

The Norwegian Mother and Child study

Questionnaire 3

This questionnaire will be processed by a computer. It is therefore important that you follow these instructions:

- Please use a blue or black ballpoint pen.
- Put a cross in the box that is most relevant like this: X
- Should you put a cross in the wrong box correct it by filling in the box completely like this: ■
- In the large green boxes write a *number* or a *capital letter*

It is important that you only write in the white area of each box like this:

Number: Letter:

- When filling in a single figure in boxes containing two or more squares please use the square to the right. For example: 5 is written like this:
- A number of questions in this questionnaire concern the week of pregnancy. For example, fill in week 5 for something that occurred 5 weeks after your last period.
- Specific information concerning, for example, medication or profession should be written in the boxes or on the lines provided. Please write clearly in CAPITAL LETTERS.
- Remember to provide the date on which you completed the questionnaire.

Please return the completed questionnaire in the stamped addressed envelope provided.

Date on which the questionnaire was completed: Day, month and year (write the year with 4 numbers, ex. 2000)

Question	Answer
Antenatal care and health	
1. Where and how often have you been to antenatal check ups? (<i>Fill in one or several boxes.</i>)	Health center/ Doctor's office /Hospital polyclinic / times
2. Who has examined you each time? (<i>Fill in one or several boxes.</i>)	Midwife /General practitioner /Gynaecologist / Public health nurse / times
3. Is your doctor male or female? How many times have you gone to him/her?	General practitioner /Gynaecologist / Male / Female/ times
4. If you visit or have visited a gynaecologist or hospital polyclinic for your antenatal check ups, what is or was the reason?	Referred due to complications during this pregnancy /Referred due to previous illness or complications in previous pregnancies /On your own initiative without a referral/ Referred for another reason
5. Do you agree with the following statements concerning your antenatal check ups?	<i>Agree completely /Agree /Agree somewhat /Disagree somewhat /Disagree / Disagree completely</i> I have been given sufficient advice and information / I have been well taken care of / There was not enough time during the consultations /I felt secure during these check ups / I have been able to discuss everything I needed to during the check ups / I am satisfied with the way I have been followed up by the health service
6. Have you needed to contact a midwife or doctor in addition to your normal check ups?	<i>No/ Yes</i> Midwife /Doctor
7. If yes, was it difficult to get an appointment?	<i>Midwife /Doctor</i> Not difficult /Somewhat difficult /Very difficult
8. Have you had a gynaecological examination during your pregnancy (internal examination)? If so how many times?	Yes /No / times
9. How many ultrasound examinations have you had during your pregnancy?	External examination / Internal examination/ times
10. How many children are you expecting?	
11. Have you been offered an amniocentesis or placenta biopsy?	No (proceed to question 15) Yes
12. If yes, were any tests performed and what were the results?	<i>Was the test performed? / Were the results normal?</i> <i>Yes /No</i> Amniocentesis /Placenta biopsy If the tests were abnormal describe the findings:
13. If an amniocentesis or placenta biopsy was performed, what was the reason?	Due to my age (normally 38 or older at the time of delivery)/ Previous child with a chromosome disease/ Previous child with spina bifida/ Epilepsy (medication for
	epilepsy)/ Ultrasound findings /Other

