Imperial College London
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Airwave Health Monitoring Study

Dear participant,

This is an important letter inviting you to take part in the largest health monitoring study ever undertaken among the British police force. The goal of this study is to investigate any possible health effects associated with Airwave, the new communications system for the police force.

Although there is no current evidence to suggest any adverse health effect associated with Airwave use, the National Radiological Protection Board's Advisory Group on Non-ionizing Radiation recently recommended the need for further medical research as a precautionary measure. Imperial College has therefore been commissioned to conduct a health monitoring study to be offered to more than 100,000 police Airwave users in Great Britain to investigate any possible impact on health in both the short and long term.

For this research to be successful it is essential that we gain the most accurate and complete information we can in order to check your health. We therefore need your help in completing the enclosed questionnaire and consent form, and returning these to the researchers in the **FREEPOST** envelope provided as soon as possible. IT IS IMPORTANT TO REPLY EVEN IF YOU DO NOT CURRENTLY HAVE ANY HEALTH PROBLEMS. While some questions may seem unrelated to Airwave use, all questions cover issues that have or may have an impact on your health.

We are also asking whether you would be willing to accept the **offer of a free health screen**, details of which can be found over the page. The health screen will improve our assessment of your health and give us the opportunity to provide free and independent health feedback directly to you including blood pressure, blood cholesterol and risk of coronary heart disease. We stress that all the information we collect from the questionnaire and from the health screen will be kept strictly confidential at all times.

For further information about the study, an information leaflet and a support letter from your police force are enclosed. More information can also be found on the website http://www.police-health.org.uk/ and on the Airwave website on your Force Intranet. Alternatively, please email us at Airwave@imperial.ac.uk or write to us via the contact details below.

Thanking you in anticipation of your help.

Yours sincerely,

Dr David Neasham,
Co-Principal Investigator and Research Coordinator,
Airwave Health Monitoring Study,
Department of Epidemiology & Public Health,
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Free Health Screen Offer

In the Airwave Health Monitoring Questionnaire enclosed, you will have the opportunity to indicate your interest in attending a free health screen that will involve:

- Physical tests including height, weight, waist size, hip size and lung function (blowing into a mouthpiece connected to an instrument), heart trace (ECG) and blood pressure.
- Collection of blood and urine samples. Blood samples will be analyzed for cholesterol levels and other biochemical and haematological factors, and then blood and urine samples will be stored on a long-term basis.

Data from the health screen will allow the researchers to:

- Take into account other clinical and/or lifestyle factors when estimating the possible risk of ill-health and disease associated with long-term exposure to Airwave
- Help rule out other possible causes of ill-health and disease that may be explaining the research findings
- Provide vital information for improving future treatment of illness, health promotion, diagnosis and prevention of disease

We will also send you free and confidential information on results of your health screen which you may wish to discuss with your GP. We can reassure you that **under no circumstances will any personally identifiable information from an individual record or health screen be made available to the Home Office, Police Force or anyone else outside the research team.**

All results of the health screen, including results of physical tests, identification of biological samples and results of laboratory tests will be treated as strictly confidential. Questionnaire data and data on height, weight, waist size, hip size, blood pressure, ECG and lung function will be stored securely on a private and secure computer network. All samples will be barcoded, instead of being labelled with personal identifiers such as name or address, so that you are not individually identifiable from any of the samples or analyses.

You will be given abstraction time to attend a health screening appointment which will take place later in the year. When you arrive for the appointment, a nurse will explain the health screen to you and help you with any questions or concerns you may have. The nurse will then ask for your consent to take part in the research and take you through the health screen. The whole process should take around 40-50 minutes to complete.

If you have any questions or concerns about the health screen, please feel free to contact the research team (see contact details on the information leaflet).

For us to plan ahead and organize the health screening appointments, we would greatly appreciate if you could indicate whether you would be interested in attending a free appointment. Please tick the box below if you would like to attend:

I would like to attend a free health screen

Please tick box: ☐

AIRWAVE HEALTH MONITORING STUDY CONSENT

Thank you for taking the time to read the enclosed information about the Airwave Health Monitoring Study. While participation in the study is voluntary, it is vital for the success of the study that we get as many completed health questionnaires returned to us as possible so that we have enough statistical data to detect possible health effects associated with Airwave use. We can reassure you that neither you nor anyone else in the study will be identified or named in any of the results, reports, documents or scientific papers that we produce.

It is also vital that we have your consent to follow-up your health in the future via health records. Without your consent, we will not be able monitor your health via GP and hospital records, or national registers of cancer and deaths.

In addition, the researchers will need to examine health problems you may have in the future, which may be linked to sickness absence and early retirements. To do this, we will need to obtain data from your personnel files.

Lastly, we need to know if you leave the police or transfer to another police force so that we can keep up to date with who are current users of Airwave.

For us to monitor your health we need to ask your permission:

"*I have read the enclosed introduction letter and information leaflet on the Airwave and Health Monitoring Study and understand why this project is being done.*

I understand that all the questionnaire answers and data will be kept strictly confidential and stored securely on a private and secure computer network at Imperial College.

I allow the research team access to my medical files, including GP and hospital records as well as data on cancer and mortality held on National Registers.

I allow the research team access to data contained in my police personnel records to identify job, change of police force, retirement and sickness absence".

Under no circumstances will any information from an individual record or questionnaire be made available to the Home Office or Police Force.

Please sign below:

Signed _____ Print name _____

Name of participant (BLOCK CAPITALS)

Date _____

CONTACT INFORMATION

PLEASE USE BLOCK CAPITALS TO COMPLETE THIS SECTION

Without your personal details, we will not be able to trace your health in the future via medical registers. Therefore, we would appreciate you providing the following information to help us with tracking your future health. If you do not know your details or it does not apply to you, please leave it blank. All information provided will be kept strictly confidential:

First name | Surname

Address

Postcode | Phone number

E-mail | Collar number

Maiden name (if applicable) | NHS number (if known)

Name of Force

Name of Division/OCU

When people leave the Police Force it often proves difficult to contact them. In order to help us keep in touch with you to conduct further important research, we would appreciate it if you would provide the name and address of TWO people who are likely to know where you are in the future should we lose contact with you.

1. First name of contact | Surname of contact

   Relationship (i.e. parent, sibling, friend)

   Address:

   Postcode: | Phone number:

2. First name of contact | Surname of contact

   Relationship (i.e. parent, sibling, friend)

   Address:

   Postcode: | Phone number:

In addition, we would like you to provide us with the name and address of your GP. This again will help us in tracing your health in the future.

