10- being very good

Musculoskeletal disorders → Modified Nordic Musculoskeletal Questionnaire

If you are not currently working, please think about your daily activities instead of work.

Explanation:

The health questions cover the following 9 body parts.



We ask you to answer the questions for each body part, even if you do not feel any pain or symptoms in that part of the body.

1. Neck

1. Over the past 12 months, how much pain have you experienced in your neck? Please tick one answer only

Neck	No pain	<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"/>	Worst pain ever
		0	1	2	3	4	5	6	7	8	9	10	

If 0, go to part 2. Shoulder

If >0, answer questions 1.1 to 1.6

1.1 Over the past 12 months, what is the total length of time that you have suffered from neck pain? Please tick one answer only

	Less than 24 hours	From 1 to 7 days	8 to 30 days	More than 30 days	All the time
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1.2 To what extent has this neck pain limited your ability to work? Please tick one answer only

Neck	No limitation	<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"/>	Inability to work due to neck pain
		0	1	2	3	4	5	6	7	8	9	10

1.3 In the last 12 months, have you ever had to stop work because of this neck pain? Please tick one answer only

Yes No

1.4 In the last 12 months, have you ever had to change/adapt your job or workstation because of neck pain? Please tick one answer only

Yes No

2. Shoulders

2. **Over the past 12 months**, how much pain have you experienced in either shoulder? *Please tick one answer only*

Shoulder	No pain	<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"/>	Worst pain ever
		0	1	2	3	4	5	6	7	8	9	10	

If 0, go to part 3. Upper back

If >0, answer questions 2.1 to 2.6

2.1 **Over the past 12 months**, what is the **total** length of time that you have suffered from shoulder pain? *Please tick one answer only*

	Less than 24 hours	From 1 to 7 days	8 to 30 days	More than 30 days	All the time
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.2 To what extent has this shoulder pain limited your ability to work? *Please tick one answer only*

Shoulder	No limitation	<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"/>	Inability to work due to shoulder pain
		0	1	2	3	4	5	6	7	8	9	10

2.3 **In the last 12 months**, have you ever been off work due to shoulder pain? *Please tick one answer only*

Yes No

2.4 **In the last 12 months**, have you ever had to change/adapt your job or workstation because of shoulder pain? *Please tick one answer only*

Yes No

3. Upper back

3. Over the past 12 months, how much pain have you experienced in your upper back? Please tick one answer only

Upper back	No pain	<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"/>	Worst pain ever
		0	1	2	3	4	5	6	7	8	9	10	

If 0, go to part 4. Elbow

If >0, answer questions 3.1 to 3.6

3.1 Over the last 12 months, what is the total length of time that you have suffered from upper back pain? Please tick one answer only

	Less than 24 hours	From 1 to 7 days	8 to 30 days	More than 30 days	All the time
Upper back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3.2 To what extent has this upper back pain limited your ability to work? Please tick one answer only

Upper back	No limitation	<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"/>	Inability to work due to upper back pain	
		0	1	2	3	4	5	6	7	8	9	10	

3.3 In the last 12 months, have you ever had to stop work because of this pain in your upper back? Please tick one answer only

Yes No

3.4 In the last 12 months, have you ever had to change/adapt your job or workstation because of upper back pain? Please tick one answer only

Yes No

4. Elbow

4. Over the past 12 months, how much pain have you experienced in one or both elbows? Please tick one answer only

Elbow	No pain	<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"/>	Worst pain ever
		0	1	2	3	4	5	6	7	8	9	

If 0, go to part 5. Lower back

If >0, answer questions 4.1 to 4.6

4.1 Over the past 12 months, what is the total length of time that you have suffered from pain in one or both elbows? Please tick one answer only

	Less than 24 hours	From 1 to 7 days	8 to 30 days	More than 30 days	All the time
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.2 To what extent has this pain in one or both elbows limited your ability to work? Please tick one answer only

Elbow	No limitation	<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"/>	Inability to work due to elbow pain
		0	1	2	3	4	5	6	7	8	9	

4.3 In the last 12 months, have you ever had to stop work because of pain in one or both elbows? Please tick one answer only

Yes No

4.4 In the last 12 months, have you ever had to change/adapt your job or workstation because of pain in one or both elbows? Please tick one answer only

Yes No

5. Lower back

5. Over the past 12 months, how much pain have you experienced in your lower back? Please tick one answer only

Lower back	No pain	<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"/>	Worst pain ever
		0	1	2	3	4	5	6	7	8	9	10	

If 0, go to part 6. Wrist/hand

If >0, answer questions 5.1 to 5.7

5.1 Over the last 12 months, what is the total length of time that you have suffered from lower back pain? Please tick one answer only

	Less than 24 hours	From 1 to 7 days	8 to 30 days	More than 30 days	All the time
Lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.2 To what extent has this lower back pain limited your ability to work? Please tick one answer only

Lower back	No limitation	<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"/>	Inability to work due to lower back pain	
		0	1	2	3	4	5	6	7	8	9	10	

5.3 In the last 12 months, have you ever been off work due to this lower back pain? Please tick one answer only

Yes No

5.4 In the last 12 months, have you ever had to change/adapt your job or workstation because of lower back pain? Please tick one answer only

Yes No

6. Wrist/hand

6. Over the last 12 months, how much pain have you experienced in one or both wrists or hands?
Please tick one answer only

Wrist	No pain	<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"/>	Worst pain ever
/hand		0	1	2	3	4	5	6	7	8	9	10	

If 0, go to part 7. Hip/thigh

If >0, answer questions 6.1 to 6.6

6.1 In the last 12 months, what is the total length of time that you have suffered in one or both wrists or hands? *Please tick one answer only*

	Less than 24 hours	From 1 to 7 days	8 to 30 days	More than 30 days	All the time
Wrist/hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.2 To what extent has this pain in one or both wrists or hands limited your ability to work? *Please tick one answer only*

Wrist/hand	No limitation	<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"/>	Inability to work due to wrist/hand pain
		0	1	2	3	4	5	6	7	8	9	10

6.3 In the last 12 months, have you ever had to stop work because of pain in one or both wrists or hands? *Please tick one answer only*

Yes No

6.4 In the last 12 months, have you ever had to change/adapt your job or workstation because of pain in one or both wrists or hands? *Please tick one answer only*

Yes No

7. Hip/thigh

7. **Over the past 12 months**, how much pain have you experienced in one or both hips/thighs?

