

Questionnaire 2

Your Diet



Please fill in today's date:

<input type="text"/>				
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day

month

year

Instructions

This questionnaire encompasses your diet from you became pregnant until now. We therefore ask you to recapitulate what you have been eating the last three to four months.

We know that many of you have experienced nausea and perhaps still are nauseated part of the day in a way that affects or has affected your diet. Still we would like to have information on your actual diet during this period.

We greatly appreciate your cooperation in this study, and wish you good luck for the remaining part of your pregnancy.

This questionnaire will be processed by a computer and it is therefore important that you follow the instructions below:

- Please use a blue or black ballpoint pen
- Mark the most relevant box, like this:
- You should only mark **one** box for each line
- If you have marked the wrong box fill it completely, like this and then mark the correct box.

Example

Cheese	<u>Slices of bread with this food item</u>												
	per day						or per week			or per month			
Hard cheese (fat 27%)	6+	5	4	3	2	1	5-6	3-4	1-2	3	2	1	0
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input style="background-color: black; color: black;" type="checkbox"/>	<input type="checkbox"/>						

- The (plus) sign "+" means "more than". Example: 6+ means 6 and more than 6
- Please fill in the mean intake of the food items eaten since you became pregnant.
Example: If you have had fried chicken twice a week for 2 weeks in a row during the first month, but have not had fried chicken since, you have had fried chicken 4 times. Mean intake of fried chicken will then be once a month, and you mark the question like this;

Dinners with poultry	<u>Number of times eaten</u>									
	per week					or per month				
Fried chicken	5+	4	3	2	1	3	2	1	1	0
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Some places we ask you to write a text, please write clearly and only when you are asked.

When completed, please return the form in the stamped addressed envelope provided.

Your diet

1. How would you describe your diet since you became pregnant?

My diet	Mark only one box
I eat both meat and fish	<input type="checkbox"/>
I avoid meat, but eat fish	<input type="checkbox"/>
I avoid fish, but eat meat	<input type="checkbox"/>
I'm a vegetarian and include dairy products and eggs in my diet (ovo-lacto-vegetarian)	<input type="checkbox"/>
I'm a vegetarian and include dairy products but not eggs in my diet (lacto-vegetarian)	<input type="checkbox"/>
I'm a vegetarian and avoid all dairy products and eggs (vegan)	<input type="checkbox"/>

2. Have you used ecologically grown food products since you became pregnant?

Ecologically grown food products	Seldom/never	Sometimes	Often	Usually
Milk, dairy products, cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bread and cereals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your meal pattern

3. How often have you had the following meals per week since you became pregnant?

A snack is a smaller meal consisting of for example a fruit, biscuit, cake, yogurt or chocolate. A snack consisting only of a drink should not be considered. Beverage will be covered later.

	Number of meals per week							
	7	6	5	4	3	2	1	0
Breakfast	<input type="checkbox"/>							
Snack, a.m.	<input type="checkbox"/>							
Lunch	<input type="checkbox"/>							
Snack, before dinner	<input type="checkbox"/>							
Dinner	<input type="checkbox"/>							
Snack, in the afternoon	<input type="checkbox"/>							
Supper	<input type="checkbox"/>							
Night meal	<input type="checkbox"/>							

Bread/ crispbread/ crackers

4. How many slices of bread/ crispbread/ crackers have you eaten on average per day since you became pregnant? When answering this question we ask you to include bread eaten during the whole day, i.e. with all meals. Half a roll = 1 slice of bread, 1 baguette = 4 slices of bread, 1 ciabatta = 3 slices of bread.

