



WOMEN'S HEALTH OF AUSTRALIA SURVEY

Thank you for participating in this important study.

Please read [this](#) important information about your survey.

▶What is your ID number?


## INSTRUCTIONS

- Please answer every question you can. If you are unsure about how to answer a question, mark the response for the closest answer to how you feel.
- Please answer the survey for the time period indicated even if you are pregnant or your circumstances are unusual in some way.
- Questions marked with a star are compulsory. Often this is because your response will alter the path of the survey, tailoring it so that unnecessary content is skipped.
- If you need help to answer any questions, please ring 1800 068 081 (This is a FREECALL number).
- If you are concerned about any of your health experiences and would like some help, you may like to contact:
  - your nearest Women's Health Centre or Community Health Centre
  - your doctor 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 131 114 (local call).



LOGIN

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▶ What is your date of birth?   
(dd/mm/yyyy)



RESUME LATER



0% Complete



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▶Are you living overseas?

- Yes
- No



RESUME LATER



2% Complete



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Do you need to update your contact details?

Please let us know your new details if you move, change your name or email address.

Your details

Title		Home Phone	
Given Names		Work Phone	
Preferred Name		Mobile	
Family Name		Email	
Maiden Name			

Postal Address

Building address or CV-details	
Address	
Suburb	
State	
Postcode	

Residential Address

Building address or CV-details	
Address	
Suburb	
State	
Postcode	

▶ Please check the box for any details that you'd like to change.

- Name(s)
- Email & Phone information
- Address



RESUME LATER



2% Complete



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**Thanks for submitting your personal details.**

The survey for our research starts here. Please click the next arrow to continue.



RESUME LATER



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## Women's health is about you and your life

### 1 ▶ In general, would you say your health is:

(Mark *one only*)

- Excellent
- Very good
- Good
- Fair
- Poor

### 2 ▶ Where do you get information about your health?

(Mark *all that apply*)

- School, University, TAFE, work
- Friends
- Internet
- Journal articles, textbooks, books
- Mother / father / sister / brother or other family member
- Nurse
- Doctor
- Family planning or sexual health clinic
- Youth or community services (e.g. mother's group)
- Other health professionals
- TV / radio, magazines, poster / leaflet
- None of these**

### 3 ▶ In general, do you prefer to see a female doctor?

(Mark *one only*)

- Yes, always
- Yes, but only for certain things
- No
- Don't care



RESUME LATER



14% Complete



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4 In the last 12 months, have you had any of the following:  
(Mark one on each line)

	Never	Rarely	Sometimes	Often
Allergies, hay fever, sinusitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breathing difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



RESUME LATER



15% Complete



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5 In the last 12 months, have you had any of the following:

(Mark *one* on each line)

	Never	Rarely	Sometimes	Often
Headaches / migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Severe tiredness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stiff or painful joints	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problems with one or both feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



RESUME LATER



17% Complete



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6 In the last 12 months, have you had any of the following:  
 (Mark one on each line)

	Never	Rarely	Sometimes	Often
Difficulty sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Episodes of intense anxiety (eg panic attacks)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other mental health problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Palpitations (feeling that your heart is racing or fluttering in your chest)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



RESUME LATER



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7 In the last 12 months, have you had any of the following:  
 (Mark one on each line)

	Never	Rarely	Sometimes	Often
Vaginal discharge or irritation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Premenstrual tension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irregular periods	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heavy periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Severe period pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



RESUME LATER



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8 In the last 12 months, have you had any of the following:  
*(Mark one on each line)*

	Never	Rarely	Sometimes	Often
Urine that burns or stings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Leaking urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Haemorrhoids (piles)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other bowel problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



RESUME LATER



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

9 ▶ **Have you ever been diagnosed with or treated for:**

*(Mark all that apply)*

- Depression
- Anxiety disorder
- Post-traumatic stress disorder (PTSD)
- Anorexia
- Bulimia
- Other eating disorder
- Bipolar disorder
- Obsessive Compulsive Disorder
- Borderline Personality Disorder
- Other major mental illness (please specify)
- None of these conditions**