Surname of GP

Address:

Postcode: (if known) | Phone number: (if known)

Instructions

Please read all questions carefully. Most of the questions can be answered by putting a cross in the box next to the answer that applies to you, like this:

☒ 1 Yes
☐ 2 No

Sometimes you have to write a number in a box, for example:

1 2 6 9 (mm/yy)

Some questions may not apply to everyone. Where you need to skip a question, we have indicated which question or section to go to next. If you do not know the answer to a question, please leave it blank. ***All information will be kept strictly confidential****.*

SECTION 1 – Personal Details and Work History

We would like some information on your personal details and work history. This will allow us to take into account variation in background and socioeconomic factors.

1. Are you:

☐ 1 Male
☐ 2 Female

2. What is your date of birth?

☐☐ ☐☐ ☐☐ (dd/mm/yy)

3. Do you consider yourself to be:

☐ 1 White – British
☐ 2 White – Irish
☐ 3 Any other White background
☐ 4 Mixed – White and Black Caribbean
☐ 5 Mixed – White and Black African
☐ 6 Mixed – White and Asian
☐ 7 Any other mixed background
☐ 8 Asian - Indian
☐ 9 Asian – Pakistani
☐ 10 Asian – Bangladeshi
☐ 11 Any other Asian background
☐ 12 Black – Caribbean
☐ 13 Black – African
☐ 14 Any other Black background
☐ 15 Chinese
☐ 16 Any other Asian background
☐ 17 Any other

4. What is the highest level of education you have completed to date?

☐ 1 Left school before taking O levels / GCSE's
☐ 2 GSCE/O-Level/CSE
☐ 3 Vocational qualifications (NVQ1+2)
☐ 4 A levels / Highers or equivalent (NVQ3)
☐ 5 Bachelor Degree or equivalent (NVQ4)
☐ 6 Postgraduate qualifications

5. When did you first join the police force?

☐☐ ☐☐ (mm/yy)

6. What is your role within the force?

☐ 1 Police staff
☐ 2 Police Constable/Sergeant
☐ 3 Inspector/Chief Inspector
☐ 4 Superintendent or above

7. How long have you served in your current role?

☐☐ years ☐☐ months

8. At this time, what is your total household annual income?

☐ 1 Less than £10,000
☐ 2 £10,001 - £20,000
☐ 3 £20,001 - £30,000
☐ 4 £30,001 - £50,000
☐ 5 £50,001 - £75,000
☐ 6 More than £75,000

SECTION 2 – Airwave Usage Information

We would like some information on your use of the new Airwave technology. If you are not yet using Airwave, please go to SECTION 3.

Always enter one number in each box, like this:

Hr	Hr	Min	Min
0	3	2	5

1. When did you first start using Airwave radios?

☐☐ ☐☐ (mm/yy)

2. This question asks you about any symptoms you may have experienced *during* or *shortly after* using your Airwave radio.

a) *While using* your Airwave radio, do you experience any of the following acute symptoms?

i) **Airwave radio use in *transmit* ("press to talk", PTT) mode:**

- ☐ 1 Headache
- ☐ 2 Dizziness
- ☐ 3 Numbness in hands
- ☐ 4 Nausea
- ☐ 5 Warming sensation on face
- ☐ 6 Deafness
- ☐ 7 Burning sensation in ear
- ☐ 8 Any other symptom (please specify:)

ii) **Airwave radio use in *mobile phone* mode:**

- ☐ 1 Headache
- ☐ 2 Dizziness
- ☐ 3 Numbness in hands
- ☐ 4 Nausea
- ☐ 5 Warming sensation on face
- ☐ 6 Deafness
- ☐ 7 Burning sensation in ear
- ☐ 8 Any other symptom (please specify:)

b) Do you experience any of the following symptoms *within 15 – 20 minutes after* using your Airwave radio?

i) **Airwave radio use in *transmit* ("press to talk", PTT) mode:**

- ☐ 1 Headache
- ☐ 2 Dizziness
- ☐ 3 Numbness in hands
- ☐ 4 Nausea
- ☐ 5 Warming sensation on face
- ☐ 6 Deafness
- ☐ 7 Burning sensation in ear
- ☐ 8 Any other symptom (please specify:)

ii) **Airwave radio use in *mobile phone* mode**

- ☐ 1 Headache
- ☐ 2 Dizziness
- ☐ 3 Numbness in hands
- ☐ 4 Nausea
- ☐ 5 Warming sensation on face
- ☐ 6 Deafness
- ☐ 7 Burning sensation in ear
- ☐ 8 Any other symptom (please specify:)

c) Do you have any concerns about your health or safety regarding use of Airwave radios?

☐ 1 Yes: *Please specify below:* ☐ 2 No

#

d) Have you had any technical or performance problems with your Airwave radio, either in transmit or phone mode?

☐ 1 Yes: *Please specify below:* ☐ 2 No

3. a) Please provide details of the date of your last full shift when you used an Airwave radio:

☐☐ ☐☐ ☐☐ (dd/mm/yy)

b) Please provide details of the start time (*using the 24-hour clock*) and duration (*in hours and minutes*) of your last full shift when you used an Airwave radio:

	Hr	Hr		Min	Min
Start time of shift :	☐	☐	:	☐	☐
Duration of shift :	☐	☐	:	☐	☐

4. Approximately how much of your last full shift while using an Airwave radio was spent at the following locations?

Location	Hr	Hr		Min	Min
On foot patrol (outside)	☐	☐	:	☐	☐
In a police vehicle	☐	☐	:	☐	☐
On a police motorcycle	☐	☐	:	☐	☐
At the police station	☐	☐	:	☐	☐
Hospitals or other areas where my Airwave radio is switched off	☐	☐	:	☐	☐
Inside other buildings other than a hospital or police station	☐	☐	:	☐	☐

Please provide information on where you carry your Airwave radio.

5. a) Do you usually wear your Airwave radio on your body armour while on duty?

☐ 1 Yes: *Please go to question 5.b)*
☐ 2 No: *Please go to question 5.c)*
☐ 3 I don't wear body armour while on duty: *Please go to question 5.c)*

b) If *yes*, where do you usually carry your Airwave radio on your body armour?

☐ 1 My left side lapel mounting
☐ 2 My right side lapel mounting
☐ 3 My lower left side waist mounting
☐ 4 My lower right side waist mounting

c) If *no*, where do you usually carry your Airwave radio?