14. Were there complications during the first 2 weeks following the amniocentesis?	No/ Yes
15. If yes, which complications?	Vaginal bleeding /Leakage of amniotic fluid/ Abdominal pain (similar to but stronger than menstrual pains)/ Other
16. Have you taken an X-ray during pregnancy?	No /Yes
17. If yes, what part of the body was X-rayed? How many X-rays were taken and in which week of pregnancy? (Fill in one or several boxes.)	<i>Week of pregnancy</i> 0-12/ 13-16/ 17-20/ 21-24/ 25-28/ 29+/ <i>No. of times</i> Teeth/ Lungs/ Arms or legs/ Pelvis/abdomen/back / Other
18. Have you been treated to prevent a premature birth during this pregnancy? (Fill in one or several boxes.)	No / Yes, relax or bed-rest /Yes, medication/ Which medicines?
19. Have you been vaccinated during this pregnancy?	No/ Yes/ Which vaccine?
20. Has the midwife or doctor told you that you have or have had high blood pressure during this pregnancy?	No/ Yes
21. If yes, what was the highest reading during this pregnancy? (High blood pressure is over 140/90) (Refer to your health card)	/ Ex. 150/90 Don't know
22. Have you had high blood pressure before becoming pregnant?	No/ Yes/Don't know
23. If yes, what was the highest reading before you became pregnant?	/ Ex. 150/90 Don't know
24. What was your haemoglobin (Hb) value during this pregnancy? (Refer to your health card and note the most recent in addition to the highest and lowest values.)	<i>Haemoglobin (Hb)/ Week of pregnancy</i> Most recent value/ Highest value during pregnancy/ Lowest value during pregnancy
25. How much did you weigh at your last antenatal check up and when was it? (Refer to your health card)	Weight / kilos Date of antenatal check up/ day /month/year
26. Have you been admitted to hospital since you became pregnant?	No/ Yes, which hospital(s)
27. If yes, why and when were you hospitalised (Fill in one or several boxes.)	<i>In which week of pregnancy were you admitted?</i> 0-4/5-8/ 9-12/ 13-16/ 17-20/ 21-24/ 25_28/ 29+ Recurrent nausea and vomiting/ Bleeding/ Leakage of amniotic fluid/ Early labour/ High blood pressure/ Eclampsia/ Other
28. Do you have or have you ever had any of the following?	<i>No/ Yes</i> <i>If yes, how often have you had problems?</i> <i>Never/ 1-4 times a month/ 1-6 times a week/ Once a day/ More than once a day</i> <i>How much at a time? Drops/ Large amounts</i> <i>Before this pregnancy/ In this pregnancy</i> Incontinence when coughing, sneezing or laughing/ Incontinence during physical activity (running or jumping)/ Incontinence with strong need to urinate/ Problems with bowel movements/ Problems with passing gas

29. Do you have or have you had pain in any of the following parts of your body? Where and when?. (Fill in one or several boxes.)	No During this pregnancy/ During earlier pregnancies/ Between pregnancies/ Prior to my first pregnancy Mild pain/ Severe pain Small of the back/ One of the pelvic-sacral joints on the backside/ Both pelvic-sacral joints on the backside/ Tailbone/ In the buttocks/ Over the pubic bone/ Groin/ Other back pains
30. Do you wake up at night due to pelvic pain?	Yes, frequently/ Yes, sometimes/ No, never
31. Do you have to use a cane or crutches in order to walk due to pelvic pain?	No, never/ Yes, but not every day, the pain varies from day to day/ Yes, I have to use a cane or crutches every day
32. Have you received anaesthetics in connection with surgery or dental treatment during this pregnancy?	No/ Yes
33. If yes, what type of anaesthetic have you had? (Fill in one or several boxes.)	General (full) anaesthetic/ Spinal anaesthetic (epidural)/ Local anaesthetic/ Don't know
34. Have you been to the dentist during this pregnancy?	No/ Yes
35. If yes, did the dentist perform any of the following treatments? (Fill in one or several boxes.)	Yes/ No Put in new amalgam fillings (silver fillings)/ Removed /replaced amalgam fillings/ Put in new white fillings
36. How many teeth do you have and how many are filled with amalgam? (Look in the mirror and count.)	Total number of teeth/ Number of teeth with amalgam fillings/ Number of teeth with other types of fillings
37. Do your gums bleed when you brush your teeth?	No, never or seldom/ Yes, occasionally/ Yes, frequently/ Yes, nearly always
38. Have you had a tattoo or body piercing? (Do not include pierced ears if you have one hole in each ear.)	No/ Yes
39. If yes, where and when was it done? (Fill in one or several boxes.)	Tattoo/ Body piercing Before this pregnancy/ During this pregnancy In Norway/ Abroad/
40. Have you ever had a blood transfusion? If yes, give the number of transfusions.	No/ Yes, during this pregnancy/ Yes, before this pregnancy/ times
41. If yes, in which country and which year? (Give the last 2 transfusions.)	Country/ Year
42. Have you ever had breast surgery?	No/ Yes
43. If yes, was it:	Breast enlargement/ Breast reduction/ Cancer/biopsy/ Other describe:
44. Have you ever had cervical dysplasia?	No/ Yes/ Year the dysplasia was detected the first time
45. Have you been operated on the cervix?	No/ Yes/ Year of operation
44. Have you ever had a gamma globulin injection? (Used to prevent infection of hepatitis A primarily when travelling abroad)	No/ Yes/ If yes, which year?

