

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

THE SASKATCHEWAN HEART HEALTH SURVEY

Reference Number

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Interviewer's Name

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Participant's Name

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Address

Apt.

Street

City

Postal Code

Telephone

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SHSB Number

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Contact Person #1 for Follow-up Survey

Name

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Address

Apt.

Street

City

Prov.

Postal Code

Telephone

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Contact Person #2 for Follow-up Survey

Name

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Address

Apt.

Street

City

Prov.

Postal Code

Telephone

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First, I would like to ask you a few general questions about heart disease.

1. Can you tell me the major causes of heart disease or heart problems.

Check all that apply.
DO NOT READ LIST.

- 01 ☐ poor diet
- 02 ☐ overweight
- 03 ☐ excess fats
- 04 ☐ excess salt
- 05 ☐ high blood cholesterol
- 06 ☒ foods with high cholesterol
- 07 ☐ excess stress, worry or tension
- 08 ☒ overwork or fatigue
- 09 ☐ lack of exercise
- 10 ☐ smoking
- 11 ☐ heredity
- 12 ☐ high blood pressure/hypertension
- 13 ☐ arteriosclerosis or hardening of the arteries
- 14 ☒ don't know
- 15 ☐ other (specify) _____

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

- 01 yes
- 02 no
- 03 ☐ not sure

BLOOD PRESSURE

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

- 01 yes
- 02 no ---- GO TO Q#8

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

- 01 less than 6 months
- 02 ☒ 6 - 12 months
- 03 over a year
- 04 ☐ don't know

5. Who checked your blood pressure at that time?

- 01 ☒ doctor
- 02 nurse
- 03 ☐ family member or friend
- 04 ☐ coin operated machine
- 05 ☒ check self
- 06 ☒ not sure
- 07 ☐ other (specify)

5. Which of the following describes the information you were given?
Was your blood pressure:

- 01 ☐ described in numbers
- 02 ☐ described in numbers and words like high/low/normal
- 03 ☐ described in words only, no numbers were used
- 04 ☐ not described
- 05 ☐ not sure

GO
TO
Q#8

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

S D

9 ☐ can't remember

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

- 01 ☐ yes
- 02 ☐ no
- 03 ☐ can't remember

GO
TO
Q#15

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

- 01 ☐ yes
- 02 ☐ no
- 03 ☐ can't remember

GO
TO
Q#15

10. What were you told?
Check all that apply.
DO NOT READ LIST.

- 01 ☐ take medicine
- 02 ☐ take medicine and some other treatment
- 03 ☐ go on 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 ☐ other treatment (please specify)

11. Are you still following that program or are you doing something different?

- 01 ☐ different program now
- 02 ☐ same program
- 03 ☐ not following any program now
- 04 ☐ not sure
- 05 ☐ no answer

GO
TO
Q#
15

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12. What program are you now following?

Check all that apply.
DO NOT READ LIST.

- 01 ☐ take medicine
- 02 ☐ take medicine and some other treatment
- 03 ☐ go on 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 ☐ other treatment (please specify)
- _____

13. Are you now taking medication for your high blood pressure?

- 01 **yes** — GO TO Q #15
- 02 no
- 03 not sure

14. Have you ever taken medication for your high blood pressure?

- 01 yes
- 02 no
- 03 ☐ not sure

15. As far as you know is your blood pressure normal now?

- 01 yes
- 02 no
- 03 ☐ not sure

16. Do you think that high blood pressure can affect a person's health?

- 01 yes
- 02 ☐ no
- 03 ☐ not sure — **GO TO Q#18**

17. How do you think high blood pressure can affect your health? **PROBE. Up to three answers given. If respondent hesitant, probe.**

18. Do you know what things can cause high blood pressure?

PROBE. Up to three answers given. If respondent hesitant, probe.

If respondent answers "Food" or "Beverages" to Question 18, go to Question 20.

