

# *The Tomorrow Project*

Albertans Studying the Connection Between Lifestyle and Cancer

In partnership with :

*The Canadian Partnership for Tomorrow Project*

## Update: Health and Lifestyle Questionnaire



73



Office use only

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L	C	V	QA

## Directions For Completing This Questionnaire

The Update: Health and Lifestyle Questionnaire may take about 40 to 60 minutes to answer. Please follow the directions carefully. You will be asked to skip certain questions that do not apply to you.

- We appreciate you completing the whole survey. However, if you prefer not to answer a question, write '**Decline**' beside it.

- Use a ballpoint pen, **not a felt pen**.

- Shade in the bubbles completely, like this: ●

Write numbers in boxes like this:

2	1
---	---

If you are writing a single digit where there is more than one box, it does not

- matter which box you write the number in.

- If you make an error, put an X through the incorrect bubble like this:



Please leave the booklet stapled together. The pages will be separated at the study centre.

If you are not sure how to answer a question, please feel free to contact us:

Call our toll-free number in Canada: 1-877-919-9292

Email us at: [tomorrow@cancerboard.ab.ca](mailto:tomorrow@cancerboard.ab.ca)

For answers to commonly asked questions, check our website at [www.thetomorrowproject.org](http://www.thetomorrowproject.org)



## GENERAL HEALTH

# GH

GH 1 How would you rate your general health?


- Excellent
- Very good
- Good
- Fair
- Poor

GH 2 Has a doctor ever told you that you had cancer or a malignancy of any kind?

- Yes
- No

→ SKIP TO GH 4 (PAGE 5)

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GH 3 What **type** of cancer was it and how **old** were you when the cancer was first diagnosed?  
If you have had cancer more than once, please list each one separately.

First type of Cancer  Age

Did you receive treatment for this cancer?

- Yes → What type of treatment was it? (Choose **ALL** that apply)
- No
- Chemotherapy
  - Radiation
  - Surgery
  - Other (Please specify):

Second type of Cancer  Age

Did you receive treatment for this cancer?

- Yes → What type of treatment was it? (Choose **ALL** that apply)
- No
- Chemotherapy
  - Radiation
  - Surgery
  - Other (Please specify):

Third type of Cancer  Age

Did you receive treatment for this cancer?

- Yes → What type of treatment was it? (Choose **ALL** that apply)
- No
- Chemotherapy
  - Radiation
  - Surgery
  - Other (Please specify):



GH 4 to GH 10

Has a doctor ever told you that you had any of the following conditions? If yes, please provide your **age** when you were first diagnosed and whether or not you are currently under **medical treatment** for the condition.

			Age when <u>first</u> diagnosed		<u>Currently</u> under medical treatment
GH 4	High blood pressure (hypertension, <b>not</b> including during pregnancy)	<input type="radio"/> Yes → <input type="radio"/> No	<input type="text"/>	→	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
GH 5	Heart attack (myocardial infarction)	<input type="radio"/> Yes → <input type="radio"/> No	<input type="text"/>	→	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
GH 6	Stroke	<input type="radio"/> Yes → <input type="radio"/> No	<input type="text"/>	→	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
GH 7	Asthma	<input type="radio"/> Yes → <input type="radio"/> No	<input type="text"/>	→	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
GH 8	Emphysema	<input type="radio"/> Yes → <input type="radio"/> No	<input type="text"/>	→	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
GH 9	Chronic bronchitis	<input type="radio"/> Yes → <input type="radio"/> No	<input type="text"/>	→	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
GH 10	Diabetes	<input type="radio"/> Yes → <input type="radio"/> No	<input type="text"/>	→	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know

If yes, which **kind** of diabetes was it?

- Gestational diabetes **only**
- Type 1 diabetes
- Type 2 diabetes
- Don't know



GH 11 to GH 24 Has a doctor ever told you that you had any of the following long-term health conditions?

- GH 11 Liver cirrhosis  Yes  No
- GH 12 Chronic hepatitis  Yes  No
- GH 13 Crohn's disease  Yes  No
- GH 14 Ulcerative colitis  Yes  No
- GH 15 Irritable bowel disease  Yes  No
- GH 16 Eczema  Yes  No
- GH 17 Systemic lupus erythematosus  Yes  No
- GH 18 Psoriasis  Yes  No
- GH 19 Multiple sclerosis  Yes  No
- GH 20 Osteoporosis  Yes  No
- GH 21 Underactive thyroid (hypothyroid)  Yes  No
- GH 22 Overactive thyroid (hyperthyroid)  Yes  No
- GH 23 Arthritis  Yes  No

If yes, which kind of arthritis was it?

