

Transport Personnel Health Cohort Study (TRAPHEAC)
Annual follow-up survey

A few questions about you

As a member of the TRAPHEAC cohort, you are receiving this questionnaire to update your information and notify any changes that have occurred in the past year.

1. Have you moved house in the last 12 months?

Yes No → go to **Personal information**

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

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"/>

¹ We ask this question to estimate the radon concentration in the soil of your home. Radon is a toxic natural element whose concentration varies according to geographic region.

Personal information

This information is **essential** for understanding the results of the study. It **will not be examined individually**, but together with the responses of all participants.

1. Has your marital status changed in the last year?

- Yes No → **go to Q2**

1.1 If yes. What is your current marital status?

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

2. Are you still working as a bus driver?

- Yes → **go to Working Conditions** No

If no :

2.1 When did you finish your job as a driver?

Date (Day : Month : Year) : : :

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

- Retired
 Training for professional retraining
 On disability pension or permanent total work incapacity
 Looking for work
 Homemaker

Another profession

2.3 If practicing another profession :

Which profession: _____

In which sector of activity: _____

If the employment end date is more than 2 months before the questionnaire completion date, the following message will be displayed:

The rest of the follow-up questionnaire concerns active drivers only, so you don't need to answer it. Thank you for this information and for your participation.

Working conditions

We're going to ask you a few questions about your working conditions and how they've changed over **the last 12 months**. Many of you work in blocks of varying lengths, but for this follow-up study we need to calculate hours over a standard 7-day week, in order to make our statistical comparisons. Even if this does not correspond exactly to your daily routine, please provide average figures for a 7-day week. Please take your time to answer.

Your working hours -

1. Compared to a year ago, have your working hours changed?

No change It has improved It has deteriorated

2. In the last 12 months, have you worked irregular 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

2.1. 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

3. Do you have a rotating schedule?

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

3.1 If yes to 3, How often are schedules rotated?

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

3.2 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)

3.3 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

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

days

We will now ask you to take a 7-day week as a reference, so that we can make statistical comparisons in regards to the baseline study.

4. How many times a week do you work in the morning between 04:00 and 06:00 (on average, in the last 12 months)? *(one answer possible)*

- | | | |
|---|--|---|
| <input type="checkbox"/> 0 times a week | <input type="checkbox"/> 1 time per 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 | |

4.1 How many times a week do you work in the evenings between 8pm and midnight (on average, over the last 12 months)? *(one answer possible)*

- | | | |
|---|--|---|
| <input type="checkbox"/> 0 times a week | <input type="checkbox"/> 1 time per 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 | |

4.2 How many times a week do you work between 00:00 and 04:00 (on average, in the last 12 months)? *(one answer possible)*

- | | | |
|---|--|---|
| <input type="checkbox"/> 0 times a week | <input type="checkbox"/> 1 time per 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 | |

4.3. If 4, 4.1 and 4.2 > 0,

In 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)

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

: Hour : minute /day

6. How many hours a WEEK do you usually work?

hours/week

7. How many times a week have you worked over 10 hours (on average, over the last 4 weeks)?

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

- 0 times a week
- 1 time per week
- 2 times a week
- 3 times a week
- 4 times a week
- 5 times a week
- 6 times a week
- 7 times a week

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

Weekdays (Monday - Friday) Saturday Sunday

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

Yes

No

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

Yes

No

Your paid breaks and terminal stop

11. Compared to a year ago, have you noticed any changes in your (paid) break periods?

No change → go to Q21

Yes, and I'm more satisfied with my breaks.

Yes, and I'm less satisfied with my breaks.