How have you been recently? Some questions about the time that has elapsed since you filled in the last questionnaire	
47. Have you had one or more episodes of vaginal bleeding after the 13 th week of pregnancy?	No/ Yes
48. If yes, how much did you bleed, in which week(s) of pregnancy and how many days did the bleeding last? (If you have had more than 2 episodes of bleeding describe the last 2 only.)	<i>In which week of pregnancy did the bleeding occur?</i> 13-26/ 17-20/ 2024/ 25-28/29+/ No. of days bleeding lasted <i>The amount of blood (spotting means a few drops)</i> Spotting/ More than spotting/ Large amounts Number of episodes of bleeding if more than 2
49. Do you know why you bled?	No/ Yes
50. If yes, what was the reason? (Fill in one or several boxes.)	The placenta is too low/is in a difficult position/ placenta previa/ Premature separation of the placenta/abruptio/ablatio placenta / Threatening miscarriage/premature birth/ A sore on the cervix, bleeding of the mucus membrane in the vagina/ Following intercourse/ Other reason
51. Have you been bothered by uterine contractions?	No/ Yes, a little/ Yes, a lot
52. Do you have or have you experienced any of the following illnesses or problems after the 13 th week of pregnancy? If you have used tablets, mixtures, suppositories, inhalers creams etc. in conjunction with the illness or problem give the name(s) of the medication(s), when an how long you took them. (Fill in one or several boxes.) (This applies to all types of medicines including alternative and herbal remedies, both regular and occasional use. Do not include vitamins and nutritional supplements as these are discussed elsewhere.)	In which week of pregnancy did you have problems? /13-16/17-20/21-24/25-28/29+ /The name of the medication taken/ In which week of pregnancy did you take medication?/ 13-16/17-20/21-24/25-28/29+/ No. of days taken 1. Pelvic relaxation/ 2. Back pains/ 3. Other pains in muscles/joints/ 4. Nausea/ 5. Long-term nausea and vomiting/ 6. Vaginal thrush/ 7. Vaginal catarrh/unusual discharge/ 8. Itching due to pregnancy/ 9. Constipation/ 10. Diarrhoea /gastric flu/ 11. Unusual tiredness/sleepiness/ 12. Heartburn/indigestion/ 13. Swelling in the body (oedema)/ 14. Common cold/ 15. Throat infection/ 16. Sinusitis/ear infection/ 17. Influenza/ 18. Pneumonia/bronchitis/ 19. Other cough/ 20. Sugar in urine/ 21. Albumin (protein) in the urine/ 22. Bladder infection/ 23. Incontinence/ 24. High blood pressure/ 25. Leg cramps/ 26. Asthma/ 27. Hay fever/other allergy/ 28. Headache/migraine/ 29. Depression/ 30. Other psychological problems/ 31. Other

53. If you have had a high fever once or more since the 13 th week of pregnancy indicate in which week of pregnancy, name of any medication taken to reduce the fever and the highest temperature measured. (<i>If more than 3 times indicate the last 3.</i>)	Which week of pregnancy did you have a fever/ 13-16/17-20/21-24/25-28/29+ Name any medication taken to lower the fever Highest recorded temperature (ex. 38.9° C) Temperature not taken 1st time/ 2nd time/ 3rd time/ Fever more than 3 times
54. Have you taken other medication after the 13 th week of pregnancy not previously mentioned, for example sleeping tablets or sedatives? Give the name, when and how many days the medication was taken.) (<i>This applies to all types of medicines including alternative and herbal remedies, both regular and occasional use. Do not include vitamins and nutritional supplements as these are discussed elsewhere.</i>)	Name of medication (ex. Valium, Rohypnol, Paracetamol) Use of medication in week of pregnancy/ 13-16/ 17-20/ 21-24/ 25-28/ 29+ No. of days taken
55. During this pregnancy have you been involved in an accident or been injured (<i>ex. traffic accident, fall, hit in the stomach</i>)?	No/ Yes
56. If yes, in which week of pregnancy?	
Vitamins, minerals and dietary supplements	