RESUME LATER



24% Complete



10▶ **Have you ever been diagnosed with or treated for:**

*(Mark all that apply)*

- Insulin dependent (Type 1) diabetes Non-
- insulin dependent (Type 2) diabetes Heart
- disease
- Hypertension (high blood pressure)
- Low iron (iron deficiency or anaemia)
- Asthma
- Bronchitis
- Endometriosis
- Thrombosis
- Polycystic Ovary Syndrome
- Skin cancer
- Other major physical illness (please specify)
- None of these conditions**



RESUME LATER



25% Complete



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11 ▶ **Have you ever been diagnosed with or treated for:**

*(Mark all that apply)*

- Urinary tract infection
- Thrush or yeast infection
- Chlamydia
- Gonorrhoea
- Genital herpes
- Genital warts (HPV)
- Hepatitis B or C
- None of these conditions**



RESUME LATER



25% Complete



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12 ▶ Have you consulted the following services for your own health in the last 12 months?  
 (Mark *one* on each line)

	Yes	No
A chiropractor	<input type="radio"/>	<input type="radio"/>
An osteopath	<input type="radio"/>	<input type="radio"/>
▪ A massage therapist	<input type="radio"/>	<input type="radio"/>
An acupuncturist	<input type="radio"/>	<input type="radio"/>
A naturopath/herbalist	<input type="radio"/>	<input type="radio"/>
Another alternative health practitioner (eg aromatherapist, homeopath, reflexologist, iridologist)	<input type="radio"/>	<input type="radio"/>
A midwife	<input type="radio"/>	<input type="radio"/>
A counsellor or other mental health worker	<input type="radio"/>	<input type="radio"/>
A community nurse, practice nurse or nurse practitioner	<input type="radio"/>	<input type="radio"/>
A physiotherapist	<input type="radio"/>	<input type="radio"/>



RESUME LATER



26% Complete



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13 ▶ How often have you used the following therapies for your own health in the last 12 months?  
 (Mark one on each line)

	Never	Rarely	Sometimes	Often
Vitamins/minerals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yoga or meditation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Herbal medicines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Aromatherapy oils	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chinese medicines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other alternative therapies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



RESUME LATER



29% Complete



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## Women's health is about reproductive health

### 14▶ Have you ever had vaginal sex?

*This means penis in vagina sex.*

- Yes
- No
- I prefer not to answer



RESUME LATER



31% Complete



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15 ▶ How old were you when you first had vaginal sex?

(Age in years)

years old

16 ▶ Thinking about the LAST TIME you had vaginal sex, did you use any of the following?  
(Mark all that apply)

- The Pill
- Condoms
- Implanon
- Mirena
- Other contraceptive
- None



RESUME LATER



32% Complete



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17 ▶ **Have you ever become pregnant by accident?**

*(Mark one only)*

- Yes
- No
- I prefer not to answer



RESUME LATER



33% Complete



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## Women's health is about using health services

18 ▶ Within the last two years, have you had:  
(Mark one on each line)

	Yes	No
A Pap test?	<input type="radio"/>	<input type="radio"/>
▪ Your blood pressure checked?	<input type="radio"/>	▪ <input type="radio"/>
Your skin checked (eg spots, lesions, moles)?	<input type="radio"/>	<input type="radio"/>
Your weight checked by a health professional	<input type="radio"/>	<input type="radio"/>



RESUME LATER



33% Complete



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19 ▶ **Do you have a Health Care Card?** This is a card that entitles you to discounts and assistance with medical expenses. This is not the same as a Medicare card.  
(Mark one only)



Yes  No



RESUME LATER



35% Complete



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## Women's health is about lifestyle choices

20 ▶ How often do you currently smoke cigarettes or any tobacco products?  
(Mark *one only*)

- Daily
- At least weekly (but not daily)
- Less often than weekly
- Not at all



RESUME LATER



35% Complete



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21 ▶ **If you smoke daily, on average how many cigarettes do you smoke EACH DAY?**

*(Type the number in the box)*

cigarettes per day

22 ▶ **If you smoke, but not daily, on average how many cigarettes do you smoke PER WEEK?**

*(Type the number in the box)*

cigarettes per week



RESUME LATER



37% Complete



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23 ▶ **At what age did you start smoking tobacco?**

*Type the number in the box*

years old



RESUME LATER



37% Complete



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24 ▶ In your lifetime, would you have smoked at least 100 cigarettes (or equivalent)?