Please tick one answer only

Hip/thigh	No pain	<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"/>	Worst pain ever
		0	1	2	3	4	5	6	7	8	9	

If 0, go to part 8. Knee

If >0, answer questions 7.1 to 7.6

7.1 **Over the past 12 months**, what is the **total** length of time that you have suffered from pain in one or both hips/thighs? Please tick one answer only

	Less than 24 hours	From 1 to 7 days	8 to 30 days	More than 30 days	All the time
Hip/thigh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.2 To what extent has this pain in one or both hips/thighs limited your ability to work? Please tick one answer only

Hip/thigh	No limitation	<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"/>	Inability to work due to hip/thigh pain
		0	1	2	3	4	5	6	7	8	

7.3 **In the last 12 months**, have you ever had to stop work because of this pain in one or both hips/thighs? Please tick one answer only

Yes No

7.4 **In the last 12 months**, have you ever had to change/adapt your job or workstation because of pain in one or both hips/thighs? Please tick one answer only

Yes No

8. Knee

8. Over the past 12 months, how much pain have you experienced in one or both knees? *Please tick one answer only*

Knee	No pain	<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"/>	Worst pain ever
		0	1	2	3	4	5	6	7	8	9	10

If 0, go to part 9. Ankle and Foot

If >0, answer questions 8.1 to 8.6

8.1 Over the past 12 months, what is the **total** length of time that you have suffered from one or both knees? *Please tick one answer only*

	Less than 24 hours	From 1 to 7 days	8 to 30 days	More than 30 days	All the time
Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.2 To what extent has this pain in one or both knees limited your ability to work? *Please tick one answer only*

Knee	No limitation	<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"/>	Inability to work due to knee pain
		0	1	2	3	4	5	6	7	8	9	10

8.3 In the last 12 months, have you ever had to stop work because of pain in one or both knees? *Please tick one answer only*

Yes No

8.4 In the last 12 months, have you ever had to change/adapt your job or workstation because of pain in one or both knees? *Please tick one answer only*

Yes No

9. Ankle/foot

9. Over the past 12 months, how much pain have you experienced in one or both feet or ankles?
Please tick one answer only

Ankle/foot	No pain	<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"/>	Worst pain ever
		0	1	2	3	4	5	6	7	8	9	

If 0, go to next section.

If >0, answer questions 9.1 to 9.6

9.1 Over the past 12 months, what is the total length of time that you have suffered from one or both feet or ankles? *Please tick one answer only*

	Less than 24 hours	From 1 to 7 days	8 to 30 days	More than 30 days	All the time
Ankle/foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.2 To what extent has this pain in one or both feet or ankles limited your ability to work? *Please tick one answer only*

Ankle/foot	No limitation	<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"/>	Inability to work due to ankle/foot pain
		0	1	2	3	4	5	6	7	8	9	

9.3 In the last 12 months, have you ever had to stop work because of pain in one or both feet or ankles? *Please tick one answer only*

Yes No

9.4 In the last 12 months, have you ever had to change/adapt your job or workstation because of pain in one or both feet or ankles? *Please tick one answer only*

Yes No

Well-being

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example. If you have felt cheerful and in good spirits more than half of the time during the last two weeks, select number three.

In the last two weeks (*One answer possible per line*)

	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
	5	4	3	2	1	0
I have felt cheerful in good spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt calm and relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have felt active and vigorous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I woke up feeling fresh and rested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My daily life has been filled with things that interest me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YOUR LIFE BALANCE

We'll now ask you a few questions about your life balance. There will be questions about your well-being, your eating and exercise habits, and so on. Please answer each question as precisely as possible. Please take your time to answer them.

Some of the questions we're about to ask you are sensitive. They may be more difficult to answer. If you feel uncomfortable answering these questions, don't hesitate to contact an association offering support by calling 143, or by writing to www.143.ch. This contact is completely anonymous.

Personality → Scale: BFI-2-XS

1. Here are a number of characteristics that may or may not apply to you. For example, do you agree that you are someone who likes to spend time with others? Please write a number next to each statement to indicate the extent to which you agree or disagree with that statement. *(One possible answer)*

	Disagree strongly	Disagree a little	Neutral, no opinion	Agree a little	Agree strongly
Tends to be quiet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is compassionate, has a soft heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tends to be disorganized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is fascinated by art, music, or literature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is dominant, acts as a leader	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is sometimes rude to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty getting started on tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tends to feel depressed, blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has little interest in abstract ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is full of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assumes the best about people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is reliable, can always be counted on	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is emotionally stable, not easily upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is original, comes up with new ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Quality of life and satisfaction → WHOQOL-Bref scale

1. Choose the statements that best describe how you feel (one possible answer per line).

	Very poor	Poor	Neither poor nor good	Good	Very good
How would you rate your quality of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
How satisfied are you with your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Not at all	A little	A moderate amount	Very much	An extreme amount
To what extent do you feel that physical pain prevents you from doing what you need to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do you need any medical treatment to function in your daily life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do you enjoy life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To what extent do you feel your life to be meaningful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Not at all	A little	Moderately	Mostly	Completely
How well are you able to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How safe do you feel in your daily life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How healthy is your physical environment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Not at all	A little	Moderately	Mostly	Completely
Do you have enough energy for everyday life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to accept your bodily appearance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you enough money to meet your needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How available to you is the information that you need in your day-to-day life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To what extent do you have the opportunity for leisure activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Very poor	Poor	Neither poor nor good	Well	Very well
How well are you able to get around?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
How satisfied are you with your sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied are you with your ability to perform your daily living activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How satisfied are you with your capacity for work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied are you with yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied are you with your personal relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied are you with your intimate life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied are you with the support you get from your friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied are you with the conditions of your living place?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied are you with your access to health services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How satisfied are you with your mode of transportation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Seldom	Quite Often	Very often	Always
How often do you have negative feelings, such as blue mood, despair, anxiety, depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nutrition → Swiss Health Study (SHeS)

1. How often do you eat the following foods?

Two answers per line: food frequency and percentage of organic products.

										How often do you eat these organic products?			
	Rarely/never	1 time per month	Every 2 weeks	1-2 times a week	3-6 times a week	Every day	2-3 times a day	More than 4 times a day	<10%	10-50%	50-90%	>90%	
Meat (beef, veal, pork, game, etc.), excluding poultry	<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"/>	
Charcuterie (sausage, pâté, dried meat, etc.)	<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"/>	
Wholegrain cereals (wholemeal bread, wholegrain rice, etc.)	<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"/>	
Fruits	<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"/>	
Sweets or desserts (chocolate, cookies, pastries, ice cream, cake, etc.)	<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"/>	

2. Do you usually add salt to your food at the table?

	When you eat at home	When you eat out
No, never (0 meals out of 10)	<input type="checkbox"/>	<input type="checkbox"/>
Yes, occasionally (1 to 5 meals out of 10)	<input type="checkbox"/>	<input type="checkbox"/>
Yes, often (6 to 9 meals out of 10)	<input type="checkbox"/>	<input type="checkbox"/>
Yes, always (10 out of 10 meals)	<input type="checkbox"/>	<input type="checkbox"/>

3. How much of the following do you usually drink a day? 1 glass corresponds to 0.2 L. *One answer per line.*

	More than 3 liters per day	2-3 liters per day	1-2 liters per day	0.5- 1 liters per day	2-3 glasses per day (2-5 dL)	1 glass per day	1-6 glasses by week	Less than one glass by week
Fruit juice (100% fruit juice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit nectar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweet tea, cola, lemonade, cold tea, syrup, chocolate drinks, energy drinks, etc. (excluding sweetened drinks, e.g. "light" or "zero").	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweetened drinks (Diet Coke, Coke Zero, blue rivella, diet energy drinks, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsweetened tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water (tap or mineral)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol, Tobacco, Drugs

Alcohol

4. Has there ever been a time in your life when you consumed more than 5 glasses of alcoholic beverage (all beverages combined) every day?

Yes No I don't know

5. Do you currently drink alcohol (alcoholic beverages)?

Yes No → go to question 8 (tobacco and caffeine)

6. How many bottles (3 dl) of beer have you drunk in the last 7 days?

Bottles (0 if none)

7. How many glasses of wine (1 dl) have you drunk in the last 7 days?

Glasses (0 if none)

8. How many glasses of spirits (cognac, kirsch, liqueur, whisky, brandy, etc.) (0.4 dl) have you drunk in the last 7 days?

