

CONSTANCES

Lifestyle and health questionnaire (to fill at home)

Date
Date of birth
Gender

I. YOUR HEALTH

1. How do you judge/consider your general health condition?
Scale from very good -> very bad (8 answer possibilities)
2. How do you judge/consider your health condition compared to a relative of the same age?
Scale from very good -> very bad (8 answer possibilities)

II. PHYSICAL ACTIVITY

3. In your present work or in your last work if you are not working at the moment, what level of physical effort do/did you have to provide
Sedentary work
Light work: walk, light/small handling (<10kg)
Medium work: handling of quite heavy objects (between 10-25kg)
Hard physical work: Heavy handling (>25kg)
Never worked
4. In the last year, have you regularly practiced any sport (besides commuting, gardening and do-it-yourself)?
Never
Yes, less than 2 hours/week
Yes, more than 2 hours/week
If yes, for how many years: ___ years or _ less than 1 year
5. In the last year, have you cycled or walked regularly?
No trip or less than 15 min per trip
Yes, more than 15 min per trip
If yes, how many trip / week in average: ___
For how many years: ___ or _ less than 1 year
6. In the last year, have you regularly done gardening, do-it-yourself or housework works?
Never
Yes, less than 2 hours/week
Yes, more than 2 hours/week
If yes, for how many years: ___ years or _ less than 1 year

7. Which one of the 4 following conditions better describes your current physical activity, occupation excluded
- No weekly physical activity
 - Only light physical activity almost every week
 - Intense physical activity for at least 20 min, 1-2 times a week
 - Intense physical activity for at least 20 min, 3 times or more a week

III. DIET

8. Do you think you have a proper diet?
- Yes
 - No
 - Don't know
9. How many meals a day (breakfast included) do you usually have?
- One meal
 - Two meals
 - Three meals
10. How often do you usually eat the following types of food? (table form)
- Never or almost never
 - Less than 1 time / week
 - About 1 time / week
 - 2-3 times /week
 - 4-6 times /week
 - 1 time /day or more (in this case, how many portion/day)?
- x
- Milk or dairy products
 - Meat (beef, veal, lamb, pork...), poultry (chicken...), rabbit
 - Fish or seafood
 - Cooked meat
 - Eggs
 - Bread, cereals
 - Pasta, potato, rice, semolina
 - Fruits, raw or cooked, fruit juice included (100%)
 - Vegetables raw or cooked, apart from potato
 - Dried vegetables (lentil, chickpea, beans)
 - Ready cooked dish
 - Cheese
11. How many cups a day of the following drinks do you usually take?
- Thee ___
 - Coffee ___
12. How many glasses a day of sweet drink or soda do you usually take? ___
13. What type of fat among the followings do you preferably use (several answers possible)? (table)
- Never
 - Rarely
 - Often

- Almost always
- X
- Butter
- Margarine
- Goose or duck fat/grease
- Corn oil
- Groundnut oil
- Sunflower oil
- Pip grapes oil
- Olive oil
- Mixed oil
- Colza oil
- Walnut oil
- Other

14. Do you like to eat very salty or do you put salt on your meal before having tried it?

Y/N

15. Have you had an appetite loss during the last 3 months?

- No
- Yes, mild
- Yes, important
- Don't know

IV. EYESIGHT

16. Are you actually regularly wearing:

Glasses Y/N

Contact lenses Y/N

If yes, when did you start wearing them? Long sight year ____
Short sight year ____

17. During your life, have you already suffered from eye diseases?

Y/N

If yes:

Age related macular degeneration: left/right eye, year: ____

Glaucoma or eye hypertension: left/right eye, year: ____

Other eye diseases: indicate ____ left/right eye, year: ____

18. Have you had a cataract operation?

Y/N

If yes: how many times?

For each operation, indicate right/left eye and year?

19. Are you actually using eye drops daily?

Y/N

If yes, indicate the name of the treatment as well as the year of the treatment start _____

V. RESPIRATORY CAPACITY

20. All in all, do you think that during the last 10 years, the state of your lung and of your breathing (beside the effect due to age) :

Hasn't changed

Improved

Worsened

21. Did you in the last 12 months have wheezing

Y/N

If yes: Were you out of breath, even slightly at that time? Y/N

Did you have them even when you hadn't a cold? Y/N

22. Did you wake up, during the last 12 months, with a respiratory discomfort feeling? Y/N

23. Did you have, during the last 12 months, an attack of breathlessness, at rest, during the day? Y/N

24. Did you have, during the last 12 months, an attack of breathlessness after a particularly important physical effort? Y/N

25. Have you been wakening up by an attack of breathlessness during the last 12 months? Y/N

26. Have you been wakening up by a fit of coughing in the last 12 months? Y/N

27. Do you usually cough when you stand up in the winter? Y/N

28. Do you usually cough during the day or the night in the winter? Y/N

If "yes" at question 27 or 28: Do you cough like that almost every day during 3 months in a row each year? Y/N

29. Do you usually have spits coming from your chest, when you stand up in the winter? Y/N

30. Do you usually have spits coming from your chest during the day or night in winter? Y/N

IF "yes" at question 29 or 30: do you spit like that almost every day 3 months in a row each year? Y/N

31. Are you out of breath by walking fast on a flat ground or by walking at normal speed on a small slope? Y/N

If yes: do you sometimes stop to take your breath when you walk at your own speed on a flat ground? Y/N

32. Have you already suffered from asthma? Y/N

If yes: was it diagnosed by a doctor? Y/N

How old were you when you had your first attack of asthma?
How old were you when you had your last attack of asthma?
Have you had an attack of asthma during the last 12 months?
N/Y
Are you actually taking medicine for asthma? Y/N

33. Do you have any nose allergy, hay fever included? Y/N

VI. DIABETES

34. Has a doctor or a health professional already told you that you suffer from diabetes (pregnancy period excluded if you are a women)? Y/N
If yes, how old were you when you were told about his problem for the first time?