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

01 ☐ yes

02 ☐ no ---- GO TO
"DIABETES" Q# 21

20. 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

CONTINUED NEXT COLUMN

16 ☐ calcium

17 ☐ red meats

18 ☐ fast foods (specify)

19 ☐ don't know

20 ☐ other (specify)

DIABETES

I would like to ask you some questions about diabetes.

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

01 ☐ yes

02 ☐ no ---- GO TO
"ALCOHOL" Q#24

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

Enter age

95 ☐ Can't remember

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

01 ☐ no current treatment

02 ☐ insulin

03 ☐ pills to control
blood sugar

04 ☐ diet

05 ☐ weight loss

06 ☐ other (specify)

<p>ALCOHOL</p> <p>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, glass of draft, or can of beer One small glass of wine One shot or mixed drink with hard liquor.</p> <p>24. Have you ever taken a drink of beer, wine, liquor or other alcoholic drink?</p> <p>01 yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> Refused</p> <p style="text-align: right;">} GO TO "WEIGHT" Q #28</p>	<p>27. On the days that you drink, how many drinks do you have per day on the average?</p> <p><input type="text"/> <input type="text"/> Number of drinks</p> <p>01 <input type="checkbox"/> Don't know</p> <p>02 <input type="checkbox"/> refused ---- GO TO "WEIGHT" Q#28</p>
<p>25. In the past 12 months, have you taken a drink of beer, wine, liquor or other alcoholic drink?</p> <p>01 yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> Refused</p> <p style="text-align: right;">} GO TO "WEIGHT" Q #28</p>	<p>WEIGHT</p> <p>I would like to ask you some questions about your weight.</p> <p>28. Have you ever tried to lose weight?</p> <p>01 yes</p> <p>02 <input type="checkbox"/> no</p> <p>29. Are you presently trying to lose weight, gain weight, or neither?</p> <p>01 <input type="checkbox"/> lose weight</p> <p>02 <input type="checkbox"/> gain weight</p> <p>03 <input type="checkbox"/> neither</p> <p style="text-align: right;">} GO TO "EATING HABITS" Q #33</p>
<p>26. How often, on the average, did you have an alcoholic drink in the past 12 months?</p> <p><input type="text"/> <input type="text"/> Number of times per week</p> <p style="text-align: center;">OR</p> <p><input type="text"/> <input type="text"/> Number of times per month</p> <p>1 <input type="checkbox"/> less than once a month</p> <p>2 <input type="checkbox"/> refused ---- GO TO "WEIGHT" Q #28</p>	<p>30. Which of the following are you doing to lose weight? Check all that apply. Read list from 1 to 5.</p> <p>01 <input type="checkbox"/> dieting</p> <p>02 <input type="checkbox"/> exercising</p> <p>03 <input type="checkbox"/> skipping meals</p> <p>04 <input type="checkbox"/> taking diet pills</p> <p>05 attending weight control programs</p> <p>06 <input type="checkbox"/> something else (specify) _____</p>

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31. Why would you like to lose weight?

Check all that apply.

DO NOT READ LIST.

- 01 ☐ to become more attractive
- 02 ☐ to improve general health
- 03 ☐ to decrease risk of heart attack
- 04 ☐ to maintain an acceptable level of blood pressure
- 05 ☐ to maintain an acceptable level of blood cholesterol
- 06 ☐ to slow down hardening of the arteries
- 07 ☐ to decrease the risk of getting diabetes
- 08 ☐ other (specify)
- _____
- _____

32. How much would you like to weigh?

							or					
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Pounds

Kilograms

EATING HABITS

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

33. Of the following types of milk, which do you usually drink?

READ THE LIST.

- 01 ☐ whole or homo milk
- 02 ☐ 2% milk
- 03 ☐ 1% milk
- 04 ☐ skim milk
- 05 ☐ I don't drink milk

34. Of the following types of spreads, which do you usually use?

READ THE LIST.

