

Table of Contents

ADMINISTRATION	4
PERSON - BIRTH.....	5
PERSON - FAMILY	5
PERSON - EDUCATION	6
OCCUPATION - EMPLOYMENT	7
OCCUPATION - CURRENT	7
OCCUPATION - PAST	8
RESIDENCE.....	11
EXPOSURE - GARDEN.....	12
EXPOSURE - INDOOR	12
EXPOSURE – WORK/HOBBIES	13
BIRTH ¹ - BIRTH WEIGHT	14
BIRTH ¹ - PREGNANCY DURATION.....	14
BIRTH ¹ - BIRTH.....	14
WOMEN - MENARCHE	16
WOMEN - CONTRACEPTION	16
WOMEN - PREGNANCY	16
WOMEN - MENSTRUATION	17
NUTRITION (DAIMON).....	18
ALCOHOL (DAIMON).....	22
ALCOHOL	25
SMOKING ¹ - START	27
SMOKING ¹ - CURRENT	27
SMOKING ¹ - PAST	27
PASSIVE SMOKING ¹ - GENERALLY	28
PASSIVE SMOKING ¹ - DETAILS.....	28
CHRONIC DISEASES - LIVER	29
CHRONIC DISEASES - GOUT.....	29
CHRONIC DISEASES - OSTEOPOROSIS	29
CHRONIC DISEASES - VASCULITIS.....	29
CANCER	30
DIABETES.....	31
KIDNEY ¹ - DISEASES	32
KIDNEY ¹ – RENAL FAILURE	33
KIDNEY ¹ – SURGERY.....	34
BLOOD VALUES ¹ - HYPERTENTION	35
BLOOD VALUES ¹ - MEDICATION FOR HYPERTENTION	35

BLOOD VALUES ¹ - BLOOD LIPIDS.....	35
THYROID ¹ - DISEASES.....	36
THYROID ¹ - SURGERY.....	36
THYROID ¹ - THERAPY	37
THYROID ¹ - FAMILIARITY	37
MYOCARDIAL INFARCTION - ANGINA PECTORIS	39
MYOCARDIAL INFARCTION - ANGINA PECTORIS (REVISED)	40
MYOCARDIAL INFARCTION - CORONARY HEART DISEASE.....	40
MYOCARDIAL INFARCTION.....	41
MYOCARDIAL INFARCTION - SURGERY	41
HEART FAILURE - SYMPTOMS	42
HEART FAILURE - DISEASES.....	42
HEART FAILURE - ECG	43
HEART FAILURE	43
CARDIAC ARRHYTHMIAS - ATRIAL FIBRILLATION	44
CARDIAC ARRHYTHMIAS - SYMPTOMS.....	44
CARDIAC ARRHYTHMIAS - CHRONIC.....	44
CARDIAC ARRHYTHMIAS - ARRHYTHMIAS.....	45
CARDIAC ARRHYTHMIAS - TREATMENT	45
HEART DISEASES - OTHER	46
CIRCULATION ¹ - ARTERIES	47
CIRCULATION ¹ - VEINS	47
STROKE ¹ - TIA	49
STROKE ¹	49
STROKE ¹ - SYMPTOMS1	49
STROKE ¹ - SYMPTOMS2	50
NEUROLOGY - EPILEPSY	51
NEUROLOGY - TREMOR	51
NEUROLOGY - PARKINSON ¹	51
NEUROLOGY - FORGETFULNESS.....	52
NEUROLOGY - MULTIPLE SCLEROSIS.....	52
NEUROLOGY - CARPAL TUNNEL SYNDROME.....	53
NEUROLOGY - OTHER	53
MIGRAINE	54
MIGRAINE - CHARACTERISTICS	54
MIGRAINE - INTENSITY	55
PAIN ¹ - BACK PAIN.....	56
PAIN ¹ - JOINT PAIN	56
PAIN ¹ - OTHER	57
PAIN ¹ – MAIN PAIN	57
OTHER DISEASES - INJURIES.....	58
OTHER DISEASES - DISEASES.....	59

OTHER DISEASES - SURGERIES	61
ALGOMETER	62
MINI MENTAL STATE EXAMINATION (MMSE)¹ – ORIENTATION	63
MINI MENTAL STATE EXAMINATION (MMSE)¹ – REGISTRATION	63
MINI MENTAL STATE EXAMINATION (MMSE)¹ – LANGUAGE	64
SNIFFIN'STICKS¹ - GENERAL	66
SNIFFIN'STICKS¹ - DETAILS	66
SNIFFIN'STICKS¹ (1).....	67
SNIFFIN'STICKS¹ (2).....	67
FAMILY	69

Version in use since 2013-11-21

Version used until - - -

LAST CHANGES:

Until 2014-05-16 the Nutrition + Alcohol module (DAIMON) was still in use;
since 2014-05-19 the reduced Alcohol module in LimeSurvey is applied. Nutrition is assessed by a paper-based self-administrated FFQ since 2014-05-05.

2014-09-01: Introduction of MMSE + Sniffin'Sticks

2014-09-01: Revision of the logic in "Angina pectoris" module

2015-04-16: x0_opint and x0_opint2 (add new study assistant "SaS"); x0bl12 and x0th12b (correct typos German)

Administration

	<i>First of all, do you agree to the recording of the interview? This is important for the quality control.</i>			
x0_opint	Int: Please insert your name	x0_opint	<input type="checkbox"/> ByK <input type="checkbox"/> GrB <input type="checkbox"/> GuR <input type="checkbox"/> LiB <input type="checkbox"/> MoL <input type="checkbox"/> ObT <input type="checkbox"/> PaL <input type="checkbox"/> TeR <input type="checkbox"/> SaS	
		x0_opinta	Other _____	

Person - Birth

x0_sex	(Sex)	x0_sex	<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	
x0_birthd	When were you born?	x0_birthd	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">D</div> </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">M</div> </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> <div style="border-bottom: 1px solid black; width: 20px; text-align: center;">Y</div> </div>	
x0pe05	Where did your family live when you were born?	x0pe05a x0pe05b x0pe05c	Place _____ Province _____ Country _____	

Person - Family

x0pe02	How many brothers and sisters have you or have you had (including possible deceased siblings, except yourself)?	x0pe02a x0pe02b	Number of brothers <div style="border-bottom: 1px solid black; width: 40px; text-align: center;"> </div> Number of sisters <div style="border-bottom: 1px solid black; width: 40px; text-align: center;"> </div>	if x0pe02= 0 x0pe06
	How many brothers are still alive? How many sisters are still alive?	x0pe02c x0pe02d	<div style="border-bottom: 1px solid black; width: 40px; text-align: center;"> </div> <div style="border-bottom: 1px solid black; width: 40px; text-align: center;"> </div>	
x0pe04	Are you a twin or part of a multiple birth?	x0pe04	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
x0pe06	What is your marital status?	x0pe06	<input type="checkbox"/> 1 Married <input type="checkbox"/> 2 Separated/Divorced <input type="checkbox"/> 4 Widowed <input type="checkbox"/> 5 Single/never married <input type="checkbox"/> 6 Prefer not to answer	
x0pe11	How many sons and daughters do you have?	x0pe11a x0pe11b	Number of sons <div style="border-bottom: 1px solid black; width: 40px; text-align: center;"> </div> Number of daughters <div style="border-bottom: 1px solid black; width: 40px; text-align: center;"> </div>	

Person - Education

x0pe08	What is the highest level of education you have completed?	x0pe08	<input type="checkbox"/> 1 No formal education or degree <input type="checkbox"/> 2 Primary school <input type="checkbox"/> 3 Lower secondary school <input type="checkbox"/> 4 Professional school (istituto professionale) <input type="checkbox"/> 5 Upper secondary school (liceo/istituto tecnico) <input type="checkbox"/> 6 College/University or higher	
x0pe09	In total, how many years did you attend school (starting from the first year of primary school)?	x0pe09	<div style="border-bottom: 1px solid black; width: 100px; display: inline-block;"></div> <div style="border-bottom: 1px solid black; width: 30px; display: inline-block;"></div>	

Occupation - Employment

	<i>The next questions are about your occupation.</i>			
x0oc00	Are you employed at the moment?	x0oc00	<input type="checkbox"/> 1 Yes, all-day <input type="checkbox"/> 2 Yes, regularly part-time	x0oc01
			<input type="checkbox"/> 3 Yes, less than p-t or irregularly <input type="checkbox"/> 4 No	
	Which is the address of your current workplace?		Street and house number: _____ Postcode: _____ Municipality / village: _____ Province: _____ Country: _____	x0oc13

Occupation - Current

x0oc01	Have you been employed or self-employed before?	x0oc01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	if age ≤ 75 x0oc10 if age > 75 x0oc13
x0oc01a	Until when have you been regularly employed?	x0oc01a	Year _ _ _ _ _		if age > 75 x0oc13
x0oc10	Are you at the moment ...?		<input type="checkbox"/> 1 Unemployed		if x0oc01 = 1 x0oc13 if x0oc01 = 2 x0rh01
		x0oc10	<input type="checkbox"/> 2 Housewife / househusband <input type="checkbox"/> 3 Student <input type="checkbox"/> 5 In education or retraining <input type="checkbox"/> 6 in maternity protection, parental leave or other leave <input type="checkbox"/> 4 Pensioner / retiree <input type="checkbox"/> 7 In the military service or alternative service		
x0oc11	Since when are you unemployed without interruption?	x0oc11a, x0oc11b	_ _ . _ _ _ _ _ MM Y Y Y Y		
x0oc13	Do you receive or did you received in the past a pension for reduced working capacity?	x0oc13	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0oc02 if x0oc01 = 2 x0rh01

x0oc13	Since when have you received this pension?	x0oc13a	From (year)		if x0oc01= 2 x0rh01
	Until when have you received this pension?	x0oc13b	To (year)		
	Or until now	x0oc13c	<input type="checkbox"/> 1 Until now <input type="checkbox"/> 2 {No}		

Occupation - Past

x0oc02	Which profession / occupation have you carried out for a least 1 year?	x0oc02a	<input type="checkbox"/> 1 Farmer <input type="checkbox"/> 2 Office employee <input type="checkbox"/> 3 Electrician <input type="checkbox"/> 4 Building industry <input type="checkbox"/> 5 Hotel/restaurant industry <input type="checkbox"/> 6 Waiter/barista/chef <input type="checkbox"/> 7 Nurse/doctor <input type="checkbox"/> 8 Teacher <input type="checkbox"/> 9 Mechanic <input type="checkbox"/> 10 Carpenter		
		x0oc02b	Other _____		
	Since when have you carried out this occupation? Until when have you carried out this occupation? Or until now	x0oc02c x0oc02d	From (year) To (year) <input type="checkbox"/> 1 Until now <input type="checkbox"/> 2 {No}		
	Have you carried out another profession / occupation for a least 1 year?	x0oc03	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0oc08
x0oc03	Which?	x0oc03a	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (as above)		
		x0oc03b	Other _____		
	Since when have you carried out this occupation? Until when have you carried out this occupation? Or until now	x0oc03c x0oc03d	From (year) To (year) <input type="checkbox"/> 1 Until now <input type="checkbox"/> 2 {No}		
	Have you carried out another profession / occupation for a least 1 year?	x0oc04	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0oc08

x0oc04	Which?	x0oc04a	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (as above)	
		x0oc04b	Other _____	
	Since when have you carried out this occupation? Until when have you carried out this occupation? Or until now	x0oc04c	From (year) _____ To (year) _____ <input type="checkbox"/> 1 Until now <input type="checkbox"/> 2 {No}	
	Have you carried out another profession / occupation for a least 1 year?	x0oc05	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	x0oc08
x0oc05	Which?	x0oc05a	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (as above)	
		x0oc05b	Other _____	
	Since when have you carried out this occupation? Until when have you carried out this occupation? Or until now	x0oc05c	From (year) _____ To (year) _____ <input type="checkbox"/> 1 Until now <input type="checkbox"/> 2 {No}	
	Have you carried out another profession / occupation for a least 1 year?	x0oc06	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	x0oc08
x0oc06	Which?	x0oc06a	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (as above)	
		x0oc06b	Other _____	
	Since when have you carried out this occupation? Until when have you carried out this occupation? Or until now	x0oc06c	From (year) _____ To (year) _____ <input type="checkbox"/> 1 Until now <input type="checkbox"/> 2 {No}	
	Have you carried out another profession / occupation for a least 1 year?	x0oc07	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	x0oc08
x0oc07	Which?	x0oc07a	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (as above)	
		x0oc07b	Other _____	

