

# HEALTH & LIFESTYLE SURVEY OF YOUNG PEOPLE

## You and Your Home

1. Are you **Male** or **Female** ?  
(Please tick one box only)

Male

Female

2. How **old** are you ?  
(Please tick one box only)

11 years

12 years

13 years

14 years

15 years

3. What **school year** are you ?  
(Please tick one box only)

Year 7

Year 8

Year 9

Year 10

4. How many **brothers/sisters** have you who are **younger than you**?

(Please include step-brothers and step-sisters if living with you. Please write the numbers in the boxes)

5. How many **brothers /sisters** have you who are **older than you**?

(Please include step-brothers and step-sisters if living with you. Please write the numbers in the boxes)

6. What is your **postcode**?  
(Please write it in the box)

7. How many **times** have you moved home in the last two years  
(Please write how many times)

8. Do you help look after any of these people?  
(Please tick as many as apply)

No-one	<input type="checkbox"/>
Ill or disabled mother	<input type="checkbox"/>
Ill or disabled father	<input type="checkbox"/>
Ill or disabled brother or sister	<input type="checkbox"/>
Elderly grandparents	<input type="checkbox"/>
Someone else	<input type="checkbox"/>

9. How do you **usually** get to school?  
(Please tick one box)

by Car

by Bus

by Train

by Bike

by Walking

10. How do you **usually** get home  
from school?  
(Please tick one box)

by Car

by Bus

by Train

by Bike

by Walking

11. Is your home –  
(Please tick one box only)

Rented from the council	<input type="checkbox"/>
Rented from a private landlord	<input type="checkbox"/>
Rented from a housing association	<input type="checkbox"/>
Owned by your parents/being bought on a mortgage	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

12. Is your mother (female guardian) –  
(Please tick one box only)

In full time paid work	<input type="checkbox"/>
In part time paid work	<input type="checkbox"/>
At home looking after the family	<input type="checkbox"/>
Unemployed	<input type="checkbox"/>
Sick or disabled	<input type="checkbox"/>
A student	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

<b>13. Is your father (male guardian) –</b> <i>(Please tick one box only)</i>	In full time paid work	<input type="checkbox"/>
	In part time paid work	<input type="checkbox"/>
	At home looking after the family	<input type="checkbox"/>
	Unemployed	<input type="checkbox"/>
	Sick or disabled	<input type="checkbox"/>
	A student	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>

<b>14. To which of these ethnic groups do you belong?</b> <i>(Please tick one box only)</i>	White	<input type="checkbox"/>
	Mixed	<input type="checkbox"/>
	Asian or Asian British	<input type="checkbox"/>
	Black or Black British	<input type="checkbox"/>
	Chinese	<input type="checkbox"/>
	Other	<input type="checkbox"/>

**15. How many hours do you spend watching television on a normal school day?**

*(Please say how many hours in the box)*

**16. Do you have a television in your bedroom?** Yes  No

*(Please tick one box only)*

**17. Do you have access to a computer at home?** Yes  No

Do not include games consoles, e.g. Nintendo, Gameboys, etc.  
*(Please tick one box only)*

**18. Are you connected to the internet at home?** Yes  No

*(Please tick one box)*

**If yes**

**19. How many hours do you spend on the internet in a normal week?**

*(Please say how many hours in the box)*

**20. How many hours do you spend playing computer games in a normal week? – include Gameboys, etc.**

*(Please say how many hours in the box)*

<b>21. How much does it mean to you to do well at school?</b>	<b>A great deal</b>	<b>Quite a lot</b>	<b>A bit but not much</b>	<b>Very little</b>	<b>Not at all</b>
<i>(Please tick one box only)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**22. Do you want to leave school at 16?** Yes  No  Don't know

*(Please tick one box only)*

**23. Would you like to stay in education in the 6<sup>th</sup> form or in a college?** Yes  No  Don't know

*(Please tick one box only)*

**24. Some people think that these things are important about a job, how important are they to you ?**  
*(Please tick one box for each line)*