- Rheumatoid arthritis
- Osteoarthritis
- Other (Please specify):
- Don't know

GH 24 Any other long term conditions?  Yes  No

If yes, what was it?


## FAMILY HEALTH HISTORY

# FH

For your family health history, please **ONLY** include your **biological, first-degree** family members, including mother, father, biological children, full and half brothers and sisters. Do not include relatives by marriage, stepbrothers and stepsisters, parents by adoption, stepchildren or adopted children.

FH 1 Do you know about your **biological** family's health history?

Yes

No

→ SKIP TO SIBLINGS, SIB 1 (PAGE 11)


FH 2 Have any of your **first-degree biological** relatives ever been told by a doctor that they had cancer?

Yes

No

→ SKIP TO FH 4 (PAGE 9)

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FH 3 For each **biological, first-degree** family member listed below, please print the **type** of cancer or where it started and the **age** when it was first diagnosed. Please include only where the cancer started and not places where it may have spread to.

	Type of Cancer	Age
Mother		<input type="text"/> <input type="text"/>
Father		<input type="text"/> <input type="text"/>
Brother 1		<input type="text"/> <input type="text"/>
Brother 2		<input type="text"/> <input type="text"/>
Brother 3		<input type="text"/> <input type="text"/>
Brother 4		<input type="text"/> <input type="text"/>
Sister 1		<input type="text"/> <input type="text"/>
Sister 2		<input type="text"/> <input type="text"/>
Sister 3		<input type="text"/> <input type="text"/>
Sister 4		<input type="text"/> <input type="text"/>
Son 1		<input type="text"/> <input type="text"/>
Son 2		<input type="text"/> <input type="text"/>
Son 3		<input type="text"/> <input type="text"/>
Son 4		<input type="text"/> <input type="text"/>
Daughter 1		<input type="text"/> <input type="text"/>
Daughter 2		<input type="text"/> <input type="text"/>
Daughter 3		<input type="text"/> <input type="text"/>
Daughter 4		<input type="text"/> <input type="text"/>

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FH 4 Have any of your **first-degree biological** relatives been told by a doctor that they had any of the following chronic or long-term health conditions?

First-degree biological relatives include mother, father, brothers, sisters and children.

	Health Condition			
Mother	Heart attack (myocardial infarction)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
	Stroke	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
	Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
	Chronic obstructive pulmonary disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
Father	Heart attack (myocardial infarction)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
	Stroke	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
	Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
	Chronic obstructive pulmonary disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
Brothers <input type="radio"/> I do not have any brothers	Heart attack (myocardial infarction)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
		If yes, how many brothers?		<input type="text"/> <input type="text"/>
	Stroke	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
		If yes, how many brothers?		<input type="text"/> <input type="text"/>
Sisters <input type="radio"/> I do not have any sisters	Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
		If yes, how many brothers?		<input type="text"/> <input type="text"/>
	Chronic obstructive pulmonary disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
		If yes, how many brothers?		<input type="text"/> <input type="text"/>
Sisters <input type="radio"/> I do not have any sisters	Heart attack (myocardial infarction)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
		If yes, how many sisters?		<input type="text"/> <input type="text"/>
	Stroke	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
		If yes, how many sisters?		<input type="text"/> <input type="text"/>
Sisters <input type="radio"/> I do not have any sisters	Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
		If yes, how many sisters?		<input type="text"/> <input type="text"/>
	Chronic obstructive pulmonary disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know
		If yes, how many sisters?		<input type="text"/> <input type="text"/>



	Health Condition
Sons <input type="radio"/> I do not have any sons	Heart attack (myocardial infarction) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, how many sons? <input type="text"/> <input type="text"/>
	Stroke <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, how many sons? <input type="text"/> <input type="text"/>
	Diabetes <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, how many sons? <input type="text"/> <input type="text"/>
	Chronic obstructive pulmonary disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, how many sons? <input type="text"/> <input type="text"/>
Daughters <input type="radio"/> I do not have any daughters	Heart attack (myocardial infarction) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, how many daughters? <input type="text"/> <input type="text"/>
	Stroke <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, how many daughters? <input type="text"/> <input type="text"/>
	Diabetes <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, how many daughters? <input type="text"/> <input type="text"/>
	Chronic obstructive pulmonary disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, how many daughters? <input type="text"/> <input type="text"/>

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## SIBLINGS

# SIB

- SIB 1 How many **biological** siblings (brothers and sisters) do you have, including those who have died?  
Include half siblings (one common parent) but not step siblings or adopted siblings.

Siblings →

If "0", SKIP TO SIB 4 (THIS PAGE)

Don't know

- SIB 2 How many of your **biological** siblings are older than you, including those who have died?  
Do not count step siblings or adopted siblings. If you are part of a multiple birth (e.g. twins, triplets etc), please treat all of the siblings that were born with you as being the same age as you, regardless of the order that you were actually born.