Yes	No
<input type="radio"/>	<input type="radio"/>



RESUME LATER



36% Complete



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25 ▶ **Have you ever smoked DAILY?**

*(Mark one only)*

- Yes
- No



RESUME LATER



38% Complete



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26 ▶ **At what age did you start smoking DAILY?**

Type the number in the box

years old

27 ▶ **At what age did you finally stop smoking DAILY?**

(TYPE age in the box)

▪  years old



RESUME LATER



39% Complete



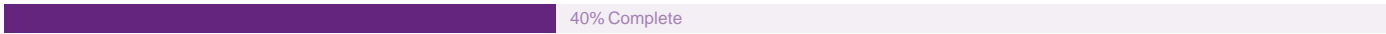
Powered by DatStat

28 ▶ **At what age did you stop smoking?**  
(TYPE age in the box)

years old






RESUME LATER



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29 ▶ At what age did you first have a standard drink of alcohol?  
(Mark *one only*)

		
<b>1</b>	<b>1</b>	<b>1</b>
100ml red wine 13% alc. vol	30ml / 1 nip spirit 40% alc. vol	375ml mid strength beer 3.5% alc. vol

- I have never drunk alcohol
- I started drinking alcohol at age



RESUME LATER



40% Complete



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30 ▶ **How often do you usually drink alcohol?**

*(Mark one only)*

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



RESUME LATER



41% Complete



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31 ▶ **On a day when you drink alcohol, how many standard drinks do you usually have?**  
(Mark *one only*)

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

32 ▶ **How often do you have five or more standard drinks of alcohol on one occasion?**  
(Mark *one only*)

- Never
- Less than once a month
- About once a month
- About once a week
- More than once a week



RESUME LATER



41% Complete



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**Remember that any information you give us is kept confidential**

The following questions ask about the use of drugs for non medicinal purposes

We want to know about general patterns of use

Please do not give details of specific instances of use (mark all that apply)



RESUME LATER



42% Complete



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33 ▶ **Have you tried Marijuana/Cannabis?** [-]

(pot, grass, weed, ya(r)ndi, rope, mull, dope, skunk, bhang, ganja, hash, chronic, reefer, joint, cone or spliff).

(Mark *all that apply*)

- In the last 12 months
- More than 12 months ago
- Never

34 ▶ **Have you tried any other illicit drugs?** [-]

(Ice, Speed, GHB, Amphetamines, LSD, Natural Hallucinogens, Tranquilisers, Ketamine, Cocaine, Ecstasy, Inhalants, Heroin or Barbiturates)

(Mark *all that apply*)

- In the last 12 months
- More than 12 months ago
- Never



RESUME LATER



43% Complete



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35 ▶ At what age did you first use Marijuana/Cannabis?

years old

36 ▶ At what age did you first use any other illicit drug?

years old



RESUME LATER



44% Complete



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37 ▶ **Thinking about the last 6 months, how frequently do you read the following information on food labels?**  
*(Mark one on each line)*

	Always	Often	Occasionally	Rarely	Never
Nutrition information/panel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Information on ingredients (eg ingredient lists, quantity of ingredients)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

38 ▶ **How many MEALS (including breakfast, lunch and dinner) do you usually eat in a typical day, including evenings?**  
*(Mark one only)*

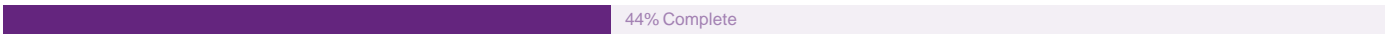
- None
- One
- Two
- Three
- Four
- Five