Glasses (0 if none)

Tobacco

9. Check the box that best describes you:

I currently smoke → go to question 10
 I used to smoke → go to question 11
 I've never smoked → go to question 12

10. What is the main product you currently smoke? (indicate quantity)

Cigarettes per day
Cigars per day (zero if less than 1/day)
Cigarillos per day (zero if less than 1/day)
Pipes per day (zero if less than 1/day)
E-cigarette liquid **with** and/or **without** nicotine?

11. At what age did you start/ stop smoking?

I started at _____ I stopped at _____

11a. During this period, for how many years did you stop, including all breaks?

_____ years

Passive smoking

12. In the last 12 months, were you exposed to tobacco smoke in your work environment (bus booths, breaks, etc.)?

No, never Yes, sometimes Yes, regularly

13. In the last 12 months, were you exposed to tobacco smoke in your personal environment?

No, never Yes, sometimes Yes, regularly

Drugs

14. Have you ever used drugs in your life, or do you currently use drugs (e.g. cannabis, cocaine...)?

	Never	1 single once	Rarely	Each month	Each week	Every day
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I do not wish to answer

A few questions about your home habits

Electrical and communications equipment

15. How many electrical and communication devices (telephone, alarm clock, computer, etc.) do you have in your bedroom?

- None 1 to 3 4 to 6 More than 6

16. How many devices that emit radio waves, such as telephones and WiFi-connected devices, do you have in your bedroom?

- None 1 to 3 4 to 6 more than 6

17. Do you have a WiFi box or relay in your bedroom?

- Yes No

18. Do you regularly use (>1h per week) any of the following devices (multiple answers possible) :

- Electric radiator (close proximity < 40 cm)
 Drill Hair dryer
 Induction stoves Magnetic mattresses
 Electric bed-heaters (e.g. electric blanket, waterbed) No

19. How often do you use your cell phone?

- I don't have a cell phone Less than an hour a day
 1 to 2 hours a day 2 to 3h per day 3 to 4h per day 4 to 5h per day
 More than 5h per day

20. Over the past week, how much time in total have you spent on the phone without an earpiece (with the phone pressed against your ear)?

- I don't have a cell phone
 < 1 minute per day 1-10 minutes per day 10 - 20 minutes per day

20 - 40 min per day 40 min - 60 min per day 1h - 2h per day

> 2h per day

21. What is your main use (which represents the most time spent on your cell phone)?

Phone call Media Social network

Games Utilities Others

22. On average, how long before going to sleep do you stop using screens (telephone, TV, computer, etc.)?

Less than one hour 1 to 2h 2 to 3h 3 to 4h 4 to 5h More than 5h

23. Have you ever received an electric shock?

Yes No

Your physical activity → Scale: International Physical Activity Questionnaire (IPAQ)

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

1. Think about all the **vigorous** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

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

Day(s) per week

No vigorous physical activities → **Skip to Q2**

1.2 How much time did you usually spend doing vigorous physical activities on one of those days?

HH : MM - : / day Don't know/Not sure

2. Think about all the **moderate** activities that you did in the **last 7 days**. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

2.1. During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

Day(s) per week

No moderate physical activities → **Go to Q3**

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

HH : MM - : / day Don't know/Not sure

3. Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.

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

Day(s) per week

No walking → **Skip to Q4**

3.2 How much time did you usually spend **walking** on one of those days?

HH : MM - : / day Don't know/Not sure

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

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

HH : MM - : / day Don't know/Not sure

Your stress→ Scale: Perceived Stress Scale (PSS)

1. The following questions ask about your feelings and thoughts in the past month. In each case, you will be asked to indicate how often you have felt or thought in a certain way. Some of the questions are similar, but their value is different. Answer them as quickly as possible, and don't try to count the number of times you've felt a certain way. *Only one answer per line.*

	Never	Almost never	Sometimes	Fairly often	Very Often
In the last month, how often have you been upset because of something that happened unexpectedly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt nervous and stressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt that things were going your way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you found that you could not cope with all the things that you had to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you been able to control irritations in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt that you were on top of things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you been angered because of things that happened that were outside of your control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**In the last month, how often
have you felt difficulties were
piling up so high that you
could not overcome them?**

Depression → BDI-II scale (Beck)

97. Here you will find 21 groups of questions. For each group, choose the answer that best describes how you've been feeling over the past two weeks, including today. If several statements in the group seem to apply equally well, circle the highest number for that group. (only one answer per group).

Sadness	
0. I do not feel sad.	<input type="checkbox"/>
1. I feel sad much of the time.	<input type="checkbox"/>
2. I am sad all the time.	<input type="checkbox"/>
3. I am so sad or unhappy that I can't stand it.	<input type="checkbox"/>
Pessimism	
0. I am not discouraged about my future.	<input type="checkbox"/>
1. I feel more discouraged about my future than I used to.	<input type="checkbox"/>
2. I do not expect things to work out for me.	<input type="checkbox"/>
3. I feel my future is hopeless and will only get worse.	<input type="checkbox"/>
Past Failures	
0. I do not feel like a failure.	<input type="checkbox"/>
1. I have failed more than I should have.	<input type="checkbox"/>
2. As I look back, I see a lot of failures.	<input type="checkbox"/>
3. I feel I am a total failure as a person.	<input type="checkbox"/>
Loss of Pleasure	
0. I get as much pleasure as I ever did from the things I enjoy.	<input type="checkbox"/>
1. I don't enjoy things as much as I used to.	<input type="checkbox"/>
2. I get very little pleasure from the things I used to enjoy.	<input type="checkbox"/>
3. I can't get any pleasure from the things I used to enjoy.	<input type="checkbox"/>
Guilty Feelings	
0. I don't feel particularly guilty.	<input type="checkbox"/>
1. I feel guilty over many things I have done or should have done.	<input type="checkbox"/>
2. I feel quite guilty most of the time.	<input type="checkbox"/>
3. I feel guilty all the time.	<input type="checkbox"/>
Punishment Feelings	
0. I don't feel I am being punished.	<input type="checkbox"/>
1. I feel I may be punished.	<input type="checkbox"/>
2. I expect to be punished.	<input type="checkbox"/>
3. I feel I am being punished.	<input type="checkbox"/>
Self Dislike	
0. I feel the same about myself as ever.	<input type="checkbox"/>
1. I have lost confidence in myself.	<input type="checkbox"/>
2. I am disappointed in myself.	<input type="checkbox"/>
3. I dislike myself.	<input type="checkbox"/>
Self-Criticalness	
0. I don't criticize or blame myself more than usual.	<input type="checkbox"/>
1. I am more critical of myself than I used to be.	<input type="checkbox"/>
2. I criticize myself for all of my faults.	<input type="checkbox"/>
3. I blame myself for everything bad that happens.	<input type="checkbox"/>
Suicidal Thoughts or Wishes	
0. I don't have any thoughts of killing myself.	<input type="checkbox"/>
1. I have thoughts of killing myself, but I would not carry them out.	<input type="checkbox"/>