Siblings older than me

Don't know

- SIB 3 Are you a twin or part of a multiple birth, including stillborns and those who have died?  
Multiple births include twins, triplets, quadruplets, quintuplets, sextuplets, etc.

- Yes  
 No  
 Don't know

- SIB 4 Were you adopted?

- Yes  
 No  
 Don't know



## HEALTH CHECK-UPS

# HC

HC 1 Have you ever had a Fecal Occult Blood Test or FOBT?

A Fecal Occult Blood Test or FOBT is a test to check for hidden blood in your stool, where you have a bowel movement and use a stick to smear a small sample on a special card. It is usually collected at home for three days in row.

Yes

No

Don't know

→ → SKIP TO HC 3 (THIS PAGE)

HC 2 When was the last time you had a Fecal Occult Blood Test?

Less than 6 months ago

6 months to less than 1 year ago

1 year to less than 2 years ago

2 years to less than 3 years ago

3 or more years ago

HC 3 Have you ever had a sigmoidoscopy or colonoscopy?

These are tests where a tube is inserted into the rectum to view the bowel for early signs of cancer and other health problems.

Yes

No

Don't know

→ → SKIP TO HC 5 (NEXT PAGE)

HC 4 When was the last time you had a sigmoidoscopy or a colonoscopy?

Less than 6 months ago

6 months to less than 1 year ago

1 year to less than 2 years ago

2 years to less than 3 years ago

3 or more years ago



HC 5 When was the last time you saw a dental professional, including dentist or hygienist?

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago
- Never

HC 6 Do you have routine or annual medical check-ups undertaken by a doctor or a nurse?

A medical check-up is a physical exam that you usually schedule separate from visiting the doctor about a medical problem or issue. It should include at least a blood pressure measurement and height and weight measurement.

- Yes
- No

HC 7 When was the last time you had a routine or annual medical check-up?

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago
- Never

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**MEN'S HEALTH**

**MH**

MH 1 Have you ever had a PSA blood test?

A PSA test is a specific blood test ordered by a doctor to test men for prostate cancer.

Yes

No

Don't know

→ → **SKIP TO MH 3 (THIS PAGE)**

MH 2 When was the last time you had a PSA blood test?

Less than 6 months ago

6 months to less than 1 year ago

1 year to less than 2 years ago

2 years to less than 3 years ago

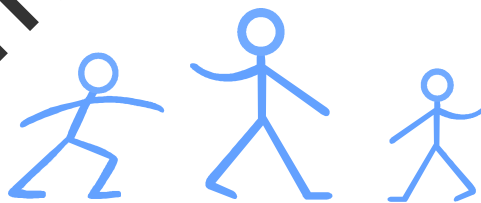
3 or more years ago

MH 3 How many children have you fathered, including live births only?

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Children

Don't know



**WOMEN'S HEALTH**

**WH**

WH 1 Have you ever had a mammography or mammogram?

A mammogram is an x-ray of the breast in a device that compresses and flattens the breast and is used as a screening test for breast cancer.

- Yes
- No
- Don't know

→ → SKIP TO WH 3 (THIS PAGE)

WH 2 When was the last time you had a mammography or a mammogram?

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago

WH 3 Have you ever had a Pap test or smear test?

A Pap test (sometimes called a cervical smear) is a procedure in which cells are scraped from the cervix by a physician for examination under a microscope. Amongst other uses, it is often used as a screening test for cervical cancer.

- Yes
- No
- Don't know

→ → SKIP TO WR 1 (NEXT PAGE)

WH 4 When was the last time you had a Pap test or a smear test?

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago



## WOMEN'S REPRODUCTIVE HEALTH

# WR

WR 1 How old were you when you had your first menstrual period?

- Never had menstrual periods
- Don't know

WR 2 Have you ever used any hormonal contraceptives for any reason?  
Hormonal contraceptives include birth control pills, implants, patches, injections, and rings or intra-uterine devices that release female hormones.

- Yes
- No
- Don't know

→ SKIP TO WR 5 (THIS PAGE)

WR 3 **In total**, how many years did you use or have been using hormonal contraceptives?  
Add up all the time that you used contraceptives even if you started and stopped several times. Round to the nearest number of years.

 Years

WR 4 How old were you when you started using hormonal contraceptives?

WR 5 Have you ever been pregnant?

- Yes
- No
- Don't know

→ SKIP TO WR 13 (NEXT PAGE)

WR 6 How many times have you been pregnant, including live births, stillbirths, spontaneous miscarriage or therapeutic abortion?  
Stillbirth is a birth of a dead fetus after a pregnancy of at least 20 weeks or a birth weight of at least 500g if the gestational age is unknown.