35. Do you regularly seek medical attention for your diabetes follow-up? Y/N
If yes, is it: a GP ___ a specialist (endocrinologist, diabetologist...) _

36. Are you actually taking pills for your diabetes? Y/N
If yes, since what age?

37. Are you actually having one or more insulin shot for your diabetes? Y/N
If yes, since what age?

38. Have you already heard from HbA1c? Y/N
If yes, do you know your last HbA1c result? __, __%

39. During the last 12 months, have you consulted:
An ophthalmologist Y/N
A nephrologist Y/N
A foot specialist (chiroprapist, podologist) Y/N
A dietetician Y/N

VII. MUSCULOSKELETAL PROBLEMS

40. In the last 12 months, have you had problems (pain, muscles soreness, stiffness, numbness, difficulties...) in the following body areas (see picture):
Neck/nape Y/N
Shoulder Y/N
Elbow/Forearm Y/N
Hand/wrist/fingers Y/N
Lower back Y/N
Knee/leg Y/N

41. During the last 12 months, how long in total, have you suffered? (table)
<24h
1-7 days
8-30 days
More than 30 days
Continuously

x

Neck/nape
Shoulder
Elbow/Forearm
Hand/wrist/fingers
Lower back
Knee/leg

42. If you had lower back pain (lombalgy) during at least one day, was it?
Sciatic with pain spreading lower than the knee Y/N
Sciatic with pain not spreading lower than the knee Y/N
Lumbago (acute lumbar pain) Y/N
Other type of back pain Y/N
43. Have you already had a surgery for
Back problem (sciatic, slipped disc...) Y/N
Knee problem Y/N
Arm or hand problem (carpal tunnel) Y/N
Another problem concerning articulations Y/N indicate which one: _____
44. Have you already changed work or job position for
Back problem (sciatic, slipped disc...) Y/N
Knee problem Y/N
Arm or hand problem (carpal tunnel) Y/N
Another problem concerning articulations Y/N, indicate which one:
45. In the last 7 days, have you had problems (pain, muscle soreness, stiffness, numbness, difficulties...) in the following body areas:
Neck/nape Y/N
Shoulder Y/N
Elbow/Forearm Y/N
Hand/wrist/fingers Y/N
Lower back Y/N
Knee/leg Y/N
46. How would you rate, when you are filling this questionnaire, the intensity of this problem on the following scale?
Scale from “no pain, no problem” -> “maximal pain possible”, 10 answers possible
For each of the following body areas, thick the correct answer
Neck/nape
Shoulder
Elbow/Forearm
Hand/wrist/fingers
Lower back
Knee/leg
47. Did you stop working definitively, before the official retirement date, because you had a back problem or any problem related to your joints? Y/N
If yes, describe precisely:

VIII. YOUR MOOD

48. Could you indicate the frequency with which you felt the feelings or behaviours described in the following list during the past week. Thick the box corresponding to your choice (**French version of the CES-D Depression scale**) (table)

Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or moderate amount of the time (3-4 days)
Most or all the time (5-7 days)

x

I was bothered by things that don't usually bother me
I did not feel like eating; my appetite was poor
I felt that I could not shake off the blues even with the help of my family or friends.
I felt that I could not shake off the blues even with the help of my family or friends.
I felt that I was just as good as other people
I had trouble keeping my mind on what I was doing
I felt depressed
I felt everything I did was an effort
I felt hopeful about the future
I thought my life had been a failure
I felt fearful
My sleep was restless
I was happy
I talked less than usual
I felt lonely
People were unfriendly
I enjoyed life
I had crying spells
I felt sad
I felt that people disliked me
I could not get "going".

IX. Handicap, limitations

49. Do you had any limitations, lasting for at least 6 months, because of a health problem to do things that people from your age do or can usually do at home, at work, at school or in other occupations like moving, games, sports, hobbies...?(no-> yes a lot)
- Yes, very limited
Yes limited
Yes, slightly limited
No
- If yes, for what reason(s)
- Nervous condition (anxiety, behaviour trouble)
Depression
Ageing
Important pain

Chronic disease(s)
Sight or hearing trouble
Congenital malformation
Disease after-effect
Traffic road accident
Other type of accident which one: _____
Other health condition which one: _____

50. Can you walk one floor up or down without another person's help?

Yes without any difficulty
Yes but with some difficulties
Yes but with many difficulties
No, I need someone's help
No, I am in a wheelchair
Don't want to answer
Don't know

51. Can you walk 1km alone without stopping or being seriously bothered? Y/N

52. Can you carry a 5kg object on a 10m distance (for example a shopping bag, a schoolbag)?

Yes without difficulty
Yes without too many difficulties
Yes but with many difficulties
No, I need someone's help
No, I am in a wheelchair
Don't want to answer
Don't know

53. Do you have in everyday's life any reading, writing or calculating problem?

Reading Y/N
Writing Y/N
Calculating Y/N

54. Do you need help to deal with papers, administrative procedures (eg, cheques, form for reimbursement of medical expenses...)