	Since when have you carried out this occupation? Until when have you carried out this occupation? Or until now	x0oc07c x0oc07d	From (year) _ _ _ _ _ To (year) _ _ _ _ _ <input type="checkbox"/> 1 Until now <input type="checkbox"/> 2 {No}	
x0oc08	How would you rate your profession or regular occupation?	x0oc08	<input type="checkbox"/> 1 Heavy physical activity <input type="checkbox"/> 2 Medium heavy physical activity <input type="checkbox"/> 3 Light physical activity <input type="checkbox"/> 4 No physical activity	

Residence

	Until now, where have you lived for at least 1 year? (place) (x0rh01a / x0rh02a / x0rh03a / x0rh04a / x0rh05a / x0rh06a / x0rh07a / x0rh08a / x0rh09a / x0rh10a) From (year) (x0rh01b / x0rh02b / x0rh03b / x0rh04b / x0rh05b / x0rh06b / x0rh07b / x0rh08b / x0rh09b / x0rh10b) To (year) (x0rh01c / x0rh02c / x0rh03c / x0rh04c / x0rh05c / x0rh06c / x0rh07c / x0rh08c / x0rh09c / x0rh10c) Do you have lived in another place for at least 1 year? (x0rh02 / x0rh03 / x0rh04 / x0rh05 / x0rh06 / x0rh07 / x0rh08 / x0rh09 / x0rh10)						
	Place	From (year)	To (year) /Until now	Other place?			
				Yes	No		
x0rh01	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="text"/>	
x0rh02	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="text"/>	
x0rh03	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="text"/>	
x0rh04	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="text"/>	
x0rh05	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="text"/>	
x0rh06	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="text"/>	
x0rh07	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="text"/>	
x0rh08	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="text"/>	
x0rh09	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="text"/>	
x0rh10	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> 1				

end

Exposure - Garden

	<i>The next questions are about exposure to environmental risk factors.</i>				
x0ex10	Do you do gardening (also allotment garden)?	x0ex10	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ex12
x0ex11	Do you use pesticides? (insecticides, herbicides, fungicides)	x0ex11	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ex12
x0ex11a	How often do you use these substances?	x0ex11a	<input type="checkbox"/> 1 Once a week and more <input type="checkbox"/> 2 1-3 times per month <input type="checkbox"/> 3 Less frequently		

Exposure - Indoor

x0ex12	Do you use or did you use insecticides in your habitation? (e.g. repellent, electric diffuser with plates)	x0ex12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ex13
x0ex12a	How often do you use these substances?	x0ex12a	<input type="checkbox"/> 1 Once a week and more <input type="checkbox"/> 2 1-3 times per month <input type="checkbox"/> 3 Less frequently		
x0ex13	Do you use or did you use wood preservatives in your habitation?	x0ex13	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ex21
x0ex13a	How often do you use these substances?	x0ex13a	<input type="checkbox"/> 1 More than once a year <input type="checkbox"/> 2 Approximately once a year <input type="checkbox"/> 3 Less than once a year		

Exposure – Work/Hobbies

x0ex21	Does your work or your hobbies expose you FREQUENTLY to the following substances?			Yes	No	
		x0ex21	Detergent, disinfectant	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex22	Engine exhaust	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex23	Wood dust	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex24	Grain dust	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex25	Glass wool/mineral wool	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex26	Asbestos	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex27	Metals (nickel, chromium, iron, steel)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex28	Heavy metals (lead, cadmium, mercury) or arsenic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex29	Solvents (e.g. PER, TRI) or paint	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex30	Petroleum products (gasoline, diesel, tar)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex31	X-rays/ microwaves/ radioactive materials	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0ex32	Pesticides	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
x0ex20	Are you exposed to heavy noise at your workplace?	x0ex20	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No			

Birth¹ - Birth weight

	<i>The next questions are about your birth and development.</i>			
x0bi01a	Do you know your exact birth weight?	x0bi01a	<input type="checkbox"/> 1 Exactly <input type="checkbox"/> 2 Approximately	
			<input type="checkbox"/> 3 I do not know	x0bi03
	What was your birth weight?	x0bi01	_ _ _ In grams	

Birth¹ - Pregnancy duration

x0bi03	Are you born preterm or postterm?	x0bi03	<input type="checkbox"/> 1 Preterm birth	
			<input type="checkbox"/> 2 Normal	x0bi04
			<input type="checkbox"/> 3 Postterm birth <input type="checkbox"/> 4 I do not know	
x0bi02a	Do you know exactly in which week of pregnancy your mother was when you were born?	x0bi02a	<input type="checkbox"/> 1 Exactly <input type="checkbox"/> 2 Approximately	
			<input type="checkbox"/> 3 I do not know	x0bi04
	For how many weeks was your mother pregnant until you were born?	x0bi02	_ _ In weeks	

Birth¹ - Birth

x0bi04	How were you born?	x0bi04	<input type="checkbox"/> 1 Normal birth <input type="checkbox"/> 2 Birth with the aid of delivery forceps or vacuum <input type="checkbox"/> 3 Caesarean section <input type="checkbox"/> 4 I do not know	
---------------	--------------------	--------	--	--

x0bi05	For how long were you breastfed?	x0bi05	<input type="checkbox"/> 1 I was not breastfed <input type="checkbox"/> 2 I was breastfed, but I do not know for how long <input type="checkbox"/> 3 Up to 2 weeks <input type="checkbox"/> 4 3 to 4 weeks (up to 1 month) <input type="checkbox"/> 5 2 to 3 months <input type="checkbox"/> 6 4 to 6 months <input type="checkbox"/> 7 More than 6 months <input type="checkbox"/> 8 I do not know, if I was breastfed		
x0bi06	Were you born with one or more congenital malformations?	x0bi06	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
	Please specify:	x0bi06a	_____		

¹ LifeLines - Questions about birth and development

<http://www.p3gobservatory.org/questionnaireblock/viewAllBlocks.htm?questionnaireId=48> (last checked July 2012)

J:\5-5 New Research Initiatives\5-50 Vinschgau-Study\5-50-5 Study Phenotypes\SIMILAR STUDIES\LifeLines

Women - Menarche

	<i>The next questions are directed especially to women. These are questions on reproductive history and women's health e.g. on pregnancies, sexual hormone use etc.</i>			if male end
x0wo01	Do you know the age when you had at your first menstruation (menarche)?		<input type="checkbox"/> 0 Yes	
		x0wo01	<input type="checkbox"/> 1 I have not had my period so far <input type="checkbox"/> 2 I don't know	x0wo03
	How old were you at your first menstruation (menarche)?	x0wo01a	Age (Years) <input type="text"/> <input type="text"/>	

Women - Contraception

x0wo03	Do you currently take contraceptive pills?		<input type="checkbox"/> 1 Yes	x0wo04a
		x0wo03	<input type="checkbox"/> 6 No	
			<input type="checkbox"/> 2 Prefer not to answer	if age<=55y x0wo05 if age>55y x0wo12
x0wo02	Have you ever taken contraceptive pills?	x0wo02	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	if age<=55y x0wo05 if age>55y x0wo12
x0wo04	How many months or years have you taken contraceptive pills?	x0wo04a	<input type="text"/> <input type="text"/> Number of months	if age>55y c103
		x0wo04b	<input type="text"/> <input type="text"/> or number of years	

Women - Pregnancy

x0wo05	Are you pregnant at the moment?	x0wo05	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know, possibly	x0wo06
	In which week of pregnancy are you at the moment?	x0wo05a	<input type="text"/> <input type="text"/>	
x0wo12	Have you ever been pregnant? (Including stillbirths and miscarriages!)	x0wo12	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0wo06
x0wo12a	How many children have you given birth to, including stillborn children? INT: Definition stillbirth: Birth of a dead foetus after a pregnancy of at least 28 weeks (or 7 months).	x0wo12a	<input type="text"/> <input type="text"/>	

Women - Menstruation

x0wo06	Do you still have regular menstrual bleedings?	x0wo06	<input type="checkbox"/> 1 Yes		end
			<input type="checkbox"/> 2 No		
			<input type="checkbox"/> 3 I don't know		end
	When did you have your last menstruation? (Age)	x0wo07	Age (Years) __ __		
x0wo08	What was the reason for the menstruation cease?		<input type="checkbox"/> 1 Menopause		
		x0wo08	<input type="checkbox"/> 2 Operation <input type="checkbox"/> 3 Other reason		end
		x0wo08a	_____		
x0wo09	Do you take hormones replacement preparations at the moment (estrogens or gestagens, i.e. sexual hormone preparations especially for women except the birth-control pill, e.g., in the form of tablets, ointments, plasters or injections)?	x0wo09	<input type="checkbox"/> 1 Yes		x0wo11
			<input type="checkbox"/> 2 No		
			<input type="checkbox"/> 3 I don't know		x0wo11
x0wo10	Have you ever taken any hormone replacement therapy?	x0wo10	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
x0wo11	How many years have you taken these hormone preparations all together?	x0wo11a	__ __ Number of years		
		x0wo11b	__ __ Number of months if less than 1 year		

Nutrition (DAIMON)

In use until 2014-05-16

	How often do you eat the following foods?						
		Almost Daily	Several times a week	About once a week	Several times a month	Once a month or less frequent	Never
x0fd01	Meat (without sausages)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd02	Sausages, ham	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd03	Poultry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd04	Fish	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd05	Potatoes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd06	Pasta	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd07	How often do you eat the following foods?						
		Almost Daily	Several times a week	About once a week	Several times a month	Once a month or less frequent	Never
x0fd07	Rice	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd08	Salad or vegetable, raw	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd09	Vegetable, cooked	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd10	Fresh fruit	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd11	Chocolate, chocolates	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd12	Cakes, pastries, biscuits	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd13	How often do you eat the following foods?						
		Almost Daily	Several times a week	About once a week	Several times a month	Once a month or less frequent	Never
x0fd13	Other sweets (candies, among other things)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd14	Salted snacks such as salted peanuts, crisps, and others	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd15	White bread, brown bread, toast bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd16	Whole grain bread, black bread, crisp bread	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd17	Flaked oats, muesli, cornflakes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
x0fd18	Curd, yoghurt, sour milk	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
	How often do you eat the following foods?						