 Pregnancies



WR 7 Of your pregnancies, how many ended before 20 weeks?

Pregnancies

WR 8 Of your pregnancies, how many lasted 20 weeks or more?  
Please include all pregnancies that ended in live births and stillbirths.

Pregnancies

WR 9 How many children have you given birth to, considering live births only?

Live births

WR 10 How old were you when you first became pregnant?

WR 11 How old were you when you last became pregnant?

WR 12 **In total**, how many months did you breastfeed or nurse your child or children for?  
Think about **all** the children you breastfed and the **total** number of months that you breastfed. Take the number of months that you breastfed each child and add them together. If you did not breastfeed any children, enter "0" in the box.

Months

WR 13 Have you ever received hormonal fertility treatment to help you to get pregnant?

Yes

No

WR 14 Have you gone through your menopause, meaning that your menstrual periods stopped for at least one year and did **not** restart?

Yes

No

Don't know

→  SKIP TO WR 16 (NEXT PAGE)



WR 15 How old were you when you had your last menstrual period before your periods stopped for at least one year and did **not** restart?

WR 16 Did you ever have a hysterectomy (an operation to have your uterus or womb removed)?

Yes

No

Don't know

→ → SKIP TO WR 18 (THIS PAGE)

WR 17 How old were you when you had your hysterectomy?

WR 18 Did you ever have an operation to have your ovaries removed?

Yes

No

Don't know

→ → SKIP TO Hormone Replacement Therapy, HR 1 (NEXT PAGE)

WR 19 Did you have one or both ovaries removed?

Both

One

Don't know

→ → SKIP TO WR 21 (THIS PAGE)

WR 20 Were both of your ovaries removed at the same time?

Yes

→ → How old were you when your ovaries were removed?

→ → SKIP TO Hormone Replacement Therapy, HR 1 (NEXT PAGE)

No

Don't know

WR 21 How old were you when you had your first ovary removed?

→ → If you had only **one** ovary removed  
SKIP TO Hormone Replacement Therapy, HR 1 (NEXT PAGE)

WR 22 How old were you when you had your second ovary removed?



# HORMONE REPLACEMENT THERAPY

# HR

HR 1 Have you ever used hormone replacement therapy (HRT) for any reason?  
Hormone replacement therapy includes progesterone and/or estrogen. It includes all forms such as patches, rings, creams and other topical forms prescribed by a doctor. It does **not** include thyroid hormone treatment or hormonal contraceptives and it does not include other 'natural' treatments that can be bought over the counter.

Yes

No

Don't know

→ → SKIP TO Medication Intake, MI 1 (NEXT PAGE)

HR 2 **In total**, for how many years did you use, or have you been using, hormone replacement therapy?

Add up all the time that you used hormone replacement therapy even if you started and stopped several times. Round to the nearest number of years.

Years

HR 3 How old were you when you started using hormone replacement therapy?



# MEDICATION INTAKE

# MI

MI 1 Are you currently taking any medications prescribed by a doctor and dispensed by a pharmacist?  
Refer to all medications including hormonal contraception and other hormonal therapies.

- Yes
- No
- Don't know

SKIP TO Alcohol Use, AU 1, (NEXT PAGE)

MI 2 For **each** prescribed medication that you are currently taking, please write down the name of the medication and the drug identification number (DIN).  
If you have access to the bottles and containers, write down the name of each medication and DIN from the label. The DIN is an 8 digit number that should be printed on the label that is attached to the container by the pharmacist.

	Name of the medication	Drug Identification Number (DIN)
Medication 1		
Medication 2		
Medication 3		
Medication 4		
Medication 5		
Medication 6		
Medication 7		
Medication 8		
Medication 9		
Medication 10		

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AU 1 Have you ever drunk alcohol?

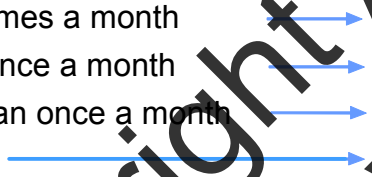
- Yes
- No
- Don't know



SKIP TO Tobacco Use, TU 1 (PAGE 24)

AU 2 During the past 12 months, how often did you drink alcohol?

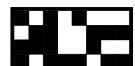

- 6 or more times a week
- 4 to 5 times a week
- 2 to 3 times a week
- Once a week
- 2 to 3 times a month
- About once a month
- Less than once a month
- Never



SKIP TO AU 4 (PAGE 23)

SKIP TO AU 6 (PAGE 23)

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AU 3 In a **typical week** during the past 12 months, how many drinks of red wine, white wine, beer, liquor or spirit did you drink on weekdays and weekends?  
 A drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43 ml) of liquor.