Never
Sometimes
Often
Always

55. Do you sometimes meet a social worker? (Y/N)

X. YOUR HOME, LIVING ENVIRONMENT AND YOUR HEALTH

56. What is your nationality?

French from birth
Became French
Foreign nationality

57. If you weren't born in France, at what age did you arrive? ___ years

58. In which language did your parents usually talk to you when you were a child?
 French only
 Other language than French
 French and another language
59. In which country is your father born? _____
60. In which country is your mother born? _____
61. What occupation had the head of the family when you were a teenager?
 “Farmer”
 Hand worker, shopkeeper, company manager
 “Cadres” (eg professor, engineer, doctor...)
 “Intermediate occupation” (eg school teacher, nurse, social worker, technician, supervisor, lower management...)
 Employee (eg by the post, day-care nanny ...)
 Manual worker
 Other _____
62. What is your marital status, according to the law?
 Single (never been married)
 “Pacsé” (*Civil contract, “false wedding”*)
 Married
 Separated
 Divorced
 Widow
63. What is the highest education level you have reached (with or without obtaining the diploma)?
 Primary school
 “Collège” (1 level of secondary school)
 Short technical education (“CAP”, “BEP”)
 High School (general, professional or technical)
 1st university level
 2nd and 3rd university level, engineer school...
 Other _____
64. What is the highest diploma you have obtained?
 No diploma
 General formation certificates (“BEPC, brevet”)
 Professional certificates (“CAP, BEP”)
 A-Level, “DAEU, BP, BT”
 A-Level + 2-3 years (“BTS, DUT, BM, DMA, DEUG, DEUST, licence”)
 A-level +4 or more years (“maitrise, DEA, DESS”, PHD)
 Other _____
65. What is your occupation? If you are currently working, indicate the situation that best suits you. If you are not working at the moment (unemployment, retirement...) indicate the occupation you had during the longest time.

“Farmer”
 Hand worker, shopkeeper, company manager
 “Cadres” (eg professor, engineer, doctor...)
 “Intermediate occupation” (eg school teacher, nurse, social worker,
 technician, supervisor, lower management...)
 Employee (eg by the post, day-care nanny ...)
 Manual worker
 Other _____

66. In your home, are you living with
 Your partner Y/N
 Your children or the ones from your partner Y/N
 Other persons (family, friends...)? Y/N
67. If you live with your partner, when is he/she born (year)? ____
68. If you are not living with your partner in your home, do you have a “regular”
 love relationship (which is very important for you)? Y/N
69. How many persons, you included, are currently living in your home? _ persons
70. How many children are currently living in your home? ____ children
71. How many ascendants (eg grandparents, parents)) are currently living in your
 home? ____ ascendants
72. How many children do you have (living or not in the family house)? _children
73. If you are living with a partner, does he/she or has he/she have a job? Y/N
 If yes, what occupation?
 “Farmer”
 Hand worker, shopkeeper, company manager
 “Cadres” (eg professor, engineer, doctor...)
 “Intermediate occupation” (eg school teacher, nurse, social
 worker, technician, supervisor, lower management...)
 Employee (eg by the post, day-care nanny ...)
 Manual worker
 Other _____
- If your partner does not have at the moment work, what is her/his
 situation?
 Unemployed or looking for a job
 Retired
 Still in training (apprentice, student, trainee..)
 At home, without occupation
 Does not work for health related reasons (invalidity, long disease)
 Other _____
74. What are the sources of your personal income (indicate the 1-2 most important
 ones)?

Occupational income
 Unemployment allowance
 Retirement allowance
 RMI (“*Minimal insertion income*”)
 Maintenance(s)
 Adult handicapped allowance, invalidity allowance, occupational
 diseases allowance...
 Single parent allowance
 Other allowances (family, home...)
 Capital income (rent..)
 Regular help from the family or relatives
 Other _____

75. What is the total amount of the net incomes of your household?

Less than 450 Euros
 450 to less than 1000 Euros
 1000 to less than 1500 Euros
 1500 to less than 2100 Euros
 2100 to less than 2800 Euros
 2800 to less than 4200 Euros
 >4200 Euros
 Don't want to answer

76. In total, how many adults (yourself, your partner, dependants...) do contribute to the income of your home, whatever the sources of this income is (salary, pension, social security benefits...)? ____ number of persons

77. Did you pay any income tax last year? Y/N

78. At the moment, do you have any loan (property, personal loan, revolving, leasing, on credit purchases...)? Y/N

79. At the moment, do you have one or more maintenance to pay to somebody who is not living with you? Y/N

80. Are there moments during the month where you are really facing financial problems to meet your needs (groceries, rent, electricity, loan...)?

No and it has never happened
 No, but it did happen in the past
 Yes, for many years
 Yes, for less than 1 year

81. Do you have an internet access? Y/N

If yes, would you agree to answer a questionnaire online? Y/N

XI. SEXUAL LIFE

82. During your life, have you been attracted

Only by men
 More by men but also by women
 By men as well as by women

- Only by women
- More by women but also by men
- Don't want to answer

83. During your life, have you had sexual intercourse? Y/N/don't want to answer

84. How old were you when you had your first sexual intercourse? ____ years

85. This first intercourse was
- With a man
 - With a women
 - Don't want to answer

86. This first sexual intercourse was
- Something you wanted at that time
 - Something you didn't want but you accepted
 - Something you were forced to do against your will
 - Don't want to answer

87. During you life, how many different sexual partners did you have?
 ____ partners Don't want to answer

88. Was it
- Only men
 - Only women
 - Men and women
 - Don't want to answer

89. During the last 12 months, have you had a new partner? Y/N/don't want to answer

- If yes, at the beginning of this relationship, did you
- Talk about aids Y/N
 - Use a condom: Yes
 - No, by common agreement
 - No, I refused
 - No, my partner refused

90. During the last month, how often would you say that you had sexual intercourse?

- Less than one time in the month
- 1-3 times in the month
- 1-2 times / week
- 3-6 times / week
- 1 time or more / day
- Don't want to answer

