

11 December 2013

# China Kadoorie Biobank

## 【2<sup>nd</sup> Resurvey Questionnaire】

The items in red are changes from the first resurvey.

Version 2.2, CKB/ICC/2013

## Section 1: Background information

1.1 Resurvey ID:                       Baseline ID:

1.2 Name: \_\_\_\_\_, Sex: Male  Female  , Name of spouse: \_\_\_\_\_

1.3 Date of birth:     Year   Month   Day

1.4 National ID number (if no, put #)

1.5 Home address: \_\_\_\_\_ Province \_\_\_\_\_ City \_\_\_\_\_ District/County \_\_\_\_\_ Street/Village

Home telephone: Not available  , Yes:     -

Mobile telephone: Not available  , Yes:

1.5.1 Were you born in this province [i.e. where the interview is taking place] (to the best of your knowledge)?

- Yes  
 No → *If ticked, Go to 1.5.1a*  
 Don't know

1.5.1a Where were you born?

Drop down list of 31 provinces with "Other" and "Don't know" at the end (see Appendix 1)

1.5.2 Were any of your parents or grandparents born outside the province where you were born?

- Yes  
 No  
 Don't know

1.5.3 Are you Han Chinese?

- Yes  
 Partly (i.e. Han-mixed)  
 No  
 Don't know

1.5.4 Are any of your parents and/or grandparents non-Han or mixed ethnic group?

- Yes  
 No  
 Don't know

1.5.5 Do you have a religion?

- Yes, → If ticked, specify type (**Q1.5.5a**):  Buddhist,  Christian,  Muslim,  Other  
 Do not wish to say  
 No

## 1.6 What is the highest level of school education you ever received?

- |   |   |
|---|---|
| <input type="checkbox"/> No formal school | <input type="checkbox"/> High School / Technical School |
| <input type="checkbox"/> Primary School   | <input type="checkbox"/> College                        |
| <input type="checkbox"/> Middle School    | <input type="checkbox"/> University                     |
- 

## 1.7 What is your current occupation?

- |  |  |
|--|--|
| <input type="checkbox"/> Agriculture & related workers | <input type="checkbox"/> Retired. <i>If "YES", Go to <a href="#">Q1.7.1</a> &amp; <a href="#">Q1.7.2</a></i> |
| <input type="checkbox"/> Factory worker                | <input type="checkbox"/> House wife / husband  |
| <input type="checkbox"/> Administrator / manager       | <input type="checkbox"/> Self-employed   |
| <input type="checkbox"/> Professional / technical      | <input type="checkbox"/> Unemployed  |
| <input type="checkbox"/> Sales & service workers       | <input type="checkbox"/> Other or not stated   |

### 1.7.1 What was your last occupation before you retired?

- |  |   |
|--|---|
| <input type="checkbox"/> Agriculture & related workers | <input type="checkbox"/> House wife / husband |
| <input type="checkbox"/> Factory worker                | <input type="checkbox"/> Self-employed        |
| <input type="checkbox"/> Administrator / manager       | <input type="checkbox"/> Unemployed           |
| <input type="checkbox"/> Professional / technical      | <input type="checkbox"/> Other or not stated  |
| <input type="checkbox"/> Sales & service workers       |   |

### 1.7.2 Why did you retire?

- |  |
|--|
| <input type="checkbox"/> Reaching retirement age           |
| <input type="checkbox"/> Health related (excluding injury) |
| <input type="checkbox"/> Other                             |
- 

## 1.8 How many people live together as a family in the household? persons

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## 1.9 What is your current marital status

- |                                  |   |
|----------------------------------|---|
| <input type="checkbox"/> Married | <input type="checkbox"/> Separated / divorced |
| <input type="checkbox"/> Widowed | <input type="checkbox"/> Never married        |
- 

## 1.10 What is the total income last year in your household?

- |   |   |
|---|---|
| <input type="checkbox"/> <2,500 yuan        | <input type="checkbox"/> 35,000-49,999 yuan |
| <input type="checkbox"/> 2,500-4,999 yuan   | <input type="checkbox"/> 50,000-74,999 yuan |
| <input type="checkbox"/> 5,000-9,999 yuan   | <input type="checkbox"/> 75,000-99,999 yuan |
| <input type="checkbox"/> 10,000-19,999 yuan | <input type="checkbox"/> ≥100,000 yuan      |
| <input type="checkbox"/> 20,000-34,999 yuan |   |
- 

## 1.11 Do you have any of the following items in your household?

Yes No

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Health care cover (for yourself only)                              |
| <input type="checkbox"/> | <input type="checkbox"/> Own house / apartment  |
| <input type="checkbox"/> | <input type="checkbox"/> Tap water in your own house (Note: it was option 7 in last survey) |

- Toilet for private use
- Telephone or mobile phone
- Car (*Note: used to be in the same question as Motorbike*)
- Motorbike / other motor vehicle
- Computer (incl. laptop, tablet, iPad)
- Web access
- Email/QQ (for yourself only)
- Holiday during last five years

## Section 2: Tea & coffee drinking

2.1 During the past 12 months, how often did you drink any tea?

- Never or almost never
- Only occasionally
- Only at certain seasons
- Every month but less than weekly
- Usually at least once a week → If ticked, Go to Q2.3

2.2 In the past, did you ever have a period of at least 1 year during which you usually drank tea at least once a week?

- Yes, → if so, how long ago did it end (Q2.2a)?   Years } Go to Q2.11
- No

2.3 During the past 12 months, on how many days did you drink tea in a typical week?

- 1-2 days/week
- 3-5 days/week
- Daily or almost every day

2.4 At about what age did you start drinking tea in most weeks?   Years

2.5 On days when you drink tea, how many cups do you usually drink? (choose one only)

	cups/day
Green /Jasmine tea	<input type="text"/> <input type="text"/>
Oolong tea	<input type="text"/> <input type="text"/>
Black tea	<input type="text"/> <input type="text"/>
Other tea	<input type="text"/> <input type="text"/>

2.6 How often do you change tea leaves during a day?   times

2.7 About how much tea leaves do you usually add each time?   grams

2.8 What strength of tea do you usually prefer to drink?

- Weak
- Moderate
- Strong

2.9 At about what temperature do you usually drink your tea?

- Room temperature / warm
- Hot
- Burning hot

**2.10 Has your tea consumption changed significantly compared with that some years ago?**  About the same as before,  Has increased a lot,  Has decreased a lot

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**2.11 During the past 12 months, how often did you drink any coffee?**

- Never or almost never
- Only occasionally
- Every month but less than weekly
- Usually at least once a week

## Section 3: Alcohol consumption

### 3.1 During the past 12 months, how often did you drink any alcohol?

- Never or almost never  
 Only occasionally  
 Only at certain seasons  
 Every month but less than weekly  
 Usually at least once a week → *If ticked, Go to Q3.3*

### 3.2 In the past, did you ever have a period of at least 1 year, during which you usually drank some alcohol at least once a week?

- Yes → If so, how long ago did it end (Q3.2a)?   Years → *Go to Q3.2b*  
 No → *Go to section 4*

### 3.2b What was your main reason for stopping?

- Physical illness that you already had  
 Health concerns (about future illness)  
 Money  
 Family against  
 Doctor's advice  
 Other

→ *Go to section 4*

### 3.3 During the past 12 months, on how many days did you drink alcohol in a typical week?

- 1-2 days/week  
 3-5 days/week  
 Daily or almost every day

### 3.4 At about what age did you start drinking some alcohol in most weeks? years

### 3.5 On three different situations, what kind(s) of alcoholic drinks you choose and how much you drink in a day?

(If used to drink more than one kind on a single occasion, can choose up to 3 types of alcohol for all occasions; fill in other fields with 0)

Alcohol type	On a typical day	On a special day when you drink a lot	Last time when you drank
Beer (large)	<input type="text"/> <input type="text"/> bottle	<input type="text"/> <input type="text"/> bottle	<input type="text"/> <input type="text"/> bottle
Rice Wine	<input type="text"/> <input type="text"/> liang	<input type="text"/> <input type="text"/> liang	<input type="text"/> <input type="text"/> liang
Wine	<input type="text"/> <input type="text"/> liang	<input type="text"/> <input type="text"/> liang	<input type="text"/> <input type="text"/> liang
Spirit ( $\geq 40\%$ alcohol)	<input type="text"/> <input type="text"/> liang	<input type="text"/> <input type="text"/> liang	<input type="text"/> <input type="text"/> liang
Spirit ( $< 40\%$ alcohol)	<input type="text"/> <input type="text"/> liang	<input type="text"/> <input type="text"/> liang	<input type="text"/> <input type="text"/> liang