12. On average, how many paid breaks do you take a day?

breaks/day

13. On average, how long does each break last?

minutes

14. On average, how long do you work between breaks?

: Hour : Minute

15. During these breaks, 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"/>

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
- 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

16. On a normal working day, how much time can you spend in a break room? (indicate duration in hours OR minutes, as appropriate)

HH : MM - :

Stopping time at terminus

17. On average, how many times a day do you stop at the terminus?

terminal/beat time/day

18. On average, how long does it take to stop at the terminus?

minute(s)

19. During your terminal stop, 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

A pretty rural landscape

Inside

Green plants

Is calm, unhurried

Includes games to relax (table soccer)

- The presence of plants or flowers
- Is airy
- Nothing remarkable
- Sports equipment
- Armchair, sofa, relaxation area
- Nothing remarkable

Your working conditions

20. Compared to a year ago, do you think your job now requires :
 More physical effort Less physical effort As much as before → **go to Q23**

21. 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"/>

22. Compared to a year ago, have you noticed a change in the way you reconcile your work and family commitments?
 No, no change Yes, reconciliation has become more difficult Yes, reconciliation has become easier

23. Compared to a year ago, do you think your work has :
 Become more stressful Become less stressful Not changed regarding stress → **go to Q26**

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

	Strongly disagree	No agreement	Neutral (Neither agree nor disagree)	I agree	I couldn't agree more
My job is stressful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking about my work makes me anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel under pressure when I am working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My work has negative effects on my health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. Compared with a year ago, do you think road traffic conditions have:

More traffic jams Less traffic jams No change

27. 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"/>

28. 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

1. Compared to last year, would you say that the quality of your sleep :

Improved Worsened Has not changed → **move to Q3**

2. We're going to ask you a few questions about your sleep. Choose the answer that best suits you. *(one answer per line)*

	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"/>

3. On average, over the last 12 months, how long before going to sleep did you stop using screens (phone, tablet, TV, computer...)?

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

Health

We will now ask you a few questions about your current state of health and how it has changed over the past 12 months. 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. Compared with a year ago, how would you rate your general state of health?