91. Do you have a stable relationship at the moment? Y/N

92. In your current relationship, did you use condoms to protect yourself from HIV?

Never

Yes, at a point of time of your relationship and you stopped thereafter

Yes, at a point of time of your relationship and you stopped after an
HIV test

Yes, but not systematically

No relationship at the moment

93. Do you sometimes feel pain during the sexual intercourse (of just after it)?

Never or exceptionally

Sometimes

Often

Always

94. If you feel pain during sexual intercourse, how do these pains have an effect on sexual intercourses?

Pain does not disturb intercourses

Pain does disturb intercourses but does not force me to interrupt them

Pain does sometimes force me to stop them

Intercourses are impossible because of the pain

95. At the moment, would you say that you are

Not satisfied at all with your sexual life

No satisfied with your sexual life

Satisfied

Very satisfied with your sexual life

Don't want to answer

Does not apply to me

96. For you, your couple life seems to be

Very satisfying

Satisfying

Not satisfying

Don't want to answer

Live alone

XII. BEHAVIOUR AND HEALTH

97. Are you smoker?

Smoker (at least one cigarette/day)

Non smoker or less than one cigarette/day

Ex smoker (stopped smoking a least one year ago)

98. If you are a smoker or an ex-smoker, how old were you when you started to smoke regularly? ____

99. If you are an ex-smoker, how old were you when you gave up smoking? ____

100. How many do you smoke a day (for ex-smokers, how many did you smoke on average during the last 12 months before quitting)?

____ cigarettes

____ cigarillos

____ pipes
____ cigars

101. Does your partner smoke?

Yes
Never smoked
Ex-smoker

102. Have you shared a working place (office, workshop...) with one or more smokers? Y/N/don't know

If yes, for how long: ____ years

103. Has someone ever offered you cannabis, hashish, marijuana, weeds, joint or shit? Y/N/don't know

104. During your life, have you ever consumed cannabis (hashish, marijuana, weeds, joint, shit)? Y/N/don't know

If YES,

Have you consumed cannabis (hashish, marijuana, joint, shit) during the last 12 months? Y/N/don't know

If yes, how many time during the last 12 months: ____

Have you consumed cannabis (hashish, marijuana, joint, shit) during the last 30 days? Y/N/don't know

If yes, how many time during the last 30 days: ____

For each of the three following questions, tick the box that best suits you, for the last 12 months

105. How often would you drink alcohol?

Never
Once a month or less
2-4 times / month
2-3 times / week
At least 4 times / week

106. How many glasses containing alcohol would you drink on a typical drinking day?

1 or 2
3 or 4
5 or 6
7 to 9
10 or more

107. How often would you drink 6 glasses or more on special occasions?

Never
Less than once a month
1 time / month
One time / week
Almost everyday

108. During the last week, have you drunken
Wine Y/N
Beer or cider Y/N
Aperitif or digestive Y/N

If you drank wine, which maximal quantity per day (see pictures):
1 glass, 2 glasses, 3 glasses, 4 glasses, 5 and more glasses, 1 liter
and more, 2 liter and more
How many days in the week, have you drunken wine (from 1 to 7)_

If you drank beer or cider, which maximal quantity per day (see pictures)
1 glass of 0,25l, 2 glasses of 0,25l, 3 glasses of 0,25l, 4 glasses of
0,25l, 5 or more glasses of 0,25l
How many days in the week, have you drunken beer (from 1 to 7)_

If you drank aperitif, which maximal quantity per day
1 glass, 2 glasses, 3 and more glasses
How many days in the week, have you drunken at least one aperitif
(from 1 to 7)_

XIII. LIFE AT WORK

109. Have your or did you had a job?

Effort-reward imbalance model from Siegrist 2002 (question 110-119)

110. I have constant time pressure due to heavy work load
111. I have many interruptions and disturbances in my job
112. Over the past years, my job has become more and more demanding
113. I receive the respect I deserve from my superiors
114. My job promotion prospects are poor
115. I have experienced or I expect to experience an undesirable change in my
work situation
116. My security job is poor
117.
118.
119.

Occupational calendar (to fill at home)

Date

Date of birth

Gender

If you are retired, indicate your retirement date:

If you have never had a job for 6 months at least, indicate for which reasons and do not fill the following calendar

Still a student

Looking for a job but never worked

Had jobs but less than 6 months

Other reason: _____

JOB n°1

Period from ____ to ____

Location (Département): ____

Occupation

Activity

Status: - Employee

- Self -employee

- Seasonal worker/ temping worker

Type of contract: - permanent contract

- fixed term contract

- Others : _____

Work: - full-time

- Part-time

If you had an interruption for more than 6 months between this job and the next one, please indicate the period and the reason

Period: from ____ to ____

Reason: health

Unemployment

Other _____

Same from job 2 to job 7

Women's health (to fill at the study centre)

Date of the day

Date of birth

1. How old were you when you first had your periods? ___ years
2. Could you, please, indicate the date when you last had them (even approximately): dd/mm/yyyy

I. MENSTRUATIONS

The following questions concerned your menstruations and menstrual cycles during the last 3 months.