<p>57. Have you take vitamins, minerals or other nutritional supplements after the 13th week of pregnancy?</p> <p>If you take supplements, please find the package/bottle.</p>	<p>No (proceed to question 61)/ Yes</p>
<p>58. Fill in the table below for the vitamins and minerals found on the vitamin package/bottle. Fill in when and approximately how often you have taken them.</p>	<p><i>Week of pregnancy supplement taken?</i> 13-16/ 17-20/ 21-24/ 25-28/ 29+ <i>Approx. how often did you take this supplement?</i> Daily/4-6 times a week/1-3 times a week 1. Folic acid/ 2. Vitamins B1 (Thiamine)/ 3. B2 (Riboflavin)/ 4. B6 (Pyridoxine)/ 5. B12/ 6. Niacin/ 7. Pantothenic acid/ 8. Biotin / 9. Vitamin C/ 10. Vitamin A/ 11. Vitamin D/ 12. Vitamin E/ 13. Iron/ 14. Calcium/ 15. Iodine/ 16. Zinc/ 17. Selenium/ 18. Copper / 19. Chromium/ 20. Magnesium/ 21. Cod liver oil/ 22. Omega -3 fatty acid</p>
<p>59. Give the complete name(s) of all vitamins and nutritional supplements you take. Include also herbal remedies and diet products. (<i>Write clearly using CAPITAL LETTERS since this will be read by a computer.</i>)</p>	<p>ex.. VITAPLEX WITHIRON 1.2.3.4.5.6.</p>
<p>60. If you take multivitamins (with or without minerals) do these contain folic acid?</p>	<p>No/ Yes/ Don't know</p>
<p>Work</p>	
<p>61. Have you been employed during this pregnancy?</p>	<p>No (<i>proceed to question 76</i>) / Yes</p>
<p>62. Do you have the same job now after the 13th week of pregnancy that you described in the first questionnaire?.</p>	<p>No/ Yes (<i>proceed to question 66</i>)</p>
	<p>arrangements</p>
<p>63. If no, in which week of pregnancy did you work situation change?</p>	<p>Week of pregnancy</p>

64. How has your work situation changed?	I have stopped working/ I have a part-time position/ Other
65. If you have stopped working, why did you stop?	I handed in my notice/ The work was temporary (seasonal, limited contract)/ I was laid off/ Other
66. Have your working arrangements been changed during this pregnancy making your job more suitable for you now that you are pregnant?	No/ Yes
67. If no, why have your working conditions not been changed to be more suitable for you?	Not necessary/ Impossible or nearly impossible/ I have asked for changes but no changes have been made/ It is difficult to ask/ None of the above (explain why)

68. What are your working hours? (Fill in one or several boxes.)	Permanent day work / Permanent afternoon or evening work/ Permanent night work/ Shift work (day and night) or shift rotations/ No set times (extra work, extra shifts, temporary employment, etc.)/ Other
69. Answer each of the following questions for your present work. (Fill in each line.)	<i>Yes daily, more than half my working hours/ Yes daily, less than half my working hours/ Yes in periods, but not daily/ Infrequently or never</i> Do you ever have so much to do that your work situation becomes stressful and bothersome?/ Do you have to bend and turn many times a day?/ Do you work with your hands at shoulder level or higher?/ Do you work standing or walking?/ In some jobs it is possible to decide yourself how much and how quickly you work each day. One can for example work hard one day and take it a little easier the next. Do you have this opportunity?/ Is there so much noise at your workplace that it is uncomfortable? / Is there so much noise that you have to raise your voice to speak with others even at a distance of one meter?
70. How often have you worked with a radio transmitter or radar after the 13 th week of pregnancy?	Infrequently/never/ A few times a week/ Daily/ On average more than 1 hour a day
71. How often have you worked with x-ray equipment (at a distance of less than 2 meters) after the 13 th week of pregnancy? (Do not include treatment as a patient.)	Infrequently/never/ A few times a week/ daily/ On average more than 1 hour a day
72. Have you been absent from your regular work for more than two weeks after the 13 th week of pregnancy?	No/ Yes, part time/ Yes
73. Are you absent from work at the present time?	No/ Yes, part time/ Yes
74. If yes, why are you currently absent from work? (Fill in only one line.)	Medical leave with medical compensation salary/Absent due to sick child/ Laid off with compensation/ Absent with maternity allowance due to the working environment/ Started maternity leave with allowance/Service leave/ Other (explain)
75. Complete the table below if you were on medical leave (full or part time) after the 13 th week of pregnancy. Fill in the reason (ex. pelvic relaxation, pneumonia), which weeks you were on medical leave, the number of days and the percent of each medical leave. (Write one medical leave per line.)	<i>Reason for medical leave:</i> Example: Pelvic relaxation <i>Medical leave during week of pregnancy:</i> 13-16/ 17-20/ 21-24/ 25-28/ 29+/ Number of days/ % medical leave
76. Do you currently lift over 10 kilos while you are pregnant? (10 kilos is equivalent to a full bucket of water)	<i>Home/ At work</i> Infrequently or never/ Yes, less than 20 times a week/ Yes, more than 20 times a week/ Yes, 10-20 times a day/ Yes, more than 20 times a day
77. Have others helped you with housework or childcare more than usual to relieve you during this pregnancy?	Yes, considerable/ Yes, somewhat/ No, no one has offered/ No, it has not been necessary
78. If you are on maternity leave for this pregnancy, when did you start?	Date: day/ month/ year
Habits	
79. How often do you use a cell phone?	Infrequently/never/ A few times a week/ Daily/ On average more than 1 hour a day