		Almost Daily	Several times a week	About once a week	Several times a month	Once a month or less frequent	Never
x0fd19	Low-fat milk products up to 1.5% fat content (yoghurt, milk, curd, and others)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd20	Cheese	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd21	Eggs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd22	Milk including buttermilk	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd23	Margarine (as a spread)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd24	Margarine, half-fat ("light")	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd25	How often do you eat the following foods?						
		Almost Daily	Several times a week	About once a week	Several times a month	Once a month or less frequent	Never
x0fd25	Butter (as a spread)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd26	Butter, half-fat ("light")	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd27	Diet lemonade, other diet beverages	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd28	Fruit juices, other soft drinks (lemonades, cola-beverages, and others)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd29	Mineral water	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
x0fd31	Have you ever drunk espresso/ mocha coffee one or more times per month for at least 6 months in your lifetime? (except decaffeinated)	x0fd31	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0fd32	
	When did you start drinking regularly espresso/ mocha coffee? (age) Or: as child (<12), as teenager (13-18) or as adult (>19)?	x0fd31a	Age <input type="text"/> <input type="text"/> <input type="text"/>				
		x0fd31b	<input type="checkbox"/> 1 Child <input type="checkbox"/> 2 Teenager <input type="checkbox"/> 3 Adult				
	Do you drink regularly espresso/ mocha coffee at the moment? (at least once a month)	x0fd31c	<input type="checkbox"/> 2 No		<input type="checkbox"/> 1 Yes		x0fd31f
	When did you stop drinking regularly espresso/ mocha coffee? (age) Or: In total, how many years have you been drinking espresso/ mocha coffee?	x0fd31d , x0fd31e	<input type="text"/> <input type="text"/> <input type="text"/> Age <input type="text"/> <input type="text"/> <input type="text"/> or how many years				

x0fd31f	How many cups of espresso/ mocha coffee do you normally drink or have you drunk during a day?	x0fd31f			
x0fd32	Have you ever drunk black tea one or more times per month for at least 6 months in your lifetime?	x0fd32	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0fd33
	When did you start drinking regularly black tea? (age) Or: as child (<12), as teenager (13-18) or as adult (>19)?	x0fd32a x0fd32b	Age <input type="checkbox"/> 1 Child <input type="checkbox"/> 2 Teenager <input type="checkbox"/> 3 Adult		
	Do you drink regularly black tea at the moment? (at least once a month)	x0fd32c	<input type="checkbox"/> 2 No	<input type="checkbox"/> 1 Yes	x0fd32f
	When did you stop drinking regularly black tea? (age) Or: In total, how many years have you been drinking black tea?	x0fd32d, x0fd32e	<div> <div> <div></div> <div></div> <div></div> </div> <div>Age</div> </div> <div> <div></div> <div></div> <div></div> </div> <div>or how many years</div>		

x0fd33f	How many cups of filter coffee (125 ml) do you normally drink or have you drunk during a day?	x0fd33f	_ _		
x0fd34	Have you ever drunk coke one or more times per month for at least 6 months in your lifetime? (except decaffeinated)	x0fd34	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
	When did you start drinking regularly coke? (age) Or: as child (<12), as teenager (13-18) or as adult (>19)?	x0fd34a	Age _ _		
		x0fd34b	<input type="checkbox"/> 1 Child <input type="checkbox"/> 2 Teenager <input type="checkbox"/> 3 Adult		
	Do you drink regularly coke at the moment? (at least once a month)	x0fd34c	<input type="checkbox"/> 2 No	<input type="checkbox"/> 1 Yes	x0fd34f
	When did you stop drinking regularly coke? (age) Or: In total, how many years have you been drinking coke?	x0fd34d, x0fd34e	_ _ _ _ Age or how many years		
x0fd34f	How many cans of coke (33 cl) do you normally drink or have you drunk during a day?	x0fd34f	_ _		

Alcohol (DAIMON)

In use until 2014-05-16

x0a100	Have you ever drunk alcoholic drinks?	x0a100	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	end
x0a101	During the last 12 months, on average how often have you drunk alcoholic drinks, e.g. a glass of wine, beer, cocktail, schnapps or liqueur?		<input type="checkbox"/> 1 Never <input type="checkbox"/> 2 At special occasions only <input type="checkbox"/> 3 Once a month or less		x0a105a
		x0a101	<input type="checkbox"/> 4 2-4 times per month <input type="checkbox"/> 5 2-3 times per week <input type="checkbox"/> 6 4 or more times per week but not daily <input type="checkbox"/> 7 Daily		if male x0a102a if female x0a102b
x0a102a	During the last 12 months, how often have you drunk 5 or more alcoholic drinks at a single occasion?	x0a102a	<input type="checkbox"/> 1 Never in the last 12 months <input type="checkbox"/> 2 1-2 times in the last 12 months <input type="checkbox"/> 3 3-5 times in the last 12 months <input type="checkbox"/> 4 6-11 times in the last 12 months <input type="checkbox"/> 5 Approximately once a month <input type="checkbox"/> 6 2-3 times per month <input type="checkbox"/> 7 1-2 times per week <input type="checkbox"/> 9 3-4 times per week <input type="checkbox"/> 10 Daily or almost daily		x0a103a
x0a102b	During the last 12 months, how often have you drunk 4 or more alcoholic drinks at a single occasion?	x0a102b	<input type="checkbox"/> 1 Never in the last 12 months <input type="checkbox"/> 2 1-2 times in the last 12 months <input type="checkbox"/> 3 3-5 times in the last 12 months <input type="checkbox"/> 4 6-11 times in the last 12 months <input type="checkbox"/> 5 Approximately once a month <input type="checkbox"/> 6 2-3 times per month <input type="checkbox"/> 7 1-2 times per week <input type="checkbox"/> 9 3-4 times per week <input type="checkbox"/> 10 Daily or almost daily		

x0al03a	During the last 12 months, how many of the following beverages have you usually drunk on a weekend (Friday, Saturday, Sunday)?	x0al03a x0al03b x0al03c x0al03d x0al03e x0al03f	Alcohol-free beer (number of glasses a 0.2 l) <input type="text"/> Beer (number of glasses a 0.2 l) <input type="text"/> White wine or sparkling wine (number of glasses a 0.125 l) <input type="text"/> Red wine (number of glasses a 0.125 l) <input type="text"/> Schnapps/liqueur (number of glasses a 0.02 l) <input type="text"/> Cocktails (with alcohol) (number of glasses a 0,3 l) <input type="text"/>																												
x0al04a	During the last 12 months, how many of the following beverages have you usually drunk on working days (from Monday until Thursday)?	x0al04a x0al04b x0al04c x0al04d x0al04e x0al04f	Alcohol-free beer (number of glasses a 0.2 l) <input type="text"/> Beer (number of glasses a 0.2 l) <input type="text"/> White wine or sparkling wine (number of glasses a 0.125 l) <input type="text"/> Red wine (number of glasses a 0.125 l) <input type="text"/> Schnapps/liqueur (number of glasses a 0.02 l) <input type="text"/> Cocktails (with alcohol)? (number of glasses a 0,3 l) <input type="text"/>	end																											
x0al05a	Why have you not drunk/ drunk few alcoholic drinks during the last 12 months?	x0al05a x0al05b x0al05c x0al05d x0al05e x0al05f x0al05g x0al05h	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Presence of a disease</td> <td><input type="checkbox"/>1</td> <td><input type="checkbox"/>0</td> </tr> <tr> <td>Other health reasons / for protection of the own health</td> <td><input type="checkbox"/>1</td> <td><input type="checkbox"/>0</td> </tr> <tr> <td>Recommendation of a physician</td> <td><input type="checkbox"/>1</td> <td><input type="checkbox"/>0</td> </tr> <tr> <td>Financial reasons</td> <td><input type="checkbox"/>1</td> <td><input type="checkbox"/>0</td> </tr> <tr> <td>Religious reasons</td> <td><input type="checkbox"/>1</td> <td><input type="checkbox"/>0</td> </tr> <tr> <td>I am a recovered alcoholic</td> <td><input type="checkbox"/>1</td> <td><input type="checkbox"/>0</td> </tr> <tr> <td>Other reasons</td> <td><input type="checkbox"/>1</td> <td><input type="checkbox"/>0</td> </tr> <tr> <td>I don't know</td> <td><input type="checkbox"/>1</td> <td><input type="checkbox"/>0</td> </tr> </tbody> </table>		Yes	No	Presence of a disease	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Other health reasons / for protection of the own health	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Recommendation of a physician	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Financial reasons	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Religious reasons	<input type="checkbox"/> 1	<input type="checkbox"/> 0	I am a recovered alcoholic	<input type="checkbox"/> 1	<input type="checkbox"/> 0	Other reasons	<input type="checkbox"/> 1	<input type="checkbox"/> 0	I don't know	<input type="checkbox"/> 1	<input type="checkbox"/> 0	end
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x0al06a	When did you start drinking regularly alcohol?	x0al06a, x0al06b	<table border="0"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td colspan="3">Year</td> <td colspan="3">or age at that time</td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year			or age at that time																		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>																										
Year			or age at that time																												

x0a107a	When did you stop drinking regularly alcohol?	x0a107a, x0a107b	<div><div><div></div><div></div><div></div><div></div></div><div>Year</div></div> <div><div><div></div><div></div></div><div>or age at that time</div></div>	
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Alcohol

In use since 2014-05-19

	<i>Next I would like to ask you some questions about smoking and passive smoking.</i>			
x0a100	Have you ever drunk alcoholic drinks?	x0a100	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	end
x0a101	During the last 12 months, on average how often have you drunk alcoholic drinks, e.g. a glass of wine, beer, cocktail, schnapps or liqueur?		<input type="checkbox"/> 1 Never <input type="checkbox"/> 2 At special occasions only <input type="checkbox"/> 3 Once a month or less	end
		x0a101	<input type="checkbox"/> 4 2-4 times per month <input type="checkbox"/> 5 2-3 times per week <input type="checkbox"/> 6 4 or more times per week but not daily <input type="checkbox"/> 7 Daily	if male x0a102a if female x0a102b
x0a102a	During the last 12 months, how often have you drunk 5 or more alcoholic drinks at a single occasion?	x0a102a	<input type="checkbox"/> 1 Never in the last 12 months <input type="checkbox"/> 2 1-2 times in the last 12 months <input type="checkbox"/> 3 3-5 times in the last 12 months <input type="checkbox"/> 4 6-11 times in the last 12 months <input type="checkbox"/> 5 Approximately once a month <input type="checkbox"/> 6 2-3 times per month <input type="checkbox"/> 7 1-2 times per week <input type="checkbox"/> 9 3-4 times per week <input type="checkbox"/> 10 Daily or almost daily	end
x0a102b	During the last 12 months, how often have you drunk 4 or more alcoholic drinks at a single occasion?	x0a102b	<input type="checkbox"/> 1 Never in the last 12 months <input type="checkbox"/> 2 1-2 times in the last 12 months <input type="checkbox"/> 3 3-5 times in the last 12 months <input type="checkbox"/> 4 6-11 times in the last 12 months <input type="checkbox"/> 5 Approximately once a month <input type="checkbox"/> 6 2-3 times per month <input type="checkbox"/> 7 1-2 times per week <input type="checkbox"/> 9 3-4 times per week <input type="checkbox"/> 10 Daily or almost daily	

Smoking¹ - Start

	<i>Next I would like to ask you some questions about smoking and passive smoking.</i>				
x0sm32	Have you ever smoked for as long as a year? INT: 'YES' means at least 20 packs of cigarettes or 12 oz (360 grams) of tobacco in a lifetime, or at least one cigarette per day or one cigar a week for one year	x0sm32	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0sm46
	How old were you when you started smoking?	x0sm33	Age (Years)	_ _	
x0sm34	How old were you when you started smoking daily?	x0sm34	Age (Years)	_ _	