	<b>Very important</b>	<b>Not very important</b>	<b>Not at all important</b>
The job is secure with little danger of being fired or made redundant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The working hours are short, with lots of free time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The work involves using your brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The job is well paid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The work is important and feels worthwhile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**25. How much have you worried about the following in the last month?**

*(Please tick one box for each line)*

	<b>A great deal</b>	<b>Quite a lot</b>	<b>A bit but not much</b>	<b>Very little</b>	<b>Not at all</b>
Homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Tests/Exams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting a job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with your Boyfriend/girlfriend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being bullied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The way you look	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illegal drugs being available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puberty and growing up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**26. If you are worried or upset do any of the things listed help you feel better?**

*(Please tick one box for each line)*

Talking to friends	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Talking to your family	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Sport or Exercise	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Listening to music	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
An alcoholic drink	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Smoking tobacco	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Watching TV/Videos	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Spending time on your hobbies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Prayer/Meditation	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Eating	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Crying	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Sleeping	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Medication prescribed for you by a doctor	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Taking illegal drugs	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Playing computer games	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Spending time by yourself	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If there is something else not on this list that helps you, please write in what it is:

**27. How often do you normally take part in sports and activities?**

*(Please tick one box for each line)*

	<b>Never or Hardly ever</b>	<b>Once or twice a month</b>	<b>Weekly</b>	<b>Twice a week or more</b>
During school lessons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In an organised club (football team etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At a leisure centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At a swimming pool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the park, street, etc. (riding your bike, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. What are your 3 favourite sports/physical activities (Please name them and show how often you take part in them)				
	Never or Hardly ever	Once or twice a month	Weekly	Twice a week or more
a. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## You and Your Health

29. In the last month have you taken medicines for any of these problems? (Please tick <u>one</u> box for each line)	For asthma (pills, inhaler)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	For infections (antibiotics)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	For diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	For epilepsy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	For hay fever or allergies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	For eczema	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

30. In the last month have you taken any of these? (Please tick <u>one</u> box for each line)	Iron tablets	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Vitamin tablets	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Painkillers (for headaches, etc.)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Cold or flu cures	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Laxatives	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

31. When you run, do you 'wheeze' and have trouble breathing? (not just out of breath) (Please tick <u>one</u> box only)	Never <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Quite often <input type="checkbox"/>	Very often <input type="checkbox"/>
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32. Do you cough at night enough to disturb you? (Please tick <u>one</u> box only)	Never <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Quite often <input type="checkbox"/>	Very often <input type="checkbox"/>
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33. During the last year have you used or attended any of the following as a patient? (Please tick <u>one</u> box for each line)	An Accident and Emergency (Casualty) department	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	A Minor Injuries Unit	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	A hospital clinic (out-patient department)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	A hospital as a 'day' patient (where you had an operation/procedure but <u>did not stay overnight</u> )	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	A hospital as an 'in-patient' (where you did <u>stay overnight</u> )	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

34. During the past month apart from any hospital visits have you seen your family doctor (GP) about yourself for any reason? (Please tick <b>as many boxes</b> as apply)	No	<input type="checkbox"/>
	Yes - at your home	<input type="checkbox"/>
	Yes - in the doctor's surgery	<input type="checkbox"/>

35. When did you LAST visit your dentist? (Please tick <u>one</u> box only)	During the past 6 months	<input type="checkbox"/>
	Between 7 and 12 months ago	<input type="checkbox"/>
	Between 1 and 2 years ago	<input type="checkbox"/>
	More than 2 years ago	<input type="checkbox"/>
	Never	<input type="checkbox"/>
	Don't know	<input type="checkbox"/>

<b>36. The LAST TIME you visited your dentist, WHY did you go; was it because?</b> <i>(Please tick one box only)</i>	You went for a check up	<input type="checkbox"/>
	You were having trouble with your teeth or gums	<input type="checkbox"/>
	You had a note from school	<input type="checkbox"/>
	You can't remember	<input type="checkbox"/>
	You have never been to a dentist	<input type="checkbox"/>