- 01 ☐ butter
- 02 ☐ hard margarine
- 03 ☐ butter-margarine blend
- 04 ☐ soft margarine
- 05 ☐ "light" or diet margarine
- 06 ☐ I don't use butter or margarine

35. How often do you eat meats such as beef, pork or veal?

READ THE LIST.

- 01 ☐ 1 to 3 times a week
- 02 ☐ 4 to 6 times a week
- 03 ☐ usually once a day
- 04 ☐ more than once a day
- 05 ☐ I don't eat meat

<p>36. When you eat meat or poultry, do you trim off the fat or remove the skin READ THE LIST.</p> <p>01 <input type="checkbox"/> all the time</p> <p>02 <input type="checkbox"/> occasionally</p> <p>03 <input type="checkbox"/> never</p>	<p>40. When you buy ground beef, do you buy.... READ THE LIST.</p> <p>01 <input type="checkbox"/> regular</p> <p>02 <input checked="" type="checkbox"/> lean</p> <p>03 <input checked="" type="checkbox"/> extra lean</p>
<p>37. How many eggs do you eat each week? READ THE LIST.</p> <p>01 <input type="checkbox"/> less than one</p> <p>02 <input type="checkbox"/> 1 to 3</p> <p>03 <input type="checkbox"/> 4 to 7</p> <p>04 <input type="checkbox"/> more than 7</p>	<p>41. Do you add salt to your food when cooking..... READ THE LIST.</p> <p>01 <input type="checkbox"/> always</p> <p>02 <input type="checkbox"/> occasionally</p> <p>03 <input type="checkbox"/> never</p>
<p>38. In your home, do you do any cooking or baking?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input checked="" type="checkbox"/> no ----- GO TO Q# 42</p>	<p>42. Do you add salt to your food at the table? READ THE LIST.</p> <p>01 <input type="checkbox"/> always</p> <p>02 <input type="checkbox"/> occasionally</p> <p>03 <input checked="" type="checkbox"/> never</p>
<p>39. When you cook OR bake, which of the following types of fat do you usually use? READ THE LIST.</p> <p>01 <input type="checkbox"/> corn, sunflower, safflower, soy oil</p> <p>02 <input checked="" type="checkbox"/> canola, olive oil</p> <p>03 <input type="checkbox"/> hard margarine</p> <p>04 <input type="checkbox"/> shortening and/or blended vegetable oil</p> <p>05 <input type="checkbox"/> butter, lard, meat drippings</p>	<p>43. Do you think that the amount of salt people eat can affect their health?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input checked="" type="checkbox"/> don't know</p> <p style="text-align: right;">} GO TO "FATS " Q #49</p>

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14. How would your health 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
- 06 ☐ increase the risk of kidney problems
- 07 ☐ need to take blood pressure pills or medication
- 08 ☐ speeds up hardening of the arteries
- 09 ☐ other (specify) _____

45. How often do you eat fried, deep fried or breaded foods? READ THE LIST.

- 01 ☐ less than once a week
- 02 ☐ 1 to 2 times a week
- 03 ☐ 3 to 4 times a week
- 04 ☐ more than 4 times a week
- 05 ☐ I don't eat fried or breaded foods

46. How many times a day do you eat fruits and vegetables? READ THE LIST.

- 01 ☐ less than once a day
- 02 ☐ 1 to 2 times
- 03 ☐ 3 to 4 times
- 04 ☐ more than 4 times

47. How many times a day do you eat breads and cereals? READ THE LIST.

- 01 ☐ less than once a day
- 02 ☐ 1 to 2 times
- 03 ☐ 3 to 4 times
- 04 ☐ more than 4 times

48. How many times a day do you eat oat bran, oat meal and legumes (baked beans, peas, lentils): READ THE LIST.

- 01 ☐ less than once a day
- 02 ☐ 1 to 2 times
- 03 ☐ 3 to 4 times
- 04 ☐ more than 4 times

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FATS

I would like to ask you some questions about fats.