Type of bread	Number of slices													
	per day										or per week			
	13+	9-12	8	7	6	5	4	3	2	1	5-6	3-4	1-2	0
White bread (baguettes, ciabatta, bagels etc.)	<input type="checkbox"/>													
Wholemeal bread (Kneipp, Graham etc.)	<input type="checkbox"/>													
Dark bread (Danish ryebread etc.)	<input type="checkbox"/>													
Fiber bread, fiber crispbread, ryecrisp	<input type="checkbox"/>													
Crispbread, rusk etc.	<input type="checkbox"/>													
Crackers (Cream cracker etc.)	<input type="checkbox"/>													

5. Do you use butter/ margarine with your sandwiches?

Yes

No (go to question 8)

6. If you use butter /margarine, on how many sandwiches on average and what kind do you use?

Number of slices

Type of butter/ margarine	per day										or per week			
	13+	9-12	8	7	6	5	4	3	2	1	5-6	3-4	1-2	0
Butter/ /Bremyk	<input type="checkbox"/>													
Hard margarine (Per, Melange)	<input type="checkbox"/>													
“Brelett”	<input type="checkbox"/>													
Soft margarine (Soft, Vita, Olivero etc.)	<input type="checkbox"/>													
Light margarine (Soft light, Vita lett etc.)	<input type="checkbox"/>													

7. How much butter/ margarine do you use on you sandwiches?

Plenty

Medium

Minimum

Cheese/ meat cold cuts/ fish/ spreads

8. How often do you have the following food items on your sandwiches?

Number of slices with this food item

Cheese	per day						or per week			or per month			
	6+	5	4	3	2	1	5-6	3-4	1-2	3	2	1	0
Whey cheese goat milk, regular	<input type="checkbox"/>												
Whey cheese low fat, spread goat milk	<input type="checkbox"/>												
Hard cheese (Norvegia etc.), cream cheese	<input type="checkbox"/>												
Hard cheese and cream cheese, low fat	<input type="checkbox"/>												
Blue cheese (Camembert, Norzola etc.)	<input type="checkbox"/>												
Other kinds of cheese	<input type="checkbox"/>												
Fish													
Roe spread	<input type="checkbox"/>												
Mackerel/sardine in tomato sauce	<input type="checkbox"/>												
Sardine in oil	<input type="checkbox"/>												
Smoked salmon/trout/mackerel	<input type="checkbox"/>												
Herring, pickled	<input type="checkbox"/>												
Shrimp, Northern	<input type="checkbox"/>												
Crab	<input type="checkbox"/>												
Tuna	<input type="checkbox"/>												
Svolværpostei etc (spread of fish liver/roe)	<input type="checkbox"/>												
Other kinds of fish	<input type="checkbox"/>												
Meat													
Low fat cold cuts (ham, roast beef etc.)	<input type="checkbox"/>												
Medium fat cold cuts of lamb, calf etc.	<input type="checkbox"/>												
Salami, Swedish sausage etc.	<input type="checkbox"/>												
Cold cuts of turkey, chicken	<input type="checkbox"/>												
Liver paste	<input type="checkbox"/>												
Other kinds of meat	<input type="checkbox"/>												

Number of slices with this food item

	per day						or per week			or per month			
	6+	5	4	3	2	1	5-6	3-4	1-2	3	2	1	0
Other spreads													
Spread with mayonnaise (Italian etc.)	<input type="checkbox"/>												
Spread made with mayonnaise and yogurt	<input type="checkbox"/>												
Mayonnaise	<input type="checkbox"/>												
Jam	<input type="checkbox"/>												
Honey	<input type="checkbox"/>												
Peanut butter	<input type="checkbox"/>												
Other nut spreads (Nugatti etc.)	<input type="checkbox"/>												
Other sweet spreads (Sjokade, Hapå etc.)	<input type="checkbox"/>												
Tartex and other vegetarian spreads	<input type="checkbox"/>												
Fruit (banana, apple etc.)	<input type="checkbox"/>												
Vegetable (tomato, cucumber etc.)	<input type="checkbox"/>												

Eggs

9. How many eggs have you eaten on average since you became pregnant? Include eggs eaten with all meals; however, do not include eggs in pastries.

Eggs	per day		or per week			or per month		
	2+	1	5-6	3-4	1-2	2-3	1	0
Eggs, - fried, boiled, scrambled, omelet	<input type="checkbox"/>							
Number of seagull eggs eaten last year	0	<input type="checkbox"/>	1-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>	more than 10	<input type="checkbox"/>

Breakfast cereals

10. How often have you eaten breakfast cereals on average since you became pregnant? Please include breakfast cereals eaten with all meals.