Smoking¹ - Current

x0sm00	Do you now smoke, as of one month ago ?	x0sm00	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0sm39
x0sm35	How much do you now smoke on average?	x0sm35	Number of cigarettes per day:	_ _	
		x0sm36	Number of cigarillos per day:	_ _	
		x0sm37	Number of cigars a week:	_ _	
		x0sm38	Pipe tobacco in grams / week:	_ _ _	

Smoking¹ - Past

x0sm39	Have you stopped or cut down smoking?	x0sm39	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0sm45
	Have you stopped or cut down smoking because of respiratory problems?	x0sm39a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
	How old were you when you stopped or cut down smoking?	x0sm40	Age (Years)	_ _	
x0sm41	On average of the entire time you smoked, before you stopped or cut down, how much did you smoke?	x0sm41	Number of cigarettes per day:	_ _	
		x0sm42	Number of cigarillos per day:	_ _	
		x0sm43	Number of cigars a week:	_ _	
		x0sm44	Pipe tobacco in grams / week:	_ _ _	
x0sm45	Do you or did you inhale the smoke?	x0sm45	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	

Passive Smoking¹ - Generally

x0sm46	Have you been regularly exposed to tobacco smoke in the last 12 months? INT: 'Regularly' means on most days or nights	x0sm46	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	end
	Not counting yourself, how many people in your household smoke regularly?	x0sm47	_ _		
	Do people smoke regularly in the room where you work?	x0sm48	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	

Passive Smoking¹ - Details

	How many hours per day are you exposed to other people's smoke?	x0sm49	_ _ hours per day	if 0 end
x0sm49a	Please provide more information. How many hours per day, are you exposed to other peoples tobacco smoke in the following locations?	x0sm49a	at home: _ _ hours per day	
		x0sm49b	at workplace: _ _ hours per day	
		x0sm49c	in bars, restaurants, cinemas or similar social settings: _ _ hours per day	
		x0sm49d	elsewhere: _ _ hours per day	

¹ European Community Respiratory Health Survey (ECRHS) III <http://www.ecrhs.org/Quests.htm> (last checked July 2012)

Chronic diseases - Liver

	<i>The next questions are about your health status.</i>					
x0cd01	Has a doctor ever told you that you have a liver disease?	x0cd01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0cd06	
	Do you remember the name of the disease?	x0cd01e	<input type="checkbox"/> 1 Cirrhosis			
			<input type="checkbox"/> 2 Other			
		x0cd01f	Other _____			
	In which year was it diagnosed for the first time?	x0cd01a	Year _____			

Chronic diseases - Gout

x0cd06	Has a doctor ever told you that you have gout?	x0cd06	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0cd10	
	In which year was it diagnosed for the first time?	x0cd06a	Year _____			

Chronic diseases - Osteoporosis

x0cd10	Has a doctor ever told you that you have osteoporosis?	x0cd10	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0cd14	
	In which year was it diagnosed for the first time?	x0cd10a	Year _____			

Chronic diseases - Vasculitis

0cd14	Have you ever been told that you have a vasculitis (including lupus erythematosus)?	x0cd14	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end	
	Do you remember the name of the disease?	x0cd14d	_____			
	In which year was it diagnosed for the first time?	x0cd14a	Year _____			

Cancer

x0ca00	Have you ever had cancer?	x0ca00	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	end																														
x0ca00a	How many malignant tumours (cancer) have you had?	x0ca00a	_ _																																	
x0ca01a	<p>In which year was the first/ second/ third / fourth/ fifth cancer ascertained? (x0ca01a/ x0ca02a/ x0ca03a/ x0ca04a/ x0ca05a)</p> <p>What kind of cancer? (x0ca01b/ x0ca02b / x0ca03b / x0ca04b / x0ca05b)</p> <p>Were you hospitalised for in-patient treatment? (x0ca01c / x0ca02c / x0ca03c / x0ca04c / x0ca05c)</p> <p>In which hospital were you treated? (x0ca01d / x0ca02d / x0ca03d / x0ca04d / x0ca05d)</p>																																			
	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Year</th> <th style="width: 20%;">Kind of cancer</th> <th style="width: 20%;">Treated in-patient? No Yes</th> <th style="width: 20%;">Hospital</th> <th style="width: 25%;"></th> </tr> </thead> <tbody> <tr> <td> _ _ _ _ </td> <td>_____</td> <td><input type="checkbox"/>2 <input type="checkbox"/>1 ➡</td> <td>_____</td> <td>= 1</td> </tr> <tr> <td> _ _ _ _ </td> <td>_____</td> <td><input type="checkbox"/>2 <input type="checkbox"/>1 ➡</td> <td>_____</td> <td>= 2</td> </tr> <tr> <td> _ _ _ _ </td> <td>_____</td> <td><input type="checkbox"/>2 <input type="checkbox"/>1 ➡</td> <td>_____</td> <td>= 3</td> </tr> <tr> <td> _ _ _ _ </td> <td>_____</td> <td><input type="checkbox"/>2 <input type="checkbox"/>1 ➡</td> <td>_____</td> <td>= 4</td> </tr> <tr> <td> _ _ _ _ </td> <td>_____</td> <td><input type="checkbox"/>2 <input type="checkbox"/>1 ➡</td> <td>_____</td> <td></td> </tr> </tbody> </table>					Year	Kind of cancer	Treated in-patient? No Yes	Hospital		_ _ _ _	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 1 ➡	_____	= 1	_ _ _ _	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 1 ➡	_____	= 2	_ _ _ _	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 1 ➡	_____	= 3	_ _ _ _	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 1 ➡	_____	= 4	_ _ _ _	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 1 ➡	_____		end if x0ca00a
Year	Kind of cancer	Treated in-patient? No Yes	Hospital																																	
_ _ _ _	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 1 ➡	_____	= 1																																
_ _ _ _	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 1 ➡	_____	= 2																																
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_ _ _ _	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 1 ➡	_____	= 4																																
_ _ _ _	_____	<input type="checkbox"/> 2 <input type="checkbox"/> 1 ➡	_____																																	

Diabetes

x0dm00	Do you have diabetes mellitus?	x0dm00	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
x0dm01	In which year was it diagnosed?	x0dm01a	Year <div style="display: flex; justify-content: flex-end; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	
x0dm02	Do you know which type of diabetes you have?	x0dm02	<input type="checkbox"/> 1 Juvenile diabetes (type 1) <input type="checkbox"/> 2 Adult diabetes (type 2) <input type="checkbox"/> 3 Pregnancy diabetes <input type="checkbox"/> 4 Diabetes after pancreatitis <input type="checkbox"/> 5 I do not know	
x0dm03	How are you treated?		<input type="checkbox"/> 1 Only with tablets	end
		x0dm03	<input type="checkbox"/> 2 Only with insulin <input type="checkbox"/> 3 With insulin and tablets	
			<input type="checkbox"/> 4 Only diet <input type="checkbox"/> 5 No treatment	end
x0dm04	Please, indicate the year since when you are treated with insulin.	x0dm04a	Year <div style="display: flex; justify-content: flex-end; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	

Kidney¹ - Diseases

x0ki00	Has a doctor ever told you that you have a kidney disease?	x0ki00	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0ki09
x0ki01	Was it a glomerulonephritis?	x0ki01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0ki02
	In which year was it diagnosed for the first time?	x0ki01a	Year _ _ _ _ 		
	Do you remember the exact name of the disease?	x0ki01d	<hr/>		
x0ki02	Was it a pyelonephritis?	x0ki02	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0ki04
	In which year was it diagnosed for the first time?	x0ki02a	Year _ _ _ _ 		
x0ki04	Was it a disease of the renal arteries (including renal artery stenosis)?	x0ki04	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0ki05
	In which year was it diagnosed for the first time?	x0ki04a	Year _ _ _ _ 		
	Do you remember the exact name of the disease or the diagnosis?	x0ki04d	<hr/>		
x0ki05	Was it a hereditary or congenital kidney disease (including polycystic kidney disease)?	x0ki05	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0ki07
	In which year was it diagnosed for the first time?	x0ki05a	Year _ _ _ _ 		
	Do you remember the exact name of the disease or the diagnosis?	x0ki05d	<hr/>		
x0ki07	Have you ever been told that you have kidney stones?	x0ki07	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0ki08
	In which year were the kidney stones diagnosed for the first time?	x0ki07a	Year _ _ _ _ 		
x0ki08	Have you ever been told that you have another kidney disease, not mentioned yet?	x0ki08	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0ki09
	If you remember it, please specify the name of the disease:	x0ki08d	<hr/>		

	In which year was it diagnosed for the first time?	x0ki08a	Year	_ _ _ _	
--	--	---------	------	---------	--

Kidney¹ – Renal Failure

x0ki09	Has a doctor ever told you that you have a reduced kidney function or a renal failure?	x0ki09	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ki19
	In which year?	x0ki09a	Year	_ _ _ _		
	Is the renal failure still present?	x0ki09c	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0ki22	Have you ever been on dialysis?	x0ki22	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 Non lo so	x0ki23
	When did you the first dialysis?	x0ki22a	Year	_ _ _ _		
x0ki23	Are you still on dialysis?	x0ki23	<input type="checkbox"/> 2 No	<input type="checkbox"/> 1 Yes		x0ki10
	When did you the last dialysis?	x0ki23a	Year	_ _ _ _		
x0ki10	Have you ever undergone a kidney transplantation?	x0ki10	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ki19
	How many transplantations?	x0ki10a	_			
x0ki11a	Year of the first transplantation	x0ki11a	Year	_ _ _ _	if x0ki10a = 1	x0ki19
x0ki12a	Year of the second transplantation	x0ki12a	Year	_ _ _ _	if x0ki10a = 2	x0ki19
x0ki13a	Year of the third transplantation	x0ki13a	Year	_ _ _ _	if x0ki10a = 3	x0ki19
x0ki14a	Year of the fourth transplantation	x0ki14a	Year	_ _ _ _	if x0ki10a = 4	x0ki19
x0ki15a	Year of the fifth transplantation	x0ki15a	Year	_ _ _ _		

Kidney¹ – Surgery

x0ki19	Have you ever donated a kidney?	x0ki19	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ki20
	In which year?	x0ki19a	Year _ _ _ _ 			
x0ki20	Were you operated for angioplasty of the renal arteries?	x0ki20	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ki21
	In which year?	x0ki20a	Year _ _ _ _ 			
x0ki21	Have you undergone a renal surgery for another reason?	x0ki21	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	end
	Please specify:	x0ki21c	<hr style="border: none; border-top: 1px solid black; width: 100%;"/>			
	In which year?	x0ki21a	Year _ _ _ _ 			

¹ based on Renal DataSchema (modified by PaC)

[http://www.datashaper.org/Datashaper.html?jsessionid=C2EB9C7F6D2FEF61C2D17C1453BE1D68#dataschemasTab\\$REL EASE\\$RENAL_1](http://www.datashaper.org/Datashaper.html?jsessionid=C2EB9C7F6D2FEF61C2D17C1453BE1D68#dataschemasTab$REL EASE$RENAL_1) (last checked July 2012)

J:\5-5 New Research Initiatives\5-50 Vinschgau-Study\5-50-5 Study Phenotypes\CARDIO\Kidney

Blood values¹ - Hypertention

x0bl01	Has a doctor ever said that you have high blood pressure or hypertension?	x0bl01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0bl02
x0bl01b	At what age were you first told this?	x0bl01b	Age (Years) __ __		if sex = male c04_056
x0bl01c	Was this during pregnancy only?	x0bl01c	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	