39 ▶ **How many SNACKS do you usually eat in a typical day, including evenings?**  
*(Mark one only)*

- None
- One
- Two
- Three
- Four
- Five



RESUME LATER



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40 ▶ **How many days per week do you usually have something to eat for breakfast?**

*(That is, not long after you get up in the morning)*

*(Mark one only)*

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7

41 ▶ **How many pieces of fresh fruit do you usually eat per day?**

*(Count 1/2 cup of diced fruit, berries or grapes as one piece)*

*(Mark one only)*

- I don't eat fruit
- Less than 1 piece of fruit per day
- 1 piece of fruit per day
- 2 pieces of fruit per day
- 3 pieces of fruit per day
- 4 or more pieces of fruit per day

42 ▶ **How many serves of vegetables do you usually eat each day?**

*(A serve = half a cup of cooked vegetables or a cup of salad vegetables)*

*(Mark one only)*

- None
- Less than one serve
- 1 serve
- 2 serves
- 3 serves
- 4 serves
- 5 serves or more



RESUME LATER



46% Complete



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43 ▶ **Do you EXCLUDE any of the following food groups from your diet?**

*(Mark all that apply)*

- Red meat (beef, lamb, pork)
- Fish
- Poultry
- Eggs
- Milk and milk products
- I do not exclude any of these food groups



RESUME LATER



47% Complete



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44 Over the last 12 months, on average, how often did you drink the following?

(Mark one on each line)

	Never	Less than once per month	1 to 3 times per month	1 time per week	2 times per week	3 to 4 times per week	5 to 6 times per week	1 time per day	2 times per day	3 or more times per day
Cola drinks - not diet (eg Coke™)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diet cola drinks (eg Diet Coke™)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other carbonated drinks - not diet (eg fizzy / soft drinks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other diet carbonated drinks (eg diet lemonade)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-carbonated cordials, fruit or sport drinks - not diet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-carbonated diet cordials, fruit or sport drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Milk or soya milk (including flavoured varieties)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fruit or vegetable juices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never	Less than once per month	1 to 3 times per month	1 time per week	2 times per week	3 to 4 times per week	5 to 6 times per week	1 time per day	2 times per day	3 or more times per day
Herbal tea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water (including soda or plain mineral water)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



RESUME LATER



48% Complete



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The next two questions are about the amount of physical activity you did LAST WEEK.

45 ▶ Please state **HOW MANY TIMES** you did each type of activity **LAST WEEK**.

Only count activities that lasted for 10 minutes or more.  
(If you did **not** do an activity, please type "0")

	Number of times
Walking briskly (for recreation or exercise, or to get from place to place)	<input type="text"/>
Moderate leisure activity (like social tennis, moderate exercise classes, recreational swimming, dancing)	<input type="text"/>
Vigorous leisure activity (that makes you breathe harder or puff and pant like aerobics, competitive sport, vigorous cycling, running, swimming)	<input type="text"/>
Vigorous household or garden chores (that make you breathe harder or puff and pant)	<input type="text"/>



RESUME LATER



51% Complete



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46 ▶ Please state the **TOTAL TIME** you spent altogether doing each type of activity **LAST WEEK**.

Add up all the times you spent in each activity to get the total time for each activity.

	Hours	Minutes
Walking briskly (for recreation or exercise, or to get from place to place)	<input type="text"/>	<input type="text"/>
Moderate leisure activity (like social tennis, moderate exercise classes, recreational swimming, dancing)	<input type="text"/>	<input type="text"/>
Vigorous leisure activity (that makes you breathe harder or puff and pant like aerobics, competitive sport, vigorous cycling, running, swimming)	<input type="text"/>	<input type="text"/>
Vigorous household or garden chores (that make you breathe harder or puff and pant)	<input type="text"/>	<input type="text"/>



RESUME LATER



54% Complete



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47 ▶ Have you ever had a partner or spouse?  
(Mark one only)

Yes	No
<input type="radio"/>	<input type="radio"/>



RESUME LATER



55% Complete



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**The following questions ask about difficult situations you may have experienced.**

Some people prefer not to answer questions of this nature.