Breakfast cereals	How often								
	per day		or per week			or per month			
	2+	1	5-6	3-4	1-2	2-3	1	0	
Porridge, cream of wheat, rice etc.	<input type="checkbox"/>								
Muesli									
Unsweetened (4-korn, All-Bran Flakes etc.)	<input type="checkbox"/>								
Sweetened muesli with dried fruit, nuts etc.	<input type="checkbox"/>								
Corn Flakes, Frosties etc.	<input type="checkbox"/>								
Sugar with your cereals	<input type="checkbox"/>								
Jam with your cereals	<input type="checkbox"/>								

Beverage

11. How many cups/glasses have you been drinking on average of the following beverages since you became pregnant? Please include also milk/yogurt with your breakfast cereals. 1 mug = 1 glass = 2 cups = 2,5 dl, ½ liter bottle = 2 glasses.

Milk and yogurt		How many glasses										
		per day					or per week			or per month		
		8+	6-7	4-5	2-3	1	5-6	3-4	1-2	2-3	1	0
Full-fat milk, Kefir, Kulturmilk	(1 glass)	<input type="checkbox"/>										
Low-fat milk	(1 glass)	<input type="checkbox"/>										
Extra low-fat milk	(1 glass)	<input type="checkbox"/>										
Skimmed milk, fermented sk. milk	(1 glass)	<input type="checkbox"/>										

		How many glasses										
		per day					or per week			or per month		
		8+	6-7	4-5	2-3	1	5-6	3-4	1-2	2-3	1	0
Milk and yogurt												
Cultura, all types	(1 glass)	<input type="checkbox"/>										
Biola milk, Biola yogurt	(1 glass)	<input type="checkbox"/>										
Yogurt, plain/with fruit	(1 glass)	<input type="checkbox"/>										
Low-fat yogurt	(1 glass)	<input type="checkbox"/>										
Go'morgen yogurt	(1 serving)	<input type="checkbox"/>										
Chocolate milk, Litago	(1 glass)	<input type="checkbox"/>										
Soy milk	(1 glass)	<input type="checkbox"/>										
Rice and oat milk	(1 glass)	<input type="checkbox"/>										

		How many glasses										
		per day					or per week			or per month		
		8+	6-7	4-5	2-3	1	5-6	3-4	1-2	2-3	1	0
Juice/ soft drink/ water/ alcohol												
Orange juice	(1 glass)	<input type="checkbox"/>										
Other fruit juices, nectar	(1 glass)	<input type="checkbox"/>										
Tomato- and vegetable juices	(1 glass)	<input type="checkbox"/>										
Fruit syrup, sweetened	(1 glass)	<input type="checkbox"/>										
Fruit syrup, light products	(1 glass)	<input type="checkbox"/>										
Coca Cola/Pepsi with sugar	(1 glass)	<input type="checkbox"/>										
Other soft drinks with sugar	(1 glass)	<input type="checkbox"/>										
Coca Cola-light/Pepsi-light	(1 glass)	<input type="checkbox"/>										
Other light soft drinks	(1 glass)	<input type="checkbox"/>										
Energy drinks (Battery etc.)	(1 glass)	<input type="checkbox"/>										
Tap water	(1 glass)	<input type="checkbox"/>										
Uncarbonated water, bottled	(1 glass)	<input type="checkbox"/>										
Carbonated water	(1 glass)	<input type="checkbox"/>										
Non-alcoholic beer, small beer	(1 glass)	<input type="checkbox"/>										
Pilsner beer	(1 glass)	<input type="checkbox"/>										
Wine	(1 glass)	<input type="checkbox"/>										
Spirits, brandy, liqueur	(1 drink)	<input type="checkbox"/>										