80. Do you speak on a cell phone for more than 15 minutes at a time?	Never/ Infrequently/ Frequently
81. How frequently have you worked with a data screen, laser printer or photocopying machine (at a distance of less than 2 meters) after the 13 th week of pregnancy?	<i>Data screen/ Laser printer/ Photocopying machine</i> Infrequently/never/ A few times a week/ Daily/ On average more than 1 hour a day
82. Do you live close to high voltage power lines?	No/ Yes, closer than 50 meters/ Yes, between 50 - 100 meters/ Yes, more than 100 meters
83. How often have you been to a discotheque since you answered the previous questionnaire?	Never/ At least 1-2 times a week/ Less often
84. How often do you exercise at present? (<i>Fill in each line.</i>)	<i>Never / 1-3 times a month / Once a week / Twice a week / 3 times or more a week</i> 1. Walking/ 2. Brisk walking/ 3. Running/jogging/cross-country running/ 4. Bicycling/ 5. Training studio/weight training / 6. Special gymnastics/aerobics for pregnant women/7. Aerobics/gymnastics/dance without running and jumping/ 8. Aerobics/gymnastics with running and jumping/ 9. Dancing (swing/rock/folk)/ 10. Skiing/ 11. Team sports/ 12. Swimming/13. Riding/14. Other
85. How often do you do exercises at home or at a gym for the following groups of muscles? (<i>Fill in each line.</i>)	<i>Never/ 1-3 times a month/ Once a week/ Twice a week/ 3 or more times a week</i> Abdominal muscles/ Back muscles/ Pelvic floor muscles (Muscles around the vagina, urethra, anus)
86. How often are you currently so physically active in your leisure and/or at work that get out of breath or sweat? (<i>Fill in for both leisure and work.</i>)	<i>Leisure/ At work</i> Never/ Less than once a week/ Once a week/ Twice a week/ 3-4 times a week/ 5 or more times a week
87. How often have you had sexual intercourse on average during the last month?	Daily/ 5-6 times a week/ 3-4 times a week/ 1-2 times a week/ Less frequently/ Never
88. Have you been abroad during the last year?	No/ Yes
89. If yes, which countries did you visit and when?	Country/ Month/ Year
90. Have you had contact with animals either at work or in your leisure?	No/ Yes
91. If yes, with which animals have you had contact and how often?	<i>Daily/ 3-6 times a week/ Once a week/ Less often</i> Dog/ Cat/ Guinea pig/hamster/rabbit/rat etc./ Canary or other caged birds/ Hens and other poultry/ Cow/sheep/goat/ Horse/ Pig/ Other
92. How many hours a day do you usually sleep when you are pregnant?	More than 10 hours/ 8-9 hours/ 6-7 hours/ 4-5 hours/ Less than 4 hours
93. Do you currently sleep on a waterbed or use an electric blanket?	<i>Yes/ No</i> Waterbed/ Electric blanket
94. Can you rest during the day (both at home and at work)?	No/ Yes
95. Have you been in a sauna while you have been pregnant?	No/ 1-5 times/ 6-10 times/ More than 10 times
96. Have you been in a solarium while you have been pregnant?	No/ 1-5 times/ 6-10 times/ More than 10 times