Better Less good No change

2. 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

3. What is your current weight?

kg

4. What is your current height?

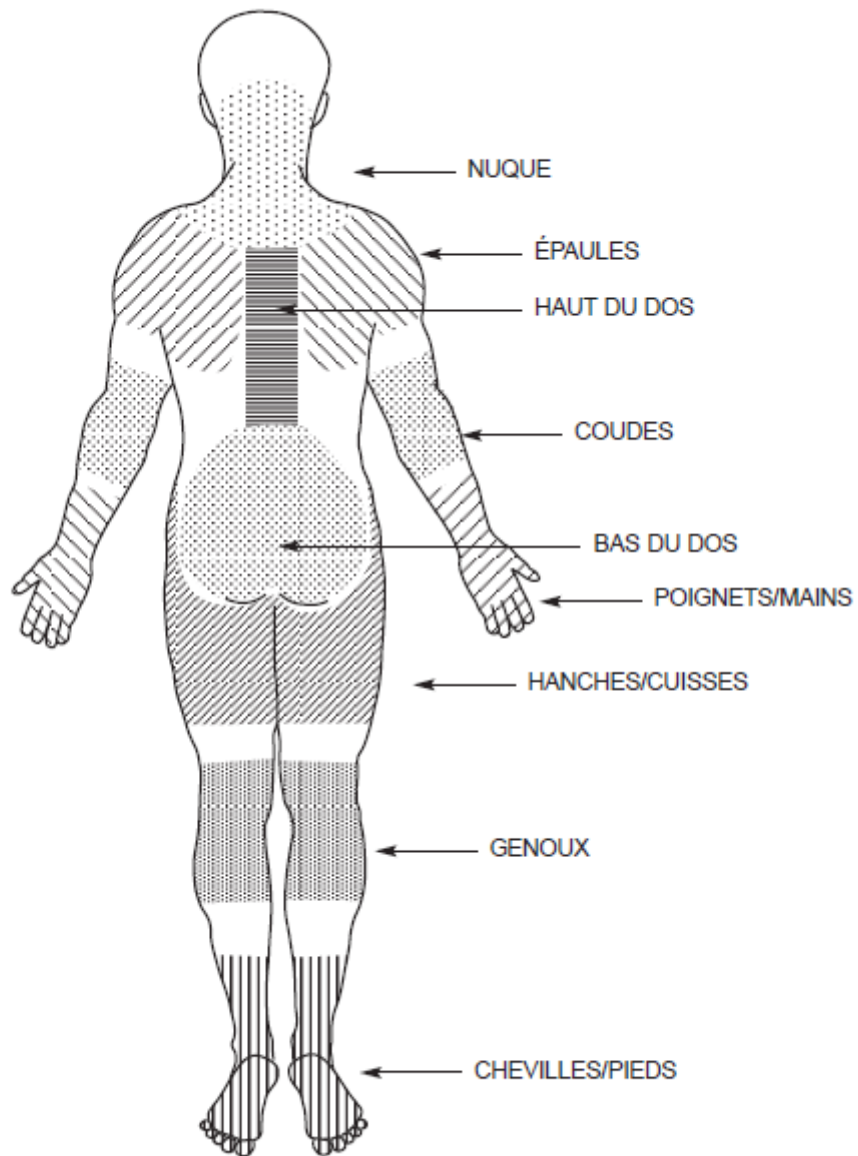
cm

Musculoskeletal disorders

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. Tick the ones that cause you pain (multiple answers possible).



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"/>	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	10

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	10

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"/>	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	10

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"/>	<input type="checkbox"/>	Inability to work due to hip/thigh pain
		0	1	2	3	4	5	6	7	8	9	10

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	

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	

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"/>	<input type="checkbox"/>	Worst pain ever
		0	1	2	3	4	5	6	7	8	9	10	

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	10

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"/>

Life balance

We'll now ask you a few questions about your current life balance. There will be questions about your well-being, your eating and exercise habits etc. 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.**

Your lifestyle

Alimentation

1. Has your diet changed in the last 12 months:

Yes No → go to Q4

2. If yes, please indicate your current consumption frequency.

	Rarely /Never	Between 1 and 4 times a month	Between 1 and 6 times a week	At least once a day
Meat (beef, veal, pork, game, etc.) - poultry excluded	<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"/>
Fast food (sandwiches, burgers, chips, etc.) :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wholegrain cereals (whole meal bread, wholegrain rice, etc.) :	<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"/>
Sweets or desserts (chocolate, cookies, pastries, ice cream, cake)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. How much of the following drinks do you usually drink a day? 1 glass corresponds to 0.2 dL. 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"/>
Café	<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"/>

4. Has your overall consumption of *alcoholic beverages* changed in the last 12 months?

- No, no change → **upgrade to Q9**
- Yes, it increased
- Yes, it reduced

5. Was there a time during the last 12 months when you consumed more than 5 glasses of alcoholic beverages (all beverages combined) each day?

Yes No

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. In the last 12 months:

- I started smoking → switch to Q10
- I've stopped smoking → go to Q11
- I've continued to smoke → switch to Q10
- I've never smoked → go to Q11

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?

Passive smoking

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

No, never Yes, some of the time Yes, regularly

12. In the last 12 months, were you exposed to tobacco smoke in your personal environment (at home, with relatives, etc.)?

No, never Yes, some of the time Yes, regularly

Drugs

13. In the last 12 months, have you used any of the following drugs? (e.g. cannabis, cocaine...)

	Never	One single time	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

Physical activity questionnaire

0. Over the past 12 months, would you say that your physical activity has :

Improved Worsened Has not changed → **Go to next section**

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

Event management and self-control

1. Compared to last year, do you perceive your stress as :

Higher Lower No change

2. 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?

In the last month, how often have you found that you could not cope with all the things that you had to do?

In the last month, how often have you been able to control irritations in your life?

In the last month, how often have you felt that you were on top of things?

In the last month, how often have you been angered because of things that happened that were outside of your control?