If this is true for you, please go to the next question.

48 ▶ **This question asks about situations you may have experienced with current or past partners[?]**  
 (Mark as many as apply on each line)

<i>My partner:</i>	In the last 12 months	More than 12 months ago	Never
Told me that I was ugly, stupid or crazy, or that I wasn't good enough or that no one would ever want me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Followed me or harassed me around my neighbourhood / work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried to turn my family, friends or children against me or tried to convince them I was crazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kicked, bit, slapped or hit me with a fist or tried to hit me with something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forced me to take part in unwanted sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried to keep me from seeing or talking to my family, friends or children, or didn't want me to socialise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushed, grabbed, shoved, shook or threw me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blamed me for causing their violent behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harassed me over the telephone, email, Facebook or internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used a knife or gun or other weapon or beat me up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Became upset if dinner / housework wasn't done when they thought it should be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refused to let me work outside the home or took my wallet and left me stranded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



RESUME LATER



55% Complete



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The following questions ask about difficult situations you may have experienced.

Some people prefer not to answer questions of this nature.

If this is true for you, please go to the next question.

49 ▶ Have you ever been in a violent relationship with a partner / spouse?

(Mark *one only*)

- Yes
- No



RESUME LATER



59% Complete



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**The following questions ask about difficult situations you may have experienced.**

Some people prefer not to answer questions of this nature.

If this is true for you, please go to the next question.

50 ▶ **This question asks about situations that you may have experienced with people other than your current or past partners, including family members, friends, fellow students, work colleagues or strangers.**

*(Mark as many as apply on each line)*

<b>Someone not my partner:</b>	<b>In the last 12 months</b>	<b>More than 12 months ago</b>	<b>Never</b>
Told me that I was ugly, stupid or crazy, or that I wasn't good enough or that no one would ever want me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Followed me or harassed me around my neighbourhood / work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried to turn my family, friends or children against me or tried to convince them I was crazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kicked, bit, slapped or hit me with a fist or tried to hit me with something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forced me to take part in unwanted sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushed, grabbed, shoved, shook or threw me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blamed me for causing their violent behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harassed me over the telephone, email, Facebook or internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used a knife or gun or other weapon or beat me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refused to let me work outside the home or took my wallet and left me stranded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



RESUME LATER



60% Complete



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**If you feel distressed about any experiences of violence and abuse and would like some help to deal with this, please consider contacting one of the following:**

- 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 to talk to
- A Lifeline counsellor on 13 11 14 (local call)



RESUME LATER



63% Complete



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51 ▶

Mark *as many as apply on each line*

	Yes, in the last 12 months	Yes, more than 12 months ago	Never
Have you been feeling that life isn't worth living?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you deliberately hurt yourself or done anything that you knew might have harmed or even killed you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered yes to either of the last 2 questions, you might like to talk to someone about how you are feeling.**

**You could ring Lifeline on 13 11 14 (local call).**



RESUME LATER



64% Complete



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52 **In the past 4 weeks:**  
*(Mark one on each line)*

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
About how often did you feel tired out for no good reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
▪ About how often did you feel nervous?	▪ <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> ▪
About how often did you feel so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel so restless you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel that everything is an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you would like some help with any of the symptoms listed above, a link to MoodGYM, an interactive website, will be provided at the end of the survey.