3. Considering the last 3 months, have your menstruation be
Regular spontaneously (24-32 day approximately)
Regular under pill or other hormonal treatment
Irregular
4. What is the mean duration of your periods (number of days of bleeding)?
5. What is the length of your menstrual cycle (from the first day of your period until the first day of the next period)? Indicate a minimal and a maximal length?
Minimal length ___ days Maximal length ___ days
6. Considering the last 3 menstrual cycles, tick on the following scale the mean pain intensity you had during your period?
Scale from 0 (no pain) to 10 (maximal pain possible)
7. Apart from the pain during your periods, do you regularly suffer from pain in the lower abdomen? Y/N
8. Do you have breast pain before your period? Y/N
If yes, does the pain concern: One breast
Both
How many days before your periods do you feel the pain?
Less than 4 days
4-8 days
9-15 days
More than 15 days
Does the pain disappear with your period? Y/N
Has the pain appeared: Spontaneously
Under hormonal treatment only
(contraception, menopause treatment..)
9. If you do not have any menstruations for 3 months or more
Is it for: less than 12 months
More than 12 months
Are you (several answer possible):

Pregnant
 Breastfeeding
 Carrying an hormonal coil
 Taking the continuous contraception pill
 You had a surgery (which ones)
 Ablation of your uterus date _____
 Ablation of your 2 ovaries date _____
 Menopause
 Other _____

II. CONTRACEPTION

10. Are you currently using a mean to not become pregnant? Y/N
 If yes, could you indicate which one(s)
 Pills Y/N if yes, which one _____
 Coil Y/N if yes, copper, hormonal, I don't know
 Diaphragm (?) Y/N
 Spermicidal cream or pessary Y/N
 Coitus interruptus Y/N
 You don't have sexual intercourse on days at risk (Ogino method, temperature, natural method...) Y/N
 Female condom Y/N
 Male condom Y/N
 Contraceptive implant Y/N
 You or your partner had a surgery to become sterile Y/N
 Other Y/N _____
11. During your life, have you already used the contraceptive pill? Y/N
 If yes : How old were you when you started taking it? ___ years
 During how long in total did you take it (sum all the periods during which you, did you take it)
 Less than a year
 Between 1-2 years
 From 3 to 5 years
 More than 5 years

III. FERTILITY

12. Do you actually try to be pregnant? Y/N
13. Would you say that you wish to be pregnant
 In the next 6 months
 In the next 6 months to 1 year
 In 1-2 years
 Not immediately
 You don't want (or don't want anymore) to be pregnant
 You can't be pregnant (or can't be pregnant anymore)
14. Have you, or your partner, consult a specialist during the last 6 months, because you had problems becoming pregnant?

- Yes, yourself
- Yes, your partner
- Yes, both
- No, neither you nor your partner

15. Have you, or your partner, used (or are you using) during the last 6 months a medical treatment to facilitate a pregnancy?

- Yes, yourself
- Yes, your partner
- Yes, both
- No, neither you nor your partner

16. Did you have one or more interventions in order to improve your fertility?

- Yes, yourself
- Yes, your partner
- Yes, both
- No, neither you nor your partner

17. Have you already had a salpingitis? Y/N/don't know

- If yes, which treatment did you receive?
 - Antibiotics only
 - Coelioscopic treatment and antibiotics
 - Don't know

IV. PREGNANCIES

For questions 18-20, you have to take into account all your pregnancies, whatever the way they ended, even in case of abortion, medical abortion, miscarriage, extra-uterine pregnancy, in-utero death)

18. Have you ever been pregnant, whatever the way the pregnancy ended? Y (even if you are actually pregnant)/N

19. In total, how many pregnancies did you have (including the actual one if you are pregnant), whatever the way they ended? ___ pregnancies

20. When did you last pregnancy end? (Whatever the way it ended)? Date or I'm pregnant

21. How many children (biological children born after 5 months pregnancy, living or not) do you have? ___

22. For each of your biological child, could you please indicate in the following table, his/her gender, his/her year of birth, his/her birth weight, the delivery mode (Caesar section or natural), if you breastfeed him/her and if yes during how many months?

23. During your life, have you had one extra-utero pregnancy? Y/N

24. During your life, did you have one or more "voluntary" abortion(s)? Y/N if yes, how many

25. In your life, did you have one or more medical abortion? Y/N if yes, how many

V. BREAST DISEASES

26. Have you already undergone breast surgery (classical surgery or biopsy)? Y/N
If yes: which year (if you had more than 2, indicate only the last 2 ones, starting by the more recent one): intervention 1 intervention2

Do you know, if it was: cyst

Microcalcifications

Adenofibroma

Fibrocystic disease

Breast cancer

Other diagnosis _____

Don't know

VI. GYNECOLOGIC SURVEILLANCE

27. Have your already had one or more cervical smear test? Y/N

If yes, could you say when the last one was? Date

Was it done by: a GP

a gynaecologist

other _____

28. Have you already have one or more osteodensitometry? Y/N

If yes, could you indicate when the last one was?

29. Have you already have one or more mammography? Y/N

If yes, Could you indicate when the last one was?

Has this mammography been prescribed?

By invitation to the organized screening program in your department

By your doctor, in the absence of any symptoms

By your doctor, after the discovery (by yourself or your doctor) of an anomaly in your breast

If this mammography wasn't prescribed in the organized screening program, was it prescribed by

A GP

A gynaecologist

Other _____

VII. MENOPAUSE

30. Have you reached menopause? Y/N/Don't know

31. Is your menopause being confirmed by hormonal measurement? Y/N/Don't know

32. How old were you when you reached menopause? __ years

If you don't know exactly, was it: for 1-2 years
For 3-5 years
For 6-10 years
More than 10 years

33. Are you taking any medications related to your menopause? Y/N/Don't know

If yes, is it a treatment by:

Hormones Y/N

Local vaginal treatment Y/N

Non hormonal treatment for hot flushes Y/N

Homeopathy Y/N

Plants Y/N

If yes, is it phyto-oestrogenes (of which soja) Y/N

Acupuncture Y/N

Other Y/N

If yes _____ or you don't know

34. If you are actually taking a hormonal replacement treatment

Can you indicate for each of the product you take the name, the daily dosage, and number of days in a month (table)

For how long are you under hormonal treatment therapy (the above mentioned treatment or other equivalent)

Less than a year

Indicate the month and year of the treatment start

More than a year

Indicate the year of the treatment start

35. If you are not actually taking any hormonal treatment therapy

Did you take one in the past? Y/N

If yes, how long did you have one?