2. I would like to kill myself.	<input type="checkbox"/>
3. I would kill myself if I had the chance.	<input type="checkbox"/>
Crying	
0. I don't cry anymore than I used to.	<input type="checkbox"/>
1. I cry more than I used to.	<input type="checkbox"/>
2. I cry over every little thing.	<input type="checkbox"/>
3. I feel like crying, but I can't.	<input type="checkbox"/>
Agitation	
0. I am no more restless or wound up than usual.	<input type="checkbox"/>
1. I feel more restless or wound up than usual.	<input type="checkbox"/>
2. I am so restless or agitated, it's hard to stay still.	<input type="checkbox"/>
3. I am so restless or agitated that I have to keep moving or doing something.	<input type="checkbox"/>
Loss of Interest	
0. I have not lost interest in other people or activities.	<input type="checkbox"/>
1. I am less interested in other people or things than before.	<input type="checkbox"/>
2. I have lost most of my interest in other people or things.	<input type="checkbox"/>
3. It's hard to get interested in anything.	<input type="checkbox"/>
Indecisiveness	
0. I make decisions about as well as ever.	<input type="checkbox"/>
1. I find it more difficult to make decisions than usual.	<input type="checkbox"/>
2. I have much greater difficulty in making decisions than I used to.	<input type="checkbox"/>
3. I have trouble making any decisions.	<input type="checkbox"/>
Worthlessness	
0. I do not feel I am worthless.	<input type="checkbox"/>
1. I don't consider myself as worthwhile and useful as I used to.	<input type="checkbox"/>
2. I feel more worthless as compared to others.	<input type="checkbox"/>
3. I feel utterly worthless.	<input type="checkbox"/>
Loss of Energy	
0. I have as much energy as ever.	<input type="checkbox"/>
1. I have less energy than I used to have.	<input type="checkbox"/>
2. I don't have enough energy to do very much.	<input type="checkbox"/>
3. I don't have enough energy to do anything.	<input type="checkbox"/>
Changes in Sleeping Pattern	
0. I have not experienced any change in my sleeping.	<input type="checkbox"/>
1a. I sleep somewhat more than usual.	<input type="checkbox"/>
1b. I sleep somewhat less than usual.	<input type="checkbox"/>
2a. I sleep a lot more than usual.	<input type="checkbox"/>
2b. I sleep a lot less than usual.	<input type="checkbox"/>
3a. I sleep most of the day.	<input type="checkbox"/>
3b. I wake up 1-2 hours early and can't get back to sleep.	<input type="checkbox"/>
Irritability	
0. I am not more irritable than usual.	<input type="checkbox"/>
1. I am more irritable than usual.	<input type="checkbox"/>
2. I am much more irritable than usual.	<input type="checkbox"/>
3. I am irritable all the time.	<input type="checkbox"/>

Changes in Appetite	
0. I have not experienced any change in my appetite.	<input type="checkbox"/>
1a. My appetite is somewhat less than usual.	<input type="checkbox"/>
1b. My appetite is somewhat greater than usual.	<input type="checkbox"/>
2a. My appetite is much less than before.	<input type="checkbox"/>
2b. My appetite is much greater than usual.	<input type="checkbox"/>
3a. I have no appetite at all.	<input type="checkbox"/>
3b. I crave food all the time.	<input type="checkbox"/>
Concentration Difficulty	
0. I can concentrate as well as ever.	<input type="checkbox"/>
1. I can't concentrate as well as usual.	<input type="checkbox"/>
2. It's hard to keep my mind on anything for very long.	<input type="checkbox"/>
3. I find I can't concentrate on anything.	<input type="checkbox"/>
Tiredness or Fatigue	
0. I am no more tired or fatigued than usual.	<input type="checkbox"/>
1. I get more tired or fatigued more easily than usual.	<input type="checkbox"/>
2. I am too tired or fatigued to do a lot of the things I used to do.	<input type="checkbox"/>
3. I am too tired or fatigued to do most of the things I used to do.	<input type="checkbox"/>
Loss of interest in sex	
0. I have not noticed any recent change in my interest in sex.	<input type="checkbox"/>
1. I am less interested in sex than I used to be.	<input type="checkbox"/>
2. I am much less interested in sex now.	<input type="checkbox"/>
3. I have lost interest in sex completely.	<input type="checkbox"/>

Medical history → Swiss Health Study (SHeS)

Medical history

Below is a list of diseases. Please indicate for which you have been diagnosed.

- Musculoskeletal diseases*
- Heart Diseases*
- Metabolism diseases (e.g. diabetes or cholesterol)*
- Neurological and psychological diseases*
- Respiratory health*
- Auditory health*
- Eye health*
- Kidney, liver, stomach and intestinal diseases*
- Skin diseases*
- Allergies*
- Cancers (including prostate)*
- Gynecological diseases*
- Other illnesses and rare diseases*

..

MUSCULOSKELETAL DISEASES	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
1 Herniated disc	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
2 Osteoporosis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
3 Osteoarthritis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>

I do not wish to answer

HEART DISEASES	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
4 Myocardial infarction (heart attack)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
5 Angina pectoris, coronary artery disease	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
6 Heart failure	<input type="checkbox"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/>

		<input type="checkbox"/> No		<input type="checkbox"/> No	<input type="checkbox"/> No		<input type="checkbox"/> No	
7	Heart rhythm disorders (pacemaker)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
8	Obliterative arteriopathy of the lower limbs	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
9	Hypertension	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>

I do not wish to answer

Z 4.1 If you have already had a heart attack, how many heart attacks have you had?

Heart attack(s)

Z 4.2. At what age did you have your first heart attack?

Year

Z 4.3. At what age did you have your last heart attack?

Year

METABOLISM DISORDERS	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
10a Type I diabetes mellitus	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
10b Type II diabetes mellitus	<input type="checkbox"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/>

		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No
10c	Gestational diabetes (during pregnancy)	<input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No
11	Increased blood lipids, cholesterol or triglycerides	<input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No
12	Drop	<input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No
13a	Hyperthyroidism	<input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No
13b	Hypothyroidism	<input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No
13c	Other thyroid disorders :	<input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> No

I do not wish to answer

If you have diabetes, please answer questions Z 10.1 to Z 10.3.

Z 10.1. How are you currently treated (including insulin injections and insulin pumps)?

- Insulin only
- Tablets only Other treatment
- Insulin and tablets I do not take any treatment
- Dietary treatment only Don't know

Z 10.2. If you are taking insulin, from what age have you been taking it?

years

Z 10.2. How are you currently treated (including insulin injections and insulin pumps)?

- Retinopathy, corneal damage
- Blindness
- Renal failure or insufficiency
- Dialysis treatment or kidney transplantation
- Diabetic foot (poor wound healing)
- Amputations (toe, foot, leg)
- None of these diseases or complications
- Don't know

NEUROLOGICAL DISEASES AND PSYCHICS		Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
14	Stroke	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
15	Epilepsy	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
16	Migraines	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
17	Parkinson's syndrome	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
18	Depression	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
19	Anxiety disorders or panic attacks	<input type="checkbox"/> Yes →	□□□□	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	□□□	<input type="checkbox"/> Yes	□□□

		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No
20	Eating disorders	<input type="checkbox"/> Yes →	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No
21	Attention deficit disorder with or without hyperactivity (ADHD)	<input type="checkbox"/> Yes →	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No
22	Dementia or Alzheimer's	<input type="checkbox"/> Yes →	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No
23	Amyotrophic lateral sclerosis (ALS)	<input type="checkbox"/> Yes →	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No
24	Multiple sclerosis	<input type="checkbox"/> Yes →	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No

I do not wish to answer

If you have or have had an eating disorder, please answer the following question (Z 20.1)

Z 20.1 What type of eating disorder is/was involved?