Blood values¹ - Medication for Hypertention

x0bl02	Have you ever taken medication for hypertension or high blood pressure, following a doctor's prescription?	x0bl02	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0bl12
	At what age did you begin taking medicine for this? INT: if unknown: 99	x0bl02a	Age (Years) __ __		
	Are you still taking medicine for this?	x0bl02b	<input type="checkbox"/> 2 No	<input type="checkbox"/> 1 Yes	x0bl12
	When did you stop taking medicine for this?	x0bl02c	Age (Years) __ __		

Blood values¹ - Blood lipids

x0bl12	Has a doctor ever said you have raised blood lipids (cholesterol, triglycerides)?	x0bl12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
x0bl12a	Have you ever taken medication for this, following a doctor's prescription?	x0bl12a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
	At what age did you begin taking medicine for this?	x0bl12b	Age (Years) __ __		
	Are you still taking medicine for this?	x0bl12c	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	

¹ based on

- PhenX Toolkit Blood Pressure (Adult/Primary) #040301

<https://www.phenxtoolkit.org/index.php?pageLink=browse.protocoldetails&id=40301> (last checked July 2012)

- PhenX Toolkit Lipid Profile #040200

<https://www.phenxtoolkit.org/index.php?pageLink=browse.protocoldetails&id=40201> (last checked July 2012)

J:\5-5 New Research Initiatives\5-50 Vinschgau-Study\5-50-5 Study Phenotypes\METABOLISM\hypertension_lipids

Thyroid¹ - Diseases

x0th00	Were you ever diagnosed to have a thyroid disease?	x0th00	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0th12
x0th01	Which thyroid disease were you diagnosed for? If YES: Do you remember the year of the diagnosis?		No	Don't Know	Yes	Year of diagnosis
x0th01	1. Hypothyroidism	x0th02, x0th02a	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1 \Rightarrow Year	_ _ _ _
x0th02	2. Hashimoto's disease	x0th07, x0th07a	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1 \Rightarrow Year	_ _ _ _
x0th03	3. Hyperthyroidism	x0th01, x0th01a	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1 \Rightarrow Year	_ _ _ _
x0th04	4. Graves' disease (Basedow's disease)	x0th05, x0th05a	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1 \Rightarrow Year	_ _ _ _
x0th05	5. Goiter	x0th03, x0th03a	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1 \Rightarrow Year	_ _ _ _
x0th06	6. Nodule	x0th04, x0th04a	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1 \Rightarrow Year	_ _ _ _
x0th07	7. Cancer	x0th06, x0th06a	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 1 \Rightarrow Year	_ _ _ _
x0th09	8. A different thyroid disease, not mentioned yet?	x0th09	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
if sex = female AND children > 0 \Rightarrow x0th08 if sex = male OR children=0 AND (x0th02, ..., x0th09 = 2 or 3) \Rightarrow x0th12 if sex = male OR children=0 AND (x0th02= 1 OR x0th03= 1 OR ..., x0th09= 1) \Rightarrow x0th12						
	Do you remember the year of the diagnosis?	x0th09a	Year		_ _ _ _	
	Do you remember the name of the disease or can you describe it as precisely as possible?	x0th09b	_____			if sex = male OR children=0 x0th12
x0th08	9. Did you suffered from an alteration of the thyroid function during pregnancy?	x0th08	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	

Thyroid¹ - Surgery

x0th12	Were you ever submitted to an operation to the thyroid gland?	x0th12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0th13
x0th12a	In which year?	x0th12a	Year		_ _ _ _	

	Do you remember which kind of operation?	x0th12b	<input type="checkbox"/> 1 Partial removal <input type="checkbox"/> 2 Full removal <input type="checkbox"/> 3 Nodule	x0th13
			<input type="checkbox"/> 4 Other	
	Could you please specify as much as you can?	x0th12c	_____	

Thyroid¹ - Therapy

x0th13	Did you ever undergo a therapy for the thyroid?	x0th13	<input type="checkbox"/> 1 Yes, radioiodine therapy <input type="checkbox"/> 2 Yes, medical or pharmacological therapy	
			<input type="checkbox"/> 3 No <input type="checkbox"/> 4 I don't know	x0th14
	Do you remember the year of the first treatment?	x0th13a	From (year) _ _ _ _	
	Until when did the treatment last? Or until now	x0th13b	To (year) _ _ _ _ <input type="checkbox"/> 1 Until now <input type="checkbox"/> 2 {No}	

Thyroid¹ - Familiarity

x0th14	Did other persons in your family suffered from diseases to the thyroid function?	x0th14	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
	Please specify		[CHECKBOX] Yes No x0th14a Mother <input type="checkbox"/> 1 <input type="checkbox"/> 2 x0th14b Father <input type="checkbox"/> 1 <input type="checkbox"/> 2 x0th14c Brother(s) <input type="checkbox"/> 1 <input type="checkbox"/> 2 x0th14d Sister(s) <input type="checkbox"/> 1 <input type="checkbox"/> 2 x0th14e Son(s) <input type="checkbox"/> 1 <input type="checkbox"/> 2 x0th14f Daughter(s) <input type="checkbox"/> 1 <input type="checkbox"/> 2	
	Do you remember the name of the disease?	x0th14g	_____	

¹ Based on a template from the KORA study, the questionnaire was reviewed and entirely restructured by Cristian Pattaro, Claudia Beu Volpato, and Helmuth Weiß (Hospital of Schlanders/Silandro) on Apr/May 2012

J:\5-5 New Research Initiatives\5-50 Vinschgau-Study\5-50-5 Study Phenotypes\METABOLISM\thyroid

Myocardial infarction - Angina Pectoris

In use until 2014-08-29

x0mi00	Have you ever had any pain or discomfort in your chest?	x0mi00	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0mi08
x0mi01	Do you get it when you walk uphill or hurry?		<input type="checkbox"/> 1 Yes		
		x0mi01	<input type="checkbox"/> 2 No		x0mi07
			<input type="checkbox"/> 3 I never hurry or walk uphill <input type="checkbox"/> 4 I don't know		
x0mi02	Do you get it when you walk at an ordinary pace on the level?	x0mi02	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know		
x0mi03	What do you do, if you get it while you are walking?	x0mi03	<input type="checkbox"/> 1 I stop or slow down <input type="checkbox"/> 3 I take nitroglycerine		
			<input type="checkbox"/> 2 I carry on walking in the same pace		x0mi07
x0mi04	Does the pain/discomfort vanish within 10 minutes if you slow down or stop?	x0mi04	<input type="checkbox"/> 2 No	<input type="checkbox"/> 1 Yes	x0mi07
x0mi05a	Will you show me, where it was?	x0mi05a	Sternum	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05b	Left arterial chest	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05c	Neck / jaw	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05d	Left shoulder	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05e	Other	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05f	_____		
		If it was at another site, which?			
x0mi06	Does the pain or the discomfort radiate into the left arm?	x0mi06	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No		
x0mi07	Have you ever had a severe pain across the front of your chest lasting for half an hour or more?	x0mi07	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No		

Myocardial infarction - Angina Pectoris (revised)

In use since 2014-09-01

x0mi00	Have you ever had any pain or discomfort in your chest?	x0mi00	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0mi08
x0mi01	Do you get it when you walk uphill or hurry?		<input type="checkbox"/> 1 Yes		
		x0mi01	<input type="checkbox"/> 2 No		x0mi07
			<input type="checkbox"/> 3 I never hurry or walk uphill <input type="checkbox"/> 4 I don't know		
x0mi02	Do you get it when you walk at an ordinary pace on the level?	x0mi02	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know		
x0mi03	What do you do, if you get it while you are walking?	x0mi03	<input type="checkbox"/> 1 I stop or slow down <input type="checkbox"/> 3 I take nitroglycerine		
			<input type="checkbox"/> 2 I carry on walking in the same pace		x0mi07
x0mi04	Does the pain/discomfort vanish within 10 minutes if you slow down or stop?	x0mi04	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No		
x0mi05a	Will you show me, where it was?	x0mi05a	Sternum	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05b	Left arterial chest	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05c	Neck / jaw	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05d	Left shoulder	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05e	Other	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No	
		x0mi05f	_____		
		If it was at another site, which?			
x0mi06	Does the pain or the discomfort radiate into the left arm?	x0mi06	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No		
x0mi07	Have you ever had a severe pain across the front of your chest lasting for half an hour or more?	x0mi07	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No		

Myocardial infarction - Coronary Heart Disease

x0mi08	To your knowledge, do you have a coronary heart disease?	x0mi08	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0mi09
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	In which year was it diagnosed?	x0mi08b	Year	_ _ _ _	
	Were you or are you still treated by a doctor for this?	x0mi08d	<input type="checkbox"/> 1 Yes, in the past <input type="checkbox"/> 3 No <input type="checkbox"/> 2 Yes, currently <input type="checkbox"/> 4 I don't know		

Myocardial infarction

x0mi09	Have you ever been told by a doctor that you had a myocardial infarction?	x0mi09	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0mi16																												
x0mi10	In total, how many myocardial infarction have you had?	x0mi10	_ _																													
x0mi11a	Which year did the first/ second/ third/ fourth/ fifth myocardial infarction occur? (x0mi11a / x0mi12a / x0mi13a / x0mi14a / x0mi15a) Were you treated in-patient in a hospital? (x0mi11b / x0mi12b / x0mi13b / x0mi14b / x0mi15b) In which hospital were you treated? (x0mi11c / x0mi12c / x0mi13c / x0mi14c / x0mi15c)																															
	<table border="0"> <thead> <tr> <th>Year</th> <th colspan="2">Treated in-patient?</th> <th>Hospital</th> </tr> <tr> <th></th> <th>No</th> <th>Yes</th> <th></th> </tr> </thead> <tbody> <tr> <td> _ _ _ _ </td> <td><input type="checkbox"/>2</td> <td><input type="checkbox"/>1</td> <td>⇒ _____</td> </tr> <tr> <td> _ _ _ _ </td> <td><input type="checkbox"/>2</td> <td><input type="checkbox"/>1</td> <td>⇒ _____</td> </tr> <tr> <td> _ _ _ _ </td> <td><input type="checkbox"/>2</td> <td><input type="checkbox"/>1</td> <td>⇒ _____</td> </tr> <tr> <td> _ _ _ _ </td> <td><input type="checkbox"/>2</td> <td><input type="checkbox"/>1</td> <td>⇒ _____</td> </tr> <tr> <td> _ _ _ _ </td> <td><input type="checkbox"/>2</td> <td><input type="checkbox"/>1</td> <td>⇒ _____</td> </tr> </tbody> </table>			Year	Treated in-patient?		Hospital		No	Yes		_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____	_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____	_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____	_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____	_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____	x0mi16 if x0mi10 = 1 = 2 = 3 = 4
Year	Treated in-patient?		Hospital																													
	No	Yes																														
_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____																													
_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____																													
_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____																													
_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____																													
_ _ _ _	<input type="checkbox"/> 2	<input type="checkbox"/> 1	⇒ _____																													

Myocardial infarction - Surgery

x0mi16	Have you ever undergone a cardiac catheterization (coronary angiography)?	x0mi16	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	
x0mi17	Have you ever undergone a cardiac surgery?	x0mi17	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	
x0mi18	Have you ever undergone a bypass surgery or angioplasty (stent)?	x0mi18	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	