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

3. 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"/> |

Quality of life and satisfaction

Think about your life in general

1.1 Compared to last year, would you say that the quality of your life :

Improved
 Deteriorated
 Has not changed → **Skip to next section**

1.2 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?					
	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"/>

Medical history

1. In the last 12 months, have you been diagnosed with any new illnesses

- Yes No → **go to next section**

If yes to 1. Below is a list of different types of disease. Please indicate which type(s) of disease(s) you have been diagnosed with:

- 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*

If you have musculoskeletal diseases, please specify name, date of diagnosis and whether you are undergoing treatment.

MUSCULOSKELETAL DISEASES		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
1	Herniated disc	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Osteoporosis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Osteoarthritis	<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 cardiovascular disease, please specify name, date of diagnosis and whether treated

HEART DISEASES		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
4	Myocardial infarction (heart attack)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Angina pectoris, coronary artery disease	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Heart failure	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Heart rhythm disorders (pacemaker)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Obliterative arteriopathy of the lower limbs	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Hypertension	<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 already had a heart attack, how many heart attacks have you had?

Heart attack(s)

METABOLISM DISORDERS		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
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="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10b	Type II diabetes mellitus	<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="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10c	Gestational diabetes (during pregnancy)	<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="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Increased blood lipids, cholesterol or triglycerides	<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="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Drop	<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="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13a	Hyperthyroidism	<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="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13b	Hypothyroidism	<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="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13c	Other thyroid disorders : _____	<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="text"/>	<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 diabetes, please answer the questions Z 10.1

Z 10.1. How are you currently treated (taking into account insulin injections and insulin pumps)?

Only one possible answer

- Insulin injection only
- Insulin pumps only
- Tablets only
- Insulin and tablets
- Dietary treatment only
- Other treatment
- I am not taking any treatment
- I don't know

If neurological and psychological illnesses

NEUROLOGICAL DISEASES AND PSYCHICS		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
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
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
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
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
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
19	Anxiety disorders or panic attacks	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
20	Eating disorders	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
21	Attention deficit disorder with or without hyperactivity (ADHD)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

22	Dementia or Alzheimer's	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
23	Amyotrophic lateral sclerosis (ALS)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
24	Multiple sclerosis	<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 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		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
25	Asthma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
26	Chronic bronchitis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
27	Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
28	Pulmonary emphysema	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
29	Sleep apnea	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
30	Pneumonia	<input type="checkbox"/> Yes →	□□.□□□□	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

	<input type="checkbox"/> No		<input type="checkbox"/> No	<input type="checkbox"/> No
31 Other lung diseases:	<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

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)?

Please tick only one answer.

Yes No I don't know

AUDITORY DISORDERS	Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
32 Tinnitus	<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"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
33 Hearing loss	<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"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
34 Hearing disorders	<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"/> <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

35 Balance disorders / Vertigo Yes → □□.□□□□ Yes Yes
 No No No

I do not wish to answer

36. Do you wear a hearing aid?

Only one possible answer

Yes No

36.1 If yes, have you started wearing it in the last 12 months?

Yes No

36.2 If no, has there been any change in your hearing in the last 12 months?

Yes No

36.3 If yes to 36.1 or yes to 36.2, to which ear(s)?

Right Left Both ears

EYE DISEASES	Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
37 Cataracts	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
38 Glaucoma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
39 Age-related macular degeneration (AMD)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

40 Other eye disease: _____ Yes → Yes Yes
 No No No No

I do not wish to answer

41. Do you wear glasses or contact lenses?

Only one possible answer

Yes No

41.1 If yes, have you started wearing them in the last 12 months?

Yes No

41.2 If no, has your correction changed in the last 12 months?

Yes No

41.3 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

KIDNEY DISEASE, LIVER, STOMACH, INTESTINS		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
42	Gastric or duodenal ulcer	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
43	Heartburn or upset stomach	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
44	Intestinal inflammation (e.g. ulcerative colitis or Crohn's disease)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
45	Gallstones	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
46	Cirrhosis of the liver	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
47	Kidney stones in the ureter or bladder	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
48	Impaired renal function (e.g. chronic renal failure)	<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 ever had kidney failure, please answer the following question.