Multiple answers possible

Anorexia Bulimia Binge-Eating Other _____

PULMONARY ILLNESSES	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
25 Asthma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
26 Chronic bronchitis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
27 Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
28 Pulmonary emphysema	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
29 Sleep apnea	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
30 Pneumonia	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
31 Other lung diseases:	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>

I do not wish to answer

If you have ever had asthma (even if not diagnosed by a doctor), please answer questions Z 25.1 to Z 25.3.

Z 25.1 Have you had one or more asthma attacks in the last 12 months?

Yes No I don't know

Z 25.2 If yes, how many attacks have you had in the last 12 months?

Enter even an approximate number

Asthma attack(s)

Z 25.3 Are you currently taking asthma medication (also inhalers, aerosols, tablets)?

Yes No I don't know

HEARING DISORDERS	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
32 Tinnitus	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
33 Hearing loss	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
34 Hearing disorders	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
35 Balance disorders / Vertigo	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>

I do not wish to answer

36. Do you wear a hearing aid?

Yes No

36.1 If yes to 36 which ear(s)?

Right Left Both ears

36.2 If yes, how long have you been wearing your hearing aid(s)?

year

EYE DISEASES	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
37 Cataracts	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
38 Glaucoma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
39 Age-related macular degeneration (AMD)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
40 Other eye disease: _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>

I do not wish to answer

41. Do you wear glasses or contact lenses?

Yes No

41.1 If yes to 80.1 or yes to 80.2, what is your current correction? :

Right eye : Myopia (-)
 Hyperopia (+)
 Astigmatism Yes No

Left eye : Myopia (-)
 Hyperopia (+)
 Astigmatism Yes No

Presbyopia Yes No

41.2 How long have you worn glasses or contact lenses?

Years

KIDNEY, LIVER, STOMACH, INTESTINS DISEASES	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
42 Gastric or duodenal ulcer	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
43 Heartburn or upset stomach	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

44 Intestinal inflammation (e.g. ulcerative colitis or Crohn's disease)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
45 Gallstones	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
46 Cirrhosis of the liver	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
47 Kidney stones, in the ureter or bladder	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
48 Impaired renal function (e.g. chronic renal failure)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

I do not wish to answer

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

Z 48.1. Have you ever had dialysis?

Yes No I don't know

SKIN DISORDERS	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
49 Atopic dermatitis (neurodermatitis) or eczema	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
50 Psoriasis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

51 Severe acne	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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I do not wish to answer

ALLERGIES	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
52 Hay fever	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53 Other allergic colds	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54 Allergy to insect stings (bee, wasp, bumblebee, hornet)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55 Dust mite allergy	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56 Animal hair allergy	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57 Contact allergies (latex, nickel, perfumes, etc.)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58 Chronic sinusitis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59 Food allergy (specify) : ____	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60 Food intolerance (specify) : ____	<input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No		<input type="checkbox"/> No
61 Other allergy (specify): _____	<input type="checkbox"/> Yes →	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="text"/>	<input type="checkbox"/> Yes	<input type="text"/>
	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> No	<input type="text"/>

CANCER	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
62 Lung	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
63 Colorectal	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
64 Stomach	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
65 Esophagus	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
66 Hepatocellular carcinoma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
67 Sein	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
68 Glioma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>

69 Meningioma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
70 Women: cervix	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
71 Men: prostate	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
72 Leukemia	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
73 Hodgkin's disease	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
74 Cutaneous melanomas	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
75 Salivary gland tumors	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
76 Pituitary adenoma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
77 Malignant tumor of the eye and adnexa	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
78 Other cancer (specify) : _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
79 Other cancer (specify) : _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

I do not wish to answer

GYNAECOLOGICAL DISEASES		Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
80	Polycystic ovary syndrome (Stein-Leventhal syndrome)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
81	Endometriosis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
82	Uterine myoma (benign tumor)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
83	Uterine prolapse (or uterine descent)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>
84	Papillomavirus or HPV infection (in the cervix)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/>

I do not wish to answer

OTHER ILLNESSES AND RARE DISEASES	Have you been diagnosed by a doctor?	In what year was your illness diagnosed?	Are you currently taking treatment for this disease?	Do you see a doctor regularly for this condition?	How many times have you consulted a doctor in the last 12 months for this condition?	Have you been hospitalized for this disease?	How many nights have you spent in hospital for this illness in the last 12 months?
85 Urinary tract infection (UTI)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
86 Rheumatoid arthritis / Polyarthritis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
87 Fibromyalgia	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
88 Congenital malformation	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
89 Electrohypersensitivity	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
90 Other disease 1 : _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□
91 Other illness 2 : _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	□□□

I do not wish to answer

If you have a congenital malformation, please answer the following question (Z 88.1):

Z 88.1. What type of congenital malformation is it?

Multiple answers possible

- | | |
|---|--|
| <input type="checkbox"/> Musculoskeletal malformations (e.g. clubfoot, hip dysplasia) | <input type="checkbox"/> Cardiovascular deformities |
| <input type="checkbox"/> Malformations of the internal genitourinary system (e.g. renal malformation) | <input type="checkbox"/> Malformations of the digestive system |
| <input type="checkbox"/> Central nervous system defects (e.g. non-closure of the neural tube) | <input type="checkbox"/> Chromosomal aberrations |
| <input type="checkbox"/> Malformations of the external genitourinary system (e.g. hypospadias) | <input type="checkbox"/> Ear deformities |
| <input type="checkbox"/> Facial clefts (e.g. cleft lip and/or palate) | <input type="checkbox"/> Eye deformities |
| <input type="checkbox"/> Minor morphogenesis malformations (e.g., single palmar crease, non-closure of rectus muscles, excess or fusion of fingers or toes, hemangiomas, nevi, ...) | |
| <input type="checkbox"/> Other | |

Your Surgeries → Swiss Health Study (SHeS)

92. Have you had any of the following operations? Please check when the operation took place.
Multiple answers possible.

- I've never had a surgery before.
- Heart valve surgery
- Coronary angioplasty (PTCA) with or without stent placement
- Coronary artery bypass grafting
- Fitting a pacemaker
- Balloon dilatation of a leg vein with or without stent placement
- Peripheral leg artery bypass surgery
- Carotid artery surgery
- Refractive surgery/laser eye surgery
- Cataract 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
- Appendectomy

- Spleen surgery*
- Throat or tonsil surgery*
- Thymus*
- Surgery for polyps in the paranasal sinuses*
- Gallbladder surgery*
- Thyroid surgery*
- Uterine surgery (woman)*
- Ovarian surgery (woman)*
- Left breast operation*
- Right breast operation*
- Prostate surgery (men)*
- If Other, which one? _____*
- I do not wish to answer*

Your treatments → Swiss Health Study (SHeS)

93. At present, how many medications do you use regularly (i.e. at least once a week for at least one month), including painkillers, tranquilizers, sleeping pills and natural treatments (tablets, syrups, nasal sprays, eye drops, suppositories, injections, ointments, etc.)?

Please indicate the number (even approximate) of medications; if you do NOT take medication regularly, please enter 0.

medications taken regularly

94. Please indicate the name and frequency of all medications you are taking (including painkillers, tranquilizers, sleeping pills and natural treatments).

