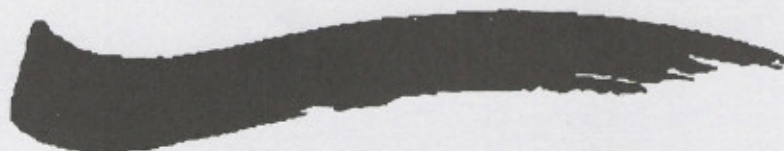


women's
health
a u s t r a l i a



We want to hear from YOU

YOUR views and experiences are important

Please complete the survey and send it back to us soon!

women's health *is about how you are feeling*

Please answer every question by circling the appropriate number next to your answer. If you are unsure about how to answer a question, please give the closest answer to how you feel.

The questions on the first page ask only about NOW - how your health is NOW and about how your health limits certain activities NOW.

1 In general, would you say your health is
(Circle one number only)

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2 Compared to one year ago, how would you rate your health in general now?
(Circle one number only)

Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same as one year ago	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

3 The following questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much? (Circle one number on each line)

	Yes limited a lot	Yes limited a little	No not limited at all
a VIGOROUS activities such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
c Lifting or carrying groceries	1	2	3
d Climbing SEVERAL flights of stairs	1	2	3
e Climbing ONE flight of stairs	1	2	3
f Bending, kneeling or stooping	1	2	3
g Walking MORE THAN ONE kilometre	1	2	3
h Walking HALF a kilometre	1	2	3
i Walking 100 metres	1	2	3
j Bathing or dressing yourself	1	2	3

4 During THE PAST 4 WEEKS, have you had any of the following problems with your work (including your work outside the home and housework) or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?

(Circle one number on each line)

	Yes	No
a Cut down on the amount of time you spent on work or other activities	1	2
b Accomplished less than you would like	1	2
c Were limited in the kind of work or other activities	1	2
d Had difficulty performing the work or other activities (for example it took extra effort)	1	2

5 During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

(Circle one number on each line)

	Yes	No
a Cut down on the amount of time you spent on work or other activities	1	2
b Accomplished less than you would like	1	2
c Didn't do work or other activities as carefully as usual	1	2

6 During the PAST 4 WEEKS, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups?

(Circle one number only)

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

7 How much BODILY pain have you had during the PAST 4 WEEKS?

(Circle one number only)

No bodily pain	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very severe	6

8 During the past four weeks, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

(Circle one number only)

Not at all	1
A little bit	2
Moderately	3
Quite a bit	4
Extremely	5

9 For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS
(Circle one number on each line)

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a	Did you feel full of life	1	2	3	4	5	6
b	Have you been a very nervous person	1	2	3	4	5	6
c	Have you felt so down in the dumps that nothing could cheer you up	1	2	3	4	5	6
d	Have you felt calm and peaceful	1	2	3	4	5	6
e	Did you have a lot of energy	1	2	3	4	5	6
f	Have you felt down	1	2	3	4	5	6
g	Did you feel worn out	1	2	3	4	5	6
h	Have you been a happy person	1	2	3	4	5	6
i	Did you feel tired	1	2	3	4	5	6

10 During the PAST 4 WEEKS, how much of the time has your **PHYSICAL HEALTH OR EMOTIONAL PROBLEMS** interfered with your social activities (like visiting with friends, relatives, etc)?
(Circle one number only)

All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5

11 How TRUE or FALSE is EACH of the following statements for you?
(Circle one number on each line)

		Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a	I seem to get sick a little easier than other people	1	2	3	4	5
b	I am as healthy as anybody I know	1	2	3	4	5
c	I expect my health to get worse	1	2	3	4	5
d	My health is excellent	1	2	3	4	5

women's health *is about using health services*

12 How many times have you consulted the following for YOUR OWN HEALTH in the LAST 12 MONTHS?

(Circle one number on each line)

	None	Once or twice	Three or four times	Five or six times	Seven or more times
a Family doctor or another general practitioner	0	1	2	3	4
b Hospital doctor (eg as an outpatient or in casualty)	0	1	2	3	4
c Specialist doctor	0	1	2	3	4
d Allied health professional (eg optician, dentist, physiotherapist, podiatrist, dietitian, counsellor etc)	0	1	2	3	4
e "Alternative" health practitioner (eg chiropractor, naturopath, acupuncturist, herbalist etc)	0	1	2	3	4
f Family Planning service	0	1	2	3	4
g Sexual health service	0	1	2	3	4

13 Here are some questions about your MOST RECENT VISIT to a general practitioner. How would you rate each of the following?