		How many cups/mugs										
		per day					or per week			or per month		
		8+	6-7	4-5	2-3	1	5-6	3-4	1-2	2-3	1	0
Coffee/tea												
Filter coffee	(1 cup)	<input type="checkbox"/>										
Coffee instant	(1 cup)	<input type="checkbox"/>										
Coffee boiled/press	(1 cup)	<input type="checkbox"/>										
Cafe latte, cappuccino	(1 cup)	<input type="checkbox"/>										
Espresso	(1 cup)	<input type="checkbox"/>										
Decaffeinated coffee	(1 cup)	<input type="checkbox"/>										
Fig/ barley coffee	(1 cup)	<input type="checkbox"/>										
Tea (ordinary, Lipton fruit tea etc.)	(1 mug)	<input type="checkbox"/>										
Green tea	(1 mug)	<input type="checkbox"/>										
Rosehip tea, herb tea	(1 mug)	<input type="checkbox"/>										

12. In how many cups do you use milk/ cream/ sugar with your coffee/ tea?

		How many cups/mugs										
		per day					or per week			or per month		
		8+	6-7	4-5	2-3	1	5-6	3-4	1-2	2-3	1	0
Milk/ cream/ sugar in coffee and tea												
Milk/ cream in coffee/ tea		<input type="checkbox"/>										
Sugar/ honey in coffee/ tea		<input type="checkbox"/>										

Artificial sweetener in coffee/ tea

| |

Hot meals

First, we ask you to answer a couple of general questions concerning your hot meals. We then put forward more detailed questions about your intake of hot meals since you became pregnant.

13. How often have you on average had the following for your hot meals since you became pregnant?

General questions	How often									
	per week						or per month			
	6+	5	4	3	2	1	3	2	1	0
Meat and meat products	<input type="checkbox"/>									
prepared as grilled	<input type="checkbox"/>									
Offal	<input type="checkbox"/>									
Chicken, turkey	<input type="checkbox"/>									
Fish, fish products, boiled/ cooked in oven	<input type="checkbox"/>									
Fish, fish products, fired	<input type="checkbox"/>									
Vegetarian dishes	<input type="checkbox"/>									

More detailed questions

14. How often have you on average had the following for your hot meals since you became pregnant?

Hot meal with meat products	How often									
	per week						or per month			
	6+	5	4	3	2	1	3	2	1	0
Meat /pork sausage	<input type="checkbox"/>									
Hot dogs and/or frankfurters	<input type="checkbox"/>									
Chicken and/or turkey sausage	<input type="checkbox"/>									
Meat balls, meat loaf	<input type="checkbox"/>									
Hamburger, meat patty	<input type="checkbox"/>									
Minced meat	<input type="checkbox"/>									
Beef/ veal										
Beef and/or veal roast	<input type="checkbox"/>									
Beef (fillet, tenderloin, sirloin, entrecote)	<input type="checkbox"/>									
T-bone steak, beef and veal	<input type="checkbox"/>									
Beef stew, beef soup	<input type="checkbox"/>									
Pork										
Pork chop, pork roast, pork schnitzel	<input type="checkbox"/>									
Pork tenderloin, fillet	<input type="checkbox"/>									
Pork loin smoked	<input type="checkbox"/>									
Pork belly bacon, spareribs	<input type="checkbox"/>									
Bacon	<input type="checkbox"/>									
Pork stew	<input type="checkbox"/>									
Lamb										
Lamb roast, lamb sirloin	<input type="checkbox"/>									
Lamb stew (Fårikål etc.)	<input type="checkbox"/>									
Venison										
Reindeer roast	<input type="checkbox"/>									
Roast of elk, roe deer, fallow deer	<input type="checkbox"/>									
Reindeer patty/reindeer stew	<input type="checkbox"/>									
Patty/ stew of elk, roe deer, fallow deer	<input type="checkbox"/>									
Offal										
Liver, kidney from beef, pork	<input type="checkbox"/>									
Liver kidney from lamb	<input type="checkbox"/>									