Drug name (Dosage) as indicated on the box	Several times a day	1 time a day	Several times a week	1 time per week
	<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"/>
	<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"/>
	<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"/>
<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"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I do not wish to answer

Family medical history

Some of the questions we're about to ask you are sensitive. They may be more difficult to answer. If you feel uncomfortable answering these questions, don't hesitate to contact an association offering support by calling 143, or by writing to www.143.ch. **This contact is completely anonymous.**

95. In the last 12 months, have you lost a biological parent?

Yes, my father Yes, my mother No I don't know I don't wish to answer

If yes for my father, at what age?

If yes, what was the cause of death? _____

If yes for my mother, at what age?

If yes, what was the cause of death? _____

96. Have your parents been diagnosed with any of these diseases? If yes, tick the appropriate boxes and, if necessary, fill in the approximate age at diagnosis:

	Biological father	Biological mother
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Specify location		
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Specify location		
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Sudden death	<input type="checkbox"/>	<input type="checkbox"/>
Age	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
AVC	<input type="checkbox"/>	<input type="checkbox"/>
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Severe psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>
Specify		
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Suicide	<input type="checkbox"/>	<input type="checkbox"/>
Age	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Type II diabetes (NIDDM)	<input type="checkbox"/>	<input type="checkbox"/>
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Dialysis or kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>
Age	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Age at diagnosis	<input type="text"/> <input type="text"/> years	<input type="text"/> <input type="text"/> years

I do not wish to answer

Women's health

(TO BE COMPLETED BY WOMEN ONLY)

Here we ask questions about gynecological health to assess the impact of working conditions on women's health, particularly in relation to stress, fatigue and irregular working hours. Your answers are **de-identified to strictly protect your anonymity**. They will never be used individually, but together with the answers of all participants. They will **never be shared with your employer**.

Some questions are sensitive and may be difficult to answer. You have the choice not to answer. If you feel uncomfortable answering these questions, don't hesitate to contact an association offering support by calling 143, or by writing to www.143.ch. **This contact is completely anonymous.**

1. At what age did you have your first period?

years

I do not wish to answer

2. When was your last period?

Less than 3 months

Between 3 and 12 months

Over 12 months

Year

I don't know

I do not wish to answer

3. According to your last 3 cycles, your periods are :

Regular, naturally

Regular hormone therapy (e.g. the pill)

Irregular

I don't know

I do not wish to answer

4. On average, how long are your menstrual cycles?

- days
- My cycles are too irregular
- I do not wish to answer

5. What is the reason for the absence of your period for 3 months or more?

- I am in menopause
- I'm breastfeeding
- I am pregnant
- I'm an elite sportswoman
- I had my uterus removed
- I had 2 ovaries removed
- I take a continuous hormonal treatment (pill, IUD or other).

Specify : _____

- Other situation

Specify : _____

- I don't know
- I do not wish to answer

6. Are you taking or have you ever taken hormone replacement therapy such as estrogen, progestin or a combination of the 2 (e.g. to treat menopausal symptoms or absence of menstrual periods)?

Please consider all forms of treatment: tablets, creams or gels, patches, injections, suppositories or drops.

- No
- Yes, in the past
- Yes
- I don't know
- I do not wish to answer

7. Are you currently using hormonal contraception?

Please consider all forms of treatment: tablets, creams or gels, patches, injections, suppositories or drops.

No

Yes

Which one?

Pill

Hormonal implant

Hormonal IUD

Copper coil

Vaginal ring

Other hormone treatments

Product name : _____

Age:

I do not wish to answer

8. Have you ever been pregnant while actively working as a bus driver?

Yes

No

I do not wish to answer

9. If yes, did you benefit from job accommodation or other measures during your pregnancy?

Yes. Can you describe them? : _____

No

I do not wish to answer

9.1 Has your employer made any arrangements to facilitate your return to work after your pregnancy?

Yes

Can you describe them? : _____

No

I do not wish to answer

Reproductive health

Some of the questions we're about to ask you are sensitive. They may be more difficult to answer. If you feel uncomfortable answering these questions, don't hesitate to contact an association offering support by calling 143, or by writing to www.143.ch. This contact is completely anonymous.

10. Do you have one or more biological children?

No

Yes. Total number of biological children: _____?

11. For each of your biological children, please indicate in the table below: their gender, year of birth, birth weight, whether they were breastfed (even partially) and, if so, for how many months:

Child	Gender		Year of birth	Birth weight	Born premature			Breastfeeding			Malformation (p. e.g. heart, hearing impairment, spina bifida...)
	♂	♀			Yes	No	How many weeks of amenorrhea (SA)	Yes	No	How many months (*)	
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> g	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> month	
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> g	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> g	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> g	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> g	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		

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

12. Have you experienced a miscarriage or loss of child at birth in your relationship?

No

Yes,

If so, how many times?

- Miscarriage _____
- Child born dead / loss of child at birth _____

At what week(s) of pregnancy (SA)

- Miscarriage _____
- Child born dead/ / loss of child at birth _____

I do not wish to answer

13. Have you ever tried to conceive a child for at least 1 year (6 months if you were over 35), without success?

No

Yes

If so, has a medical diagnosis been made?

No

Yes, diagnosis : Male infertility (specify) _____

Female infertility (specify) _____

Other (specify) _____

Reason unknown

I do not wish to answer

YOUR PROFESSIONAL CAREER

We'll start by asking you a few questions about your professional career. The questions will cover the company you currently work for or have worked for in the past, as well as the bus models you use or have used. This information will enable us to assess your exposure to physicochemical and ergonomic risks. Please answer each question as accurately as possible.