(Circle one number on each line)

	Excellent	Very good	Good	Fair	Poor
a The convenience of the location of the surgery	1	2	3	4	5
b The length of time you waited in the waiting room	1	2	3	4	5
c The personal manner (courtesy, respect, sensitivity, friendliness) of the doctor	1	2	3	4	5
d The doctor's explanation of your problem and treatment	1	2	3	4	5
e The doctor's interest in how you felt about having the tests, treatment or the advice given	1	2	3	4	5
f Your opportunity to ask all the questions you wanted to	1	2	3	4	5
g The amount of time you spent with the doctor	1	2	3	4	5
h The cost of your visit	1	2	3	4	5
i The visit overall	1	2	3	4	5

14 In general do you prefer to see a female doctor?

(Circle one number only)

Yes always	Yes, but only for certain things	No	Don't care
1	2	3	4

15 Have you ever been told by a doctor that you have:

(Circle one number on each line)

		Yes	No
a	Diabetes (high blood sugar)	1	2
b	Heart disease	1	2
c	Hypertension (high blood pressure)	1	2
d	Low iron level	1	2
e	Asthma	1	2
f	Cancer <i>(Please specify type)</i>	1	2
g	Other major illness <i>(Please specify on line)</i>	1	2

16 Have you ever been told by a doctor that you have any sexually transmissible disease (STD)?

(Circle one number on each line)

		Yes	No	Don't want to answer
a	Chlamydia	1	2	3
b	Genital herpes	1	2	3
c	Genital warts (HPV)	1	2	3
d	Other STD <i>(Please specify on line)</i>	1	2	3

17 This question is about health care

(Circle one number on each line)

		Yes	No
a	Have you been admitted to hospital in the LAST 12 MONTHS?	1	2
b	Do you have private hospital insurance?	1	2
c	Do you have private health insurance for ancillary services (eg dental, physiotherapy etc)?	1	2

18 During the PAST 4 WEEKS, how many different types of medication (eg tablets/medicine) have you used which were:

(Circle one number on each line)

		None	One	Two	Three	Four or more
a	Prescribed by a doctor	0	1	2	3	4
b	Bought without a prescription at the chemist, supermarket or health food shop	0	1	2	3	4
c	For any chronic (long-term) illness	0	1	2	3	4

19 When did you last have a Pap test?
A Pap test (cervical smear) is a routine test carried out by a doctor or nurse during an internal (vaginal) examination. (Circle one number only)

- I have never had a Pap test 1
- Less than 2 years ago 2
- 2 - 5 years ago 3
- More than 5 years ago 4
- Not sure 5

If never go to question 21

20 Have you EVER had an abnormal Pap test?
(Circle one number only)

- Yes 1
- No 2

21 Are you currently pregnant?
(Circle one number only)

- Yes 1
- No 2
- Don't know 3

22 How many times have you:
(Circle one number on each line)

- Never
- Once
- Twice
- Three times
- Four or more times
- Don't want to answer

- | | | | | | | | |
|---|------------------------|---|---|---|---|---|---|
| a | Been pregnant | 0 | 1 | 2 | 3 | 4 | 5 |
| b | Had a miscarriage | 0 | 1 | 2 | 3 | 4 | 5 |
| c | Had a termination | 0 | 1 | 2 | 3 | 4 | 5 |
| d | Given birth to a child | 0 | 1 | 2 | 3 | 4 | 5 |

23 What sort of contraception do you use now?
(Circle one number only)

- Don't need to use any (eg pregnant or no sex) 1
- Choose not to use any (eg want to be pregnant) 2
- Oral contraceptive pill 3
- Condoms 4
- Other *(Please specify on line)* 5

24 For how many years in total have you EVER taken the oral contraceptive pill?
(Circle one number only)

- Never used 1
- Less than one year 2
- 1 - 4 years 3
- 5 years or more 4

25 Are you currently using:
(Circle one number on each line)

- | | | | |
|---|--|-----|----|
| | | Yes | No |
| a | condoms for STD/HIV prevention | 1 | 2 |
| b | the oral contraceptive pill for reasons other than contraception | 1 | 2 |

women's health *is about coping with common problems*

26 a In the LAST 12 MONTHS have you had any of the following:

b If you have had any of these problems, were you satisfied with the health services available to help you deal with this problem? If you did not seek help, circle 3.