Liver, kidney from venison	<input type="checkbox"/>									
Black pudding, lungemos ["hashed lungs"]	<input type="checkbox"/>									
Hot meal with	per week						or per month			
Poultry	6+	5	4	3	2	1	3	2	1	0
Chicken fillet, turkey fillet	<input type="checkbox"/>									
Fried chicken	<input type="checkbox"/>									
Pan fried/baked/boiled chicken, hen, turkey	<input type="checkbox"/>									
Chickenschnitzel, nuggets	<input type="checkbox"/>									
Game (grouse, pheasant etc.)	<input type="checkbox"/>									
Other poultry (duck, goose, ostrich)	<input type="checkbox"/>									
Seafood										
Cod, saithe, haddock, Pollack	<input type="checkbox"/>									
Mackerel, herring	<input type="checkbox"/>									
Salmon, trout	<input type="checkbox"/>									
Halibut, plaice, flounder	<input type="checkbox"/>									
Tuna fish	<input type="checkbox"/>									
Perch, pike, pikecake	<input type="checkbox"/>									
Other fishes	<input type="checkbox"/>									
Fish cake, fish pudding, fish balls	<input type="checkbox"/>									
Fish fingers, breaded fish	<input type="checkbox"/>									
Fish casserole, soup	<input type="checkbox"/>									
Shrimps	<input type="checkbox"/>									
Mussels	<input type="checkbox"/>									
Crab	<input type="checkbox"/>									
Roe	<input type="checkbox"/>									
Fish liver	<input type="checkbox"/>									
Pasta										
Pasta with meat (Spaghetti bolognaise Lasagna etc.)	<input type="checkbox"/>									
Pasta with fish/ mussels/ shrimp	<input type="checkbox"/>									
Pasta with vegetables	<input type="checkbox"/>									
Pasta with only tomato sauce/ ketchup	<input type="checkbox"/>									
Cheese (Parmesan etc.) with your pasta	<input type="checkbox"/>									
Other hot meals										
Pizza	<input type="checkbox"/>									
Taco, burritos etc.	<input type="checkbox"/>									
Vegetable dishes as main course										
Only with vegetables	<input type="checkbox"/>									
With beans and/or lentils	<input type="checkbox"/>									
With soy products (sausage, burger etc)	<input type="checkbox"/>									
Pancakes	<input type="checkbox"/>									
Cream of rice etc. (not breakfast)	<input type="checkbox"/>									
Soup, home made and packaged soups	<input type="checkbox"/>									

With your hot meal

15. How often have you on average eaten the following food items since you became pregnant?

	How often						
	per day		or per week			or per month	
Potato/ rice/ spaghetti	1	5-6	3-4	1-2	2-3	1	0
Potatoes (boiled, baked, mashed)	<input type="checkbox"/>						
French fries, fried potatoes	<input type="checkbox"/>						
Creamed potatoes, potato casserole	<input type="checkbox"/>						
Spaghetti, macaroni, noodles	<input type="checkbox"/>						
Rice	<input type="checkbox"/>						
Millet, couscous etc.	<input type="checkbox"/>						

16. How often have you on average eaten gravy and trimmings since you became pregnant?

	How often						
	per day		or per week			or per month	
Gravy/ trimmings	1	5-6	3-4	1-2	2-3	1	0
Melted butter	<input type="checkbox"/>						
Melted margarine	<input type="checkbox"/>						
Brown/white gravy	<input type="checkbox"/>						
Béarnaise sauce etc.	<input type="checkbox"/>						
Mayonnaise, remoulade	<input type="checkbox"/>						
Crème Fraîche	<input type="checkbox"/>						
Light Crème Fraîche	<input type="checkbox"/>						
Ketchup	<input type="checkbox"/>						
Mustard	<input type="checkbox"/>						

Cooking fat

17. How often have you used the following types of fat in your cooking since you became pregnant? Mark only one box for each line.

	How often							
	per day		or per week			or per month		
Cooking fat	2+	1	5-6	3-4	1-2	2-3	1	0
Butter	<input type="checkbox"/>							
Margarine soft (Bremyk, Smørgod)	<input type="checkbox"/>							
Margarine hard (Melange, Per)	<input type="checkbox"/>							
Soft, Soya margarine	<input type="checkbox"/>							
Margarine with olive oil (Olivero)	<input type="checkbox"/>							
Other types of margarine	<input type="checkbox"/>							
Soya oil	<input type="checkbox"/>							
Cooking oil	<input type="checkbox"/>							
Olive oil	<input type="checkbox"/>							
Corn oil	<input type="checkbox"/>							
Other types of oil	<input type="checkbox"/>							

Vegetables

First we ask you a couple of general questions concerning your intake of vegetables. We then put forward more detailed questions about your intake of vegetables since you became pregnant.