☐ 1 My left side hip (belt mounted)
☐ 2 My front left side (belt mounted)
☐ 3 My back left side (belt mounted)
☐ 4 At the base of my spine (belt mounted)
☐ 5 In a jacket pocket
☐ 6 My right side hip (belt mounted)
☐ 7 My front right side (belt mounted)
☐ 8 My back right side (belt mounted)
☐ 9 In a handbag or briefcase
☐ 10 Other (please specify:)

6. This question relates to your use of Airwave radios in *transmit or "press-to-talk" (PTT) mode only* and excludes use in mobile phone mode.

Please provide information on the usual location of your Airwave radio in transmit mode. *Please tick one box in each line:*

Location of Airwave radio (*not in mobile phone mode):*	Approximate amount of time used in this position:		
	All of time	Some of the time	None of the time
a) Lapel mounted	☐ 1	☐ 2	☐ 3
b) Hand-held in front of face	☐ 1	☐ 2	☐ 3
c) Hand-held next to left ear	☐ 1	☐ 2	☐ 3
d) Hand-held next to right ear	☐ 1	☐ 2	☐ 3
e) Lapel mounted with earpiece	☐ 1	☐ 2	☐ 3
f) Lapel mounted using earpiece & remote speaker	☐ 1	☐ 2	☐ 3
g) Belt mounted with earpiece	☐ 1	☐ 2	☐ 3
h) Belt mounted using earpiece & remote speaker	☐ 1	☐ 2	☐ 3
i) Desk mounted	☐ 1	☐ 2	☐ 3
j) Other (please specify:)	☐ 1	☐ 2	☐ 3

k) If you usually use them, when did you first start using a remote speaker microphone and/or earpiece with your Airwave radio in *transmit mode*?

☐☐ ☐☐ (mm/yy)

7. This question relates to your use of Airwave radios in *mobile phone mode only* and excludes use in transmit (PTT) mode.

Please provide information on the usual location of your Airwave radio in transmit mode. *Please tick one box in each line:*

Location of Airwave radio (*not in mobile transmit or press-to-talk(PTT) mode):*	Approximate amount of time used in this position:		
	All of the time	Some of the time	None of the time
a) Lapel mounted	☐ 1	☐ 2	☐ 3
b) Hand-held in front of face	☐ 1	☐ 2	☐ 3
c) Hand-held next to left ear	☐ 1	☐ 2	☐ 3
d) Hand-held next to right ear	☐ 1	☐ 2	☐ 3
e) Lapel mounted with earpiece	☐ 1	☐ 2	☐ 3
f) Lapel mounted using earpiece & remote speaker	☐ 1	☐ 2	☐ 3
g) Belt mounted with earpiece	☐ 1	☐ 2	☐ 3
h) Belt mounted using earpiece & remote speaker	☐ 1	☐ 2	☐ 3
i) Desk mounted	☐ 1	☐ 2	☐ 3
j) Other (please specify:)	☐ 1	☐ 2	☐ 3

k) If you usually use them, when did you first start using a remote speaker microphone and/or earpiece with your Airwave radio in *mobile phone mode*? ☐☐ ☐☐ (mm/yy)

8. This question is about any work you may have carried out on Airwave or other appliances emitting radiofrequency fields.

a) Are you involved with the installation, operation, maintenance, or repair of Airwave equipment or transmitters at work?

☐ 1 Yes: *Please specify below:* ☐ 2 No

b) Do you use, install, operate, maintain, or repair any non-Airwave equipment or transmitters at work or off-duty ?

☐ 1 Yes: *Please specify below:* ☐ 2 No

c) Have you ever worked as an electrician or electrical appliances repair technician?

☐ 1 Yes: *If yes, from what dates?* ☐☐ ☐☐ to ☐☐ ☐☐ (mm/yy)

☐ 2 No

9. a) In the last full shift when you used an Airwave radio, did you also use your old analogue Police radio?

☐ 1 Yes: *Please go to question 9.b)* ☐ 2 No: *Please go to Section 3*

b) Please estimate the total duration of calls you made *and* received only on your old analogue Police radio while on your last full shift, in addition to your Airwave calls:

	Approximate total duration of calls in minutes
Use of old analogue Police phone	☐☐☐

SECTION 3 – Mobile Phone Use

We would now like some information about the use of your own or any other mobile phone (*not including* the use of your Airwave radio).

1. Do you use a mobile phone?

☐ 1 Yes

☐ 2 No: *Please go to Section 4*

2. Which year did you start using a mobile phone?

☐☐ ☐☐ (mm/yy)

3. Have you changed your conversation time or number of mobile phone calls in the past year?

☐ 1 No

☐ 2 Yes: Increased

☐ 3 Yes: Decreased, due to symptoms experienced in relation to calling

☐ 4 Yes: Decreased, due to concern about health risks

☐ 5 Yes: Decreased, for other reasons

☐ 6 Don't know

4. a) Not counting SMS text messaging, please estimate the total duration of phone calls you made *and* received on your mobile phone(s) *in the last 24 hours*.

Approximate total duration of calls in minutes

Use of mobile phone(s) ☐☐☐

b) Please estimate the length of your longest mobile phone call and your average mobile phone call length *in the last 24 hours*.

	Longest call in minutes	Average call duration in minutes
Use of mobile phone(s)	☐☐☐	☐☐☐

Question 5 a), b) and c) are about your mobile phone use with hands-free equipment or a handset:

5. a) Do you use hands-free equipment or a headset with your mobile phone(s)?

☐ 1 Yes

☐ 2 No: *Please go to question 6*

b) When did you first start using hands-free equipment or a headset?

☐☐ ☐☐ (mm/yy)

c) Please estimate the proportion of time you usually spend using hands-free equipment or a handset while talking on your mobile phone(s) *1=none of the time up to 10=all of the time (please cross one box)*

None of the time — All of the time

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. When you use a mobile phone, do you generally use it on the right or left side of your head?

☐ 1 Right side

☐ 2 Left side

☐ 3 Both/either

7. How often do you move the mobile phone from ear to ear during calls?

☐ 1 Almost never

☐ 2 Occasionally

☐ 3 During most calls

8. *While using* your mobile phone(s), do you experience any of the following acute symptoms?

☐ 1 Headache

☐ 2 Dizziness

☐ 3 Numbness in hands

☐ 4 Nausea

☐ 5 Warming sensation on face

☐ 6 Deafness

☐ 7 Burning sensation in ear

☐ 8 Any other symptom (please specify:)

9. Do you experience any of the following symptoms *within 15 – 20 minutes after* using your mobile phone(s)?

☐ 1 Headache

☐ 2 Dizziness

☐ 3 Numbness in hands

☐ 4 Nausea

☐ 5 Warming sensation on face

☐ 6 Deafness

☐ 7 Burning sensation in ear

☐ 8 Any other symptom (please specify:)

SECTION 4 – General Health

The next few questions ask you about your general health and family history.