(Circle one number on each line, here)

(Circle one number on each line)

	Never	Rarely	Sometimes	Often	Yes	No	Not applicable
a Allergies, hayfever, sinusitis	1	2	3	4	1	2	3
b Asthma	1	2	3	4	1	2	3
c Headaches/migraines	1	2	3	4	1	2	3
d Constant tiredness	1	2	3	4	1	2	3
e Back pain	1	2	3	4	1	2	3
f Urine that burns or stings	1	2	3	4	1	2	3
g Leaking urine	1	2	3	4	1	2	3
h Constipation	1	2	3	4	1	2	3
i Haemorrhoids (piles)	1	2	3	4	1	2	3
j Other bowel problems	1	2	3	4	1	2	3
k Vaginal discharge or irritation	1	2	3	4	1	2	3
l Premenstrual tension	1	2	3	4	1	2	3
m Irregular monthly periods	1	2	3	4	1	2	3
n Heavy periods	1	2	3	4	1	2	3
o Severe period pain	1	2	3	4	1	2	3
p Skin problems	1	2	3	4	1	2	3
q Difficulty sleeping	1	2	3	4	1	2	3

women's health *is about coping with stress*

27 Over the LAST 12 months, how stressed have you felt about the following areas of your life:

(Circle one number on each line)

		Not applicable	Not at all stressed	Somewhat stressed	Moderately stressed	Very stressed	Extremely stressed
a	Own health	1	2	3	4	5	6
b	Health of other family members	1	2	3	4	5	6
c	Work/Employment	1	2	3	4	5	6
d	Living arrangements	1	2	3	4	5	6
e	Study	1	2	3	4	5	6
f	Money	1	2	3	4	5	6
g	Relationship with parents	1	2	3	4	5	6
h	Relationship with partner/spouse	1	2	3	4	5	6
i	Relationship with other family members	1	2	3	4	5	6
j	Relationships with boyfriends	1	2	3	4	5	6
k	Relationships with girlfriends	1	2	3	4	5	6
l	Anything else (<i>Please specify on line</i>)	1	2	3	4	5	6

28 When you feel stressed, do you use any of the following methods to reduce stress?

(Circle one number on each line)

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
a	Walking, exercise or working out	1	2	3	4	5
b	Music, reading, sleeping, meditation	1	2	3	4	5
c	Talking to a good friend	1	2	3	4	5
d	Writing, drawing or creative activity	1	2	3	4	5
e	Being alone, watching TV	1	2	3	4	5
f	Letting off steam, eg throwing things, slamming doors, etc	1	2	3	4	5
g	Smoking, using drugs or alcohol	1	2	3	4	5
h	Eating more or less	1	2	3	4	5

29 In the LAST 12 MONTHS, have you experienced any of the following events?

(Circle one number on each line)

		Yes	No
a	Major personal illness	1	2
b	Major personal injury	1	2
c	Major surgery (not including dental work)	1	2
d	Pregnancy	1	2
e	Birth of your first child	1	2
f	Starting a new, close personal relationship	1	2
g	Problem in a close personal relationship	1	2
h	Break-up of a close personal relationship	1	2
i	Getting married (or starting to live with someone)	1	2
j	Infidelity of partner or spouse	1	2
k	Becoming a sole parent	1	2
l	Increased hassling with parents	1	2
m	Serious conflict between members of your family	1	2
n	Parents getting divorced, separated or remarried	1	2
o	Partner/close family member/close friend having trouble with alcohol	1	2
p	Death of partner or close family member	1	2
q	Death of a close friend	1	2
r	Leaving home for the first time	1	2
s	Beginning university, college or training program	1	2
t	Exam stress	1	2
u	Difficulty finding a job	1	2
v	Beginning/resuming work outside the home	1	2
w	Change in your type of work/hours/conditions/responsibilities at work	1	2
x	Distressing harassment at work	1	2
y	Loss of job	1	2
z	Parent losing a job	1	2
aa	Decreased income	1	2
bb	Natural disaster (fire, flood, drought, earthquake etc) or house fire	1	2
cc	Major loss or damage to personal property	1	2
dd	Being robbed	1	2
ee	Involvement in a serious accident	1	2
ff	Being pushed, grabbed, shoved, kicked or hit	1	2
gg	Being forced to take part in unwanted sexual activity	1	2
hh	Legal troubles or involved in a court case	1	2
ii	Family member/close friend being arrested/in gaol	1	2