18. How often have you on average had the following vegetable since you became pregnant?

General questions	How often								
	per day		or per week			or per month			
	2+	1	5-6	3-4	1-2	2-3	1	0	
Raw vegetables (salads etc.)	<input type="checkbox"/>								
Vegetables in casseroles, soups, wok etc.	<input type="checkbox"/>								
Boiled vegetables with main dish	<input type="checkbox"/>								

19. More detailed question about vegetables

Vegetable	How often								
	per day		or per week			or per month			
	2+	1	5-6	3-4	1-2	2-3	1	0	
Frozen vegetables	<input type="checkbox"/>								
Cucumber	<input type="checkbox"/>								
Aubergine	<input type="checkbox"/>								
Avocado	<input type="checkbox"/>								
Cauliflower, raw	<input type="checkbox"/>								
Cauliflower, boiled/ in casseroles	<input type="checkbox"/>								
Broccoli, raw	<input type="checkbox"/>								
Broccoli, boiled/ in casseroles	<input type="checkbox"/>								
Green beans, haricots verts	<input type="checkbox"/>								
Peas	<input type="checkbox"/>								
Carrots, raw	<input type="checkbox"/>								
Carrots, boiled/ in casseroles	<input type="checkbox"/>								
Cabbage, raw	<input type="checkbox"/>								
Cabbage, boiled/ in casseroles	<input type="checkbox"/>								
Garlic	<input type="checkbox"/>								
Swede, raw	<input type="checkbox"/>								
Swede, boiled/ in casseroles	<input type="checkbox"/>								
Onion, leek, spring onion, raw	<input type="checkbox"/>								
Onion, leek, boiled/ in casseroles	<input type="checkbox"/>								
Corn, corn-on-the-cob	<input type="checkbox"/>								
Pepper, raw	<input type="checkbox"/>								
Pepper in casseroles	<input type="checkbox"/>								
Brussels sprouts, boiled/ in casseroles	<input type="checkbox"/>								
Green salad mix in plastic bag	<input type="checkbox"/>								
Lettuce, Chinese cabbage	<input type="checkbox"/>								
Celery, celeriac	<input type="checkbox"/>								
Mushroom common, raw	<input type="checkbox"/>								
Mushroom common, fried/ in casseroles	<input type="checkbox"/>								
Mushroom	<input type="checkbox"/>								
Spinach	<input type="checkbox"/>								
Squash (zucchini)	<input type="checkbox"/>								
Tomato	<input type="checkbox"/>								
Other vegetables	<input type="checkbox"/>								

20. How often have you had dressing and other trimmings with your salad since you became pregnant?

Dressing/ trimmings	How often								
	per day		or per week			or per month			
	2+	1	5-6	3-4	1-2	2-3	1	0	
Dressing (Thousand-island etc.)	<input type="checkbox"/>								
Light dressing, yogurt dressing	<input type="checkbox"/>								
Home made dressing									
With oil	<input type="checkbox"/>								
Without oil	<input type="checkbox"/>								
With Crème Fraîche/ yogurt	<input type="checkbox"/>								
Olives, black/green	<input type="checkbox"/>								
Feta cheese	<input type="checkbox"/>								

21. How would you characterize the usual proportion between vegetables and meat/ fish in your casseroles.

	Have not eaten	More vegetables than meat	Same amount meat and veg.	More meat than vegetables
Casseroles with meat/ fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Casseroles with minced meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Casseroles with offal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fruit

22. How many fresh fruits have you eaten on average since you became pregnant?

Fresh fruit	per day					or per week			or per month		
	8+	6-7	4-5	2-3	1	5-6	3-4	1-2	2-3	1	0
Fresh fruit	<input type="checkbox"/>										