Less than a year, indicate how many months ____ months

More than a year, indicate how many years ____ years

VIII. OTHER GYNECOLOGIC TREATMENT

36. Are you actually taking any hormonal treatment in relation with gynaecological problems, menopause excluded (eg for breast pain, fibroma...)?

If yes, could you indicate the name of the treatment(s), the time you take it during your menstrual cycle, and the date of treatment's start?

Occupational exposure (to fill at the study centre)

Date of the day

What is the participant's gender

What is the participant's date of birth

I. Whole occupational career history

Part 1: "In this part, we are interested in your whole occupational career, this means all the jobs you had during your professional career, your current job included, if you are working"

A. Organisational constraint

For each of the following aspects, are you concerned (or have you been concerned) in your life at work? If you are currently concerned or have been in the past, please indicate the corresponding period(s) by giving the year of begin and of end. If you had been concerned several times, please indicate all these different periods.

1. Did or do you have working schedules and commuting time that force/forced you to go to bed after midnight (at least 50 days a year)? Y/N
If yes, period from ___ to ___, from ___ to ___, from ___ to ___
2. Did or do you have working schedules and commuting time that force/forced you to stand up before 5am (at least 50 days a year)? Y/N
If yes, period from ___ to ___, from ___ to ___, from ___ to ___
3. Did or do you have working schedules and commuting time that force/forced you not to sleep at night (at least 50 days a year)? Y/N
If yes, period from ___ to ___, from ___ to ___, from ___ to ___
4. Did or do you have a daily workload from more than 10 hours (at least 50 days a year)? Y/N
If yes, period from ___ to ___, from ___ to ___, from ___ to ___
5. Did or do you have a job where you have to work more than one Saturday out of 2 during the year? Y/N
If yes, period from ___ to ___, from ___ to ___, from ___ to ___
6. Did or do you have a job where you have to work more than one Sunday out of 2 during the year? Y/N
If yes, period from ___ to ___, from ___ to ___, from ___ to ___
7. Did or do you have regularly less than 48 hours rest in a row per week? Y/N
If yes, period from ___ to ___, from ___ to ___, from ___ to ___
8. Did you or do you have a repetitive work with time constraint (assembly-line, product or piece moving, rhythm imposed by strict norm...)?

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

9. Did you or do you have a shift work with alternative schedule (by teams, rotation...)? Y/N

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

B. Noise exposure

10. Did you or do you work in an atmosphere where you sometimes need(ed) to rise your voice to talk to your neighbour or to a person located less than 2-3m from you? Y/N

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

11. In one of your job, have you used or did someone use close to you, noisy tools, machines or vehicle? Y/N

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

C. Exposure to a particularly hard physically job

12. During your professional life, have you been exposed to a particularly physically hard job? Y/N

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

13. During your professional life, do you or did you carry heavy weight? Y/N

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

D. Biological or chemical exposure

During your professional life, have you been or are you currently exposed to the following nuisances:

14. Exhaust (commuting trip excluded)

Diesel Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Essence Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

15. Smoke

Welding, "brasage", "oxycoupage", smoke Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Plastic or rubber smoke Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Heating or combustion from other material smoke (wood, coal...), Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Other smoke (except cigarette) Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

16. Dust

Building material dust

Cement dust Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Fibro-cement dust Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Sand dust Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Dry concrete dust Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Plastic material or rubber dust Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Coal dust Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Wood dust Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Textile dust Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Metal dust

Iron, Cast iron, "soft steel" Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Stainless steel Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Copper Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Other metal dust Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Other dust: indicate which one

Period from ___ to ___ , from ___ to ___ , from ___ to ___

17. Oil and grease (motor oil, hydraulic oil, ...) Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

18. Fuel

Diesel Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Petrol Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

19. Solvent, diluents, grease-removing (soap excluded), disinfecting for cleaning material or your hands

Petrol Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Trichloréthylène Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

White spirit Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Cellulosic diluent Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Formaldehyde (formol) Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Other solvents Indicate which one

Period from ___ to ___ , from ___ to ___ , from ___ to ___

20. Other nuisances

Pesticides (weed-killing, insecticide, fungicide) Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Fertilizer Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Acids Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Glue or adhesive Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Asbestos Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Glass wool, "roche" wool Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Isolation material (other than asbestos or glass wool) Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Painting, "varnish" Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Ink, dyeing products Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

Other chemical product Indicate which one

Period from ___ to ___ , from ___ to ___ , from ___ to ___

E. Biological exposure

21. During your professional life, did or does your work present infectious hazards (microbes, virus, parasites...)? Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

22. Have you been or are you in contact with animals, dead or alive? Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

F. Other exposures

23. During your professional life, have you been or are you exposed to radiations (X-rays, gamma...)? Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

24. During your professional career, have you been or are you exposed to artificial UV? Y/N/don't know

If yes, period from ___ to ___ , from ___ to ___ , from ___ to ___

II. CURRENT JOB

Part 2: "In this part, we are now interested in your current job (if you have more than one job, answer for your main job, the one you are spending the most time at). If you are currently unemployed, you don't have to answer this part".