30 Which of the following best describes your smoking status NOW?
 (Please circle one number here and follow instructions)

- 1 I have never smoked Go to Q35
- 2 I used to smoke Go to Q31
- 3 I now smoke occasionally Go to Q32a
- 4 I now smoke regularly Go to Q32a

31 If you used to smoke, how long ago did you give up smoking?
 (Circle one number or write years on line)

- Within the last 6 months 77
- 6 - 12 months ago 88
- _____ years ago

Go to question 32b

32a If you NOW smoke, how many cigarettes do you usually smoke in a day?
 (Write number on line)

_____ a day

OR

32b If you used to smoke, how many cigarettes did you usually smoke in a day?
 (Write number on line)

_____ a day

33 At what age did you start smoking?
 (Write years on line)

_____ years

34 Have you ever smoked daily for six months or more?
 (Circle one number only)

- | | |
|------------|-----------|
| Yes | No |
| 1 | 2 |

35 How often do you usually drink alcohol?
 (Circle one number only)

- I never drink alcohol 1
- I drink rarely 2
- Less than once a week 3
- On 1 or 2 days a week 4
- On 3 or 4 days a week 5
- On 5 or 6 days a week 6
- Every day 7

If never go to question 38

36 On a day when you drink alcohol, how many drinks do you usually have?
 (Circle one number only)

- 1 or 2 drinks per day 1
- 3 or 4 drinks per day 2
- 5 - 8 drinks per day 3
- 9 or more drinks per day 4

37 How often do you have five or more drinks of alcohol on one occasion?
 (Circle one number only)

- Never 1
- Less than once a month 2
- About once a month 3
- About once a week 4
- More than once a week 5

women's health *is about healthy weight and shape*

- 38 How tall are you without shoes? _____ cms OR _____ ft _____ ins
- 39 How much do you weigh without clothes or shoes? _____ kgs OR _____ stones _____ pounds
- 40 How would you describe yourself now?
(Circle one number only)
- | | |
|----------------------|---|
| Very underweight | 1 |
| Underweight | 2 |
| Slightly underweight | 3 |
| Average | 4 |
| Slightly overweight | 5 |
| Overweight | 6 |
| Very overweight | 7 |
| Don't know | 8 |
- 41 When you were a child (say age 10) how would you describe your weight?
(Circle one number only)
- | | |
|----------------------|---|
| Very underweight | 1 |
| Underweight | 2 |
| Slightly underweight | 3 |
| Average | 4 |
| Slightly overweight | 5 |
| Overweight | 6 |
| Very overweight | 7 |
| Don't know | 8 |
- 42 How much would you LIKE to weigh?
(Circle one number only)
- | | |
|-----------------|---|
| Over 5 kg more | 1 |
| 1 - 5 kg more | 2 |
| Happy as I am | 3 |
| 1 - 5 kg less | 4 |
| 6 - 10 kg less | 5 |
| Over 10 kg less | 6 |
- 43 Have you EVER dieted to lose weight?
(Circle one number only)
- | | |
|-----|---|
| Yes | 1 |
| No | 2 |
- If no, go to Q46
- 44 How often have you gone on a diet, (that is, limited how much you ate) in order to lose weight DURING THE LAST YEAR?
(Circle one number only)
- | | |
|--------------------------------------|---|
| Never | 1 |
| 1-4 times | 2 |
| 5-10 times | 3 |
| More than 10 times | 4 |
| I am always on a diet to lose weight | 5 |

45 How old were you when you first dieted to lose weight? If you are not sure, what is your best guess? _____ years
 (Write number on line)

46 Have you ever
 (Circle one number on each line)

		Yes	No
a	LOST 5 kg or more on purpose	1	2
b	LOST 5 kg or more without wanting to	1	2

IF YOU HAVE NEVER LOST 5 KGS, GO TO QUESTION 48

47 Have you regained that lost weight?
 (Circle one number only)

Yes	1
No	2

48 In the past month how dissatisfied have you felt about
 (Circle one number on each line)

		Not at all		Slightly		Moderately		Markedly
a	Your weight	0	1	2	3	4	5	6
b	Your shape	0	1	2	3	4	5	6