Heart failure - Symptoms

x0hf01	Do you have shortness of breath during exercise e.g. when climbing stairs?	x0hf01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0hf02
	Since when? (Year)	x0hf01a	Year _ _ _ _ 			
x0hf02	Do you have "water in the lung" (pulmonary edema)?	x0hf02	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0hf03
	Since when? (Year)	x0hf02a	Year _ _ _ _ 			
x0hf03	Do you often have swollen legs, because of "water in the legs"?	x0hf03	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0hf04
	Since when? (Year)	x0hf03a	Year _ _ _ _ 			

Heart failure - Diseases

x0hf04	Do you have myocarditis?	x0hf04	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0hf05
	Since when? (Year)	x0hf04a	Year _ _ _ _ 			
	Describe the disease as accurately as possible:	x0hf04c	<hr/>			
x0hf05	Do you have myocardial diseases? (e.g. hypertrophic cardiomyopathy)	x0hf05	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0hf06
	Since when? (Year)	x0hf05a	Year _ _ _ _ 			
	Describe the disease as accurately as possible:	x0hf05c	<hr/>			
x0hf06	Have you ever been told that you have a heart defect (as a child)?	x0hf06	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0hf07
	Describe the problem as accurately as possible:	x0hf06a	<hr/>			

Heart failure - ECG

x0hf07	Has a doctor ever performed an ECG on you (except surgical preparation or sport competitions)?	x0hf07	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0hf08
	Where there conspicuous findings?	x0hf07c	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0hf08
	Which?	x0hf07d	<hr/>		
	Do you remember in which year the ECG showed conspicuous findings for the first time?	x0hf07a	Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Heart failure

x0hf08	Has a doctor ever told you that you have a heart failure?	x0hf08	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
	In which year was it diagnosed for the first time?	x0hf08a	Year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Cardiac arrhythmias - Atrial Fibrillation

x0af02	Do you have atrial fibrillation?	x0af02	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0af07
	Was it diagnosed by a doctor?	x0af02a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0af03
	In which year was it diagnosed for the first time?	x0af02b	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	Were you or are you still treated by a doctor for this?	x0af02d	<input type="checkbox"/> 1 Yes, in the past <input type="checkbox"/> 3 No <input type="checkbox"/> 2 Yes, currently <input type="checkbox"/> 4 I don't know			

Cardiac arrhythmias - Symptoms

x0af03	Do you experience discomfort during atrial fibrillation?	x0af03	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0af04
x0af03a	Which?		<div>Yes</div> <div>No</div>			
		x0af03a	Tachycardia	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
		x0af03b	Extrasystole	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
		x0af03c	Weakness/tiredness	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
		x0af03d	Shortness of breath	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
		x0af03e	Chest pain	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
		x0af03f	Anxiety	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
		x0af03g	Dizziness	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
		x0af03h	Other	<input type="checkbox"/> 1	<input type="checkbox"/> 0	
x0af03i	Describe the other discomfort:	x0af03i	<input type="text"/>			

Cardiac arrhythmias - Chronic

x0af04	Is the atrial fibrillation chronic i.e. continuously, without a break?		<input type="checkbox"/> 1 Yes	x0af07
		x0af04	<input type="checkbox"/> 2 No	
			<input type="checkbox"/> 3 I don't know	x0af07

x0af05	How often do you have atrial fibrillation?	x0af05	<input type="checkbox"/> 1 Once a day <input type="checkbox"/> 2 Once a week <input type="checkbox"/> 3 Once a month <input type="checkbox"/> 4 Once a year	
x0af06	On average, how long does an attack of atrial fibrillation last?	x0af06	<input type="checkbox"/> 1 Seconds <input type="checkbox"/> 2 Minutes <input type="checkbox"/> 3 Hours <input type="checkbox"/> 4 Days	

Cardiac arrhythmias - Arrhythmias

x0af07	Had you have extrasystole, irregular heartbeat, tachycardia or cardiac flutter?	x0af07	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0af08	
	Since when? (Year)	x0af07a	Year	_ _ _ _			
	Describe the type of cardiac arrhythmia	x0af07c	_____				

Cardiac arrhythmias - Treatment

x0af08	Have you undergone an electric shock therapy because of a cardiac arrhythmia?	x0af08	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0af09	Do you have experienced a loss of consciousness with a cardiac arrest?	x0af09	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0af10
	Were you under physical or psychological stress at that time?	x0af09a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		
x0af10	Have you ever been reanimated by a doctor, an ambulance man or another person?	x0af10	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0af11	Are you carrier of a pacemaker or an implanted defibrillator?	x0af11	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	

Heart diseases - Other

x0af12	Have you or had you in the past any other diseases of the heart we did not mention yet?	x0af12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	end
	Describe the diseases of the heart as accurately as possible:	x0af12a	_____		

Circulation¹ - Arteries

x0ci01	Did a doctor <u>ever</u> say that you had claudication or peripheral arterial disease (poor blood flow to the legs or blocked or narrowed arteries to the legs)? INT: Do not include varicose veins or phlebitis.	x0ci01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ci03
x0ci02a	For the above condition have you ever had ... Angiography (dye in the arteries of the legs)?	x0ci02a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0ci02b	For the above condition have you ever had ... Angioplasty (balloon catheter to open blockage)?	x0ci02b	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0ci02c	For the above condition have you ever had ... Surgery to improve blood flow in your legs (do not include surgery for varicose veins)?	x0ci02c	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	

Circulation¹ - Veins

x0ci03	Did you ever had varicose veins in the legs (excluding during pregnancy)?	x0ci03	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0ci04	Did you ever had phlebitis at superficial veins on the legs?	x0ci04	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0ci05	Has a doctor ever told you that you had pulmonary embolus or blood clots in your lungs?	x0ci05	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0ci06	Has a doctor ever told you that you had deep venous thrombosis or blood clots in your legs?	x0ci06	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	end
	Have you ever been treated by a doctor or a nurse with shots at home or as an outpatient (usually followed by blood thinning medications such as Coumadin, Warfarin) for blood clots in the legs called deep vein thrombosis or DVT?	x0ci06a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
	Have you ever had outpatient test(s) performed for blood clots in the legs called deep vein thrombosis or DVT?	x0ci06b	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	

¹ Based on MICROS questionnaire and

- PhenX Toolkit Peripheral Arterial Disease Protocol

<https://www.phenxtoolkit.org/index.php?pageLink=browse.protocoldetails&id=40901> (last checked July 2012)

- PhenX Toolkit Pulmonary Embolism Protocol

<https://www.phenxtoolkit.org/index.php?pageLink=browse.protocoldetails&id=41301> (last checked July 2012)

- PhenX Toolkit Deep Venous Thrombosis Protocol

<https://www.phenxtoolkit.org/index.php?pageLink=browse.protocoldetails&id=41201> (last checked July 2012)

J:\5-5 New Research Initiatives\5-50 Vinschgau-Study\5-50-5 Study Phenotypes\CARDIO

Stroke¹ - TIA

x0st21	Have you ever been told that you had a transient ischemic attack (TIA)?	x0st21	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0st00
	When? (Year)	x0st21a	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	Describe the situation as accurately as possible:	x0st21c	<input type="text"/>			

Stroke¹

x0st00	Have you ever been told by a doctor that you had a stroke?	x0st00	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0st07
x0st06a	When did the first stroke occur?	x0st06a x0st06b	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> M M Y Y Y Y			

Stroke¹ - Symptoms¹

x0st07	Have you ever had any sudden loss or changes in speech lasting 24 hours or longer?	x0st07	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0st08
	Did the episode come on suddenly?	x0st07a	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No			
x0st08	Have you ever had any sudden loss of vision, or blurring, lasting 24 hours or longer?	x0st08	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0st09
	Did the episode come on suddenly?	x0st08a	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No			
x0st09	Have you ever had a sudden spell of double vision, which lasted 24 hours or longer?	x0st09	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0st10
x0st09a	If you closed one eye, did the double vision go away?		<input type="checkbox"/> 1 Yes			
		x0st09a	<input type="checkbox"/> 2 No			x0st10
			<input type="checkbox"/> 3 I do not know			
	Did the episode come on suddenly?	x0st09b	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No			

Stroke¹ - Symptoms²

x0st10	Have you ever had sudden numbness, tingling, or loss of feeling on one side of your body, including your face, arm, or leg which lasted 24 hours or longer?	x0st10	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0st11
	Did the feeling of numbness or tingling occur only when you kept your arms or legs in a certain position?		<input type="checkbox"/> 1 Yes		c02_043
		x0st10a	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know		
	Did the episode come on suddenly?	x0st10b	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No		
x0st11	Have you ever had any sudden episode of paralysis or weakness on one side of your body, including your face, arm, or leg which lasted at least 24 hours?	x0st11	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0st12
	Did the episode come on suddenly?	x0st11a	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No		
x0st12	Have you had any sudden spells of dizziness, loss of balance, or sensation of spinning which lasted 24 hours or longer?	x0st12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
	Did the dizziness, loss of balance or spinning sensation occur only when changing the position of your head or body?	x0st12a	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know		

¹ based on Jackson Heart Study (JHS). Stroke Symptoms Form. Version A. December 7, 2000.: <https://www.phenxtoolkit.org/index.php?pageLink=browse.protocoldetails&id=130301>

J:\5-5 New Research Initiatives\5-50 Vinschgau-Study\5-50-5 Study Phenotypes\NEURO\Stroke (last checked July 2012)

Neurology - Epilepsy

x0ne09	Has a doctor ever told you that you have epilepsy?	x0ne09	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ne10
	In which year was epilepsy diagnosed for the first time?	x0ne09a	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
x0ne10	Has a doctor ever told you that you have febrile seizures (mostly as a child)?	x0ne10	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ne02
	In which year was febrile seizures diagnosed for the first time?	x0ne10a	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

Neurology - Tremor

x0ne02	Do you have uncontrollable tremor?	x0ne02	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0pk01
	Was it diagnosed by a doctor?	x0ne02a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ne03
	When? (Year)	x0ne02b	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	Were you or are you still treated by a doctor for this?	x0ne02d	<input type="checkbox"/> 1 Yes, in the past <input type="checkbox"/> 3 No <input type="checkbox"/> 2 Yes, currently <input type="checkbox"/> 4 I don't know			
x0ne03	Where do you tremble (arms, legs, head...):	x0ne03a	<input type="text"/>			
	Do you tremble at rest? (e.g. when you are sitting on the couch watching TV)	x0ne03b	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		
	Do you tremble in movement/ certain postures? (e.g. when you hold a cup, a glass or a spoon for the soup)	x0ne03c	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		

Neurology - Parkinson¹

x0pk01	Do you or did you have trouble arising from a chair?	x0pk01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0pk02	Is your handwriting smaller than it once was?	x0pk02	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0pk03	Has anyone told you that your voice is softer than in once was?	x0pk03	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	

x0pk04	Is or was your balance poor?	x0pk04	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0pk05	Do your feet even seem to get stuck to the floor?	x0pk05	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0pk06	Has anyone told you that your face seems less expressive than it once was?	x0pk06	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0pk07	Do your arms or legs shake?	x0pk07	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0pk08	Do you have trouble fastening buttons?	x0pk08	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0pk09	Do you shuffle or take small steps when you walk?	x0pk09	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0pk10	Has anyone ever told you that you have Parkinson's disease?	x0pk10	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	
x0pk11	Have you ever taken drugs such as Sinemet or Madopar?	x0pk11	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	

¹ Pramstaller PP. et al. Validation of a mail questionnaire for parkinsonism in two languages (German and Italian). J Neurol. 1999 Feb;246(2):79-86.