Type of alcohol	Number of drinks on weekdays (Sunday to Thursday)	Number of drinks on weekends (Friday to Saturday)
<b>Red wine</b> (one glass of 142 ml or 5 ounces)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>White wine</b> (one glass of 142 ml or 5 ounces)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Beer</b> (one bottle or can of beer or a glass of draft of 341 ml or 12 ounces)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Liquor and Spirit</b> (one straight or mixed drink with 1.5 ounces or 43 ml of liquor)	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Other kinds of alcohol</b>	<input type="text"/> <input type="text"/> <input type="text"/> What kind of alcohol? <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> What kind of alcohol? <input type="text"/>



**MEN ONLY, WOMEN SKIP TO AU 5 (THIS PAGE)**

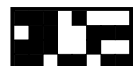
- AU 4 During the past 12 months, how often did you have **five or more drinks** at the **same sitting** or occasion?  
A drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43 ml) of liquor.
- 6 or more times a week
  - 4 to 5 times a week
  - 2 to 3 times a week
  - Once a week
  - 2 to 3 times a month
  - About once a month
  - 6 to 11 times a year
  - 1 to 5 times a year
  - Never

→ **MEN SKIP TO AU 6 (THIS PAGE)**

**WOMEN ONLY, MEN SKIP TO AU 6 (THIS PAGE)**

- AU 5 During the past 12 months, how often did you have **four or more drinks** at the **same sitting** or occasion?  
A drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43 ml) of liquor.
- 6 or more times a week
  - 4 to 5 times a week
  - 2 to 3 times a week
  - Once a week
  - 2 to 3 times a month
  - About once a month
  - 6 to 11 times a year
  - 1 to 5 times a year
  - Never

- AU 6 How does your current consumption of alcohol compare to your **heaviest period** of drinking?
- About the same
  - Less than the heaviest period of drinking
  - Don't know



## TOBACCO USE

# TU

TU 1 In your lifetime have you smoked a **total** of 100 cigarettes or more?  
A total of 100 cigarettes means about 5 packs.

Yes

No

Don't know

→  No →  Don't know → **SKIP TO TU 10 (PAGE 26)**

TU 2 Do you currently smoke cigarettes **daily**, **occasionally**, or **not at all**?

Daily (At least one cigarette every day for the past 30 days)

Occasionally (At least one cigarette in the past 30 days, but not every day)

Not at all (No cigarettes at all in the past 30 days) → **SKIP TO TU 6 (NEXT PAGE)**

TU 3 How old were you when you first started smoking cigarettes **daily** or **occasionally**?

--	--

TU 4 On average how many cigarettes do you currently smoke per **day** or per **week**, including hand-rolled cigarettes? Use only one unit of time.

--	--

Cigarettes per day OR

--	--	--

Cigarettes per week

TU 5 How does the amount you currently smoke compare to the amount you smoked during the period in your life when you **smoked the most**?

About the same

→ **SKIP TO TU 9 (NEXT PAGE)**

Less than the period when I smoked the most

→ **SKIP TO TU 8 (NEXT PAGE)**





TU 6 Have you ever smoked cigarettes **daily** (one cigarette every day for 30 days) or **occasionally** (at least one cigarette every 30 days)?

Yes → How old were you when you last smoked cigarettes daily or occasionally?

No

Don't know

→ **SKIP TO TU 10 (NEXT PAGE)**

TU 7 How old were you when you first started smoking cigarettes **daily** (one cigarette every day for 30 days) or **occasionally** (at least one cigarette every 30 days)?

TU 8 During the period in your life when you **smoked the most**, how many cigarettes did you smoke per **day** or per **week**?  
Use only one unit of time

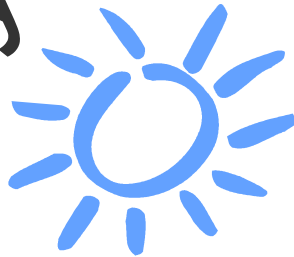
Cigarettes **per day** OR

Cigarettes **per week**

TU 9 How long did the period of time in your life when you **smoked the most** last?

Years

Months



TU 10 **In your lifetime**, have you ever used any of the other types of tobacco or tobacco-like stimulants listed below either **daily** (at least once per day) or **occasionally** (at least once every 30 days), for a period of at least six months?