### 3.6 On a typical day when you drink alcohol, when do you usually take the drink?

- Usually drink with the meal  
 Usually drink between or after the meals

No regular pattern

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**3.7 After drinking alcohol, do you usually experience hot flushes or dizziness?**

- Yes, soon after first mouthful → *If ticked, Go to Q3.8*
- Yes, after drinking small amount of alcohol → *If ticked, Go to Q3.8*
- Yes, but only after drinking large amount of alcohol
- No

**3.7.1 In the first one or two years when you started drinking regularly, did you experience hot flushes or dizziness?**

- Yes, soon after first mouthful
  - Yes, after drinking small amount of alcohol
  - Yes, but only after drinking large amount of alcohol
  - No
- 

**3.8 During the past month, how often have you drunk alcohol in the morning?**

- Never
  - <1 day/week
  - A few days a week
  - Daily or almost daily
- 

**3.9 During the past month, have you ever had the following experiences?**

- | <b>Yes</b>               | <b>No</b>  |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Unable to work or to do anything because of drinking              |
| <input type="checkbox"/> | <input type="checkbox"/> Felt depressed, angry or couldn't control yourself after drinking |
| <input type="checkbox"/> | <input type="checkbox"/> Could not keep away from drinking                                 |
| <input type="checkbox"/> | <input type="checkbox"/> Had shakes when you stopped drinking                              |
- 

**3.10 Has your alcohol consumption changed significantly compared with that some years ago?**

- About the same as before
- Has increased a lot
- Has decreased a lot

**3.11 Have you drunk any alcohol today? (previously Q3.1)**       Yes,  No



## Section 4: Smoking history

4.1 Have you smoked any tobacco today?  Yes ,  No, → if yes, **(Q4.1a)** how many: \_\_\_ total, & **(Q4.1b)** how many: \_\_\_ in last hour

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4.2 How often do you smoke tobacco now?

- Do not smoke now  
 Only occasionally  
 Yes, on most days  
 Yes, daily or almost every day
- } → *If ticked, Go to **Q4.3***

4.2.1 How soon after waking in the morning do you usually have your first smoke?

- ≤5 minutes  
 6-30 minutes  
 31-60 minutes  
 >60 minutes

*After completing Q4.2.1, Go to **Q4.7***

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4.3 In the past, how frequently did you smoke?

- Did not smoke  
 Smoked only occasionally  
 Smoked on most days  
 Smoked daily or almost every day
- } → *If ticked, Go to **Q4.5***
- 

4.4 In your life time, have you smoked a total of at least 100 cigarettes or equivalent?

- Yes  
 No
- } → *Go to **Section 5***
- 

4.5 How many years ago did you last stop smoking regularly?   Years   Months

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4.6 What was your main reason for stopping?

- Physical illness that you already had  
 Health concerns (about future illness)  
 Money  
 Family against  
 **Doctor's advice**  
 Other
- 

4.7 At about what age did you first start smoking on most days?   Years

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4.8 What tobacco did you use when you first started smoking on most days?

Mainly cigarette , Mainly non-cigarette , Mixed types

↳ **Q4.8a** From the time you first started until now or first stopped, did you always smoke some cigarettes on most days, never having a month or more without them? Yes , No

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**4.9 What kind(s) of tobacco do you usually smoke (or did you smoke before giving up) and how much?**

Filter cigarettes (factory) .....	.....	<input type="text"/>	<input type="text"/>	number/day
Non-filter cigarettes (factory).....	.....	<input type="text"/>	<input type="text"/>	number/day
Hand-rolled cigarettes .....	.....	<input type="text"/>	<input type="text"/>	liang/month
Pipe or water pipe .....	.....	<input type="text"/>	<input type="text"/>	liang/month
Cigars .....	.....	<input type="text"/>	<input type="text"/>	number/day

**4.10 How deeply do (or did) you usually inhale the smoke?**

- Mouth only
- Throat
- Lung → If ticked, then **Q4.10a**: have you nearly always inhaled a lot of smoke into your lung when smoking?  
Yes , No

*If ex-smoker (ie, answered Q4.5), move to **Q4.12c***

**4.11 Has your tobacco consumption changed significantly compared with that some years ago?**

- About the same as before,     Has increased a lot,     Has decreased a lot

**4.12 Have you ever tried to quit smoking (without smoking for at least one week)?**

Yes,  No; → If “No”, then Go to **Section 5**:

**4.12a How many years ago did you last try to quit?**     Years     Months

**4.12b How long did it last?**     Years     Months

**4.12c Have you ever used the following methods to assist with smoking cessation?**

- | Yes                      | No                       |                           |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Accupuncture              |
| <input type="checkbox"/> | <input type="checkbox"/> | Nicotine gum/patch        |
| <input type="checkbox"/> | <input type="checkbox"/> | Bupropion                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Chanpix                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoking cessation clinics |
| <input type="checkbox"/> | <input type="checkbox"/> | Special support group     |
| <input type="checkbox"/> | <input type="checkbox"/> | Quitline                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Exercise routine          |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other methods         |



**5.2 During the past 12 months, about how often did you do the following things?**

	Daily	4-6 days per week	1-3 days per week	Monthly	Never or rarely
Snacking (including late-night snacks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skipping breakfast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating in restaurants, street food stalls etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating deep fried foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Western-type fast foods (eg pizza/burgers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5.3 What is your preferred saltiness for your dishes compared with your friends or colleagues?**

- Very light
- About average
- Very salty

**5.4 About how many days on average would the following cooking ingredients usually last in your household? (if none/unknown enter #)**

- a) A bag (500 gram) of salt:  days
- b) A bottle (500 ml) of soy sauce:  days
- c) A bottle (1 liter) of cooking oil:  days

**5.5 During the past 12 months, have you taken the following supplements regularly?**

- | Yes                                 | No   |
|-------------------------------------|--|
| <input type="checkbox"/>            | <input type="checkbox"/> Fish oil/cod liver oil                  |
| <input type="checkbox"/>            | <input type="checkbox"/> Vitamins                                |
| <input type="checkbox"/>            | <input type="checkbox"/> Calcium/iron/zinc                       |
| <input type="checkbox"/>            | <input type="checkbox"/> Ginseng and related products            |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> Traditional Chinese medicine |
| <input type="checkbox"/>            | <input type="checkbox"/> Other herbal health supplements         |

**5.6 Have you ever experienced any severe food shortage?**  Yes,  No → if No, Go to **Q5.9**

**5.7 What year was the worst food shortage you experienced?**  years

**5.8 During the most severe food shortage have you experienced following situations?**

- | Yes                      | No                       | Don't know               |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lose weight? → If "Yes", then <b>Q5.8a</b> : by about how much ____ jin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Develop specific diseases related to food shortage?                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Death of family member or close friend/neighbour during food shortage?  |

**5.9 Did your mother experience any severe food shortage when expecting you?**

- Yes,  No,  don't know

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5.10 How many years have you had a refrigerator in your home?   Years

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5.11 During the past month, about how often did you eat hot spicy food?

- Never or almost never  
 Only occasionally  
 1-2 days/week
- } → Go to Section 6
- 3-5 days/week  
 Daily or almost every day

5.12 At what age did you start to eat spicy food at least once a week?   Years

---

5.13 What strength of spicy food do you usually prefer to eat?

- Weak,  Moderate,  Strong
- 

5.14 On day when you eat spicy food, what are the main sources of spice usually used?

- | Yes                      | No                       |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chili sauce         |
| <input type="checkbox"/> | <input type="checkbox"/> | Chili oil           |
| <input type="checkbox"/> | <input type="checkbox"/> | Dried chili pepper  |
| <input type="checkbox"/> | <input type="checkbox"/> | Fresh chili pepper  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other or don't know |
-

## Section 6: Passive smoking & air pollution

6.1 Have you ever lived with a smoker in the same house for at least 6 months?

- Never  
 Yes, but not now  
 Yes, at present

} → If yes, **Q6.1a** duration of living together   Years  
If 1<sup>st</sup> box is ticked, then **Go to Q6.3**. If 2<sup>nd</sup> box is ticked, then **Go to Q6.3** after answering duration

6.2 During the past 12 months, how frequently have you been exposed to tobacco smoke from a family member **at home or someone you shared a room with?** (i.e. a minimum of 5 consecutive minutes each time)

- Occasionally (<1 day / week) → If ticked, Go to **Q6.3**  
 1-2 days/week  
 3-5 days/week  
 Daily or almost every day

6.2.1 What is the usual duration of your exposure per week?   Hours

6.3 During the past 12 months, about how frequently have you been exposed to other people's tobacco smoke **in workplace or public places?** (i.e. a minimum of 5 consecutive minutes each time)

- Never or almost never  
 Occasionally (<1 time/week) } → If ticked, Go to **Q6.4**  
 1-2 days/week  
 3-5 days/week  
 Daily or almost every day

6.3.1 What is the usual duration of your exposure per week?   Hours

6.4 During past year, how long did you store pesticides at home?   Months

6.5 Please tell us the duration you lived in 3 most recent houses (each for at least 1 year)?

Present house   years  
Previous house   years  
The house before previous   years

6.6 How far are your present & previous houses from any main/busy road with traffic?

Present house:  <50m,  50-100m,  100-200m,  >200m  
Previous house1:  <50m,  50-100m,  100-200m,  >200m (skip if #)  
Previous house2:  <50m,  50-100m,  100-200m,  >200m (skip if #)

6.7 Are your present & previous houses within 10 kilometres of heavily air-polluted (with smoke/gas/dust) industry/industrial zone?