J:\5-5 New Research Initiatives\5-50 Vinschgau-Study\5-50-5 Study Phenotypes\NEURO\PD-ET

Neurology - Forgetfulness

x0ne06	Did you notice forgetfulness (also orientation problems)? e.g. loose the way on known routes	x0ne06	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ne07
	Was it diagnosed by a doctor?	x0ne06a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ne07
	Since when? (Year)	x0ne06b	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	Were you or are you still treated by a doctor for this?	x0ne06d	<input type="checkbox"/> 1 Yes, in the past	<input type="checkbox"/> 3 No		
			<input type="checkbox"/> 2 Yes, currently	<input type="checkbox"/> 4 I don't know		

Neurology - Multiple Sclerosis

x0ne07	Has a doctor ever told you that you have multiple sclerosis?	x0ne07	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ne08
	In which year was multiple sclerosis diagnosed for the first time?	x0ne07a	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

Neurology - Carpal Tunnel Syndrome

x0ne08	Do you suffer from paraesthesias or (burning) pain in the hand?	x0ne08	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ne21
	Since when? (Year)	x0ne08a	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

Neurology - Other

x0ne21	Have you any other symptoms or neurologic diseases we did not mention yet?	x0ne21	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	end
x0ne21e	Describe the neurologic disease as accurately as possible:	x0ne21e	<input type="text"/>			
	Was it diagnosed by a doctor?	x0ne21a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ne22
	When? (Year)	x0ne21b	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	Were you or are you still treated by a doctor for this?	x0ne21d	<input type="checkbox"/> 1 Yes, in the past <input type="checkbox"/> 3 No <input type="checkbox"/> 2 Yes, currently <input type="checkbox"/> 4 I don't know			
x0ne22	Have you any other neurologic diseases we did not mention yet?	x0ne22	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		end
x0ne22e	Describe the neurologic disease as accurately as possible:	x0ne22e	<input type="text"/>			
	Was it diagnosed by a doctor?	x0ne22a	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	end
	When? (Year)	x0ne22b	Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	Were you or are you still treated by a doctor for this?	x0ne22d	<input type="checkbox"/> 1 Yes, in the past <input type="checkbox"/> 3 No <input type="checkbox"/> 2 Yes, currently <input type="checkbox"/> 4 I don't know			

Migraine

x0mg01	Have you had migraine (attack-like headaches) within the last 12 months?	x0mg01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	end
x0mg02a	How often have you had headache within the last 3 months?	x0mg02a	<input type="checkbox"/> 1 Rarely or never (max. 1 day per month) <input type="checkbox"/> 2 Occasionally (from 2 to 4 days per month) <input type="checkbox"/> 3 Frequently (from 5 to 15 days per month) <input type="checkbox"/> 4 Chronically (more than 15 days per month)		
x0mg04	How long does your headache last if you do not take drugs or if the treatment has no effect?	x0mg04	<input type="checkbox"/> 1 Up to 30 minutes <input type="checkbox"/> 2 More than 30 minutes up to 4 hours <input type="checkbox"/> 3 More than 4 hours up to 3 days <input type="checkbox"/> 4 More than 3 up to 7 days <input type="checkbox"/> 5 More than 7 days <input type="checkbox"/> 6 Don't Know		

Migraine - Characteristics

x0mg05	Please indicate whether the following headache characteristics apply to you or do not. Do you have a headache ...		Yes	No	
		x0mg05	which is limited to one side of the head? <input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mg06	that occurs on both sides of the head? <input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mg07	with pulsating or throbbing quality? <input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mg08	with a dull, oppressive quality? <input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mg09	that occurs suddenly at a single point of the head and lasts only few seconds? <input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mg10	that impairs considerably your usual daily activities? <input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mg11	that is aggravated by physical activity, e.g. climbing the stairs? <input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mg12	accompanied by nausea? <input type="checkbox"/> 1	<input type="checkbox"/> 2	

		x0mg13	accompanied by vomiting? <input type="checkbox"/> 1 <input type="checkbox"/> 2	
		x0mg14	accompanied by hypersensitivity to sound? <input type="checkbox"/> 1 <input type="checkbox"/> 2	
		x0mg15	accompanied by hypersensitivity to light? <input type="checkbox"/> 1 <input type="checkbox"/> 2	
		x0mg16	accompanied by hypersensitivity to smell? <input type="checkbox"/> 1 <input type="checkbox"/> 2	
		x0mg17	accompanied by flickering before the eyes or an interruption of the visual field? <input type="checkbox"/> 1 <input type="checkbox"/> 2	
		x0mg18	accompanied by red or watery eyes or runny nose on the side of the head affected by the headache? <input type="checkbox"/> 1 <input type="checkbox"/> 2	
		x0mg19	accompanied by weakness, paralysis or numbness of an arm or a leg, or by speech disturbance? <input type="checkbox"/> 1 <input type="checkbox"/> 2	
		x0mg20	that occurs only during the sleep and therefore wakes you up? <input type="checkbox"/> 1 <input type="checkbox"/> 2	

Migraine - Intensity

x0mg21	How many years have you been suffering from headaches?	x0mg21	<input type="text"/> <input type="text"/> <input type="text"/>	
x0mg22	How would you rate the intensity of your headaches on average?	x0mg22	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 1 = very weak pain ... 10 = very severe pain	

Pain¹ - Back Pain

x0pn00	Do you suffer from recurrent pain in general (excluding headache) for more than 6 months?	sv00	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	end
x0pn01	Do you suffer from back pain?	sv01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0pn11
x0pn05a	Localisation of the pain (see image)			Yes No	
		sv01a_1	lumbar	<input type="checkbox"/> 1 <input type="checkbox"/> 2	
		sv01a_2	thoracic	<input type="checkbox"/> 1 <input type="checkbox"/> 2	
		sv01a_3	cervical	<input type="checkbox"/> 1 <input type="checkbox"/> 2	
x0pn06a	Does the pain radiate into the leg or into the arm?			Yes No	
		sv01b_1	Leg	<input type="checkbox"/> 1 <input type="checkbox"/> 2	
		sv01b_2	Arm	<input type="checkbox"/> 1 <input type="checkbox"/> 2	
x0pn02a	Since when is the back pain present?	sv01c_1	_ _ Months		
		sv01c_2	_ _ Years		
	Frequency in days/month or days/year	sv01c_3	_ _ Days/Month		
		sv01c_4	_ _ Days/Year		
	Intensity of the pain	sv01c_5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 1 = very weak pain ... 10 = very severe pain		

Pain¹ - Joint Pain

x0pn11	Do you suffer from joint pain?	sv03_1	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0pn21
	Since when is the joint pain present?	sv03_2	_ _ Months		
		sv03_3	_ _ Years		
	Frequency in days/month or days/year	sv03_4	_ _ Days/Month		
		sv03_5	_ _ Days/Year		

x0pn14	How strong is the joint pain?	sv03a_1	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 1 = very weak pain ... 10 = very severe pain	
	Which joints are affected?	sv03a_2	_____	

Pain¹ - Other

x0pn21	Do you suffer from other pain (e.g. abdominal pain, menstrual cramps, toothache)?	sv04_1	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0pn30
	Since when is this pain present?	sv04_2	_ _ Months		
		sv04_3	_ _ Years		
	Frequency in days/month or days/year	sv04_4	_ _ Days/Month		
		sv04_5	_ _ Days/Year		
x0pn24	Intensity of the pain	sv04a_1	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 1 = very weak pain ... 10 = very severe pain		
	Description/localisation:	sv04a_2	_____		

Pain¹ – Main Pain

x0pn30	Which is the main pain?	sv05	_____	
x0pn31	How big is the impairment of daily life caused by the pain(s)?	sv06	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 1 = no impairment ... 10 = very high impairment	

¹ Erhebungsbogen Schmerz-Vorgeschichte (strukturiertes Interview)

Other diseases - Injuries

x0ot01	Have you ever had an accident with injuries? e.g. accident at work, road accident	x0ot01	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know	x0ot11
x0ot01a	Description of the injury:	x0ot01a	_____		
	When? (Year)	x0ot01b	Year	_ _ _ _	
	Have you had another accident with injuries?	x0ot02	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ot11
x0ot02a	Description of the injury:	x0ot02a	_____		
	When? (Year)	x0ot02b	Year	_ _ _ _	
	Have you had another accident with injuries?	x0ot03	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ot11
x0ot03a	Description of the injury:	x0ot03a	_____		
	When? (Year)	x0ot03b	Year	_ _ _ _	
	Have you had another accident with injuries?	x0ot04	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ot11
x0ot04a	Description of the injury:	x0ot04a	_____		
	When? (Year)	x0ot04b	Year	_ _ _ _	

Other diseases - Diseases

x0ot11	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot11	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	x0ot21
x0ot11a	Describe the disease as precisely as possible:	x0ot11a	<hr/>			
	Since when? (Year)	x0ot11b	Year	_ _ _ _		
	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot12	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		x0ot21
x0ot12a	Describe the disease as precisely as possible:	x0ot12a	<hr/>			
	Since when? (Year)	x0ot12b	Year	_ _ _ _		
	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot13	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		x0ot21
x0ot13a	Describe the disease as precisely as possible:	x0ot13a	<hr/>			
	Since when? (Year)	x0ot13b	Year	_ _ _ _		
	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot14	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		x0ot21
x0ot14a	Describe the disease as precisely as possible:	x0ot14a	<hr/>			
	Since when? (Year)	x0ot14b	Year	_ _ _ _		
	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot15	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		x0ot21
x0ot15a	Describe the disease as precisely as possible:	x0ot15a	<hr/>			
	Since when? (Year)	x0ot15b	Year	_ _ _ _		
	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot16	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No		x0ot21
x0ot16a	Describe the disease as precisely as possible:	x0ot16a	<hr/>			

	Since when? (Year)	x0ot16b	Year	_ _ _ _	
	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot17	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ot21
x0ot17a	Describe the disease as precisely as possible:	x0ot17a	_____		
	Since when? (Year)	x0ot17b	Year	_ _ _ _	
	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot18	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ot21
x0ot18a	Describe the disease as precisely as possible:	x0ot18a	_____		
	Since when? (Year)	x0ot18b	Year	_ _ _ _	
	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot19	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ot21
x0ot19a	Describe the disease as precisely as possible:	x0ot19a	_____		
	Since when? (Year)	x0ot19b	Year	_ _ _ _	
	Have you any other disease we did not mention yet, which was diagnosed by a doctor?	x0ot20	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	x0ot21
x0ot20a	Describe the disease as precisely as possible:	x0ot20a	_____		
	Since when? (Year)	x0ot20b	Year	_ _ _ _	

Other diseases - Surgeries

x0ot21	Did you have any surgery we did not mention yet?	x0ot21	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	<input type="checkbox"/> 3 I don't know	end
x0ot21a	What type of surgery did you have?	x0ot21a	_____			
	When? (Year)	x0ot21b	Year	_ _ _ _		
	Did you have any other surgery we did not mention yet?	x0ot22	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	end	
x0ot22a	What type of surgery did you have?	x0ot22a	_____			
	When? (Year)	x0ot22b	Year	_ _ _ _		
	Did you have any other surgery we did not mention yet?	x0ot23	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	end	
x0ot23a	What type of surgery did you have?	x0ot23a	_____			
	When? (Year)	x0ot23b	Year	_ _ _ _		
	Did you have any other surgery we did not mention yet?	x0ot24	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	end	
x0ot24a	What type of surgery did you have?	x0ot24a	_____			
	When? (Year)	x0ot24b	Year	_ _ _ _		
	INT: Now stop the recording.					