<b>37. The LAST TIME you saw a dentist, was it?</b> <i>(Please tick one box only)</i>	At school	<input type="checkbox"/>
	In a Health Centre	<input type="checkbox"/>
	At the Dentist's surgery	<input type="checkbox"/>
	At a Dental Hospital	<input type="checkbox"/>

<b>38. Have you ever had gas to have a tooth out?</b> <i>(Please tick one box only)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
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<b>39. Have you ever worn a brace on your teeth?</b> <i>(Please tick one box only)</i>	Never worn a brace	<input type="checkbox"/>
	Waiting to have one fitted	<input type="checkbox"/>
	Yes wear one now	<input type="checkbox"/>
	Yes, completed the treatment	<input type="checkbox"/>
	Yes, but did not complete the treatment	<input type="checkbox"/>

<b>40. In general would you say your health is:</b> <i>(Please tick only one box only)</i>	Excellent <input type="checkbox"/>	V Good <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
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<b>41. Is there anything that you do in your day to day life that you think keeps <u>YOU</u> healthy?</b> <i>(Please tick one box only)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>If YES please write what it is that you do:</b>		

<b>42. Is there anything that you do in your day to day life that you think may make <u>YOU</u> unhealthy?</b> <i>(Please tick one box only)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>If YES please write (i) what it is that you do:</b>		
<b>and (ii), why do you think that you do it?</b>		

## Your Diet

43. How often do you eat the following : <i>(Please tick one box for each line)</i>	Every Day	3 or 4 times per week	1 or 2 times per week	Less than once a week	Never
Breakfast before coming to school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breakfast at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School dinners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A "packed lunch" from home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lunch bought outside school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

44. <b>Would you like to eat a healthier diet?</b>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't know	<input type="checkbox"/>
45. <b>Would you like to lose weight?</b>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't know	<input type="checkbox"/>
46. <b>Would you like to increase weight?</b>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't know	<input type="checkbox"/>

*(Please tick one box for each line)*

47. <b>Which bread do you eat most often ?</b> <i>(Please tick one box only)</i>	Wholemeal (eg. stoneground / granary)	<input type="checkbox"/>
	Brown (eg. Vitbe, Hovis)	<input type="checkbox"/>
	High Fibre White (eg. Champion, Mighty White)	<input type="checkbox"/>
	White	<input type="checkbox"/>
	Do not usually eat bread	<input type="checkbox"/>
	An alternative to bread (eg crispbread, rice cakes)	<input type="checkbox"/>
	Do not know	<input type="checkbox"/>

48. <b>Which do you usually spread on your bread ?</b> <i>(Please tick one box only)</i>	Butter	<input type="checkbox"/>
	Soft margarine (e.g. Flora)	<input type="checkbox"/>
	Neither	<input type="checkbox"/>

49. <b>Which type of milk (bottles or cartons, including UHT) do you use most often ?</b> <i>(Please tick one box only)</i>	Whole Milk	<input type="checkbox"/>
	Semi-skimmed (Half Fat)	<input type="checkbox"/>
	Skimmed	<input type="checkbox"/>
	Other	<input type="checkbox"/>
	None	<input type="checkbox"/>
	Do not know	<input type="checkbox"/>

50. <b>How many pieces of fruit did you eat yesterday (banana, apples, plums, etc)?</b> <i>(Please write number in the box)</i>	<input type="text"/>
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51. <b>How many portions of vegetables other than potatoes did you eat yesterday (peas, Sweetcorn, salad, cabbage, etc)?</b> <i>(Please write number in the box)</i>	<input type="text"/>
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52. <b>How many glasses of <u>real</u> fruit juice did you drink yesterday?</b> <i>(Please write number in the box)</i>	<input type="text"/>
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53. <b>How many glasses (or small cartons) of squash or fruit drink did you have yesterday?</b> <i>(Please write number in the box)</i>	<input type="text"/>
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## Alcohol, Tobacco and other Drugs