1. Would you say that you have bothersome headaches?

- ☐ 1 Yes
- ☐ 2 No: *Please go to question 6*

2. How often do you get these headaches at the moment?

- ☐ 1 Almost every day
- ☐ 2 5 or 6 times a week
- ☐ 3 3 to 4 times a week
- ☐ 4 Once or twice a week
- ☐ 5 Once or twice a month
- ☐ 6 Once or twice in the last year
- ☐ 7 Not at all in the last 12 months

3. Do *any* of these bothersome headaches fit the following descriptions? *Please tick one box in each line:*

	All	Some	None
a) Moderate or severe headache pain	☐ 1	☐ 2	☐ 3
b) Headache pain on one side of the head only	☐ 1	☐ 2	☐ 3
c) Throbbing/pulsating headache pain	☐ 1	☐ 2	☐ 3
d) Made worse by light exercise, such as going upstairs	☐ 1	☐ 2	☐ 3
e) Lasting 4 – 72 hours if left untreated	☐ 1	☐ 2	☐ 3

4. How often do you get the headaches that **fit the description in *question 3*?**

- ☐ 1 Almost every day
- ☐ 2 5 or 6 times a week
- ☐ 3 3 to 4 times a week
- ☐ 4 Once or twice a week
- ☐ 5 Once or twice a month
- ☐ 6 Once or twice in the last year
- ☐ 7 Not at all in the last 12 months

5. With the headaches described in *question 3*:

	Every time	Sometimes	Never
a) Do you feel sick or vomit?	☐ 1	☐ 2	☐ 3
b) Does ordinary daylight bother you?	☐ 1	☐ 2	☐ 3
c) Does general noise bother you?	☐ 1	☐ 2	☐ 3

6. We would like some information about any symptoms and conditions you may have. Please complete both sides of the table. If you do not have any symptoms, please leave that line blank.

Please tick if you have had this symptom in the *past month*	If yes, how bad has it been?			Please tick if you have had this symptom in the *past month*	If yes, how bad has it been?		
	Mild[1]	Moderate[2]	Severe[3]		Mild[1]	Moderate[2]	Severe[3]
☐[1] Rapid heartbeat	☐	☐	☐	☐[12] Feeling jumpy/easily startled	☐	☐	☐
☐[2] Irritability/outbursts of anger	☐	☐	☐	☐[13] Feeling unrefreshed after sleep	☐	☐	☐
☐[3] Unable to breathe deeply enough	☐	☐	☐	☐[14] Increased sensitivity to noise	☐	☐	☐
☐[4] Faster breathing than normal	☐	☐	☐	☐[15] Loss of hearing	☐	☐	☐
☐[5] Feeling short of breath at rest	☐	☐	☐	☐[16] Ringing in the ears	☐	☐	☐
☐[6] Wheezing	☐	☐	☐	☐[17] Pulsing sound in ears	☐	☐	☐
☐[7] Sleeping difficulties	☐	☐	☐	☐[18] Loss of smell	☐	☐	☐
☐[8] Dizziness	☐	☐	☐	☐[19] Loss of concentration	☐	☐	☐
☐[9] Feeling disorientated	☐	☐	☐	☐[20] Itchy or painful eyes	☐	☐	☐
☐[10] Vomiting	☐	☐	☐	☐[21] Shaking	☐	☐	☐
☐[11] Nausea	☐	☐	☐	☐[22] Seizures	☐	☐	☐

7. a) During the *past month*, have you had any ache or pain which has lasted for one day or longer?

☐[1] Yes: *Please complete 7. b), 7. c), 7. d) and 7. e)*

☐[2] No: *Please go to question 8*

b) Do you have any pain now?

☐[1] Yes

☐[2] No

c) When did the pain start?