RESUME LATER



65% Complete



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## Women's health is about coping with stress

53 ▶ Over the last 12 months, how stressed have you felt about the following areas of your life?  
(Mark one on each line)

	Not applicable	Not at all stressed	Somewhat stressed	Moderately stressed	Very stressed	Extremely stressed
Own health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health of family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work / employment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Living arrangements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Study	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship with parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship with partner / spouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship with other family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship with friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Motherhood / Children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



RESUME LATER



68% Complete



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## Women's health is about pregnancy

54 ▶ **Are you currently pregnant?**

*(Mark one only)*

- No
- Less than 3 months
- 3 to 6 months
- More than 6 months
- Don't know



RESUME LATER



71% Complete



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55 ▶ **How many times have you been pregnant?**  
(Please type "0" if you have never been pregnant)

times



RESUME LATER



72% Complete



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56 ▶ **How many times have you had each of the following pregnancy outcomes?**

*(Type the number. Please type "0" for any of these you have not experienced.) Twins count as 2.*

Live births	<input type="text"/>
Stillbirths	<input type="text"/>
Miscarriages	<input type="text"/>
Abortions or terminations (for personal reasons)	<input type="text"/>
Abortions or terminations (for medical reasons)	<input type="text"/>
Ectopic pregnancies (tubal pregnancies)	<input type="text"/>



RESUME LATER



73% Complete



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57 ▶ When did your live births occur?

	When (month)	When (year)	Weeks Pregnant	Did your baby receive any breast milk? (Tick if yes)
Live birth 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Live birth 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>



RESUME LATER



77% Complete



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58 ▶ This question is about breastfeeding:

	How many complete months was your baby breastfed?	Are you currently breastfeeding?
Live birth 1	<input type="text"/>	<input type="checkbox"/>
Live birth 2	<input type="text"/>	<input type="checkbox"/>



RESUME LATER



79% Complete



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59 ▶ When did your stillbirths (20 or more weeks pregnant) occur? Twins count as 2.

	When (month)	When (year)
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>

60 ▶ When did your miscarriages (before 20 weeks pregnant) occur?

	When (month)	When (year)
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>

61 ▶ When did your abortions / terminations (for personal reasons) occur?

	When (month)	When (year)
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>

62 ▶ When did your abortions / terminations (for medical reasons), not including ectopic pregnancy occur?

	When (month)	When (year)
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>

63 ▶ When did your ectopic pregnancies (tubal pregnancy) occur?

	When (month)	When (year)
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>



RESUME LATER



81% Complete



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64 ▶ **How tall are you without shoes?**  
*(If you are not sure, please estimate)*

cms

65 ▶ **How much do you weigh without clothes or shoes?**  
**If you are pregnant now, write in the weight you were in the month prior to pregnancy.**

*(If you are not sure, please estimate)*

▪  kgs



RESUME LATER



86% Complete



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## Women's health is about considering diversity

66 ▶ **Are you of Aboriginal or Torres Strait Islander origin?**

(Mark *all that apply*)

- No
- Aboriginal
- Torres Strait Islander

67 ▶ **In which country were you born?**

(Mark *one only*)

-- Select One --

68 ▶ **What is the highest level of education you have completed?**

(Mark *one only*)

- Year 10 or below
- Year 11 or equivalent
- Year 12 or equivalent
- Certificate I / II
- Certificate III / IV
- Advanced Diploma / Diploma
- Bachelor degree
- Graduate diploma / Graduate certificate
- Postgraduate degree

69 ▶ **Are you currently unemployed and actively seeking work?**

(Mark *one only*)

- No
- Yes, unemployed for less than 6 months
- Yes, unemployed for 6 months or more

Q67 response options:

Australia  
China  
Hong Kong  
India  
Indonesia  
Iraq  
Malaysia  
New Zealand  
Philippines  
Singapore  
South Africa  
South Korea  
United Kingdom  
United States of America  
Vietnam  
Other



RESUME LATER



87% Complete



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### Women's health is about juggling time

70 ▶ In a usual week, how many hours do you spend doing paid work?

Hours

71 ▶ In a usual week, how many hours do you spend studying?

Hours

72 ▶ In a usual week, how many hours do you spend doing work without pay?

Hours

73 ▶ How do you manage on the income you have available?

