L-Università ta' Malta
Centre for Molecular Medicine & Biobanking

DWARNA

StudjuDWARNA Participant Questionnaire

Assessment Date	Assessor	CODE (affix label below)

Section 1 – Demographics

1. Sex		
2. Year of birth		
3. Participant's Nationality		
4. Mother's Nationality		
5. Father's Nationality		
6. Domestic status	Single	☐
	Married	☐
	Other	☐ _____
7. Highest level of education	Primary school	☐
	Secondary school	☐
	6th Form	☐
	University/Technical	☐
	Post-graduate studies	☐
8. Town/Residence		
9. Occupation		

Section 2 – Lifestyle

10. Do you smoke tobacco regularly? (regular = 1 or more cigarettes/day for 6 months or longer)	Yes ☐	No ☐
11. At what age did you begin smoking regularly?		
12. On average, how many cigarettes per day do you smoke?	1 – 4	☐
	5 – 10	☐
	11 – 20	☐
	> 21	☐

13. Did your mother smoke when she was pregnant with you?	Yes ☐	No ☐	Don't know ☐
14. Did your father/mother smoke inside of the house when you were a child?	Yes ☐	No ☐	
15. Do you consume alcohol regularly? (regularly = up to 3 glasses per week over the past year)	Yes ☐	No ☐	
If yes, please specify the type of alcohol consumed:	Beer ☐		
	Wine ☐		
	Spirits ☐		
16. At what age did you start to consume alcohol regularly?			
17. Approximately how many glasses of alcohol per week did you consume over the past year?	1 – 3 ☐		
	4 – 7 ☐		
	8 – 14 ☐		
	> 15 ☐		
18. Do you/have you ever made use of the following substances?	Marijuana	Yes ☐	No ☐
	Heroin	Yes ☐	No ☐
	Cocaine	Yes ☐	No ☐
	Amphetamines	Yes ☐	No ☐
	Ecstasy	Yes ☐	No ☐
19. Do you exercise regularly?	Yes ☐	No ☐	
If yes, please specify the type of physical activity and the number of times per week that you perform this activity: _____			
	Less than once ☐		
	Once ☐		
	2 – 4 times ☐		
	5 or more times ☐		

Section 3 – Health

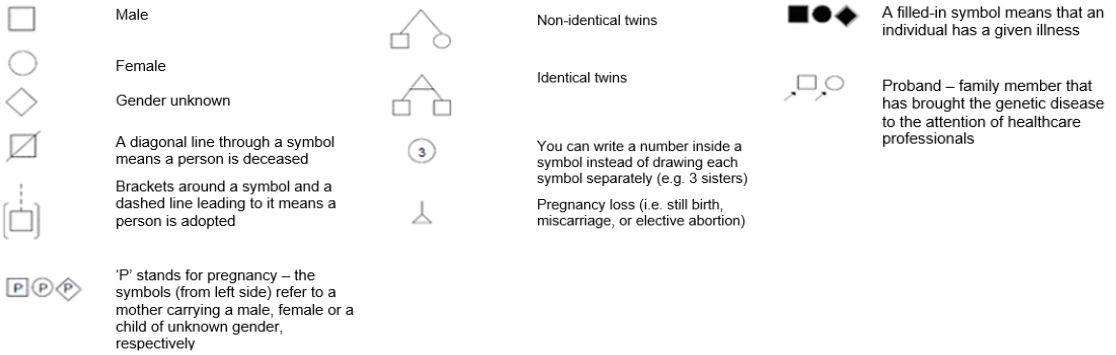
20. Do you suffer from any chronic medical condition?	Yes ☐	No ☐
Please specify below:		
a. Diabetes mellitus type 1	Yes ☐	No ☐
b. Diabetes mellitus type 2	Yes ☐	No ☐

c. Hypertension	Yes ☐	No ☐
d. Ischaemic heart disease/Coronary artery disease	Yes ☐	No ☐
e. Other circulatory disease (e.g. poor circulation in the legs, strokes, etc.)	Yes ☐	No ☐
f. Inflammatory bowel disease	Yes ☐	No ☐
g. Coeliac disease	Yes ☐	No ☐
h. Kidney disorders	Yes ☐	No ☐
i. Asthma	Yes ☐	No ☐
j. Eczema/Dermatitis	Yes ☐	No ☐
k. Psoriasis	Yes ☐	No ☐
l. Systemic lupus erythematosus, Rheumatoid arthritis	Yes ☐	No ☐
m. Haematological (blood) disorders	Yes ☐	No ☐
n. Neurological disease	Yes ☐	No ☐
o. Malignancy (Cancer)	Yes ☐	No ☐
p. Other If yes, please specify:	Yes ☐	No ☐
q. If you answered yes to any of the above, please specify: i. Age of onset ii. Relevant details		
21. Have you ever had surgery? If yes, please specify:	Yes ☐	No ☐
22. Were you unwell over the past 6 weeks? (e.g. fever, URTI, gastroenteritis, etc.) If yes, please specify:	Yes ☐	No ☐
23. Were you prescribed antibiotics over the past 6 weeks?	Yes ☐	No ☐
24. Were you administered any vaccinations over the past 6 weeks?	Yes ☐	No ☐

25. Family history:

To your knowledge, does anyone in your family have any specific disease?

If yes, please provide a pedigree using the following key:



26. Are you on regular treatment? Yes ☐ No ☐

If yes, specify drug, dose taken, and duration of treatment:

Section 4 – Physical Examination

27. Height (m)
28. Weight (kg)
29. Waist circumference (cm)
30. Hip circumference (cm)
31. Systolic blood pressure (mmHg)
32. Diastolic blood pressure (mmHg)