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

01 ☐ yes

02 ☐ no/not sure -- GO TO
"CHOLESTEROL" Q #51

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

01 ☐ overweight/obesity

02 ☐ heart disease/ coronary
disease/ heart problems/
heart attack

03 ☐ high blood cholesterol

04 ☐ high blood pressure

05 ☐ arteriosclerosis/
hardening of the
arteries

06 ☐ not sure

07 ☐ other (specify) _____

CHOLESTEROL

The next set of questions are about cholesterol.

51. Have you heard about cholesterol?

01 ☐ yes

02 ☐ no --GO TO SMOKING Q#65

52. What have you heard about cholesterol?

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

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

01 ☐ yes

02 ☐ no

03 ☐ don't know } GO TO
Q #55

54. 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 ☐ sea foods

06 ☐ milk (specify) _____

07 ☐ cheese (specify) _____

08 ☐ butter

09 ☐ ham

10 ☐ bacon

11 ☐ red meats

12 ☐ fast foods (specify) _____

13 ☐ don't know

14 ☐ other (specify) _____

<p>55. Do you think that cholesterol in the foods people eat can affect their health?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> don't know</p>	<p>59. Have you ever had your blood cholesterol measured?</p> <p>01 yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> not sure</p> <p style="text-align: right;">} GO TO Q #61</p>
<p>56. Do you think that cholesterol is found in peoples blood?</p> <p>01 yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> don't know</p> <p style="text-align: right;">} GO TO Q # 59</p>	<p>60. Were you told what your blood cholesterol level was?</p> <p>01 yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> can't remember</p>
<p>57. Do you think that too much cholesterol in blood can affect peoples health?</p> <p>01 yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> don't know</p> <p style="text-align: right;">} GO TO Q #59</p>	<p>61. Were you ever told by a doctor, nurse or other health professional that your blood cholesterol was high?</p> <p>01 yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> can't remember</p> <p style="text-align: right;">} GO TO Q #64</p>
<p>58. How do you think cholesterol in blood can affect peoples' health? Check all that apply. DO NOT READ LIST.</p> <p>01 <input type="checkbox"/> hardening or clogging of arteries</p> <p>02 <input type="checkbox"/> increased blood pressure</p> <p>03 <input type="checkbox"/> heart attack</p> <p>04 <input type="checkbox"/> stroke</p> <p>05 <input type="checkbox"/> angina (pain in the chest)</p> <p>06 <input type="checkbox"/> other (specify) _____</p>	<p>62. Did the doctor prescribe any treatment or tell you what to do to lower your blood cholesterol?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> can't remember</p> <p>63. Are you presently on a special diet, which was recommended by a doctor or other health professional, to lower your blood cholesterol?</p> <p>01 yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> can't remember</p>

<p>64. 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.</p> <p>01 <input type="checkbox"/> exercise regularly</p> <p>02 <input type="checkbox"/> control stress and fatigue</p> <p>03 <input type="checkbox"/> take prescribed medicine</p> <p>04 <input type="checkbox"/> eat food with less cholesterol</p> <p>05 <input type="checkbox"/> eat less fatty foods</p> <p>06 <input type="checkbox"/> lose weight</p> <p>07 <input type="checkbox"/> use skim milk or low fat dairy products</p> <p>06 <input type="checkbox"/> <u>other (specify)</u></p>	<p>68. At the present time do you smoke cigars?</p> <p>01 yes</p> <p>02 no --- GO TO Q# 70</p>
<p>SMOKING I would now like to ask you some questions about smoking.</p> <p>65. Have you ever smoked cigarettes, cigars or a pipe?</p> <p>01 yes</p> <p>02 no -- GO TO "EXERCISE" Q #73</p>	<p>69. At the present time do you smoke a cigar regularly (usually every day) or occasionally (not every day)?</p> <p>01 <input type="checkbox"/> regularly</p> <p>02 <input type="checkbox"/> occasionally</p>
<p>66. At the present time do you smoke a pipe?</p> <p>01 yes</p> <p>02 no -- GO TO Q #68</p>	<p>70. At the present time do you smoke cigarettes?</p> <p>01 yes</p> <p>02 no ---- GO TO "EXERCISE" Q #73</p>
<p>67. At the present time do you smoke a pipe regularly (usually every day) or occasionally (not every day)?</p> <p>01 regularly</p> <p>02 <input type="checkbox"/> occasionally</p>	<p>71. At the present time do you smoke cigarettes regularly (usually every day) or occasionally (not every day)?</p> <p>01 regularly</p> <p>02 <input type="checkbox"/> occasionally</p> <p>72. How many cigarettes do you usually smoke per day?</p> <p><input type="text"/> <input type="text"/> Enter number of cigarettes</p>