54. <b>Have you ever drunk alcohol?</b> <i>(Please tick one box only)</i>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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55. <b>How often do you normally have an alcoholic drink?</b> <i>(Please tick one box only)</i>	Every day	<input type="checkbox"/>
	4-6 days a week	<input type="checkbox"/>
	1-3 days a week	<input type="checkbox"/>
	1-3 days a month	<input type="checkbox"/>
	Less than once a month	<input type="checkbox"/>
	Never	<input type="checkbox"/>

**56. If you have had any alcoholic drinks in the last 7 days, please write how much of these drinks you have had.**  
*(Please write the amount you have drunk in each box)*

**Assume that one small can/bottle = half a pint**

Shandy (canned)	pints
Shandy (mixed)	pints
Ordinary beer or lager (e.g. Riding bitter, Heineken Lager etc.)	pints
Strong beer or lager (e.g. Stella Artois, Tennant Extra)	pints
Low alcohol beer or lager	pints
Ordinary Cider (e.g. Woodpecker, etc.)	pints
Strong Cider (e.g. Diamond White)	pints
Alcopops (eg Hooch, Two Dogs, etc) <b>or</b> pre-mixed spirits (Bacardi Breezer, Metz, Mule, Smirnoff Ice, V2 etc.)	bottles
Wine	glasses
Low alcohol wine	glasses
Spirits (Gin, Whisky, Vodka, Rum, etc.)	measures

**If there is any alcoholic drink you have drunk not mentioned in the list please write in below:**

	pints
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<b>57. Did you drink alcohol at any of these places during the last 7 days?</b> <i>(Please tick one box for each line)</i>	At home	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	At a disco, club or party	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	At a pub or bar	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	At a relation's home	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	At a friend's	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	In a restaurant	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	In a public place (e.g. street, park)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Somewhere else	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If somewhere else please write in where:					

**58. Have you ever asked somebody else to buy alcohol for you?** Yes  No   
*(Please tick one box only)*

**59. During the last 7 days, on how many days did you drink alcohol? (do not include cans of shandy)** *(Please write how many days in the box)*

**60. Have you bought any alcoholic drinks in the last 7 days?** Yes  No   
*(Please tick one box only)*

<b>61. If YES where did you buy the alcohol?</b> <i>(Please tick as many boxes as apply)</i>	I bought it in a supermarket	<input type="checkbox"/>
	I bought it in an off-licence	<input type="checkbox"/>
	I bought it in a pub or bar	<input type="checkbox"/>
	I bought it in a disco or club	<input type="checkbox"/>
	I bought it somewhere else	<input type="checkbox"/>
	I never buy alcohol	<input type="checkbox"/>

**62. Have you ever taken alcohol from home without permission?**  
*(Please tick one box only)* Yes  No

**63. Do you think that the amount of alcohol you usually drink could damage your health**  
*(Please tick one box only)*

<b>Do not drink alcohol</b>	<b>No</b>	<b>Possibly</b>	<b>Yes: it is likely</b>	<b>Don't know</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**64. Have you smoked any cigarettes during the last 7 days?**  
*(Please tick one box only)* Yes  No

**65. If YES, how many cigarettes have you smoked during the last 7 days?**  
*(Please write the total number of cigarettes smoked in the box)*

**66. Which statement describes you best?**  
*(Please tick one box only)*

I have never smoked at all, not even a puff	<input type="checkbox"/>
I have tried smoking once or twice	<input type="checkbox"/>
I used to smoke, but I don't now	<input type="checkbox"/>
I smoke occasionally	<input type="checkbox"/>
I smoke regularly	<input type="checkbox"/>

**67. Which statement describes you best?**  
*(Please tick one box only)*

I don't smoke now and I never will	<input type="checkbox"/>
I don't smoke now but I may when I am older	<input type="checkbox"/>
I smoke, but would like to give up	<input type="checkbox"/>
I smoke and don't want to give up	<input type="checkbox"/>

**68. If you have ever tried a cigarette, how old were you when you smoked your first cigarette?**  
*(Please write how old you were in the box)* Age =  Never smoked