97. Are you subjected to passive smoking either at home or at work? If yes, how many hours a day?	<i>No/ Yes/ No. of hours</i> Home/Work
98. Do you smoke at present? If yes, how many cigarettes?	No/ Sometimes/ Daily Cigarettes per week/ Cigarettes per day
99. Does the baby's father smoke at present? If yes, how many cigarettes?	No/ Sometimes/ Daily Cigarettes per week/ Cigarettes per day
100. If one or both of you have stopped smoking during the pregnancy, in which week of pregnancy did you stop?	You/ Baby's father Week of pregnancy
101. If you or the baby's father has smoked during the pregnancy, were there periods during which you or the baby's father did not smoke? (<i>Fill in the weeks during pregnancy when you did not smoke.</i>)	Weeks of pregnancy without smoking 0-4/ 5-8/ 9-12/ 13-16/ 17-20/ 21-24/ 25-28/ 29+ You/ Baby's father
102. Have you used other forms of nicotine after the 13 th week of pregnancy?	No/ Yes Nicotine chewing gum/ Nicotine bandages/ Nicotine inhaler/ Chewing tobacco/snuff
103. Have you used any of the following substances after the 13 th week of pregnancy?	<i>No/ Yes</i> Hash/ Amphetamine/ Ecstasy/ Cocaine/ Heroin
104. Have you ever used any of the following substances? (<i>Fill in each line.</i>)	<i>No/ Previously/ Last 6 months before pregnancy/ During this pregnancy</i> Anabolic steroids/ Testosterone products/ Growth hormones (ex. Genotropin/Somatropin)
Food and drink	
105. How often do you eat the following foods? (<i>Fill in each line.</i>)	<i>Before the pregnancy/ During the pregnancy</i> <i>Never/ A few times a year/ 1-3 times a month/ Once a week or more</i> 1. Crabs/ 2. Shrimp/ 3. Shellfish (ex. mussels, oysters)/ 4. Fish liver/ 5. Tuna fish or halibut/ 6. Flounder/other flat fish/ 7. Pike or perch/ 8. Other fresh water fish/ 9. Reindeer meat/ 10. Mutton/ 11. Liver or kidney from game/ 12. Wild mushrooms
106.. How often do you eat the following types of food? (<i>Fill in each line.</i>)	<i>Never/ A few times a year/ 1-3 times a month/ Once a week or more</i> Restaurant/ street vendors/canteen or the like/ Meat (not including canned) bought in other countries/ Meat (including poultry) that is raw or undercooked (pink near the bone)/ Raw ground meat/meat mixtures (even to taste)/ Smoked or treated salmon or trout (uncooked)/ Soft cheeses (ex. cream cheese, camembert, blue cheese etc.)/ Unwashed raw vegetables, unwashed fruit
107. Did you avoid eating the following foods during this pregnancy?	<i>No/ Yes</i> Fish/ Eggs/ Nuts/ Oranges/lemons/ Strawberries/ Other, what?
108. What type of drinking water do you have?	Own water source (ex. well)/ Water supply (public or private)/ Other source Name of water company Don't know