EXERCISE

The next few questions are about your current physical activities.

YOUR LIFESTYLE

73. In a typical week, how many hours do you spend doing the following activities?

		hours per week					
		0	1-2	3-4	5-9	10-14	15+
01	watching television	1	2	3	4	5	6
02	reading	1	2	3	4	5	6
03	crafts or hobbies done mainly on your own	1	2	3	4	5	6
04	visiting with relatives	1	2	3	4	5	6
05	visiting with friends	1	2	3	4	5	6
06	attending cultural events such as musical performances or plays	1	2	3	4	5	6
07	organizing or coaching physical activity or sports programs as a volunteer	1	2	3	4	5	6
08	involvement with religious groups or church activity	1	2	3	4	5	6
09	involvement in service or fraternal organizations such as hospital auxilliary, Rotary or Shriners	1	2	3	4	5	6
10	involvement with social or entertainment groups such as a card club or cooking club	1	2	3	4	5	6
11	Other group activities (Please specify) Activity _____	1	2	3	4	5	6
	Activity _____	1	2	3	4	5	6

74. Does your spouse (or partner) exercise regularly?

01 yes

02 no

03 ☐ I don't have one

75. Of your other relatives and friends, how many exercise regularly?

01 friends

02 relatives

03 ☐ none exercise regularly

PHYSICAL ACTIVITY IN YOUR SPARE TIME

76. The following activities refer to physical activities that are not related to work. Have you done any of the following physical activities in the past 12 months?

Please indicate whether the participant has done each activity listed below. Then for those activities which he/she has done, please complete the number of times done each month, and the average time spent on each occasion (not counting travel time, changing, etc.).

	no	yes	No. of times each month												Average time Per Occasion	
			J	F	M	A	M	J	J	A	S	O	N	D	Hr	Min
01 Walking for exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
02 Jogging or running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
03 Home exercises																
04 Exercise class																
05 Ice skating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
06 Crosscountry skiing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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			J	F	M	A	M	J	J	A	S	O	N	D	Hr	Min
07 Downhill skiing	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
08 Ice hockey	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
09 Swimming	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
10 Gardening, yard work	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
11 Golf	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
12 Tennis, badminton	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
			J	F	M	A	M	J	J	A	S	O	N	D	Hr	Min
13 Weight training	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
14 Baseball, softball	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
15 Popular or social dance	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
16 Bowling	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
17 Snow shovelling	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
Please list any other activities that you have done in the past 12 months.																
	no	yes	J	F	M	A	M	J	J	A	S	O	N	D	Hr	Min
	<input type="checkbox"/>	<input type="checkbox"/>														
	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														
	no	yes														
	<input type="checkbox"/>	<input type="checkbox"/>														