Present house:  Yes  No

Previous house1:  Yes  No (skip if Previous house1 is #)  
Previous house2:  Yes  No (skip if Previous house2 is #)

---

**6.8 During the past 12 months, how often did you cook at home?**

- Daily or almost every day  
 A few times a week  
 A few times a month  
 Never or rarely  
 No cooking facility
- *If ticked, Go to Q6.9*  
→ *If ticked, Go to Q6.11*

**6.8.1 How much time on average do you spend in front of the fire/stove while cooking per week?** \_\_\_\_\_ Hours

**6.8.2 At about what age did you start cooking regularly at home?**   Years

**6.8.3 What is the main cooking oil used now?**

- Rapeseed  Lard  
 Peanut  Other  
 Soybean
- 

**6.9 In your household, what is the main cooking fuel used now?**

- Gas  Electricity  
 Coal → *If ticked, Go to Q6.9a*  Other  
 Wood

**6.9a Please specify the main type of coals used?**

- Smokeless coal  Coal brick / Coalite (smokeless)  
 Smoky coal  Other
- 

**6.10 In your household, do all stoves have a chimney / extractor?**

- Yes  Not all stoves  No

**6.10.1 Apart from cooking, is your stove always kept under slow burning throughout the day?**

- Yes, always  Yes, sometimes  No → *If ticked, Go to Q6.11*

**6.10.2 Where is the stove usually kept?**

- Inside the house  Outside the house
- 

**6.11 In winter, do you normally heat your house?**

- Yes,  No → *If No, Go to Q6.12*

**6.11.1 What is the main heating fuel?**

- Central heating  Wood  
 Gas  Electricity  
 Coal → *If ticked, Go to Q6.11.2*  Other

**6.11.2 Please specify the main type of coals used:**

- Smokeless coal                       Coal brick / Coalite (smokeless)  
 Smoky coal                               Other

**6.11.3 When you heat the house in winter, do you still need to wear plenty of warm clothes at home?**                       Yes,  No

---

**6.12 From what year did the inside of your house tend to be coal-smoky in winter?**

- Never → *If ticked, Go to **Q6.13***  
 Ever since childhood  
 Since the year: \_\_\_\_\_ year

**6.12.1 In what year did the inside of your house stop being really coal-smoky in winter?**

- In the year: \_\_\_\_\_ year  
 Still is
- 

**6.13 During your working life, have you ever been exposed to any of the following for at least 6 consecutive months?**

- Gas/Vapour/Fume/Mist       Yes,  No; →if Yes, then **Q6.13a** total years of exposure? \_\_\_years  
Dust (eg. silica/coal/cotton)  Yes,  No; →if Yes, then **Q6.13b** total years of exposure? \_\_\_years  
Fibres (eg, asbestos/textile)  Yes,  No; →if Yes, then **Q6.13c** total years of exposure? \_\_\_years
-



## Section 7: Personal & family medical history

### 7.1 How is your current general health status?

#### 7.1.1 Self-rated health status?

- Excellent  
 Good  
 Fair  
 Poor

#### 7.1.2. Compared to someone of your own age?

- Better  
 About the same  
 Worse  
 Don't know

### 7.2 If you were walking on level ground with other healthy people of the same age, would you usually:

#### 7.2.1 Become short of breath?

- Yes  
 No  
 Disabled

#### 7.2.2 Slow down due to chest discomfort?

- Yes  
 No  
 Disabled

### 7.3 During the past 12 months, have you usually had the following symptoms?

#### 7.3.1 Cough frequently?

- No  
 Yes, for <3 months  
 Yes, for ≥3months

#### 7.3.2 Cough up sputum after getting up in the morning?

- No  
 Yes, for <3 months  
 Yes, for ≥3 months → If yes, **Q7.3.2a** for how long \_\_\_ years

#### 7.3.3 Wheeze or whistle in the chest?

- No  
 Yes  
 Yes, but only when having a cold or viral infection

### 7.4 Has a doctor EVER told you that you had had the following disease?

Diagnosed disease?	Q7.4a		Age of first diagnosis	Q7.4b**		Q7.4c		Q7.4d If yes, date of last hospitalisation
	Yes	No		Still on Treatment	Hospitalized?	Yes	No	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acute MI	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other IHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke or TIA	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary heart dis#	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic heart dis.	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
TB	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema#	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic bronchitis#	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD#	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cirrhosis/chronic hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallstone/gallbladder dis.	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fracture	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression <sup>†</sup>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety <sup>‡</sup>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurasthenia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer*	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

\*If yes, **Q7.4e** please indicate the site of cancer  (If more than one, choose the first one)

1. Lung 2. Esophagus 3. Stomach 4. Liver 5. Intestine 6. Breast 7. Prostate 8. Cervix 9. Other

**\*\*Note: See Appendix 2 for drug list related to diabetes, CVD (acute MI, angina, other IHD, stroke/TIA) and hypertension.**

<sup>†</sup> If answered “yes”, then go to CIDI-A questionnaire

<sup>‡</sup> If answered “yes”, then go to CIDI-B questionnaire

**7.5 Link to COPD questionnaire: if “Yes” for any of the 4 diagnosed conditions marked with #, or  $\geq 2$  years in Q7.3.2a (Appendix 3)**

**7.6 During the past 12 months, how many times have you visited hospital as an outpatient for any reason? (If none, put 0)**

times



**7.7 During the past 12 months, how many times have you been hospitalized overnight for any reason? (If none, put 0)**



times

**7.8 How many blood transfusions have you ever received? (If none, put 0)**   times

**7.9 How many times have you ever donated blood for financial payment? (If none, put 0)**   times

**7.10 About how often do you have bowel movements each week?**

- More than once on most days
- About daily
- Every other day
- Less than 3 times a week

---

**7.11 How often do your gums bleed when you brush your teeth?**

- Occasionally, rarely or never
- Sometimes
- Always
- Brush teeth rarely or never
- Have false teeth

---

**7.12 How many brothers & sisters do you have?** *(Including half siblings. If unknown, put#)*

---

**7.13 How many children do you have?** *(Including only biological ones)*

---

**7.14 Is your mother still alive?**

- Yes → If ticked, **Q7.14a** current age:  Years
- No → If ticked, **Q7.14b** age at death:  Years
- Unknown

---

**7.15 Is your father still alive?**

- Yes → If ticked, **Q7.15a** current age:  Years
- No → If ticked, **Q7.15b** age at death:  Years
- Unknown

---

**7.16 Did any of your parents, siblings or children have following diseases?** *(For sibling and children, please record the number with disease)*

	Mother	Father	Siblings (inclu.half)	Children
Stroke	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="text"/> <input type="text"/> person	<input type="text"/> <input type="text"/> person
Heart attack	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="text"/> <input type="text"/> person	<input type="text"/> <input type="text"/> person
Diabetes	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="text"/> <input type="text"/> person	<input type="text"/> <input type="text"/> person
Depression	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="text"/> <input type="text"/> person	<input type="text"/> <input type="text"/> person
Cancer	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="text"/> <input type="text"/> person	<input type="text"/> <input type="text"/> person
COPD/Bronchitis Emphysema/PHD	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="checkbox"/> Yes; <input type="checkbox"/> No	<input type="text"/> <input type="text"/> person	<input type="text"/> <input type="text"/> person

---

**7.17 Do you know your birth weight?**

- Yes, → If ticked, **Q7.17a** what was your weight:  jin (rounded to 0.1 jin)
- No

---

**7.18 Were you born prematurely?**  Yes,  No,  Not sure

**7.19 Were you born through Caesarean Section?**

- Yes
- No
- Not sure

**7.20 Did you suffer any birth-related trauma when born?**

- Yes
  - No
  - Not sure
-

## Section 8U: Physical activities (Non-Agriculture & related workers)

8.1 During the past 12 months, how active were you at work?

- Mainly sedentary (e.g. office worker)
- Standing occupation (e.g. guard, shop assistant)
- Manual work (e.g. plumber, carpenter)
- Heavy manual work (e.g. miner, construction worker)
- Retired or housewife/husband or unemployed or disabled → *If ticked, Go to Q8.9 (was Q8.8)*