49 Have there been times when you felt that you have eaten what other people would regard as an unusually large amount of food GIVEN THE CIRCUMSTANCES?
 (Circle one number only)

Yes, in the past month	1
Yes, more than one month ago	2
No	3

If no, go to Q52

50 During these times of overeating did you have a sense of having lost control over your eating, that is, feeling that you couldn't stop eating once you had started?
 (Circle one number only)

Yes	1
No	2

If no, go to Q52

51 Can you say how old you were when you first started overeating like this? If you are not sure, what is your best guess? _____ years
 (Write years on line)

52 Have you used any of the following to CONTROL YOUR WEIGHT OR SHAPE?

(Circle one number on each line)

	Yes, in the past month	Yes, more than one month ago	Never
a Vomited on purpose after eating	1	2	3
b Laxatives	1	2	3
c Diuretics	1	2	3
d Fasting (not eating food for at least a day)	1	2	3

53 In a NORMAL week, how many times do you engage in VIGOROUS exercise lasting for 20 minutes or more? (exercise which makes you breathe harder or puff and pant, such as netball, squash, jogging, aerobics, vigorous swimming, etc.)

(Circle one number only)

Never	1
Once a week	2
Two or three times a week	3
Four, five or six times a week	4
Once every day	5
More than once every day	6

54 In a NORMAL week, how many times do you engage in LESS VIGOROUS exercise which lasts for 20 minutes or more? (exercise which does not make you breathe harder or puff and pant, like walking, gardening, swimming and lawn bowls)

(Circle one number only)

Never	1
Once a week	2
Two or three times a week	3
Four, five or six times a week	4
Once every day	5
More than once every day	6

55 In the course of your WORK (paid or unpaid) how many times in a NORMAL week would your work involve exertion for MORE THAN 20 MINUTES WITHOUT STOPPING, that is, exertion which makes you breathe harder and puff or pant?

(Circle one number only)

Never	1
Once a week	2
Two or three times a week	3
Four, five or six times a week	4
Once every day	5
More than once every day	6

56 How often do you eat takeaway food?

(Circle one number only)

Never	1
Less than once a month	2
About once a month	3
About once a week	4
More than once a week	5
Almost every day	6

women's health *is about juggling time*

57 Which of the following BEST describes your MAIN current employment status? If you are studying AND working, circle the number corresponding to your MAIN activity.
(Circle one number only)

- In full time paid work
- In part time or casual paid work
- Work without pay (eg in a family business)
- Home duties only - no paid work
- Studying
- Unemployed - looking for work
- Unpaid voluntary work
- Unable to work due to sickness or injury
- Other *(Please specify on line)*

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9

If in full or part time paid work go to question 58

If no paid work go to question 62

58 How many hours do you normally spend in all your PAID jobs each week?
(Circle one number only)

- 1 - 15 hours 1
- 16 - 24 hours 2
- 25 - 34 hours 3
- 35 - 40 hours 4
- 41 - 48 hours 5
- 49 hours or more 6

59 Do you normally do paid shift work?
(Circle one number only)

- Yes 1
- No 2

60 Do you normally do paid work at night?
(Circle one number only)

- Yes 1
- No 2

61 Is your home your normal ("paid work") work-place? *(Circle one number only)*

- Yes 1
- No 2

62 How often do you feel rushed/pressured/ too busy?
(Circle one number only)

- Every day 1
- A few times a week 2
- About once a week 3
- About once a month 4
- Never 5

63 How often do you feel you have time on your hands that you don't know what to do with?
(Circle one number only)

- Every day 1
- A few times a week 2
- About once a week 3
- About once a month 4
- Never 5

GO TO QUESTION 62, ON THIS PAGE

64 How happy are you with the amount of time you spend in the following aspects of your life?

(Circle one number on each line)

Time spent:

		Happy the way it is	Would like to do more	Would like to do less	Not applicable (Don't do this)
a	In paid work	1	2	3	4
b	In ACTIVE leisure (eg sport, art, drama, music)	1	2	3	4
c	In PASSIVE leisure (eg reading, TV, writing letters)	1	2	3	4
d	Studying	1	2	3	4
e	Doing voluntary work	1	2	3	4
f	In religious activities	1	2	3	4
g	Sleeping	1	2	3	4
h	Alone	1	2	3	4