<p>77. Compared to other people your age <u>when you were 15 Years old</u>, would you say you were.....</p> <p>01 <input type="checkbox"/> more physically active</p> <p>02 <input type="checkbox"/> equally physically active</p> <p>03 <input type="checkbox"/> less physically active</p>	<p>HEART DISEASE Now I would like to ask you a few questions about your health.</p> <p>CHEST PAIN ON EFFORT</p> <p>81. Have you ever had any pain or discomfort in your chest?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no ---- GO TO Q #91</p>						
<p>78. Compared to the way other people your age now spend their spare time, would you say you are.....</p> <p>01 <input type="checkbox"/> more physically active</p> <p>02 <input type="checkbox"/> equally physically active</p> <p>03 <input checked="" type="checkbox"/> less physically active</p>	<p>82. Do you get it when you walk uphill or hurry?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no ----- GO TO Q #91</p>						
<p>79. In the past 12 months, have you suffered an injury that has limited your physical activity?</p> <p>01 Cl yes</p> <p>02 Cl no -- GO TO Q #81</p>	<p>83. Do you get it when you walk at an ordinary pace on the level?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p>						
<p>30. During which months did this injury limit your physical activity?</p> <p>J F M A M J</p> <table border="1" data-bbox="240 1527 418 1596"> <tr> <td></td> <td></td> <td></td> </tr> </table> <p>J A S O N D</p> <table border="1" data-bbox="490 1655 669 1723"> <tr> <td></td> <td></td> <td></td> </tr> </table>							<p>84. What do you do if you get it while you are walking?</p> <p>01 <input type="checkbox"/> stop or slow down</p> <p>02 <input type="checkbox"/> carry on --GO TO Q #91</p> <p>Record "stop or slow down" if the subject carries on after taking nitroglycerine.</p> <p>85. If you stand still, what happens to it?</p> <p>01 <input type="checkbox"/> relieved</p> <p>02 <input checked="" type="checkbox"/> not relieved-GO TO Q91</p> <p>86. How soon?</p> <p>01 <input type="checkbox"/> 10 minutes or less</p> <p>02 <input type="checkbox"/> more than 10 minutes</p>

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<p>87. Will you show me where it is?</p> <p>01 <input type="checkbox"/> sternum upper/middle</p> <p>02 <input type="checkbox"/> sternum lower</p> <p>03 <input type="checkbox"/> left anterior chest</p> <p>04 <input type="checkbox"/> left arm</p> <p>05 <input type="checkbox"/> other _____</p> <p>Record all areas mentioned.</p>	<p>93. What did he say it was?</p> <p>01 <input type="checkbox"/> heart attack</p> <p>02 <input type="checkbox"/> other disorder</p>
<p>88. Do you feel it anywhere else?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p>	<p>94. Have you ever had a heart attack? (If necessary, explain what a heart attack is)</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> uncertain</p> <p style="text-align: right;">] GO TO Q #97</p>
<p>89. Did you see a doctor because of this pain or discomfort?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no ---GO TO Q #91</p>	<p>35. How old were you when you had your first heart attack?</p> <p><input type="text"/> <input type="text"/></p>
<p>90. What did he say it was?</p> <p>01 <input type="checkbox"/> angina</p> <p>02 <input type="checkbox"/> other</p>	<p>36. Were you hospitalized for your most recent heart attack?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> uncertain</p>
<p>POSSIBLE INFARCTION</p> <p>91. Have you ever had a severe pain across the front of your chest lasting for half an hour or more?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no --- GO TO Q #97</p>	<p>97. Have you ever had a stroke? (if necessary explain what a stroke is)</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> not sure</p>
<p>92. Did you see a doctor because of this pain?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no ---GO TO Q #94</p>	<p>38. Based on what you have heard do you believe that strokes can be prevented?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> not sure</p>