8.2 In a typical week, about how many days did you usually work? \_\_\_\_ days

8.2a On days when you work, on average how many hours do you work? \_\_\_\_ hours

8.3 During the past 12 months, how did you usually get to work?

- Mainly walk
  - By motorbike/mopad
  - By bicycle
  - By bus/ferry/train
  - By car/taxi
  - Mainly stay at home or work near home
- ↳ *If ticked, Go to Q8.9 (was Q8.8)*

8.4 How much time did you spend each day on commuting? \_\_\_\_ minutes

## Section 8F: Physical activities (Agriculture & related workers)

8.1 During the past 12 months, did your farming work change seasonally?

- No → *If ticked, Go to Q8.3*
- Yes

8.2 Please specify your activities during the farming season in the last 12 months:

8.2.1 How many months did it usually last?   month

8.2.2 What types of work did it usually involve?

- Manual
- Semi-mechanized
- Fully mechanized

8.2.3 How many hours did you usually work each day?   hours

8.2.4 Of which, how many hours did you sweat or have a much faster heartbeat?   hours

8.3 In a typical week (of non-farming season), how many hours did you usually work in the field?   hours

8.4 Apart from agriculture work, did you have any other job?

- No → *If ticked, Go to Q8.7*
- Yes

8.5 How active were you at work with other job?

- Mainly sedentary
- Mainly standing

- Mainly general manual work
- Mainly heavy manual work

---

**8.6** In a typical week, about how many days did you usually work at other job?  
\_\_\_\_ days

**8.6a** On days when you work at your other job, on average how many hours do you work? \_\_\_\_\_ hours

---

**8.7** During the past 12 months, how did you usually get to work?

- Mainly walk
  - By motorbike
  - By bicycle
  - By bus/ferry/train
  - By car/taxi
  - Mainly stay at home or work near home
- ↳ If ticked, Go to Q8.9 (was 8.8)
- 

**8.8** How much time in total did you usually spend each day on commuting?  
 minutes

---

### Section 8C: Physical activities (Common to all participants)

**8.9** During the past 12 months, how often did you do exercise in your leisure time?

- Never or almost never
  - 1-3 times/month
  - 1-2 times/week
  - 3-5 times/week
  - Daily or almost every day
- } → If ticked, Go to Q8.12 (was 8.11)
- 

**8.10** What is your main type of leisure exercise? (tick one box only)

- Taichi / Qigong
  - Jogging/aerobic dancing
  - Ball games (basketball, table tennis, etc)
  - Walking
  - Swimming
  - Other (eg. hill walking, mountain climbing, rope jumping, kicking shuttlecock)
- 

**8.11** About how many hours per week did you do such exercise in total in leisure time?  
\_\_\_\_\_ hours

---

**8.12** In a typical week during the past 12 months, how often did you sweat or have a much faster heartbeat because of heavy physical activities/exercise?

- Never or almost never
  - <1 time / week
  - 1-2 times/week
  - 3-5 times/week
  - Daily or almost every day
- } → If ticked, Go to Q8.14 (was 8.13)
- 

**8.13** About how many hours per week did you do such activities? \_\_\_\_\_ hours

---

**8.14** About how many hours per day did you do house work? \_\_\_\_\_ hours

---

**8.15** While not working, on average about how many hours per day did you spend on sitting activities, including watching TV, reading etc? \_\_\_\_hours/day

---

**8.16** During the past 12 months, about how often did you do the following sitting activities?

	Daily	4-6 days per week	1-3 days per week	Monthly	Never or rarely	On the day you do that activity, how long do you spent on it? (Q8.16a)
Watching TV/DVD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours/day
Reading books / newspapers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours/day
Eating, chatting or socializing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours/day
Playing cards/mahjong/board games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours/day
Doing household paper work/writing /internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours/day

---

**8.17** During the past 12 months, has your weight changed significantly?

About the same as before     Yes, gained  $\geq 5$  jin     Yes, lost  $\geq 5$  jin

**8.18** Have you tried to reduce weight in the past 12 months?    No , Yes

---

**8.19** How much did you weigh when you were at age 25? (If unknown put #)     jin

---

## Section 9: Reproductive history (for women)

9.1 -- How old were you when you had your first menstrual period? (if none put #, Go to [Q9.7](#))   years

9.2 Have you had your menopause?

No → *If ticked, Q9.2a Are you on your period today* ( Yes,  No), then **Go to [Q9.3](#)**

Yes, currently

Yes, had menopause → If so, [Q9.2b](#) age of completion of menopause:   year

9.2.1 Are you taking or have you taken any medications to relieve the symptoms associated with menopause?  Yes,  No; → If yes, [Q9.2.1a](#) please specify type of medication used:

Yes No

HRT

Traditional Chinese medicine

Other medication

9.3 How many times have you ever been pregnant?   times

*If none then Move to [Q9.5](#)*

9.3.1 Please give number for different pregnancy outcome:

a) Live birth:   times → *If none, Go to [Q9.5](#)*

b) Still birth:   times

c) Spontaneous abortion:   times

d) Induced abortion:   times

9.4 Age and length of breastfeeding at each live birth (twins or more =one birth)?

Live Birth	<a href="#">Q9.4a</a>	<a href="#">Q9.4b</a>	<a href="#">Q9.4c</a>	
	Age at end of pregnancy	Months of breastfeeding	Twins or more Yes	No
1 <sup>st</sup>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 <sup>nd</sup>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 <sup>rd</sup>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
...	.....	.....	...	...
N <sup>th</sup>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.5 Have you ever used oral contraceptive pills?

Never → *If ticked, Go to [Q9.6](#)*

Past use → If ticked, [Q9.5a](#) age when you last stopped the pill:   Year

Current use

9.5.1 How old were you when you first used oral contraceptives?   Year



---

9.5.2 For how long altogether have you used oral contraceptives?

--	--

 Year

---

9.6 Have you ever used a contraceptive coil?

Never → *If ticked, Go to Q9.7*

Past use → if ticked, **Q9.6a** age when you last stopped using the coil?

--	--

 Year

Current use

---

9.6.1 How old were you when you first used a coil?

--	--

 Year

9.6.2 For how long altogether have you used a coil?

--	--

 Year

---

9.7 Have you ever had any of the following procedures?

	Yes	No	If YES, age of operation?
a) Hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years
b) Removal of one or both ovaries?	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years
c) Surgery to remove a breast lump?	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years
d) Sterilization?	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years
e) Caesarean Section?	<input type="checkbox"/>	<input type="checkbox"/>	_____ Years

## Section 10: Sleeping, mood & mental situation

### 10.1 In general, how satisfied are you with your life?

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Unsatisfied
- Very unsatisfied

### 10.2 See Appendix 4 for Attitude N scale B questionnaire)

10.2.1 Was the N Scale B questionnaire self-administered?  Yes,  No

### 10.3 Over the past two years have you had any of the following major events in your life?

- | Yes                      | No                       |                              | Yes                      | No                       |  |
|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Marital separation/divorce   | <input type="checkbox"/> | <input type="checkbox"/> | Major injury or traffic accident                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of job/retirement       | <input type="checkbox"/> | <input type="checkbox"/> | Death / major illness of spouse                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Business bankrupt            | <input type="checkbox"/> | <input type="checkbox"/> | Death / major illness of other close family member |
| <input type="checkbox"/> | <input type="checkbox"/> | Violence                     | <input type="checkbox"/> | <input type="checkbox"/> | Major natural disaster (e.g. flood & drought)      |
| <input type="checkbox"/> | <input type="checkbox"/> | Major conflict within family | <input type="checkbox"/> | <input type="checkbox"/> | Loss of income / living on debt                    |

### 10.4 During the past month, did you have any of the following sleeping problem for $\geq 3$ days each week?

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Taking >30 minutes to fall asleep after going to bed or waking up in the middle of the night     |
| <input type="checkbox"/> | <input type="checkbox"/> | Waking up early and not being able to go back to sleep   |
| <input type="checkbox"/> | <input type="checkbox"/> | Needing to take medicine (including herbal or sleeping pills) at least once a week to help sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | The quality of sleep has adversely affect your daytime performance or activities                 |

If ticked "No" to all the four questions, then **Go to Q10.5**

**10.4.1 How long has your sleeping problem lasted? \_\_\_\_\_ Years**

10.5 Do you usually take a daytime nap?  Yes usually,  Yes, only in **certain season**,  No

10.6 Do you snore during sleep?  Yes, Frequently,  Yes, Sometimes,  No / Don't know

**10.7 Do you have to do nightshift regularly in your current or previous work?**

- Yes,  No; →If yes, **Q10.7a** how often:  Daily,  Weekly,  Monthly; and  
**Q10.7b** for how many years \_\_\_\_\_ Years

10.8 How many hours do you typically sleep per day (incl. naps)?   Hours

**10.9 During your **entire life**, have you had the following situations for 2 or more weeks continuously?**

**Yes No**

- Feeling much more sad, or depressed than usual
- Loss of interest in most things like activities that usually give you pleasure
- Being so hopeless that you had no appetite to eat even your favourite food
- Feeling worthless and useless, everything went wrong was your fault and life is very difficult that there was no way out

***(If answer “Yes” to any of the questions, then complete CIDI-A:Appendix 5, Section A)***

---

**10.10 During your **entire life**, have you experienced the following situations?**

**Yes No**

- Having a period lasting one month or longer when most of time you felt worried, tense, or anxious and it interfered your life ***(if ticked “Yes”, then complete CIDI-B: Appendix 5, Section B)***
  - Having a pain or discomfort in your body lasting  $\geq 3$  months that interfered with your life
  - Having had a spell or an attack when all of sudden felt frightened, anxious, or very uneasy
  - Having had inexplicable strong fear in situations such as closed space (cave, elevator, airplane etc), in the crowds or public such that you would avoid such situations
-

## Section 11: Physical examination

11.1 **Standing height** (without shoes) .....    .   cm

11.2 **Sitting height** .....    .   cm

11.3 **Waist** .....    .   cm

11.4 **Hip** .....    .   cm

11.5 **Hand grip strength** ..... Right.....   .   kg *Staff code*

Left.....   .   kg

11.6 **Weight** (without shoes, but in light clothing) .....    .  Kg *Staff code*

11.7 **BMI**.....   .   kg/m<sup>2</sup> *Staff code*

For all these above questions (Q11.1~Q11.7), enter # if not measured.

11.8 **Did you take any drugs to lower blood pressure in the last 2 days?**  Yes  No

11.9 **Do you have any of the peripheral artery disease symptoms including painful cramping legs, leg numbness or weakness, and cold legs?**  Yes  No

11.10 **Blood pressure & heart rate** (to be measured after 5 minutes in the seated position)

	First	Second	
<b>SBP</b>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	mmHg
<b>DBP</b>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	mmHg
<b>Heart rate</b>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	bpm
<b>Ankle blood pressure (enter # if not measured)</b>			
<b>SBP</b>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	mmHg
<b>DBP</b>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	mmHg
			<i>Staff code</i>

11.11 **Hours since last ate or drank anything (ignore non-caloric drinks such as water and tea)?** \_\_\_\_\_ hours *Staff code*

11.12 **Blood sample collected:** Yes   Failed

----- *Staff code* -----

11.13 **Urine sample collected:** Yes   No

**11.14 Lung function & COex levels (enter # if not measured):**

	First	Second		
COex.....	<input type="text"/> <input type="text"/>	..... <input type="text"/> <input type="text"/>	ppm	
%COHB .....	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	%	
FEV1	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Liter	<i>Staff code</i>
FVC	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Liter	<input type="text"/> <input type="text"/> <input type="text"/>

---

**11.15 Assessment of subject's cooperation and the reliability of data collected?**

a) Assessment of subject's cooperation?

- Good
- Fair
- Poor

b) Assessment of the reliability of the information collected?

- Good
  - Fair
  - Poor
- 

**Date of interview** \_\_\_\_\_ **Year** \_\_\_\_\_ **Month** \_\_\_\_\_ **Day** \_\_\_\_\_, **Signature of interviewer** \_\_\_\_\_

## Appendix 1: List of province in mainland China (plus other and don't know)

1. Anhui
2. Beijing
3. Chongqing
4. Fujian
5. Gansu (local province for RC58, Tianshui, Gansu)
6. Guangdong
7. Guangxi (local province for RC46, Liuzhou)
8. Guizhou
9. Hainan (local province for RC26, Haikou)
10. Hebei
11. Heilongjiang (local province for RC16, Haerbin)
12. Henan (local province for RC68, Huixian, Henan)
13. Hubei
14. Hunan (local province for RC88, Liuyang, Hunan)
15. Jiangsu (local province for RC36, Suzhou)
16. Jiangxi
17. Jilin
18. Liaoning
19. Nei Mongol
20. Ningxia
21. Qinghai
22. Shaanxi
23. Shandong (local province for RC12, Qingdao)
24. Shanghai
25. Shanxi
26. Sichuan (local province for RC52, Sichuan)
27. Tianjin
28. Xinjiang
29. Xizang
30. Yunnan.
31. Zhejiang (local province for RC78, Tongxiang, Zhejiang)
32. Others (eg, Hong Kong, Macau, Taiwan)
33. Don't know

Note: unlike most questions, coding for this question is one-based, as shown, e.g. 1 = Anhui, 2 = Beijing etc.

Note: The order of provinces name in LTFollow up does not seem to have any logics (eg, PINYIN or Chinese words). So, for easiness of use I would prefer to use the present list. In addition, there are also two new area codes compared with that in LTFollow up (code 66 is not a province name and for the present questionnaire needs to be removed).



## Appendix 2: Drug list

### List 1: for diabetes

1. Aspirin
2. ACE-I
3. Beta-blocker
4. Statins
5. Diuretics
6. Ca<sup>++</sup> antagonist
7. Clopidogrel
8. ARB
9. Other anti-hypertensive drugs
10. Traditional Chinese medicine
11. Chlorpropamide or metformin (oral tablets)
12. Insulin (injection)

### List 2: for MI/angina/other IHD/stroke/hypertension

1. Aspirin
2. ACE-I
3. Beta-blocker
4. Statins
5. Diuretics
6. Ca<sup>++</sup> antagonist
7. Clopidogrel
8. ARB
9. Other anti-hypertensive drugs
10. Traditional Chinese medicine



## Appendix 3: COPD questionnaire (Q7.5)

The following questions are related to your chronic lung disease. Please give the answers you feel most appropriate.

**1. Overall, how would you rate the severity of your chronic lung disease now?**

- Very severe
- Severe
- Moderate
- Mild
- Very mild

**2. How does your doctor classify the severity of your condition?**

- Stage1 (mild)
- Stage 2 (moderate)
- Stage 3 (severe)
- Stage 4 (very severe)
- Doctor has not diagnosed or told me
- Don't know

**3. The next part of the questionnaire is to measure the impact of respiratory symptoms on wellbeing and your daily life. Please indicate on a scale of 0 to 5 how strongly you feel about the two pair of the statements related to each question.**

Score

- | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**1) Frequency of your cough?**

0= Never cough; 5= Cough all the time

**2) Amount of mucus in your chest?**

0= No mucus at all; 5= Full of mucus

**3) Tightness of your chest?**

0= Not tight at all; 5= Very tight

**4) Breathless when walking up a hill/one flight of stairs?**

0= Not breathless; 5= Very breathless

**5) Limitation of daily activities at home by the condition?**

0= Not limited; 5= Very limited

**6) Degree of confidence about leaving your home?**

0= Confident; 5= Not confident at all

**7) Quality of sleep at night and whether it is affected by the condition?**

0= I sleep soundly; 5= I don't sleep soundly because of my lung condition

**8) Usual levels of energy?**

0= I have lots of energy; 5= I have no energy at all

4. Have you ever had your lung function tested by blowing hard into a tube (excluding the present and previous CKB tests)?

- Yes
- No
- Don't know

5. Have you ever had your lung function tested in a cabin, called a plethysmograph?

- Yes
- No
- Don't know

6. In the past 12 months what types of health care professionals have you seen about your condition?

**Yes No**

- General physician
- Respiratory specialist
- Cardiologist/heart specialist
- Traditional Chinese medicine doctor
- Local health centre or village doctor
- Other medical professional

7. In the past 12 months, how many times have you been hospitalised overnight, or longer, as a direct result of your condition? \_\_\_\_\_ times (If none, put 0)

8. In the past 12 months, have you taken any of the following to treat worsening of your breathing problems?

**Yes No**

- Antibiotics
- Oral steroids
- Injectable steroids

} → *If ticked "NO" for all items, Go to Q9.*

8.1 In the past 12 months, how many episodes of COPD exacerbation have you had when you took antibiotics, oral steroids, or injectable steroids to treat worsening of your breathing problems? (if none, put 0) \_\_\_\_\_ times

9. In the past seven days, have you taken any prescriptive medicine (such as inhalers, tablets or something else) for the condition?

- Yes → *If ticked, Go to Q9.1*
- No
- Don't know

9.1 What types of medication have you taken in the past seven days?

**Yes No**

- Short-acting beta-agonists (e.g. albuterol, salbutamol)
- Short-acting anti-muscarinic agents (e.g. Atrovent, Combivent)
- Long-acting beta-agonists (salmeterol/Serevent, formoterol/Foradil)

- Long-acting anti-muscarinic agent (tiotropium/Spiriva)
- Oral bronchodilators
- Long-acting beta agonist+inhaled corticosteroid combination inhalers
- Inhaled corticosteroids
- Traditional Chinese medicine
- Other treatments

**10. In the past 12 months have you used home oxygen for your condition?**

- Yes → *If ticked, Go to Q10.1*
- No
- Don't know

**10.1 About how often do you use oxygen at home?**

- Every day
- Most days
- Once a week
- Once a month
- Only occasionally

**11. In the past 12 months, have you had an influenza vaccine (also called a flu shot)?**

- Yes
- No
- Don't know

**12. In the past 12 months, have you had a vaccine or shot which protects you against pneumonia?**

- Yes
- No
- Don't know

**13. How well informed do you feel you are about your condition and its treatment?**

- Well informed
- Less than adequately informed
- Very poorly informed
- Don't know

## Appendix 4: N scale B

I am going to give you a set of questions about the way of your thinking and doing things. These questions have no right or wrong answers. Please answer each question by choosing either YES or NO. The best answer is usually the one that comes to mind first, so work quickly and do not think too long about each question. If you are having a hard time making up your mind about a question, ask yourself: Is this more true for me (if so, answer YES) or more false for me (if so, answer NO).

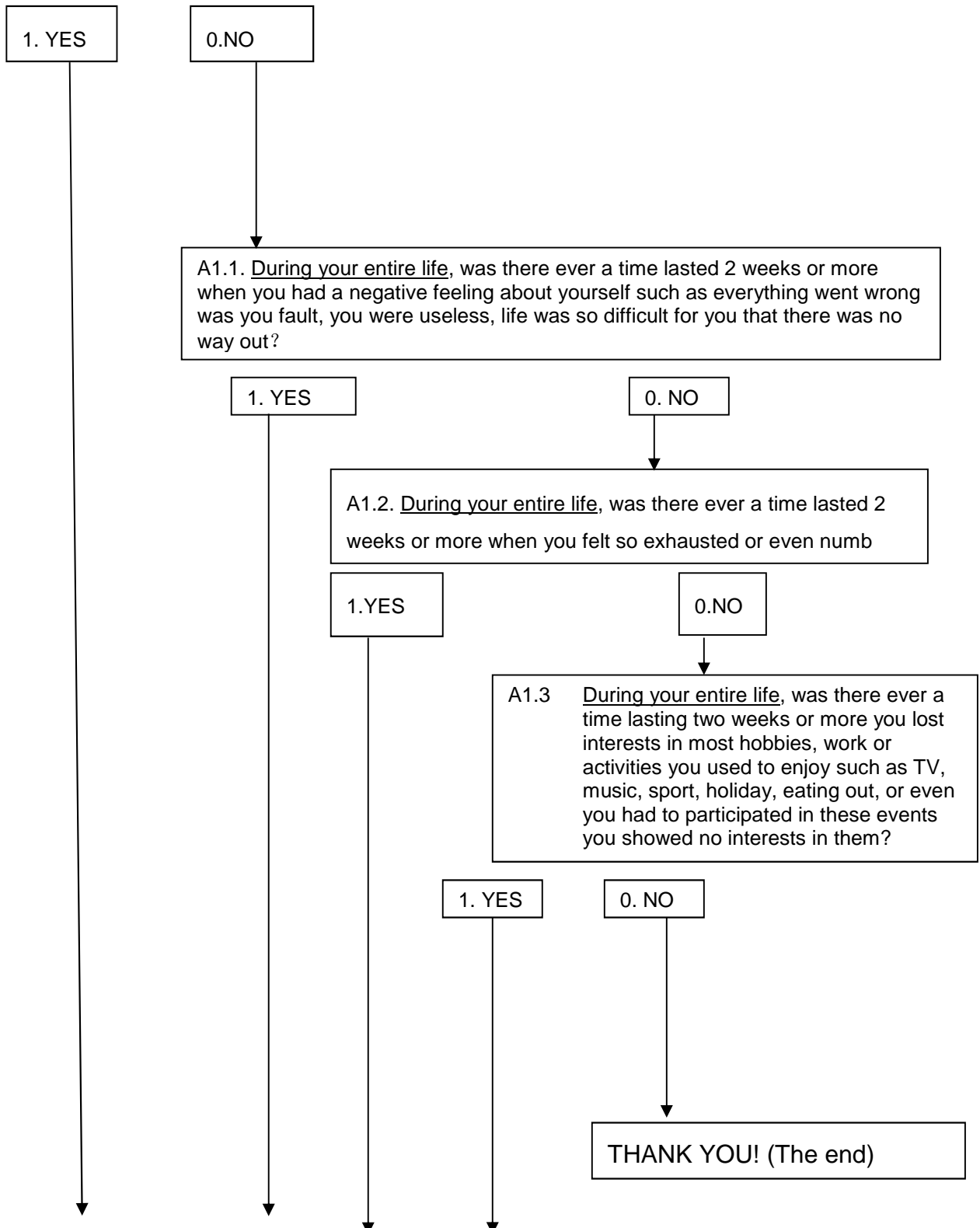
- Q1 Do you often worry about things you should not have done or said? 1. Yes  0. No
- Q2 Are you an irritable person? 1. Yes  0. No
- Q3 Are your feelings easily hurt? 1. Yes  0. No
- Q4 Do you often feel "fed-up"? 1. Yes  0. No
- Q5 Are you often troubled about feelings of guilt? 1. Yes  0. No
- Q6 Does your mood often go up and down? 1. Yes  0. No
- Q7 Would you call yourself a nervous person? 1. Yes  0. No
- Q8 Are you a worrier? 1. Yes  0. No
- Q9 Do you worry about awful things that might happen? 1. Yes  0. No
- Q10 Would you call yourself tense or highly-strung? 1. Yes  0. No
- Q11 Do you worry about your health? 1. Yes  0. No
- Q12 Do you suffer from sleeplessness? 1. Yes  0. No
- Q13 Have you often felt listless and tired for no reason? 1. Yes  0. No
- Q14 Do you often feel life is very dull? 1. Yes  0. No
- Q15 Do you worry a lot about your looks? 1. Yes  0. No
- Q16 Have you ever wished that you were dead? 1. Yes  0. No
- Q17 Do you ever feel "just miserable" for no reason? 1. Yes  0. No
- Q18 Do you worry too long after an embarrassing experience? 1. Yes  0. No
- Q19 Do you suffer from "nerves"? 1. Yes  0. No
- Q20 Do you often feel lonely? 1. Yes  0. No
- Q21 Are you easily hurt when people find fault with you or the work you do? 1. Yes  0. No
- Q22 Are you sometimes bubbling over with energy and sometimes very sluggish? 1. Yes  0. No
- Q23 Are you touchy about some things? 1. Yes  0. No

## Appendix 5: CIDI-SF A & B

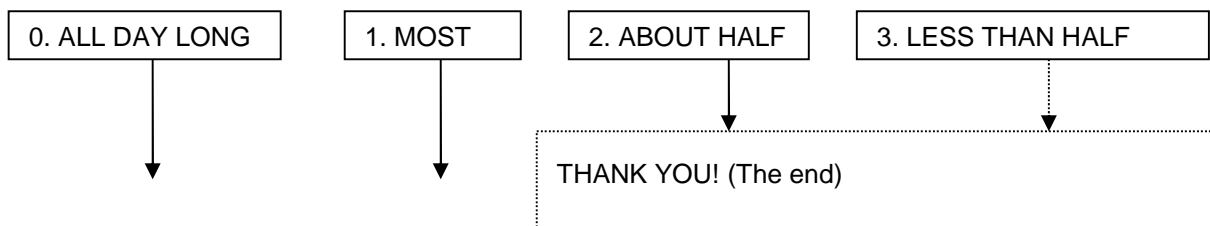
### SECTION A: MAJOR DEPRESSIVE EPISODE

The next set of questions cover experiences you may have had at any point in your life. Since these questions cover a long time period, please take your time to think over your entire life before answering.

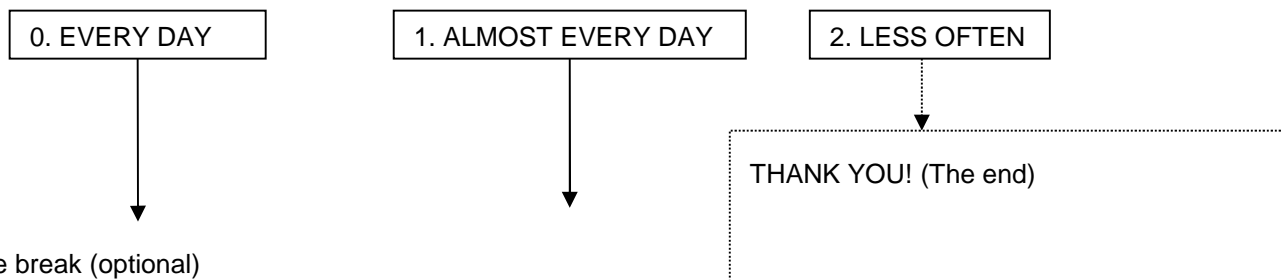
A 1. During your entire life, was there ever a time when you felt sad, blue, or depressed for two weeks or more in a row?



A1a. For the next few questions, please think of the two-week period during your entire life when these feelings were worst (if A1=1 or A1.1=1 or A1.2=1)/ when you had the most complete loss of interest in things (if A1.3=1). During that time did the feelings of being sad, blue, or depressed (if A1=1 or A1.1=1 or A1.2=1)/did the loss of interest (if A1.3=1) usually last all day long, most of the day, about half the day, or less than half the day?



A1b. During those two weeks, did you feel this way every day, almost every day, or less often?



Page break (optional)

A1c. During those two weeks did you lost interests in most hobbies, work or activities you used to enjoy such as TV, music, sport, holiday, eating out, or even you had to participated in these events you showed no interests in them?

1. YES      0. NO

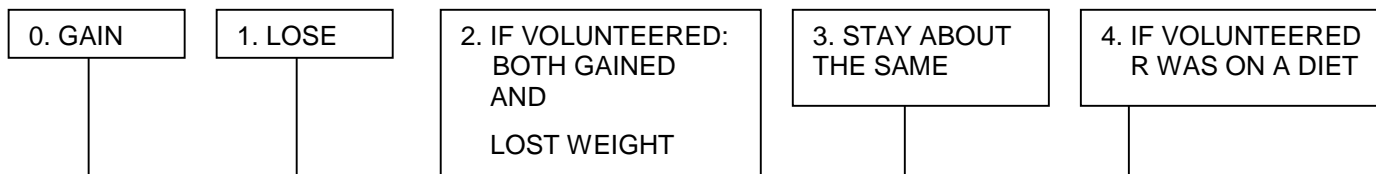
A1d. Thinking about those same two weeks, did you feel more tired out or low on energy than is usual for you?

1. YES      0. NO

Page Break (optional)

A2. Did you gain or lose weight without trying, or did you stay about the same?

**Interviewer: If R asks: "Are we still talking about the same two weeks?" Answer: "Yes."**



A2a. About how much did you gain/you lose/ your weight change?  
 \_\_\_\_\_ JIN (accept range of value, e.g, 5-8, using the average)  
Minimum: >=1  
Maximum: warning if entry >=100 JIN  
Data type: Integer or 1 decimal place (only allow 0.5 for half Jing)

A3. Did you have more trouble falling asleep than you usually do during those two weeks?

1. YES	0. NO	GO TO A4
--------	-------	----------

A3a. Did that happen every night, nearly every night, or less often during those two weeks?

0. EVERY NIGHT	1. NEARLY EVERY NIGHT	2. LESS OFTEN
----------------	-----------------------	---------------

A4. During those two weeks, did you have a lot more trouble concentrating than usual?

**Interviewer: If R asks: "Are we still talking about the same two weeks?" Answer: "Yes."**

1. YES	0. NO
--------	-------

A5. People sometimes feel down on themselves, no good, or worthless. During that two week period, did you feel this way?

1. YES	0. NO
--------	-------

**Interviewer: If R asks: "Are we still talking about the same two weeks?" Answer: "Yes."**

A5.1 During those two weeks, did you feel hopeless about things?

1. YES	0. NO
--------	-------

**Interviewer: If R asks: "Are we still talking about the same two weeks?" Answer: "Yes."**

A6. Did you think a lot about death -- either your own, someone else's, or death in general during those two weeks?

**Interviewer: If R asks: "Are we still talking about the same two weeks?" Answer: "Yes."**

1. YES	0. NO
--------	-------

A7a. Did you have a plan to harm yourself on purpose during those two weeks?

1. YES	0. NO
--------	-------

A7b. Did you take any action to harm yourself on purpose during those two weeks?

1. YES	0. NO
--------	-------

CHECKPOINT -- (COUNT YES RESPONSES IN A1-A7)

1. ZERO QUALIFYING RESPONSES GOTO End (Thank you!)

Qualifying Responses: A1c=1, A1d=1, A2a >=10Jin, A3a=0 or 1, A4=1, A5=1, A5.1=1; A6=1; A7a=1; A7b=1

2. IF ONE OR MORE QUALIFYING RESPONSE GO TO A8

A8. To review, you had two weeks in a row during your entire life,  
(IF "YES" to A1 ) then "when you were sad, blue, or depressed, also you had some other feelings or problems like"... (READ UP TO FIRST 3 QUALIFYING RESPONSES)

(IF "YES" TO A1.1) then "when you had a negative feeling about yourself such as everything went wrong was you fault, you were useless, life was so difficult for you that there was no way out and also had some other feelings or problems like"... (READ UP TO FIRST 3 QUALIFYING RESPONSES)

(IF "YES" to A1.2) then "when you felt so exhausted or even numbers that you would burst into tears without a reason, also you had some other feelings or problems like"... (READ UP TO FIRST 3 QUALIFYING RESPONSES)

(IF "YES" to A1.3) then "when you lost interest in most things like hobbies, work, or activities that usually give you pleasure, also you had some other feelings or problems like"... (READ UP TO FIRST 3 QUALIFYING RESPONSES)

About how many years altogether did you feel this way during your entire life?

\_\_\_\_\_ # OF YEARS →

Minimum value: 2 WKS (if <1 year) OR 1 YEAR; Maximum value: 51 WEEKS (if <1 years) OR current age;  
Data type: integer (other values unacceptable)

A8.1 How old were you when you had your first episode of depression -- that is, when you felt sad or not interested in things for at least two weeks and had several of the other symptoms you described above? Age: \_\_\_\_\_

Minimum value: 0; Maximum value: current age

A9. Think about this most recent time when you had two weeks in a row when you felt this way. How long ago was that?

\_\_\_\_\_ MONTHS in the past (if at present, enter "0"; If less than 1 month, round up to half month and enter 0.5)

Minimum value: 0; Maximum value: 12 x age; Data type: integer or 1 decimal place (only allow 0.5 for half month)

A9.1. How many times you feel like this, that is, when you felt sad or not interested in things for at least two weeks, in your life? \_\_\_\_\_

Minimum value: 0; Maximum value: 999

Page Break (optional)

A10. Did you tell a doctor about these problems? (By "doctor" I mean either a medical doctor or osteopath, or a student in training to be either a medical doctor or osteopath, i.e., medical staff working in a hospital.)

A11. Did you tell any other professional (such as a psychologist, social worker, counsellor, nurse, Clergy, or other helping professional working in non-hospital environment)?

A12. Did you tell your family members or close friends or relatives?

A13. Did you take medication or use drugs or alcohol more than once for these problems?



A14. Did you take any treatments for your condition? (More than one answer can be selected)

Treatments	YES (1)	NO (0)
Psychiatric		
Herbal medicine		
Vitamin or other health products		

A15. How much did these problems interfere with your life or activities -- a lot, some, a little, or not at all

0. A LOT

1. SOME

2. A LITTLE

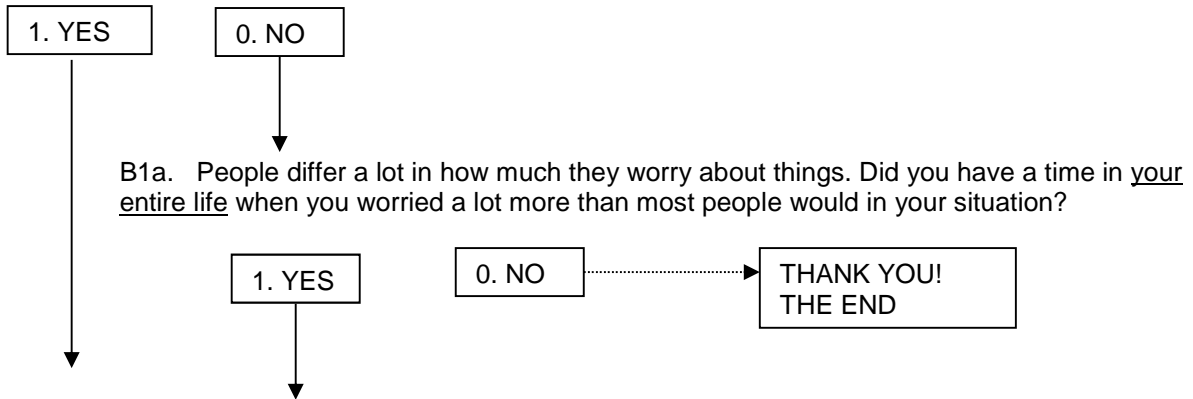
3. NOT AT ALL

THANK YOU!  
(The end)

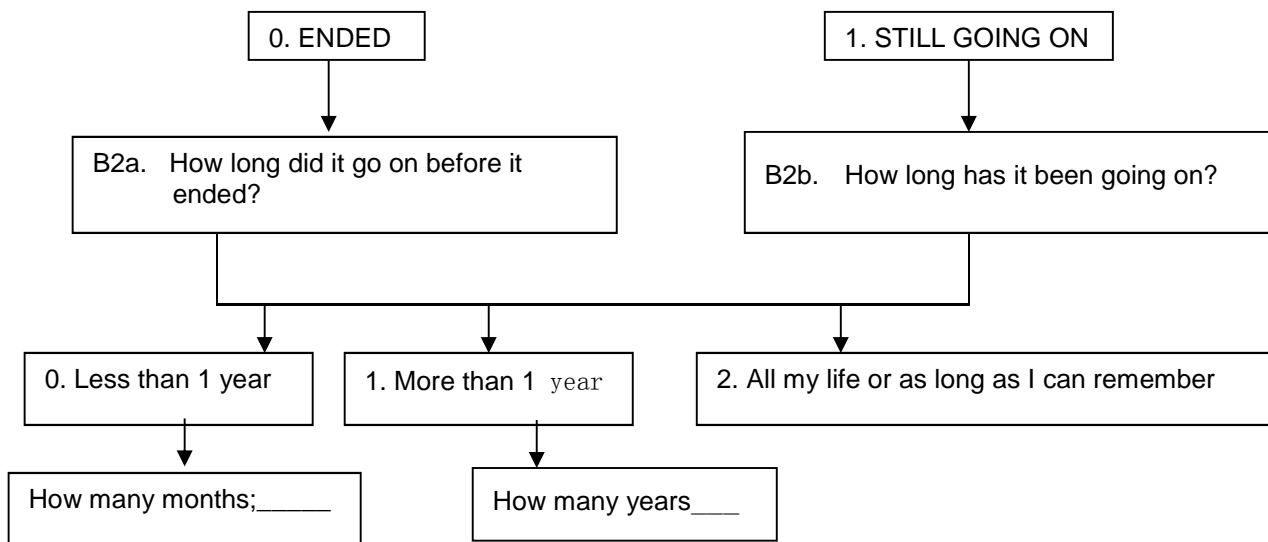
## SECTION B: GENERALIZED ANXIETY DISORDER

The next set of questions cover experiences you may have had at any point in your life. Since these questions cover a long time period, please take your time to think over your entire life before answering.

B1. During your entire life, did you ever have a period lasting one month or longer when most of the time you felt worried, tense, or anxious?



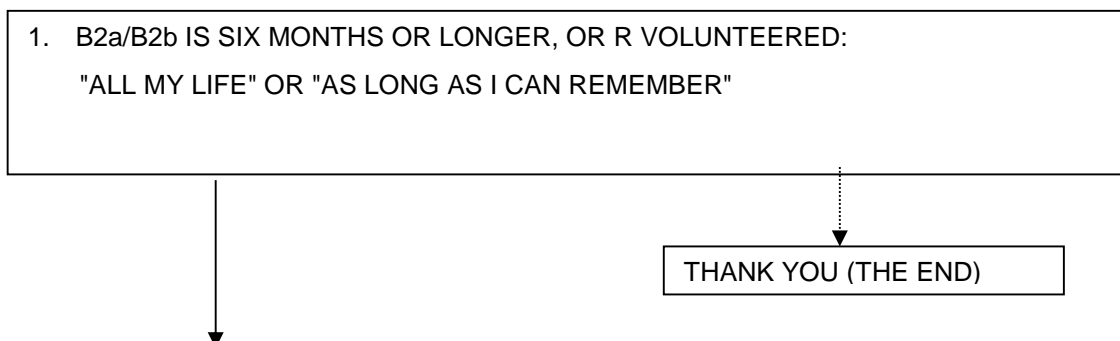
B2. Has that period ended or is it still going on?



Minimum value: 1;  
 Maximum value: 12;  
 Data type: integer  
 Decimal place: 1 (only allow 0.5 for half month)

Minimum value: 1;  
 Maximum value: 99, warning if entry >=50 year  
 Data type: integer  
 Decimal place: 1 (only allow 0.5 for half year)

### INTERVIEWER CHECKPOINT



B3. (During that period, was your/is your) worry stronger than in other people?

1. YES       0. NO

B4. (Did/Do) you worry most days?

1. YES       0. NO

B5. (Did/Do) you usually worry about one particular thing, such as your job security or the failing health of a loved one, or more than one thing?

0. ONE THING       1. MORE THAN ONE THING

B6. (Did/Do) you find it difficult to stop worrying?

1. YES       0. NO

B7. (Did/Do) you ever have different worries on your mind at the same time?

1. YES       0. NO

B8. How often (was/is) your worry so strong that you (couldn't/can't) put it out of your mind no matter how hard you (tried/try) -- often, sometimes, rarely, or never?

0. OFTEN       1. SOMETIMES       2. RARELY       3. NEVER

B9. How often (did/do) you find it difficult to control your worry -- often, sometimes, rarely, or never?

0. OFTEN       1. SOMETIMES       2. RARELY       3. NEVER

B10. What sort of things (did/do) you mainly worry about?

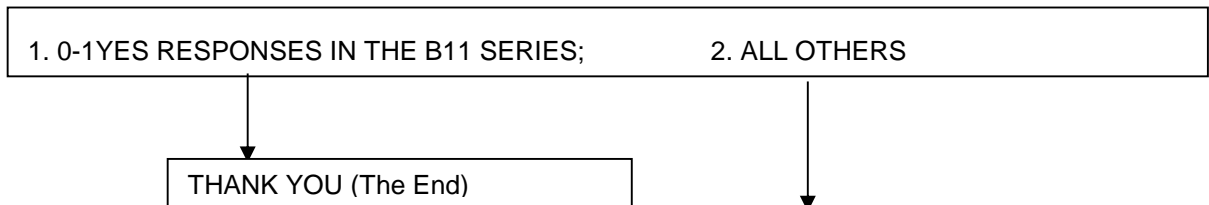
	YES (1)	NO (0)
1. Relationship (spouse, partner, ex-spouse)?		
2. Other family members (including members of spouse family)?		
3. Own children (including step-children, grown up children) or parents (including step-parents)?		
4. Job (course study)?		

	YES (1)	NO (0)
5. Social and/or interpersonal relationships?		
6. Housing/economic situation		
7. Problems other than specified above?		
8. Some terrible things will happen (but nothing has happened yet)		

B11. When you (are/were) worried or anxious, (are/were) you also

	YES (1)	NO (0)
1. Restless?		
2. keyed up or on edge?		
3. easily tired?		
4. have difficulty keeping your mind on what you were doing?		
5. more irritable than usual?		
6. have tense, sore or aching muscles		
7. have trouble falling asleep or staying asleep?		

CHECKPOINT



B12. Did you tell a doctor in hospital about these problems? (By "doctor" I mean either a medical doctor or osteopath, or a student in training to be either a medical doctor or osteopath, i.e., medical staff working in a hospital.)

1. YES

0. NO

B13. Did you tell any other professional (such as a psychologist, social worker, counsellor, nurse, Clergy, or other helping professional working in non-hospital environment)?

1. YES

0. NO

B14. Did you tell your family members or close friends or relatives about these problems?

1. YES

0. NO

B15. Did you take medication or use drugs or alcohol more than once for these problems?

1. YES

0. NO

B16. Did you take any treatments for your condition?

Treatments	YES (1)	NO (0)
Psychiatric		
Herbal medicine		
Vitamin or other health products		

B17. How much did these problems interfere with your life or activities -- a lot, some, a little, or not at all

0. A LOT

1. SOME

2. A LITTLE

3. NOT AT ALL

THANK YOU!  
(The end)