(Mark *one only*)

- It is impossible
- It is difficult all the time
- It is difficult some of the time
- It is not too bad
- It is easy

Q70-72 response options:

- 0
- 1 - 15
- 16 - 29
- 30 - 34
- 35 - 40
- 41 - 49
- 50 or more



RESUME LATER



88% Complete



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74 ▶ **Which of these most closely describes your sexual orientation?**

(Mark *one only*)

- I am exclusively heterosexual
- I am mainly heterosexual
- I am bisexual
- I am mainly homosexual (lesbian)
- I am exclusively homosexual (lesbian)
- I don't know
- I don't want to answer

75 ▶ **What is your current relationship status?**

(Mark the response that best suits your *current circumstances*)

- I am single
- I am in a relationship (not living together)
- I am living with a partner
- I am engaged
- I am married
- I am divorced
- I am separated
- I am widowed

76 ▶ **What are your living arrangements?**

(Mark *all that apply*)

- I live alone
- I live with one or both parents
- I live with other adults
- I live with my male partner
- I live with my female partner
- I live with children

77 ▶ **What is your residential postcode?**



RESUME LATER



90% Complete

78 ▶ **When you are 40, would you like to be in:**

(Mark *one only*)

- Full-time paid employment
- Part-time paid employment
- Full-time unpaid work in the home
- Self-employment / own business

79 ▶ **When you are 40, would you like to be:**

(Mark *one only*)

- Married
- In a stable relationship but not married
- Single (not in a stable relationship)

80 ▶ **When you are 40, would you like to have:**

(Mark *one only*)

- No children
- 1 child
- 2 children
- 3 or more children

81 ▶ **When you are 40, would you like to have more educational qualifications than you have now?**

(Mark *one only*)

- Yes
- No
- Not sure



RESUME LATER



92% Complete



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82 ▶ In a seven day week, on how many DAYS would you say you are AT WORK (paid or unpaid)?

Number of days

83 ▶ On average, on days when you are AT WORK (paid or unpaid), how many hours per day do you work?

Number of hours



RESUME LATER



93% Complete



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Now think about all of the time you spend sitting during EACH DAY while at home, at work, while getting from place to place or during your spare time.

84 Please estimate how much time you spent SITTING in each of the following activities on your last WORKING day and on your last NON-WORKING day (weekend day or day off).



	WORK DAY		NON-WORK DAY	
	hours	minutes	hours	minutes
For TRANSPORT (eg in car, bus, train etc)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
At WORK (eg sitting at a desk or using a computer)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Watching TV	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Using a computer at home (email, games, information, chatting)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other leisure activities (socializing, movies etc, but NOT including TV or computer use)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

85 What is your waist measurement?

*If you are pregnant now, write in your waist measurement for the month prior to your pregnancy. Please measure your waist while in your underwear. Find the top of your hip bone and the bottom of your ribs. Breathe out normally. Place the tape measure midway between these points and wrap it around your waist. Check your measurement. Write the measurement to the nearest centimetre.*

cm

86 Have we missed anything?

If you have anything else you would like to tell us, please type in the box below.

87 Did someone help you fill in this survey?

(Mark one only)

- No
- Yes, but I told them the answers I wanted
- Yes, but the helper answered for me using his / her own judgement



RESUME LATER



94% Complete



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88 ▶ **What was the MAIN reason for your needing help to fill in this survey?**  
*(Please describe)*



RESUME LATER



96% Complete



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### Help us keep in touch!

It would be helpful if you could give us details of a **relative or friend** who will be able to help us find you, after checking that the relative or friend is happy for you to provide these details.

▶What is their full name?

▶What is their relationship to you?

- Relative
- Friend
- Other (please specify)

▶What is their email address?

▶What is their phone number?

▶Building name / C\ instructions:

▶Unit / Street address:

▶Suburb:

▶State:

- ACT
- NSW
- NT
- QLD
- SA
- TAS
- VIC
- WA

▶Postcode:



RESUME LATER



98% Complete

# THANK YOU FOR TAKING PART IN THIS SURVEY

For more information on the Australian Logitudinal Study on Women's Health:

Visit the [MoodGYM website](#) for mental health information and coping strategies

**For a copy of the information statement that contains some important information regarding your participation, [click here](#).**

**To review the prize draw Terms and Conditions, [click here](#).**