<p>99. Do you suffer from any kind of heart disease that you have not yet told me about?</p> <p>01 yes -- what is it? _____</p> <p>02 <input type="checkbox"/> no</p>	<p>103. Does this pain ever begin when you are standing still or sitting?</p> <p>01 yes--GO TO Q #111</p> <p>02 <input type="checkbox"/> no</p>
<p>100. Are you presently taking any medicine for your heart prescribed by a doctor?</p> <p>01 yes ----- what type? _____</p> <p>02 <input type="checkbox"/> no</p> <p>Ask to see bottles/prescriptions if possible.</p>	<p>104. In what part of your leg do you feel it?</p> <p>01 <input type="checkbox"/> pain includes calf/calves</p> <p>2 <input type="checkbox"/> pain does not include calf/calves ----- GO TO Q #111</p> <p>If calves not mentioned, ask: anywhere else?</p>
<p>101. ASK WOMEN ONLY: Are you presently taking.....</p> <p>01 <input type="checkbox"/> oral contraceptives -- what brand name? _____</p> <p>02 <input type="checkbox"/> hormonal pill ----- what brand name? _____</p> <p>03 <input type="checkbox"/> neither</p> <p>Ask to see bottles or prescriptions if possible.</p>	<p>105. Do you get it if you walk uphill or hurry?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> never hurries or walks uphill</p>
<p>INTERMITTENT CLAUDICATION</p> <p>102. Do you feel pain in either leg on walking?</p> <p>01 yes</p> <p>02 no -- GO TO Q #111</p>	<p>106. Do you get it if you walk at an ordinary pace on the level?</p> <p>01 yes</p> <p>02 no</p>
	<p>107. Does the pain ever disappear while you are walking?</p> <p>01 yes --- GO TO Q#111</p> <p>02 no</p> <p>108. What do you do if you get it when you are walking?</p> <p>01 <input type="checkbox"/> stop or slow down</p> <p>02 <input type="checkbox"/> carry on --- GO TO Q#111</p>

<p>109. What happens to it if you stand still?</p> <p>01 <input type="checkbox"/> relieved</p> <p>02 <input type="checkbox"/> not relieved</p>	<p>114. Has (Did) your father had (have) a heart attack or angina?</p> <p>01 yes</p> <p>02 no</p> <p>03 unknown</p> <p style="text-align: right;">1 GO TO Q #116</p>
<p>110. How soon?</p> <p>01 <input type="checkbox"/> 10 minutes or less</p> <p>02 <input type="checkbox"/> more than 10 minutes</p>	<p>115. Did this occur before he was 60?</p> <p>01 yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> unknown</p>
<p>FAMILY HISTORY</p> <p>Now I would like to ask you some questions about your family's health.</p> <p>111. Is your father alive?</p> <p>01 yes -- GO TO Q #113</p> <p>02 no</p> <p>03 <input type="checkbox"/> unknown or uncertain</p>	<p>116. Has (Did) your father had (have) strokes or cerebral vascular disease?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> unknown</p> <p style="text-align: right;">1 GO TO Q #118</p>
<p>112. What was the cause of death?</p> <p>01 <input type="checkbox"/> an accident</p> <p>02 <input type="checkbox"/> cancer</p> <p>03 <input type="checkbox"/> stroke</p> <p>04 <input type="checkbox"/> heart attack</p> <p>05 <input type="checkbox"/> other</p> <p>06 <input type="checkbox"/> unknown or uncertain</p>	<p>117. Did this occur before he was 60?</p> <p>01 yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> unknown</p>
<p>113. How old is your father? or How old was your father when he died?</p> <p><input type="text"/> <input type="text"/></p>	<p>118. Has (Did) your father had (have) high blood pressure or hypertension?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> unknown</p>