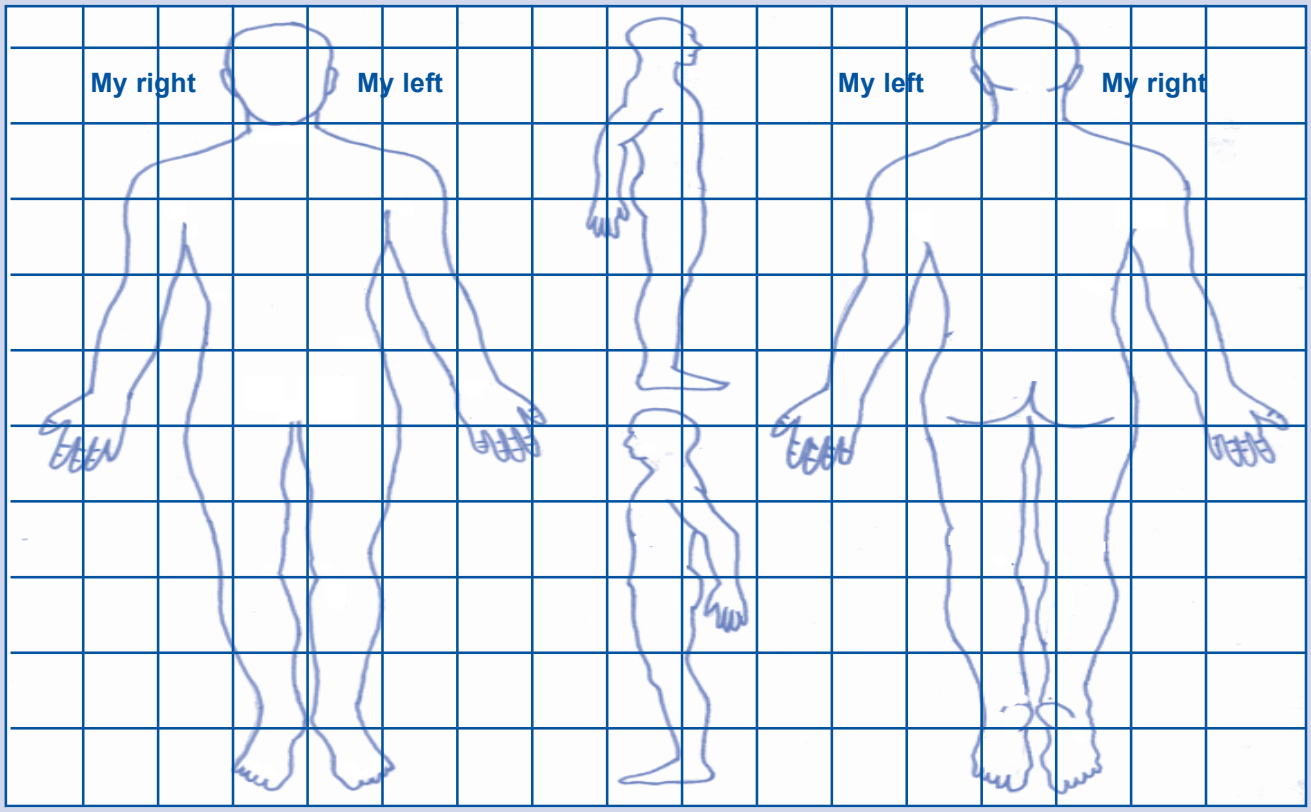
☐[1] Less than 3 months ago

☐[2] More than 3 months ago

d) What do you think has been the cause of your pain?

7. continued

e) Please shade in on the diagram below where you felt or feel the aches and pains:



8. Have you ever experienced loss of sight or impairment of vision in one eye, accompanied by pain around the eye caused by eye movement (opticus neuritis)?

☐ 1 Yes

☐ 2 No

9. Have you ever been diagnosed by a doctor with any of the following conditions? *(please cross where appropriate)*

☐ 1 High blood pressure

☐ 2 Angina

☐ 3 Heart attack

☐ 4 Stroke/transient ischaemic attack (TIA)

☐ 5 Heart murmurs

☐ 6 COPD (Chronic Obstructive Pulmonary Disease)

☐ 7 Cancer (please specify type:)

☐ 8 Diabetes mellitus

☐ 9 Asthma

☐ 10 Allergy (i.e. eczema, hay fever, rhinitis)

☐ 11 Cataract

☐ 12 Glaucoma or high eye pressure

☐ 13 Epilepsy

☐ 14 Arthritis

☐ 15 Parkinson's Disease

☐ 16 Deafness

☐ 17 Chronic Fatigue Syndrome/ME

☐ 18 Depression

☐ 19 Chronic liver disease

10. What was your own birth weight?

☐☐ pounds ☐☐ ounces ☐ 1 I do not know my own birth weight

To help us make the most comprehensive health assessment, please complete the following questions on your family medical history. Thank you for your help.

11. a) Is your biological father still alive?

☐ 1 Yes: *Please go to question 12*

☐ 2 No *Please go to question 11b*

☐ 3 Don't know: *Please go to question 12*

b) How old were you when your father died?

☐ years old

c) How old was your father when he died?

☐ years old

d) What did he die from?

☐ 1 Heart attack (coronary)

☐ 2 Stroke

☐ 3 Neurological condition

☐ 4 Cancer (please specify type:)

☐

☐ 5 Other causes (please specify:)

☐

☐ 6 Don't know

12. a) Is your biological mother still alive?

☐ 1 Yes: *Please go to question 13*

☐ 2 No *Please go to question 12b*

☐ 3 Don't know: *Please go to question 13*

b) How old were you when your mother died?

☐ years old

c) How old was your mother when she died?

☐ years old

d) What did she die from?

☐ 1 Heart attack (coronary)

☐ 2 Stroke

☐ 3 Neurological condition

☐ 4 Cancer (please specify type:)

☐

☐ 5 Other causes (please specify:)

☐

☐ 6 Don't know

13. a) This question concerns any medicines that you may have taken during the last 14 days. Have you been taking any medicines, tablets, tonics or pills *prescribed by a doctor* (excluding contraceptive pills) within the last 14 days?

☐ 1 Yes *Please go to question 13.b*) If yes,

☐ 2 No: *Please go to question 14*) If yes,

b) please list any medicines below:

i) ☐

ii) ☐

iii) ☐

iv) ☐

v) ☐

vi) ☐

14. How many times have you consulted your GP in the last *12 months*?

☐ times

15. a) In the past year, have you had any pain or discomfort in your chest?

☐ 1 Yes: *Please complete question 15 and 16*

☐ 2 No: *Please go to question 17*

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

☐ 1 Yes

☐ 2 No

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

☐ 1 Yes

☐ 2 No

#

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

☐ 1 Stop
☐ 2 Slow down
☐ 3 Continue at same pace

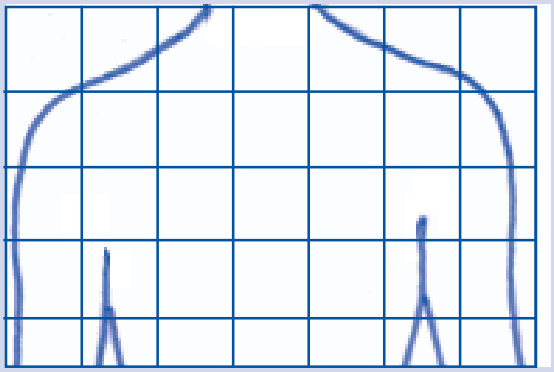
e) Does it go away when you stand still?

☐ 1 Yes
☐ 2 No: *Please go to question 15. g)*

f) If yes, how soon does the pain take to go away?

☐ 1 In 10 minutes or less
☐ 2 More than 10 minutes

g) Where on your chest do you get this pain or discomfort? Mark the place with an **X** on the diagram



16. a) In the past year, have you had a severe pain across the front of your chest lasting half an hour or more?

☐ 1 Yes
☐ 2 No: *Please go to question 17*

b) If yes, did you talk to a doctor about it?

☐ 1 Yes
☐ 2 No: *Please go to question 16. d)*

c) If yes, what did he/she say it was?

d) How many of these attacks have you had in the past year?

☐☐ attacks in the past year

17. In the past year, have you had any of the following tests or treatments?

a) An exercise/stress ECG heart trace whilst running or walking on a treadmill?

☐ 1 Yes
☐ 2 No

b) An angiogram or X-ray of your coronary arteries? (a dye test of the arteries)

☐ 1 Yes
☐ 2 No

c) Angioplasty of coronary arteries (balloon treatment for angina) or insertion of a stent?

☐ 1 Yes
☐ 2 No

d) Coronary artery bypass graft (CABG) operation?

☐ 1 Yes
☐ 2 No

e) Other heart tests or operations, or admissions to hospital for any other heart trouble?

☐ 1 Yes (p*lease specify:)*

☐ 2 No

We would now like to ask you some questions on you and your partner's reproductive health. Thank you.

