

## 9.0 Study Instruments for Adults

### 9.1 Instructions for preparing the questionnaire

The following instructions are to be undertaken **BEFORE** the questionnaire is printed including pre-coding the office use only boxes (see page 183). The content of the questions 1-24 are fixed. Questions 25 onwards are strongly recommended.

**Question 14.** After e.g. Please delete the words “puffers (*use local terminology*)” and insert your local terminology for inhalers, prior to printing the questionnaire.

**Question 14a.** Please insert the name of your local brand of SABAs, LABAs, ICSs and combination ICS and LABA prior to printing the questionnaire.

**Question 15.** After e.g. Please delete the words “pills (*use local terminology*)” and insert your local terminology for tablets, capsules, liquids or pills, prior to printing the questionnaire.

**Question 15a.** We are only interested in 4 categories of medicines: leukotriene receptor antagonists,  $\beta_2$  agonist bronchodilator, theophylline and oral corticosteroid. Please delete the words (*Put your local brand name here*) and insert the chemical name, and then in brackets the brand/local name of the tablets, capsules, liquids or other medicines e.g. pills (using your local terminology), prior to printing the questionnaire.

**Question 25.** What level of education have you received? (*use local terminology*). Please delete the words (*use local terminology*) and insert your local wording for the levels of education using 3 levels. For example, in New Zealand we would delete College as College is another term for Secondary school. If the wording is changed, the Data Centre would appreciate clarification, such as: Primary school = 5 years of age to 12 years of age (or years 1 – 7). This will ensure a more accurate analysis of this question. The categories you use would ideally cover the following area: Education during childhood (approx up to 12 years of age); Education during adolescence (approx 13 to 17 years of age); and advanced education.

**Question 37** “In the past 12 months how often, on average, did you eat or drink the following?”

If there are foods listed that are not applicable to your country you may delete them. Similarly, if you consider the list too comprehensive, you may delete some of the foods. For MEAT, we include examples that would be applicable for New Zealand. Other countries may like to delete our examples and include relevant examples for their country, prior to printing the questionnaire.

**Question 42.** There are various terms used to describe a water pipe. Please use the terminology most suitable for your country, prior to printing the questionnaire.

## 9.2 Instructions for completing the demographic questions

### Surveillance and management questionnaire for adults

In addition to the information about your child, we are also seeking information from parents (or guardians), about their health and lifestyle (ADULT QUESTIONNAIRE).

If your child lives with two parents (or guardians), we would be grateful if **BOTH** of you could complete an ADULT QUESTIONNAIRE.

If your child lives with one parent (or guardian), we expect that ONE ADULT QUESTIONNAIRE will be completed.

Other questions require you to tick your answer in a box, write a number or a few words as indicated. If you make a mistake put a cross in the box and tick the correct answer. Tick only one option unless otherwise instructed.

Examples of how to mark questionnaires:

Age   
years

To answer Yes/No, put a tick in the appropriate box as per example

YES ☐ NO ☒

TODAY'S DATE:

Day Month Year

YOUR NAME:

YOUR AGE:

years

YOUR DATE OF BIRTH:

Day Month Year

Are you:

MALE ☐ FEMALE ☐

What is your relationship to the child who brought this questionnaire home from school?

Parent / Grandparent / Other (please describe \_\_\_\_\_)

Optional questions on Ethnicity here:

***The rest of this questionnaire refers to YOUR health (and not to the health of your child).***

1. Do you ever have trouble with your breathing? (Tick one box only)

never

☐

only rarely

☐

repeatedly, but it always gets completely better

☐

continuously, so that your breathing is never quite right

☐

2. Have you had wheezing or whistling in your chest at any time  
**in the past 12 months?**

Yes

☐

No

☐

***IF YOU HAVE ANSWERED “NO”  
PLEASE SKIP TO QUESTION 9***

3. How many attacks of wheezing have you had **in the past 12 months?**

None

☐

1-3

☐

4-12

☐

more than 12

☐

4. **In the past 12 months,** how often, on average, has your sleep been disturbed  
due to wheezing?

Never woken with wheezing

☐

Less than one night per week

☐

One or more nights per week

☐

5. Have you ever been breathless when the wheezing noise was present?

Yes

☐

No

☐

6. **In the past 12 months**, how often, on average, has your sleep been disturbed due to shortness of breath?

Never ☐

Less than one night per week ☐

One or more nights per week ☐

7. **In the past 12 months**, how often, on average, has your sleep been disturbed due to coughing?

Never ☐

Less than one night per week ☐

One or more nights per week ☐

8. **In the past 12 months**, has wheezing ever been severe enough to limit your speech to only one or two words at a time between breaths?

Yes ☐

No ☐

- 
- 
9. Have you ever had asthma?

Yes ☐

No ☐

***IF YOU HAVE ANSWERED "NO"  
PLEASE SKIP TO QUESTION 20***

- 
10. Was your asthma confirmed by a doctor?