**69. If you have never smoked please tick the 'never smoked' box**

**70. If you have ever smoked regularly, how old were you when you became a regular smoker?**  
*(Please write how old you were in the box)* Age =  Not regularly

**71. If you have never smoked ever or not regularly please tick the 'not regularly' box**

**72. Do any of these people smoke on most days ?**  
*(Please tick one box for each line)*

Mother	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Father	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
A brother	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
A sister	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
A grandparent	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Another close relation	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
A close friend	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>



# What do You know about other Drugs?

## 73. What do you know about these drugs ? (This list gives their real names and some street names)

(Please tick one box for each drug)

	Safe if properly used	Always unsafe	Don't Know
Amphetamines (eg speed, uppers, Billy, sulphate, whizz, crystal meth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anabolic steroids – for body building/strength (e.g. Deca)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis (eg grass, pot, marijuana, dope, blow, skunk, hash, puff, draw, ganja, spliff, joints, smoke, weed, Leb black, moroccan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (eg snow, coke, Charlie, C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack (eg rock, stone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy (E, MDMA, XTC, Mitsibishis/Mitzis, Rolexes, Doves, Beans Rolls, X)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin (eg H, junk, smack, skag, gear, Brown)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LSD (eg acid, tabs, trips, dots)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone (Linctus, Physeptone, meth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural Hallucinogens ( eg. magic mushrooms. shrooms)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poppers (eg liquid gold, rush)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Semeron (Sem)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents used as drugs (eg glue, gas refills, cleansing fluid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Synthetic Hallucinogens (eg. acid, angel dust, LSD, Trips)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temgesic (Tem, Reckitts, Ricketts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers (eg Downers, Barbiturates, Blues, Librium, Valium, Tamazepam, wobbly eggs, jellies, tranx)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other illegal drugs - Please say what

## 74. Has anyone offered or encouraged you to try any of the drugs listed below in the last three months?

(Please tick one box for each drug)

Amphetamines (eg speed, uppers, Billy, sulphate, whizz, crystal meth)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Anabolic steroids – for body building/strength (e.g. Deca)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Cannabis (eg grass, pot, marijuana, dope, blow, skunk, hash, puff, draw, ganja, spliff, joints, smoke, weed, Leb black, moroccan)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Cocaine (eg snow, coke, Charlie, C)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Crack (eg rock, stone)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Ecstasy (E, MDMA, XTC, Mitsibishis/Mitzis, Rolexes, Doves, Beans, Rolls, X)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Heroin (eg H, junk, smack, skag, gear, Brown)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
LSD (eg acid, tabs, trips, dots)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Methadone (Linctus, Physeptone, meth)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Natural Hallucinogens ( eg. magic mushrooms. shrooms)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Poppers (eg liquid gold, rush)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Semeron (Sem)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Solvents used as drugs (eg glue, gas refills, cleansing fluid)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Synthetic Hallucinogens (eg. acid, angel dust, LSD, Trips)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Temgesic (Tem, Reckitts, Ricketts)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Tranquilizers (eg Downers, Barbiturates, Blues, Librium, Valium, Tamazepam, wobbly eggs, jellies, tranx)	No <input type="checkbox"/>	Yes <input type="checkbox"/>

Other illegal drugs - Please say what

**75. Please say when, if ever, you have used any of the drugs listed below**

(Please tick one box for each drug)