Your career → Bus

A FEW QUESTIONS ABOUT YOUR PROFESSIONAL CAREER

1st vehicle

1. Which company do you currently work for, or did you work for last? *(one answer only)*

3, Aargau Verkehr (AVA) | 4, Busbetrieb Aarau AG (BBA) | 5, Aare Seeland mobil | 6, Autilinea Mendriense (AMSA) | 7, Autolinee Bleniesi SA (ABL) | 8, Auto AG Group (AAGR) | 9, Auto AG Schwyz | 10, Auto Ag Uri | 11, Autobetrieb Sernftal | 12, Autobetrieb Weesen-Amden (AWA) | 13, Autobus AG Liestal (AAGL) | 14, Autokurse Oberthurgau (AOT) | 15, Autolinee Regionali Luganesi (arl) | 16, Automobilverkehr Frutigen-Adelboden (AFA) | 17, Baselland Transport (BLT) | 18, Basler Verkehrsbetriebe (BVB) | 19, Bernmobil | 20, Busbetrieb Seetal Freiamt (BSF) | 21, BUS Ostschweiz AG (BO) | 22, Bus sédunois | 23, Busbetrieb Grenchen und Umgebung (BGU) | 24, Bus Sarganserland-Werdenberg (BSW) | 25, Busbetrieb Linchtensteig-Wattwil-Ebnat-Kappel (blwe) | 26, Busbetrieb Olten Gösigen Gäu (BOGG) | 27, Busbetrieb Solothurn und Umgebung (BSU) | 28, Busland AG Langnau Burgdorf (BLS) | 29, Chemin de fer du jura | 30, Compagnie de Chemin de fer et d'autobus Sierre-Montana-Crans SA (SMC) | 31, Engadin Bus | 32, Ferrovie Autolinee Regionali Ticinesi (FART) Locarno | 33, GEM'Bus | 34, Genève tour (G-tour) | 35, Globe Limo | 36, Odier Excursion | 37, Pfosi Arosa Bus AG | 38, PostAuto Schweiz AG (Carpostal) | 39, Ratpdev | 40, RDTA | 41, Regiobus AG Gossau (Regio) | 42, Regionalbus Lenzburg (RBL) | 43, Regionale Verkehrsbetriebe Baden-Wettingen (RVBW) | 44, Regionale Verkehrsbetriebe Schaffhausen RVSH | 45, Rottal Auto AG | 46, SBB-Bus Zofingen/Reiden | 47, Schneider Busbetriebe | 48, Seebus | 49, Sihltal Zürich Uetliberg Bahn AG (SZU) | 50, Stadtbus Chur | 51, Stadtbus Frauenfeld | 52, Stadtbus Kreuzlingen | 53, Stadtbus Winterthur (SW) | 54, STI Bus AG | 55, Tellbus Altdorf-Luzern | 56, Transports de la région Morges-Bière-Cossonay (MBC) | 57, Transports Martigny Région (TMR) | 58, Transports publics de la région lausannoise (tl) | 59, Transports publics de la région yvernoise (tpn) | 60, Transports publics du Chablais (TPC) | 61, Transports publics fribourgeois (TPF) | 62, Transports publics genevois (TPG) | 63, Transports publics neuchâtelais (TransN) | 64, Transports urbains delémontains (TUD) | 65, Transports Vallée de Joux, Yverdon-les-Bains, Saint croix (Travys) | 66, Trasporti Pubblici Luganesi (TPL) | 67, Verkehrsbetriebe Zürich (VBZ) | 68, Verkehrsbetriebe Biel (TpB) | 69, Verkehrsbetriebe Davos (VBD) | 70, Verkehrsbetriebe Glattal AG (vbg) | 71, Verkehrsbetriebe Luzern (vbl) | 72, Verkehrsbetriebe Schaffhausen (vbsh) | 73, Verkehrsbetriebe St. Gallen (VBSG) | 74, Verkehrsbetriebe Biel (TpB) Gallen (VBSG) | 74, Verkehrsbetriebe Zürichsee und Oberland (VZO) | 75, Vevey-Montreux-Chillon-Villeneuve (VMCV) | 76, WilMobil AG (Wilmob) | 77, Zugerland Verkehrsbetriebe AG (zvb) | 78, Regionalverkehr Bern-Solothurn (RBS) | 79, Other

1.1 If other *(specify)*

.....

2. When did you start working there? *Date:*

 .

Month .Year

3. Do you work or have you worked there full time (100%)?

Yes No

3.1 If not, at what rate do you or did you work there?

%

4. How many bus models have you driven for this company?

model(s)

Number from 1 to 10

According to the number indicated, display the following text.

If 1 new model: Can you tell us more about this bus?

If >1 new models: Can you tell us more about these buses, starting with the latest?

Displaying block questions

5. Using the search tool below, please select the bus model (one answer only).

Filtrer :

Entreprise

Marque

Modèle

Boîte de vitesse

Gabarit

Motorisation

Show entries Search:

Entreprise	Marque	Modèle	Année de mise en service (Suisse)	Année de mise en service (Entreprise)	Boîte de vitesse	Gabarit	Motorisation
Transports publics fribourgeois (TPF)	Berliert	EH 100 S	1962	1963	Continue/sans (avant/arrière)	Standard & midi	Trolley
Stadtbus Winterthur (SW)	Berna	4 GTP	1965	1965	Continue/sans (avant/arrière)	Articulé	Trolley
Verkehrsbetriebe Schaffhausen (vbsh)	Berna	4 GTP	1965	1966	Continue/sans (avant/arrière)	Articulé	Trolley

I can't find the bus model I don't know

6.1. If "I can't find the bus model". What is the model of the bus you currently drive or have driven most often in this company?

List currently being updated (given as an example)

1, Alexander Denis | 2, Berliert | 3, Berna | 4, Beulas | 5, BOVA/ VDL | 6, BredaMenarinibus | 7, Büssing | 8, FBW | 9, FHS | 10, FIAT | 11, Ford | 12, Hess | 13, Heuliez | 14, Irisbus-Iveco | 15, Irizar | 16, K-Bus / Kutsenits | 17, Magirus-Deutz | 18, MAN | 19, Merceds-Benz | 20, NAW | 21, Neoplan | 22, Opel | 23, Renault | 24, Saurer | 25, Scania | 26, Setra | 27, Solaris | 28, Temsa | 29, Van Hool | 30, Vetra | 31, Volvo | 32, Other

6.2. What is the vehicle size?

Mini Midi and standard (8-15 m) Articulated Bi-articulate Imperial (two-stage)

6.3. What type of engine does the vehicle have?

Combustion engine (diesel, gasoline, gas) Hybrid Electric Trolley

6.4. What type of gearbox does the vehicle have?

Manual Semi-automatic automatic Robotic Without gearbox or Continuous (forward/reverse)

7. How often do you or did you drive this vehicle? Please indicate the number of half-days per week (to determine driving rate).

1 2 3 4 5 6 7 8 9 10 11 12 13 14

Less than half a day

8. When did you start driving this bus?

.

Month Year

9. When did you stop driving it?

.

Month Year

10. What type of service do you perform or have you performed with this bus?

Urban

Regional

Mixed

10.1 If mixed, what percentage do you estimate drives or has driven this vehicle on urban routes? (Indicate percentage rate)

%

Repeat Vehicle block

Questionnaire on driver station ergonomics and comfort

We're now going to ask you a few questions about the ergonomics and comfort of the driver's cab. Please think about the bus model you have driven most often in the last 12 months.

Which bus model have you driven most often in the last 12 months?

Using the search tool below, please select the bus model.

Filterer :

Entreprise

Marque

Modèle

Boîte de vitesse

Gabarit

Motorisation

Show entries Search:

Entreprise	Marque	Modèle	Année de mise en service (Suisse)	Année de mise en service (Entreprise)	Boîte de vitesse	Gabarit	Motorisation
Transports publics fribourgeois (TPF)	Berliert	EH 100 S	1962	1963	Continue/sans (avant/arrière)	Standard & midi	Trolley
Stadtbus Winterthur (SW)	Berna	4 GTP	1965	1965	Continue/sans (avant/arrière)	Articulé	Trolley
Verkehrsbetriebe Schaffhausen (vbsh)	Berna	4 GTP	1965	1966	Continue/sans (avant/arrière)	Articulé	Trolley

1. Seat comfort

1. On a scale of 1 to 10, how would you rate the overall comfort of the seat? (1 = very uncomfortable / 10 = perfect)

1 2 3 4 5 6 7 8 9 10

2. Is the seat adjustable to your body type?

Yes, perfectly Yes, but with limited adjustment No, it's difficult to adjust

No, it's not adjustable

3. What settings are available to adapt your seat to your needs?

- Height adjustment : Yes No

- Depth adjustment : Yes No
- Lumbar adjustment : Yes No
- Back adjustment : Yes No
- Head adjustment : Yes No