18. Has there ever been a time, lasting three months or more, when you were having unprotected sex regularly with your husband/wife/partner but did not conceive?

☐ 1 Yes: *Please answer questions 19, 20 , 21 and 22*
☐ 2 No: *Please go to question 23*

19. When did this start?

☐☐ ☐☐ (mm/yy)

20. Is this still continuing?

☐ 1 Yes
☐ 2 No

21. How long did it last? ☐☐ months

22. How did it end?

☐[1] Started using birth control again
☐[2] The relationship ended
☐[3] A pregnancy was conceived
☐[4] Other (specify:)

23. Have you or your husband/wife/partner ever sought any medical help because of problems with conceiving?

☐[1] Yes: *Please go to question 24*
☐[2] No: *Please go to the next section*

24. Did either of you receive any treatment for infertility?

☐[1] Yes: *Please answer question 25 and 26*
☐[2] No: *Please go to the next section*

25. What kind of treatment did you receive? Please write in details of what this was, and which of you was affected:

26. When was this treatment?

☐☐ ☐☐ (mm/yy)

27. In what year was your husband/wife/partner born?

☐☐ ☐☐ (mm/yy)

SECTION 5 – Women's Health

This section is for women only (men please go to SECTION 6). Thank you for taking the time to complete this section.

1. a) Are you still having periods or menstrual bleeding?

☐[1] Yes
☐[2] No: *Please go to question 2*

b) Have you had a period or menstrual bleed in the last 3 months?

☐[1] Yes
☐[2] No

c) Which of the following descriptions apply to your period during the last 12 months?

	Yes	No
Normal	☐[1]	☐[2]
Less regular than usual	☐[3]	☐[4]
More frequent than usual	☐[5]	☐[6]
Shorter in duration over the year	☐[7]	☐[8]
One or more skipped periods	☐[9]	☐[10]

Please go to question 3

2. a) How old were you when your periods or menstrual bleeding stopped?

☐☐ years old

b) Was the cessation of your periods or menstrual bleeding caused by:

☐[1] Natural menopause
☐[2] Hysterectomy (removal of womb only)
☐[3] Hysterectomy (plus removal of ovaries)
☐[4] Other (please specify:)

3. a) Have you ever had hormone replacement therapy (HRT)?

☐[1] Yes
☐[2] No: *Please go to question 4*

b) Are you still taking HRT?

☐[1] Yes
☐[2] No

3. continued

c) What brand did you or are you taking?

☐[1] Patch (please specify brand:)

☐[2] Tablet (please specify brand:)

☐[3] Other (please specify brand:)

4. a) Are you *currently* or have you *ever* taken oral contraceptives (the pill)?

☐[1] Yes
☐[2] No: *Please go to question 5*

b) What year did you first start taking oral contraceptives? ☐☐☐☐ (year)

c) What year did you stop taking oral contraceptives?

☐☐☐☐ (year)

☐[1] Tick here if still taking oral contraceptives

d) What brand are you taking?

5. a) Are you *currently* or have you *ever* used injectable contraceptives (birth control injections)?

☐[1] Yes
☐[2] No: *Please go to Section 6*

b) What year did you first start using injectable contraceptives? ☐☐☐☐ (year)

c) What year did you stop using injectable contraceptives? ☐☐☐☐ (year)

☐[1] Tick here if still using injectable contraceptives

d) What brand are you using?

SECTION 6 – Lifestyle

In this section, we would like to ask you questions about your general lifestyle habits, including questions on smoking, alcohol intake, exercise and nutrition. This will help us take into account other important factors that may affect your health.

1. Do you currently smoke cigarettes?

☐ 1 Yes: *Please go to question 2*

☐ 2 No: *Please go to question 3*

2. a) About how many cigarettes per day do you smoke?

☐☐ cigarettes per day

b) When did you first start smoking?

☐☐☐☐ (year)

c) Are these:

☐ 1 Manufactured cigarettes

☐ 2 "Roll your own" cigarettes

☐ 3 Both of the above: *Please go to question 6*

3. If you are not a cigarette smoker now, did you *ever* smoke 5 or more cigarettes a day?

☐ 1 Yes: *Please complete questions 4 and 5*

☐ 2 No: *Please go to question 6*

4. How many a day did you usually smoke?

☐☐ cigarettes per day

5. How long ago did you quit smoking?

☐☐ years ago

6. Do you currently smoke a pipe?

☐ 1 Yes

☐ 2 No

7. Do you currently smoke cigars?

☐ 1 Yes

☐ 2 No

8. Do you currently drink alcohol?

☐ 1 Yes: *Please complete questions 9-14*

☐ 2 No: *Please go to question 15*

9. How often do you have a drink containing alcohol?

☐ 1 Never

☐ 2 Monthly or less

☐ 3 Two to four times a month

☐ 4 Two or three times a week

☐ 5 Four or more times a week

10. How many drinks containing alcohol do you have on a typical day when you are drinking? (*one drink = half a pint of beer, a small glass of wine, or one measure of spirits*)

☐ 1 1 or 2

☐ 2 3 or 4

☐ 3 5 or 6

☐ 4 7 to 9

☐ 5 10 or more

11. How often do you have six or more drinks on one occasion?

☐ 1 Never

☐ 2 Monthly or less

☐ 3 Two to four times a month

☐ 4 Two or three times a week

☐ 5 Four or more times a week

12. How often during the past year have you found that you were not able to stop drinking once you had started?

☐ 1 Never

☐ 2 Monthly or less

☐ 3 Two to four times a month

☐ 4 Two or three times a week

☐ 5 Four or more times a week

13. How often during the past year have you failed to do what was normally expected of you because of drinking?

☐ 1 Never

☐ 2 Monthly or less

☐ 3 Two to four times a month

☐ 4 Two or three times a week

☐ 5 Four or more times a week

14. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

☐ 1 Never

☐ 2 Monthly or less

☐ 3 Two to four times a month

☐ 4 Two or three times a week

☐ 5 Four or more times a week

Please go to question 20

For Non-Drinkers Only

15. Did you ever drink alcohol?

☐ 1 Yes: *Please complete questions 16-19*

☐ 2 No: *Please go to question 20*

16. About how long ago did you stop drinking alcohol?

☐ 1 Less than 1 year ago

☐ 2 1 to 2 years ago

☐ 3 More than 2 years ago

17. Did you stop drinking alcohol for health reasons?

☐ 1 Yes

☐ 2 No

18. Did you stop drinking alcohol on the advice of a health care professional?

☐ 1 Yes

☐ 2 No

19. Concerning the amount of alcohol you drank in the past, were you:

☐ 1 A light drinker

☐ 2 A moderate drinker

☐ 3 A heavy drinker

The following questions on EXERCISE should be completed by everyone:

20. Think about all the *vigorous activities* which take hard physical effort that you did in the *last 7 days*. Vigorous activities make you breathe harder than normal and may include heavy lifting, sports activities such as squash or football, or fast cycling. Think only about those physical activities that you did for at least 10 minutes at a time.

a) During the *last 7 days*, on how many days did you do vigorous physical activities?