	Never	In the last year	In the last 4 weeks
Amphetamines (eg speed, uppers, Billy, sulphate, whizz, crystal meth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anabolic steroids – for body building/strength (e.g. Deca)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis (eg grass, pot, marijuana, dope, blow, skunk, hash, puff, draw, ganja, spliff, joints, smoke, weed, Leb black, moroccan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (eg snow, coke, Charlie, C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack (eg rock, stone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy (E, MDMA, XTC, Mitsibishis/Mitzis, Rolexes, Doves, Beans, Rolls, X)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin (eg H, junk, smack, skag, gear, Brown)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LSD (eg acid, tabs, trips, dots)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone (Linctus, Physeptone, meth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural Hallucinogens ( eg. magic mushrooms. shrooms)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poppers (eg liquid gold, rush)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Semeron (Sem)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents used as drugs (eg glue, gas refills, cleansing fluid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Synthetic Hallucinogens (eg. acid, angel dust, LSD, Trips)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temgesic (Tem, Reckitts, Ricketts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers (eg Downers, Barbiturates, Blues, Librium, Valium, Tamazepam, wobbly eggs, jellies, tranx)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other illegal drugs - Please say what			

**76. Where would you go, or who would you ask for help or advice about any drug (including alcohol and tobacco)**

(Please write where or whom in the box)

## Sexual Health

**77. What risk do you think there is of getting HIV or Aids in the following situations in this country?**

(Please tick one box for each item)

	High risk	Low risk	No risk	Don't know
Donating (giving) blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receiving a blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharing needles for injecting drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharing a house, flat, workplace or school with someone who has HIV or Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kissing someone who has HIV or Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having sexual intercourse with someone who has HIV or Aids - <b>not</b> using a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having sexual intercourse with someone who has HIV or Aids - using a condom <b>correctly</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**78. If you wanted some help and advice on sexual health who would you ask?**  
*(Please tick as many boxes as apply)*

My parents	<input type="checkbox"/>
School teacher	<input type="checkbox"/>
Friends	<input type="checkbox"/>
Brothers, sisters, other close relations	<input type="checkbox"/>
Family Doctor	<input type="checkbox"/>
School nurse	<input type="checkbox"/>
Family Planning Clinic	<input type="checkbox"/>
Youth worker	<input type="checkbox"/>
Do not know	<input type="checkbox"/>
Do not want any advice	<input type="checkbox"/>

If there is someone else please write in below

**79. Do you know anything about sexually transmitted infections for example as chlamydia, HIV, Aids, etc?**  
*(Please tick one box only)*

Yes  No  Don't know

**80. If yes where did you get the information ?**  
*(Please tick as many boxes as apply)*

My parents	<input type="checkbox"/>
School teacher	<input type="checkbox"/>
Friends	<input type="checkbox"/>
Brothers, sisters, other close relations	<input type="checkbox"/>
Family Doctor	<input type="checkbox"/>
School nurse	<input type="checkbox"/>
Family Planning Clinic	<input type="checkbox"/>
Youth worker	<input type="checkbox"/>
Radio	<input type="checkbox"/>
TV	<input type="checkbox"/>
Books	<input type="checkbox"/>
Internet	<input type="checkbox"/>
Magazines/newspapers	<input type="checkbox"/>
Leaflets	<input type="checkbox"/>
Do not know	<input type="checkbox"/>

If there is someone/somewhere else please write in below

**81. What do you think is the best way to get information about contraception or sexual health?**  
*(Please tick one box only)*

Written information only (a leaflet or similar)	<input type="checkbox"/>
Talking to a health professional (school nurse, etc)	<input type="checkbox"/>
Talking to a relation or close friend	<input type="checkbox"/>
Talking to a teacher or youth worker	<input type="checkbox"/>
Talking to someone and having written information to take away	<input type="checkbox"/>

**82. Do you know where you can get condoms free?**  
*(Please tick one box only)*

Yes  No

**If YES - Please write where**

**83. At what age can you obtain condoms free?**  
*(Please write in at what age or tick 'Do not Know' box)*

Age =  Do not Know

84. Do you know where your local birth control (contraception/family planning) services are available ? (Please tick one box only) Yes  No   
If YES - Please write where

85. Do you know where your local birth control (contraception/family planning) services for young people are available locally ? (Please tick one box only) Yes  No   
If YES - Please write where

86. At what age can you use such a family planning clinic ? (Please write in at what age or tick 'Do not Know' box) Age =  Do not Know

**Is there anything else you would like to add to the answers you have already given?**

**Thank you very much for completing this questionnaire**