Algometer

	<p><i>With this test we will assess your sensibility to pressure pain. In a moment, I will press this pressure measuring instrument on the tip of your finger. This will cause initially a feeling of pressure; eventually, the pressure will be painful. Please, say immediately "Stop" when you feel no longer only pressure but, in addition, pain. Do not wait until the pain becomes unbearable but rather say "Stop" just in the moment when you start feeling pain. Now, I will show it to you on the middle finger. Then, we will carry out the actual measurement on the index finder.</i></p>			
	Insert the value in kg	algo_1	<div style="border-bottom: 1px solid black; width: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border-bottom: 1px solid black; width: 20px; display: inline-block; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border-bottom: 1px solid black; width: 20px; display: inline-block;"></div>	

Mini Mental State Examination (MMSE)¹ – Orientation

In use since 2014-09-01

	Intro				
x0mm01			True	False	
	x0mm01	What year is this?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm02	Which season is this?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm03	What month is this?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm04	What is today's date?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm05	What day of the week is this?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
x0mm06	Where are we now?		True	False	
	x0mm06	What country are we in?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm07	What province are we in?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm08	What town are we in?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm09	What is the name of this building?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm10	What floor are we on?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	

Mini Mental State Examination (MMSE)¹ – Registration

In use since 2014-09-01

	<p><i>SAY: I am going to name three objects. When I am finished, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes.</i></p> <p><i>Say the following words slowly at 1-second intervals - BALL/ CAR/ MAN</i></p>				
x0mm11	Please, repeat the three objects:		True	False	
	x0mm11	BALL	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm12	CAR	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	x0mm13	MAN	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
	Number of tries:	x0mm31	_		
	Intro				
	Spell the word WORLD .				

x0mm14	Now spell it backwards			True	False	
		x0mm14	D	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mm15	L	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mm16	R	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mm17	O	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mm18	W	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
x0mm19	Now what were the three objects I asked you to remember?			True	False	
		x0mm19		<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mm20	BALL	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mm21	CAR	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
			MAN	<input type="checkbox"/> 1	<input type="checkbox"/> 2	

Mini Mental State Examination (MMSE)¹ – Language

In use since 2014-09-01

x0mm22	What is this called? (SHOW wristwatch) What is this called? (SHOW pencil)			True	False	
		x0mm22	wristwatch	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mm23	pencil	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
x0mm24	I would like you to repeat this phrase after me:			True	False	
		x0mm24	"No ifs, ands or buts."	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
x0mm25	Read the words on the page and then do what it says. INT: Then hand the person the sheet with CLOSE YOUR EYES on it. If the subject reads and does not close their eyes, repeat up to three times. Score only if subject closes eyes			True	False	
		x0mm25	(On the sheet: CLOSE YOUR EYES) <input type="checkbox"/> 1	<input type="checkbox"/> 2		
x0mm26	Write any complete sentence on that piece of paper. INT: The sentence must make sense. Ignore spelling errors			True	False	
		x0mm26	Complete sentence	<input type="checkbox"/> 1	<input type="checkbox"/> 2	

x0mm27	Copy this design please. INT: Allow multiple tries. Wait until person is finished and hands it back. Score only for correctly copied diagram with a 4-sided figure between two 5-sided figures.	x0mm27	Design copied	True <input type="checkbox"/> 1	False <input type="checkbox"/> 2	
x0mm28	ASK the person if he is right or left-handed. Take a piece of paper and hold it up in front of the person. SAY: Take this paper in your right/left hand (whichever is non-dominant), fold the paper in half once with both hands and put the paper down on the table. INT: Score 1 point for each instruction executed correctly.	x0mm28	Takes paper correctly in hand	True <input type="checkbox"/> 1	False <input type="checkbox"/> 2	
		x0mm29	Folds it in half	<input type="checkbox"/> 1	<input type="checkbox"/> 2	
		x0mm30	Puts it on the table	<input type="checkbox"/> 1	<input type="checkbox"/> 2	

¹ Folstein MF, Folstein SE, Mc Mugh PR. "Mini-mental state": a practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res 1975; 12:189-198.

J:\5-5 New Research Initiatives\5-50 Vinschgau-Study\5-50-5 Study Phenotypes\NEURO\Cognition\MMSE

Sniffin‘Sticks¹ - General

In use since 2014-09-01

	<i>Here the ability to indentify everyday smells by means of a card with 4 choices is determined. It is a mulitple-choice procedure, which means the patient has to pick one of the 4 terms. Altogether, 16 odours are presented in the Identification Test.</i>				
x0ss00	Do you currently have ... a cold?	x0ss00a	<input type="checkbox"/> 2 No	<input type="checkbox"/> 1 Yes	end
	hay fever?	x0ss00b	<input type="checkbox"/> 2 No	<input type="checkbox"/> 1 Yes	end
	sinusitis?	x0ss00c	<input type="checkbox"/> 2 No	<input type="checkbox"/> 1 Yes	end

Sniffin‘Sticks¹ - Details

x0ss22	Please rate your olfactory sensibility. Is it decreased or increased?		<input type="checkbox"/> 1 Decreased				
		x0ss22	<input type="checkbox"/> 2 Normal <input type="checkbox"/> 3 Increased				
	Did the smell deterioration (or the loss of smell) happen after a viral infection or a sinusitis?	x0ss22a	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know				
x0ss23	Did you have a surgery on the paranasal sinuses or because of nasal polyps (even in childhood and adolescence)?		Yes No Don't know				
		x0ss23a	Paranasal sinuses	<input type="checkbox"/> 1	<input type="checkbox"/> 2		<input type="checkbox"/> 3
		x0ss23b	Nasal polyps	<input type="checkbox"/> 1	<input type="checkbox"/> 2		<input type="checkbox"/> 3
x0ss24	Have you ever suffered a skull fracture?	x0ss24	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No <input type="checkbox"/> 3 I don't know			
	Localisation of the skull fractur	x0ss24a	<div></div>				

Sniffin'Sticks¹ (1)

	How well can you identify smells? 16 smells known from everyday life will be presented to you. You have to assign each smell to one of four terms on a card that describes the smell best.			
x0ss01	Sniffin'Stick 1	x0ss01	<input type="checkbox"/> 1 Orange <input type="checkbox"/> 3 Strawberry <input type="checkbox"/> 2 Blackberry <input type="checkbox"/> 4 Pineapple	
	Sniffin'Stick 2	x0ss02	<input type="checkbox"/> 1 Smoke <input type="checkbox"/> 3 Leather <input type="checkbox"/> 2 Glue <input type="checkbox"/> 4 Grass	
	Sniffin'Stick 3	x0ss03	<input type="checkbox"/> 1 Honey <input type="checkbox"/> 3 Chocolate <input type="checkbox"/> 2 Vanilla <input type="checkbox"/> 4 Cinnamon	
	Sniffin'Stick 4	x0ss04	<input type="checkbox"/> 1 Chive <input type="checkbox"/> 3 Fir <input type="checkbox"/> 2 Peppermint <input type="checkbox"/> 4 Onion	
	Sniffin'Stick 5	x0ss05	<input type="checkbox"/> 1 Coconut <input type="checkbox"/> 3 Walnut <input type="checkbox"/> 2 Banana <input type="checkbox"/> 4 Cherry	
	Sniffin'Stick 6	x0ss06	<input type="checkbox"/> 1 Peach <input type="checkbox"/> 3 Lemon <input type="checkbox"/> 2 Apple <input type="checkbox"/> 4 Grapefruit	
	Sniffin'Stick 7	x0ss07	<input type="checkbox"/> 1 Liquorice <input type="checkbox"/> 3 Chewing gum <input type="checkbox"/> 2 Gummi bear <input type="checkbox"/> 4 Cookies	
	Sniffin'Stick 8	x0ss08	<input type="checkbox"/> 1 Mustard <input type="checkbox"/> 3 Menthol <input type="checkbox"/> 2 Rubber <input type="checkbox"/> 4 Turpentine	

Sniffin'Sticks¹ (2)

x0ss09	Sniffin'Stick 9	x0ss09	<input type="checkbox"/> 1 Onion <input type="checkbox"/> 3 Garlic <input type="checkbox"/> 2 Sauerkraut <input type="checkbox"/> 4 Carrot	
	Sniffin'Stick 10	x0ss10	<input type="checkbox"/> 1 Cigarette <input type="checkbox"/> 3 Wine <input type="checkbox"/> 2 Coffee <input type="checkbox"/> 4 Smoke	

	Sniffin'Stick 11	x0ss11	<input type="checkbox"/> 1 Melon <input type="checkbox"/> 3 Orange <input type="checkbox"/> 2 Peach <input type="checkbox"/> 4 Apple	
	Sniffin'Stick 12	x0ss12	<input type="checkbox"/> 1 Clove <input type="checkbox"/> 3 Cinnamon <input type="checkbox"/> 2 Pepper <input type="checkbox"/> 4 Mustard	
	Sniffin'Stick 13	x0ss13	<input type="checkbox"/> 1 Pear <input type="checkbox"/> 3 Peach <input type="checkbox"/> 2 Plum <input type="checkbox"/> 4 Pineapple	
	Sniffin'Stick 14	x0ss14	<input type="checkbox"/> 1 Camomile <input type="checkbox"/> 3 Rose <input type="checkbox"/> 2 Raspberry <input type="checkbox"/> 4 Cherry	
	Sniffin'Stick 15	x0ss15	<input type="checkbox"/> 1 Anis <input type="checkbox"/> 3 Honey <input type="checkbox"/> 2 Rum <input type="checkbox"/> 4 Fir	
	Sniffin'Stick 16 Fish	x0ss16	<input type="checkbox"/> 1 Bread <input type="checkbox"/> 3 Cheese <input type="checkbox"/> 2 Fish <input type="checkbox"/> 4 Ham	

¹ Hummel T, Sekinger B, Wolf SR, Pauli E, Kobal G. 'Sniffin' sticks': olfactory performance assessed by the combined testing of odor identification, odor discrimination and olfactory threshold. Chem Senses. 1997 Feb;22(1):39-52.

J:\5-5 New Research Initiatives\5-50 Vinschgau-Study\5-50-5 Study Phenotypes\NEURO\Healthy Aging\Sniffin Sticks

Family

	<i>The next questions are about your parents and grandparents.</i>			
	When were you born?		<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border-bottom: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">D</div> <div style="border-bottom: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">D</div> </div> <div style="display: flex; align-items: center; justify-content: center;">·</div> <div style="border-bottom: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">M</div> <div style="border-bottom: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">M</div>	

·

Y

Y

Y

Y

	Where does she come from? (place)		<div></div>	
	When is she born? (date) Or: year of birth (if the exact date is unknown)		<div><div><div></div><div></div><div></div><div></div></div><div>DD</div><div>.</div><div><div></div><div></div><div></div><div></div></div><div>MM</div><div>.</div><div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div><div>YYYY</div></div> <div>Year</div> <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>	
fh06	What is the name and surname of your father's father? (paternal grandfather)		<div></div>	
	Where does he come from? (place)		<div></div>	
	When is he born? (date) Or: year of birth (if the exact date is unknown)		<div><div><div></div><div></div><div></div><div></div></div><div>DD</div><div>.</div><div><div></div><div></div><div></div><div></div></div><div>MM</div><div>.</div><div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div><div>YYYY</div></div> <div>Year</div> <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>	