☐☐ days ☐ don't know/not sure

b) How much *total time* did you usually spend doing vigorous physical activities on one of those days?

☐☐☐ minutes ☐ don't know/not sure

c)If your pattern of activity varies from day to day, how much *total time* did you spend over the *last 7 days* doing vigorous physical activity?

☐☐ hours ☐ don't know/not sure

21. Think about the activities which take *moderate physical effort* that you did in the *last 7 days*. Moderate physical activity makes you breathe somewhat harder than normal and may include carrying light loads, cycling at a slow pace or slow jogging. Do not include walking. Again, think only about those activities that you did for at least 10 minutes.

a) During the *last 7 days*, on how many days did you do moderate physical activities?

☐☐ days ☐ don't know/not sure

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

☐☐☐ minutes ☐ don't know/not sure

c) If your pattern of activity varies from day to day, how much *total time* did you spend over the *last 7 days* doing moderate physical activity?

☐☐ hours ☐ don't know/not sure

22. Now 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.

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

☐☐ days ☐ don't know/not sure

b) How much *total time* did you usually spend walking on one of those days?

☐☐☐ minutes ☐ don't know/not sure

23. Think about the time you spent *sitting* on weekdays during the *last 7 days*. Include time spent at work, at home, and during leisure time.

a) During the *last 7 days*, how much *total time* did you usually spend sitting on a weekday?

hours/day ☐☐ : ☐☐ minutes

☐ don't know

The following questions are about your diet:

24. How often do you eat the following?

	5 + times a week	3-4 times a week	1-2 times a week	2-3 times a month or less	Never
a) Beef	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b) Lamb	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c) Pork	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d) Bacon	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e) Ham	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f) Sausages	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g) Chicken/poultry	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
h) Fish	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
i) Dairy products	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
j) Eggs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

25. How often do you eat the following from a fast-food restaurant?

	5 + times a week	3-4 times a week	1-2 times a week	2-3 times a month or less	Never
a) Burger	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b) Pizza	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c) Pie and chips/mash	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d) Fish and chips	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e) Fried chicken	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f) Kebab/doner	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g) Chinese/oriental food	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
h) Indian food	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
i) Other: (please specify)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

26. a) How many days a week do you eat vegetables?

Vegetables : ☐ days per week

b) How many heaped tablespoons of vegetables do you eat each day? *Please include all types independent of preparation method, e.g. fresh, canned, frozen, cooked.*

☐ number of heaped *tablespoons* of vegetables per day

27. a) About how many days a week do you usually eat fruit? *Please include fresh, dried and canned fruit.*

Fruit: ☐ days per week

b) How many pieces or portions of fruit do you eat on a *day* in which you eat fruit? (one medium portion is one large fruit e.g. apple/pear, or two small fruits, e.g. plums/ apricots)

☐☐ portions per day of fruit

28. How often do you eat a portion (*e.g. one slice of bread, one bowl of pasta)* of the following?

	5 + times a week	3-4 times a week	1-2 times a week	2-3 times a month or less	Never
a) White bread	☐1	☐2	☐3	☐4	☐5
b) Whole-wheat or rye bread	☐1	☐2	☐3	☐4	☐5
c) Wholemeal bread	☐1	☐2	☐3	☐4	☐5
d) Crackers, crispbread	☐1	☐2	☐3	☐4	☐5
e) Pasta or noodles	☐1	☐2	☐3	☐4	☐5
f) Rice (boiled or fried)	☐1	☐2	☐3	☐4	☐5
g) Hot cereal	☐1	☐2	☐3	☐4	☐5
h) Cold cereal, sweetened	☐1	☐2	☐3	☐4	☐5
i) Cold cereal, bran or high fibre	☐1	☐2	☐3	☐4	☐5

29. About how many of the following do you eat in a week?

a) Sweet biscuits: ☐☐ number each week

b) Cakes, puddings pies, buns etc ☐☐ number each week

c) Chocolate ☐☐ number of pieces each week

d) Crisps ☐☐ number of packets each week

e) Boiled/hardsweets ☐☐ number each week

f) Jams/marmalades ☐☐ heaped tablespoons each week

30.a) How often do you eat peanuts?

☐ 1 Almost never
☐ 2 Once a week
☐ 3 Two to four times a week
☐ 4 More than five times a week

b) How often do you eat any other type of nuts?

☐ 1 Almost never
☐ 2 Once a week
☐ 3 Two to four times a week
☐ 4 More than five times a week

31. About how much do you drink each day of:

a) Tea: ☐☐ cups daily

b) Coffee: ☐☐ cups daily

32. What type of spreading fat do you use most often for your bread, rolls, crackers, etc?

☐ 1 None
☐ 2 Butter
☐ 3 Hard margarine, wrapped, not tub *(e.g. Stork)*
☐ 4 Polyunsaturated margarine, in tub *(e.g. Flora, Vitalite)*
☐ 5 Monounsaturated margarine *(e.g. Olivio)*
☐ 6 Other soft margarine, dairy spreads *(e.g. Blue Band)*
☐ 7 Other low fat spread, in tub *(e.g. Flora extra light)*
☐ 8 Plant sterol margarine (*e.g. Benecol)*
☐ 9 Other (please specify:)

33. What type of fat do you usually use for frying, roasting or grilling your food?

☐ 1 None
☐ 2 Butter
☐ 3 Lard/dripping
☐ 4 Olive oil
☐ 5 Other vegetable oil
☐ 6 Solid vegetable fat
☐ 7 Margarine
☐ 8 Other (please specify:)

34. Are you following any special kind of diet right now?

☐ 1 Yes

☐ 2 No: *Please go to question 38*

35. Is your diet for:

☐ 1 Losing weight

☐ 2 High blood pressure

☐ 3 Ulcers (gastric, peptic)

☐ 4 Gallstones

☐ 5 Kidney failure

☐ 6 Diabetes

☐ 7 Food allergy

☐ 8 High cholesterol

☐ 9 Other (please specify:)

36. Are you on any of these specific diets?

☐ 1 Atkins diet

☐ 2 The Zone diet

☐ 3 Sugar Busters

☐ 4 Weight Watchers

☐ 5 Blood Type diet

☐ 6 Other:

☐ 7 No, not on any of these diets

37. If you are following a special diet at the time, was it prescribed by a doctor or dietician?

☐ 1 Yes

☐ 2 No

The next few questions ask about activities you might do during a typical day and whether your health limits you in any way.