Yes ☐

No ☐

11. Do you have a written plan which tells you how to look after your asthma?
- Yes ☐
- No ☐
12. How old were you when you had your first attack of asthma?
- Years ☐
13. Have you had an attack of asthma **in the past 12 months**?
- Yes ☐
- No ☐
14. Have you used any inhaled medicines e.g. puffers (*use local terminology*) to help your breathing at any time **in the past 12 months**? (when you did not have a cold)
- Yes ☐
- No ☐

***IF YOU HAVE ANSWERED “NO”  
PLEASE SKIP TO QUESTION 15***

14a. Please indicate how often you used each of the **inhaled** medicines listed below **in the past 12 months**:

(delete the words below and put your local brand) only when needed / in short courses / every day

<i>Short acting <math>\beta</math>- agonists (SABA)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Long acting <math>\beta</math>- agonists (LABA)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Inhaled corticosteroids (ICS)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Combination ICS and LABA</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Have you used any tablets, capsules, liquids or other medicines e.g. pills (*use local terminology*) that you swallowed to help your breathing at any time **in the past 12 months**? (when you didn't have a cold)

Yes ☐

No ☐

***IF YOU HAVE ANSWERED "NO"  
PLEASE SKIP TO QUESTION 16***

15a. Please indicate how often you used each of the tablets, capsules, liquids or other medicines e.g. pills (*use local terminology*) listed below **in the past 12 months**:

	only when needed	/ in short courses	/ every day
(Put your local brand name here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Put your local brand name here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Put your local brand name here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Put your local brand name here)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. **In the past 12 months**, how many times have you **urgently** been to a doctor because of your breathing problems?

None	1-3	4-12	more than 12
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. **In the past 12 months**, how many times have you **urgently** been to an Emergency Department without being admitted to hospital because of breathing problems?

None	1-3	4-12	more than 12
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. **In the past 12 months** how many times have you been admitted to hospital because of your breathing problems?

None	1	2	more than 2
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. **In the past 12 months**, how many days was your usual activity (at work or in the home) limited because you had breathing problems?

None

1-3

4-12

more than 12

☐☐☐☐

- 
- 
20. Have you ever worked in any job that caused wheezing or whistling in your chest?

Yes

☐

No

☐

***IF YOU HAVE ANSWERED "NO"  
PLEASE SKIP TO QUESTION 21***

**If yes:**

- 20a. Have you had to leave any of these jobs because they affected your breathing?

Yes

☐

No

☐

- 
- 
21. Have you ever had hay fever?

Yes

☐

No

☐

***IF YOU HAVE ANSWERED "NO"  
PLEASE SKIP TO QUESTION 23***

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22. Was your hay fever confirmed by a doctor?

Yes

☐

No

☐

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23. Have you ever had eczema?

Yes

☐

No

☐

***IF YOU HAVE ANSWERED  
“NO” PLEASE SKIP TO  
QUESTION 25***

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24. Was your eczema confirmed by a doctor?

Yes

☐

No

☐

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***Questions 25 to 42 are about other aspects of your life and environment***

25. What level of education have you received? (*use local terminology*)

Primary school

☐

Secondary school

☐

College, University or other form of tertiary education

☐



26. Does or did your home have visible moisture or mould spots on the walls or ceiling, anywhere in the home? (multiple answers are possible).

**26a. Moisture or damp spots**

At this moment	During pregnancy of this child	During the first year of this child	At some other time
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>

**26b. Mould spots**

At this moment	During pregnancy of this child	During the first year of this child	At some other time
Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>

***IF YOU ANSWERED “NO” TO EVERY OPTION FOR MOISTURE/DAMP AND MOULD SPOTS PLEASE SKIP TO QUESTION 29***

27. Where in the home do these moisture/damp/mould spots occur (more than one answer is possible)

Living room	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Parent’s Bedroom	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Your child’s Bedroom	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Kitchen	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bathroom	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other	Yes <input type="checkbox"/>	No <input type="checkbox"/>

28. Does the total area affected by all moisture/damp/mould spots exceed the size of one postcard?

Yes

☐

No

☐

29. What type of fuel does your household **use daily** for cooking?

1. No food cooked at home

☐

2. Electricity

☐

3. Liquefied petroleum gas

☐

4. Natural gas

☐

5. Biogas

☐

6. Kerosene

☐

7. Coal/lignite

☐

8. Charcoal

☐

9. Wood

☐

10. Straw/shrubs/grass

☐

11. Animal Dung

☐

12. Agricultural crop residue

☐

*If you checked an answer between 7 and 12, please go to question 30*

*If you did not check an answer between 7 and 12, please go to question 34*

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30. What type of stove is **usually** used for cooking?