<p>119. Has (Did) your father had (have) high cholesterol or high blood fats?</p> <p>01 yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> unknown</p>	<p>24. Did this occur before she was 60?</p> <p>01 yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> unknown</p>
<p>120. Is your mother alive?</p> <p>01 yes -- GO TO Q # 122</p> <p>02 no</p> <p>03 <input type="checkbox"/> unknown or uncertain</p>	<p>25. Has (Did) your mother had (have) strokes or cerebral vascular disease?</p> <p>01 yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> unknown-1</p> <p style="text-align: right;">GO TO Q #127</p>
<p>L21. What was the cause of death?</p> <p>01 <input type="checkbox"/> an accident</p> <p>02 cancer</p> <p>03 <input type="checkbox"/> stroke</p> <p>04 heart attack</p> <p>05 <input type="checkbox"/> other</p> <p>06 <input type="checkbox"/> unknown or uncertain</p>	<p>127. Did this occur before she was 60?</p> <p>01 <input type="checkbox"/> yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> unknown</p>
<p>122. How old is your mother? or How old was your mother when she died?</p> <p><input type="text"/> <input type="text"/></p>	<p>L27. Has (Did) your mother had (have) high blood pressure or hypertension?</p> <p>01 yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> unknown</p>
<p>123. Has (Did) your mother had (have) a heart attack or angina?</p> <p>01 yes</p> <p>02 no</p> <p>03 <input type="checkbox"/> unknown</p> <p style="text-align: right;">1 GO TO Q #125</p>	<p>128. Has (Did) your mother had (have) high cholesterol or high blood fats?</p> <p>01 yes</p> <p>02 <input type="checkbox"/> no</p> <p>03 <input type="checkbox"/> unknown</p>

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

130. Of these, how many are living?

131. How many of your brothers or sisters, or half-brothers and half-sisters, whether living or not, have had the following disorders?

Do not include "Uncertain" or "Unknown" responses.

- 01 Heart attack or angina before age 60
- 02 High blood pressure or hypertension
- 03 Strokes, cerebral vascular disease
- 04 High cholesterol, high blood fats

132. What is the total number of your father's brothers, sisters, half-brothers, and half-sisters?

133. Of these, how many are living?

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

- 01 Heart attack or angina before age 60
- 02 High blood pressure or hypertension
- 03 Strokes, cerebral vascular disease
- 04 High cholesterol, high blood fats

L35. What is the total number of your mother's brothers, sisters, half-brothers, and half-sisters?

136. Of these, how many are living?

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

- 01 Heart attack or angina before age 60
- 02 High blood pressure or hypertension
- 03 Strokes, cerebral vascular disease
- 04 High cholesterol, high blood fats

138. How many of your grandparents are living?

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

- 01 Heart attack or angina before age 60
- 02 High blood pressure or hypertension
- 03 Strokes, cerebral vascular disease
- 04 High cholesterol, high blood fats

DEMOGRAPHIC INFORMATION

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

140. ENTER RESPONDENT'S SEX:

- 01 ☐ Male
- 02 ☐ Female

141. What is your date of birth?

<input type="text"/>	<input type="text"/>	<input type="text"/>
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day month year

- 01 ☐ refused

142. What is your current employment status?
READ THIS LIST.

- 01 ☐ full time (35 hours or more a week)
- 02 ☐ part time (less than 35 hours a week)
- 03 ☐ unemployed
- 04 ☐ laid off
- 05 ☐ retired
- 06 ☐ other (specify) _____
- 07 ☐ homemaker
- 08 ☐ student

GO TO
Q #144

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143. What is your occupation?
(specify)

DO NOT READ LIST.

Check most appropriate box.

- 01 ☐ professional
- 02 ☐ clerical worker
- 03 ☐ skilled/foreman
- 04 ☐ manager, official proprietor
- 05 ☐ sales worker
- 06 ☒ non-skilled
- 07 ☐ other (specify)
- _____

146. What language did you first speak in childhood?

- 01 ☐ english
- 02 ☐ french
- 03 ☒ other (specify)
- _____

147. How many people live in this household?

1

148. 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 of your household?

READ THIS LIST.

- 01 ☐ under \$12,000
- 02 ☐ \$12,000 to \$24,999
- 03 ☐ \$25,000 to \$49,999
- 04 ☐ \$50,000 and over
- 05 ☐ refused to answer

144. What is your marital status?

Read list from 1 to 5.

- 01 ☐ never married
- 02 ☐ divorced
- 03 ☒ married/common law
- 04 ☐ widow/widower
- 05 ☐ separated
- 06 ☒ refused to answer

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

1

Grade (Elementary, Secondary)

1

Years (College, University)

If there is some doubt, record the response.