109. Is your water treated (chlorinated or radiated with UV)	No/ Yes, UV radiation/ Yes, chlorinated/ Don't know
110. What was your fluid consumption (number of cups/glasses) per day after the 13 th week of pregnancy? (1 mug = 2 cups, 1 small plastic bottle (0.5 litre) = 4 cups, 1 large plastic bottle (1.5 litres) = 12 cups)	<i>Number of cups/glasses/ Decaffeinated</i> 1. Filter coffee/ 2. Instant coffee/ 3. Percolated coffee/ 4. Tea/ 5. Herbal tea/ 6. Coca cola/Pepsi/Diet Coke/ 7. Other sodas/ 8. Coca Cola, Pepsi light/ 9. Other diet sodas/ 10. Tap water/ 11. Bottled water <i>Number of cups/glasses/ Ecological</i> 12. Nectar/squash/ 13. Diet nectar/squash/ 14. Skimmed, low fat and/or whole milk/ 15. Yogurt, all types/ 16. Yogurt with active Lactobacillus, all types/ 17. Other sour milk (kefir)/ 18. Other
111. How often did you consume alcohol before and how much do you consume now?	<i>Last 3 months before last menstruation</i> <i>In this pregnancy/ week of pregnancy/ 0-12/ 13-24/ 25+</i> Approximately 6-7 times a week/ Approximately 4-5 times a week/ Approximately 2-3 times a week/ Approximately once a week/ Approximately 1-3 times a month/ Less than once a month/ Never
Alcohol units Alcohol units are used to compare the different types of alcoholic beverages. 1 alcohol unit = 1.5 cl. pure alcohol. 1 beer glass of beer = 1 alcohol unit 1 wine glass red or white wine = 1 alcohol unit 1 wine glass sherry or other fortified wine = 1 alcohol unit 1 snaps glass spirits or liqueur = 1 alcohol unit 1 bottle/can energy drink or cider = 1 alcohol unit	
112. In the period just before you became pregnant and during this	<i>Last 3 months before last menstruation/</i> <i>In this pregnancy/ week of pregnancy/ 0-12/ 13-24/ 25+</i>
pregnancy how many times have you consume 5 units or more (<i>See the above explanation.</i>)	Several times a week/ Once a week/ 1-3 times a month/ Less than once a month/ Never
113. How many units do you usually drink when you consume alcohol? (<i>See the above explanation.</i>)	<i>Last 3 months before last menstruation</i> <i>In this pregnancy/ week of pregnancy/ 0-12/ 13-24/ 25+</i> 10 or more/ 7-9/ 5-6/ 3-4/ 1-2/ Less than 1
114. If your drinking habits have changed during or before this pregnancy when did the change occur? (<i>Fill in one or several boxes.</i>)	<i>Reduced/ Increased</i> Last 3 months before last menstruation/ During pregnancy weeks 0-6/ During pregnancy weeks 7-12/ During pregnancy weeks 13-24/ After week 24
115. If you have modified your use of alcohol how important were the following factors? (<i>Fill in one or several boxes.</i>)	<i>Not relevant/ Not very important/ Quite important/ Important/ Very important</i> Nausea/discomfort/ Altered taste/ For the baby's sake/ Depression/problems/Other reasons
You and your life now	

116. What is your current civil status?	Married/ Cohabitant/ Single/ Divorced/separated/ Widow/ Other
117. Do you have anyone other than your husband/partner you can ask for advice in a difficult situation?	No./ Yes, 1-2 people /Yes, more than 2 people
118. How frequently do you meet or talk on the telephone with your family (other than your husband/partner and children) or close friends?	Once a month or less/ 2-8 times a month/ More than twice a week
119. Do you often feel lonely?	Almost never/ Infrequently/ Sometimes/ Usually/ Almost always
120. If you have given birth before, in general how was the birthing experience?	Very good/ Good/ Alright/ Poor/ Very poor
121. Do you agree or disagree with the following statements related to the upcoming birth? (Fill in only one box in each line.)	<i>Agree completely/ Agree/ Agree somewhat/ Disagree somewhat/ Disagree/ Disagree totally</i> I want to give birth as naturally as possible without painkillers or intervention/ I am really dreading giving birth/ I want to have enough medication so that the birth will be painless / I want to have an epidural regardless/ I want to have an epidural if the midwife agrees/ If I could choose I would have a caesarean/ I think the woman herself should decide whether or not to have a caesarean/ I worry all the time that the baby will not be healthy or normal/ I am really looking forward to the baby coming
122. How do these statements describe your relationship? (Only answer if you have a partner.) (Fill in only one box in each line.)	<i>Agree completely/ Agree/ Agree somewhat/ Disagree somewhat/ Disagree/ Disagree completely</i> My husband/partner and I have a close relationship/ My partner and I have problems in our relationship/ I am very happy with our relationship/ My partner is usually understanding/ I often think about ending our relationship/ I am satisfied with my relationship with my partner/ We often disagree about important decisions/ I have been lucky in my choice of a partner/ We agree about how our child should be raised/ I think my partner is satisfied with our relationship
123. Have you been bothered with any of the following during the past 2 weeks? (Fill in only one box in each line.)	<i>Not bothered/ A little bothered/ Quite bothered/ Very bothered</i> Constantly frightened or anxious/ Nervous, inner turmoil/ Feeling of hopelessness with regard to the future/ Depressed, sad/ Frequently worried or uneasy/ Feeling of hardship/ Feel tense or stressed/ Sudden fear without reason
124. How often do you experience the following in your everyday life? (Fill in only one box per line.)	<i>Almost never/never/ Infrequently/ Sometimes/ Frequently/ Very often</i> Feel happy about something/ Feel lucky/fortunate/ Feel optimistic, as though everything falls in place for you/ Feel that you will scream at someone or break something/ Feel angry, irritated or annoyed/ Feel furious with someone
125. How well do these statements describe you? (Fill in each line.)	<i>Incorrect/ Partly correct/ Almost correct/ Completely correct</i> I always manage to solve difficult problems if I try hard enough/ If anyone opposes me I find a way to get what I want/ I am sure that I can cope with unexpected events/ I am calm when I encounter difficulties because I trust my ability to cope/ When I am in a difficult situation I usually find a solution