Cigars	<input type="radio"/> Never <input type="radio"/> Daily <input type="radio"/> Occasionally
Small cigars (cigarillos)	<input type="radio"/> Never <input type="radio"/> Daily <input type="radio"/> Occasionally
Tobacco pipes	<input type="radio"/> Never <input type="radio"/> Daily <input type="radio"/> Occasionally
Chewing tobacco or snuff	<input type="radio"/> Never <input type="radio"/> Daily <input type="radio"/> Occasionally
Betel nut	<input type="radio"/> Never <input type="radio"/> Daily <input type="radio"/> Occasionally
Paan	<input type="radio"/> Never <input type="radio"/> Daily <input type="radio"/> Occasionally
Sheesha	<input type="radio"/> Never <input type="radio"/> Daily <input type="radio"/> Occasionally
Other nicotine products Please specify:	<input type="radio"/> Never <input type="radio"/> Daily <input type="radio"/> Occasionally <input type="text"/>

TU 11 How often do you currently use any of the other types of tobacco or tobacco-like stimulants listed below? **Daily** is at least once per day for the past 30 days and **occasionally** is at least once in the past 30 days.

Cigars	<input type="radio"/> Not at all <input type="radio"/> Daily <input type="radio"/> Occasionally
Small cigars (cigarillos)	<input type="radio"/> Not at all <input type="radio"/> Daily <input type="radio"/> Occasionally
Tobacco pipes	<input type="radio"/> Not at all <input type="radio"/> Daily <input type="radio"/> Occasionally
Chewing tobacco or snuff	<input type="radio"/> Not at all <input type="radio"/> Daily <input type="radio"/> Occasionally
Betel nut	<input type="radio"/> Not at all <input type="radio"/> Daily <input type="radio"/> Occasionally
Paan	<input type="radio"/> Not at all <input type="radio"/> Daily <input type="radio"/> Occasionally
Sheesha	<input type="radio"/> Not at all <input type="radio"/> Daily <input type="radio"/> Occasionally
Other nicotine products Please specify:	<input type="radio"/> Not at all <input type="radio"/> Daily <input type="radio"/> Occasionally <input type="text"/>



## PASSIVE SMOKING EXPOSURE

PS

PS 1 From birth until the age of 18, how many years did you live with a person who smoked cigarettes, cigars or pipes **inside your home**? Round to the nearest number of years.

Years

PS 2 As an adult, from age 18 years to now, how many years did you live with a person who smoked cigarettes, cigars or pipes **inside your home**? Round to the nearest number of years.

Years

PS 3 As an adult, from age 18 years to now, how many years did you regularly **work** in an environment where other people smoked cigarettes, cigars or pipes in your presence? Round to the nearest number of years.

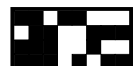
Years

PS 4 **At home** how often are you usually exposed to other people's tobacco smoke **inside the home**?

- Never
- Every day
- Almost every day
- At least once a week
- At least once a month

PS 5 During leisure time undertaken **outside of your home**, how often are you usually exposed to other people's tobacco smoke?

- Never
- Every day
- Almost every day
- At least once a week
- At least once a month



PS 6 **At work** how often are you usually exposed to other people's tobacco smoke?

- Never
- Every day
- Almost every day
- At least once a week
- At least once a month

## UV EXPOSURE

UV 1 During this past April through September, how much time each day did you typically spend in the sun between 11 am and 4 pm on weekdays?

- Less than 30 minutes
- 30 to 59 minutes
- 1 hour to less than 2 hours
- 2 hours to less than 3 hours
- 3 hours to less than 4 hours
- 4 hours or more

UV 2 During this past April through September, how much time each day did you typically spend in the sun between 11 am and 4 pm on weekends?

- Less than 30 minutes
- 30 to 59 minutes
- 1 hour to less than 2 hours
- 2 hours to less than 3 hours
- 3 hours to less than 4 hours
- 4 hours or more

UV 3 During April through September, when you are in the sun for **30 minutes or more**, how often do you use sun protection including sunscreen lotion, hat or protective clothing?

- Never
- Rarely
- Sometimes
- Often
- Always



UV 4 In the past 12 months, how many times have you used artificial tanning equipment such as a tanning bed, sunlamp or tanning light for any reason, including medical reasons?

- Never
- 1 to 4 times
- 5 to 9 times
- 10 to 14 times
- 15 to 19 times
- 20 to 24 times
- 25 or more times

UV 5 What is your natural hair colour?  
If your hair is now grey, please select the colour of your hair before it turned grey.

- Blonde
- Red
- Light brown
- Dark brown
- Black

UV 6 After several months of not being in the sun, if you then went out in the sun during the summer in the middle of the day without sunscreen or protective clothing for one hour, which one of these would happen to your skin?  
If you do not go out in the sun, make your best guess of what would happen if you did.

- Nothing would happen in an hour
- Turning darker without a sunburn
- Mildly burned with some tanning
- A severe sunburn for a few days with peeling
- A severe sunburn with blisters

Other (Please specify):



## SLEEP PATTERN

# SP

SP 1 On average how many hours per day do you usually sleep, including naps?  
A day refers to a 24 hour period and does not refer to daytime versus night-time sleep.