4. Is the seatbelt comfortable and properly positioned?

- Yes, all the time Yes, sometimes No, it's uncomfortable

5. Does the seat cushioning system work properly?

- Yes, always No, never Don't know

6. Do you notice any wear on the seat?

- Yes, significantly Yes, slightly No, it's in good condition

7. On a scale from 1 to 10, how much does seat wear affect your comfort? (1 = not at all / 10 = very much)

- 1 2 3 4 5 6 7 8 9 10

2. Temperature and ventilation

1. Does the seat have an integrated ventilation system?

- Yes, heating only Yes, heating and cooling No Don't know

2. Are your feet cold or too hot in winter?

- Cold Too hot Correct temperature

3. Do you feel draughts in the cabin?

- Yes, often Yes, sometimes No, never

4. Is the ventilation easy to adjust?

- Yes, often Yes, sometimes No, never

5. Regarding air conditioning, would you like :

- More efficient air conditioning More air conditioning Less air conditioning Better individual control

3. Driving position and physical pain

1. Is the steering wheel position adapted to your morphology?

Yes, perfectly Yes, but with some difficulty No, it's uncomfortable

2. On a scale of 1 to 10, how would you rate the physical effort required to manoeuvre the steering wheel on a daily basis? (1 = very easy / 10 = very tiring)

1 2 3 4 5 6 7 8 9 10

3. Do you feel any pain while driving? (multiple choices possible)

Arm pain Shoulder pain Back pain Leg pain

Neck pain No pain

4. Do you think these pains are related to :

The hardness of the steering wheel The number of bends or turns Prolonged posture Other : _____

4. Visibility and sound environment

1. On a scale of 1 to 10, how would you rate visibility from your driving position? (1 = very poor / 10 = perfect)

1 2 3 4 5 6 7 8 9 10

2. Do any accessories interfere with your visibility (screen, tablet, stand, etc.)?

Yes, often Yes, sometimes No, never

3. If yes, please rate the following on a scale of 1 to 5 (from "Not at all bothersome" to "Very bothersome"), ranking them from most to least bothersome:

Passenger information display Management tablet Phone holder

Reflections/excessive brightness Positioning of accessories (screen, tablet, etc.)

Notifications or alerts displayed on devices

4. Does the noise level in the cabin bother you?

Yes, often Yes, sometimes No, never

5. If yes, please rate the following on a scale of 1 to 5 (from "Not at all bothersome" to "Very bothersome"), ranking them from most to least bothersome:

- Passengers talking loudly Passengers using their phones
- Mechanical bus noises Audible safety signals (beeps, alarms, etc.)

5. Customer relations

1. Would you like to be more isolated from customers?

- Yes, in most situations Yes, but only in certain situations No, I prefer to stay in contact with customers

2. Does direct contact with customers interfere with your concentration?

- Yes, often Yes, sometimes No, never

6. Vehicle condition

1. Does the age of your vehicle have an impact on your driving comfort?

- Yes, often Yes, sometimes No, never

2. Do you experience technical or comfort problems with older vehicles?

- Yes, often Yes, sometimes No, never

If yes, please specify:

- _____
- _____

11. Have you worked for another public transport company?

- Yes No

If yes to Q11: Former company

11.1 In which company did you previously work?

3, Aargau Verkehr (AVA) | 4, Busbetrieb Aarau AG (BBA) | 5, Aare Seeland mobil | 6, Autilinea Mendriense (AMSA) | 7, Autolinee Bleniesi SA (ABL) | 8, Auto AG Group (AAGR) | 9, Auto AG Schwyz | 10, Auto Ag Uri | 11, Autobetrieb Sernftal | 12, Autobetrieb Weesen-Amden (AWA) | 13, Autobus AG Liestal (AAGL) | 14, Autokurse Oberthurgau (AOT) | 15, Autolinee Regionali Luganesi (arl) | 16, Automobilverkehr Frutigen-Adelboden (AFA) | 17, Baselland Transport (BLT) | 18, Basler Verkehrsbetriebe (BVB) | 19, Bernmobil | 20, Busbetrieb Seetal Freiamt (BSF) | 21, BUS Ostschweiz AG (BO) | 22, Bus sédunois | 23, Busbetrieb Grenchen und Umgebung (BGU) | 24, Bus Sarganserland-Werdenberg (BSW) | 25, Busbetrieb Linchtensteig-Wattwil-Ebnat-Kappel (blwe) | 26, Busbetrieb Olten Gösgen Gäu (BOGG) | 27, Busbetrieb Solothurn und Umgebung (BSU) | 28, Busland AG Langnau Burgdorf (BLS) | 29, Chemin de fer du jura | 30, Compagnie de Chemin de fer et d'autobus Sierre-Montana-Crans SA (SMC) | 31, Engadin Bus | 32, Ferrovie Autolinee Regionali Ticinesi (FART) Locarno | 33, GEM'Bus | 34, Genève tour (G-tour) | 35, Globe Limo | 36, Odier Excursion | 37, Pfosi Arosa Bus AG | 38, PostAuto Schweiz AG (Carpostal) | 39, Ratpdev | 40, RDTA | 41, Regiobus AG Gossau (Regio) | 42, Regionalbus Lenzburg(RBL) | 43, Regionale Verkehrsbetriebe Baden-Wettingen (RVBW) | 44, Regionale Verkehrsbetriebe Schaffhausen RVSH | 45, Rottal Auto AG | 46, SBB-Bus Zofingen/Reiden | 47, Schneider Busbetriebe | 48, Seebus | 49, Sihltal Zürich Uetliberg Bahn AG (SZU) | 50, Stadtbus Chur | 51, Stadtbus Frauenfeld | 52, Stadtbus Kreuzlingen | 53, Stadtbus Winterthur (SW) | 54, STI Bus AG | 55, Tellbus Altdorf-Luzern | 56, Transports de la région Morges-Bière-Cossonay (MBC) | 57, Transports Martigny Région (TMR) | 58, Transports publics de la région lausannoise (tl) | 59, Transports publics de la région nyonnaise (tpn) | 60, Transports publics du Chablais (TPC) | 61, Transports publics fribourgeois (TPF) | 62, Transports publics genevois (TPG) | 63, Transports publics neuchâtelois (TransN) | 64, Transports urbains delémontains (TUD) | 65, Transports Vallée de Joux, Yverdon-les-Bains, Saint croix (Travys) | 66, Trasporti Pubblici Luganesi (TPL) | 67, Verkehrsbetriebe Zürich (VBZ) | 68, Verkehrsbetriebe Biel (TpB) | 69, Verkehrsbetriebe Davos (VBD) | 70, Verkehrsbetriebe Glattal AG (vbg) | 71, Verkehrsbetriebe Luzern (vbl) | 72, Verkehrsbetriebe Schaffhausen (vbsh) | 73, Verkehrsbetriebe St. Gallen (VBSG) | 74, Verkehrsbetriebe Biel (TpB) Gallen (VBSG) | 74, Verkehrsbetriebe Zürichsee un Oberland (VZO) | 75, Vevey-Montreux-Chillon-Villeneuve (VMCV) | 76, WilMobil AG (Wilmob) | 77, Zugerland Verkehrsbetriebe AG (zvb) | 78, Regionalverkehr Bern-Solothurn (RBS) | 79, Other

11.2 When did you start working for this company?

 .

Month . Year

11.3 When did you stop working for this company?

 .

Month . Year

11.4. Did you work full-time (100%)?

Yes No

11.5 If not, at what rate did you work?

%

Repeat Vehicle block

Repeat block Old company