126. Do you agree or disagree with the following statements? (Fill in only one box in each line.)	<i>Disagree completely/ Disagree/ Disagree somewhat/ Don't agree or disagree/ Agree somewhat/ Agree/ Agree completely</i> My life is largely what I wanted it to be/ My life is very good/ I am satisfied with my life/ To date, I have achieved what is important for me in my life/ If I could start all over, there is very little I would do differently
127. How do you feel about yourself? (Fill in only one box in each line.)	<i>Agree completely/ Agree/ Disagree/ Disagree completely</i> I have a positive attitude toward myself/ I feel completely useless at times/ I feel that I do not have much to be proud about/ I feel that I am a valuable person, as good as anyone else
128. Have you experienced any of the following during the last 12 months? If yes, how painful or difficult was it for you? (Fill in each line.)	<i>No/ Yes</i> <i>If yes</i> <i>Not too bad/ Painful/difficult/ Very painful/difficult</i> Have you had problems at work or where your study/ Have you had financial problems/ Have you been divorced, separated or ended your relationship with your partner/ Have you had problems or conflicts with your family, friends or neighbors/ Have you been seriously ill or injured/ Have any of your relatives or friends been seriously ill or injured/ Have you been involved in a serious accident, fire or robbery/ Have you lost someone close to you/ Other
129. Have you ever experienced any of the following? (Fill in each line.)	<i>No, never / Yes, as a child (under 18) / Yes, as an adult (over 18)</i> <i>Who was responsible for this?</i> <i>A stranger/ Family or relative/ Another known person</i> <i>Has this occurred during the last year</i> <i>No/ Yes</i> That anyone has over a long period of time systematically tried to subdue, degrade or humiliate you?/That anyone has threatened to hurt you or someone close to you?/ That you have been subjected to physical abuse?/ That you have been forced to have sexual relations?
Miscellaneous	
130. Has anyone living with you had any of the following illnesses during your pregnancy?	<i>In which week of pregnancy?/ 0-9 / 10-19 / 20-29 / 30+</i> Influenza/ Childhood diseases (fever and rash) /Long lasting cough /Other infectious disease
131. Have there been any instances of crib death in your family or your partner's family?	No / Don't know / Yes in my family (see question 128) / Yes in the baby's father's family (see question 129)
132. The child that died of crib death in my family was:	My sister/ My brother/ My sister's child/ My brother's child/ My mother's sibling/ My father's sibling/ Other <i>Boy/ Girl / Sex unknown</i>

133. The child that died of crib death in the baby's father's was:	The baby's father's sister/ The baby's father's brother/ The baby's father's sister's child/ The baby's father's brother's child/ The baby's paternal grandmother's sibling/ The baby's paternal grandfather's sibling/ Other <i>Boy / girl / Sex unknown</i>
134. Have you ever lost a child?	No (if no, you are finished with the questionnaire)/ Yes
135. If yes, what was the cause of death and when did the death occur?	Stillbirth (Birth after the 16 th week of pregnancy.)/ Crib death/ Accident/ Illness/birth defect/ Which illness/birth defect:/ Other <i>Year/ Child's age/ year/ months</i> Child 1/ Child 2
136. Did you receive counselling from health personnel or other persons after the death? How many discussions did you have with health personnel, and/or parent support group, family and friends? How many weeks did you receive support?	<i>Health personnel/ Parent support group, family, friends</i> Number of discussions at meetings (approximately):/ Number of discussions via telephone (approximately):/ Weeks of support (approximately):
137. Do you feel that the follow up you received after the child's death was adequate?	No follow up was provided/ Very good/ Good enough/ Should have been better/ Poor/
138. Has the death made you more anxious during this pregnancy?	No, not at all/ No, not very much/ Yes, somewhat/ Yes, very much
139. Do you feel that the health care personnel at the antenatal clinics took into consideration this painful experience in their contact with you?	Yes, very much/ Yes, somewhat/ No, not at all

Have you remembered to fill in the date on which you completed the questionnaire on page 1?

Thank you very much for your help!

Please return the completed questionnaire in the stamped addressed envelope provided.