23. How often have you on average eaten the following fresh fruits since you became pregnant?

Fresh fruit		How often									
		per day				or per week			or per month		
		4+	3	2	1	5-6	3-4	1-2	2-3	1	0
Orange, clementine	(1 piece)	<input type="checkbox"/>									
Banana	(1 piece)	<input type="checkbox"/>									
Grapes	(8-10 pieces)	<input type="checkbox"/>									
Apple	(1 piece)	<input type="checkbox"/>									
Peach, nectarine	(1 piece)	<input type="checkbox"/>									
Grapefruit	(½ piece)	<input type="checkbox"/>									
Strawberries	(1 cup)	<input type="checkbox"/>									
Other berries (blueberries etc.)	(1 cup)	<input type="checkbox"/>									
Mango	(½ piece)	<input type="checkbox"/>									
Melon	(1 slice)	<input type="checkbox"/>									
Papaya	(½ piece)	<input type="checkbox"/>									
Plum	(1 piece)	<input type="checkbox"/>									
Pear	(1 piece)	<input type="checkbox"/>									
Other fruits		<input type="checkbox"/>									

23. How often have you on average eaten the following dried fruits since you became pregnant?

Dried fruit /nuts	How often									
	per day				or per week			or per month		
	4+	3	2	1	5-6	3-4	1-2	2-3	1	0
Apricots	<input type="checkbox"/>									
Raisins	<input type="checkbox"/>									
Prune, fig, date	<input type="checkbox"/>									

Peanuts	<input type="checkbox"/>								
Almonds, hazelnuts, cashew nuts etc.	<input type="checkbox"/>								

Desserts, ice cream, cakes, candy

24. How often have you on average eaten the following sweets since you became pregnant?

Dessert/ice cream	How often								
	per day		or per week			or per month			
	2+	1	5-6	3-4	1-2	2-3	1	0	
Pudding (chocolate, creme caramel etc.)	<input type="checkbox"/>								
Canned fruit, stewed fruit thickened with potato flour	<input type="checkbox"/>								
Fruit salad made of fresh fruit	<input type="checkbox"/>								
Ice cream	<input type="checkbox"/>								
Ice cream made of yogurt, low fat ice cream	<input type="checkbox"/>								
Water ice sticks, sherbet	<input type="checkbox"/>								
Vanilla sauce	<input type="checkbox"/>								
Cream, whipped cream	<input type="checkbox"/>								

25. How often have you on average eaten cakes and buns since you became pregnant?

Cakes, buns		How often									
		per day				or per week			or per month		
		4+	3	2	1	5-6	3-4	1-2	2-3	1	0
Sweet bun	(1 piece)	<input type="checkbox"/>									
Danish pastry	(1 piece)	<input type="checkbox"/>									
Doughnut, sponge cake	(1 piece)	<input type="checkbox"/>									
Waffle	(1 plate)	<input type="checkbox"/>									
Chocolate cake, cream layer cake etc.	(1 piece)	<input type="checkbox"/>									
Cookie	(1 piece)	<input type="checkbox"/>									

26. How often have you on average eaten sweets and snacks since you became pregnant?

Sweets and snacks	How often									
	per day				or per week			or per month		
	4+	3	2	1	5-6	3-4	1-2	2-3	1	0
Plain chocolate	<input type="checkbox"/>									
Fancy and filled chocolate	<input type="checkbox"/>									
Caramel, candies, liquorice	<input type="checkbox"/>									
Jelly sweets, marshmallow	<input type="checkbox"/>									
Pastille with sugar	<input type="checkbox"/>									
Pastille sugar free	<input type="checkbox"/>									
Marzipan	<input type="checkbox"/>									
Potato chips	<input type="checkbox"/>									
Popcorn	<input type="checkbox"/>									
Salty snacks	<input type="checkbox"/>									

Other food items

27. It will not be possible to include all kinds of food in a questionnaire. We therefore ask you to write down food items that you have eaten since you became pregnant and that you have not yet been asked about.