A. Description of your current job

25. What type of contract do you have?
 Permanent contract, civil servant
 Fixed term contract
 Apprenticeship
 Temporary work (“interim”)
 Other
 Not applicable (not employee)
26. Are you working
 Full time
 Part time
 If you are working part-time, how many hours a week ___
27. How big is the firm you are working for?
 Less than 10 employees
 Between 10-49 employees
 Between 50-199 employees
 200 and more employees
28. Is the firm part of a bigger group? Y/N/don’t know
29. How long does your commuting trip (return) last?
 Less than 1h
 1-2h,
 >2h
30. What means of transport do you usually take to commute?
 Personal car
 Public transportation
 Other
31. Are you working the same number of hours each day? Y/N
32. Are you working the same number of days each week? Y/N
33. Do you have fix work schedule? Y/N
34. Do you have the choice of your working schedule? Y/N
35. Do you have to clock in/out (badge, paper, machine)? Y/N
36. Are you in contact with the public, physically or over the phone (patients, users, clients, travellers...)? Y/N
 If yes, do you have some tense relationship with the public
 No, almost never
 Seldom
 Often
 Always, almost always

B/ Postural constraints

The following questions concerned a typical day of work.

37. How do you evaluate the physical intensity effort of your work on a typical day of work? Thick the box corresponding to your choice on the following scale from 6 to 20

Scale from no effort at all, extremely light effort, X, very light, X, light, X, slightly hard, X, hard, X, very hard, extremely hard, exhausting

38. Does your work usually imply to repeat the same actions more than 2 -4 times /minute?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

39. Can you interrupt your work or change tasks or activity during 10 min or more each hour?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

40. On a typical day of work, are you standing?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

41. On a typical day of work, can you take your eyes out of your work during few seconds, apart from breaks?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

42. On a typical day of work, do you have to kneel or to squat?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

43. On a typical day of work, do you have to lean forward or on the side regularly or during prolonged time?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

44. On a typical day of work, do you have to drive a tractor, a building engine, or a car on your working place....?
- No or almost never
 - Rarely (<2h/day)
 - Often (2-4 hours/day)
 - Always or almost always
45. On a typical day of work, do you have to drive a vehicle (car, truck, bus, ambulance, motorized two-wheeled....) on public road, commuting trip home-work excluded?
- No or almost never
 - Rarely (<2h/day)
 - Often (2-4 hours/day)
 - Always or almost always
46. On a typical day of work, do you have to handle, lift, carry a weight, an object?
Y/N
47. How many time do you spend doing the following tasks or activities :
- Handle, move regularly a weight, a piece, an object, weighting between 1-4kg
- No or almost never
 - Rarely (<2h/day)
 - Often (2-4 hours/day)
 - Always or almost always
- Handle, move regularly a weight, a piece, an object, weighting more than 4 kg
- No or almost never
 - Rarely (<2h/day)
 - Often (2-4 hours/day)
 - Always or almost always
- Carry a weight weighting <10kg
- No or almost never
 - Rarely (<2h/day)
 - Often (2-4 hours/day)
 - Always or almost always
- Carry a weight weighting between 10-25kg
- No or almost never
 - Rarely (<2h/day)
 - Often (2-4 hours/day)
 - Always or almost always
- Carry a weight >25kg
- No or almost never
 - Rarely (<2h/day)
 - Often (2-4 hours/day)
 - Always or almost always

48. On a typical day of work, do you use :
Vibrating tools or do you have to put your hand(s) on vibrating machines?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

A computer screen or control screen?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

A key board to enter data or a mouse or a similar device (optic pen, scanner, bar code reader...)?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

49. For how long do you have to adopt the following postures in a typical day of work? (See pictures on the original questionnaire)

Bent the head forward regularly or during a prolonged period?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

Work with one or two arms over the head (over the shoulder) regularly or during a prolonged period?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

Catch regularly objects behind the back?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

Work with on or two arms outspread regularly or during a prolonged period?

- No or almost never
- Rarely (<2h/day)
- Often (2-4 hours/day)
- Always or almost always

Bend the elbow(s) regularly or during a prolonged period?

- No or almost never

Rarely (<2h/day)
Often (2-4 hours/day)
Always or almost always

Turn the hand as if to screw?
No or almost never
Rarely (<2h/day)
Often (2-4 hours/day)
Always or almost always

Twist the wrist?
No or almost never
Rarely (<2h/day)
Often (2-4 hours/day)
Always or almost always

Lean or hit with the base of the hand on a hard surface or on a tool?
No or almost never
Rarely (<2h/day)
Often (2-4 hours/day)
Always or almost always

Press or take firmly objects or pieces between the thumb and the index
finger? No or almost never
Rarely (<2h/day)
Often (2-4 hours/day)
Always or almost always

C Exposure to extreme temperatures

50. Are you working outside, open-side?
No or almost never
Rarely (<2h/day)
Often (2-4 hours/day)
Always or almost always

51. Apart from work period outside, is the temperature at work:
Very high (>30°)
No or almost never
Rarely (<2h/day)
Often (2-4 hours/day)
Always or almost always

Very low (<10°)
No or almost never
Rarely (<2h/day)
Often (2-4 hours/day)
Always or almost always

Medical questionnaire (to be filled by a doctor)

Date of the day

Participant's gender

Participant's date of birth

PERSONAL MEDICAL HISTORY

Did the participant bring his « Carnet de santé » (*his health book*) ? Y/N

Birthweight, as written in the « Health book »: _____ g

For any positive answer to the following question, please indicate age at diagnosis

1. Cardiovascular diseases

Hypertension	Y/N	Age at diagnosis ___ years
Angor pectina	Y/N	Age at diagnosis ___ years
Myocardial infarcts	Y/N	Age at diagnosis ___ years
Stroke	Y/N	Age at diagnosis ___ years
Oblitering arteriopathy	Y/N	Age at diagnosis ___ years
Other disease		_____

2. Respiratory illnesses

COPD	Y/N	Age at diagnosis ___ years
Asthma	Y/N	Age at diagnosis ___ years
Other disease	Y/N	Age at diagnosis ___ years