Z 48.1. Have you ever had dialysis?

Only one possible answer

Yes No I don't know

SKIN DISORDERS		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
49	Atopic dermatitis (neurodermatitis) or eczema	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
50	Psoriasis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
51	Severe acne	<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

ALLERGIES		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
52	Hay fever	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
53	Other allergic colds	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
54	Allergy to insect stings (bee, wasp, bumblebee, hornet)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
55	Dust mite allergy	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
56	Animal hair allergy	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
57	Contact allergies (latex, nickel, perfumes, etc.)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
58	Chronic sinusitis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

59	Food allergy (specify) : _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
60	Food intolerance (specify) : _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
61	Other allergy (specify): _____	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

CANCER	Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
62 Lung	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
63 Colorectal	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
64 Stomach	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
65 Esophagus	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
66 Hepatocellular carcinoma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
67 Breast	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
68 Glioma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
69 Meningioma	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

I do not wish to answer

GYNAECOLOGICAL DISEASES		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
80	Polycystic ovary syndrome (Stein-Leventhal 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
81	Endometriosis	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
82	Uterine myoma (benign tumor)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
83	Uterine prolapse (or uterine descent)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	□□.□□□□	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
84	Papillomavirus or HPV infection (in the cervix)	<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

OTHER ILLNESSES AND RARE DISEASES		Disease diagnosis	Month and year of diagnosis	Hospitalization for this diagnosis	Current treatment
85	Urinary tract infection (UTI)	<input type="checkbox"/> Oui → <input type="checkbox"/> Non	□□.□□□□	<input type="checkbox"/> Oui <input type="checkbox"/> Non	<input type="checkbox"/> Oui <input type="checkbox"/> Non
86	Rheumatoid arthritis / Polyarthritits	<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	Multiple sclerosis	<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	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
89	Congenital malformation	<input type="checkbox"/> Yes →	□□.□□□□	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

	<input type="checkbox"/> No		<input type="checkbox"/> No	<input type="checkbox"/> No
90 Electrohypersensitivity	<input type="checkbox"/> Yes →	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> No	<input type="checkbox"/> No
91 Other disease 1 : _____	<input type="checkbox"/> Yes →	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> No	<input type="checkbox"/> No
92 Other illness 2 : _____	<input type="checkbox"/> Yes →	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> No	<input type="checkbox"/> No

I do not wish to answer

Your Surgeries

93. Have you had any operations in the last 12 months?

Yes No

93.1 If yes, what operations have you undergone in the last 12 months?

(Multiple answers possible).

- 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 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)*
- Other, which one? _____*
- I do not wish to answer*

94. Have you received an electric shock in the last 12 months?

- Yes No

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 Don't know Don't want to

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 so, what was the cause of death? _____

96. During the last 12 months, have your parents been diagnosed with any of these diseases?

	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"/>
<i>Age at diagnosis</i>	<input type="checkbox"/> <input type="checkbox"/> years	<input type="checkbox"/> <input type="checkbox"/> years
Sudden death	<input type="checkbox"/>	<input type="checkbox"/>
<i>Age</i>	<input type="checkbox"/> <input type="checkbox"/> years	<input type="checkbox"/> <input type="checkbox"/> years
AVC	<input type="checkbox"/>	<input type="checkbox"/>
<i>Age at diagnosis</i>	<input type="checkbox"/> <input type="checkbox"/> years	<input type="checkbox"/> <input type="checkbox"/> years
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>
<i>Age at diagnosis</i>	<input type="checkbox"/> <input type="checkbox"/> years	<input type="checkbox"/> <input type="checkbox"/> years
Severe psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>
Specify	_____	_____
<i>Age at diagnosis</i>	<input type="checkbox"/> <input type="checkbox"/> years	<input type="checkbox"/> <input type="checkbox"/> years
Suicide	<input type="checkbox"/>	<input type="checkbox"/>
<i>Age</i>	<input type="checkbox"/> <input type="checkbox"/> years	<input type="checkbox"/> <input type="checkbox"/> years
Type II diabetes (NIDDM)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Age at diagnosis</i>	<input type="checkbox"/> <input type="checkbox"/> years	<input type="checkbox"/> <input type="checkbox"/> years
Dialysis or kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>
<i>Age</i>	<input type="checkbox"/> <input type="checkbox"/> years	<input type="checkbox"/> <input type="checkbox"/> years
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<i>Age at diagnosis</i>	<input type="checkbox"/> <input type="checkbox"/> years	<input type="checkbox"/> <input type="checkbox"/> years