65 Are you happy with YOUR SHARE of the following tasks and activities?

(Circle one number on each line)

		Happy the way it is	Would like other family members to do more	Would prefer another arrangement	Not applicable (Don't do this)
a	Domestic work (shopping, cooking, cleaning etc)	1	2	3	4
b	Child care	1	2	3	4
c	Caring for another adult (who is elderly/disabled/sick)	1	2	3	4
d	Other household work (gardening, home/car maintenance)	1	2	3	4

66 What is your main occupation? (If you are a student, circle the occupation you are studying for)

(Circle one number only)

Manager or administrator (including shop manager, farm manager)	1
Professional (including artist, teacher)	2
Para-professional (including technician, pilot, police etc)	3
Tradesperson (including gardener, hairdresser)	4
Clerk (including telephonist, secretary)	5
Sales and personal service worker (including child care worker, enrolled nurse)	6
Machine operator or driver	7
Manual worker (including cleaner, caretaker)	8
Never had a paid job	9
Other (Please specify on line)	10

women's health *is about family and friends*

67 Who lives with you?

(Circle one number on each line)

		Yes	No
a	No-one, I live alone	1	2
b	Partner/spouse	1	2
c	Own children	1	2
d	Someone else's children	1	2
e	Parents	1	2
f	Brothers/sisters	1	2
g	Other adult relatives	1	2
h	Other adults who are not family members	1	2

If live alone, go to question 69

IF YOU HAVE NO CHILDREN LIVING WITH YOU, GO TO QUESTION 69

68 Most parents need someone to care for their children when they cannot. How satisfied are you with your child care arrangements?

(Circle one number only)

Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	Not applicable
1	2	3	4	5

69 Do you regularly PROVIDE care or assistance (eg personal care, transport) to any other person because of their long-term illness, disability or frailty?

(Circle one number only)

Yes	No
1	2

70 Do you regularly NEED help with daily tasks because of a long-term illness or disability (eg help with personal care, getting around, preparing meals etc)?

(Circle one number only)

Yes	No
1	2

If no go to Q 72

71 How satisfied are you with the help you receive for your own personal care?

(Circle one number only)

Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
1	2	3	4

72 These questions are about getting on with other people:

(Circle one number on each line)

		Yes	No
a	Has anyone close to you tried to hurt you or harm you recently	1	2
b	Are you sad or lonely often	1	2
c	Do you feel that nobody wants you around	1	2
d	Does anyone in your family drink a lot of alcohol	1	2
e	Are you afraid of anyone in your family	1	2
f	Do you have enough privacy at home	1	2
g	Have you ever been in a violent relationship with a partner/spouse	1	2
h	Has anyone close to you called you names or put you down or made you feel bad recently	1	2

73 Now some questions about your family and friends

(Circle one number on each line)

		Hardly ever	Some of the time	Most of the time
a	Does it seem that your family and friends (ie people who are important to you) understand you?	1	2	3
b	Can you talk about your deepest problems with at least some of your family and friends?	1	2	3

74 Other than members of your family, how many persons in your local area do you feel you can depend on or feel very close to?

(Circle one number only)

None	1
1-2 people	2
More than 2 people	3

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75 What is your date of birth?

(Write date on line below)

___ ___ ___ ___ 1 9 ___ ___
 Day Month Year

76 How old were you when you left school?

(Please include both full and part time schooling. Circle one number only)

- Still at school 1
- Never attended school 2
- 14 years or less 3
- 15 -16 years 4
- 17 -18 years 5
- 19 years or older 6

77 Are you currently attending an educational institution?

(Circle one number only)

- No 1
- Yes, part-time student 2
- Yes, full-time student 3

78 What is the highest qualification you have completed?

(Circle one number only)

- No formal qualifications 1
- School Certificate (Year 10 or equivalent) 2
- Higher School Certificate (Year 12 or equivalent) 3
- Trade/apprenticeship (eg Hairdresser, Chef) 4
- Certificate/diploma (eg Child Care, Technician) 5
- University degree 6
- Higher University degree (eg Grad Dip, Masters, PhD) 7

79 Are you of Aboriginal or Torres Strait Islander origin?

(Circle one number only)

- No 1
- Aboriginal 2
- Torres Strait Islander 3

80 In which country were you born?

(Circle one number only)

- Australia 1
- United Kingdom 2
- Italy 3
- Greece 4
- New Zealand 5
- Vietnam 6
- Other *(Please specify on line)* 7

If Australia go to Q82

81 If you were not born here, when did you first arrive in Australia with the intention of living here for one year or more?