--	--

Hours

--	--

Minutes

SP 2 How often do you have trouble getting to sleep or staying asleep?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

SP 3 On average how much light enters into your room while you are sleeping?

- Virtually no light
- Some light
- A lot of light

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## WORKING STATUS

# WS

WS 1 Which of the following best describes your current situation? (Choose **ALL** that apply)  
Full time means 30 hours or more per week. Part time means less than 30 hours per week.

- Employed/Self-employed → Please specify:  full-time  
 part-time
- Retired
- Looking after home and/or family
- Unable to work because of sickness or disability
- Unemployed
- Doing unpaid or voluntary work
- Student

SKIP TO WS 7 (PAGE 33)

WS 2 What is currently your main job title, meaning the job at which you work the most hours?  
Give as full a description as you can (e.g. office clerk, factory worker, forestry technician.)

WS 3 How old were you when you started working at your current job?



WS 4 What kind of business, industry or service do you work in? (Choose **ONE** only)

- Agriculture, hunting, forestry and logging (include related service activities)
- Fishing (include fish hatcheries, fish farms, incidental service activities)
- Mining and quarrying (include extraction of crude petroleum, natural gas, peat, and surveying)
- Manufacturing (include recycling)
- Electricity, gas, steam and water supply (include collection, purification and distribution of water)
- Construction
- Wholesale and retail trade; repair of motor vehicles, motorcycles and personal and household goods
- Hotels and restaurants
- Transport, storage and communications (land, pipeline, water and air transport, supporting transport, travel agencies, post, telecommunications)
- Financial intermediation (obtaining and redistributing funds, insurance, pension, related services)
- Real estate, renting and business activities (include renting machinery, equipment, personal and household goods, computers, research and development)
- Public administration and defence; compulsory social security (community economic and social policy and services)
- Education
- Health and social work
- Other community, social and personal service activities (sewage, refuse, sanitation, recreational, cultural, sporting, membership organizations, other services)
- Private households with employed persons (domestic personnel such as maid, cook, valet, butler, gardener, caretaker, babysitter, tutor)
- Extra-territorial organizations and bodies (international organizations)
- Other (Please specify):





WS 5 Which one of following **best describes** your working schedule in your current job?  
(Choose **ONE** only)

A night shift is work during the early hours of the morning, after midnight. An evening shift is work during the evening ending at or before midnight.

- Regular daytime schedule or shift
- Regular evening shift
- Regular night shift
- Rotating shift, changing periodically from days to evenings or to nights
- Split shift, consisting of two or more distinct periods each day
- Irregular schedule, or on call

Other (Please specify):

WS 6 Is your current job the one you have worked in for the longest time (most number of years)?

- Yes
- No

→ SKIP TO Education Level, EL 1 (PAGE 35)

WS 7 What was the title of the main job that you held for the **longest time**, meaning the one at which you worked the most hours?

Refer to the jobs that you did when you were employed by someone else, or when you were self-employed. Give as full a description as you can (e.g. office clerk, factory worker, forestry technician.)



WS 8 What kind of business, industry or service did you work in for the **longest time** (most number of years)? (Choose **ONE** only)

- Agriculture, hunting, forestry and logging (include related service activities)
- Fishing (include fish hatcheries, fish farms, incidental service activities)
- Mining and quarrying (include extraction of crude petroleum, natural gas, peat, and surveying)
- Manufacturing (include recycling)
- Electricity, gas, steam and water supply (include collection, purification and distribution of water)
- Construction
- Wholesale and retail trade; repair of motor vehicles, motorcycles and personal and household goods
- Hotels and restaurants
- Transport, storage and communications (land, pipeline, water and air transport, supporting transport, travel agencies, post, telecommunications)
- Financial intermediation (obtaining and redistributing funds, insurance, pension, related services)
- Real estate, renting and business activities (include renting machinery, equipment, personal and household goods, computers, research and development)
- Public administration and defence; compulsory social security (community economic and social policy and services)
- Education
- Health and social work
- Other community, social and personal service activities (sewage, refuse, sanitation, recreational, cultural, sporting, membership organizations, other services)
- Private households with employed persons (domestic personnel such as maid, cook, valet, butler, gardener, caretaker, babysitter, tutor)
- Extra-territorial organizations and bodies (international organizations)
- Never been employed or self-employed →

SKIP TO Education Level, EL1  
(NEXT PAGE)



WS 9 Which one of the following **best describes** your working schedule for the job that you held for the **longest time**?

- Regular daytime schedule or shift
- Regular evening shift
- Regular night shift
- Rotating shift, changing periodically from days to evenings or to nights
- Split shift, consisting of two or more distinct periods each day
- Irregular schedule, or on call

Other (Please specify):

WS 10 How old were you when you started working in the job that you held for the **longest time**?

WS 11 How old were you when you stopped working in the job that you held for the **longest time**?

## EDUCATION LEVEL

**EL**

EL 1 What is the highest level of education you have completed? (Choose **ONE** only)

- None → SKIP TO Household Status, HS 1 (NEXT PAGE)
- Elementary school
- High school
- Trade, technical or vocational school, apprenticeship training or technical CEGEP
- Diploma from a community college, pre-university CEGEP or non-university certificate
- University certificate below bachelor's level
- Bachelor's degree
- Graduate degree (MSc, MBA, MD, PhD, etc.)

EL 2 How old were you when you completed your highest level of education?



## HOUSEHOLD STATUS

HS

HS 1 What is your current marital status?

Please choose the **one** that best describes your current situation.

- Married/living with a partner
- Divorced
- Separated
- Widowed
- Single, never married

HS 2 How many **adults** including yourself are currently living in your household? Individuals who are 18 years or older are considered adults, those less than 18 are children.

Adults

HS 3 How many **children** are currently living in your household? Individuals who are less than 18 years old are considered children.

Children

## INCOME

IN

The next question asks for your household income. We understand that this information is very private but the question is important because it helps us to determine whether or not the study includes a wide range of the population.

IN 1 What is the average total annual income, from all sources, before tax received by your entire household?

Please include the total income including salaries, pensions and allowances.

- Less than \$10,000
- \$10,000 - \$24,999
- \$25,000 - \$49,999
- \$50,000 - \$74,999
- \$75,000 - \$99,999
- \$100,000 - \$149,999
- \$150,000 - \$199,999
- \$200,000 or more

IN 2 How many individuals does that income support, including children, parents and other persons living outside your home?

Individuals



# LANGUAGES AND ETHNIC BACKGROUND

# LS

LS 1 What is the language that you first learned at home in childhood and can still understand? (Choose **ALL** that apply if more than one language was learned at the same time.)

- English
- French
- Arabic
- Cantonese
- Cree or other Aboriginal language
- Dutch
- German
- Greek
- Hindi
- Hungarian
- Italian
- Korean
- Mandarin
- Persian/Farsi
- Polish
- Portuguese
- Punjabi
- Russian
- Spanish
- Tagalog/Philipino
- Tamil
- Ukrainian
- Urdu
- Vietnamese
- Other (Please specify):

LS 2 In what country were you born?

If Canada, SKIP TO LS 4 (THIS PAGE)

- Don't know

LS 3 How old were you when you first came to Canada to live?

LS 4 In what country was your **biological** (non-adoptive) mother born?

- Don't know

LS 5 In what country was your **biological** (non-adoptive) father born?

- Don't know



## RESIDENCES

# RE

RE 1 In which city, town or village do you live?

RE 2 What is your postal code?

RE 3 How old were you when you started living where you live now?

RE 4 Throughout your life to date, is the dwelling that you live in now, the one where you have lived for the **longest period time** (most number of years)?

Yes



SKIP TO FN 1 (NEXT PAGE)

No

Please think about the dwelling where you lived for the **longest time** in your life so far and answer questions RE 5 to RE 12 about this dwelling.

RE 5 In which country was the dwelling that you lived in for the **longest period of time** in your life so far?

RE 6 In which province, state, territory or region was the dwelling that you lived in for the **longest period of time** in your life so far?

RE 7 In which city, town or village was the dwelling that you lived in for the **longest period of time** in your life so far?

RE 8 What was your postal code at the dwelling where you lived for the **longest period of time** in your life so far?

Don't know



RE 9 What was the name of the street the dwelling was on where you lived for the **longest period of time** in your life so far?

Don't know

RE 10 What was the nearest cross street to the dwelling you lived in for the **longest period of time** in your life so far?  
If you lived in the middle of your block, please enter either one of the cross streets.

Does not apply/No nearby cross streets

Don't know

RE 11 How old were you when you started living at the place where you lived for the **longest period of time** throughout your life?  
If this is the place where you lived when you were born, please enter **0**.

Don't know

RE 12 How old were you when you stopped living at the place where you lived for the **longest period of time** throughout your life?  
Please enter the age when you stopped living there on a permanent basis. For example, if you went away for schooling and only lived at the dwelling in the summers, enter your age when you first left for school.

Don't know

FN 1 What is your current age?

FN 2 Date survey completed:      DD      MM      YYYY  
         

**Thank you for taking the time to complete this survey!**

**Please bring it with you to you study centre appointment  
OR**

**If you are not going to the study centre,  
please return it in the enclosed postage paid envelope.**