I do not wish to answer

Women's health, gynecological 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. Compared to last year, have you noticed any changes in your menstrual cycle (regularity and/or length of periods)?

Yes No I do not wish to answer

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

Indicate one answer only.

- Regular, naturally
- Regular hormone therapy (e.g. the pill)
- Irregular
- I don't have anymore
- I don't know
- I do not wish to answer

2.1 How long are your menstrual cycles on average?

days

My cycles are too irregular

I do not wish to answer

2.2 If I have stopped menstruating. Why haven't you had your period for 3 months or more?

I am menopausal 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

3. Have you changed your contraceptive method in the last 12 months?

No

Yes

Which one?

Pill

Hormonal implant

Hormonal IUD

- Copper coil
- Vaginal ring
- Other hormone treatments

Product name : _____

- Other types of contraception

Laquelle -----

- I do not wish to answer

4. Have you become pregnant in the last 12 months?

- Yes
- No
- I do not wish to answer

4.1 If yes to 4. Did you benefit from any job accommodation during your pregnancy?

- Yes
- Can you describe them? : _____
- No
- I do not wish to answer

4.2 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

5. In the last 12 months, have you had one or more biological children?

(indicate 0, if no children)

5.1 If yes. For each child recently born, please indicate: gender, year of birth, birth weight, whether breast-fed (even partially) and, if so, for how many months.

Child	Gender		Year of birth	Birth weight	Born premature?		How many weeks of amenorrhea (SA)	Breastfeeding		How many months (*)	Malformation (p. e.g. heart, hearing impairment, spina bifida...)
	♂	♀			Yes	No		Yes	No		
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.

6. In the last 12 months, have you experienced a miscarriage or loss of child at birth within your couple?

No

Yes,

If so, how many times?

- Miscarriage _____

- Child born dead / loss of child at birth _____

At what week(s) of pregnancy (SA)?

- Miscarriage _____

- Stillborn child/loss of child at birth _____

I do not wish to answer

7. Have you tried to conceive a child in the last 12 months (or 6 months if you are 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

Professional career

We're going to ask you a few questions about changes in your work over the past year, including your company and 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 precisely.

1. Are you still working for the same company as a year ago?

Yes → go to Q3 No

1.2 If NO to 1. how many different transport companies have you worked for in the last 12 months?

Number of transport companies

2. If NO to 1. In which company do you currently work or did you work last? (only one answer)

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 yvonnoise (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

2.1 If other (specify)

.....

2.2 When did you start working for this company? Approximate date :

.

Month Year

3. At what rate do you work there?

%

4. Compared with last year, did you drive any bus models that you hadn't driven before?

Yes No → skip to next part: Preference for cohortists

5. If YES to 4, how many new bus models have you driven in the last year?

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

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

Filtrer :

Entreprise

Marque

Modèle

Boîte de vitesse

Gabarit

Motorisation

Show 10 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 brand of this bus?

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, Mercedes-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 An imperial (Double-decker)

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
 Robotics Gearless/Continuous (forward/reverse)

7. How many half-days (about 4 hours) a week do you drive this bus most often?

- 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? Approximate

.

Month . Year

9. Do you still drive this model of bus?

- Yes No

9.1 If NO, when did you stop driving it?

.

Month . Year

10. What type of service do you usually perform or have 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)

%

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.

Filtrer :

Entreprise

Marque

Modèle

Boîte de vitesse

Gabarit

Motorisation

Show 10 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:
