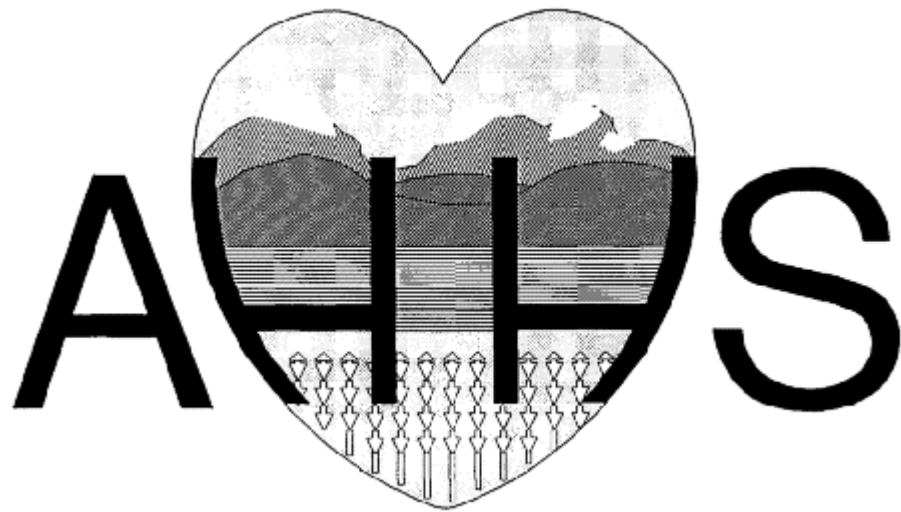


Return to [Canadian Heart Health Database](#) | [Main Page](#)

ALBERTA



HEART HEALTH SURVEY

Reference Number

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Health Unit

Interviewer's Name

Participant's Name

Address

City / Town

Postal Code

Telephone

FIRST BLOOD PRESSURE READING

Blood Pressure Reading **S** / **D**

1. Before this interview, have you ever had your blood pressure checked?

1 ☐ Yes

2 ☐ No **Go to 6**

2. How long ago did you last have your blood pressure checked?

1 ☐ less than 6 months

2 ☐ 6-12 months

3 ☐ over a year

4 ☐ don't know

3. Who checked your blood pressure at that time?

1 ☐ doctor

2 ☐ nurse

3 ☐ family member or friend

4 ☐ coin operated machine

5 ☐ check self

6 ☐ don't know

7 ☐ other (specify) _____

4. Which of the following describes the information you were given: Was it:

1 ☐ described in numbers

2 ☐ described in numbers and in words like high/low/normal

3 ☐ described in words only
- no numbers were used

4 ☐ not described

5 ☐ don't know

Go to 6

5. What was your blood pressure reading in numbers when it was last taken?

S / **D**

0 ☐ Can't remember

6. Were you ever told by a doctor, nurse, or some other health care professional that you had high blood pressure?

1 ☐ Yes

2 ☐ No

3 ☐ Can't remember **Go to 13**

7. Was any treatment or program prescribed for your high blood pressure?

1 ☐ Yes

2 ☐ No

3 ☐ Can't remember **Go to 13**

8. What were you told to do? *Check all that apply. DO NOT READ LIST.*

01 ☐ take medicine only

02 ☐ take medicine and some other treatment

03 ☐ go on a salt free diet

04 ☐ watch weight

05 ☐ avoid stress, slow down and relax

06 ☐ cut down or stop smoking

07 ☐ cut down alcohol intake

08 ☐ start exercise program

09 ☐ use biofeedback

10 ☐ nothing

11 ☐ other treatment (specify) _____

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<p>9. Are you still following that program or are you doing something different?</p> <p>1 <input type="checkbox"/> different program now</p> <p>2 <input type="checkbox"/> same program</p> <p>3 <input type="checkbox"/> not following any program now</p> <p>4 <input type="checkbox"/> don't know</p> <p>5 <input type="checkbox"/> no answer</p> <p style="text-align: right;">Go to 11</p>	<p>12. Have you ever taken medication for your high blood pressure?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p>
<p>10. What program are you now following? <i>Check all that apply. DO NOT READ LIST.</i></p> <p>01 <input type="checkbox"/> take medicine only</p> <p>02 <input type="checkbox"/> take medicine and some other treatment</p> <p>03 <input type="checkbox"/> on a salt free diet</p> <p>04 <input type="checkbox"/> watch weight</p> <p>05 <input type="checkbox"/> avoid stress, slow down and relax</p> <p>06 <input type="checkbox"/> cut down or stop smoking</p> <p>07 <input type="checkbox"/> cut down alcohol intake</p> <p>08 <input type="checkbox"/> exercise program</p> <p>09 <input type="checkbox"/> use biofeedback</p> <p>10 <input type="checkbox"/> none</p> <p>11 <input type="checkbox"/> other treatment (specify) _____</p>	<p>13. As far as you know, is your blood pressure normal now?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p>
<p>11. Are you now taking medication for your high blood pressure?</p> <p>1 <input type="checkbox"/> Yes ——— Go to 13</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p>	<p>14. Do you think that high blood pressure can affect your health?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p> <p style="text-align: right;">Go to 16</p> <p>15. How do you think high blood pressure can affect your health? Record up to three answers given. If respondent is hesitant, probe.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>16. Do you know what things can cause high blood pressure? Record up to three answers given. If respondent is hesitant, probe.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><i>If respondent answers "Food" or "Beverages" to Question 76, go to Question 18.</i></p>

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17. Have you heard anything about high blood pressure being related to things people eat or drink?

1 ☐ Yes

2 ☐ No **Go to "DIABETES"**

18. What things that people eat and drink, do you think are related to high blood pressure?

Check all that apply. DO NOT READ LIST.

01 ☐ salt/salty foods

02 ☐ sodium

03 ☐ alcohol

04 ☐ fats

05 ☐ saturated fats

06 ☐ cholesterol

07 ☐ calories/eating too much

08 ☐ additives/preservatives/food colouring

09 ☐ caffeine/coffee

10 ☐ sugar/sweet foods

11 ☐ starch/starchy foods

12 ☐ pork

13 ☐ specific meat other than pork

14 ☐ meats generally

15 ☐ fried foods/greasy foods/oily foods

16 ☐ calcium

17 ☐ don't know

18 ☐ other (specify) _____

DIABETES

I would like to ask you some questions about diabetes.

19. Have you ever been told by a doctor that you have diabetes?

1 ☐ Yes

2 ☐ No **Go to "ALCOHOL"**

20. How old were you when you were first told you had diabetes?

Enter age

0 ☐ Can't remember

21. Are you now on any treatment for your diabetes?
Check all that apply.

1 ☐ no current treatment

2 ☐ insulin

3 ☐ pills to control blood sugar

4 ☐ diet

5 ☐ weight loss

6 ☐ other (specify) _____

ALCOHOL

Now I would like to ask some questions about alcohol consumption. In the next questions, when we use the word "Drink" it means:

One bottle of beer or glass of draft

One small glass of wine

One shot or mixed drink with hard liquor

22. Have you ever taken a drink of beer, wine, liquor or other alcoholic drink?

1 ☐ Yes

2 ☐ No

Go to "WEIGHT"

3 ☐ Refused I

23. In the past 12 months, have you taken a drink of beer, wine, liquor or other alcoholic drink?

1 ☐ Yes

2 ☐ No

Go to "WEIGHT"

3 ☐ Refused ¹

24. How often, on the average, did you have an alcoholic drink in the past 12 months?

Number of times per week

OR

Number of times per month

0 ☐ Less than once a month

00 ☐ Refused — Go to "WEIGHT"

25. On the days that you drink, how many drinks do you have per day, on the average?

Number of drinks

0 ☐ Don't know

00 ☐ Refused

WEIGHT

I would now like to ask you some questions about your weight.

26. Have you ever tried to lose weight?

1 ☐ Yes

2 ☐ No

27. Are you presently trying to lose weight, gain weight or neither?

1 ☐ lose weight

2 ☐ gain weight

Go to "EATING HABITS"

3 ☐ neither ¹

28. Which of the following are you doing to lose weight? *Check all that apply. READ LIST FROM 1 TO 5.*

1 ☐ dieting

2 ☐ exercising

3 ☐ skipping meals

4 ☐ taking diet pills

5 ☐ attending weight control programs

6 ☐ other (specify) _____

29. Why would you like to lose weight? *Check all that apply. DO NOT READ LIST.*

1 ☐ To become more attractive

2 ☐ To improve general health

3 ☐ To decrease the risk of heart attack

4 ☐ To maintain an acceptable level of blood pressure

5 ☐ To maintain an acceptable level of blood cholesterol

6 ☐ To slow down the hardening of the arteries

7 ☐ To decrease the risk of getting diabetes

8 ☐ other (specify) _____

30. How tall are you without your shoes?

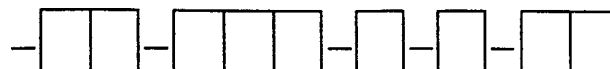
1 Feet / Inches or 2 Centimetres

31. How much do you weigh?

1 Pounds Or 2 Kilograms Note: _____ months pregnant

32. How much would you like to weigh?

1 Pounds or 2 Kilograms



EATING HABITS

Now I would like to ask you some questions about your eating habits.

33. How often would you say salt is added to your food during cooking?

- 1 ☐ often/always
 2 ☐ sometimes
 3 ☐ occasionally
 4 ☐ almost never/never
 5 ☐ don't know

34. How often would you say you add salt to your food at the table?

- 1 ☐ often/always
 2 ☐ sometimes
 3 ☐ occasionally
 4 ☐ almost never/never

35. Do you think that the amount of salt people eat can affect their health?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Don't know
 Go to "FATS"

36. How do you think your health would be affected if you ate too much salt? Check all that apply. *DO NOT READ LIST.*

- 01 ☐ blood pressure would increase
 02 ☐ weight would increase
 03 ☐ ankles may become swollen
 04 ☐ increase the risk of heart attack
 05 ☐ increase the risk of stroke

CONTINUED NEXT COLUMN

- 06 ☐ increase the risk of kidney problems
 07 ☐ need to take blood pressure pills/ medication
 08 ☐ speeds up the hardening of the arteries
 09 ☐ don't know
 10 ☐ other (specify) _____

FATS

I would like to ask you some questions about fats.

37. Another thing found in many foods is fat. Have you heard about any health problems that might be related to how much fat people eat?

- 1 ☐ Yes
 2 ☐ No — Go to "CHOLESTEROL"

38. What health problems do you think might be related to the amount of fat people eat? *Check all that apply. DO NOT READ LIST.*

- 1 ☐ overweight/obesity
 2 ☐ heart disease/coronary disease/heart problems/heart attack
 3 ☐ high blood cholesterol
 4 ☐ high blood pressure
 5 ☐ arteriosclerosis/hardening of the arteries/ fat build-up on the arteries
 6 ☐ don't know
 7 ☐ other (specify) _____

CHOLESTEROL

The next set of questions are about cholesterol.

39. Have you heard about cholesterol?

- 1 ☐ Yes
 2 ☐ No — Go to "SMOKING"

40. What have you heard about cholesterol?

Record up to three answers given. If respondent is hesitant, probe.

41. Do you think that cholesterol is found in foods?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know

} Go to 44

42. Which foods do you think contain cholesterol?

Check all that apply. DO NOT READ LIST.

01 ☐ eggs/egg yolk

02 ☐ poultry

03 ☐ beef

04 ☐ pork

05 ☐ seafoods

06 ☐ milk (specify) _____

07 ☐ cheese (specify) _____

08 ☐ butter

09 ☐ ham

10 ☐ bacon

11 ☐ red meats

12 ☐ fast food (specify) _____

13 ☐ don't know

14 ☐ other (specify) _____

43. Do you think that cholesterol in the foods people eat can affect their health?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know

44. Do you think that cholesterol is found in people's blood?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know

Go to 47

45. Do you think that too much cholesterol in people's blood can affect their health?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know

Go to 47

46. How do you think cholesterol in blood can affect people's health? *Check all that apply. DO NOT READ LIST.*

1 ☐ hardening or clogging of arteries

2 ☐ increase blood pressure

3 ☐ heart attack

4 ☐ stroke

5 ☐ angina (pain in the chest)

6 ☐ don't know

7 ☐ other (specify) _____

47. Have you ever had your blood cholesterol measured?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know

Go to 49

48. Were you told what your blood cholesterol level was?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Can't remember

49. Were you ever told by a doctor, nurse or other health professional that your blood cholesterol was high?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Can't remember
- Go to 52

50. Did the doctor prescribe any treatment or tell you what to do to lower your blood cholesterol?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Can't remember

51. Are you presently on a special diet, which was recommended by a doctor or other health professional, to lower your blood cholesterol?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Can't remember

52. Can you tell me what a person can do to lower his or her blood cholesterol level?

Check all that apply. DO NOT READ LIST.

- 01 ☐ exercise regularly
 02 ☐ control stress and fatigue
 03 ☐ take prescribed medication
 04 ☐ eat food with less cholesterol
 05 ☐ eat less fatty foods

CONTINUED NEXT COLUMN

06 ☐ lose weight

07 ☐ use skim milk or low fat dairy products

08 ☐ nothing

09 ☐ don't know

10 ☐ other (specify) _____

SMOKING

I would now like to ask you some questions about smoking.

53. Have you ever smoked cigarettes, cigars or a pipe?

- 1 ☐ Yes
 2 ☐ No — Go to "EXERCISE"

54. At the present time do you smoke a pipe?

- 1 ☐ Yes
 2 ☐ No — Go to 56

55. At the present time do you smoke a pipe regularly (usually every day) or occasionally (not every day)?

- 1 ☐ Regularly
 2 ☐ Occasionally

56. At the present time do you smoke cigars?

- 1 ☐ Yes
 2 ☐ No — Go to 58

57. At the present time do you smoke cigars regularly (usually every day) or occasionally (not every day)?

- 1 ☐ Regularly
 2 ☐ Occasionally

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<p>58. At the present time do you smoke cigarettes?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No ——— Go to "EXERCISE"</p>	<p>63. How long do you usually exercise? <i>READ THIS LIST.</i></p> <p>1 <input type="checkbox"/> less than 15 minutes</p> <p>2 <input type="checkbox"/> 15 to 30 minutes</p> <p>3 <input type="checkbox"/> 31 to 60 minutes</p> <p>4 <input type="checkbox"/> more than 60 minutes</p> <p>5 <input type="checkbox"/> don't know</p>
<p>59. At the present time do you smoke cigarettes regularly (usually every day) or occasionally (not every day)?</p> <p>1 <input type="checkbox"/> Regularly</p> <p>2 <input type="checkbox"/> Occasionally</p>	<p>64. Does your work require strenuous physical activity?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Can't remember</p> <p>4 <input type="checkbox"/> Not applicable</p>
<p>60. How many cigarettes do you usually smoke per day?</p> <p><input type="text"/> Enter number of cigarettes</p>	<p>HEART DISEASE</p> <p>Now I would like to ask you a few questions about heart disease.</p> <p>65. Can you tell me the major causes of heart disease or heart problems? Check all that apply. <i>DO NOT READ LIST.</i></p> <p>01 <input type="checkbox"/> poor diet</p> <p>02 <input type="checkbox"/> overweight</p> <p>03 <input type="checkbox"/> excess fats</p> <p>04 <input type="checkbox"/> excess salt</p> <p>05 <input type="checkbox"/> high-blood cholesterol level</p> <p>06 <input type="checkbox"/> foods with high cholesterol</p> <p>07 <input type="checkbox"/> excess stress, worry or tension</p> <p>08 <input type="checkbox"/> overwork or fatigue</p> <p>09 <input type="checkbox"/> lack of exercise</p> <p>CONTINUED NEXT COLUMN</p>
<p>EXERCISE</p> <p>The next few questions are about your current physical exercise.</p> <p>61. Do you regularly engage in physical exercise during your leisure time? By regularly we mean at least once a week during the past month.</p> <p>1 <input type="checkbox"/> Yes How many times a week? <input type="text"/></p> <p>2 <input type="checkbox"/> No Go to 64</p> <p>3 <input type="checkbox"/> Can't remember I</p> <p>62. How much of this exercise is strenuous enough to cause sweating or breathing heavily?</p> <p>1 <input type="checkbox"/> Most of it</p> <p>2 <input type="checkbox"/> Some of it</p> <p>3 <input type="checkbox"/> None of it</p>	



- 10 ☐ smoking
- 11 ☐ heredity
- 12 ☐ high blood pressure/hypertension
- 13 ☐ arteriosclerosis/hardening of the arteries
- 14 ☐ don't know
- 15 ☐ other (specify) _____

66. Based upon what you have heard or read, do you believe that heart disease can be prevented?

- 1 ☐ Yes
- 2 ☐ No
- 3 ☐ Don't know

67. Have you ever had a heart attack?
(If necessary explain what a heart attack is).

- 1 ☐ Yes
- 2 ☐ No
- 3 ☐ Don't know

68. Have you ever had a stroke?
(If necessary explain what a stroke is).

- 1 ☐ Yes
- 2 ☐ No
- 3 ☐ Don't know

69. Based upon what you have heard or read, do you believe that strokes can be prevented?

- 1 ☐ Yes
- 2 ☐ No
- 3 ☐ Don't know

70. Do you suffer from any kind of heart disease that you have not yet told me about?

- 1 ☐ Yes What is it? _____
- 2 ☐ No

71. Are you presently taking any medicine for your heart prescribed by a doctor?

- 1 ☐ Yes What type? _____
- 2 ☐ No

Ask to see bottles/prescriptions if possible.

72. **ASK WOMEN ONLY:**

Are you presently taking

- 1 ☐ Oral contraceptives?
What brand name? _____
- 2 ☐ Hormonal pills?
What brand name? _____
- 3 ☐ Neither

Ask to see bottles/prescriptions if possible.

FAMILY HISTORY

Now I would like to ask you some questions about your family's health.

73. Is your father alive?

- 1 ☐ Yes — Go to 75
- 2 ☐ No
- 3 ☐ Don't know — Go to 75

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<p>74. What was the cause of death?</p> <p>1 <input type="checkbox"/> An accident</p> <p>2 <input type="checkbox"/> Cancer</p> <p>3 <input type="checkbox"/> Stroke</p> <p>4 <input type="checkbox"/> Heart attack</p> <p>5 <input type="checkbox"/> Other</p> <p>6 <input type="checkbox"/> Don't know</p>	<p>80. Has (Did) your father had (have) high blood pressure or hypertension?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p>
<p>75. How old is your father? or How old was your father when he died?</p> <p><input type="text"/> <input type="text"/> <input type="text"/></p> <p>0 <input type="checkbox"/> Don't know</p>	<p>81. Has (Did) your father had (have) high cholesterol or high blood fats?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p>
<p>76. Has (Did) your father had (have) a heart attack or angina?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p> <p style="text-align: right;">Go to 78</p>	<p>82. Is your mother alive?</p> <p>1 <input type="checkbox"/> Yes — Go to 84</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know — Go to 84</p>
<p>77. Did this occur before he was 60?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p>	<p>83. What was the cause of death?</p> <p>1 <input type="checkbox"/> An accident</p> <p>2 <input type="checkbox"/> Cancer</p> <p>3 <input type="checkbox"/> Stroke</p> <p>4 <input type="checkbox"/> Heart attack</p> <p>5 <input type="checkbox"/> Other</p> <p>6 <input type="checkbox"/> Don't know</p>
<p>78. Has (Did) your father had (have) strokes or cerebral vascular disease?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p> <p style="text-align: right;">} Go to 80</p>	<p>84. How old is your mother? or How old was your mother when she died?</p> <p><input type="text"/> <input type="text"/> <input type="text"/></p> <p>0 <input type="checkbox"/> Don't know</p>
<p>79. Did this occur before he was 60?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p>	<p>85. Has (Did) your mother had (have) a heart attack or angina?</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>3 <input type="checkbox"/> Don't know</p> <p style="text-align: right;">} Go to 87</p>

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86. Did this occur before she was 60?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Don't know

87. Has (Did) your mother had (have) strokes or cerebral vascular disease?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Don't know

} Go to 89

88. Did this occur before she was 60?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Don't know

89. Has (Did) your mother had (have) high blood pressure or hypertension?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Don't know

90. Has (Did) your mother had (have) high cholesterol or high blood fats?

- 1 ☐ Yes
 2 ☐ No
 3 ☐ Don't know

91. What is the total number of brothers, sisters, half-brothers and half-sisters you have had?

— If zero, Go to 94

99 ☐ Don't know

92. Of these, how many are living?

99 ☐ Don't know

93. How many of your brothers, sisters, half-brothers and half-sisters, whether living or not, have had the following disorders? Do not include "Uncertain or Unknown" responses.

- 1 Heart attack or angina before age 60
 2 High blood pressure or hypertension
 3 Stroke or cerebral vascular disease
 4 High cholesterol or high blood fats

94. How many of your grandparents are living?

99 ☐ Don't know

95. How many of your grandparents, whether living or not, have had the following disorders? Do *not* include "Uncertain or Unknown" responses.

- 1 Heart attack or angina before age 60
 2 High blood pressure or hypertension
 3 Strokes or cerebral vascular disease
 4 High cholesterol or high blood fats

DEMOGRAPHIC INFORMATION

The next few questions let us look at health factors by different groups like age, sex, income and occupation.

96. ENTER RESPONDENTS SEX:

- 1 ☐ Male
 2 ☐ Female

97. What is your date of birth?

Day Month Year

0 ☐ Refused

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98. What is your current employment status? *READ THIS LIST.*

- 1 ☐ full time (35 hours or more a week)
- 2 ☐ part time (less than 35 hours a week)
- 3 ☐ unemployed
- 4 ☐ laid off
- 5 ☐ retired
- 6 ☐ other (specify) _____

7 ☐ homemaker

Go to 100

8 ☐ student

99. What is your occupation? *Check most appropriate. DO NOT READ LIST.*

- 1 ☐ Professional
- 2 ☐ Clerical worker
- 3 ☐ Skilled / foreman
- 4 ☐ Manager, Official Proprietor
- 5 ☐ Sales worker
- 6 ☐ Non-skilled
- 7 ☐ Other (specify) _____

100. What is your current marital status? *READ LIST FROM 1 TO 5.*

- 1 ☐ never married
- 2 ☐ divorced
- 3 ☐ married/common law
- 4 ☐ widowed/widower
- 5 ☐ separated
-
- 6 ☐ refused to answer

101. What is the highest grade or year of school you have completed?

Grade (Elementary, Secondary)

Years (College, University)

If there is some doubt, record the response.

102. To which ethnic or cultural group(s) do you or did your ancestors belong? *Check all that apply.*

01 ☐ English

02 ☐ French

03 ☐ Irish

04 ☐ Scottish

05 ☐ German

06 ☐ Italian

07 ☐ Ukrainian

08 ☐ Dutch (Netherlands)

09 ☐ Chinese

10 ☐ Jewish

11 ☐ Polish

12 ☐ Black

13 ☐ Inuit

14 ☐ North American Indian

15 ☐ Metis

Other ethnic or cultural group(s). For example, Portuguese, Greek, Indian (India), Pakistani, Filipino, Japanese, Vietnamese (specify below).

Other (specify) _____

Other (specify) _____

Other (specify) _____

103. What language did you first speak in childhood?

1 ☐ English

2 ☐ French

3 ☐ Other (specify) _____

104. How many people live in this household?

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105. For statistical purposes only, we need to know the range of your total, gross household income last year. Could you please indicate from the list the income range for your household? *Read this list.*

1 ☐ Under \$12,000

2 ☐ \$12,000 to \$24,999

3 ☐ \$25,000 to \$49,999

4 ☐ \$50,000 and over

5 ☐ Respondent refused to answer

SECOND BLOOD PRESSURE READING

Blood Pressure Reading S D

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