3. Digestive illnesses

Hepatitis B	Y/N	Age at diagnosis ___ years
Hepatitis C	Y/N	Age at diagnosis ___ years
Other hepatitis	Y/N	Age at diagnosis ___ years
Other affection	Y/N	Age at diagnosis ___ years

4. Urogenital illnesses

Condylomes or HPV	Y/N	Age at diagnosis ___ years
Other genital infection	Y/N	Age at diagnosis ___ years

5. Kidney diseases

Chronic kidney diseases	Y/N	Age at diagnosis ___ years
Other affection	Y/N	Age at diagnosis ___ years

6. Psychiatric or neurological diseases

Hospitalized or treated depression	Y/N	Age at diagnosis ___ years
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If yes, suicide attempt Y/N

Parkinson	Y/N	Age at diagnosis ___ years
Other affection	Y/N	Age at diagnosis ___ years

7. Osteo-articular diseases

Inflammatory arthritis	Y/N	Age at diagnosis ___ years
Other osteo-articular disease	Y/N	Age at diagnosis ___ years

8. Fractures

Wrist fracture	Y/N	Age at fracture ___ years
Thighbone neck fracture	Y/N	Age at fracture ___ years
Humerus fracture (shoulder)	Y/N	Age at fracture ___ years
Vertebrae fracture (compression-fracture of the vertebrae)	Y/N	Age at fracture ___ years

9. Endocrinal diseases

Thyroid disease	Y/N	Age at diagnosis ___ years
Diabetes type I	Y/N	Age at diagnosis ___ years
Diabetes typ II	Y/N	Age at diagnosis ___ years
Treated hypercholesterolemia	Y/N	Age at diagnosis ___ years
Treated hypertriglycerimia	Y/N	Age at diagnosis ___ years
Other diseases	Y/N	Age at diagnosis ___ years

10. Cancer Y/N

If yes

Breast	Age at diagnosis ___ years
Uterus Neck	Age at diagnosis ___ years
Uterus body	Age at diagnosis ___ year
Ovarian	Age at diagnosis ___ years
Lung	Age at diagnosis ___ years
Prostata	Age at diagnosis ___ years
Colon/rectum	Age at diagnosis ___ years
Other where _____	Age at diagnosis ___ years
where _____	Age at diagnosis ___ years

FAMILY PAST MEDICAL HISTORY

Thick the corresponding boxes and if necessary indicates the age at diagnosis, even if approximately

Cancer	Father	Mother
Localisation	_____	_____
Age at diagnosis	_____ years	_____ years
Myocardial Infarct	Father	Mother
Age at diagnosis	_____ years	_____ years
Angina pectoris	Father	Mother
Age at diagnosis	_____ years	_____ years
Hypertension	Father	Mother
Age at diagnosis	_____ years	_____ years

Stroke	Father	Mother
Age at diagnosis	_____ years	_____ years
Serious psychiatric disease	Father	Mother
Indicate which one	_____	_____
Age at diagnosis	_____ years	_____ years
Suicide	Father	Mother
Sudden death	Father	Mother
Age at diagnosis	_____ years	_____ years
Diabetes typ II (DNID)	Father	Mother
Age at diagnosis	_____ years	_____ years
Dialyse or kidney graft	Father	Mother
Age at diagnosis	_____ years	_____ years
Other serious disease	Father	Mother
Indicate which one	_____	_____
Age at diagnosis	_____ years	_____ years

Senior questionnaire for the >55 years

1. What is the last diploma you obtained? _____
2. What is your occupation or your last one if you are retired? _____
3. Do you feel you have any memory trouble? Y/N
4. If yes, did you talk about it with your doctor? Y/N
5. Has someone, in your relatives, told you, you had some memory troubles? Y/N
6. Do you usually have any of the following symptoms
Forgetting in everyday's life (grocery shopping, use of electronic devices...) Y/N
Problems to remember new easy information Y/N
Problems to remember older memories Y/N
Problems to calculate (in comparison with what it was before) Y/N
Problems with language (to find words, recognize objects) Y/N
Problem with orientation in the city, in the street Y/N
7. If you answered yes to one of those 6 questions, did you talk about one or these symptoms with your doctor? Y/N
8. Have you already undergone memory test by doctor or psychologist? Y/N
9. Have you already had any balance trouble? Y/N
10. Did you fall during the last 10 months? Y/N

+ **The Lawton Instrumental Activities of daily living scale**

Questionnaires origin

DIMENSION ETUDIÉE	SOURCE
Echelles de santé	Cohorte GAZEL (1)
Consommation d'alcool et de tabac	Cohorte GAZEL (1), Audit C (3)
Consommation de cannabis	Baromètre santé 2005(12),
Alimentation	Cohorte 3C (10)
Dépression	Version française de l'échelle de dépression CES-D (2)
Capacité respiratoire	Étude ECRHS (<i>European Community Respiratory Health Survey</i>) (5),
Capacité visuelle	C. Delcourt (Inserm Unité 897).
Diabète	R. Dray-Spira (Inserm Unité 687).
Troubles musculo-squelettiques	« Questionnaire nordique » (6,7).
Les contraintes ergonomiques	L'étude Troubles musculo-squelettiques en Pays de Loire (9)
Facteurs psychosociaux au travail	Modèle « Efforts-Récompenses » de Siegrist (4)
Expositions professionnelles	Étude ICARE (8)
Handicap	Étude HID (11)
Activité physique	L'IPAQ version courte (13) et un questionnaire inspiré de l'étude MONICA.
Position sociale	C. Ribet et al. (14)
Vie sexuelle et la santé des femmes	V. Ringa (Inserm Unité 822),