Other food items eaten	How often										
	per day						or per week			or per month	
Name:	6+	5	4	3	2	1	5-6	3-4	1-2	2-3	1
Name:	<input type="checkbox"/>										
Name:	<input type="checkbox"/>										
Name:	<input type="checkbox"/>										
Name:	<input type="checkbox"/>										
Name:	<input type="checkbox"/>										

Genetically modified food

28. Many countries, i.e. USA, England and France, have opened up for genetically modified food. Most European countries, however, require labeling of such food items. We wish to know if you have eaten any genetically modified food items, either abroad or in Norway, since you became pregnant?

Yes No Do not know

If yes, we ask you to write the name on the gene modified food item(s) you have eaten.

Gene modified food items	How often										
	per day						or per week			or per month	
Name	6+	5	4	3	2	1	5-6	3-4	1-2	2-3	1
Name	<input type="checkbox"/>										
Name	<input type="checkbox"/>										
Name	<input type="checkbox"/>										
Name	<input type="checkbox"/>										
Name	<input type="checkbox"/>										

Hot meals bought at kiosks, gas stations and fast food restaurants

29. How often have you eaten hot meals bought at kiosks, gas stations and fast food restaurants?

Food bought from	How often								
	per day			or per week			or per month		
	4+	2-3	1	5-6	3-4	1-2	2-3	1	0
Kiosks	<input type="checkbox"/>								
Gas stations	<input type="checkbox"/>								
Fast food restaurants (McDonald's etc)	<input type="checkbox"/>								

Dietary changes due to this pregnancy

30. Please mark if you have eaten more, less or the same amount of the following food items compared to before you became pregnant

Food item	Did not eat or drink				
	Completely this before pregnancy	As before	More	Less	stopped
Milk, dairy products and cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bread and cereals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biscuits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks with sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks sugar free	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. Have you experienced nausea during this pregnancy? Yes No

If yes:

Has this caused you to eat less than before? Yes No

Has this caused you to eat more than before? Yes No

In which week(s) have you been most bothered with nausea?

From pregnancy week	To pregnancy week	Still nauseated
		<input type="checkbox"/>

32. Have you been throwing up (vomiting) during this pregnancy? Yes No

In which week(s) have you been throwing up (vomiting)?

From pregnancy week	To pregnancy week	Still throwing up
		<input type="checkbox"/>

33. Have you started to eat or drink certain food items during this pregnancy? Yes No

If yes, name the two most important food items you have started to eat/drink.

Write the name of the food item

Supplements

34. Do you use, or have you used supplements during this pregnancy? Yes No

If yes, we ask you to name and quantify the supplements you have used/are using
(ts = teaspoon, bs = dessert spoon, ss = tablespoon)

Liquid supplements	Times per week									Amount			
	7	6	5	4	3	2	1	<1	0	1 ts	1bs	1ss	
Cod liver oil	<input type="checkbox"/>												
Omega-3 cod liver oil	<input type="checkbox"/>												
Sanasol	<input type="checkbox"/>												
Biovit	<input type="checkbox"/>												
Liquid iron mixture (Floradix etc.)	<input type="checkbox"/>												
Other liquid supplements													
Name:	<input type="checkbox"/>												
Corporation:													
Name:	<input type="checkbox"/>												
Corporation:													
Capsules/tablets	Times per week									Number(s) at a time			
	7	6	5	4	3	2	1	<1	0	1	2	3	4+
Cod liver capsules	<input type="checkbox"/>												
Cod liver capsules without A and D-vitamins	<input type="checkbox"/>												
Vitaplex	<input type="checkbox"/>												
Kostpluss/nyco plus multi	<input type="checkbox"/>												
Nyco plus folic acid 0,4 mg	<input type="checkbox"/>												
Spektro (Solaray)	<input type="checkbox"/>												
Hemofer	<input type="checkbox"/>												
Duroferon duretter	<input type="checkbox"/>												
Other supplements													
Name:	<input type="checkbox"/>												
Corporation:													
Name:	<input type="checkbox"/>												
Corporation:													

Your comments to this questionnaire

We know that you have spent time and energy to complete this questionnaire and we are grateful for your cooperation. To evaluate the time spent on completing the questionnaire we ask you to estimate the time you used.

I have used approximately _____ minutes to complete this questionnaire.

Thank you very much for taking your time to fill out this information!