(Circle one number only)

- 1975 or earlier 1
- 1976 - 1985 2
- 1986 - 1990 3
- 1991 or later 4

82 Do you usually speak a language other than English AT HOME?

(Circle one number only)

- No, I speak only English at home 1
- Yes, Italian 2
- Yes, Greek 3
- Yes, Cantonese 4
- Yes, Mandarin 5
- Yes, German 6
- Yes, Arabic 7
- Yes, other *(Please specify on line)* 8

If no go to Q84

83 How well do you speak English?

(Circle one number only)

- | | |
|------------|---|
| Very well | 1 |
| Well | 2 |
| Not well | 3 |
| Not at all | 4 |

84 What is your PRESENT marital status?

(Circle one number only)

- | | |
|------------------------|---|
| Married | 1 |
| Defacto (opposite sex) | 2 |
| Defacto (same sex) | 3 |
| Separated | 4 |
| Divorced | 5 |
| Widowed | 6 |
| Never married | 7 |

85 How do you manage on the income you have available?

(Circle one number only)

- | | |
|----------------------------------|---|
| It is impossible | 1 |
| It is difficult all the time | 2 |
| It is difficult some of the time | 3 |
| It is not too bad | 4 |
| It is easy | 5 |

86 Which of the following best describes your housing situation? Do you live in:

(Circle one number only)

- | | |
|---------------------------------------|---|
| A house | 1 |
| A flat/unit/apartment | 2 |
| A caravan/tent/cabin/houseboat | 3 |
| Other <i>(Please specify on line)</i> | 4 |
-

87 In whose name is the ownership/ purchasing agreement/ tenancy agreement?

(Circle one number only)

- | | |
|---------------------------------------|---|
| Self | 1 |
| Partner/spouse | 2 |
| Partner/spouse and self together | 3 |
| Parents or other family members | 4 |
| Self and others | 5 |
| Not applicable | 6 |
| Other <i>(Please specify on line)</i> | 7 |
-

88 What is your postcode?

____ _

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89 When you are 35, would you like to be:
(Circle one number only)

- In full-time paid employment 1
 - In part-time paid employment and part-time work at home 2
 - In full-time unpaid work in the home 3
 - Other (Please specify on line) 4
-

90 When you are 35, what would be your ideal job?
(Please specify on line)

91 When you are 35, would you like to be:
(Circle one number only)

- Married 1
 - In a stable relationship but not married 2
 - Single and not in a stable relationship 3
 - Other (Please specify on line) 4
-

94 In general, are you satisfied with what you have achieved in your life so far in the areas of:
(Circle one number on each line)

		Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
a	Work/career/study	1	2	3	4
b	Family relationships	1	2	3	4
c	Partner/closest personal relationship	1	2	3	4
d	Friendships	1	2	3	4
e	Social activities	1	2	3	4

92 When you are 35, would you like to have:
(Circle one number only)

- No children 1
- 1 or 2 children 2
- More than 2 children 3

93 When you are 35, would you like to have more educational qualifications than you have now?
(Circle one number only)

- Yes 1
- No 2
- Not sure 3

Have we missed anything? If you have ANYTHING else you would like to tell us, please write on the lines below.

- * *If you need help to answer any of the questions ring our Freecall number 1800 068 081*
- * *If you are concerned about any of your health experiences and would like some help, please contact:*
 - *Your nearest Women's Health Centre or Community Health Centre*
 - *Your general practitioner for advice about who would be the best person in your community for you to talk to*
- * *If you feel distressed NOW and would like someone to talk to, you could ring Lifeline on 131114 (local call)*

*Thank you very much for taking the time to complete this survey.
Please fold the survey in half and place it in the reply-paid envelope.*

DON'T FORGET TO ENCLOSE THE CONSENT FORM

as we will need this to contact you again.

You are a valuable contributor to this women's health research.

Don't forget to let us know your new address if you move!

If you have any questions you can contact us by telephoning

1800 068 081 (This is a FREECALL number)

or writing to us at the address below.

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