38. In general, would you say your health is:

Excellent ☐ 1 Very good ☐ 2 Good ☐ 3 Fair ☐ 4 Poor ☐ 5

	Yes, limited a lot	Yes, limited a little	No, not limited at all
39. a) Does your health now limit you in *moderate* activities, such as moving a table, pushing a Hoover, or golf?	☐ 1	☐ 2	☐ 3
b) Does your health limit you in climbing *several* flights of stairs?	☐ 1	☐ 2	☐ 3

40. During the *past four weeks*, how much of the time have you had any of the following problems with your work or regular activities as a result of your *physical health*?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a) How much of the time have you *accomplished less* than you would like?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b) How much of the time were you limited in the *kind* of work or other activities you could do?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

41. During the *past four weeks*, how much of the time have you had any of the following problems with your work or other daily activities as a result of *any emotional problems*, such as feeling depressed or anxious?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a) How much of the time have you *accomplished less* than you would like?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b) How much of the time did you have trouble doing work or other activities as *carefully* as usual?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

42. During the *past four weeks*, how much did *pain* interfere with your normal work, including both work outside the home and housework?

Not at all	Slightly	Moderately	Quite a bit	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

43. How much time during the *past four weeks* have you felt calm and peaceful?

None of the time	A little of the time	Some of the time	Most of the time	All of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

44. How much of the time during the *past four weeks* did you feel you had a lot of energy?

None of the time	A little of the time	Some of the time	Most of the time	All of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

45. How much time during the *past four weeks* have you felt down?

None of the time	A little of the time	Some of the time	Most of the time	All of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

46. During the *past four weeks*, how much of the time has your physical health or emotional problems interfered with your social activities such as visiting friends or relatives?

None of the time	A little of the time	Some of the time	Most of the time	All of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Here are some general questions about your current health.
Please tick the statement which best applies to how you have been feeling recently.

47. *Have you recently:*

a) Been able to concentrate on whatever you're doing?	☐ 1 Better than usual	☐ 2 Same as usual	☐ 3 Less than usual	☐ 4 Much less than usual
b) Lost much sleep over worry?	☐ 1 Not at all	☐ 2 No more than usual	☐ 3 Rather more than usual	☐ 4 Much more than usual
c) Felt that you are playing a useful part in things?	☐ 1 More so than usual	☐ 2 Same as usual	☐ 3 Less useful than usual	☐ 4 Much less than usual
d) Felt capable of making decisions about things?	☐ 1 More so than usual	☐ 2 Same as usual	☐ 3 Less useful than usual	☐ 4 Much less than usual
e) Felt under constant strain?	☐ 1 Not at all	☐ 2 No more than usual	☐ 3 Rather more than usual	☐ 4 Much more than usual
f) Felt you couldn't overcome your difficulties?	☐ 1 Not at all	☐ 2 No more than usual	☐ 3 Rather more than usual	☐ 4 Much more than usual
g) Been able to enjoy you're normal day to day activities?	☐ 1 More so than usual	☐ 2 Same as usual	☐ 3 Less useful than usual	☐ 4 Much less than usual
h) Been able to face up to your problems?	☐ 1 More so than usual	☐ 2 Same as usual	☐ 3 Less useful than usual	☐ 4 Much less than usual

47. continued

i) Been feeling unhappy or depressed?	☐ 1 Not at all	☐ 2 No more than usual	☐ 3 Rather more than usual	☐ 4 Much more than usual
j) Been losing confidence in yourself?	☐ 1 Not at all	☐ 2 No more than usual	☐ 3 Rather more than usual	☐ 4 Much more than usual
k) Been thinking of yourself as a worthless person?	☐ 1 Not at all	☐ 2 No more than usual	☐ 3 Rather more than usual	☐ 4 Much more than usual
l) Been feeling reasonably happy, all things considered?	☐ 1 Not at all	☐ 2 No more than usual	☐ 3 Rather more than usual	☐ 4 Much more than usual

48. We would like to know whether or not you have been having any problems with feeling tired, weak or lacking in energy *during the last month*. If you have been feeling tired for a long time we want you to compare yourself to how you felt when you were last well.

Please tick the box next to the answer which you think most nearly applies to you.

a) Do you have problems with tiredness?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
b) Do you need to rest more?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
c) Do you feel sleepy or drowsy?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
d) Do you have problems starting things?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
e) Do you lack energy?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
f) Do you have less strength in your muscles?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
g) Do you feel weak?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
h) Do you have difficulty concentrating?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
i) Do you make slips of the tongue whenspeaking?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
j) Do you find it more difficult to find the correct word?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
k) How is your memory?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
l) Do your muscles hurt at rest?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual
m) Do your muscles hurt after exercise?	☐ 1 Less than usual	☐ 2 No more than usual	☐ 3 More than usual	☐ 4 Much more than usual

49. How many hours of sleep do you usually get over a 24 hour period?

☐☐ hours of sleep

The following question is about your work.

50. To what extent do you agree with the following statements about your normal day to day work for the Police Force? Please tick one option for each statement.

In my normal day to day work for the Police Force:

a) I have to work very hard	☐[1] Strongly agree	☐[2] Agree	☐[3] Disagree	☐[4] Strongly disagree
b) I have an excessive amount of work to do	☐[1] Strongly agree	☐[2] Agree	☐[3] Disagree	☐[4] Strongly disagree
c) I have a lot of say about what happens on the job	☐[1] Strongly agree	☐[2] Agree	☐[3] Disagree	☐[4] Strongly disagree
d) I have a high level of skill	☐[1] Strongly agree	☐[2] Agree	☐[3] Disagree	☐[4] Strongly disagree
e) I have the freedom to decide how I do my work	☐[1] Strongly agree	☐[2] Agree	☐[3] Disagree	☐[4] Strongly disagree
f) I have the chance to be creative	☐[1] Strongly agree	☐[2] Agree	☐[3] Disagree	☐[4] Strongly disagree

Thank you very much for completing the questionnaire. We value and appreciate your participation in this important study.

Are there any issues which we haven't raised that you think might be important?

£ £

Please do not write in this section

£

Please do not write in this section