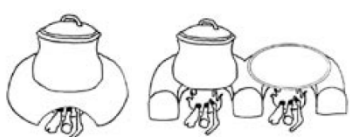
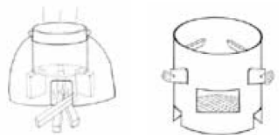

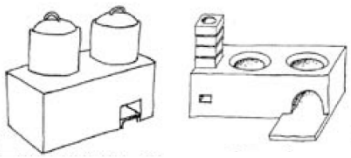
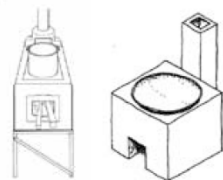
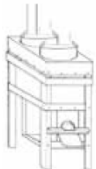
Select the type (number) from the chart below

☐

Other (*specify*): \_\_\_\_\_

Don't know

☐

1. Open fire	2. Surrounded fire
<p>Unprotected fire; pot or griddle is supported with rocks, mud or other materials</p> 	<p>Fire is partially or completely surrounded; pot or griddle is supported with rocks, mud or other materials</p> 
3. Surrounded fire with sunken pot	4. Stove with combustion chamber
<p>Fire and pot are completely surrounded by mud or metal; pot is sunken into the stove</p> 	<p>Fire is surrounded by a combustion chamber, usually "L" shaped, inside the stove</p> 
5. Two or three pot stove	6. Griddle stove
<p>Fire is surrounded; heat goes directly to two or three pots</p> 	<p>Fire is surrounded; the pot is placed on top of a metal or clay cooking surface</p> 
7. Sunken pot stove	
<p>Fire and pot are surrounded; the pot is sunken into the stove</p> 	

Source: WHO. Tuberculosis prevalence surveys: a handbook. 2011

31. Is smoke removed by hood or chimney?

Neither ☐

Hood ☐

Chimney ☐

*If you checked chimney above:*

31a. When was chimney last cleaned?

- |                        |                          |
|------------------------|--------------------------|
| Never                  | <input type="checkbox"/> |
| More than 3 months ago | <input type="checkbox"/> |
| 1 to 3 months ago      | <input type="checkbox"/> |
| Less than 1 month ago  | <input type="checkbox"/> |
| Don't know             | <input type="checkbox"/> |

32. Where is the cooking usually done?

- |  |                          |
|--|--------------------------|
| In a room used for living / sleeping     | <input type="checkbox"/> |
| In a separate room used as a kitchen     | <input type="checkbox"/> |
| In a separate building used as a kitchen | <input type="checkbox"/> |
| Outdoors                                 | <input type="checkbox"/> |
| Other (specify)_____                     | <input type="checkbox"/> |

33. What type of ventilation is present where the stove is used?

- |                                |                          |
|--------------------------------|--------------------------|
| Closed room                    | <input type="checkbox"/> |
| Room with eaves spaces         | <input type="checkbox"/> |
| Room with open windows / doors | <input type="checkbox"/> |
| Room with 3 or fewer walls     | <input type="checkbox"/> |
| Other (specify)_____           | <input type="checkbox"/> |

34. Do you heat your house when it is cold?

Yes

☐

No

☐

***IF YOU HAVE ANSWERED “NO”  
PLEASE SKIP TO QUESTION 37***

**If yes:**

35. What type of fuel do you **mainly** use for heating?

1. Electricity

☐

2. Liquefied petroleum gas

☐

3. Natural gas

☐

4. Biogas

☐

5. Kerosene

☐

6. Coal/lignite

☐

7. Charcoal

☐

8. Wood

☐

9. Straw/shrubs/grass

☐

10. Animal Dung

☐

11. Agricultural crop residue

☐

***If you checked an answer between 6 and 11, please go to question 36***

***If you did not check an answer between 6 and 11, please go to question 37***

36. What type of stove is usually used for heating?

Select the type (number) from the chart in question 30

☐

Other (specify): \_\_\_\_\_

37. **In the past 12 months**, how often, on average, did you eat or drink the following?  
*(please leave blank if you do not know what a food is)*

	Never or only only occasionally	Once or twice per week	Most or all days
Meat (eg beef, lamb, chicken, pork)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seafood (including fish)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooked Vegetables (green and root)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Raw Vegetables (green and root)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulses (peas, beans, lentils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cereals (excluding bread)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pasta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Margarine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Olive Oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk (include flavoured milk)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other dairy (include cheese and yoghurt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar (including lollies/candies/sweets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fastfood/burgers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fast food, excluding burgers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fizzy or soft drinks (include local terminology)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

38. In the past, have you smoked tobacco on a daily basis, less than daily, or not at all?

Not at all ☐

Less than daily ☐

Daily ☐

39. Do you currently smoke tobacco on a daily basis, less than daily, or not at all?

Not at all ☐

Less than daily ☐

Daily ☐

40. If you have smoked tobacco ever, either daily or less than daily, at what age did you first smoke cigarettes, cigars, or pipe?

Age ☐

Not applicable ☐

41. On average over the entire time you have smoked, how many cigarettes, cigars, or pipe did you smoke each day?

Number per day ☐

Not applicable ☐

42. Do you smoke water pipe (*use local terminology e.g. bong, crack pipe, hookah, hubble-bubble, narghile, shisha, vapourizer, water vapour*) at home?

Yes ☐

No ☐

**Thank you very much for completing this questionnaire. We would appreciate this being returned to your child's school as soon as possible.**